**AGENDA**

Welcome to Members of the Public and the Press

Apologies for Absence

1. **Items for Approval**

   1.1. Minutes of the Previous Board Meeting held on 5 February 2014
       **Lead Member:** BH *

   1.2. Cancer Strategy
       **Lead Member:** AMcM *

   1.3. Integration of Health & Social Care
       **Lead Member:** AMcM *

   1.4. Workforce Risk Assessment
       **Lead Member:** DF *

   1.5. Unscheduled Care
       **Lead Member:** MJ *

   1.6. Waiting Times Performance, Progress and Elective Capacity Investment
       **Lead Member:** JC *

   1.7. Financial Position to 28 February 2014
       **Lead Member:** SG *

   1.8. Corporate Objectives for 2014/15
       **Lead Member:** AMcM *

   1.9. Performance Management
       **Lead Member:** AMcM *

   1.10. Healthcare Associated Infection Update
       **Lead Member:** MJ *

   1.11. Review of the Standing Orders
       **Lead Member:** SG *

   1.12. South East Scotland Research Ethics Committees
       **Lead Member:** AKM *

   1.13. Audit & Risk Committee - Minutes of the Meeting held on 10 February 2014
       **Lead Member:** JB *

   1.14. Finance & Resources Committee - Minutes of the Meetings held on 22 January & 5 March 2014
       **Lead Member:** GW *

   1.15. Healthcare Governance Committee - Minutes of the Meeting held on 21 January 2014
       **Lead Member:** MB *

   1.16. Staff Governance Committee - Minutes of the Meeting held on 29 January 2014
       **Lead Member:** AJ *

   1.17. Strategic Planning Committee - Minutes of the Meetings held on 13 February 2014
       **Lead Member:** BH *

   1.18. Edinburgh Shadow Health & Social Care Partnership - Minutes of the Meeting held on 4 December 2013
       **Lead Member:** RH *

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

For further information please contact Peter Reith, ☏ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk
1.19. Midlothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 30 January 2014  
1.20. West Lothian Health & Care Partnership Sub-Committee - Minutes of the Meeting held on 6 February 2014  
1.21. West Lothian Health & Care Partnership Board - Minutes of the Meeting held on 28 January 2014  

2. Items for Discussion (subject to review of the items for approval)  
(9:45am - 12:00pm)  
2.1. Strategic Plan AMcM *  
2.2. Local Delivery Plan AMcM *  
2.3. Improving the Health and Well-Being of Lothian’s Children and Young People - The NHS Lothian Children and Young People’s Strategy 2014 - 2020 AMcM *  
2.4. Integrating Children's Services in Lothian AMcM *  
2.5. Local Access Policy JC *  
2.6. Quality Report DF/MJ *  
2.7. Financial Plan 2014/15 - 2018/19 SG *  
2.8. Property and Asset Management Investment Programme 2014/15 - 2018/19 SG *  
2.9. Staff Survey Results - Presentation from Alan Boyter AB p  

3. Next Development Session: Wednesday 7 May 2014 at 9:30 a.m. in the Boardroom, Waverley Gate.  
4. Next Board Meeting: Wednesday 25 June 2014 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 5 February 2014 BH ®  
7. Matters Arising  
8. Any Other Competent Business  

Board Meetings in 2014  
25 June 2014  
6 August 2014  
1 October 2014  
3 December 2014  

Development Sessions in 2014  
7 May 2014  
16 July 2013  
10 September 2014  
5 November 2014
<table>
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<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Due Date</th>
<th>Action Taken</th>
<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Medical Workforce Risk Assessment (26/06/13)</strong></td>
<td>AMcM</td>
<td>March 2014</td>
<td>Work under way. Staff and process agreed. Strategic Planning Committee established. Draft Plan is going to March Strategic Planning Committee and then to 2 April Board.</td>
<td>In Progress</td>
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<tr>
<td>• Strategic Plan to come to Board by March 2014.</td>
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<tr>
<td><strong>Renewing NHS Values (24/07/13)</strong></td>
<td>AMcM</td>
<td>TBC</td>
<td>The Associate Director of Workforce is leading on this process.</td>
<td>In Progress</td>
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<td>• Arrange engagement sessions for service teams.</td>
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<tr>
<td>• Development of the Implementation Plan to be included as a separate Board seminar.</td>
<td>AMcM</td>
<td>TBC</td>
<td>The Associate Director of Workforce is leading on this process.</td>
<td>In Progress</td>
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<td><strong>Little France Campus Redevelopment (24/07/13)</strong></td>
<td>SG</td>
<td>January 2014</td>
<td>Workshop held with Consort and Lenders advisors and template Supplemental Agreement now agreed.</td>
<td>Completed</td>
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<tr>
<td>• Continue dialogue with Consort and their lenders with an objective of achieving betterment for future Supplemental Agreement.</td>
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<td><strong>NHS Lothian Homeopathy Service</strong></td>
<td>AMcM</td>
<td>1 April 2014</td>
<td>Possible judicial review. As of 7 March no notice has been served.</td>
<td>In Progress</td>
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<tr>
<td>• Cease provision of an NHS Homeopathy Service in Lothian and cease NHS referral to the Glasgow Homeopathic Hospital from 1 April 2014.</td>
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<td><strong>Review of the Quality Report</strong></td>
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<tr>
<td>• Arrange training for Board members on the interpretation of data focusing on meaningful outcomes.</td>
<td>DF/ SJM</td>
<td>January 2014</td>
<td>Discussed at January 2014 Board Development Session.</td>
<td>Completed</td>
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<tr>
<td><strong>Quality Report (23/10/13)</strong></td>
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<td>• Provide Healthcare Governance Committee briefing on stroke to all Board members.</td>
<td>MJ</td>
<td>January 2014</td>
<td>Distributed on 13 January 2014.</td>
<td>Completed</td>
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<tr>
<td><strong>Scottish Public Services Ombudsman Case 201200092 (23/10/13)</strong></td>
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<td>• Report to a future Board meeting on how NHS Lothian now deals with complaints and demonstrate the benefits in terms of improved performance.</td>
<td>SRW</td>
<td>June 2014</td>
<td>A quarterly Customer Relations and Feedback Quality Report now goes to the Board that goes into detail about complaints, trends and actions. Feedback form the Short Life Working Group examining the future handling of complaints will be discussed at the Healthcare Governance Committee on 25 March and come to the next Board meeting thereafter (June).</td>
<td>In Progress</td>
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<td><strong>Winter Plan (23/10/13)</strong></td>
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<td>• A multidisciplinary approach to be taken to winter publicity distribution arrangements.</td>
<td>SRW</td>
<td>December 2013</td>
<td>The Scottish Government took the lead on this issue and NHS Lothian was fully joined into the 2013/2014 campaign, the materials associated with it and the necessary actions required to promote the campaign using all available communication channels. We had a very good</td>
<td>Completed</td>
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<td><strong>Unscheduled Care / Winter Plan (27/11/13)</strong></td>
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<td>• A written report to be submitted for future meetings.</td>
<td>MJ</td>
<td>February 2014 onwards</td>
<td>Written report will now be submitted routinely.</td>
<td>Completed</td>
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<td><strong>Medical Workforce Risk Assessment</strong></td>
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<td>• Further consideration is needed in a future paper around overall developments, staffing, culture &amp; values and their impact on individual areas including service redesign.</td>
<td>AB</td>
<td>June 2014</td>
<td>This work will be undertaken in the HR&amp;OD Strategy which will come to the Board in June 2014.</td>
<td>In Progress</td>
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<tr>
<td>• The development of Primary Care to feature in the February Board paper and would address issues around CHP engagement.</td>
<td>NMcA</td>
<td>April 2014</td>
<td>A separate paper is being taken to the April Board outlining the workforce challenges within CHP health visiting workforces. Further work is being undertaken to review district nursing workforce planning across CHPs and will be detailed in a future Board paper.</td>
<td>Complete</td>
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<td><strong>Waiting Times Performance, Progress &amp; Elective Capacity Investment</strong></td>
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<td>• Further work needs to be undertaken around Psychological Therapies. A progress report to be made to the February Board meeting.</td>
<td>JF</td>
<td>April 2014</td>
<td>A fuller analysis being undertaken and update to the April Board meeting.</td>
<td>In Progress</td>
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<td><strong>2014/15 Corporate Objectives (05/02/14)</strong></td>
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<tr>
<td>• A paper to be produced for the April Board.</td>
<td>AMcM</td>
<td>April 2014</td>
<td>Draft 2014/15 objectives will be taken to the April Board.</td>
<td>April Board</td>
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<tr>
<td><strong>Waiting Times Performance, Progress &amp; Elective Capacity Investment (05/02/2014)</strong></td>
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<td>• Invite the Director of West Lothian Community Health and Care</td>
<td>JC</td>
<td>April</td>
<td>Director will attend April Board</td>
<td>In Progress</td>
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<td>Action Required</td>
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<td>Partnership and Clinical Leads to a future meeting to explain the provision</td>
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<td>2014</td>
<td>meeting to update.</td>
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<td>of Mental Health Services across sites and specialties focusing on the longest</td>
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<td>waiters.</td>
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<td>Scheduled Care Access Policy (05/02/2014)</td>
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<td>• The Board to receive an update report at its next meeting.</td>
<td>JC</td>
<td>April</td>
<td>Revised Access Policy will be discussed at April Board</td>
<td>In Progress</td>
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<td>Quality Report (05/02/2014)</td>
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<td>2014</td>
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<td>• The paper to the next Board to provide details about what patients were</td>
<td>DF/AB</td>
<td>April</td>
<td>The Quality Paper for April states that Patient</td>
<td>In Progress</td>
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<td>complaining about &amp; the next steps being taken to make progress against the</td>
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<td>2014</td>
<td>Experiences will be reported through the Lanarkshire</td>
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<td>target response time.</td>
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<td>Review paper in June. Complaints should be a separate</td>
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<td>Financial Position to 31 December 2013 (05/02/2014)</td>
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<tr>
<td>• Finances / LRP to be discussed at a future development session.</td>
<td>SG</td>
<td>November</td>
<td>On 5 November development agenda.</td>
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<td>Integration Process &amp; Milestones (05/02/2014)</td>
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<td>• The four draft integration plans would be submitted to the Board in December.</td>
<td>AMcM</td>
<td>December</td>
<td>A paper on the work plan and process for 2014/15 will</td>
<td>April Board</td>
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<td>2014</td>
<td>be taken to the April Board. Session on 17 April for</td>
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<td>Chairs of Shadow Boards and Joint Directors and others</td>
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<td>on delegation of functions.</td>
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<td>Staff Survey (05/02/14)</td>
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<tr>
<td>• Present the outcomes of the staff survey to a future Board meeting.</td>
<td>AB</td>
<td>April</td>
<td>On April Board agenda.</td>
<td>In Progress</td>
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Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 5 February 2014 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Executive and Corporate Directors: Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Mr J Crombie (Director of Scheduled Care); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Ms M Johnson (Director of Unscheduled Care and Executive Nurse Director); Professor A K McCallum (Director of Public Health and Health Policy) and Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information).

Non-Executive Directors: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mr J Brettell; Dr M Bryce; Councillor D Grant; Councillor R Henderson; Mrs J McDowell; Mrs A Meiklejohn; Councillor F Toner; Mr G Warner; Dr R Williams and Mr R Wilson.

In Attendance: Dr A Bennett (Consultant in ENT Medicine, shadowing Dr Farquharson), Mr P Gabbitas (Director of Edinburgh Health and Social Care Partnership), Professor E Ireland (Chair NHS National Services Scotland, shadowing the Chairman), Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications and Public Affairs).

Apologies for absence were received from Mrs K Blair, Professor J Iredale, Mr P Johnston, Councillor C Johnstone, Mr A Joyce, Mrs A Mitchell 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.

116. Welcome to Members of the Public and Press

116.1 The Chairman welcomed members of the public and press. He also welcomed Professor E Ireland, Chair, NSS Scotland who was shadowing him and Dr Bennett, Consultant in ENT Medicine who was shadowing Dr Farquharson. He also welcomed Ms N Lansley, School Nurse, Midlothian and Ms S Brown, Respiratory Facilitator, West Lothian who were the only 2 nurses in Scotland on the Nurse First Programme.

117. Chairman’s Opening Remarks

117.1 The Chairman commented it had been over two months since the last Board meeting and this in part explained the volume on the agenda. He reported further
changes had been made to the nature of the Board process and in the interest of more intensive debate attendance around the Board table had been restricted to the statutory attendees and those charged with decision making responsibility. He stressed this did not divest the impact or contribution from others. The Chairman advised the process would be kept under review and refined if necessary.

117.2 The Chairman advised it was with sadness he had to report on the death of Mr Harry Purser, Associate Director of Information Services. Mr Purser’s funeral would be held on 8 February 2014 in the Pentland Chapel, Mortonhall Crematorium at 11.30am. The Chairman commented he was aware those who had known Mr Purser felt he was a respected and revered colleague who was held in high affection. It was noted the Chairman and Chief Executive had conveyed their condolences to Mr Purser’s wife and family.

118. Items for Approval

118.1 The Chairman commented the agenda for the current meeting had been circulated to Board members to scrutinise the papers and to advise whether any items should move from the approval to the discussion section of the agenda. It was noted a request had been made for the paper at item 1.2 (Workforce Risk Assessment) to be moved to the discussion section. The Board agreed this request.

118.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the for approval papers without further discussion.

118.3 Minutes of the Previous Board Meeting held on 27 November 2013 – Approved subject to deleting Mr G Warner from the list of those attending.

118.4 Performance Management – The Board: -

118.5 Received the update on the current performance against those HEAT targets and standards the Board had agreed to receive in the performance paper as set out in appendix 1.

118.6 Noted that work to produce the Local Delivery Plan (LDP) for 2014/15 was underway. The LDP was the delivery contract between the Scottish Government and NHS Boards in Scotland, and set out how Boards would meet HEAT targets and other national priorities.

118.7 It was noted that draft plans were to be submitted to the Scottish Government by 14 February 2014, with final plans submitted by 14 March 2014.

118.8 Healthcare Associated Infection Update – The Board: -

118.9 Acknowledged receipt of the HAI reporting template for December 2014.

118.10 Noted the NHS Lothian staphylococcus aureus bacteraemia target by March 2015 was to achieve a rate of 0.24 per 1000 bed days. The current rate was 0.31. NHS
Lothian was currently off trajectory as the projected rate for December 2013 was 0.27 and multidisciplinary effort was needed if the target was to be achieved.

118.11 Supported staff to improve the clinical management of invasive devices in accordance with NHS Lothian and Patient Safety Standards.

118.12 Noted the NHS Lothian clostridium difficile infection target by March 2015 was to achieve a rate of 0.32 per 1000 days. The current target was 0.55. NHS Lothian was currently off trajectory as the projected rate for December 2013 was 0.38. A multidisciplinary effort was essential if the target was to be delivered.

118.13 Supported the antimicrobial team activities in relation to the antimicrobial prescribing review and reduction of antimicrobial associated with clostridium difficile.

118.14 Encouraged General Practitioners to share information associated with investigations of community health associated clostridium difficile.

118.15 Corporate Risk Register – The Board: -

118.16 Agreed the current updated NHS Lothian Corporate Risk Register, highlights of which were contained in section 3.2 and summarised in appendix 1.

118.17 Noted the draft risk appetite and the further work being undertaken by the Audit and Risk Committee.

118.18 Corporate Objectives – The Board: -

118.19 Noted progress towards NHS Lothian Corporate Objectives for 2013/14.

118.20 Noted that the Corporate Objectives were aligned to the 6 key aims of the current Clinical Strategy Framework and the 2020 Vision route Map as well as the content of the Local Delivery Plan.

118.21 Noted that of the 74 actions within the corporate objectives the system was reporting a position of ‘green’ for 54 and ‘red’ for 20 in the latest quarter. This was against the last quarter position reported to the Board in November 2013 of 58 being reported at green and red for 16.

118.22 Noted that those actions that had moved from green to red were preparing NHS Lothian to deliver high impact interventions that would support the delivery of the acute Scottish Patients Safety Programme outcome measures to reduce mortality by 20% and achieve 95% harm free care by the end of 2015. As well as ‘ensuring the current safe care patient safety programme measures are met and reported’ ‘deliver faster access to mental health services for CAMHS and psychological therapies as well as’ ‘further reduce healthcare associated infections’ and the current performance related to 95% of patients being seen within 4 hours.

118.23 It was noted for the 2014/15 corporate objectives propositions would be brought forward to the April Board. These would be set against the strategic plan and the 2014/15 LDP which would also be presented at the April Board. In doing so an
attempt would be made to reduce the overall number of actions but there would be a requirement to ensure those agreed were better articulated in terms of measurability.

118.24 Health and Social Care Integration in East Lothian – Update on Shadow Board Arrangements – The Board noted the developments in the East Lothian Shadow Board arrangements.

118.25 Committee Memberships – The Board agreed to appoint Dr Andreas Kelch to West Lothian Community Health & Care Partnership Sub-committee, replacing Dr Annabel Ross.

118.26 Audit & Risk Committee – Minutes of the meeting held on 9 December 2013 – Adopted.

118.27 Finance & Resource Committee – Minutes of the meeting held on 18 December 2013 – Adopted.

118.28 Healthcare Governance Committee – Minutes of the meeting held on 3 December 2013 – Adopted.

118.29 Strategic Planning Committee – Minutes of the meetings held on 29 November, 13 December 2013 and 9 January 2014 – Adopted.

118.30 East Lothian Community Health Partnership Sub-committee – Minutes of the meetings held on 31 October and 19 December 2013 – Adopted.

118.31 Edinburgh Shadow Health and Care Partnership Sub-committee – Minutes of the meeting held on 20 December 2013 – Adopted.

118.32 Midlothian Community Health Partnership Sub-committee – Minutes of the meeting held on 28 November 2013 – Adopted.

118.33 West Lothian Community Health and Care Partnership Sub-committee – Minutes of the meeting held on 26 November 2013 – Adopted.

**Items for Discussion**

119. **Workforce Risk Assessment**

119.1 As previously agreed the Board discussed the Workforce Risk Assessment paper which had been moved from the consent agenda.

119.2 The Medical Director advised the Workforce paper had changed from previous versions as it now looked at wider workforce issues and was not just confined to medical aspects. The paper included nursing and a skill risk review and focussed on priority areas to be looked at in further detail. In addition pressures around radiotherapy and medical physics were discussed.
The Board noted obstetrics and gynaecology posts would be re-advertised in the summer at which point a number of current trainees would be eligible to apply for posts in obstetrics. Recruitment to gynaecology posts had been more successful. The Medical Director suggested in future there might be merit in adopting a more generic approach with fewer specialist posts.

The Medical Director reported maternity leave issues at St Johns Hospital needed to be addressed with the review group looking at a pan Lothian approach.

The Board were advised in respect of paediatrics there was a deficit of 1 consultant at St Johns Hospital with the position in respect of neonatology being positive. The Medical Director commented the next challenge would be recruiting to paediatric nurse specialist posts. It was noted that the Myanmar recruits continued to undergo induction and training with it being expected it would be May 2014 or beyond before they could contribute to the out of hours rota.

The position in respect of radiotherapy was showing an increase in demand because of demographics, activity increases from the North of Scotland and workforce issues. It was noted the opening of the West of Scotland Satellite Cancer Unit which would be recruiting new staff in 2014 represented a risk for Lothian. A need for a National Clinical Training Programme had been identified in order to ensure a sufficient number of posts to meet future challenges.

Dr Williams commented it would be important the paper to the next Board meeting covering primary care included Health Visitors as there were challenges in recruiting to these posts. The Director of Unscheduled Care and Executive Nurse Director confirmed this would be the position advising changes to the provision of Children's Services would be considered. She advised there had been additional posts recruited to in order to build local capacity. She stressed vacancies were not being held and the issue related solely to challenges around recruitment.

The Medical Director in response to Councillor Toner advised the paediatric rota for February was in place although a relatively a small number of people were covering it. It was anticipated the position would improve once winter had passed. The Director of Human Resources and Organisational Development advised he and the Medical Director had met staff and it appeared the biggest pinch point on the rota was around Easter and this was being worked on.

Mrs Meiklejohn commented whilst she understood the focus on nursing and medical workforce issues she felt there was a need to look at patient pathways and how the rest of the workforce could be used to deliver less traditional models to reduce pressures. The Director of Unscheduled Care and Executive Nurse Director advised this was currently under consideration particularly in respect of the role of Allied Health Professionals.

The Board agreed the recommendations contained in the circulated paper.
120. Unscheduled Care

120.1 The Director of Unscheduled Care and Executive Nurse Director reminded the Board the 4 hour access target was 95% with Lothian having achieved 92% in December; 90% in January and 93% to date in February. She advised in comparison to the previous year the position was improving although not quickly enough. It was noted there was significant variance in performance across sites with particular challenges around the Western General Hospital with the model of care being re-visited. In respect of the Western General Hospital helpful input had been received from the Scottish Government with the outputs being reported back to a future meeting of the Board as current resources did not match activity. The Board were updated on other workstreams that were underway across all sites.

120.2 The Board noted there had been some elective deferrals across specialties and this was a position that could not be sustained with there being work in progress around the elective programme. The Delayed Discharge position remained static with focussed work continuing in the City of Edinburgh with East Lothian also adopting a similar approach. It was noted homecare capacity was rising and there had been an increase of 32 step-down beds with another 20 due to come on stream. The Board noted the Care Inspectorate had imposed restrictions on a number of nursing homes and this was having an impact on bed numbers.

120.3 The Director of Unscheduled Care and Executive Nurse Director reported the Lothian Unscheduled Care Action Plan continued to be worked on and would be discussed at the forthcoming Strategic Planning Committee and thereafter at the Board. It was anticipated this would improve the pan Lothian patient flow.

120.4 The Chief Executive commented there was a need for a strategic response to unscheduled care and the strategic plan due to be submitted to the April Board would start to address this. It was noted there were significant strategic thoughts around redesigning the model of care for older people through the balance of hospital and community facilities. In addition work was underway to increase the out of hours provision and 7 day working as well as replacing outdated facilities with modern purpose built replacements with the process being led by the Shadow Health and Social Care Partnerships. The Chief Executive advised as previously alluded to there was a need to change the model of care at the Western General Hospital which currently operated on a hybrid model with an acute receiving unit with no accident and emergency department although 4 hour access targets were measured as if an accident and emergency was in place and this was not appropriate. The Chief Executive commented the January position was improving and moving forward a sticking plaster approach would not suffice and the position needed to be looked at strategically.

120.5 The Director of Unscheduled Care and Executive Nurse Director reported despite continuing pressure on unscheduled care the stroke position was improving with discussion ongoing about the future provision of stroke services in Edinburgh which would be reported back to the Board in due course.

120.6 The Board were advised the opening of the 31 additional beds at the Royal Infirmary of Edinburgh was on track and this would initially help with winter
capacity. The future use of those beds across specialties would be developed through the clinical strategy.

120.7 Dr Bryce commended the improved stroke performance and upward trajectory. She advised that the stoke alliance reported 80% of strokes were preventable by working with primary care to influence lifestyle factors and she suggested therefore there was a need for an active prevention programme. The Director of Public Health and Health Policy commented this approach was more cost effective than treatment but less cost effective than upstream intervention like tackling the cause of obesity, smoking and reducing alcohol consumption. It was noted comprehensive stroke registers were in place and the treatment of hypertension was now more successful than previously had been the case. It was noted there was evidence the primary care Quality and Outcomes Framework had made a significant impact with there being no socio economic gradient in terms of people seeing GPs.

120.8 The Director of Public Health and Health Policy commented there was a need for continued multiagency work to reduce the burden of ill health and subsequent care through people attending unscheduled care services because of violence and injuries.

120.9 The Board noted the recommendations in the circulated paper and took assurance from the work currently in progress.

121. Waiting Times Performance, Progress and Elective Capacity Investment

121.1 The Director of Scheduled Care advised the paper followed the recognised format. He reported performance against the 18 week referral to treatment (RTT) target had dipped to 84% and it needed to be at 90%. It was noted 31 day cancer performance remained positive with issues around 60 day performance having been characterised and subjected to the focus of the Access Performance Team the function of which was explained to the Board.

121.2 The Board noted during December a total of 448 patients had waited beyond the Time Treatment Guarantee TTG at the month end with the vast majority of these having now been treated. It was noted the December position had largely been predicated by the loss of independent capacity support from 15 December onward. In addition the impact of winter had led to some elective cancellations.

121.3 The Director of Scheduled Care commented in respect of inpatient and day case unavailability Lothian was under reporting the position and it would be important moving forward to more robustly use unavailability when patients genuinely met the criteria. The Board noted the outpatient position had decreased in December to 4039 and this calibrated well against the national position and represented 1.6% unavailability.

121.4 The Board noted the surveillance endoscopy position was anticipated to continue to improve with 591 patients having waited beyond the review date, having reduced from 2118 in April. It was anticipated the endoscopy position would be in balance.
by the end of the financial year. Performance remained good around audiology and IVF targets.

121.5 The Director of Scheduled Care advised work continued with the Director of West Lothian Community Health and Care Partnership around Psychological Therapies and Child and Adolescent Mental Health Services (CAMHS) where performance against the 26 week target had worsened during December. It was noted support had been provided by the QUEST (Quality and Efficiency Support Team) A12 Team with a focus on administration of lists in order to ensure people were appropriately accessing the service.

121.6 The Chief Executive commented since taking up post the Director of Scheduled Care had been engaged with staff and Trade Unions around how to rationalise leadership in scheduled care and this had followed the unscheduled care model of a narrower span of control and flattening the reporting structure resulting in the introduction of a new management and clinical structure including the recruitment of managers from outwith Lothian. It was anticipated this higher visibility would have a positive impact on performance. The Chairman commented the detailed outcomes of the Access Performance Group should be reported to the Board through the Director of Scheduled Care’s routine paper in order that improvement expectations could be known and measured.

121.7 Dr Bryce commented in respect of CAMHS and Psychological Therapies whilst she recognised the gap between demand and resources she questioned whether any communications were going out to the target group to check patient experience. The Director of Scheduled Care advised the whole process of review would include patient groups and steps to improve access would be explored. This was also an area where the input of the QUEST A12 Team had been beneficial.

121.8 Dr Williams noted 8 additional therapists posts were anticipated to be recruited to by the end of January 2014 and questioned whether this had happened. He also questioned given the difficulties why posts were being recruited to short term fixed contracts. The Director of Scheduled Care advised the immediate response had been to reduce the backlog and also to appoint to short term fixed contracts to retain flexibility around the redesign of the service.

121.9 Councillor Toner questioned the reasons for the increased demand for Psychological Therapies and CAMHS and asked whether this represented a short or long term position and whether the recruitment of staff to fixed term posts was a sufficient response. The Director of Scheduled Care commented he was not yet in a position to understand the dynamics although the phenomenon was a UK wide one. The use of fixed term contracts as previously explained allowed the number of patients waiting to be reduced as well as allowing a sustainable solution to be provided moving forward. The Director of Strategic Planning, Performance Reporting and Information commented whilst the increase in referrals could be viewed as positive work was underway to ensure these referrals were appropriate and could not be treated elsewhere more effectively.

121.10 Councillor Toner commented he would welcome work to understand the reason for the increase in referrals and stressed the need to engage with other partners to improve on the current position. The Director of Scheduled Care advised the
QUEST A12 Team would capture this level of detail with there being significant management scrutiny to ensure this area received the same level of attention as other targets. This work would form a key element of understanding the demand profiles. The Director of Public Health and Health Policy advised the Board the work described represented the first part of a 3 part process the details of which The Director of Scheduled Care explained to the Board.

121.11 The Vice Chair agreed with Dr Bryce about the need to capture the patient experience particularly in respect of the reasons why people were unable to attend for appointments and also the impact on people on waiting lists not covered by the waiting time guarantee. The Director of Scheduled Care advised the Performance Review Group had asked for detailed information around waits not reported under the targets in order to understand the dynamics as it was not the intention to create a two tier system.

121.12 Mrs Meiklejohn commented within Mental Health Services teams were good at being creative and delivering different models of care and this should be encouraged elsewhere. The Chief Executive suggested for a future meeting it would be appropriate to invite the Director of West Lothian Community Health and Care Partnership and clinical leads to attend and spend some time explaining to the Board the services provided across sites and specialties focussing on the longest waiters. It was noted in the current year non recurrent investment had been made into Mental Health Services and this aligned to the fact the psychology recruitment market was buoyant provided an opportunity to remodel the service. The Director of Scheduled Care would arrange.

121.13 The Board noted the Director of Scheduled Care ensured there was a robust interaction between unscheduled care and scheduled care in order to ensure patients in the most urgent need received treatment although this was an ongoing challenge.

121.14 The Board noted and agreed the recommendations contained in the circulated paper.

122. Delivering for Patients

122.1 The Director of Scheduled Care advised the circulated paper represented a plan to move to access time recovery and ensure it was sustained. He acknowledged currently NHS Lothian was not delivering on targets and it was therefore useful to start the recovery journey at that point. He advised he was keen not to just focus on the mechanics of recovery but also the strategy to produce safe and deliverable care for patients. The Board were reminded the treatment time guarantee was enshrined in statute.

122.2 The Director of Scheduled Care advised the recovery programme would be supported by the provision of robust data and strong management focus. He commended the support provided by the late Mr Purser in producing the Board paper and the fact he had recognised the requirement and had responded rapidly.
122.3 The Director of Scheduled Care reported the paper was not proposing delivery at any cost but delivery with full compliance of regulations and in an open and transparent manner. He commented the business of sustained recovery would be achieved using a scientific approach characterised by a deep dive methodology being adopted to provide trajectory data to identify where issues lay.

122.4 The Board noted when scrutiny happened of each of the component parts of the headline indicators it allowed a more accurate picture to be formed about what was needed in respect of capacity requirements and the identification and understanding of areas of shortfall. The Director of Scheduled Care advised this approach had been used in a number of specialties and from the Board paper he provided a detailed explanation of the issues identified from this benchmarking approach. He commented in particular on issues around ophthalmology advising there was an enthusiasm and desire amongst clinicians for change and this needed to be supported by training.

122.5 The Director of Scheduled Care commented the paper also demonstrated how recovery would be monitored with a recovery profile in place. He commented sustaining compliance around the 12 week treatment time guarantee (TTG) and outpatients would be potentially vulnerable due to impacts from unscheduled care, capacity issues and the risk of the sudden loss of parts of the clinical workforce. He advised he would in all likelihood propose changes to the internal stage of treatment targets later in 2014/15 to mitigate against this.

122.6 The Board noted the recovery performance brought a significant burden to the financial plan and part of the LRP programme moving forward would need to provide revenue to support the process. It was recognised moving forward there would be a need for focused and effective use of resources.

122.7 The Director of Scheduled Care stressed the need for capital availability to invest in the infrastructure. In 2014/15 non recurrent resources would be utilised to take forward the proposals detailed in the paper i.e. the reprovisioning of the Eye Pavilion and Lauriston Campus, increasing theatre capacity and instrumentation amongst others. In future it would be important to develop an ambulatory care diagnostic model as the service default position.

122.8 The Board noted there remained a commitment on an ongoing basis to use the Golden Jubilee Hospital in Clydebank and to work to develop regional solutions. As previously stated the efficient use of resources would be key to using the existing asset base better.

122.9 The Director of Scheduled Care advised the Board the strategy set out the timescale for achieving:

- No eligible patient would be waiting beyond the TTG at the end of December 2014.

- On 31 March 2015, no patient covered by the Outpatient Standard would be waiting over 12 weeks.
122.10 The Director of Scheduled Care advised he was working with colleagues from the Scottish Government Health and Social Care Directorate who were keen to reduce the time taken to reach recovery. He felt at this point in time this could only be achieved by increased use of the independent sector and reducing the time patients had to disengage from an offer of treatment.

122.11 The Chairman commented success in this area was fundamentally important. He felt it was vastly encouraging a better process was now in place for monitoring and managing the process of implementation detailed in the recovery plans. The Chairman advised the paper was put forward for noting as a subset of the strategic plan and had been submitted to the Health and Social Care Directorate. He felt rather than merely noting the paper it would be important the Board supported and endorsed the work of the Director of Scheduled Care and his team.

122.12 The Director of Public Health and Health Policy welcomed the paper commenting on the need for further work around urology, the incontinence service and the Edinburgh Dental Institute. She stressed the need for the socio economic gradient in treatment to reflect the gradient in need in line with the rest of the population.

122.13 Dr Bryce welcomed the fact the recovery proposals were underpinned by insightful analysis. She commented the timescales around sustainability would require organisational drive.

122.14 Mrs McDowell welcomed the reassuring work and questioned given the complexity of issues and difficulties in making improvements whether it would be prudent to include a contingency in the financial plan. She commented in respect of the application of unavailability whilst she accepted the need to comply the chart in the paper only provided data for 1 month making it difficult to identify whether performance was out of line with expectations. The Director of Scheduled Care assured the Board this issue was looked at over time and could be evidenced.

122.15 Dr Williams commented he felt the paper was excellent and he supported it with the exception of the proposal to reduce the current 14 day turnaround time on patient communications down to 7 days which he felt would be unacceptable to GPs as it was wrong, unjust and unfair. Dr Williams felt the current 14 day position should be maintained even if this meant NHS Lothian was an outlier against the rest of Scotland. He reminded the Board some patients would be frail or caring for others meaning a 7 day communication period would be impractical. Dr Williams advised already GPs were snowed under dealing with issues around patients who had been taken off lists. He advised in some instances treatment offer letters had been received late and this position would be exacerbated by a move to a 7 day position.

122.16 The Director of Scheduled Care commented he did not agree with the points raised by Dr Williams. He commented people who could evidence additional needs would be provided with extra support similar to that provided in other Health Boards who were working to the 7 day communication timescale. He advised a proposal had been road tested within Lothian and feedback had shown people who had raised similar concerns to the points put forward by Dr Williams had been assured by the fact robust processes to address these issues would be put in place similar to other Boards.
122.17 The Chief Executive advised there was a desire to consult and engage on issues around the access policy with partners like the Lothian Medical Committee and this was the reason why the policy was not on the current agenda for approval. He reported the national system software was being upgraded and every other Health Board was following the 7 day rule and the new automated system would also adopt this rule. The Chief Executive commented 12 weeks was a short period of time to treat patients and if 2 weeks were lost this made the treatment guarantee difficult to achieve. He advised he was sensitive to the point raised by Dr Williams about people not receiving letters timeously and suggested further focus was need to ensure this was reflected and addressed when the access policy came forward to the Board for approval.

122.18 The Director of Finance commented when the draft financial plan was being discussed efforts were being made to build up nonrecurring flexibility which had been run down in the current year. Currently the system had no headroom and for that reason there would be a period of time when external capacity would need to be utilised through the independent sector. In terms of capital issues the Director of Finance advised the points specifically identified by the Director of Scheduled Care were in the capital plan although this was not currently displaying a balanced position. It was noted a presentation given at the last strategic planning committee had shown how theatre capacity could be developed through the site master-planning process. The Director of Finance commented national capital availability would determine when any capital work could be embarked upon. In that regard there was a need to get business cases in place ready to implement when capital became available, as internal sustainability for some specialities was dependant on more significant capital investment.

122.19 Mr Brettell commented he would welcome clarity on the difference between the lower numbers reported as breaching the targets contained in the routine Board Waiting Times report and the higher numbers contained in the Delivering for Patients trajectories. The Director of Scheduled Care commented the trajectory position took account of the impact from the imminent introduction of our upgraded system software i.e. in terms of changes to the reporting structure and methodology, the impacts of unscheduled care on elective provision and the loss of elective activity over the festive period. The Director of Scheduled Care advised the position therefore took account of these component parts.

122.20 Mr Brettell questioned what would make the current proposal sustainable as good progress had previously been made and reported with the position thereafter suffering some bounce-back in performance. He commented the level of investment looked similar to previous levels and questioned whether this truly represented investment which he understood to be a one-off cost or the actual cost of providing the service. He questioned whether the £20m cost was what made the process sustainable.

122.21 The Director of Scheduled Care advised the utilisation of the £20m on its own would not provide sustainability as this would require the totality of the unscheduled care spend to be effectively used in day surgery rather than inpatient services supported by an infrastructure review. He advised the new performance structure
brought accountable managers and clinicians together and this would assist the move to providing and supporting sustainable performance.

122.22 Mr Ash welcomed the paper as it had improved his understanding of the position and advised he had been impressed by the inclusion of the table around risk and mitigation. He questioned whether the discussion referred to in the paper meant there was a lack of clarity about the position or whether it was dependant on the availability of resources.

122.23 The Director of Scheduled Care advised on techniques used by other Boards to meet the targets with some operating a 9 week target to provide headroom to address any specific issues that might arise potentially compromising delivery. He commented however he could only characterise what such a shift would mean for Lothian once he understood fully the 12 week position. He would welcome time to concentrate on delivering to 12 weeks in the first instance.

122.24 The Director of Unscheduled Care and Executive Nurse Director stressed the importance of recognising the interplay between unscheduled care and scheduled care. She commented if the system was better able to manage the elective programme this would assist in better managing significant aspects of unscheduled care. She advised she also supported building headroom as this would reduce the time patients spent in A&E as well as reducing the cancellation of elective activity. The Director of Unscheduled Care and Executive Nurse Director commented she supported the move to a 7 day patient communication protocol.

122.25 Councillor Henderson commented whilst he understood and agreed with the need to have robust processes in place to meet treatment time guarantees he was uneasy about meeting targets if that influenced the outcome for patients. He would personally prefer to be treated slightly outwith the target and to have a successful outcome. The Director of Scheduled Care stressed the overriding ethos was to provide safe and effective care as referred to in the paper. He stressed this was of paramount importance and was one of the key reasons why he was determined sustainable performance would not be delivered at any cost.

122.26 The Chief Executive confirmed targets would be met safely and patient safety would at all times be key. He reminded the Board the TTG contained no tolerances and was uniquely unforgiving. He commented he had also questioned the reasons for the previous bounce-back in performance referred to by Mr Brettell. He advised further examination had shown in terms of outpatients one of the specific reasons had been a jump in ophthalmology numbers because each referral for a long term condition that required specialist treatment generated repeat appointments. He reported in the spring of 2012 in relation to inpatients and days cases there were around 2000 patients who had breached by a significant period and this number had reduced to around 220 in April 2013 and then returned to around 600 in January 2014. The Chief Executive advised the system managed around 35000 interventions in a 12 week period and over the pervious 5-6 months the number of patients breaching was steady at between 500-600 which represented around 5%.

122.27 The Chief Executive suggested however because the system remained reliant on the independent sector and waiting time initiatives the gap was probably nearer 8-
10%. He felt therefore to move to a sustainable position there was a need to grow capacity by 8-10%. A key constraint in moving to this position was the time taken to get capacity in place through the recruitment of appropriate teams. He felt a clearer plan about how to move to a sustainable position was now in place. He stressed the importance of maintaining strategic links between unscheduled care and scheduled care.

122.28 The Board noted the recommendations contained in the circulated paper and supported and endorsed the commitment to use the report as a key vehicle in monitoring and measuring progress.

123. Scheduled Care Access Policy

123.1 The Director of Scheduled Care reminded the Board at previous Board and Committee meetings he had made reference to the NHS Lothian Access Policy and the Patient Rights Act. He advised it was his intention to rewrite the Access Policy to better evidence NHS Lothian’s approach on rights and the responsibilities to include NHS Lothian, clinicians and patients themselves. There would be a need to engage with others in this process because the structure was now different. The Vice Chair commented on the importance of ensuring a community focus possibly through the CHCPs.

123.2 The Board would receive an update report on progress at its next meeting.

124. Quality Report

124.1 The Medical Director advised over the course of the year the quality report would change to reflect Board priorities. He advised as reported and discussed at the previous Board seminar that the Scottish Government Chief Executive letter (CEL19) issued on 2 September 2013 on ‘The Next Steps for Acute Adult Safety – Patient Safety Essentials and Safety Priorities’ set out patient safety essentials which NHS Boards were expected to put in place to ensure staff were supported to deliver the measures reliably and consistently to all patients who could benefit.

124.2 The Medical Director advised in respect of the above one of the point of care priorities was to improve the management of deteriorating patients. The previous goal for this workstream had been a 30% reduction in cardiac / respiratory arrest calls compared to the baseline. This had been increased to a 50% reduction. It was reported when considering NHS Lothians progress against this goal on a site basis it should be noted that St Johns Hospital had shown a 59% sustained reduction compared to baseline by implementing a change package based on work conducted by Salford NHS Foundation Trust. It was noted this approach was being rolled out across the other two acute sites.

124.3 The Medical Director advised that patient experience had been discussed at the January Board Development Session in respect of the Lanarkshire HSMR Review and a paper would be brought to the April Board. The Board noted the summary at appendix 2 of the next steps needed following the Health Improvement Scotland (HIS) Rapid Review in NHS Lanarkshire which the Medical Director felt was a
useful document for him moving forward given his role as Lothian’s Scottish Patients Safety Programme Lead.

124.4 Mrs McDowell expressed concern that the number of formal complaints had jumped significantly and there remained issues about responding within the 20 day target. She requested the next Board paper should provide detail about what patients were complaining about and the steps being taken to make progress against the target response time. The Chairman advised the paper should be widened to cover issues around monitoring patient feedback and experience.

124.5 Mr Wilson sought an update on the position in respect of readmission rates at St Johns Hospital. The Medical Director advised the Site Director at St Johns Hospital had undertaken work around the issue and felt the key point was around the patient pathway. A West Lothian patients collaborative had been established including patient and community representatives to see if the reasons for the readmission rate could be established. It was noted a national collaborative meeting led by Professor Jason Leitch would be held on 25 February which would look at monitoring reports and mechanisms. The Medical Director hoped to be able to report on firm outcomes in September but would in the meantime provide the Board with regular verbal reports.

124.6 Dr Williams commented in respect of pressure ulcers that a zero target had been set for March although the numbers appeared to be rising. He advised he felt this was a good target but could not understand why a pressure ulcer could be unavoidable and sought assurance enough staff were available to ensure no patient suffered a pressure ulcer whilst in hospital.

124.7 The Director of Unscheduled Care and Executive Nurse Director reported on a helpful presentation provided at a recent meeting of the Health Care Governance Committee. She reminded the Board the target was self-imposed and had initially resulted in a degree of reporting previously not experienced. She commented in respect of avoidable pressure ulcers it was important to recognise in some instances this process commenced before patients were admitted to hospital. The Director of Unscheduled Care and Executive Nurse Director stressed she would regard pressure ulcers as being a ‘never event’ when the patient was solely in NHS care. She advised she would be happy to discuss further with Dr Williams outwith the meeting and provide updates in future Board reports.

124.8 The Medical Director reported that CEL 19 as previously referred to detailed pressure ulcers as one of the areas of priority and would be addressed as part of NHS Lothians response to the Lanarkshire Review. The Director of Unscheduled Care and Executive Nurse Director commented part of the delay in reaching the March target was around administrative issues and it was clear there was now a need to look at a more reasonable trajectory which she would report back to the next Board meeting. The Vice Chair commented as part of the integration agenda it would be important to ensure people were not being compromised whilst at home through appropriate engagement with patients, relatives and neighbours. It was noted there was significant work ongoing around Falls Prevention.

124.9 The Board noted and agreed the recommendations contained in the circulated paper.
125. **Financial Position to 31 December 2013**

125.1 The Director of Finance commented she was conscious at the previous Board meeting she had been reporting on a deteriorating position and had not been able to provide her usual assurance about delivery of the financial position at the year end. She advised a detailed report had been provided to the December Finance and Resources Committee focussing on an analysis of the reasons for the challenging financial position over the previous two months. From this it had been clear the key factors were around the reduction in benefit enjoyed through not filling vacancies because of agreed improvements to the recruitment process (£400k per month) as well as an increased overspend on clinical and diagnostic supplies related directly to capacity issues where estimates had initially been set too low. The final major component had been the system had not seen the reversal in the prescribing trend despite previous assurances.

125.2 The Director of Finance advised the December position had shown a significant improvement with it being important to note there had been no adverse change in the trend. She commented following the detailed work around the deteriorating position in the previous two months she was able to assure the Board financial breakeven remained deliverable. The Director of Finance felt given the extent of additional costs around scheduled care and the increase in beds this was a good performance outcome.

125.3 The Director of Finance commented there was a need for more focus around LRP as it was becoming more difficult to identify quick wins and there was a need for a different approach which would be reflected through the financial plan. It was noted there was an LRP under delivery of between £6 - 7m moving into the next financial year.

125.4 The Board noted the capital position was positive and on trajectory. The Director of Finance advised she had agreed a position with the Scottish Government around slippage although good progress was being made with capital projects.

125.5 The Chairman commented the position around LRP was becoming more pressing. Mr Wilson commented the Director of Finance continued to do a good job balancing the books year on year. He questioned whether the funding requirements previously referred to by the Director of Scheduled Care were budgeted for or whether they still required a source of funding. The Director of Finance commented these costs had been factored into the financial plan but required achievement of LRP to deliver them. She felt LRP now needed to start to deliver service redesign rather than continuing to adopt an incremental approach at the margin although she felt there was further opportunities around corporate functions.

125.6 Dr Bryce questioned given the challenges around LRP whether pressures on staff were considered as it would be them who would be responsible for delivering LRP. The Director of Human Resources and Organisational Development advised the Staff Governance Committee had considered the recent staff survey and debated what it was telling the organisation. He commented he felt the outcomes of the
survey needed to be presented to the Board and this would coincide with the production of the refreshed Human Resources Strategy.

125.7 The Chairman commented he was concerned about LRP commenting this sat within the Finance and Resources Committee in governance terms. He questioned whether there was a need to create a different mechanism for reporting progress to the Board. The Director of Finance advised the position was being addressed in a variety of ways. A Programme Management Board had been established to support managers with a cohort of individuals identified to target LRP delivery. She commented the clinical strategy would be key as all aspects of the strategy would need to build improvements to support the delivery of LRP.

125.8 The Chairman stressed if a point was reached where the system did not have the ability to produce LRP to fill the financial gap then it would become a strategic issue rather than an operational management one.

125.9 Mr Ash commented by carrying forward unachieved LRP on a year on year basis that this created downstream pressures. He questioned the last time LRP had been fully delivered. The Director of Finance advised delivery always occurred using non recurring means. Mr Ash advised this was similar to other NHS organisations he had worked in and suggested this was a topic that would warrant further discussion at a Board Development Session.

125.10 Mrs Meiklejohn commented on the need to avoid previous difficulties where LRP delivery had impacted adversely on the flow of patients through the system.

125.11 Mr Wilson suggested the current approach to finances was unsustainable and it would not be possible to continue adopting a sticking plaster approach. The Chairman commented on the need to adopt a more radical and dramatic approach. It was noted a set of decision making criteria would be discussed later in the day that might help to form a revised approach. The Chief Executive commented later in the day there would be an opportunity to discuss in closed session the draft financial plan, LDP and the strategic plan which were all integral to the financial position moving forward.

126. Developing the Royal Victoria Hospital

126.1 The Board agreed to transfer some clinical services currently based at the Astley Ainslie Hospital and Corstorphine Hospital into more up-to-date premises at the Royal Victoria Hospital which would offer improved safety, quality and patient experience.

127. Integration Process and Milestones – Public Bodies (Joint Working) (Scotland) Bill

127.1 The Director of Strategic Planning, Performance Reporting and Information advised the Parliamentary process was still underway with the second phase having ended in January which had resulted in a raft of policy statements and amendments which were in the process of being taken into account. He advised the purpose of the
circulated paper had been to highlight the series of consultations post the enabling of the Bill. It was agreed the Director of Strategic Planning, Performance Reporting and Information would produce a briefing on the key amendments and other factors for circulating to Board members.

127.2 The Director of Strategic Planning, Performance Reporting and Information commented NHS Lothian remained committed to establishing Integrated Joint Boards as early as possible although the timeline might be subject to some slippage as a consequence of the ongoing legal process. It was agreed the Board would receive the four draft integration plans on 3 December for approval to consult with partners as prescribed by the Scottish Government. This would allow Shadow Boards to be part of discussions to be fed back to the Board.

127.3 Mr Ash reminded the Board there was an outstanding issue in respect of hosted services and he hoped the extra time would allow debate around this position. He advised his own committee had a strong appetite for debating and influencing the Governance arrangements. He stressed that links with the Community Engagement Bill would be important.

127.4 The Director of Strategic Planning, Performance Reporting and Information advised that NHS Lothian had responded to the Community Engagement Bill consultation and welcomed the appetite for further engagement and advised in respect of hosted services clearer direction had been received about what was expected to be delivered. He undertook to arrange for Partnership Board Chairs to be engaged in debate in order to maintain momentum.

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

128. Creation of the Acute Hospitals Committee

128.1 The Board agreed to establish an Acute Hospitals Committee and approved the proposed terms of reference and membership subject to the inclusion of a patient representative in the membership, consideration being given to linkages with primary care as well as ensuring explicit reference to the need for equitable prevention, treatment and care. It was noted the Audit & Risk Committee would have the same linkages as the Healthcare Governance Committee.

128.2 The Board noted in terms of membership that Mrs Blair had agreed to Chair the committee and it was remitted to the Chair to finalise the rest of the membership without the need for reference back to the Board.

129. Date and Time of Next Meeting

129.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 2 April 2014 in the Boardroom, Waverley Gate, 2-4 Waterloo Place Edinburgh.
130. Invoking Standing Order 15.2

130.1 The Chairman sought permission to invoke Standing Order 15.2 to allow a meeting of Lothian NHS Board to be held in private. The Board agreed to invoke Standing Order 15.2.
The key points of the paper are summarised here.

- The purpose of the report is to provide the Board with the draft cancer strategy ‘Better Cancer Outcomes in Lothian – A Strategy for Cancer 2014/15 – 2020’.  

- The endorsement and approval of the draft strategy by the Board is requested, and agreement that the strategy is consulted on.

- The draft cancer strategy outlines the main challenges and direction required for cancer services in Lothian. It provides an overview of cancer incidence, prevention and cancer inequalities, the need for integrated care, cancer modernisation, patient involvement in cancer planning, our vision for cancer care delivery and our need to redevelop the Edinburgh Cancer Centre, strategic measurement, and strategic resourcing.

- Risks - in order to provide adequate capacity and fit for purpose facilities for the future a programme of prevention, health improvement, and development of our cancer service infrastructure is required including capital development of the regional cancer centre service.

- Maintenance of radiotherapy capacity and machine replacement is already referenced in the risk register.

- An impact assessment has already been completed on some aspects of the draft strategy. An impact assessment of the further changes proposed by the strategy is required.

- Strategic development to date has been informed by patient involvement as outlined in section 6 of the strategy.

- A new South East of Scotland Cancer Centre is an ambitious project and the associated business case needs to be completed locally. Otherwise it is expected that most of the activity highlighted in the draft cancer strategy will be managed within current cancer allocations, and existing cancer services funding. New medicines, and outputs from the ‘models of care’ workstream will need to be assessed and costed.

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**Peter McLoughlin**  
Strategic Programme Manager – Cancer, Diagnostics & Palliative Care  
23 March 2013  
Peter.mcloughlin@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with the draft cancer strategy ‘Better Cancer Outcomes in Lothian - A Strategy for Cancer 2014/15 - 2020’.

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

2 Recommendations

2.1 To seek the endorsement and approval of the Board for the strategy.

2.2 To agree that the strategy is consulted on as part of the consultation and engagement process for ‘Our Health, Our Care, Our Future’.

3 Discussion of Key Issues

3.1 ‘Better Cancer Outcomes in Lothian – A Strategy for Cancer 2014/15 – 2020’ outlines the main challenges and direction required for cancer services in Lothian. Its direction is in line with our public health and major health service plans, the South East of Scotland Regional Cancer Plan, and the national Better Cancer Care plan workstreams.

3.2 The document is structured around the six aims previously developed in our Strategic Clinical Framework and now included in our Strategic Plan 2014-2024 - “Our Health, Our Care, Our Future”.

3.3 The cancer strategy provides an overview of:

- The changing demand and challenge of cancer in Lothian and South East Scotland
- Our required focus on prevention and tackling cancer inequalities
- Our need for integrated care, to be delivered across primary, secondary and social care and regionally across the South East of Scotland
- The rapid pace of technological change and our need to modernise cancer care based on evidence, best practice and innovation
- Our work to deliver care in the right place and in a way that is appropriate to particular needs
- Our mechanisms for patient involvement in cancer planning
- Our vision for cancer care delivery and in particular our need to redevelop the Edinburgh Cancer Centre
- How the Lothian cancer programme is measured
- Key strategic resource considerations associated with pursuing the cancer strategy
3.4 The cancer strategy seeks to support our work to review cancer pathways in Lothian, and to focus on developing the Western General Hospital as Lothian’s Cancer Services campus. Planning for the re-provision of the Edinburgh Cancer Centre (ECC) has started, with a South East of Scotland regional steering group in place and a project structure developing to take forward the programme of work over 2014/15.

4 **Key Risks**

4.1 Over the current decade in Lothian (2010 – 2020) it is estimated that there will be a further 20.5% increase in the incidence of cancer. As well as risks inherent in not pursuing the prevention and health improvement work described in the strategy, including work to tackle known cancer inequalities, the Western General Hospital in particular requires development as Lothian’s Cancer Services campus, in order to provide adequate capacity and fit for purpose facilities for the future.

5 **Risk Register**

5.1 The need to maintain and develop radiotherapy capacity to allow an efficient programme of machine replacement and technology and skills development is already referenced in the risk register.

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

6.1 An impact assessment has already been completed on some aspects of the draft strategy for example in relation to Palliative and End of Life Care, and Detect Cancer Early. An impact assessment of the further changes proposed by the strategy is required. This will be undertaken following consultation, and in advance of the final strategy being agreed by the Board as well as during the course of the work of the South East of Scotland regional steering group for cancer centre reprovision. Our focus on health inequalities, health improvement and prevention is vital to the strategy and this focus is referenced in section 2 of the strategy, and runs through the domains of the document.

7 **Involving People**

7.1 To date the strategic development work has been informed by the patient involvement outlined in section 6 of the strategy, which describes some aspects of involvement in the planning and development of Cancer Services within NHS Lothian. Further consultation with patients and the public will support service design work going forward.

8 **Resource Implications**

8.1 A new South East of Scotland Cancer Centre is an ambitious project and the associated business case needs to be completed locally and submitted into the national capital programme for consideration and prioritisation. Production of an Initial Agreement and, subject to approval, an Outline Business Case will be taken forward during 2014/15.
8.2 Based on work to date it is expected that most of the activity highlighted in this plan will be managed within current cancer allocations for specific programmes, and existing cancer services funding including development funding granted locally and regionally. There will be a need to consider opportunistically the use of any additional development / partnership funding that may become available.

8.3 As new medicines are introduced, subsequent to guidance from the Scottish Medicines Consortium and our internal processes utilising the Lothian Joint Formulary, an increase in the basic medicine spend and requirement for increased services to administer and dispense them is expected. This will be managed via the existing governance structure which ensures medicines are utilised safely, effectively and efficiently.

8.4 Outputs from the 'models of care’ workstream, where these would not form a central part of the cancer centre business case, will need to be assessed and costed.

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18 March 2013
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INTRODUCTION

Overview

This document outlines NHS Lothian’s Cancer Strategy for 2014/15 – 2020. Its direction is in line with our public health and major health service plans in Lothian, the South East of Scotland Regional Cancer Plan, and the national Better Cancer Care plan workstreams.

The document is structured around the six aims previously developed in our Strategic Clinical Framework and now included in our Strategic Plan 2014-2024 - “Our Health, Our Care, Our Future”. The six aims are:

1. Prioritise prevention, reduce inequalities and promote longer healthier lives for all.
2. Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care.
3. Ensure that care is evidence-based, incorporates best practice, fosters innovation and achieves seamless and sustainable care pathways for patients.
4. Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting.
5. Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families.
6. Use the resources we have – skilled people, technology, buildings and equipment - efficiently and effectively.

These six aims seek to ensure we can deliver safe, effective and person-centred health and social care. And in turn, these aims are aligned with the triple aim objectives of the 20-20 Vision around improving quality of care; improving population health and securing value and financial sustainability. Sections 2 to 7 of this document use one of the six aims as the section heading, to support linking the domains of the cancer strategy clearly to the wider strategic aim.

‘Better Cancer Outcomes in Lothian – A Strategy for Cancer 2014/15 – 2020’ provides an overview of:

- The changing demand and challenge of cancer in Lothian and South East Scotland
- Our required focus on prevention and tackling cancer inequalities
- Our need for integrated care, to be delivered across primary, secondary and social care and regionally across the South East of Scotland
- The rapid pace of technological change and our need to modernise cancer care based on evidence, best practice and innovation
- Our work to deliver care in the right place and in a way that is appropriate to particular needs
- Our mechanisms for patient involvement in cancer planning
- Our vision for cancer care delivery and in particular our need to redevelop the Edinburgh Cancer Centre
- How the Lothian cancer programme is measured
Some key strategic resource considerations associated with pursuing the cancer strategy

Planning and partnership working at local, regional and national levels
NHS Lothian, in partnership with other statutory and voluntary sector agencies provides a wide range of services and support related to cancer in Lothian. These include prevention, screening, genetics, and primary, secondary and tertiary healthcare services. Specialist assessment, diagnostic and treatment services are provided across Lothian. In partnership with other agencies, support services such as welfare rights, disability assessment, information and advice, and counselling and support services are provided.

NHS Lothian is also engaged in the registration, collection and reporting of cancer statistics vital to national, regional and local planning. An extensive programme of cancer research is also undertaken, some in partnership with the University of Edinburgh, in Lothian and across the South East of Scotland, including laboratory research, clinical trials, service research, evaluations, and work to assess patient experience.

In addition to territorial NHS Board level planning and delivery, NHS Lothian is part of the SCAN regional cancer network. Through participation in this network NHS Lothian works collaboratively with NHS Borders, NHS Fife, and NHS Dumfries & Galloway to plan and deliver cancer services across the South East of Scotland.

NHS Lothian, and SCAN clinical and management leads, participate in national level policy and planning through for example groups such as the Scottish Cancer Taskforce, the Detect Cancer Early Programme Board, the Radiotherapy Programme Board, the Chemotherapy Advisory Group, and the Living & Dying Well National Advisory Group for Palliative and End of Life Care. Additionally, service redesign and our population health screening programmes such as breast, bowel and cervical screening are co-ordinated with the national planning agencies (such as National Services Division) via the public health screening co-ordinator and strategic planning.

Challenges, changing experience, and service responses
In common with most of the world, the incidence of cancer is rising in Lothian and in all areas of the South East of Scotland region, and the rate of increase is higher than in previous years due to population change. Many more people however are living with and beyond cancer. Focussing on prevention and early detection, improving treatment, and tackling known cancer inequalities will help to meet the challenge of cancer, and improve cancer care and survival further.

1. THE CHALLENGE OF CANCER IN LOTHIAN

Age-standardised cancer incidence in Lothian, South East Scotland, and in Scotland overall is significantly higher than the UK average. The incidence of cancer is increasing, and the rate of increase is faster than experienced in the last few decades. Over the current decade in Lothian (2010 – 2020) it is estimated that there will be a 20.5% increase in the incidence of cancer. The most common cancers in South East Scotland region are prostate, lung, colorectal, and breast cancers. The
projected change in the South East of Scotland, by tumour type, is shown in chart 1 below.

Chart 1

![Projected percentage change in cancer cases - SCAN area](chart1.jpg)

Most of these cancers, for Lothian residents or residents of other South East Scotland NHS Boards, will be referred to NHS Lothian (either for assessment, diagnosis, staging, treatment, or all of these elements of the cancer pathway).

The prevalence of many cancers is also increasing (due for example to increasing incidence, better treatment and survival). As cancer is often a disease of old age, and more people are surviving cancer, increasingly multi-morbidity will be experienced by some cancer survivors. This means that as well has there being more able-bodied cancer survivors, there will also be more people living with the consequences of cancer, or cancer treatment, who also have other health conditions or disease, all of which increases the complexity of care planning and delivery.

Chart 2 below shows cancer incidence rates per 100,000 of the population in the South East of Scotland cancer planning region, by age-band. There is a clear increase in incidence with older age. Incidence data shown is for 2011, which is the most recent period of published data.
Significant improvement in survival has been seen over the last few decades. Appendix 2 to this document shows trends in cancer survival in Scotland over this period. We know that better survival prospects are associated with:

- Earlier presentation by patients
- Participation in screening programmes (where screen detected cancers are often found at an earlier stage)
- Improvements in specific treatments

Conversely, survival is worst in patients presenting with advanced stage disease, often as emergencies, and for cancers for which current treatments are less effective (such as lung, brain, and pancreatic etc).

Over the entire South East of Scotland cancer planning area the picture of changing incidence, prevalence and survival is common. All highly specialist cancer care is provided to these patients in NHS Lothian. Where possible, assessment and diagnosis is undertaken locally in the NHS Board of patient’s residence. Some patients from other South East of Scotland NHS Boards will however be referred to NHS Lothian for clinical assessment and diagnosis of suspected cancer. Some treatment services in the South East of Scotland such as radiotherapy and complex chemotherapy provision are exclusively provided by NHS Lothian as provider Board for the Edinburgh Cancer Centre. Healthcare planning and subsequent capacity delivered needs to take due account of the patient volumes and patient pathways followed across the whole of the South East of Scotland region.
2. PRIORITISE PREVENTION, REDUCE INEQUALITIES AND PROMOTE LONGER HEALTHIER LIVES FOR ALL

Preventing Cancer in Lothian

Public Health and Health Improvement – Smoking is the single biggest risk factor for cancer, alongside poor diet, lack of physical exercise, and alcohol misuse. A public health based strategy, and focus on health improvement is fundamentally required as a central component to any effective cancer strategy. The Lothian health improvement strategies, many flowing from areas with HEAT targets associated with them, are therefore vital.

The HEAT framework, which outlines performance standards and targets agreed each year between NHS Lothian and the Scottish Government Health Directorates, has diet, physical activity, smoking cessation, obesity, and health inequalities as a central focus, alongside cancer access and quality standards. All of these domains of work are central to the cancer programme in Lothian and need to increasingly align with specific cancer programme workstreams and operational delivery.

Public health also has a crucial role to play in supplying data and information to planners and service providers across Lothian and nationally, to guide priorities and help to assess delivery and performance.

Reducing the damage caused by the use of tobacco – NHS Lothian is implementing its Smoke Free Lothian Vision. This strategy is aligned to the Scottish Governments 2013 tobacco control strategy ‘Creating a tobacco-free generation - a tobacco control strategy for Scotland’. The national strategy has a headline aim of creating a tobacco free generation of Scots by 2034. The headline outcome measure is achieving an adult smoking prevalence below 5% by 2034. In Lothian, in 2011, smoking prevalence is recorded at 18.7% (with significant variation across our most disadvantaged to our most affluent communities and populations).

Lothian’s Smoke Free vision is being pursued currently via focussing work in three major domains:

Tackling health inequalities and focussing on specific groups – via joint work with Lothian Local Authorities and the voluntary sector. Focussing for example on young people’s health behaviour and their health education, and working with vulnerable young people such as looked-after children and young offenders, as well as building effective alliances to tackle the availability of illicit tobacco.

Improving Health protection – offering advice on creating smoke free homes, working with specific organisations such as the Scottish Prison service to plan smoke free prison facilities, and implementing our ‘Smoke Free NHS Lothian’ plan from May 2014, ensuring enforcement and compliance by March 2015.

Supporting smoking cessation – by continuing to develop and deliver our Smoke Free services, and target programmes for example to increase the number of women referred, and successfully quitting, by ensuring effective care pathways for smoking in pregnancy.
Tackling obesity, improving diets, and increasing physical activity - we will do this by:

- Supporting staff to promote healthy lifestyles, by encouraging health eating and regular physical activity, and improving training opportunities for staff i.e. in the delivery of brief intervention / brief advice.

- Increasing the awareness of recommended levels of physical activity and understanding of food and diet to maintain healthy weight.

- Developing and implementing specific initiatives to increase physical activity and promote healthy eating, and become an exemplar organisation in promoting health improvement.

- Supporting effective local and national programmes that aim to increase physical activity and promote healthy eating.

- Use our Sustainability Strategy, and the Green Travel Plan, to promote active travel and dissuade people from using cars, and promote walking or cycling including the development of secure cycle parking for NHS staff and patients on our sites.

- With partners in Local Authorities and the third sector we will provide appropriate evidence based interventions for people who are overweight and obese through our Lothian Weight Management Services.

- By continuing to develop “Get Going!” our innovative weight management programme aimed at children and young people. The programme aims to develop young people’s interest in exercise, recreation and health-related issues to increase opportunities for them to participate in physical activity within their local communities.

- Developing our catering strategy, and become an exemplar organisation in the provision of food on our premises, and through participating in the ‘Food for Life’ programme with partner organisations.

- Supporting the free school meals programme, led by Lothian Local Authorities, and developments in the curriculum on healthy living. National guidance exists for both nutritional content of meals and the health promotion activities within schools.

Tackling alcohol misuse - We will do this by:

- Supporting the specialist Alcohol Problems Service, and dedicated Drug and Alcohol Action Teams within each local authority area in Lothian.

- Work with Local Licensing Boards to map the provision of alcohol sales outlets in Lothian, and oppose any over provision.
• Expanding our programme of alcohol brief interventions by continuing to train staff to deliver these throughout the NHS.

• Supporting the Lothian and Edinburgh Abstinence Programme (LEAP). LEAP offers an alternative choice and opportunity for those with alcohol problems to change drinking habits.

**Tackling Cancer Inequalities**

We know that the incidence of cancer is higher, and cancer outcomes poorer, in our most deprived communities – including differences in the pattern of cancer in some ethnic groups. Socio-economic status is an important independent prognostic factor for most common cancers in adults.

Socio-economic differences in the stage of disease at diagnosis, and in access to and participation with optimal diagnostic and treatment services may explain at least some of the association between deprivation and poorer cancer survival. Full explanations for differences in survival are not completely documented in research. However reasons that some groups may be disadvantaged can fall into 3 groups of underlying causes:

1. **Tumour factors** – late stage of detection; delays in seeking healthcare or delayed referral; ‘stage shift’ whereby cancers are classified and recorded as earlier stage than they actually are. This is possibly because some patient groups are not completing full staging investigations (and the extent of spread is thus not detected).

2. **Patient factors** – psychosocial factors such as lack of social support; unclear access or delay in seeking healthcare; perceived social stigma attached to cancer; individual perception of personal risk; poorer mental health; poorer communication with healthcare professionals. Co-morbidity may also reduce survival by adversely interacting with or limiting the range of treatment given for cancer.

3. **Healthcare system factors** – lower uptake of screening services; treatment differences (either options not offered, for example in more elderly or co-morbid patients, or options not taken-up for example follow-up appointments); emergency admissions; and the availability of medical expertise.

Our focus on health inequalities and health improvement is vital therefore to both cancer prevention and improving cancer outcomes. Through Lothian’s Detect Cancer Early programme we are seeking to tackle many of the potential underlying causes of poorer survival, as listed above. A focus on these areas will continue to be developed throughout all of our work on prevention, health improvement, treatment and service delivery.

The Health Promoting Health Service concept - ‘every healthcare contact is a health improvement opportunity’ – is based on person centred and effective practice, and will underpin our approach. We will do this by working in partnership, and adopting a
focus on health improvement and tackling health inequalities via development, assessment, and implementation all of our policies and plans.

**Managing the late effects of cancer**

In tandem with building our focus on Transforming Care After Treatment, to support longer healthier lives we need to ensure that as we develop our cancer pathways the late effects of cancer are recognised and effective management is supported. Late effects may include the development of second cancers, and additional needs associated with cardiology, endocrinology, bone health, lymphoedema, and sexual health / gynaecology.

3. **PUT IN PLACE ROBUST SYSTEMS TO DELIVER THE BEST MODEL OF INTEGRATED CARE FOR OUR POPULATION – ACROSS PRIMARY, SECONDARY AND SOCIAL CARE**

**Earlier detection of Cancer**

The Detect Cancer Early Programme is an ambitious programme of work to improve survival for people with cancer in Scotland to amongst the best in other European countries by diagnosing and treating the disease at an earlier stage. The Detect Cancer Early programme was formally launched by the Cabinet Secretary on February 20, 2012. The NHS Lothian Detect Cancer Early (DCE) Programme is now established, focussed on breast, lung and bowel cancer. A Lothian Programme Board has been formed to develop and steer the programme over a three-year period (2012/13 – 2014/15), in line with the initial government investment period. Our approach is based on a review of the cancer inequalities evidence base, and on the national DCE programme framework. It focuses on tacking inequalities and identified ‘wicked-issues’ in cancer care, building-up our diagnostic and treatment capacity, integrating early detection into our existing service redesign work across Lothian, and increasingly focusing on targeted action to identify opportunities and service approaches to detect a higher proportion of cancers at stage 1 of disease.

In years one and two of the programme, investment has gone into primary care, diagnostic and treatment services providing care for patients with lung, breast, and bowel cancer, as well as cancer audit, e-health, and investment in cancer informatics.

Delivery of the Detect Cancer Early programme is measured via the HEAT performance framework. The programme target, at national level, is to increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015. NHS Lothian’s baseline position (an average of the combined years 2010 and 2011) was 22.6% of all breast, lung and bowel cancers diagnosed at stage 1 of the disease. By the end of 2015 we need to be achieving 29%.

Over the next two years of the programme we will focus on a number of key areas including: progressing targeted initiatives in the bowel and breast cancer screening programmes and with primary care teams to increase screening participation and
service capacity; develop our lung cancer pathway including building capability focussed on earlier detection and support, and redesign referral and initial diagnostic pathways, develop our referral and diagnostic assessment pathways for the 3 DCE tumour group areas across primary and secondary care to support referral at the earliest opportunity of people with signs and / or symptoms of suspected cancer; continue to improve our cancer intelligence strategy and deliver DCE programme reporting; invest further in diagnostic and treatment capacity; and support national and local awareness campaigns.

Providing population Screening Programmes:

Bowel Screening Programme

NHS Lothian’s participation in the National Bowel Screening programme commenced in May 2008, with our first two-year screening cycle running between May 2008 and April 2010. The administration of invitations to participate in screening, and the testing of returned screening kits, is undertaken by the national screening centre located in Kings Cross Hospital in Dundee. The rate of positive screening tests was 2.2% in Lothian (i.e. the proportion of tests that are positive from all samples returned for testing), compared to a Scottish average of 2.5%. NHS Lothian provides the clinical assessment, diagnostic and treatment pathway for all Lothian residents who return positive screening tests to the central laboratory.

The national standard for bowel screening uptake is 60%, and this is monitored by Healthcare Improvement Scotland. Uptake in Lothian in 2010 – 2012 was 53.5%, compared with a Scottish average of 54.9%. Uptake remains lower in areas of higher deprivation.

In Lothian, through the screening programme, 1,190 people have been diagnosed with an adenoma or an invasive cancer or polyp cancer. 172 of these were an invasive cancer or polyp cancer (based on screening programme data to 2012). Our yearly screening accounts for the detection of around 15-20% of all colorectal cancers in Lothian. Cancers detected through the screening programme show an earlier stage profile compared to those not detected through screening.

Our action plan for the Lothian Bowel Screening Programme includes exploring a greater use of nurse colonoscopists as part of the screening programme accredited endoscopy workforce, and exploring how radiology can be further used to support capacity in the programme, and more widely to support endoscopy capacity in Lothian.

In spring 2013, as part of the local DCE campaign, a breast and bowel screening pilot commenced with 10 GP practices in Lothian. The aim of the pilot is to identify and test ways to increase screening uptake. Additionally, the majority of GP practices in Lothian have signed up to take part in the new bowel screening Scottish Quality Outcomes Framework (SQoF) initiative (2013 – 2015) which will reward practices for increasing their bowel screening uptake.

Breast Screening Programme

The South East of Scotland Breast Screening Service is commissioned and funded by National Services Division (NSD) with the service hosted by NHS Lothian for the
South East of Scotland region. Overall uptake of the breast screening programme in NHS Lothian is 72% (over the period 2008/09-2010/11). This figure is above the QIS standard of 70% and below the Scottish average of 75%.

The overall uptake level is similar for NHS Lothian, NHS Lanarkshire and NHS Greater Glasgow & Clyde – where the majority of appointments are offered at a static centre. Uptake rates tend to be higher in Board areas where the majority of screening is undertaken in mobile units.

Our lowest uptake groups are:
- Women new to screening (first invitation)
- Women who are invited outwith five years of last attendance – (i.e. previous non attendees)

In order to address these target groups we continue to work closely with colleagues in primary care, health promotion, community development and cancer charities to promote the benefits of screening. We so provide staff with training and information to ensure a higher, positive profile of the programme at primary care level. Specific actions include:

- Introducing changes to the appointments schedule to allow extended periods of screening for localities.
- Providing targeted visits to low uptake practices by colleagues in health promotion prior to the screening round in order to support staff in promoting screening to patients.
- Providing practices with additional information to identify defaulting or DNA patients.
- Liaising with the Learning Disabilities Service to provide additional specialist care to clients.
- Providing workshops for Lothian primary care staff to update knowledge and further promote the benefits of screening.

In Lothian, uptake levels vary across deprivation categories from 79% (least deprived) to 58% (most deprived). This pattern is reflected across Scotland. An ‘Immediate Action’ pilot has been established with the agreement of some practices to evaluate whether additional targeted primary care efforts can improve uptake at practice level.

The South East Scotland Breast Screening Programme (SESBS) has implemented 2-view mammography for all women attending for screening from April 2010. Implementation of 2 views has led to higher numbers of cancers diagnosed (up by approx 25% based on 2011/12 figures).

During 2011 the National Planning Forum commissioned NSD to undertake a review of Breast Screening Service in Scotland. The Review was prompted by concern regarding the sustainability of the programme in light of work force pressures and the need to realise efficiency savings to fund the introduction of new technology. The
Review’s findings were subject to a formal option appraisal. The Review has since recommended that the status quo in terms of the organisation and commissioning of breast screening be maintained but that efforts should to be directed at achieving greater integration of the screening and symptomatic services. NSD will establish work streams to deliver the necessary service reconfiguration.

Over 2013 the South East Scotland Breast Screening Programme modernised mammography imaging by moving to digital mammography. This development is a key part of delivering the change required as part of the national service review, and will assist in improving the efficiency of the service and in supporting the earlier detection of breast cancer.

Cervical Screening

Overall the cervical screening programme in Lothian has been very successful. Age standardised incidence rates for Lothian have declined from 18.0 per 100,000 persons at risk in 1988 to 12.6 per 100,000 persons at risk in 2011. Lothian has seen a decrease in mortality from cervical cancer from 5.7 per 100,000 persons in 1986 to 3.1 per 100,000 in 2011 (25 to 15 deaths). Survival rates continue to improve for women diagnosed with cervical cancer. Five year survival is now 58.6% and one year survival is 78.6% (a 6.7% and 3.3% improvement over the last 20 years).

NHS Lothian laboratory process nearly 80,000 smears per annum. Laboratory turnaround times and overall reporting times are lower than the national average. Unsatisfactory rates are in line with practice across Scotland. The percentage of smears reported as negative is 89.1% which is slightly lower than the national average of 90.3%. Our data is quality assured by the national SCCRS laboratory group.

The cervical screening programme is at a time of transition and there is significant activity at national level to agree a new policy for future service delivery. Nationally uptake rates have been falling across Scotland over the last 5 years. Whilst there are many reasons for this the key driver is falling uptake in the 20-25 age group due to confusion about risk perception. Furthermore emerging evidence now indicates that women in this age group should not be offered screening. With this in mind there are two major changes to policy on the horizon:

1) The age range and frequency thresholds will be changed from 2015 (women between 20-25 will not be called, and women 60+ will be offered screening 5 yearly)
2) HPV screening will be implemented from 2016 with cohort clinical pathways embedded.

As a consequence the screening programme will look very different and new performance measures (uptake) will have to be agreed.

NHS Lothian has been targeting certain groups of women to shift the pattern of attendance to be more in line with the evidence base, and future national policy. Therefore our uptake rates are lower in the 20-25 age group and higher in the 40+ age group. We will continue to work collaboratively to develop and improve the screening programme in line with national policy and implementation planning.
Primary Care Cancer workplan

Many aspects of cancer care are managed in primary and community health service settings routinely across Lothian. To support a focus on specific development work NHS Lothian and Macmillan Cancer Care support a GP Lead post and a Nurse Consultant post for Cancer & Palliative Care. This team, working with colleagues across the system, manage a programme of work which aims to support:

- Participation in the Detect Cancer Early Programme at local and national level including developing and implementing specific Lothian initiatives
- Improving access to diagnostic services to support earlier detection, including scoping the potential for pathway redesign and working alongside national improvement programmes
- Assist practices in improving their screening programme uptake, in particular supporting the bowel screening Scottish Quality and Outcomes programme initiative in 2013/14 and 14/15
- Supporting the improvement of cancer referral guidelines by working locally and nationally, and supporting their local implementation in liaison with referrals advisors and others
- Supporting the palliative care programme including supporting learning and development associated with the Palliative Care Directed Enhanced Service (DES), and supporting the Lothian Palliative Care Redesign Programme
- Assessment of redesign potential to improve follow-up, and participation in the Lothian Transforming Care After Treatment programme.

4. ENSURE THAT CARE IS EVIDENCE-BASED, INCORPORATES BEST PRACTICE, FOSTERS INNOVATION AND ACHIEVES SEAMLESS AND SUSTAINABLE CARE PATHWAYS FOR PATIENTS

Better Treatment:
Modernisation of cancer services requires a collaborative regional approach across the South East of Scotland, to ensure efficient, effective and quality care is provided as close to the patient as possible. This must incorporate all the aspects of service provision, technological development and improvement to the patient pathway. Effective local and regional arrangements to support the planning and management of cancer services in an integrated way across NHS Lothian services, and with all South East Scotland NHS Boards, is vital to achieving this.

Scheduled care:

Radiotherapy
Edinburgh Cancer Centre provides radiotherapy for patients from across the South East of Scotland. Radiotherapy provision is changing rapidly, and demand for radiotherapy is set to grow significantly over the next decade, and beyond.

Our strategic priorities include
- Providing evidence on the number and location for the future provision of linear accelerators.
• Keeping pace with current technology, and ensuring that patients have timely access to the appropriate, evidence-based advancements in radiotherapy.
• To ensure optimal efficiency of the use of the machines, and to allow patients to be treated at times more suited to their needs, we will work towards the provision of extended working days, and the potential for a 7-day service, keeping in line with planned capacity requirements.

Chemotherapy
Our strategic priorities include:
• To provide chemotherapy delivery as close to the patient’s home as possible, where it is safe and effective to do so.
• To ensure optimal efficiency of the use of capacity, and to allow patients to be treated at times more suited to their needs, we will work towards extended working and consider the potential for a 7-day service.

Cancer surgery
• Ensure the outcomes for surgical intervention are compliant with best practice.
• Services are provided at locations where expert intervention is provided, and, where the evidence supports such an approach, ensure optimum outcomes through focusing pathways to high volume services

Clinical Radiology and Oncology Imaging
• The provision of imaging services should be strengthened on the site of the cancer centre to ensure complex imaging can be provided, and integration with other systems and image transfer is harmonised. This should also include the ability to link remote imaging from other Health Board areas to support efficient local and remote working.

PET scanning provision in the South East of Scotland
• In line with national planning for the provision of PET, we will continue to review the usage of PET scanning in SCAN, and ensure adequate provision for the future in conjunction with good cancer care and evidenced based medicine. PET provision in NHS Lothian should be considered alongside reviewing imaging provision to support cancer services on the Western General Hospital campus.

Unscheduled care:

Oncology Emergency Care – Effective Acute Cancer Services
Through the advancement of acute oncology services, the unscheduled element of care will continue to grow and will need to be effectively formalised across the region, maximising the contribution of services such as the cancer treatment helpline. Our strategic priorities include:

• Through safe treatment protocols and timely access to advice and interventions, to reduce as much as possible, emergency admissions for the complications of cancer therapies
• Progressing and developing management arrangements for emergency presentations by the appropriate use of telehealth

• Ensuring that all patients with cancer, who are managed outside of the Edinburgh Cancer Centre, are managed according to the best practice for their condition, including timely access to the same expertise as those managed in the Edinburgh Cancer Centre.

To support the development of a more formally agreed and co-ordinated system, the potential of telehealth should be assessed. This should consider, for example, improving arrangements for remote access to health records and clinical management advice such that clinicians seeing Oncology patients presenting anywhere in the region will have access to the same clinical data and could be discussed within a defined period of time of presentation with the on-call team at the Western General Hospital.

Cancer Modernisation and Innovation:
Over 2012/2013 and 2013/2014 we have invested in the modernisation of acute oncology, surgical oncology and radiotherapy services. We will seek to consolidate and build on the progress made in these areas. We will also seek to continue to build on the regional approach taken to date in some of our areas of specific modernisation initiatives, such as in radiotherapy and acute oncology.

South East of Scotland Non-Surgical Oncology Review
In 2010, the regional cancer network commissioned a review of non-surgical oncology services in the context of increasing demand as a result of increasing incidence, prevalence and detection of cancer and the increasing complexity of treatments.

The review concluded that the non-surgical oncology service is a highly efficient and successful service. It noted that a substantial amount of redesign work had already been undertaken but identified some scope to improve efficiency further. The review report emphasised that the recommended redesign programme, while capable of releasing some capacity, would not be sufficient to meet the expected increase in demand in the longer term and that boards would need to consider potential increases in expenditure in future if they wished to provide the same levels of service. It was estimated that implementing the redesign programme might delay the need for additional investment in non-surgical oncology services until 2014.

The review report envisaged a rolling programme of review and redesign and set out a series of recommendations grouped under seven key themes: team-based practice; acute oncology; clinical pathways, policies & guidelines; patient information; eHealth, telehealth and intelligence systems; managing interfacing and support systems; sustainability.

As a result of implementing the redesign programme, the regional boards have improved the efficiency of the non-surgical oncology service in its current configuration. Radical new approaches to service delivery will be required to meet increasing service demand and complexity over the next 5 years. Regional boards
will need to exploit the opportunities offered by national and regional initiatives, such as the Edinburgh Cancer Centre Reprovision project, the development of a national strategy for radiotherapy workforce capacity, the Transforming Care After Treatment Programme (TCAT), implementation of Quality Performance Indicators (QPI), and implementation of Systemic Anti Cancer Therapy (SACT) CEL (30) 2012.

Colorectal Cancer Services Improvement
Over 2012 and 2013 NHS Lothian was one of 5 healthcare systems internationally to participate in the Colorectal Cancer Service Improvement Network. This data driven exercise adopted a pathway focussed approach to service improvement in colorectal cancer. As a result of participating in the network, ten priority value areas began to emerge across all 5 healthcare systems internationally. These were:

- Improving screening uptake in targeted populations
- Refining colonoscopy referral protocols for symptomatic patients
- Ensuring efficient use of existing endoscopy capacity
- Adopting best practice staging protocols for treatment planning
- Using multidisciplinary teams to consistently coordinate care
- Centralizing surgical treatment for rectal cancer
- Balancing palliative care and drug treatment in late-stage disease
- Firming up risk-adaptive follow-up surveillance protocols
- Reducing variation in access and outcomes across geographies
- Tracking population-level outcomes through end-to-end data integration

NHS Lothian’s top 3 improvement priorities have been identified as below, and are being pursued particularly through the Lothian Detect Cancer early Programme and in diagnostics capacity planning.

- Increasing the share of early-stage cancers to meet Detect Cancer Early goals
- Reducing the rate of emergency presentation through improvements in diagnostic pathway
- Finding more cancers with fewer colonoscopies with improved referral protocols

Cancer Multi-Disciplinary Meetings (MDM’s)
NHS Lothian will utilise and seek to adhere to the National Cancer Audit Team Standards for the management of cancer Multi-Disciplinary-Meetings (MDM’s). Recognising that this is a critical element of the patient pathway work is being undertaken to support clinical teams in delivering safe, efficient and effective MDMs. This will enable performance against the standard to be regularly monitored, and support governance issues in being identified and addressed to ensure the delivery of appropriate clinical treatment decisions.

NHS Lothian is currently implementing a programme of work to provide a TRAK MDM module to each MDM to support meeting administration, clinical decision making, and governance. This rolling programme of work will complete in 2015. The TRAK module dataset will support efficient working and improve quality, and will
include capture of the cancer Quality Performance Indicators (QPI’s) for each tumour
type, which NHS Lothian is obligated to collect and report on as part of the National
Cancer Quality Programme. The TRAK MDM programme is supported as part of the
Lothian Detect Cancer Early Programme implementation, as a key part of improving
our use of cancer information and associated improvements in care co-ordination.

Access to Cancer Medicines
Access to existing and new cancer medicines within NHS Lothian sits within a
transparent governance structure which ensures medicines are utilised safely,
effectively and efficiently.

The Edinburgh Cancer Centre acts as a hub for the majority of this activity within
SCAN, and multidisciplinary staff across the network work together to ensure
relevant polices and procedures are implemented and maintained by all staff. NHS
Lothian cancer services ensure that the process encompassing patient access to
medicines is efficient for both existing and new medicines. Staff are in full control of
the medicine supply chain to ensure that marketed and clinical trial medicines are
available, and that they meet quality standards.

New medicines are introduced subsequent to guidance from the Scottish Medicines
Consortium and internal processes utilising the Lothian Joint Formulary. In addition,
NHS Lothian acts as a hub for an agreed regional approach to the consideration and
approval of applications for funding of non-formulary cancer medicines for patients
across SCAN who are treated by ECC clinicians. This is formalised between SCAN
Boards, and is managed by the cancer medicines management committee on behalf
of NHS Lothian.

The amount of chemotherapy prescribed and administered within NHS Lothian is
increasing which has led to a requirement for new services, more efficient medicine
pathways, and also increased medicine budgets. In 2014 there may be changes to
NHS Scotland’s system for accessing new medicines. Two changes involve:

1. A transformation of the Scottish Medicines Consortium approval process
which will provide clinicians and patients a stronger voice on SMC decisions
for life-limiting and rare conditions. This encompasses cancer.

2. The introduction of the Peer Approved Clinical System (PACS) which will
replace the Individual Patient Treatment Request (IPTR) for assessing
medicines not approved for regular use within NHS Scotland.

Assuming the policy change described above is approved and implemented
nationally, these two changes will increase the number of medicines approved for
use, and by association the basic medicine spend and requirement for increased
services to administer and dispense them. The exact effects of these changes will
become evident during 2014/15.

Cancer Informatics
NHS Lothian is a data rich system, and has comparatively an advantage over many
other healthcare systems in terms of our existing data and information infrastructure
and its reach across the whole system of care. We hold a vast amount information
about cancer patients. A strategy for cancer informatics is required to support the
integration of all related systems containing information about cancer patients and their treatment and to pull this data together in a way that best informs practice. An integrated cancer information system capability would allow reporting on patient pathways, care of specific groups of patients, anticipating care needs, and supporting the planning of services.

Under the Detect Cancer Early Programme NHS Lothian has invested in dedicated cancer analytical resource and further supported cancer audit and e-health systems development to support more efficient data capture. Furthermore, NHS Lothian Cancer Services will be appointing a Programme Manager in 2014 to undertake a review of the production, development and promotion of a range of information services, including statistical analysis, for cancer associated services within NHS Lothian and the Southeast of Scotland. The Programme will work alongside the Director of the Edinburgh Cancer Centre, strategic planning functions of S.E Scotland NHS Boards, and the Oncology Clinical Management Team to develop long term plans and provide strategic direction for Oncology, Haematology and Breast Services. Early priorities will include the amalgamation of 2 existing teams into a single Cancer Information Service, and also the transfer of the existing Oncology database on to a new and more stable platform.

The programme will also seek to identify the linkages between NHS Lothian’s cancer management information requirements and those of university researchers – both current and future; ensuring that approved statistical analysis is available for a variety of stakeholders across all aspects of healthcare. It will seek to ensure close working and undertaking of collaborative clinical research projects with academic bodies including local universities, Chief Scientists Office, MRC, Cancer Research UK etc. enabling the Edinburgh Cancer Centre to derive full potential for data contribution within joint academic - NHS research projects, including medical informatics, analyses of clinically annotated tissues etc.

Essential to the informatics strategy is single entry, multiple use of clinical data. Accurate recording at the appropriate point of care will ensure reliable data which can be made available on a “need-to-know” basis across the care pathway, and allow collation of data to facilitate detailed planning of services, anticipation of complications, whether acute or chronic, and analysis of outcomes. A portal approach creating summary data on diagnosis and treatments to facilitate a patient centred view of each cancer journey will enhance communication between the many different health care professionals involved at all stages of cancer care delivery.

Robot-assisted surgery for urological cancers
Across the South East of Scotland prostate cancer will see the greatest percentage increase in incidence over the next decade. Developing our approach to treatment and our capacity, including improving care after treatment for this group, is essential. In 2013 The Cabinet Secretary for Health & Wellbeing recommended that Scotland move to provision of radical prostatectomy being undertaken in high volume centres utilizing minimal access or laparoscopic techniques. High-volume is defined as at least 150 cases per year. At present NHS Lothian is the only Health Board in Scotland where at least 150 laparoscopic radical prostatectomies are performed.
Partial nephrectomy and cystectomy are still performed as open procedures in NHS Lothian.

Across North America, Europe and England & Wales there has been widespread adoption of robot-assisted surgery for prostate cancer (in the USA 70%, and in England almost 50% of radical prostatectomies are currently performed using a robotic system). The robotic systems are also widely used to undertake partial nephrectomy for renal cancer and radical cystectomy for bladder cancer. In England NICE has recommended that commissioners consider commissioning robot-assisted radical prostatectomy only where at least 150 cases per annum are performed, in order to ensure economic efficiency.

As the use of such technology becomes more common across the rest of the UK and Europe the training opportunities in laparoscopic radical prostatectomy in super-specialist units performing >400 cases per year will almost certainly disappear as these super high-volume centres move exclusively to robotics.

At present there are no robotic systems in Scotland. Two charities are actively raising funds to purchase systems for use in NHS Scotland (UCAN specifically for Aberdeen with the explicit support of NHS Grampian; Prostate Scotland for the central belt with support from NHS Scotland). NHS Lothian will assess the value and advantage of robot-assisted surgery, to help develop our capacity in line with national planning and developments. This will include consideration of the whole pathway of care for prostate cancer, the potential skills development for surgical staff, and imaging requirements.

Over 2014 / 15 there is therefore a requirements to work regionally to ensure that for laparoscopic prostatectomy care is being delivered in line with National Planning Forum recommendations. NHS Lothian must also assess the value and advantage of robot-assisted surgery, and assess the potential advantages, costs and risks associated with adoption or non-adoption in Lothian.

5. DESIGN OUR HEALTHCARE SYSTEMS TO RELIABLY AND EFFICIENTLY DELIVER THE RIGHT CARE AT THE RIGHT TIME IN THE MOST APPROPRIATE SETTING

Teenage Cancer

For young people with cancer, the provision of a dedicated teenage cancer unit makes the cancer pathway more bearable, makes it easier to engage with treatment, easier to keep going and easier to maintain existing social and support networks. NHS Lothian is working with the Teenage Cancer Trust (TCT) to achieve this. The TCT aims to ensure that every young person with cancer and their family receive the best possible care and professional support throughout their cancer journey. The Trust also empowers young people through education and advocacy.

In the East of Scotland our joint goal is to have age appropriate units at:
- The new Royal Hospital for Sick Children, Edinburgh, for 13-16 year olds (a refurbished unit opened at the RHSC in 2010, and this unit is included in re-provision plans for the new children’s hospital)
• The Western General Hospital, Edinburgh, for older teenagers and young adults aged 16 – 24 years (with a new unit opened in 2013, which will be further considered in the reprovision of the Edinburgh Cancer Centre).

The overall benefits associated with the provision of a dedicated unit for teenagers and young adults with cancer are:

• treatment can be delivered in a suitable environment, at appropriate times and an appropriate location
• enables the delivery of specialist care that has been demonstrated to significantly benefit this patient group
• peer support for teenage and young adults with cancer
• provide areas for patients, siblings and friends of teenagers and young adults with cancer to meet and support each other
• supports the aims of the Cancer Plan for Children and Young people in Scotland 2012-2015

Children and Young Adults – Managing Transitions in Care Provision

From the Patient Experience Programme staff in both paediatric and adult neuro-oncology services identified the need to design a better transition between services for the increasing number of teenage patients who are being seen in age inappropriate environments. The enthusiasm of key clinical staff to be involved in the design of a transition process created an ideal situation for a small scale project to begin the project work, and also demonstrated a commitment to working with hard to reach patient population groups.

Parents and teenagers feel safe and supported by their consultant and teams at Sick Children’s and express anxiety about transition to adult services. The move from children’s services should occur when the individual patient is ready and the decision should be agreed by staff in partnership with patient and parents. An outcome from the teenagers and young people’s experiences in neuro-oncology project was to create a transition clinic for current young patients and for newly diagnosed patients in this age group, which can be replicated in other specialities. Alongside the change in physical surroundings changes in practice must occur such as the young people being encouraged to see the clinicians alone as well as with their parents so that they take ownership of managing their health as they mature.

Transforming Care After Treatment

The Transforming Care After Treatment (TCAT) programme is a collaboration between Macmillan Cancer Support and NHS Scotland and aims to ensure that people diagnosed with cancer are prepared for and supported to live with the consequences of the diagnosis and its treatment. With more people living longer after cancer treatment and incidence also increasing, by 2030 there are likely to be around 360,000 people living with or after cancer treatment in Scotland. Health services need to consider how care and support should be delivered after the initial

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management phase of treatment is complete to support and enable people affected by cancer to live as healthy and as good a quality of life for as long as possible.

TCAT is a major component of the Scottish Cancer Taskforce Workplan, which will be delivered in partnership with the Scottish Government, Regional Cancer Networks, Health Boards, Local Authorities and the Voluntary Sector. Macmillan Cancer Support is providing £5 million over 5 years to facilitate the development and implementation of models of care that:

- Enable people affected by cancer to play a more active role in managing their own care.
- Provide services which are more tailored to the needs and preferences of people affected by cancer.
- Give people affected by cancer more support in dealing with the physical, emotional and financial consequences of cancer treatment.
- Improve integration between different service providers and provide more care locally.

The principles for future practice which should be integral elements of all new models of cancer care after treatment are risk stratification, personalised care planning, information to meet individual needs, care coordination across care settings and rapid access to appropriate health or care professional when problems arise. We want to promote a culture shift towards shared decision making and supporting self management. The wellbeing of people affected by cancer will be greater and their demand for services lower if they get the support that is relevant to their particular needs.

In December 2013 NHS Lothian’s TCAT proposal “Developing a recovery-based approach to cancer care in Lothian” was approved, securing Macmillan funding for a 2-year development project. The overall aim of this scheme is to evaluate the immediate and intermediate benefits of a recovery-based approach to care in patients treated for prostate, breast, gynaecological, anal/rectal and lung cancer. Needs assessment, and End of Treatment Assessment Clinics will be delivered.

The specific objectives of the scheme, to be delivered over 2014 – 2015, are:
1. To prepare and inform people about what to expect after completion of treatment including follow-up, offering tailored advice on what they can do for themselves and how to access further sources of support;

2. To evaluate the implementation of Holistic Needs Assessment and care planning and/or specific interventions to support the identified needs of patients at 6-12 weeks post treatment;

3. To evaluate the implementation of an end-of-treatment review about care and treatment received, possible treatment toxicities and/or late effects, ongoing management plan and any actions/goals to support recovery which would inform both the patient and the primary care teams;

4. To evaluate the benefits of conducting a supportive end-of-treatment approach to recovery from the perspectives of both patients and health care professionals;
5. To evaluate the feasibility of embedding this service in everyday care;

A secondary objective will be to review the key concerns raised by patients and assess whether there are common themes for all patients or within specific tumour groups. This data may help inform future intervention work.

Phase-2 of the programme, during 2014, will see the development of the TCAT initiatives further with the involvement of Lothian Health and Social Care Partnerships. This brings the opportunity to extend the improvement in care to Local Authority and NHS provided community based services.

**Breast Service Redesign**

NHS Lothian is the host Board for The South East Scotland Breast Screening Programme (SESBSP) which is commissioned by National Services Division (NSD). The service provides screening and diagnostic services for the NHS Lothian, NHS Fife (except North-East Fife), NHS Forth Valley and NHS Borders region. Breast Screening services are located at Ardmillan House, in South West Edinburgh. Symptomatic Breast services are provided at the Western General Hospital (WGH). Patients diagnosed with breast cancer in the screening pathway are referred to the breast service at the WGH for further assessment and treatment.

The screening static centre at Ardmillan carries out routine screening for over 50% of the City of Edinburgh eligible population; along with follow-up assessment. The screening service currently operates 5 mobile units to cover the eligible population of South-East Scotland.

Over the course of October and November 2013 digital screening was introduced into the screening programme (the first region in Scotland to be fully digitised). This removes the requirement to store films in the future, and is a major step forward in terms of image quality and diagnostic capability. It is anticipated that the introduction of digital screening will lead to the detection of more early stage breast cancers, including more DCIS (Ductal Carcinoma In Situ). The screening population served is predicted to increase by 14% over the next 3 screening rounds. It is likely that with the anticipated increase in eligible population, increasing uptake from the 71+ age bands and marketing campaigns designed to increase attendance that within 5 years demand will exceed capacity available in the breast screening service.

The Mammography Department at the WGH also provides breast diagnostic imaging services for symptomatic women in Edinburgh, with localisation services for patients with impalpable lesions from across Lothian, Fife, Borders, and half of Forth Valley regions. Long-term follow-up screening service for patients who have been treated for breast cancer is also provided.

Increasingly the screening and symptomatic services work in an integrated way and planning for redesign and modernisation of the breast service pathway includes consideration of the total breast pathway. As we further consider service capacity requirements, and link this work to planning for a new cancer centre, the co-location
of breast symptomatic and screening services needs to be reviewed to determine if the advantages of full co-location can be achieved in the context of potentially taking forward a major cancer services capital programme on the Western General Hospital site.

In early 2011 the National Planning Forum commissioned NSD to undertake a major review of the Breast Screening Programme across Scotland. The review group concluded that the screening service should retain a six-centre model, but pursue further integration with symptomatic breast services.

Work is underway in Lothian to assess and plan redesigned services, particularly at this stage associated with the Detect Cancer Early Programme. NHS Lothian, alongside other NHS Boards in Scotland which host breast screening services, will work with NSD and other partners as the implementation plan following the national review is rolled-out.

Palliative and End of Life Care
The Lothian Palliative and End of Life Care strategy was approved by the NHS Board, and our partner agencies involved in co-developing the strategy, in 2010.

Our vision is for high quality Palliative and End of Life care available in all settings, utilised by all who require it, and prioritised according to the patient’s need, rather than medical condition. By 2015 clinical teams in all settings across Lothian will be reliably identifying and assessing patients as they reach a palliative phase of their illness, and developing and updating integrated care plans for them and their carers, based on patients and family preferences.

Our aim is to ensure access to high quality Palliative Care to all who need it, irrespective of diagnosis, age, gender, ethnicity, religious belief, disability, sexual orientation, and socio-economic status.

Public and professional feedback alike highlighted the importance of supporting choice for people with palliative and end of life care needs. Based on this, the goals of strategic implementation in relation to supporting choice focus on action to:

- Identify people who would benefit from palliative care, and to develop care plans with people which include establishing preferred place of care and preferred place of death
- Maximise the time spent in people’s preferred place of care (home, care home, and community hospital)
- Minimise emergency admissions where these could be avoided by good anticipatory care planning
- Support realistic choice of place of death (taking into account a holistic assessment of patient, family and carer needs)

We are taking forward a model of palliative care which seeks to support the integration of disease modifying treatment and palliative care. Our approach breaks down palliative care planning and delivery into 3 tiers:
• Working with people with Long Term Conditions to make sure that the need for palliative care is identified as part of routine care at the earliest stage appropriate, helping people to plan, direct and be actively involved in their own care.

• Adopting the Palliative Care Approach from as early a stage as is agreed appropriate. The palliative care approach seeks to maximise quality of life, by maintaining good symptom control, offering holistic assessment including family and carers needs, and seeks to agree choices around treatment options, place of care and preferred place of death.

• Planning for and managing end of life care in the last days of life in a tightly co-ordinated and structured manner.

As a result of development work in recent years, there is now a stronger platform from which to make further service improvement, however our strategic indicators show that progress towards overall goals and strategy outcomes is not being made quickly enough. There is therefore a need to re-focus on the main pathways of care in palliative and end of life care to achieve better and more reliable co-ordination of care within and across service settings. All partners recognise the need for more of an emphasis on integrated community based care.

To support the necessary redesign, NHS Lothian and Marie Curie UK are jointly sponsoring the Lothian Palliative Care redesign programme, with the participation of all stakeholders. The development phase of the programme runs over 2013 and 2014, with change initiatives being delivered thereafter. In summary the programme aims to:

• Assist in taking further the community based model of palliative care in place across Lothian, and to accelerate progress in shifting the balance of end of life care towards greater community based care

• To improve co-ordination of care, within and across settings, to support patients and families with complex and unstable palliative and end of life care needs

• To increase capabilities to identify patients and to plan care in anticipation and in advance of needs

• To enhance education, and support greater recognition of non-cancer palliative care identification and planning requirements

• To increase community based care service provision

The management of elderly patients with complex needs
Fifty percent of the increasing incidence in cancer is in the retired population. Building on pilot work being undertaken in haematology to consider the additional needs associated with elderly cancer patients with complex needs, we need to further consider pathways and clinical management arrangements for older patients. A systematic analysis of need is required to support the development of pathways and protocols across the region.

Tumour specific Group issues:
Tumour Specific Groups (TSGs) are in place as part of the South East Scotland Cancer Network. Groups are in place for the following: Breast, Colorectal, Gynaecology, Haematology, Lung, Skin, Upper GI, Head & Neck and Urology.

The work programme of all of the TSG’s includes common features supporting the achievement of reliable and high quality care delivered in the right setting. Features such as:

- Identifying best practice and supporting evidence based care into practice
- Allowing regional clinical management collaboration to support and achieve new standards of care across regional units
- Participation in the development and implementation of the new Cancer Quality Performance Indicators
- Participation in cancer clinical audit
- Development of guidelines and protocols to support clinical management
- Pathway development specific to the tumour type

6. INVOLVE PATIENTS AND CARERS AS EQUAL PARTNERS, ENABLING INDIVIDUALS TO MANAGE THEIR OWN HEALTH AND WELLBEING AND THAT OF THEIR FAMILIES

Cancer patients input to service programmes and the Better Together Patient Experience Programme
Patient involvement has been, and will continue to be, a fundamental element of the planning and development of Cancer Services within NHS Lothian.

NHS-24 Cancer Treatment Helpline
Within the Acute Oncology Programme, NHS Lothian has participated as an early implementer of the NHS-24 Cancer Treatment Helpline (CTH). Lothian patients were closely involved in the planning of this national development via the SCAN (South East of Scotland Cancer Network) Patient Forum. The views and experiences of patients accessing this service continue to be sought from patients accessing this service via telephone interviews undertaken by the CTH team in Lothian. This feedback is being used to further inform service change as implementation within the other Health Boards is undertaken.
**Transforming Care After Treatment (TCAT)**

Other major programmes which have had local patient involvement from the start include the Transforming Care After Treatment (TCAT) Programme. NHS Lothian patients have been involved in the discussion and selection of potential projects from all SCAN Boards. The successful projects in each phase of this 5 year programme will be managed by a local steering group where active involvement from patients will be sought. Indeed the first project to be undertaken has been developed with direct input from the Lothian Prostate Cancer Support Group.

**Patient Experience Cancer Quality Performance Indicators (QPI’s)**

The first collection of Patient Experience Quality Performance Indicators (QPIs) will be undertaken in 2014. These were developed during 2013 with contribution from the SCAN Patient Involvement Manager, and duly ratified by the national group in December 2013. The local delivery plan for monitoring against these indicators is currently being devised and will include patient involvement via the Tumour Specific Groups (TSGs).

**Tailored Information for People of Scotland (TIPS)**

September 2013 saw the launch of Tailored Information for People of Scotland (TIPS). This is a web based service which aims to guide patients towards the information that may be useful to them at a specific point in time. It seeks to avoid ‘information overload’. The design and development of this website has involved patients from it’s inception. The information chosen to support the Chemotherapy section is taken directly from patient information leaflets developed within the Edinburgh Cancer Centre.

**Better Together Patient Experience Programme**

NHS Lothian will continue to strive to improve services based on patient feedback such as those seen in recent years. Many of these were a direct result of the Better Together Programme launched in 2008 by the Scottish Government Health Department. Projects include:-

- Development of Head and Neck specific section on SCAN website, including a DVD for patients
- A neck lump clinic set up in 2012 to ensure timely access to appropriate diagnosis
- Development of a transition clinic for young adults, as they move between paediatric and adult services.
- Redesign of chemotherapy booklet for patients, based on individual experiences
- Creation of the Teenage Cancer Trust Unit on WGH site, which opened in July 2013.
- Ongoing development of One Stop Breast Clinics at St John’s Hospital, following the Breakthrough Breast Cancer Service Pledge to patients
- Expansion of the Mammography Unit at WGH
- Recorded conversations in Urology consultations now commonplace (following on from the innovative Decision Navigator Study)
• Improvement in provision of snacks for those undergoing chemotherapy treatments
• Development of visual information to use with patients with learning difficulties in respect of Cancer treatments

SCAN Patient Forum
NHS Lothian is represented in each SCAN Tumour Specific Group. These groups now all have patient representation, thus ensuring patient involvement in all discussion around clinical developments.

The establishment of a Bladder Cancer Support Group has resulted from some of these discussions within the SCAN Urology TSG. This has a Patient and Carer reference Group as a sub group – the first of its kind in SCAN and developed to support patients and carers together. There is an aspiration to roll this out to the other TSGs, particularly Gynae and Breast.

Undertaking patient satisfaction / experience surveys will be a core part of service delivery. Following a pilot in December 2013, the ECC will be undertaking a regular programme of patient experience work within their own local quality strategy.

A national patient satisfaction survey relating to radiotherapy treatment will be completed between March and June 2014.

In undertaking the Edinburgh Cancer Centre Reprovision Programme patient involvement will be initially supported via use of the SCAN Patient Forum. Thereafter individual contribution will be built into the relevant workstreams, as required by the programme.

7. USE THE RESOURCES WE HAVE – SKILLED PEOPLE, TECHNOLOGY, BUILDINGS AND EQUIPMENT – EFFICIENTLY AND EFFECTIVELY

Our Vision for Cancer Care Delivery: Cancer Centre Reprovisioning and the Western General Hospital
The Western General Hospital is Lothian’s Cancer Services campus, providing oncology services for Lothian and the South East of Scotland region. The cancer service provided is greater than Edinburgh Cancer Centre (ECC) direct provision, for example it includes acute care provided both directly by ECC and by acute services, surgical oncology, and physician led cancer care in various specialties. As such, elements of oncology care pathways are provided all across most services at the Western General Hospital (and indeed the other Lothian main acute sites). This multi-disciplinary approach is how cancer pathways operate, supported by coordinated care managed by the cancer multi-disciplinary meetings. These clinical linkages and dependencies need to be recognised and developed to support the delivery of high quality cancer care across Lothian, and to achieve a focus for cancer care at the Western general Hospital as Lothian’s principal cancer site.

Our previous planning work on visioning and the potential for reprovisioning of the Edinburgh Cancer Centre confirmed the Western General Hospital as the preferred site for a new cancer centre. A long list of eight options were considered (including looking at the Lothian main acute sites, other Lothian sites, doing nothing / minimum,
and phased development on the existing Cancer Centre). Of these options the preferred option, based on a limited (non financial) options appraisal was for a ‘New build on the Western General Hospital development zone (DCN) – New co-located cancer centre capable of meeting 2025 activity’. This was based on consideration of the best strategic fit, service integration and clinical effectiveness, physical environment, sustainability, and deliverability.

Critically the Western General Hospital is supported in its potential to become Lothian’s designated cancer campus because of the presence of key services, capabilities and facilities, for example:

- Clinical Genetics services
- Colorectal Surgery provision in Lothian centralised on the site
- Urology
- The potential to develop leading expertise and integrated provision of complex pelvic surgical services by bringing together gynaecology, colorectal surgery, urology, and oncology for joint procedures and integrated planning and management
- The Lothian Bowel Screening Service is co-ordinated from the Western General Hospital
- Breast cancer symptomatic assessment, diagnostic and treatment services are based on the site with further potential to integrate with breast screening services
- Specialist Palliative Care services are provided
- Significant cancer imaging is undertaken, with the potential to further develop and redesign imaging services to support cancer pathways
- The Maggie’s Centre is on the Western general Hospital Site
- The University of Edinburgh, Edinburgh Cancer Research Centre is on the campus

To further progress service improvement and the delivery of co-ordinated pathways of care we will take forward throughout 2014 a ‘Model of Care’ workstream as part of the planning programme for the new cancer centre. This will consider, for each tumour group area, key clinical linkages and dependencies, pathways, and the model of care required to support effective service arrangements in each area.

The planning programme for the new cancer centre will focus around the principal workstreams of radiotherapy, workforce, accommodation, and models of care. Key cross-cutting principles such as delivery of care closest to a patients’ home without loss of quality, access or efficiency, and maximising the role and involvement of primary care will be central. In designing plans for the new centre, integration of ambulatory care facilities, acute assessment and inpatient beds will be specifically considered, as well as other key issues such as the co-location of our breast screening and symptomatic services. Maximising the potential benefits telemedicine can bring will also be key. Working with regional partners our concept will be to build a South East of Scotland Cancer Centre as the hub of a regional cancer service, with strong links to imaging, pathology and surgical services across the region.
eHealth and Cancer in Lothian

Section 4 of this document rehearses our plan to develop cancer informatics.

Our e-health developments include, for example:

- Developing the TRAK system to support cancer patient pathway management by using this system both for cancer tracking and, increasingly, to support multi-disciplinary groups (MDM’s).

- Increasingly utilising the Clinical Portal system to integrate clinical systems and support collaborative working between clinical teams, whether that be within Lothian, across the South East of Scotland Cancer Network, or nationally.

- Providing e-referral systems including cancer specific referrals guidance in line with nationally agreed cancer referral guidelines.

- Testing and further considering telehealth and telepresence technology to potentially allow remote consultation and collaboration between professionals.

- Using the C-PORT system in chemotherapy to assist with capacity and demand modelling and scenario planning. We are also utilising and further developing the CEPAS system to support prescribing.

- Using the R-PORT system to support radiotherapy department level capacity planning.

- Developing a South East of Scotland cancer e-health strategy to support all regional Boards.

- In palliative and End of Life care we are utilising the Key Information Summary (KIS) system to record and communicate palliative care anticipatory care plans across in and out-of-hours services. We are also planning to establish secure data connections between the NHS Lothian Network and the two Lothian Independent Hospices to allow electronic referral via Gateway and to support greater clinical communication.

Access to Cancer Care in Lothian

There are two headline national cancer waiting times’ targets in Scotland:

- 62 days from urgent referral with suspicion of cancer (and referrals from the national screening programmes) to first treatment
- 31 days from decision to treat to first treatment (irrespective of route of referral)

NHS Lothian’s performance against both of the headline targets in recent years has been either over the required standard or, where dips in performance in 62-days have been experienced, close to the 95% standard required. Lung cancer 62-day
performance is being further scrutinised in 2014 and an action plan for improvement in lung cancer will be developed, including review and redesign of the lung cancer pathway. Lung cancer, Head & Neck Cancers, and Lymphoma are the pathways where compliance with the 62-day pathway requires ongoing support.

NHS Lothian has consistently met the standards for acute leukaemia and for children’s cancers, both of which are subject to a separate reporting mechanism to the 62 and 31 day standards.

The leukaemia target is a maximum wait from urgent referral to treatment for acute leukaemia of one month.

The children’s cancer target is a maximum wait from urgent referral to treatment for children’s cancers of one month.

**Cancer Research**

If we aspire to optimise outcomes, incorporating clinical research as a core service is essential. Research should be embedded into the clinical service across the region, as there is a growing body of evidence that those hospitals that conduct clinical research deliver better outcomes for all their patients, not just those enrolled into clinical trials. Support departments (imaging, nursing, diagnostics, portering etc.) all have a key role to play in facilitating and maximising research activity.
8. STRATEGY MEASUREMENT

Routine measures
Cancer services in Lothian are subject to continuous measurement and reporting, all of which contribute to service scrutiny and improvement. The main areas of routine measurement are noted below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Measure</th>
<th>Published</th>
<th>Description</th>
<th>Source</th>
<th>Lothian Performance</th>
<th>Scotland Performance</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Screening</td>
<td>Uptake</td>
<td>Annually</td>
<td>Bowel Screening Key Performance Indicator report which includes 28 indicators.</td>
<td>ISD</td>
<td>53.5%</td>
<td>54.9%</td>
<td>60%</td>
</tr>
<tr>
<td>Breast Screening</td>
<td>Uptake</td>
<td>Annually</td>
<td>Report on the KC62 Health Board Standards. This includes a number of indicators around breast screening including uptake.</td>
<td>ISD</td>
<td>71.7%</td>
<td>74.5%</td>
<td>80%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>5.5 year Uptake</td>
<td>Annually</td>
<td>Data covering uptake, workload, processing, turnaround and reporting.</td>
<td>ISD</td>
<td>75.5%</td>
<td>78.1%</td>
<td>80%</td>
</tr>
<tr>
<td>Access</td>
<td>62-day referral to treatment</td>
<td>Quarterly</td>
<td>95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral</td>
<td>ISD</td>
<td>96.9%</td>
<td>94.5%</td>
<td>95%</td>
</tr>
<tr>
<td>Access</td>
<td>31-day decision to treat</td>
<td>Quarterly</td>
<td>95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat</td>
<td>ISD</td>
<td>99.6%</td>
<td>98.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Area</td>
<td>Measure</td>
<td>Published</td>
<td>Description</td>
<td>Source</td>
<td>Lothian Performance</td>
<td>Scotland Performance</td>
<td>Target</td>
</tr>
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<td>----------------------</td>
<td>----------------------------------------------</td>
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<td>-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>--------</td>
<td>---------------------</td>
<td>----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td><strong>HEAT targets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DCE HEAT Target</td>
<td>Proportion of cancers detected at stage 1 (HEAT target H10.1)</td>
<td>Annually</td>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015.</td>
<td>ISD</td>
<td>10.20%</td>
<td>4.30%</td>
<td>Local: 28.3% National: 25%</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Successful Quits (HEAT target H6.1)</td>
<td>Quarterly</td>
<td>NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most deprived within-Board SIMD areas over the three years ending March 2014.</td>
<td>ISD</td>
<td>7,779</td>
<td>48,396</td>
<td>Local: 7,011 National: 48,000</td>
</tr>
<tr>
<td><strong>Quality &amp; Outcome Indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Quality Performance indicators</td>
<td>Various - Yet to be published</td>
<td>Annually</td>
<td>The QPIs have been developed collaboratively with the three Regional Cancer Networks, Information Services Division (ISD), and Healthcare Improvement Scotland. QPIs will be kept under regular review and be responsive to changes in clinical practice and emerging evidence. They include small sets (approximately 10-15 indicators) of tumour specific and generic national quality performance indicators (QPIs).</td>
<td>HIS/ISD</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Incidence</td>
<td>Incidence</td>
<td>Annually</td>
<td>Incidence statistics by cancer type, sex, network and health board. The data is also split by age group at network level and above.</td>
<td>ISD</td>
<td>Total: 4,614 EASR: 445.1</td>
<td>Total: 30,125 EASR: 425.2</td>
<td>-</td>
</tr>
<tr>
<td>Mortality</td>
<td>Mortality</td>
<td>Annually</td>
<td>Mortality statistics by cancer type, sex, network and health board. The data is also split by age group at network level and above.</td>
<td>ISD</td>
<td>Total: 1,113 EASR: 179.4</td>
<td>Total: 15,787 EASR: 198.6</td>
<td>-</td>
</tr>
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<td>---</td>
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<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Survival</td>
<td>Survival</td>
<td>Annually</td>
<td>The National Cancer Intelligence Network (NCIN) produces a cancer e-Atlas tool that includes incidence, mortality and survival indicators for the whole of the UK.</td>
<td>NCIN</td>
<td>Currently being revised</td>
<td>Currently being revised</td>
<td>-</td>
</tr>
<tr>
<td>Quality Report – Clinical Governance</td>
<td>QoF Cancer Review</td>
<td>Annually</td>
<td>A yearly cancer quality report is produced in NHS Lothian. Clinical effectiveness measures presented include: mortality rates, smoking cessation outcomes, uptake of the three screening programmes and primary care review of patients newly diagnosed with cancer. The QOF indicator used for the final measure requires that patients are reviewed in primary care within six months of the practice receiving confirmation of the cancer diagnosis.</td>
<td>QoF Calculator</td>
<td>96.3%</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Area</th>
<th>Measure</th>
<th>Published</th>
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<th>Lothian Performance</th>
<th>Scotland Performance</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Palliative Care Strategic indicators</td>
<td>Occupied bed days</td>
<td>Annually</td>
<td>Reduction in the number of occupied bed days in last year of life (for deaths in domiciliary and care home settings)</td>
<td>LAS</td>
<td>26,923</td>
<td>-</td>
<td>22,603</td>
</tr>
<tr>
<td></td>
<td>Deaths/year</td>
<td>Annually</td>
<td>10% reduction in deaths/year in acute hospital settings between 2008 and 2015</td>
<td>LAS</td>
<td>-0.3%</td>
<td>-</td>
<td>-10%</td>
</tr>
<tr>
<td>Palliative Care Quality Outcome Measure 10</td>
<td>Quality Outcome Measure 10</td>
<td>Annually</td>
<td>Percentage of last six months of life spent at home or in a community setting</td>
<td>ISD</td>
<td>92.0%</td>
<td>91.2%</td>
<td>-</td>
</tr>
</tbody>
</table>
9. STRATEGIC RESOURCING

NHS Lothian’s operating budget for oncology in 2013 / 14 was £43.85m (covering breast screening, oncology services including breast services and palliative care, and haematology). We manage a strategic budget of £4.3m to commission hospice care in Lothian and support the palliative care strategic programme, including the managed clinical network (MCN). Specific aspects of the strategic programme such as the Detect Cancer Early Programme and the cancer modernisation programme bring additional allocations which are used to support specific services and initiatives across the system. The NHS Lothian Detect Cancer Early Programme was allocated £1.5m in revenue and £0.3m in capital in 13/14, and will be subject to further (variable) income allocations in 14/15 and 15/16 to support the programme. Cancer modernisation in NHS Lothian was allocated £0.5m in 13/14 (with 0.3m of this for regional radiotherapy modernisation), with further investment to come in 14/15. Other specific allocation routes also support the provision of cancer care in Lothian, such as for key diagnostic capacity and development (for example PET provision), and via primary care funding routes such as the GP contract / Scottish Quality and Outcomes Framework, which are for example currently being utilised nationally to further support local Detect Cancer Early Programmes and screening programmes.

Cancer pathways operate across the whole system of care. As an example, lung cancer care will include a GP or Emergency Department presentation and onward referral, initial diagnostic imaging, respiratory medicine assessment and related endoscopic diagnostics, may include thoracic surgery, and most cases will necessitate assessment, planning and treatment in oncology (radiotherapy, chemotherapy or a combination treatment), and may require palliative and end of life care. Such co-ordinated care happens across specialties and settings of care, and often across NHS Board boundaries. We do not have an accurate mechanism to determine the full costs of cancer care across the whole system. The development of the Integrated Resource Framework (IRF) in Lothian may assist in achieving a better estimate of cancer pathway costs.

At the South East of Scotland regional level the shared costs of cancer care (cross charging other South East of Scotland NHS Boards for specialist care provided by NHS Lothian) are managed via service level agreements across the region. Under this model, recovery of costs is based on annual average case volumes and costs per case.

Section 7 of this strategy outlines our ambition to develop the Western General Hospital as Lothian’s cancer campus and the base for a new South East of Scotland Cancer Centre. In order to support this ambition the associated business case needs to be completed locally and submitted into the national capital programme for consideration and prioritisation. Production of an Initial Agreement and, subject to approval, an Outline Business Case will be taken forward during 2014/15.
APPENDIX 1 - GOVERNANCE – CANCER PLANNING AND MANAGEMENT PROCESSES

This appendices provides two schematics. The first shows the organisation of the national cancer programme and the South East of Scotland regional arrangements. The second shows the Lothian cancer and palliative care programme in the context of the NHS Lothian strategic planning arrangements.
APPENDIX 2 – TRENDS IN CANCER SURVIVAL 1983-2007
All malignant neoplasms excluding non-melanoma skin cancer (ICD-9 140-208 excl. 173; ICD-10 C00-C97 excl. C44)
Trends in survival by age group and period of diagnosis
Observed and relative survival (%) at 1, 3, 5 and 10 years; patients diagnosed 1983-2007.1,2
All Persons
Observed survival (%) at

Age group Period

Relative survival (%) at

Number of
cases
analysed

1 yr

3 yr

5 yr

10 yr

1 yr

3 yr

5 yr

10 yr

15-44

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

7,237
7,818
8,115
8,290
8,487

82.6
84.4
87.6
89.4
90.4

69.3
72.3
76.8
80.1
81.8

63.5
67.2
72.1
75.8
77.6

56.9
60.6
66.2
70.4
..

82.8
84.5
87.8
89.5
90.6

69.6
72.7
77.2
80.5
82.2

64.1
67.8
72.7
76.5
78.3

58.4
62.1
67.7
71.9
..

45-54

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

9,744
10,554
11,889
12,223
12,560

65.9
70.9
74.7
78.1
81.0

49.7
56.2
60.1
64.3
68.8

43.6
50.0
54.7
58.9
63.6

35.9
41.7
46.8
51.5
..

66.3
71.4
75.1
78.5
81.4

50.7
57.3
61.1
65.4
69.8

45.2
51.8
56.4
60.6
65.3

39.2
45.6
50.6
55.3
..

55-64

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

22,274
22,086
22,593
23,092
25,133

52.7
58.2
63.8
68.0
71.6

36.1
41.9
48.0
52.4
57.3

29.8
35.3
41.5
46.0
51.7

21.3
26.7
32.7
37.1
..

53.7
59.2
64.7
69.0
72.4

38.2
44.3
50.4
54.8
59.4

33.1
39.0
45.4
49.8
55.3

27.6
34.0
40.7
44.9
..

65-74

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

30,446
32,063
35,819
34,357
34,970

45.4
48.3
52.8
57.7
62.1

29.0
31.9
36.0
40.7
45.7

22.2
25.2
29.1
33.6
38.9

13.3
15.7
18.5
22.4
..

47.5
50.4
54.8
59.6
64.0

33.4
36.5
40.8
45.4
50.3

28.7
32.1
36.3
41.1
46.3

24.4
28.2
31.9
36.5
..

75-84

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

23,669
25,794
27,953
29,067
30,581

36.3
39.9
44.8
46.8
48.9

21.0
24.0
27.4
29.3
31.3

14.1
16.9
19.5
21.7
23.3

6.0
7.1
8.4
10.4
..

39.8
43.7
48.7
50.5
52.4

28.1
32.1
35.9
37.4
39.3

23.7
28.3
31.8
33.7
35.2

19.8
23.7
27.2
30.0
..

85-99

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

5,537
7,183
9,183
9,695
10,072

26.8
29.9
33.5
34.4
34.9

12.4
14.4
17.0
17.0
17.2

6.4
7.9
9.3
9.7
9.9

1.6
2.0
2.1
2.4
..

31.7
35.5
39.7
40.6
40.8

21.1
24.8
29.5
28.9
28.4

16.4
20.9
24.5
24.7
24.3

13.3
18.8
20.4
20.4
..

15-74

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

69,701
72,521
78,416
77,962
81,150

54.5
58.6
62.9
67.3
70.9

38.4
42.9
47.4
52.1
56.7

32.0
36.5
41.0
45.8
50.8

23.5
27.7
31.9
36.4
..

56.1
60.2
64.6
68.9
72.4

41.7
46.5
51.1
55.7
60.1

36.8
41.7
46.6
51.3
56.1

32.1
37.1
42.2
46.9
..

15-99

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

98,907
105,498
115,552
116,724
121,803

48.8
52.2
56.4
59.6
62.5

32.8
36.5
40.3
43.5
47.1

26.3
29.8
33.4
36.8
40.5

18.1
20.9
23.9
27.0
..

51.3
55.0
59.3
62.7
65.6

37.8
42.1
46.5
49.9
53.5

33.3
37.8
42.3
45.9
49.8

28.9
33.5
38.2
41.9
..

Directly standardised3
15-74

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

69,701
72,521
78,416
77,962
81,150

54.7
58.6
63.1
67.2
70.8

38.5
42.9
47.6
51.9
56.5

32.2
36.5
41.3
45.7
50.6

23.9
27.8
32.3
36.5
..

55.8
59.7
64.3
68.4
71.9

41.1
45.6
50.4
54.7
59.2

36.1
40.7
45.7
50.1
55.1

31.0
35.8
40.9
45.3
..

15-99

1983-1987
1988-1992
1993-1997
1998-2002
2003-2007

98,907
105,498
115,552
116,724
121,803

47.9
51.6
56.2
59.5
62.4

32.1
36.0
40.2
43.5
47.1

25.8
29.5
33.5
36.9
40.7

18.0
21.1
24.4
27.7
..

49.9
53.8
58.5
61.8
64.6

36.2
40.6
45.2
48.4
51.8

31.3
35.9
40.5
44.0
47.6

26.7
31.6
35.8
39.4
..

'-' = zero value.
'x' = not applicable.
'..' = not available.
1
2
3

Cases diagnosed in 2005-2007 do not have 5 years' follow-up and cases diagnosed in 2000-2007 do not have 10 years' follow-up.
Cases diagnosed in 1983-1996 are coded to ICD-9 scheme and cases diagnosed in 1997-2007 are coded to ICD-10 scheme.
These rates are standardised to the European Cancer Patient Population (EUROCARE-4).

Source: Scottish Cancer Registry, ISD
Data extracted: June 2010

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SUMMARY PAPER - INTEGRATION OF HEALTH AND SOCIAL CARE

This paper aims to summarise the key points.

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Text</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>The purpose of this report is to recommend that the Board is aware of recent guidance from Scottish Government and understands the implications of this on the delegation of health functions to the Integration Joint Boards</td>
<td></td>
</tr>
<tr>
<td>2.1</td>
<td>The Board is recommended to agree that the NHS Lothian Board will receive four Integration Schemes in December 2014 for approval prior to the consultation process as will be described in the Regulations.</td>
<td></td>
</tr>
<tr>
<td>3.1</td>
<td>Note that the Public Bodies (Joint Working) (Scotland) Bill was passed on 25 February 2014</td>
<td></td>
</tr>
</tbody>
</table>

Jamie Megaw
Strategic Programme Manager
20 March 2014
Jamie.megaw@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning
alex.mcmahon@nhslothian.scot.nhs.uk
INTEGRATION OF HEALTH AND SOCIAL CARE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board is aware of recent guidance from Scottish Government and understands the implications of this on the delegation of health functions to the Integration Joint Boards.

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

2 Recommendations

2.1 Agree that the NHS Lothian Board will receive four Integration Schemes in December 2014 for approval prior to the consultation process as will be described in the Regulations.

2.2 Note that the decision on which health functions must or may be delegated to Integration Joint Boards will be made by Scottish Government and described in the Regulations.

3 Discussion of Key Issues

3.1 The Public Bodies (Joint Working) (Scotland) Bill was passed on 25 February 2014. The Bill will require local authorities and NHS Boards (parent bodies) to establish Integration Joint Boards for their areas to govern, plan for and resource integrated health and social care services. The parent bodies will be required to delegate functions to improve the health and wellbeing of service users.

3.2 NHS Lothian is committed to the ‘body corporate’ integration model where functions of the Health Board and Local Authority will be delegated to an Integration Joint Board. There will be four integration joint boards in Lothian coterminous with the current Local Authority boundaries.

3.3 It is a requirement of the Bill that an Integration Scheme is produced, consulted and submitted to Scottish Government for approval prior to the establishment of each Integration Joint Board (in previous versions of the Bill the Integration Scheme was referred to as the Integration Plan). Integration Schemes can not be consulted on until after the Bill has become legal and the Regulations published. Scottish Government has indicated that this is likely to be in November 2014. The Integration Schemes will require approval by the NHS Lothian Board and the relevant Local Authority prior to consultation. The intention is that the four Integration Schemes will be presented at the December 2014 NHS Lothian Board meeting.
4 Delegation of Function

4.1 NHS Lothian must agree which health functions are to be delegated to the four Integration Joint Boards in Lothian before the Integration Schemes are presented to the Board in December. A Board Workshop on delegation of functions is organised for 17 April 2014 for the Shadow Board Chairs; Joint Directors as well as the Chairman and Chief Executive and the Directors of Strategic Planning and Finance.

4.2 Part 1 of the Bill is concerned with the “delegation” of legal responsibility for functions from one public body to another, through the creation of an Integration Scheme. The Bill is not concerned with the management arrangements of functions and services once the Integration Schemes are in place.

4.3 The Scottish Government have also indicated that they do not intend (at least initially) to give the Integration Joint Boards the powers to employ staff and to be responsible for the direct delivery of delegated functions. There also appears to be an initial intention to avoid any financial leakage out of the overall system to avoid creating undue financial instability in the parent bodies. What this means is that Integration Joint Boards will be required to use its powers under section 22 of the Bill to direct the local authority and NHS Board to carry out delegated functions on their behalf.

4.4 In January 2014 the Scottish Government published a policy statement on the delegation of functions of Health Boards. The statement signalled a key shift in policy with Scottish Government now intending to be more prescriptive regarding the functions that ‘must’ be delegated and also to prescribe the functions that Health Boards ‘may’ delegate under an Integration Scheme. Any function not listed in the ‘must’ or ‘may’ lists are by default not delegable under an Integration Scheme. This policy statement is available here. The functions that must be delegated as described in this statement are summarised in Appendix 1

4.5 The Scottish Government proposes to require that a Health Board must delegate all of its functions as they relate to adult primary and community health services and the proportion of acute sector provision that will be part of integrated arrangements.

4.6 The Scottish Government proposes to require that those functions of a Health Board that may be delegated under an Integration Scheme are those functions that may be delivered alongside adult primary and community care, such as primary and community care for children and young people.

4.7 The functions of a Health Board that are not to be available for delegation will include matters such as the provision of regional and national services, functions relating to education and research facilities of Health Boards and some specific duties, such as the registration of professionals.

5 Transition Funding

5.1 Scottish Government confirmed in February that additional funding was available to support the transition to Integration Joint Boards. The total resource in Scotland available to be shared across all Partnerships is around £7 million and each Partnership will receive a share of that resource to be used to implement their jointly
agreed transitional/organisational plan. This budget will be allocated to partnerships via NHS Boards in April 2014.

6 Strategic Planning (Joint Strategic Commissioning) JIT Advice Note, February 2014

6.1 The Joint Improvement Team (JIT) has recently published guidance on the strategic planning that should be progressed during the 2014/15 transitional year. A link to the report is here. Action is required to migrate from current Joint Strategic Commissioning Plans for Older People (and other care groups), to Integration Joint Board Strategic Plans that incorporate a Financial Plan relating to all integrated resources by April 2015. The main actions are:

- Establish a Strategic Planning Group within each IJB area
- Identify the locality areas
- Progress discussion regarding form and scope of integrated arrangements
- Review the nature and extent of delegated authority
- Undertake Joint Strategic Needs Assessment
- Determine the governance required to fulfil the potential of locality planning
- Strengthen the delivery of Self Directed Support

7 Risk Register

7.1 The following risk is recorded in the NHS Lothian Corporate Risk Register:

7.2 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)

8 Impact on Inequality, Including Health Inequalities

8.1 The Integration Plans will need to be subject to a rapid impact assessment.

9 Involving People

9.1 The Integration Plans will be put out for public consultation.

10 Resource Implications

10.1 Integration is a substantial change to the governance of health and social care in Scotland. The Integration Joint Boards will have responsibility for a significant amount of public money. The Integration Plans will define that amount.

Jamie Megaw
Strategic Programme Manager
20 March 2014
Jamie.megaw@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: List of functions which must be delegated (as described in the Scottish Government January 2014 policy statement)
List 1 – Functions which must be delegated

This list is comprised of those functions which Ministers intend to prescribe as functions that must be delegated in their entirety in as far as they relate to primary and community health care and the proportion of acute sector provision that will be part of integrated arrangements.

National Health Service (Scotland) Act 1978 Section Function

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>2A(1)</td>
<td>Duty of Health Board, Special Health Board, the Agency and HIS to promote health improvement</td>
</tr>
<tr>
<td>2B(1)</td>
<td>Duty to encourage public involvement</td>
</tr>
<tr>
<td>2C(1)</td>
<td>Functions of Health Boards: primary medical services</td>
</tr>
<tr>
<td>2D(1)</td>
<td>Equal opportunities</td>
</tr>
<tr>
<td>12H</td>
<td>Duty of quality.</td>
</tr>
<tr>
<td>12J(1)</td>
<td>Health Boards: co-operation with other Health Boards, Special Health Boards and the Agency</td>
</tr>
<tr>
<td>13</td>
<td>Co-operation between Health Boards and other authorities.</td>
</tr>
<tr>
<td>13A(1)</td>
<td>Co-operation in planning of services for disabled persons, the elderly and others.</td>
</tr>
<tr>
<td>16</td>
<td>Assistance to voluntary organisations.</td>
</tr>
<tr>
<td>16A</td>
<td>Power to make payments towards expenditure on community services</td>
</tr>
<tr>
<td>16B</td>
<td>Financial assistance by the Secretary of State to voluntary organisations.</td>
</tr>
<tr>
<td>17C(1)</td>
<td>Personal medical or dental services.</td>
</tr>
<tr>
<td>17I</td>
<td>Use of accommodation.</td>
</tr>
<tr>
<td>25.(1)</td>
<td>Arrangements for provision of general dental services.</td>
</tr>
<tr>
<td>26.(1)</td>
<td>Arrangements for provision of general ophthalmic services.</td>
</tr>
<tr>
<td>27.(1)</td>
<td>Arrangements for provision of pharmaceutical services.</td>
</tr>
<tr>
<td>27A(1)</td>
<td>Arrangements for providing additional pharmaceutical services.</td>
</tr>
<tr>
<td>28A</td>
<td>Remuneration for Part II services.</td>
</tr>
<tr>
<td>36.(1)</td>
<td>Accommodation and services.</td>
</tr>
<tr>
<td>37</td>
<td>Prevention of illness, care and after-care.</td>
</tr>
<tr>
<td>38</td>
<td>Care of mothers and young children.</td>
</tr>
<tr>
<td>38A</td>
<td>Breastfeeding</td>
</tr>
<tr>
<td>41</td>
<td>Family planning.</td>
</tr>
<tr>
<td>42</td>
<td>Health education.</td>
</tr>
<tr>
<td>43</td>
<td>Control of spread of infectious disease.</td>
</tr>
<tr>
<td>64</td>
<td>Permission for use of facilities in private practice.</td>
</tr>
<tr>
<td>75A</td>
<td>Remission and repayment of charges and payment of travelling expenses.</td>
</tr>
<tr>
<td>98</td>
<td>Charges in respect of non-residents.</td>
</tr>
</tbody>
</table>

Disabled Persons (Services, Consultation and Representation) Act 1986 Section Function

<table>
<thead>
<tr>
<th>Section</th>
<th>Function</th>
</tr>
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<tbody>
<tr>
<td>7</td>
<td>Persons discharged from hospital</td>
</tr>
</tbody>
</table>
**Mental Health (Care and Treatment) (Scotland) Act 2003 (asp 13)**

<table>
<thead>
<tr>
<th>Section Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>17(1) Duties of Scottish Ministers, local authorities and others as respects Commission</td>
</tr>
<tr>
<td>23 Provision of services and accommodation for certain patients under 18</td>
</tr>
<tr>
<td>24 Provision of services and accommodation for certain mothers with post-natal depression</td>
</tr>
<tr>
<td>31 Assistance from Health Boards and others</td>
</tr>
<tr>
<td>34 Inquiries under section 33: co-operation</td>
</tr>
<tr>
<td>228 Request for assessment of needs: duty on local authorities and Health Boards</td>
</tr>
</tbody>
</table>

**Protection of Vulnerable Groups (Scotland) Act 2007 Section Function**

<table>
<thead>
<tr>
<th>Section Function</th>
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<tbody>
<tr>
<td>19 Information held by public bodies etc.</td>
</tr>
<tr>
<td>92 Meaning of “protected adult”</td>
</tr>
</tbody>
</table>

**Certification of Death (Scotland) Act 2011 Section Function**

<table>
<thead>
<tr>
<th>Section Function</th>
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<tbody>
<tr>
<td>21 Duty to co-operate</td>
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</tbody>
</table>

**Adults with Incapacity (Scotland) Act 2000 Section Function**

<table>
<thead>
<tr>
<th>Section Function</th>
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<tr>
<td>1(5) General principles and fundamental definitions</td>
</tr>
<tr>
<td>35 Application of Part 4(MANAGEMENT OF RESIDENTS’ FINANCES)</td>
</tr>
<tr>
<td>37 Residents whose affairs may be managed</td>
</tr>
<tr>
<td>39 Matters which may be managed</td>
</tr>
<tr>
<td>42 Authorisation of named manager to withdraw from resident’s account</td>
</tr>
<tr>
<td>44 Resident ceasing to be resident of authorised establishment</td>
</tr>
<tr>
<td>45 Appeal, revocation etc.</td>
</tr>
<tr>
<td>81 Repayment of funds</td>
</tr>
<tr>
<td>82 Limitation of liability</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Point</th>
<th>Paragraph</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>The focus of the paper has been widened to include other areas of the workforce in response to the request from board members.</td>
</tr>
<tr>
<td>3.21</td>
<td>Obstetrics &amp; Gynaecology – The readvertised consultant post within Obstetrics at the Royal Infirmary of Edinburgh (RIE) attracted no candidates at closing date in February. One of the consultants appointed in 2012 with resident middle grade out of hours shifts in their job plan resigned in February</td>
</tr>
<tr>
<td>3.22</td>
<td>Paediatrics – In response to the recent difficulty in filling a consultant vacancy the web microsite is being used to show open posts on an on-going basis. Recent successful recruitment to medical and nursing posts in neonatology has significantly mitigated the risk to the neonatal service at SJH.</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Recruitment to specialty Doctors to support the roll-out of Comprehensive Assessment (COMPASS) within Medicine of the Elderly was unsuccessful in appointing any suitable candidates. Recruitment for 3 Consultant posts at the WGH is however currently underway the outcome of which will be reported in due course.</td>
</tr>
<tr>
<td>3.26</td>
<td>A medical workforce group has been established to support services in planning for a sustainable medical workforce.</td>
</tr>
<tr>
<td>3.3</td>
<td>There are a range of nursing workforce utilisation measures reviewed on a monthly basis including staff turnover, supplementary staffing, absence and demand pressures. There have been significant developments in streamlining recruitment of nurses enabling further growth in the nursing.</td>
</tr>
<tr>
<td>3.3.2</td>
<td>The Board is taking forward training of significant numbers of Advanced Nurse Practitioners with 39 commencing training in April 2014.</td>
</tr>
<tr>
<td>3.4</td>
<td>In the face of a range of drivers for increased numbers of health visitors the Corporate Management Team supported the training of an additional 10 staff for 2014/15 at a total cost of £386k</td>
</tr>
</tbody>
</table>

Nick McAlister
Head of Workforce Planning
20 March 2014
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 specialties where high levels of risk have been identified. The scope of the paper has been widened to consider workforce risk within the wider workforce.

2 Recommendations

2.1 Recognise that staffing pressures within Obstetrics remain, following unsuccessful recruitment for four trainees and one consultant post. There has also been the resignation of a consultant with an out of hours commitment at the Royal Infirmary of Edinburgh (RIE). Cover is being provided through a combination of external and internal locum utilisation.

2.2 Staffing for the paediatric unit at St John’s Hospital (SJH) remains fragile, heavily reliant on a small number of staff doing additional night and weekend shifts.

2.3 Note a recent concerted recruitment campaign to recruit 13 Consultants across the RIE, WGH and SJH sites has been successful in filling 8 positions. Consideration is being given to further recruitment to fill the remaining vacancies.

2.4 Note that recruitment difficulties persist within Medicine for the Elderly where 2 specialty doctors to support the Comprehensive Assessment (COMPASS) initiative attracted no suitable candidates.

2.5 Support the establishment of a NHS Lothian Medical Workforce group and update of all Medical Workforce Risk Assessments.

2.6 Support the investments supported by the Corporate Management Team in training an additional 10 health visitors in 2014/15 to help address workforce supply and demand pressures.

3 Discussion of Key Issues

3.1 Background

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.

Emergency Medicine(EM) is now no longer covered as an area of high risk following successful recruitment of additional trained doctors, the creation and recruitment of clinical development fellow posts to support out of hours cover and the implementation of an updated model of care at St John’s Hospital (SJH). EM is no longer included as an area of high risk.
There has also been detail provided around other areas of significant risk in relation to recruitment to provide the required level of additional capacity and improve patient flow within Anaesthetics, Medicine of the Elderly (MoE) and Ophthalmology.

This paper provides detail on nursing workforce utilisation and also detail on the workforce pressures within the community health visiting services.

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. This has resulted in increased internal locum usage and consultants covering resident middle grade OOH shifts several times a month with a consequent impact on day time availability. The numbers of gaps varies on a month by month basis and at the RIE it can be difficult to find competent external locums to provide cover.

In order to address acute staffing shortages at the RIE within Obstetrics two further consultant posts and two further specialty doctor posts (all with resident out of hours shifts in the job plans) were advertised in December 2013. However this resulted in the appointment of only one consultant. The specialty doctor recruitment was unsuccessful, with only one individual recruited, who subsequently withdrew. The second consultant post was re-advertised with no applicants at the closing date in February 2014. In February 2014 one of the consultants recruited in 2012 with resident middle grade out of hours shifts in their job plan resigned. The inability to recruit to consultant and staff grade posts with out of hours commitments reflects a very competitive recruitment situation in obstetrics and the ability of applicants to access other opportunities with less onerous/no out of hours commitments.

Recruitment to locum registrar positions to provide cover for two maternity leave gaps in the middle grade registrar rota from early 2014 and two gaps in the GPST cohort has also been unsuccessful. Consequently one GPST gap will be covered by extending a current LAS appointment, with external agency locums covering the other GPST and the registrar gaps, with the remaining gap covered by intermittent use of internal locums.

Given the importance of sustaining services at the SCRH for both Edinburgh and the South-East region as a whole a short life working group has been established to examine ways in which a regional approach could be taken to expand the trained workforce across the region considering sources in addition to local CCT holders and avoiding competition between Boards for a limited group of specialists.

The Director of Scheduled Care is establishing 4 workstreams to examine in detail key elements of this service. The four workstreams are;

- Capacity & Demand analysis
- Consultant, medical & midwife resource
- Evolving effective skill mix models
- Effective Capacity Management

These groups will initiate in April and will provide interim reports in July 2014.
This was also agreed as a key regional priority at a SEAT Regional Demand and Capacity Event, which provided a detailed picture of the O&G workforce challenges across the region. Possible approaches to addressing challenges in the medium term were highlighted including:

- Management of certain conditions could be managed by General Practice reducing the need for referral to secondary care
- Development of self-monitoring and telehealth in 5 to 10 years, releasing capacity back to services
- Improvements in GP/consultant linkage need to be more robust e.g. referral in and back to primary care
- More coordination and consistency in recruitment across the region
- Potential for more joint appointments providing a greater mix within workloads of intense and less intense
- Reviewing capacity within the region to identify if any opportunities to manage capacity more fully across the region whilst meeting the needs of prospective parents

Once this is formally agreed as a strategic priority for SEAT work will commence in looking at these and other identified areas in further detail.

Despite the continuing pressures within Obstetrics it is however important to note recent successful appointments made within Gynaecology, including a consultant at the RIE who will take up post in March 2014 and a further consultant gynaecologist working between SJH and RIE who will also commence in March 2014.

### 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 including:

- recruitment of an additional consultant and specialty doctor at SJH in addition to two new consultants appointed in 2012,
- recruitment of two senior Clinical Fellows and two advanced neonatal nurse practitioners in neonatology at RIE,
- recruitment of two junior Clinical Fellows shared between RHSC and RIE,
- recruitment of a Clinical Fellow in Paediatric Intensive Care at RHSC
- consolidation into clinical practice of two advanced nurse practitioners in the paediatric intensive care unit at RHSC.

advanced nurse practitioner in paediatric and an advanced neonatal nurse practitioner are now established in the middle grade rota at SJH.

However one of the three new consultant paediatricians based at SJH resigned in November 2013 and there were no suitable applications as part of a recent recruitment exercise. Again this reflects the inherent unattractiveness of consultant posts with resident middle grade shifts in the job plan. However in order to maximise any potential interest the Recruitment team are reinstituting the web based microsite used in previous recruitment attempts. This will show posts open on an on-going basis to increase the chances of attracting potential candidates as part of a rolling recruitment campaign.

The situation at SJH detailed in the February Board paper remains the same, 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 and prone to short notice collapse because of sickness or other unplanned events.

Recent successful recruitment to medical and nursing posts in neonatology has significantly mitigated the risk to the neonatal service at SJH. Although one of the three consultant neonatologists resigned last year he was successfully replaced. These neonatologists are able to support the neonatal service but cannot contribute to the out of hours paediatric service. Two fixed term Clinical Fellows in neonatology were also recruited in 2013 and can make a similar contribution to neonatology but not paediatrics. The Board has also drawn up a specification for an Advanced Paediatric Nurse Practitioner post which they hope to recruit shortly due to the success of the two Advanced Neonatal Nurse Practitioners recruited last year who are based at RIE but who could contribute to cover of neonatology at SJH.

3.2.3 Other areas of the medical workforce that have been identified with high levels of risk.

The October and November Board papers highlighted that Anaesthetics, Medicine of the Elderly(MOE) and Ophthalmology are also facing significant challenges in attracting and sustaining the required numbers of trained medical staff to meet treatment time guarantees and achieve improved patients flow. The following points detail the outcomes of recent recruitment.

3.2.3.1 MOE

Within February a MOE recruitment exercise for 1.5wte Specialty Doctors to support the roll-out of Comprehensive Assessment (COMPASS) was unsuccessful in appointing any suitable candidates. This follows previous unsuccessful efforts to fill consultant posts in some areas both of which impact on the ability to improve assessment and subsequent clinical case management, monitoring and review of frail elderly patients. There is however currently a recruitment exercise underway to appoint 3 full-time consultants posts based at the WGH and 1 full-time specialty doctor doctor post at SJH. A further update will be provided to the Board once the recruitment processes for these posts complete.

3.2.3.2 Anaesthetics

Within Anaesthetics there have been difficulties in filling consultant posts across all sites during 2013. These roles have a key role in ensuring optimum theatre utilisation and ensuring a consistent flow in activity.

A concerted recruitment campaign was run at the end of 2013 to recruit 13 posts across the 3 main adult acute sites with the following appointments have recently made.

<table>
<thead>
<tr>
<th>Site</th>
<th>Appointments made Out of Vacancies Advertised</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIE</td>
<td>4 out of 6</td>
</tr>
<tr>
<td>WGH</td>
<td>3 out of 4</td>
</tr>
<tr>
<td>SJH</td>
<td>1 out of 3</td>
</tr>
</tbody>
</table>

This represents a considerable improvement on previous exercises, there remain however 5 vacancies remain unfilled and services are considering a further round of recruitment.
3.2.3.3 Ophthalmology

Within Ophthalmology there have been on-going difficulties in filling vacant Consultant posts. A recent recruitment exercise for a specialist Corneal Ophthalmologist was successful, with the successful candidate due to take up post in June. However a Paediatric Ophthalmologist advertised at the same time only received one application, which was later withdrawn. This post will be subject to another round of recruitment.

3.2.4 Primary care

The work that has been done around medical workforce risk assessment has been predominantly within hospital based specialties. The November 2013 Board paper however set out the findings from the national Primary Care Survey 2013 which highlighted pressures in workforce supply such as increasing levels of part-time working, low levels of participation in out of hours and demographic pressures. These findings provide useful intelligence at a national and board level, they do not provide detail below this level. There are clear demand pressures emerging in some areas and it is intended that the next paper will set out the process through which a more comprehensive assessment of the workforce pressures can be obtained.

Section 3.4 sets out pressures that are being faced within health visiting and the actions underway to increase capacity.

3.2.5 National planning to increase attractiveness of medical trainee posts

The risk assessment process has however 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 by using agency or bank locums, as posts may be less than full time and for a relatively short period.

As detailed in the previous Board paper the national START Alliance led by NES is developing a range of measures aimed at improving recruitment and retention within training programmes. A detailed update of progress will be provided in the next Board paper.

3.2.6 Lothian Medical Workforce Group

An NHS Lothian medical workforce group has been established led by the Medical Director and will include representation from Acute Services, Primary Care, Workforce Planning and Finance. The first meeting will be in April where the remit and terms of reference will be finalised and a workplan agreed.

3.2.7 Workforce risk assessment update process

In the next 3 months all medical workforce risk assessments will be reviewed and updated with services. These will be fed into the Lothian Medical Workforce Group as well as clinical/site management teams.

3.3 Nursing workforce utilisation

The February Board paper set out the work that is being undertaken in applying national nursing & midwifery workload and workforce planning tools. A review of all in-patient nursing and midwifery staffing levels is being carried out and will report separately to the Corporate Management Team and the Board.
As a national requirement all nursing establishments include 21.5% built in to cover predictable absence, which covers annual leave, sickness absence and study leave.

The Nursing and Midwifery workforce utilisation is monitored monthly basis through review against a range of key performance indicators including:

- funded establishment, in post, new starts and leavers
- establishment gap i.e. gap between the funded establishment and the in post staffing. This offers a more accurate picture of the level of the vacancy than the nationally reported vacancy level (which only considers the number of vacancies under active recruitment at the point in time).
- use of extra hours, overtime, bank and agency
- planned and unplanned absences
- clinical pressures impacting on staffing

### 3.3.1 Nursing workforce turnover and recruitment

Within nursing staff turnover was 5.7% (617 headcount) for the period April to December 2013, equivalent to an annual rate of 7.6% (823 headcount, approx 670wte). With this level of turnover there is an on-going requirement for significant recruitment and also the utilisation of supplementary staffing.

There has also been further growth in the nursing workforce establishments as part of investments to provide additional capacity, which have also resulted in significant additional recruitment activity. Recruitment of staff can take a minimum of 2 months between a post becoming vacant and a post being filled. This includes the advertising, short listing and interview process as well disclosure checks and induction training.

There have been significant developments in the recruitment administration process, including on-line application process and on-line shortlisting. Efforts have are also being made to reduce the number of substantive gaps through constant recruitment to band 2 and band 5 posts via a generic recruitment process where significant numbers are staff are recruited for a site and then matched with specialties.

### 3.3.2 Advanced Nurse Practitioners

The Board is taking forward training of significant numbers of Advanced Nurse Practitioners (ANP) with 20 recruits identified to begin in April 2014. These programmes require significant support from medical consultants during the training phase and represents a longer term solution to some of the shortfalls in medical staffing – taking approximately 2 years for the recruits to be fully functional as Advanced Nurse Practitioners.

The following table details the number of ANPs that have completed training, are completing training and who will be starting training in April 2014.

<table>
<thead>
<tr>
<th></th>
<th>Trained</th>
<th>In training</th>
<th>Starting in April 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult acute</td>
<td>24</td>
<td>50</td>
<td>39</td>
</tr>
<tr>
<td>Paediatrics</td>
<td>6</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>Neonates</td>
<td>3</td>
<td>5</td>
<td>0</td>
</tr>
</tbody>
</table>

Neonates and Paediatrics trainees will start in September.
3.4 Health Visiting (HV) – Developing capacity within the community workforce

There has been concern at a local and national level around current and future pressures within the Health Visiting workforce.

- Workforce supply – within NHS Lothian 49% of health visitors (HVs) could potentially retire in the next five years and 60 wte are already over the age of 55 and could potentially retire already.

- Increased workforce demands – in particular
  - increasing numbers of pre-school and school age children across Lothian – this is projected to require an addition 15 wte HVs over the next 5 years.
  - implications of the Children and Young People (Scotland) Bill – increase of 49 wte HVs (according the Scottish Government methodology)
  - the national review of health visiting (and school nursing). There are likely to be recommendations regarding HV caseload size.
  - recruitment challenges – currently there are approximately 15 wte vacancies with NHS Lothian
  - alternate opportunities for the HV workforce

**Actions underway to address capacity pressures**

In recognition of the potential gap in HV workforce supply the Corporate Management Team meeting in March 2014 approved funding for an additional 10 nurses to undertake HV training for 2014/15 at a cost of £330k for the year. This is in addition to the 6 places already funded on an on-going basis. There was also £56k funding for Specialist Practice Supervisors who will support trainees.

Proposals are currently being explored with the Finance Efficiency and Productivity team to consider whether A&C support for a group / HV team could possibly increase productivity of HV time and therefore reduce the number of additional HVs required.

The option of accommodating / encouraging HVs to continue working and not retire is being explored further. Information previously gathering from consultants regarding retiring could be repeated for HVs as well as some qualitative research into identifying what would encourage HVs to retire later.

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 draft report has been prepared. Once this report is finalised the findings will be detailed in future papers.
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. Paediatrics and Obstetrics & Gynaecology have all been supported financially at both a local and national level, to reduce workforce risks as detailed within the report. Resources for investments in Health Visitor training were confirmed by March 2014 Corporate Management Team.

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14 March 2014
SUMMARY PAPER - UNSCHEDULED CARE

This paper aims to summarise the key points in the full paper. The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian’s unscheduled care performance against the 4 hour standard for the month of February 2014 was 92.4%.</td>
<td>3.1</td>
</tr>
<tr>
<td>Our overall performance for week ending 9th March was 92.7% against the agreed LUCAP March 2014 trajectory of 93.3%. We are required to reach 95% by September 2014 and 98% thereafter.</td>
<td>3.3</td>
</tr>
<tr>
<td>Currently we have opened well in excess of 200 additional beds. A winter de-brief session will inform the downsizing of these additional beds through March and April 2014.</td>
<td>3.11/3.12</td>
</tr>
<tr>
<td>An additional 31 beds became available at RIE from 17th February (5 for orthopaedics and 26 for MoE).</td>
<td>3.13</td>
</tr>
<tr>
<td>The RVH Transition Plan has been developed jointly between NHS Lothian and City of Edinburgh Council (CEC) to expedite the discharge of patients at the RVH and to improve patient flow.</td>
<td>3.15</td>
</tr>
<tr>
<td>A series of workshops have been organised to consider the required future model of Unscheduled Care in Lothian. Any proposals to improve unscheduled care will also form a vital component of NHS Lothian’s strategic plan, ‘Our Health, Our Care, Our Future, 2014-24’</td>
<td>3.24</td>
</tr>
<tr>
<td>Each acute site has been asked to review its boarding and categorisation process. It is proposed that a new ‘set of rules’ can then be developed and applied in a consistent manner across all sites using robust and accurate data.</td>
<td>3.30</td>
</tr>
<tr>
<td>NHS Lothian noted a gradual increase in the incidence of Norovirus from October 2013. Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to the service.</td>
<td>3.33</td>
</tr>
<tr>
<td>A range of programmes and practical measures in support of stroke prevention are available across NHS Lothian.</td>
<td>3.35</td>
</tr>
<tr>
<td>NHS Lothian continues to engage with Health and Social Care Partnerships on a number of initiatives to reduce hospital admissions and to facilitate early discharge.</td>
<td>3.43</td>
</tr>
</tbody>
</table>

Neil Wilson
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18 March 2014
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Executive Director: Nursing, AHPs & Unscheduled Care

UNSCHEDULED CARE

1. Purpose of the Report

1.1 The purpose of this report is to provide the Board with data and analysis on Unscheduled Care performance, measurement against agreed national targets and an update on specific aspects or work relating to unscheduled care.

2. Recommendations

2.1 To note the targets for measurement and NHS Lothian’s performance.

2.2 To note the actions being taken forward to support NHS Lothian’s performance outcomes for unscheduled care.

2.3 To note the key challenges being faced by the service in relation to patient flow and performance

3. Discussion of Key Issues

Performance

3.1 NHS Lothian’s unscheduled care performance against the 4 hour standard for the month of February 2014 was 92.4%. This compares with a performance figure of 91.1% for the same period in 2013. There were 8 twelve hour breaches during February 2014.

3.2 The performance across individual sites for February 2014 was as follows:
   • RIE – 91.2% (2 twelve hour breaches)
   • WGH – 85.8% (5 twelve hour breaches)
   • StJ – 94.8% (1 twelve hour breach)
   • RHSC – 98.8% (zero twelve hour breaches)

3.3 The achievement of the 4 hour unscheduled care target remains challenging. While compliance varies across each site, the latest compliance data for NHS Lothian shows that our overall performance for week ending 9th March was 92.7% against the agreed LUCAP March 2014 trajectory of 93.3%. [The national target is to achieve a minimal compliance rate of 95% as at September 2014 and 98% thereafter.]

3.4 NHS Lothian is required to reduce the rate of attendance at Emergency Departments (A&E) in accordance with the trajectories agreed as part of the HEAT (T10) targets. Latest national statistics show the attendance rate at the end of January 2014 was 2,002 (per 100,000 population) but remains above the agreed HEAT T10 trajectory of 1,958 (per 100,000 population). The HEAT T10 trajectory rate is set to reduce to 1,956 (per 100,000 population) as at March 2014.

3.5 Further intelligence against HEAT T10 milestones was submitted to the Scottish Government at the beginning of February 2014 outlining the actions taken so far in
mitigating A&E attendance. This was followed with a meeting to formally review performance on 5th March 2013. The outcomes will inform a national report which is due for publication circa May 2014.

**LUCAP**

3.6 NHS Lothian’s Local Unscheduled Care Action Plan (LUCAP) was updated and submitted to the Scottish Government on 19th December 2013.

3.7 Following the Unscheduled Care Executive Leads meeting on 21st February, The Scottish Government has agreed to issue new guidance and templates for the next iteration of local action plans (LUCAP2). It is anticipated that a first draft will be required by the end of May with Board sign off in June 2014.

3.8 The new guidance will hopefully focus on integration and partnership working, for example with Local Authorities, Scottish Ambulance Service and the Care Inspectorate. It will also place a greater emphasis on the development of patient pathway approaches. The new guidance and templates are due with NHS Boards during March 2014.

3.9 A further workshop for the Executive Leads is planned for 22nd April 2014.

**Winter / Surge Capacity**

3.10 Lothian’s Winter Plan (2013/14) builds on the overall work alluded to within NHS Lothian’s Local Unscheduled Care Action Plan (LUCAP). Each winter, additional bed capacity is provided across acute hospitals, to deal with surges in activity and to cope with increasing numbers of delayed discharge.

3.11 The effects of winter were being experienced as early as November 2013. At the end of December 2013, 152 additional beds had been opened. Currently we have opened well in excess of 200 additional beds. This compares to 162 additional beds opened during winter 2012/13.

3.12 It is essential that we are able to plan the downsizing of these additional beds from through March and April 2014. A winter de-brief session will be led at the Unscheduled Care Board on 26th March 2014.

3.13 An additional 31 beds became available at RIE from 17th February (5 for orthopaedics and 26 for MoE) and looking ahead we also plan to expand the Acute Assessment footprint, including additional bed capacity in 2015.

**Delayed Discharge**

3.14 The issue of delayed discharge remains a key pressure on the system, particularly during winter. Weekly meetings involving the Chief Executives of City of Edinburgh Council and NHS Lothian, along with key executive colleagues, offers a more direct focus on the challenges posed by delayed discharge. Given Delayed Discharge pressures, Additional beds have been identified for RVH to ensure downstream flow.

3.15 The RVH Transition Plan has been developed jointly between NHS Lothian and City of Edinburgh Council (CEC) to expedite the discharge of patients at the RVH and to improve patient flow. This will also support the subsequent transfer of patients and
services from peripheral sites such as Corstorphine and Astley Ainslie to be centred at the RVH.

3.16 As a result, admissions to RVH were halted from 17th February with plans to vacate all beds by the end of April 2014. This remains on track.

3.17 Delayed Discharge (DD) admissions to Corstorphine will cease as of 7th April. DD beds at Corstorphine and Astley Ainslie will reduce from 38 to 22 whereupon these will transfer to the RVH.

3.18 DD beds at the RVH will be run down to zero by the end of May 2014. This in turn will allow for the transfer of 66 IPCC Beds to the RVH from the Corstorphine and Astley Ainslie Hospitals.

3.19 This will still leave capacity for 56 (empty) beds at RVH as contingency.

3.20 To support the reduction in DD beds at the RVH, the City of Edinburgh Council have commissioned 42 Step-Down Beds. Initially 32 were opened in two care homes (Silverlea and Cairdean). A further 20 beds are due to come on stream during March 2014. Not only will this additional capacity help to expedite the discharge of patients at the RVH but it will also allow for the transfer of patients in from peripheral sites such as Astley Ainslie and Corstorphine.

3.21 Further capacity to support issues of delayed discharge will come from additional Care Home beds (40), investment of £700k in Re-ablement services; increased budget for Home Care/ Care at Home services (to increase capacity by 2,600 hours). These have been funded by CEC using demography and the Older Peoples change fund investments.

3.22 An additional £2m from CEC has been made available to support the issue of delayed discharge.

Review of Systems/ Patient Flow

3.23 Assistance was sought from the Scottish Government to review the Western General Hospital in terms of patient flow and how this can aid our overall performance across NHS Lothian. A brief report highlighting key messages has now been received.

3.24 Building on this piece of work, a series of workshops have been organised to consider the required future model of Unscheduled Care in Lothian. Any proposals to improve unscheduled care will also form a vital component of NHS Lothian’s strategic plan, ‘Our Health, Our Care, Our Future, 2014-24’.

3.25 These multi-agency workshops will consider a range of ‘big ticket’ issues across each of the main acute sites. Examples include the future model of care at the Western General Hospital; process improvement work being led at the Emergency Department at RIE; the implications of any reconfiguration proposals for St Johns; the development of older people/ intermediate care services and the options for developing pan-Lothian models of service delivery for Stroke.

3.26 A further action-planning session is also proposed for 27th June 2014. These sessions are being led by the Chief Executive and the Director for Unscheduled Care.
Boarding of Patients

3.27 NHS Lothian acknowledges the negative consequences often associated with the boarding of patients into non-host wards. Research into the effects of boarding across NHS Scotland has identified a number of negative consequences associated with boarding. Such consequences include increased re-admission rates, increased length of stay and increased mortality rates. Furthermore, ongoing research now additionally notes the impact that boarding can also have on ‘host’ ward patients where there is boarding in from other wards/specialties. Research has differentiated between boarding occurring at the start, during and at the end of a hospital admission and differentials exist in the relative impact and clinical risk at different stages of admission.

3.28 It is therefore important that we are able to develop and deploy new systems of work in order that the boarding of patients is eradicated as far as possible. Aspects of how NHS Lothian plans to tackle this were set out in the LUCAP for 2013/14 but more work needs to be done.

3.29 The access to accurate data in order to develop new systems and processes is vital. Currently there is an issue over the reliability and robustness of available data and the data collection processes. Information on boarding is currently undertaken on a ‘snapshot’ daily basis by the Site and Capacity Team. The primary function of this data is for daily operational use to support the safe management of flow and ensuring patients are safely under a consultant at all times. While this generates trend information which is helpful in tracking the overall scale of boarding in the system, it is not robust enough to allow for the level of planning and modelling required between specialty use.

3.30 As a result, each site has been asked to review its boarding and categorisation process. It is proposed that a new ‘set of rules’ can then be developed and applied in a consistent manner across all sites using robust and accurate data. This will be developed and approved with appropriate clinical oversight. This will not replace the existing system of tracking patients safely to ensure reliable clinical and operational flow management. It will however support planning and strategic functions which will also link to specialty and site based capacity planning.

3.31 The final proposal will be reported following sign off by NHS Lothian’s Data Quality Group as well as having been approved via both scheduled and unscheduled care governance hierarchies.

3.32 NHS Lothian’s approach to the boarding of patients will form part of LUCAP2 going forward in 2014/15.

Norovirus

3.33 NHS Lothian noted a gradual increase in the incidence of Norovirus from October 2013. Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to the service.

3.34 Since October 2013 there have been 79 incidents of gastro-enteritis investigated in NHS Lothian, with 478 patients and 115 staff affected. In comparison for the same period for season 2012/13 there had been 130 incidents of gastro-enteritis investigated in NHS Lothian, with 906 patients and 235 staff affected.
3.35 Ensuring a healthy diet (increased consumption of fruit and vegetables and reduced salt intake) and the maintenance of a healthy weight matched to physical activity are part of the key messages in terms of stroke prevention. A range of programmes and practical measures in support of this goal are outlined below.

3.36 The Health Improvement Fund supports initiatives such as: Edinburgh Community Food, Toot for Fruit in Midlothian, West Lothian’s Eatright programme and Roots and Fruits in East Lothian. These provide a number of fruit and vegetables stalls and food co-ops which provide affordable, good quality fruit and vegetables within local community venues, hospitals, GP surgeries and schools. In addition to this they provide a number of information sessions to customers and staff about how to use the fruit and vegetables and how to cook with them.

3.37 To further increase capacity of staff on the ground regarding food and cooking skills, there are a number of training the trainers’ courses and courses for staff and volunteers.

3.38 Physical activity helps reduce the risk of many conditions including stroke. Only 40% of the adult population achieve the recommended level of physical activity for health, which is 30 minutes of moderate physical activity most days a week. There are multi-agency physical activity groups in each area that seek to improve overall population physical activity levels.

3.39 Physical activity is also important in the rehabilitation of people who have had a stroke. The Health Promotion Service and the Health Improvement Fund support several initiatives that provide physical activity for people with long term conditions, including those who have had a stroke. These include: Ageing Well projects, Midlothian Active Choices, ‘Move It’ in Pilton Community Health Project, Health All Round in Gorgie Dalry, Healthy Moves, in Wester Hailes Health Agency, Active Choices East Lothian.

3.40 A core component of these projects is to strengthen local physical activity pathways e.g. the lead for the Stroke MCN contributes to the development of strengthening physical activity pathways for stroke patients by contributing to the NHS Lothian Physical Activity CEL 01/ Health Promoting Health Service subgroup.

3.41 The Resource Centre holds a risk factor poster and a Think FAST card. Resources are sourced out with main stock items.

### Stroke Performance

3.42 Meanwhile performance against each of the six Health Improvement Scotland Stroke Standards is outlined below

<table>
<thead>
<tr>
<th>NHS Lothian Performance</th>
<th>Target</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Admission to Stroke Unit</td>
<td>90%</td>
<td>82%</td>
<td>78%</td>
<td>77%</td>
<td>84%</td>
<td>83%</td>
<td>71%</td>
<td>68%</td>
</tr>
<tr>
<td>Swallow Assessment</td>
<td>90%</td>
<td>81%</td>
<td>76%</td>
<td>71%</td>
<td>80%</td>
<td>75%</td>
<td>73%</td>
<td>78%</td>
</tr>
<tr>
<td>Aspirin</td>
<td>100%</td>
<td>87%</td>
<td>86%</td>
<td>74%</td>
<td>92%</td>
<td>91%</td>
<td>85%</td>
<td>80%</td>
</tr>
<tr>
<td>Scanning</td>
<td>90%</td>
<td>100%</td>
<td>99%</td>
<td>96%</td>
<td>99%</td>
<td>99%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Stroke/TIA Clinic</td>
<td>80%</td>
<td>83%</td>
<td>90%</td>
<td>85%</td>
<td>77%</td>
<td>83%</td>
<td>86%</td>
<td>86%</td>
</tr>
<tr>
<td>Thrombolysis Door to Needle</td>
<td>80%</td>
<td>38%</td>
<td>33%</td>
<td>26%</td>
<td>44%</td>
<td>46%</td>
<td>30%</td>
<td>50%</td>
</tr>
</tbody>
</table>
3.43 The Midlothian Partnership has been working with colleagues in the acute sector to reduce unscheduled admissions, provide alternative solutions and facilitate early discharge where admission has proved unavoidable. This has involved a number of preventative actions including additional nursing capacity to care homes funded via the Change Fund; the proposed extension of the rapid response service during evenings and weekends; and the piloting of a triage service at Newbattle Health Centre.

3.44 In terms of intermediate care developments, Highbank Care Home has 12 beds offering an alternative to unplanned hospital admission. A major review of Midlothian Community Hospital to consider local clinics and step down beds has also commenced.

3.45 Finally a range of initiatives are ongoing with the view to facilitating early discharge. These include additional winter beds, the use of the In-Reach Service, the access and use of real time data from acute service to support service delivery models, and the recruitment of additional resource (Geriatrician, Nursing and AHP staff) to enhance the Rapid Response Service for frail elderly patients.

4 Key Risks

4.1 The failure to deliver against the 4 hour emergency care standard increases the risk to patient safety while diminishing the overall patient experience.

4.2 The performance against Delayed Discharge and the impact this will have on patient flow and overall performance.

4.3 The impact of winter demand on current capacity and performance across all sites.

4.4 The ability to downscale the additional winter beds from April 2014 to avoid additional financial pressures

4.5 The ability to improve patient flow by reducing the number of delayed discharge beds at the RVH in accordance with the RVH transition plan.

4.6 The move from the Astley Ainslie to the RVH will reduce the fire risk.

4.7 The move from both the Corstorphine and Astley Ainslie Hospitals will reduce the risks related to Healthcare Acquired Infection (HAI) and improved patient and staff safety. Reducing the provision of services on peripheral sites will have a longer term positive impact on financial risk

5 Risk Register

5.1 Risks are noted within the NHS Lothian corporate risk register for Unscheduled Care.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment was carried out as part of the LUCA P. Any specific services moves to the RVH will be subject to a Rapid Impact Assessment according to Board policy
7 Involving People

7.1 Progress against targets and those actions detailed within the LUCAP are reported into the Unscheduled Care Board whose membership is drawn from across Councils, Primary Care, CHCPs and the Acute Sector. Any plans to transfer services are subjected to full involvement of patients, families and other stakeholders including the Scottish Health Council and Scottish Government. All proposals will follow NHS Lothian’s comprehensive Organisational Change Policy and Procedure for staff and volunteers.

8 Resource Implications

8.1 The resource implications for unscheduled care, including winter, are £14.4 million for 2013/14. This figure is regularly reviewed with Finance colleagues and through the Unscheduled Care Board.

8.2 A total of £1,331,545 has already been allocated to NHS Lothian from the Scottish Government to support unscheduled care, including £125,000 set aside as HEAT T10 funding.

8.3 Further Scottish Government investment (£1,022,317) has been allocated to NHS Lothian by the Scottish Government in support of the LUCAP in 2014/15 and 2015/16.

8.4 The Step Down programme will initially be funded through the Change Fund. It is anticipated that the development of Step Down will reduce the need for boarding beds and that this will release funding for the ongoing provision of the service.

8.5 An additional £2M identified by CEC to help tackle issues of delayed discharge for 2014/15.

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The key points of the paper are summarised here.

| 18 week performance from referral to treatment was 85.4% in January, below the 90% expected. | 3 |
| 31 day performance against Cancer was better than the 95% across the quarter, however – contrary to indications last month - the 62 day standard was not met across the period as a whole. | 4 |
| A total of 560 patients were beyond the treatment time guarantee at end of January with 473 seen in the month over 12 weeks in breach of the standard. | 5 |
| 118 inpatient and daycase patients not covered by the treatment time guarantee were waiting over 12 weeks at the end of January. | 5 |
| Outpatients over 12 weeks decreased in January to 3982. | 6 |
| 225 diagnostic scope patients were over 6 weeks, predominately in cystoscopy. 11 imaging patients waiting over the same threshold at the end of December. | 7 |
| The surveillance endoscopy position is improved slightly with 552 patients waiting beyond their review date at the end of January. | 8 |
| Unlike those children waiting, 128 adults waited beyond the audiology standards at the end of December. | 9 |
| The forthcoming standard for IVF continues to be met. | 10 |
| Psychological Therapies met the trajectory for those seen within 18 weeks during February. However at the end of the month, the number waiting over 18 weeks had increased on the previous month. | 11 |
| In Child and Adolescent Mental Health Services, although performance within 26 weeks improved, the trajectory for 18 weeks was not met and the numbers on the list grew. | 12 |
WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

1 Purpose of the Report

1.1 The purpose of this report is to update Board members on recent performance on waiting times and to seek their approval of the redrafted local access policy.

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 performance and progress on inpatient, outpatient and other waiting times.

3 18 Weeks Referral to Treatment Standard

3.1 The table below shows the recent trend for combined performance for admitted and non-admitted pathways against the 18 week referral to treatment standard. 90% compliance is expected.

3.2 As has been highlighted previously, this standard measures performance throughout the patient pathway. As a result challenges in meeting outpatient, inpatient and diagnostic stages will impact in the level of performance reported here.

<table>
<thead>
<tr>
<th>Table 1 – Trend in 18 Week Performance and Measurement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of patient journeys within 18 weeks</td>
</tr>
<tr>
<td>Number of patient journeys over 18 weeks</td>
</tr>
<tr>
<td>Patient journeys that could be fully measured (%)</td>
</tr>
</tbody>
</table>
4 Cancer

4.1 Recent performance against cancer standards is shown in the following tables.

4.2 In the previous board report, it was stated that despite difficulties in performance, with a drop in 62 day compliance in November, that across the quarter the referral to treatment standard of 95% would be met. This transpired not to be so and NHS Lothian fell 4 patients shy of meeting expectations.

4.3 As was explained in the previous report, difficulties in the lung cancer and head and neck pathways in particular contributed to the worsened performance. These difficulties have continued to impact on performance against the 62 day standard reported for January with performance placed provisionally at 91.5%.

4.4 The tables also show the proportion of cases excluded from consideration. National guidance indicates that clinically complex patients, those declining treatment and those who die during treatment should not be incorporated into performance measures.

5 Inpatients and Daycases

5.1 During January, 473 patients were seen beyond the 12 weeks specified by the Patients Rights Act. The high number reported in the month is a reflection of the higher numbers waiting beyond the guarantee in recent months.

| Table 2 – Trend in Cancer Performance (31 days from diagnosis to treatment) |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
|                             | Lothian Quarter Jul - Sep13 | Scotland Quarter Jul - Sep13 | Lothian Quarter Oct-Dec 13  | Jan 2014 Provisional        |
| Percentage Compliance       | 99.6%                       | 98.1%                       | 99.2%                       | 98.2%                       |
| Eligible Cases              | 1087                        | 5709                        | 1091                        | 329                         |
| Excluded Cases              | 6                           | 119                         | 10                          | 2                           |
| %age excluded Cases         | 0.5%                        | 2.0%                        | 0.9%                        | 0.6%                        |

| Table 3 – Trend in Cancer Performance (62 days from urgent referral to treatment) |
|-----------------------------|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
|                             | Lothian Quarter Jul - Sep13 | Scotland Quarter Jul - Sep13 | Lothian Quarter Oct-Dec 13  | Jan 2014 Provisional        |
| Percentage Compliance       | 96.9%                       | 94.6%                       | 94.3%                       | 91.5%                       |
| Eligible Cases              | 540                         | 3086                        | 542                         | 159                         |
| Excluded Cases              | 13                          | 120                         | 18                          | 4                           |
| %age excluded Cases         | 2.4%                        | 3.7%                        | 3.3%                        | 2.5%                        |

5.2 At the end of January, 560 patients were waiting in breach of the treatment time guarantee. At the time of writing, 148 of these patients remain on the waiting list, 37 of whom have a date for admission or are being contacted by an external provider. Arrangements for the remaining 111 are being pursued.
Table 5 – Treatment Time Guarantee Patients waiting beyond standard at month end.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>251</td>
<td>189</td>
<td>137</td>
<td>108</td>
<td>57</td>
<td>61</td>
<td>88</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>59</td>
<td>69</td>
<td>69</td>
<td>61</td>
<td>81</td>
<td>92</td>
<td>89</td>
</tr>
<tr>
<td>Maxillofacial</td>
<td>11</td>
<td>15</td>
<td>27</td>
<td>41</td>
<td>52</td>
<td>66</td>
<td>35</td>
</tr>
<tr>
<td>ENT</td>
<td>31</td>
<td>58</td>
<td>73</td>
<td>65</td>
<td>38</td>
<td>49</td>
<td>69</td>
</tr>
<tr>
<td>Colorectal/General</td>
<td>37</td>
<td>40</td>
<td>44</td>
<td>45</td>
<td>48</td>
<td>57</td>
<td>75</td>
</tr>
<tr>
<td>Urology</td>
<td>121</td>
<td>128</td>
<td>91</td>
<td>74</td>
<td>76</td>
<td>72</td>
<td>99</td>
</tr>
<tr>
<td>Paediatric ENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>16</td>
</tr>
<tr>
<td>Paediatric Plastic Surgery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12</td>
</tr>
<tr>
<td>Others</td>
<td>12</td>
<td>20</td>
<td>25</td>
<td>28</td>
<td>19</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>521</strong></td>
<td><strong>519</strong></td>
<td><strong>486</strong></td>
<td><strong>432</strong></td>
<td><strong>372</strong></td>
<td><strong>448</strong></td>
<td><strong>560</strong></td>
</tr>
</tbody>
</table>

Paediatric ENT and Plastic Surgery figures shown separately from December

5.2 As Board members will be aware, there are some patients admitted as inpatients and daycases who are not included within the Treatment Time Guarantee. The numbers of these patients waiting over 12 weeks is outlined in the following table.

Table 6 – Inpatients and Daycases not covered by Treatment Time Guarantee and waiting over 12 weeks

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Neurology - Videotelemetry</td>
<td>21</td>
<td>30</td>
<td>34</td>
<td>43</td>
<td>38</td>
<td>37</td>
<td>42</td>
</tr>
<tr>
<td>Neurosurgery - Spine</td>
<td>75</td>
<td>59</td>
<td>46</td>
<td>34</td>
<td>36</td>
<td>29</td>
<td>33</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>16</td>
<td>16</td>
<td>19</td>
<td>19</td>
<td>16</td>
<td>19</td>
<td>21</td>
</tr>
<tr>
<td>Ophthalmology - Corneal Graft</td>
<td>11</td>
<td>9</td>
<td>10</td>
<td>12</td>
<td>11</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Diagnostic Procedure</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>3</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Assisted Reproduction</td>
<td>11</td>
<td>7</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Pre 1st October 2012 addition</td>
<td>26</td>
<td>22</td>
<td>16</td>
<td>9</td>
<td>6</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>162</strong></td>
<td><strong>144</strong></td>
<td><strong>128</strong></td>
<td><strong>122</strong></td>
<td><strong>112</strong></td>
<td><strong>107</strong></td>
<td><strong>118</strong></td>
</tr>
</tbody>
</table>

5.3 Table 5 outlines the trend in inpatient list size and unavailability. A change of data sources caused discontinuities from July 2013.

Table 7 – Inpatient List Size and Unavailability

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Unavailable</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total Waiting List Size</td>
<td>7831</td>
<td>7960</td>
<td>7791</td>
<td>8972</td>
<td>8929</td>
<td>9177</td>
<td>9057</td>
<td>9068</td>
<td>9423</td>
<td>9476</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage Unavailable</td>
<td>14.4%</td>
<td>16.2%</td>
<td>16.7%</td>
<td>13.4%</td>
<td>12.6%</td>
<td>10.9%</td>
<td>10.8%</td>
<td>12.4%</td>
<td>11.7%</td>
<td>9.4%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

5.4 The ISD Publication last month highlighted that Lothian continues to have a low level of unavailability being applied, especially in relation to “choice” codes. The breakdown of codes is outlined in Table 6.
Table 8 - "Patient Choice" Unavailability active at end January - Inpatients

<table>
<thead>
<tr>
<th>National Specialty</th>
<th>Patient Advised - requests specific consultant</th>
<th>Patient Advised - requests specific location</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RHSC</td>
<td>RIE</td>
<td>SJH</td>
</tr>
<tr>
<td>General Surgery</td>
<td>6</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Ear Nose and Throat</td>
<td>5</td>
<td>13</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>1</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Paediatric Dentistry</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>16</strong></td>
<td><strong>13</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

6 Outpatients

6.1 The number of outpatients waiting over 12 weeks at the end of January was 3982 with improvements in colorectal surgery and at the dental institute.

Table 9 – Trend in Outpatients over 12 weeks – Key Specialties

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Rheumatology</td>
<td>417</td>
<td>587</td>
<td>664</td>
<td>701</td>
<td>631</td>
<td>650</td>
<td>691</td>
</tr>
<tr>
<td>Opthalmology</td>
<td>993</td>
<td>1108</td>
<td>905</td>
<td>704</td>
<td>682</td>
<td>668</td>
<td>605</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>187</td>
<td>334</td>
<td>513</td>
<td>445</td>
<td>465</td>
<td>488</td>
<td>504</td>
</tr>
<tr>
<td>Neurology</td>
<td>265</td>
<td>259</td>
<td>257</td>
<td>270</td>
<td>269</td>
<td>283</td>
<td>292</td>
</tr>
<tr>
<td>ENT</td>
<td>30</td>
<td>70</td>
<td>103</td>
<td>52</td>
<td>51</td>
<td>156</td>
<td>261</td>
</tr>
<tr>
<td>Colorectal</td>
<td>754</td>
<td>698</td>
<td>693</td>
<td>631</td>
<td>443</td>
<td>365</td>
<td>270</td>
</tr>
<tr>
<td>Dental Institute</td>
<td>180</td>
<td>244</td>
<td>375</td>
<td>410</td>
<td>492</td>
<td>390</td>
<td>268</td>
</tr>
<tr>
<td>Urology</td>
<td>324</td>
<td>381</td>
<td>406</td>
<td>365</td>
<td>250</td>
<td>223</td>
<td>211</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>6</td>
<td>99</td>
<td>164</td>
<td>198</td>
<td>224</td>
<td>166</td>
<td>132</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>137</td>
<td>141</td>
<td>122</td>
<td>109</td>
<td>117</td>
<td>114</td>
<td>124</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>27</td>
<td>58</td>
<td>62</td>
<td>72</td>
<td>75</td>
<td>72</td>
<td>104</td>
</tr>
<tr>
<td>Pain</td>
<td>247</td>
<td>328</td>
<td>222</td>
<td>200</td>
<td>116</td>
<td>116</td>
<td>100</td>
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<tr>
<td>Dermatology</td>
<td>0</td>
<td>45</td>
<td>36</td>
<td>71</td>
<td>31</td>
<td>71</td>
<td>62</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>71</td>
<td>56</td>
<td>33</td>
<td>21</td>
<td>23</td>
<td>21</td>
<td>49</td>
</tr>
<tr>
<td>Sleep</td>
<td>14</td>
<td>13</td>
<td>25</td>
<td>6</td>
<td>8</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>133</td>
<td>182</td>
<td>181</td>
<td>180</td>
<td>164</td>
<td>264</td>
<td>289</td>
</tr>
<tr>
<td><strong>TOTAL (inc EDI)</strong></td>
<td><strong>3675</strong></td>
<td><strong>4663</strong></td>
<td><strong>4661</strong></td>
<td><strong>4335</strong></td>
<td><strong>4034</strong></td>
<td><strong>4039</strong></td>
<td><strong>3982</strong></td>
</tr>
</tbody>
</table>

6.2 Table 8 outlines list size and unavailability for outpatients over recent months while Table 9 shows the level of patient choice unavailability being applied to outpatient waits currently.

Table 10 - Outpatient List Size and Unavailability

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Available</td>
<td>38480</td>
<td>39743</td>
<td>39026</td>
<td>41960</td>
<td>42095</td>
<td>41922</td>
<td>41343</td>
<td>40641</td>
<td>40488</td>
<td>39951</td>
</tr>
<tr>
<td>Unavailable</td>
<td>770</td>
<td>847</td>
<td>858</td>
<td>913</td>
<td>856</td>
<td>711</td>
<td>592</td>
<td>644</td>
<td>670</td>
<td>561</td>
</tr>
<tr>
<td>Total Waiting List Size</td>
<td>39250</td>
<td>40590</td>
<td>39894</td>
<td>42873</td>
<td>42953</td>
<td>42633</td>
<td>41935</td>
<td>41285</td>
<td>41158</td>
<td>40152</td>
</tr>
<tr>
<td>Percentage Unavailable</td>
<td>2.0%</td>
<td>2.1%</td>
<td>2.2%</td>
<td>2.1%</td>
<td>2.0%</td>
<td>1.7%</td>
<td>1.4%</td>
<td>1.6%</td>
<td>1.6%</td>
<td>1.4%</td>
</tr>
</tbody>
</table>
7 Diagnostics

7.1 The tables below show the breakdown on waits in both areas by diagnostic test. For scopes, numbers over those six weeks increased while those of 4 reduced. Elsewhere MRI capacity issues caused breaches for imaging services.

Table 11 – “Patient Choice” Unavailability in Outpatients

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Patient Advised - requests specific consultant</th>
<th>Patient Advised - requests specific location</th>
<th>Chalmers</th>
<th>Lauriston</th>
<th>RIE</th>
<th>SJH</th>
<th>WGH</th>
<th>ROOD</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sexual &amp; Reproductive Health</td>
<td>3</td>
<td>24</td>
<td>7</td>
<td>1</td>
<td>13</td>
<td>24</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Orthopaedics</td>
<td>2</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>8</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gynaecology</td>
<td>2</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Oncology</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>Cardiology</td>
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<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Medical Oncology</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Paediatrics</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haematology</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Grand Total</td>
<td>10</td>
<td>24</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>56</td>
<td></td>
</tr>
</tbody>
</table>

8 Surveillance Endoscopy

8.1 The number of patients waiting beyond their planned review date is outlined in the Table 12, showing overall improving pattern since April, with cystoscopy numbers fairly constant.
9 Audiology

9.1 An overall 18 week standard applies to audiology patients, which is also included with the 18 week figures covered earlier in the paper.

9.2 In addition to this pathway standard, audiology services are expected to also meet stage of treatment targets for assessment and for treating and hearing aid fitting.

9.3 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.

9.4 Performance against these two standards for these services is shown in the tables below. The number on the list is also detailed.

9.5 Difficulties were encountered with the adult service’s administration system in December which necessitated rebooking of patients and caused those to wait beyond standard at month end and have continued to impact at the end of January.

<table>
<thead>
<tr>
<th>Table 15 – Adult Audiology – Performance against Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients waiting for audiology assessment (first contact)</td>
</tr>
<tr>
<td>Number waiting 5 weeks and over</td>
</tr>
<tr>
<td>Total number waiting</td>
</tr>
<tr>
<td>Patients waiting for fitting of hearing aid</td>
</tr>
<tr>
<td>Number waiting 5 weeks and over</td>
</tr>
<tr>
<td>Total number waiting</td>
</tr>
<tr>
<td>Patients waiting for other treatment (excl. hearing aids)</td>
</tr>
<tr>
<td>Number waiting 5 weeks and over</td>
</tr>
<tr>
<td>Total number waiting</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table 16 – Paediatric Audiology – Performance against Standard</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients waiting for audiology assessment (first contact)</td>
</tr>
<tr>
<td>Number waiting 12 weeks and over</td>
</tr>
<tr>
<td>Total number waiting</td>
</tr>
<tr>
<td>Patients waiting for other treatment (excl. hearing aids)</td>
</tr>
<tr>
<td>Number waiting 6 weeks and over</td>
</tr>
<tr>
<td>Total number waiting</td>
</tr>
</tbody>
</table>

10 IVF

10.1 IVF treatment is expected to be within 12 months by March 2015.

10.2 NHS Lothian is currently meeting this standard and using capacity in its centre at the Royal Infirmary to assist reducing IVF waiting times elsewhere in Scotland.

10.3 Planning of capacity for 2014/5 is currently underway nationally. Consideration is also being given to the increase in referrals which coincided with the change in national referral criteria.
10.4 Arrangements are also progressing for reporting arrangements on performance, compliant with requirements set out by the Human Fertilisation and Embryo Authority.

11 Psychological Therapies

Table 17 – Psychological Therapies

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage seen within 18 weeks*</td>
<td>63%</td>
<td>49%</td>
<td>69%</td>
<td>71%</td>
<td>58%</td>
<td>27%</td>
<td>65%</td>
<td>73%</td>
<td>77%</td>
<td>66%</td>
<td>76%</td>
</tr>
<tr>
<td>Trajectory for seen within 18 weeks</td>
<td>60%</td>
<td>60%</td>
<td>60%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
<td>70%</td>
</tr>
<tr>
<td>Total waiting at end of month</td>
<td>820</td>
<td>858</td>
<td>874</td>
<td>879</td>
<td>894</td>
<td>1292</td>
<td>2322</td>
<td>3040</td>
<td>2787</td>
<td>2468</td>
<td>2441</td>
</tr>
</tbody>
</table>

* From July data for patients seen was adjusted for non-attendance in line with national guidance

11.1 Table 15 shows the trend in psychological therapies performance. Board members will recall from the last meeting that the trajectory from September onwards was to be considered at the A12 board. This is now included in the table above, with the trajectory achieved in February, although numbers waiting over 18 weeks increased.

11.2 Funding for 8.0 wte psychological therapies was released earlier this year to provide short term capacity to assist in the reduction of waits.

12 Child and Adolescent Mental Health

12.1 The performance against the current 26 week RTT target improved to 86% in February, with the trend shown in Table 16. Despite this improvement the trajectory for 18 weeks was not met.

Table 18 – Child and Adolescent Mental Health Performance

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage seen within 26 weeks*</td>
<td>91%</td>
<td>85%</td>
<td>84%</td>
<td>89%</td>
<td>80%</td>
<td>85%</td>
<td>82%</td>
<td>75%</td>
<td>74%</td>
<td>71%</td>
<td>68%</td>
</tr>
<tr>
<td>Percentage seen within 18 weeks</td>
<td>84%</td>
<td>73%</td>
<td>76%</td>
<td>87%</td>
<td>72%</td>
<td>75%</td>
<td>76%</td>
<td>66%</td>
<td>65%</td>
<td>65%</td>
<td>74%</td>
</tr>
<tr>
<td>Trajectory seen within 18 weeks</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>75%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
<td>82%</td>
<td>82%</td>
</tr>
<tr>
<td>Total waiting at end of month</td>
<td>1136</td>
<td>1159</td>
<td>1194</td>
<td>1170</td>
<td>1095</td>
<td>1168</td>
<td>1211</td>
<td>1268</td>
<td>1398</td>
<td>1434</td>
<td>1482</td>
</tr>
<tr>
<td>Those waiting more than 26 weeks</td>
<td>68</td>
<td>88</td>
<td>93</td>
<td>102</td>
<td>109</td>
<td>151</td>
<td>152</td>
<td>139</td>
<td>198</td>
<td>184</td>
<td>167</td>
</tr>
<tr>
<td>Those waiting more than 18 weeks</td>
<td>228</td>
<td>204</td>
<td>202</td>
<td>260</td>
<td>242</td>
<td>283</td>
<td>306</td>
<td>293</td>
<td>318</td>
<td>328</td>
<td>300</td>
</tr>
</tbody>
</table>

Data for patients seen was adjusted for non-attendance in line with national guidance.

12.2 As reported previously, the service has recruited additional staff on fixed term contracts and has increased the number of patients starting treatment each month. However, there continues to be pressures through a continued increase in referrals to the service and the numbers waiting to be seen continued to increase by the end of February.

Andrew Jackson
Strategic Planning
18 March 2014
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SUMMARY PAPER - FINANCIAL POSITION TO 28 FEBRUARY 2014

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

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

1. The under spend of £1.7m in February, bringing the year to date position to £1.2m overspent. This incorporates support of £1.3m bringing the total to £3.9m released over the previous three months. A breakeven position will be achieved utilising non-recurring reserves and slippage.

2. The key driver is unachieved efficiency savings, with a year to date shortfall of £5.6m.

3. Corporate support of £0.5m for GP payments for LUCS and waiting time pressure at Roodlands within East Lothian CHP’s. As agreed per the mid year review.

4. GP prescribing presents a year to date pressure of £2.9m. This is a deterioration in the month of £600k due to a continued price rise in drugs costs.

5. The cost of providing elective capacity to meet waiting times targets is slightly above forecast £0.3m, due to higher spend than forecast in the use of the independent sector.

Susan Goldsmith
Director of Finance
18 March 2014
susan.goldsmith@nhslothian.scot.nhs.uk
FINANCIAL POSITION TO 28th FEBRUARY 2014

1 Purpose of the Report

1.1 The purpose of this report is to provide an overview of the financial position to the end of February 2014.

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 The Board is asked to note:

- An in month under spend of £1.7m reducing the year to date overspend to £1.2m. This is after the release of £1.3m of non recurring corporate flexibility, plus release of £0.5m to support the additional cost of the LU6S service within East Lothian CHP.
- There is further in month slippage of £0.5m against the LRP target bringing the year to date position to a £5.6m shortfall;
- A break even position will be achieved utilising non-recurring reserves and slippage.

3 Discussion of Key Issues

3.1 NHS Lothian is reporting an under spend in the month of £1.7m, giving a cumulative overspend of £1.2m. Additional corporate support of £0.5m has been released to East Lothian CHP to recognise the increased costs of GP payments to LU6S and waiting times pressures at Roodlands. This pressure has been accommodated in the 2014/15 financial plan. Corporate support of £1.3m has also been released in the month to support operational pressures and slippage on efficiency savings.

3.2 The key driver of the position is unachieved efficiency savings. It is anticipated that £0.9m will be recovered in month 12 to bring the position back in line with a forecasted non delivery of £4.8m at year end, however maintaining the level of brought forward LRP as set out in the Financial Plan remains challenging.
3.3 The position is summarised in table 1 below and a detailed analysis by expenditure type is attached at Appendix 1 and by operational unit in Appendix 2.

**Table 1: Financial Position to 28 February 2014**

<table>
<thead>
<tr>
<th></th>
<th>In month</th>
<th>Year to date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline position</td>
<td>1,011</td>
<td>528</td>
</tr>
<tr>
<td>Outstanding efficiency savings</td>
<td>(534)</td>
<td>(5,629)</td>
</tr>
<tr>
<td><strong>Net operational position</strong></td>
<td>477</td>
<td>(5,101)</td>
</tr>
<tr>
<td><strong>Offset by: Corporate Support</strong></td>
<td>1,300</td>
<td>3,900</td>
</tr>
<tr>
<td><strong>Total under/(over) Spend</strong></td>
<td>1,777</td>
<td>(1,201)</td>
</tr>
</tbody>
</table>

3.4 There is an underspend of £5.6m against Pay Budgets which is mainly attributed to Medical and Dental staffing vacancies, but with vacancies across all clinical staff in the early half of the year. The in month spend on pays is on trend compared to the previous two months.

3.5 Whilst there is an overspend of £8.9m against non pay costs, the in month movement is in line with previous months, with the exception of Ancillary/Admin Costs and GP Prescribing.

- Ancillary/Admin improvements relates to additional corporate support of £0.5m for GP payments for LUCS and waiting time pressure at Roodlands within East Lothian CHP’s.

- GP prescribing shows an in year pressure of £2.9m, this represents an in month pressure of £0.6m. This was driven by an average price rise of 20p per unit coming through in December. This was not anticipated and further work is being undertaken to understand the reasons for this. The year end forecast has been revised to £3m to take account of this movement.

3.6 To assess movements in cost, compared with movements in activity, Appendix 3 provides a summary of acute activity by year to date compared to activity for the same period last year. Reduced activity of 4.6% can be seen in February compared with the 2013/14 yearly average.

4 Efficiency & Productivity

4.1 In month £2.2m of LRP has been booked, a shortfall of £0.5m against plan. This brings overall in year slippage to £5.6m. The sales proceeds expected in previous months have now been received and this will ensure that the year end £4.8m forecast shortfall will be achieved, albeit the contribution from these is non recurring.

4.2 The 14/15 Financial plan is based on an expected carry forward of undelivered LRP of £6.55m. At quarter 3 this was increased to £7.9m due to deterioration in expected delivery across the acute services. Actions were identified to bring delivery back on line however these have not yet delivered the improvement sought and any additional carry forward will be a first call against delivery of next year’s LRP.
4.3 Table 2 provides a summary of the in-year position, with further detailed analysis of delivery against local targets and specific work streams set out in Appendix 4.

**Table 2: Efficiency and Productivity 2013/14**

<table>
<thead>
<tr>
<th></th>
<th>Current Year Target</th>
<th>April - February</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Target £k</td>
<td>Actuals £k</td>
</tr>
<tr>
<td>Local Workstreams</td>
<td>(6,640)</td>
<td>(5,182)</td>
</tr>
<tr>
<td></td>
<td>(12,896)</td>
<td>(11,132)</td>
</tr>
<tr>
<td>Centrally Held</td>
<td>(7,926)</td>
<td>(7,266)</td>
</tr>
<tr>
<td>Residual</td>
<td>(370)</td>
<td>(1,261)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>(27,832)</td>
<td>(24,841)</td>
</tr>
</tbody>
</table>

5  **Waiting times**

5.1 Expenditure on elective capacity to meet waiting times totalled £27.2m at the end of February, a movement of £2.9m in the month. Table 3 provides a summary:

**Table 3: Expenditure on Elective Capacity**

<table>
<thead>
<tr>
<th></th>
<th>2012/13 Outturn £k</th>
<th>2013/14 Plan £k</th>
<th>In Month Spend £k</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Monthly Spend £k</td>
<td>YTD £k</td>
<td></td>
</tr>
<tr>
<td>Internal</td>
<td>7,905</td>
<td>12,679</td>
<td>872</td>
</tr>
<tr>
<td>Independent Sector</td>
<td>12,081</td>
<td>12,546</td>
<td>1484</td>
</tr>
<tr>
<td>Other Contractors</td>
<td>4,921</td>
<td>4,583</td>
<td>475</td>
</tr>
<tr>
<td>Other NHS</td>
<td>2,642</td>
<td>2,959</td>
<td>247</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>27,549</td>
<td>32,767</td>
<td>3,078</td>
</tr>
</tbody>
</table>

5.2 Expenditure in February is slightly over forecast giving a revised year end forecast of £17.7m, a movement of £0.3m. There has been an increase in internal costs which was anticipated due to an acceleration in the recruitment process. The use of the independent sector is also higher than anticipated, due to higher volume of out-patients for see-and-treat and casemix in some specialties.

5.3 Additional resource of £0.5m has been received from the SGHD to support improved trajectories against compliance with the delivery of Treatment Time Guarantee.

6  **Year End Forecast**

6.1 Following the mid-year review forecast, management action has focused on a combination of: local recovery plans: increased delivery of LRP: management of allocations: and slippage in investments to support the delivery of a break even position.
6.2 As previously mentioned £1m brokerage repayment to the Scottish Government has been made in 13/14. This leaves a further £4m to be repaid in 2014/15.

6.3 It is evident from Table 4 that the positive actions undertaken by the respective business units are supporting a concerted improvement in the year end forecast in terms of the baseline position.

6.4 **Table 4: Year End Forecast as at 28th February 2014**

<table>
<thead>
<tr>
<th></th>
<th>Year To Date Variance £'000</th>
<th>Mid Year Review Variance £'000</th>
<th>Year End Forecast £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh Chp</td>
<td>(287)</td>
<td>(1,076)</td>
<td>183</td>
</tr>
<tr>
<td>East Lothian Chp</td>
<td>(168)</td>
<td>(734)</td>
<td>0</td>
</tr>
<tr>
<td>Midlothian Chp</td>
<td>7</td>
<td>(17)</td>
<td>42</td>
</tr>
<tr>
<td>West Lothian Chp</td>
<td>(44)</td>
<td>(147)</td>
<td>20</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>1,557</td>
<td>(649)</td>
<td>1,398</td>
</tr>
<tr>
<td>Clinical Services</td>
<td>45</td>
<td>(630)</td>
<td>268</td>
</tr>
<tr>
<td>AHP Services</td>
<td>(13)</td>
<td>(227)</td>
<td>15</td>
</tr>
<tr>
<td>Royal Infirmary Edinburgh Site</td>
<td>(1,295)</td>
<td>(2,131)</td>
<td>(1,831)</td>
</tr>
<tr>
<td>St Johns Hospital Site</td>
<td>(541)</td>
<td>(714)</td>
<td>(614)</td>
</tr>
<tr>
<td>Surgical Services Directorate</td>
<td>(467)</td>
<td>(292)</td>
<td>(149)</td>
</tr>
<tr>
<td>Western General Hospital Site</td>
<td>(775)</td>
<td>(822)</td>
<td>(802)</td>
</tr>
<tr>
<td>Women Children &amp; Neuroscience</td>
<td>917</td>
<td>907</td>
<td>992</td>
</tr>
<tr>
<td>Corporate - Divisional</td>
<td>(201)</td>
<td>(46)</td>
<td>(46)</td>
</tr>
<tr>
<td>Primary Care Other</td>
<td>944</td>
<td>24</td>
<td>985</td>
</tr>
<tr>
<td>Strategic Services</td>
<td>849</td>
<td>3,691</td>
<td>1,188</td>
</tr>
<tr>
<td><strong>Operational Forecasts (excl LRP)</strong></td>
<td><strong>528</strong></td>
<td><strong>(2,864)</strong></td>
<td><strong>1,649</strong></td>
</tr>
<tr>
<td><strong>Offsetting FP Investments</strong></td>
<td>3,900</td>
<td>5,200</td>
<td>3,900</td>
</tr>
<tr>
<td>Corporate Flexibility</td>
<td>4,428</td>
<td>2,336</td>
<td>5,549</td>
</tr>
<tr>
<td>LRP unachieved</td>
<td>(5,629)</td>
<td>(4,114)</td>
<td>(4,833)</td>
</tr>
<tr>
<td><strong>Total Operational Position</strong></td>
<td><strong>(1,201)</strong></td>
<td><strong>(1,778)</strong></td>
<td><strong>716</strong></td>
</tr>
</tbody>
</table>

7 **Property & Asset Management**

7.1 The forecast cost of the in year programme is £56.93m, of which £35.75m has been incurred to the end of February 2014. The in month movement relates to receipts from property sales being brought forward from 2014/15 which will enable a further prioritising of in year capital schemes.

7.2 The programme for the year is shown in Appendix 5. Delivery of a break even position against the capital resource limit is expected.

8 **Risk Register**

8.1 The risk register rating for the delivery of the 2013/14 financial target remains at a medium risk.
9 Health and Other Inequalities

9.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

10 Involving People

10.1 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.

11 Resource Implications

11.1 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
18 March 2014
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List of Appendices

Appendix 1: NHS Lothian Income and Expenditure Summary February 2014
Appendix 2: NHS Lothian Summary by Operational Unit February 2014
Appendix 3: NHS Lothian Summary of Acute Activity February 2014
Appendix 4: NHS Lothian Property and Asset Management Investment Programme Summary February 2014
Appendix 5: NHS Lothian Efficiency and Productivity Summary February 2014
## NHS Lothian Income & Expenditure Summary February 2014

### APPENDIX 1

<table>
<thead>
<tr>
<th>NHS LOTHIAN CORE POSITION</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>INCOME</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Income from other health systems</td>
<td>(155,242)</td>
<td>(143,082)</td>
<td>(145,407)</td>
<td>2,325</td>
</tr>
<tr>
<td>Junior doctor and additional cost of teaching (ACT)</td>
<td>(57,025)</td>
<td>(49,882)</td>
<td>(49,888)</td>
<td>6</td>
</tr>
<tr>
<td>Private &amp; overseas patient income</td>
<td>(2,559)</td>
<td>(2,625)</td>
<td>(2,535)</td>
<td>(90)</td>
</tr>
<tr>
<td>Road traffic accident income</td>
<td>(1,918)</td>
<td>(1,758)</td>
<td>(1,758)</td>
<td>0</td>
</tr>
<tr>
<td>Other income</td>
<td>(51,671)</td>
<td>(54,161)</td>
<td>(55,240)</td>
<td>1,079</td>
</tr>
<tr>
<td><strong>Sub Total Income</strong></td>
<td>(268,414)</td>
<td>(251,507)</td>
<td>(254,828)</td>
<td>3,320</td>
</tr>
<tr>
<td>Anticipated SGHD allocation</td>
<td>(1,366,358)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>(1,634,773)</td>
<td>(251,507)</td>
<td>(254,828)</td>
<td>3,320</td>
</tr>
</tbody>
</table>

### EXPENDITURE

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical &amp; Dental Staff</td>
<td>212,474</td>
<td>192,637</td>
<td>189,678</td>
</tr>
<tr>
<td>Nursing Staff</td>
<td>353,736</td>
<td>320,177</td>
<td>319,837</td>
</tr>
<tr>
<td>Allied Healthcare Professional</td>
<td>58,450</td>
<td>52,715</td>
<td>52,272</td>
</tr>
<tr>
<td>Support Services / Other</td>
<td>57,047</td>
<td>50,127</td>
<td>51,892</td>
</tr>
<tr>
<td>Health Science Services</td>
<td>35,455</td>
<td>32,451</td>
<td>31,279</td>
</tr>
<tr>
<td>Personal &amp; Social / Therapeutic</td>
<td>25,757</td>
<td>23,498</td>
<td>22,012</td>
</tr>
<tr>
<td>Management/Admin Staff</td>
<td>87,793</td>
<td>78,695</td>
<td>77,697</td>
</tr>
<tr>
<td><strong>Total Pay</strong></td>
<td>830,712</td>
<td>750,301</td>
<td>744,668</td>
</tr>
<tr>
<td><strong>Non-Pay</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drugs</td>
<td>100,867</td>
<td>89,701</td>
<td>90,143</td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>79,195</td>
<td>72,698</td>
<td>74,123</td>
</tr>
<tr>
<td>Equipment</td>
<td>28,038</td>
<td>25,210</td>
<td>27,214</td>
</tr>
<tr>
<td>Other Non Pays</td>
<td>65,039</td>
<td>51,892</td>
<td>51,892</td>
</tr>
<tr>
<td>Prescribing</td>
<td>126,334</td>
<td>115,494</td>
<td>118,384</td>
</tr>
<tr>
<td>GMS</td>
<td>120,354</td>
<td>103,242</td>
<td>103,033</td>
</tr>
<tr>
<td>Primary Care</td>
<td>4,851</td>
<td>3,940</td>
<td>3,892</td>
</tr>
<tr>
<td>Property/Transport</td>
<td>51,081</td>
<td>45,468</td>
<td>46,825</td>
</tr>
<tr>
<td>Ancillary / Admin Costs</td>
<td>177,682</td>
<td>83,691</td>
<td>81,363</td>
</tr>
<tr>
<td><strong>Total Non-Pay</strong></td>
<td>753,170</td>
<td>615,018</td>
<td>623,945</td>
</tr>
<tr>
<td><strong>Total Expenditure</strong></td>
<td>1,583,882</td>
<td>1,365,820</td>
<td>1,368,612</td>
</tr>
</tbody>
</table>

### SUB TOTAL CORE BASELINE POSITION

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Sub Total Income</td>
<td>(50,890)</td>
<td>1,114,312</td>
<td>1,113,785</td>
</tr>
<tr>
<td><strong>LRP</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>LRP</td>
<td>(5,826)</td>
<td>(5,629)</td>
<td>0</td>
</tr>
<tr>
<td>Non Recurring Central Funds</td>
<td>3,900</td>
<td>3,900</td>
<td>3,900</td>
</tr>
<tr>
<td><strong>SUB TOTAL CORE POSITION</strong></td>
<td>(52,817)</td>
<td>1,112,583</td>
<td>1,113,785</td>
</tr>
</tbody>
</table>

### NHS LOTHIAN NON CORE POSITION

<p>| | | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Depreciation &amp; Capital Grants</td>
<td>49,758</td>
<td>32,939</td>
<td>27,440</td>
</tr>
<tr>
<td>Revenue Funded Capital Schemes</td>
<td>0</td>
<td>0</td>
<td>5,499</td>
</tr>
<tr>
<td>Impairments, Provisions &amp; Donated Depreciation</td>
<td>6,959</td>
<td>1,893</td>
<td>1,893</td>
</tr>
<tr>
<td><strong>TOTAL NHS LOTHIAN CORE/NON CORE POSITION</strong></td>
<td>3,900</td>
<td>1,147,416</td>
<td>1,148,617</td>
</tr>
</tbody>
</table>
# NHS Lothian Expenditure Summary February 2014

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget £k</th>
<th>YTD</th>
<th>Baseline Variance £k</th>
<th>LRP Variance £k</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Budget £k</td>
<td>Actuals £k</td>
<td>Variance £k</td>
</tr>
<tr>
<td><strong>Unscheduled Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Infirmary Edinburgh Site</td>
<td>68,734</td>
<td>62,046</td>
<td>63,868</td>
<td>(1,822)</td>
</tr>
<tr>
<td>Western General Hospital Site</td>
<td>58,852</td>
<td>53,227</td>
<td>54,113</td>
<td>(886)</td>
</tr>
<tr>
<td>St Johns Hospital Site</td>
<td>18,749</td>
<td>16,966</td>
<td>17,507</td>
<td>(541)</td>
</tr>
<tr>
<td>LUHS AHP Services</td>
<td>14,617</td>
<td>13,395</td>
<td>13,433</td>
<td>(38)</td>
</tr>
<tr>
<td></td>
<td><strong>160,952</strong></td>
<td><strong>145,634</strong></td>
<td><strong>148,921</strong></td>
<td><strong>(3,287)</strong></td>
</tr>
<tr>
<td><strong>Scheduled Care</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Women Children &amp; Neuroscience</td>
<td>98,836</td>
<td>89,762</td>
<td>88,813</td>
<td>949</td>
</tr>
<tr>
<td>Surgical Services Directorate</td>
<td>172,740</td>
<td>158,310</td>
<td>159,758</td>
<td>(1,448)</td>
</tr>
<tr>
<td>Clinical Services</td>
<td>155,730</td>
<td>140,705</td>
<td>141,066</td>
<td>(361)</td>
</tr>
<tr>
<td></td>
<td><strong>427,306</strong></td>
<td><strong>388,778</strong></td>
<td><strong>389,637</strong></td>
<td><strong>(859)</strong></td>
</tr>
<tr>
<td><strong>CHPs/CHCP/PCCO</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>307,846</td>
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## NHSL Lothian Summary of Acute Activity – February 2013/14

### Discharges

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## NHS Lothian Efficiency & Productivity – February 2

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### LOCAL

| Edinburgh CHP                                        | (812)               |                            | (433)     | (711)      | 278        |
| East Lothian CHP                                     | (370)               |                            | (255)     | (242)      | (13)       |
| Mid Lothian CHP                                      | (81)                |                            | (59)      | (62)       | 3          |
| West Lothian CHCP                                    | (217)               |                            | (171)     | (185)      | 14         |
| Primary Care Other                                   | (28)                |                            | -         | -          | -          |
| Estates & Facilities                                 | (343)               |                            | (296)     | (314)      | 18         |
| Corporate Areas                                      | (601)               |                            | (468)     | (356)      | (112)      |
| Scheduled Care                                       | (2,783)             |                            | (2,551)   | (1,750)    | (801)      |
| Unscheduled Care                                     | (862)               |                            | (668)     | (133)      | (535)      |
| Corporate Services UHS                               | (72)                |                            | (66)      | -          | (66)       |
| Strategic Budgets                                    | (471)               |                            | (215)     | (211)      | 4          |
|                                                      |                     |                            |           |            |            |
| Centrally held                                       | (7,926)             |                            | (7,266)   | (7,266)    | -          |
| Residual                                             | (370)               |                            | (1,261)   | -          | (1,261)    |
| **TOTAL**                                            | **(27,832)**        |                            | **(24,841)** | **(19,213)** | **(5,628)** |
## NHS Lothian Property & Asset Management Investment Programme – February 2013/14

<table>
<thead>
<tr>
<th></th>
<th>Q3 Forecast</th>
<th>Agreed Programme</th>
<th>Expenditure to month 11</th>
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<td>Mammography Upgrade WGH</td>
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| Completing Schemes                                     | 269   | 697   | 291  |

| TOTAL EXPENDITURE                                       | 54,289 | 56,927 | 35,726 |

| Total (over)/ under commitment                          | 1,860  | (776)  | 14    |
SUMMARY PAPER - CORPORATE OBJECTIVES 2014 - 2015

This paper aims to summarise the key points.

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

- The Board is provided with a draft set of the NHS Lothian Corporate Objectives for 2014 / 2015 for discussion and agreement. 1.1
- The final version of the NHS Lothian Corporate Objectives for 2014 / 2015 will be brought to the Board in June 2014 for approval. 3.1
- A final update on the delivery of NHS Lothian’s Corporate Objectives for 2013-14 will also be taken to the Board in June 2014. 3.4

Moray Joslyn
Programme Manager
18 March 2014
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Alex McMahon
Director of Strategic Planning
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NHS LOTHIAN

Board Meeting
2 April 2014

Director of Strategic Planning, Performance Reporting & Information

CORPORATE OBJECTIVES

1 Purpose of the Report

1.1 To provide the Board with an update on the progress of the NHS Lothian Corporate Objectives for 2014 / 2015.

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

2 Recommendations

2.1 Note progress towards the development of NHS Lothian’s Corporate Objectives for 2014 / 2015.

2.2 Note that this set of objectives also reads across to the Risk Register and relate to the mitigation of risk.

2.3 Note that the overall set of objectives is set within the context of the Triple Aim: improving quality of care, improving population health, securing value and financial sustainability and the 12 priority areas within the 2020 Route Map which also aligns the objectives to the delivery of the LDP and the emergent propositions and priorities within the draft Strategic Plan

3 Discussion of Key Issues

3.1 The final performance against the 2013/14 corporate objectives will be brought to the Board in June. This will allow for any time lag in reporting of key performance areas to be capture and for an accurate and up to date performance to be reported to the Board.

3.2 Any feedback from Board members on the content of the draft 2014/25 objectives will be brought back to the June Board in the final agreed set.

4 Key Risks

4.1 Risks associated with the delivery of HEAT targets and standards are detailed within the Local Delivery Plan Risk Management Plan which was accepted at the February Board and has now been submitted to the Scottish Government in final draft form.
5 Risk Register

5.1 The Corporate Objectives for 2014-15 are linked directly to and where appropriate placed on the corporate risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 All HEAT Targets and standards have been fully impact assessed as have where appropriate, many of the other targets and actions within the set of corporate objectives.

7 Involving People

7.1 Issues are highlighted within the Local Delivery Plan Risk Management Plan.

8 Resource Implications

8.1 Resource implications are highlighted within the Local Delivery Plan, Risk Management Plan and also within the financial plan that accompanies the plan.

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18 March 2014
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Alex McMahon
Director of Strategic Planning
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List of Appendices

Appendix 1: NHS Lothian Draft Corporate Objectives 2014-15
## NHS LOTHIAN CORPORATE OBJECTIVES 2014/15

Triple Aim: improving quality of care, improving population health, securing value and financial sustainability

### DOMAIN ONE – QUALITY OF CARE

<table>
<thead>
<tr>
<th>Objective</th>
<th>Corporate Actions</th>
<th>Measures of Success (HEAT and others)</th>
<th>Risk Register</th>
<th>Timing</th>
<th>CMT Lead</th>
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</thead>
</table>
| **1** Improving Patient and Staff Safety | 1.1 Implement the 4 workstreams of the Scottish Patient Safety Programme to prevent harm:  
- Acute Care  
- Primary Care  
- Maternity Care  
- Mental Health | Reduce hospital mortality by 20%  
Achieve 95% harm free care  
Specific SPSP metrics in each workstream as set out in CEL 19 | Yes  
Patient and staff safety | End 2015 | DF |
| | 1.2 Develop the Safety culture including leadership which is open, fair and enhances safety awareness | Safety Culture Survey results and improvement plans for acute inpatient sites  
Staff experience  
Implementation of Significant Adverse Event Improvement Plan  
Number of leadership walkrounds in month | Yes  
Patient and staff safety | March 2015 | DF |
| | 1.3 Reduce Healthcare Associated Infection | Achieve SAB and C.Diff HEAT targets and timescales | Yes  
Healthcare Associated | March 2015 | MJ |
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<tr>
<td><strong>1.4</strong> Reduce harm to staff</td>
<td>No. of needle stick injuries</td>
<td>Infection</td>
<td>March 15</td>
<td>AB</td>
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<tr>
<td></td>
<td>No of assaults on staff</td>
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</tr>
<tr>
<td></td>
<td>No of staff slips and trips</td>
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<td></td>
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<td></td>
<td>Rogue items in laundry</td>
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<tr>
<td><strong>2</strong> Improve Patient and staff experience</td>
<td><strong>2.1</strong> Implement the national person centred care collaborative actions</td>
<td>Patient experience surveys and reports</td>
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<td>Patient Experience</td>
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<td>Number of complaints</td>
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<td><strong>2.2</strong> Implement the Values into Action plan</td>
<td>Staff experience surveys/reports</td>
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<td></td>
<td>Staff experience</td>
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<td>Specific metrics for recommendations to be developed</td>
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<td><strong>3. Improve the way we deliver Scheduled care</strong></td>
<td><strong>3.1</strong> Deliver the waiting times recovery plan to clear backlog</td>
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<td>Achieving national waiting times targets</td>
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<td>Access to CAMHS</td>
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<td><strong>3.2</strong> Comply with TTG</td>
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</tbody>
</table>
## 3.3 Implement Delivering for Patients

- Access to psychological therapies
- IVF treatment
- Access to antenatal services
- 31 and 62 day cancer standards

**Workforce recruitment and retention numbers**

| March 15 | JC |

## 3.4 Develop recurring demand and capacity equilibrium plans

| March 15 | JC |

## 4. Improve the way we deliver unscheduled care

### 4.1 Implement Lothian Unscheduled care action plan across the system (LUCAP 2)

- A&E 4 hr waiting time Standard
- Reduced No of 8 and 12 hour trolley waits
- Reduced No. of Delayed discharges
- No. of DD > 14 days
- Reduce No of Patients Boarding

| Yes Unscheduled Care | March 15 | MJ |

| 3 |
| 4.2 | Develop a Lothian Model of Care for Frail Elderly to deliver right care, right time, right place | Stroke standard achievement Reduce emergency bed days >75
Other unscheduled care metrics including social care being developed |
| 4.3 | Improve the effectiveness of care for priority groups: Long term conditions Multi-morbidity Chronic pain Dementia | Improved management of Chronic Pain measures to be developed
Improved management of multi-morbidity – measures to be developed
Dementia post diagnostic support
Reduction in emergency presentations for diabetes, COPD |
<p>| 5. Develop whole system capacity to deliver care closer to home | 5.1 Develop a demand, capacity and access plan for Primary care and community | Improved management of multi-morbidities: | No | March 2015 | DS |</p>
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<th>5.1</th>
<th>workforce, including Review out of hours primary care delivery (LUCS)</th>
<th><strong>Increase the number of Type 2 diabetes care managed in primary care</strong></th>
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<td>5.2</td>
<td>Develop availability and use of primary care data</td>
<td>Reduced emergency presentations at hospital</td>
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<td>5.3</td>
<td>Implement ‘More Scottish’ GP Contract</td>
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<td>5.4</td>
<td>Develop a primary care premises plan</td>
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<td>5.5</td>
<td>Review opportunities for changes to locally enhanced services i.e. care home support</td>
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<td>5.6</td>
<td>Review opportunities for community specialist roles</td>
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**DOMAIN TWO – IMPROVING HEALTH OF THE POPULATION**

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<th>Screening uptake Immunisation rates</th>
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<td>Deliver population health improvement interventions and health components of single outcome agreements with partners</td>
<td>Deliver population health improvement interventions and health components of single outcome agreements with partners</td>
<td>Detect early smoking cessation</td>
<td>Alcohol Brief Interventions</td>
<td>Fluoride varnishing</td>
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<td>Implement the Health inequalities strategy</td>
<td>Implement the Health inequalities strategy</td>
<td>Develop measures of determinants of health inequalities and use these in monitoring the impacts of this and other strategies</td>
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<td>Strengthen public protection arrangements</td>
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<td>And</td>
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</tr>
<tr>
<td>6.3</td>
<td>Implement actions for emergency preparedness and limit risk (resilience)</td>
<td>Ensure robust resilience standards are met for business continuity and emergency planning</td>
<td>Yes</td>
<td>Preparedness for Emergency Planning</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Compliance checks</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• Training delivered</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>• exercises</td>
<td></td>
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</tr>
<tr>
<td>Domain Three - Secure Value and Financial Sustainability</td>
<td></td>
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<td>--------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>7. Ensure the delivery of a sustainable financial framework</strong></td>
<td></td>
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<tr>
<td><strong>7.1 Deliver a balanced Financial plan</strong></td>
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</tr>
<tr>
<td>Achieve financial balance</td>
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<tr>
<td>Deliver Capital Plan</td>
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<tr>
<td>Deliver capital projects to agreed time and budget</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Yes Achieve Financial targets And Capital Plan cannot be delivered</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>March 2015</td>
<td>SG/All</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>7.2 Delivery Efficiency and productivity plan to achieve £40m LRP</strong></td>
<td></td>
<td></td>
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<tr>
<td>Recurrent delivery of LRP</td>
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</tr>
<tr>
<td><strong>8. Ensure a sustainable workforce framework</strong></td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>8.1 Implement workforce plans as per LDP and Strategic Plan</strong></td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Recruitment and Retention rates</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Increased productivity by specialty</td>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td>Increase in 7 day working</td>
<td></td>
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<tr>
<td>Increase in extended days in theatres</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Yes Medical Workforce Sustainability And Lack of management capacity</td>
<td></td>
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</tr>
<tr>
<td>March 2015</td>
<td>AB/All</td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>
Draft at 18 March 2014

<table>
<thead>
<tr>
<th>9. Develop a co-production and Innovation plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1 Foster a system wide culture of innovation aligned to the development of the strategic plan and delivery of LDP by doing?</td>
</tr>
<tr>
<td>9.2 Develop a strategic plan for working with the 3rd sector</td>
</tr>
<tr>
<td>9.3 Co-produce new care pathways for major patient groups to achieve improved outcomes using innovative approaches</td>
</tr>
</tbody>
</table>

| Measures to be developed around each of four “typical” patient pathways |
| No of innovation ideas generated |
| No of invest to save proposals developed |
| No. of contracts with 3rd sector organisations |

<table>
<thead>
<tr>
<th>10. Deliver the agreed strategic plan 2014-2024</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1 Consult and engage on the draft strategic plan</td>
</tr>
<tr>
<td>Timetable achieved: Draft Plan to April Board</td>
</tr>
<tr>
<td>Consultation and engagement Summer</td>
</tr>
<tr>
<td>Final Plan October Board</td>
</tr>
</tbody>
</table>

| April-July 14 |
| October 14 |

| 10.2 Develop and implement Site Master Plans |
| Plans developed for SJH, WGH, RIE, Lauriston Campus and REH |

| SG/AMcM/MJ |

| 10.3 Improve sustainability of |
| Improve on environmental standards: |
| Yes |

<p>| March 2015 |
| AB/All |</p>
<table>
<thead>
<tr>
<th></th>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>estate and facilities operations</td>
<td>Reduce carbon emissions</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reduce energy consumption</td>
<td></td>
</tr>
<tr>
<td>10.4</td>
<td>Develop the process for implementing the agreed Strategic Plan</td>
<td>Timetable and committee / board approvals achieved</td>
<td>Final plan to October Board</td>
</tr>
<tr>
<td>10.5</td>
<td>Develop business cases or options appraisals for individual propositions.</td>
<td></td>
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</tr>
<tr>
<td>11. Improve integration of care by creating 4 Integrated Joint Boards in line with Public Bodies (Scotland) Act</td>
<td>11.1</td>
<td>Agree functions to be delegated from NHS Lothian to the Integrated Joint Boards</td>
<td>Timetable met: Agreed list June Board</td>
</tr>
<tr>
<td></td>
<td>11.2</td>
<td>Develop, consult and agree Integration Schedules</td>
<td>Integration plans to Oct/Dec Board – consulted and go live April 2015</td>
</tr>
<tr>
<td></td>
<td>11.3</td>
<td>Develop Strategic Commissioning Plans</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. Early Years: Implement the Children and Young People’s Strategy</td>
<td>12.1</td>
<td>Implement the Children and Young People’s Strategy</td>
<td>Agreed by the Board in April</td>
</tr>
<tr>
<td></td>
<td>Full participation in the Early Years Collaborative</td>
<td>Success measures and outcomes are being reviewed and will be part of final objectives.</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>--------------------------------------------------</td>
<td>-----------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>12.3</td>
<td>Develop children’s integration agenda in Edinburgh, East and Mid</td>
<td>Paper to April Board – consult with staff for 3 months</td>
<td></td>
</tr>
<tr>
<td>12.4</td>
<td>Comply with legislative requirements of the Children and Young People’s Act</td>
<td>Scope actions/workforce and financial impact</td>
<td></td>
</tr>
</tbody>
</table>
**SUMMARY PAPER - PERFORMANCE MANAGEMENT**

This paper aims to summarise the key points.

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3</td>
<td>The draft LDP has been submitted to Scottish Government on 14 March 2014, and requires approval by the Board at the April meeting. The LDP is a discussion item on the NHS Lothian Board Agenda.</td>
</tr>
<tr>
<td>4.1.1</td>
<td>Child Healthy Weight: NHS Lothian has delivered 2619 child healthy weight interventions to 31 December 2014, well surpassing the target of 2,268 interventions by 31 March 2014.</td>
</tr>
<tr>
<td>4.1.2</td>
<td>Antenatal Care: NHS Lothian continues to exceed the target of 80% of pregnant women in each SIMD quintile booked for antenatal care by the 12th week of gestation.</td>
</tr>
<tr>
<td>4.1.6</td>
<td>Detect Cancer Early: NHS Lothian has seen an increase in the proportion of stage-1 detected cancers in breast, lung and bowel cancer, up by 10.2% in the period 2011-2012 when compared to the baseline period of 2010-2011.</td>
</tr>
</tbody>
</table>

Moray Joslyn  
Programme Manager  
18 March 2014  
moray.paterson@nhslothian.scot.nhs.uk

Alex McMahon  
Director of Strategic Planning  
18 March 2014  
alex.mcmahon@nhslothian.scot.nhs.uk
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 current performance against those HEAT targets and standards that the Board has agreed to receive in this performance paper as set out in appendix 1.

2.2 Note that the Local Delivery Plan (LDP) for 2014/15 is the delivery contract between Scottish Government and NHS Boards in Scotland, and sets out how Boards will meet HEAT targets and other national priorities.

2.3 The draft LDP has been submitted to Scottish Government on 14th March 2014, and requires approval by the Board at the April meeting. The LDP is a discussion item on the NHS Lothian Board Agenda.

3 Discussion of Key Issues

3.1 Of the 10 items monitored within Appendix 1, the most recent data indicates NHS Lothian is off trajectory / does not meet the overall target on 5 occasions. These are highlighted in red in the appendix.

4 Key Risks and areas to highlight:

4.1.1 Child Healthy Weight (Responsible Director: Director of Public Health and Health Policy)

The latest ISD Data shows that NHS Lothian has delivered 2619 child healthy weight interventions to 31 December 2014, well surpassing the target of 2,268 interventions by 31 March 2014.

4.1.2 Early Access to Antenatal Care (Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

NHS Lothian continues to exceed the target of 80% of pregnant women in each SIMD quintile booked for antenatal care by the 12th week of gestation, and is above trajectory to meet the target by March 2015. Particular focus is now being placed on
supporting those women in more deprived communities to have access and support. Latest figures for January 2014 show that performance has dropped slightly to 89.86%.

Of note is the performance in Musselburgh, East Lothian, has consistently been 100% in the most deprived quintile (Quintile 1).

<table>
<thead>
<tr>
<th>Women booked &lt;12wks by Quintile</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>Overall</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nov-13</td>
<td>100.00%</td>
<td>83.33%</td>
<td>91.67%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>92.68%</td>
</tr>
<tr>
<td>Dec-13</td>
<td>100.00%</td>
<td>100.00%</td>
<td>87.50%</td>
<td>88.89%</td>
<td>93.75%</td>
<td></td>
</tr>
<tr>
<td>Jan-14</td>
<td>100.00%</td>
<td>100.00%</td>
<td>100.00%</td>
<td>85.71%</td>
<td>97.44%</td>
<td></td>
</tr>
</tbody>
</table>

### 4.1.3 Energy and Carbon Emissions (Responsible Director: Director of Human Resources and Organisational Development)

Whilst progress is being made in respect of reducing carbon emissions, current indicators suggest that the HEAT Target will not be met for technical reasons. The HEAT target is under review by SG due to limitations in scope and accuracy. The achievement of HEAT target will require major investment in infrastructure and although new initiatives such as Green Investment Bank funding are being explored there is no new money being allocated. Smaller capital development programmes are in place to help continue the downward trend but these cannot meet the ambitious long term objective.

### 4.1.4 Child Fluoride Varnishing (Responsible Director: Director of Public Health and Health Policy)

The latest ISD figures for the year to end of June 2013 show a dip in performance from 8.18% to 5.5% in the worst performing quintile in Lothian. Similar reductions in performance were noted across Scotland. There was a serious supply problem with fluoride varnish for the first few months of 2013 due to a manufacturing problem and it is likely that this is the reason for the fall. The worst performing quintile is the most affluent according to SIMD, and is where oral health is likely to be best. In the most deprived quintile 32% of three year olds and 44% of four year olds received two varnish applications. The Public Dental Service Childsmile Programme operates in the nurseries located in the most deprived SIMD quintile.

### 4.1.5 Dementia Diagnosis (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

To ensure that we are providing person centred care, recognising the different supports that a person may require during the post diagnostic period, this is a target that needs to be owned and delivered upon in partnership between NHS Lothian, the four Local Authorities and 3rd sector partners. The first step is to ensure that we have robust systems in place to record diagnosis with the patient’s electronic record. This will then enable the patient to be tracked across the local system of care and support. A Data Sharing Partnership has been developed which will enable to safe and appropriate transfer of data. Formal reporting against the target will commence in March 2014.
4.1.6 **Detect Cancer Early** (Responsible Director: Director of Public Health and Health Policy)

To note that work on this continues. The latest campaign is targeted at getting those that may be at risk of lung cancer to seek early diagnosis. The second round of campaigning in respect of breast cancer awareness is due to commence in April. We are making preparations now in relation to the impact that this may have as during the first campaign there was a significant increase in demand as a result of the campaign. On the 25th of February 2014 ISD Scotland published the first statistical report to provide an update on performance against our HEAT baseline 2010 – 2011 position for the DCE programme. The updated report is based on a 2011 – 2012 two-year average data period and shows NHS Lothian has seen an increase in the proportion of stage-1 detected cancers in breast, lung and bowel cancer, up by 10.2% in the period 2011-2012 when compared to the baseline period of 2010-2011. The HEAT target for NHS Lothian requires a 28.3% increase in the proportion of cancers detected at stage-1 by 2015 compared to the baseline year of 2010-2011'.

4.1.7 **Suicide prevention** (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

Note that the Scottish Government issued a revised suicide strategy in December 2013. NHS Lothian and its key partners are reviewing this revised strategy and will consider any additional actions that need to be taken through the Mental Health and Well-Being Programme Board.

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, JMT and other committees.
List of Appendices

Appendix 1: Performance Management Scorecard
### Performance Management

**Appendix 1**

**Performance Management**

**Owner:** Alex McMahon, Director of Strategic Planning, Performance Reporting & Information

**On/above target**  Not Meeting Target

**Administrators:** Moray Paterson, Business Manager; Margaret Callander, Strategic Planning

**Period:** 2013-14

**Note:** Where Target includes breakdown by quintiles, Trend uses bottom cell to calculate analysis.

#### Health Improvement

<table>
<thead>
<tr>
<th>Target Date</th>
<th>Target</th>
<th>Lothian Performance Previous Period</th>
<th>Lothian Performance Current Period</th>
<th>Trend Status Lead Dtr.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Child Healthy Weight</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-14</td>
<td>2,268</td>
<td>Apr-11 - Mar-13 1193</td>
<td>Apr-11 - Dec-13 2619</td>
<td>↑</td>
<td>AKM</td>
</tr>
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<tr>
<td><strong>Suicide Reduction</strong></td>
<td>% of suicides per yr per 100,000 popn</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2013</td>
<td>20%</td>
<td>2008-11 13.7%</td>
<td>2008-2012 14.7%</td>
<td>20%</td>
<td>↑</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Smoking Cessation</strong></td>
<td>- deliver universal smoking cessation services to achieve at least 11,686 successful quits (at one month post quit) including 7,011 in the 40% most-deprived within-Board SIMD areas over the period 2011/12 to 2013/14</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mar-14</td>
<td>11,686</td>
<td>Sep-13 12,842</td>
<td>Dec-13 13,856</td>
<td>↑</td>
<td>JF</td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>Child Fluoride Varnishing Aged 3</strong></td>
<td>achieve at least 60 per cent of 3 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td></td>
<td></td>
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<tr>
<td>Mar-14</td>
<td>30.00%</td>
<td>01/04/2012 to 31/03/2013</td>
<td>55.00%</td>
<td>↓</td>
<td>AKM</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td><strong>Child Fluoride Varnishing Aged 4</strong></td>
<td>achieve at least 60 per cent of 4 year old children in each Scottish Index of Multiple Deprivation (SIMD) quintile to receive at least two applications of fluoride varnish (FV) per year</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Mar-14</td>
<td>50%</td>
<td>01/04/2012 to 31/03/2013</td>
<td>60.00%</td>
<td>↓</td>
<td>AKM</td>
</tr>
<tr>
<td></td>
<td></td>
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<td></td>
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</tr>
<tr>
<td><strong>Detecting Cancer Early</strong></td>
<td>- of all those diagnosed with breast, colorectal and lung cancer, 20% are to be diagnosed while in the first stage of the disease</td>
<td></td>
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<tr>
<td>Mar-15</td>
<td>29%</td>
<td>Baseline 22.60%</td>
<td>75.00%</td>
<td>↓</td>
<td>AKM</td>
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<tr>
<td><strong>Reduce Carbon Emissions</strong></td>
<td>- % reduction year-on-year (Tonnes of CO2)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-15</td>
<td>-8.73%</td>
<td>Qtr 4, 12/13 6.56%</td>
<td>Qtr 2, 12/14 1.90%</td>
<td>5.61</td>
<td>Ab</td>
</tr>
<tr>
<td></td>
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<tr>
<td><strong>Reduce Energy Consumption</strong></td>
<td>- % reduction year-on-year (Energy GJ)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mar-15</td>
<td>-2.97%</td>
<td>Qtr 4, 12/13 1.34%</td>
<td>Qtr 2, 12/14 1.13%</td>
<td>1.80</td>
<td>Ab</td>
</tr>
</tbody>
</table>

**Efficiency**

**Treatment Appropriate for Patient**

<table>
<thead>
<tr>
<th>Outcome</th>
<th>Target</th>
<th>Performance Management Previous Period</th>
<th>Performance Management Current Period</th>
<th>Trend Status Lead Dtr.</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dementia Diagnosis</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Trend named cells - do not adjust**

- No change from previous reporting period
- Increase on previous reporting period
- Decrease on previous reporting period

Local trajectories still to be agreed with the Scottish Government.
<table>
<thead>
<tr>
<th>Treatment Appropriate for Patient</th>
<th>Reported in Wating Times Paper</th>
</tr>
</thead>
<tbody>
<tr>
<td>Faster access to CAMHS - deliver 18 wks Referral to Treatment</td>
<td></td>
</tr>
<tr>
<td>Faster access to Psychological Therapies - deliver 18 wks Referral to Treatment</td>
<td></td>
</tr>
<tr>
<td>A&amp;E Attendances - rate of A&amp;E attendances per 100,000 population</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>MRSA / MSSA Reductions - achieve a reduction in the infection rate of <em>Staphylococcus aureus</em></td>
<td>Reported in HAI Report</td>
</tr>
<tr>
<td>C difficile infections - achieve a reduction of the rate of <em>Clostridium difficile</em> infections in patients aged 15 and over to 0.25 cases or less per 1,000 total occupied bed days</td>
<td>Reported in HAI Report</td>
</tr>
<tr>
<td>Reduction in emergency bed day rates for patients aged 75+</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>Delayed Discharges - no people wait more than 28 days from April 2013, followed by a 14 day maximum wait from April 2015</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>IVF - Eligible patients will commence IVF treatment within 12 months by 31 March 2015</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td>4-hour A&amp;E - 95% of patients waiting wait less than 4 hours from arrival to admission, discharge or transfer for A&amp;E treatment as a minimum and NHS Boards should pursue further sustainable improvement towards the 95% 4-hour A&amp;E standard</td>
<td>Reported in Unscheduled Care Report</td>
</tr>
<tr>
<td>Drug and Alcohol waiting times - 90 per cent of clients will wait no longer than 3 weeks from receipt measured to appropriate drug or alcohol treatment that supports their recovery</td>
<td>Reported in Waiting Times Paper</td>
</tr>
<tr>
<td>Cancer Waiting Times - 82 day referral to treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 82 days of urgently referred with a suspicion of cancer, referred through A&amp;E, or referred from one of the national cancer screening programmes</td>
<td>Reported in Waiting Times Paper</td>
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<td>Cancer Waiting Times - 31-day decision to treat to first treatment - achieve 95 per cent of patients diagnosed with cancer starting treatment within 31 days of their decision to treat, irrespective of the source or urgency of the referral</td>
<td>Reported in Waiting Times Paper</td>
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<td>Stroke Unit - 90% of all stroke patients to be admitted to a stroke unit on day of admission or day following presentation</td>
<td>Reported in Unscheduled Care Report</td>
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SUMMARY PAPER - HEALTHCARE ASSOCIATED INFECTION

This paper aims to summarise the key points in the full paper available to Board members at the meeting.

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

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<thead>
<tr>
<th>Point</th>
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<tr>
<td>Progress against Health Efficiency Access Treatment Targets</td>
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<tr>
<td><em>Staphylococcus aureus</em> Bacteraemia (SAB): NHS Lothian’s <em>Staphylococcus aureus</em> Bacteraemia target by March 2015 is to achieve a rate of 0.24 per 1000 bed days. The current rate is 0.30.</td>
<td>3.2</td>
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<tr>
<td><em>Clostridium difficile</em> Infection (CDI): NHS Lothian’s <em>Clostridium difficile</em> Infection target by March 2015 is to achieve a rate of 0.32 per 1000 bed days. The current rate is 0.54.</td>
<td>3.3</td>
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<td>Norovirus outbreaks: since October 2013 there have been 79 incidents of gastro-enteritis investigated in NHS Lothian, with 478 patients and 115 staff affected. In comparison for the same period 2012/13 there were 130 incidents of gastro-enteritis investigated in NHS Lothian, with 906 patients and 235 staff affected.</td>
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<td>Mandatory Surgical Site Infection Surveillance: NHS Lothian Surgical Site Infection rate for the period October to December 13 was 0.5%, in comparison the rate for the period July to September 13 was 1.9%.</td>
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<td>MRSA Screening Programme: a trial is being undertaken in wards 116 and 118 at the Royal Infirmary where the ordering of swabs and the Clinical Risk Assessment during the admission process will be linked.</td>
<td>3.6</td>
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<tr>
<td>NHS Lothian Alert Antibiotic Policy: results from all three acute sites consistently show that approximately 50% usage of meropenem was for permitted indications while approximately 50% use was for non-permitted but approved by a microbiologist indications.</td>
<td>3.7</td>
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<tr>
<td>Healthcare Environmental Inspectorate (HEI): On 28th/29th of January 2014, the Healthcare Environmental Inspectorate carried out an announced community inspection at Astley Ainslie Hospital. The publication of the draft report and action plan is anticipated to be 3rd April 2014</td>
<td>3.8</td>
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Fiona Cameron
Head of Infection Prevention and Control Services
10 March 2014
fiona.cameron@nhslothian.scot.nhs.uk
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 (HAI) across NHS Lothian. Any member wishing additional information should contact the Nurse Director in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to:

• acknowledge receipt of the HAI Reporting Template for February 2014.
• note NHS Lothian’s Staphylococcus aureus Bacteraemia target by March 2015 is to achieve a rate of 0.24 per 1000 bed days. The current rate is 0.30. NHS Lothian is currently off trajectory as projected rate for February 2014 was 0.28 and multidisciplinary effort is required if target is to be achieved.
• support staff to improve the clinical management of invasive devices in accordance with NHS Lothian and Patient Safety Standards.
• Support procurement of a closed system of blood culture collection that should reduce contamination rates.
• note NHS Lothian’s Clostridium difficile Infection target by March 2015 is to achieve a rate of 0.32 per 1000 bed days. The current rate is 0.54. NHS Lothian is currently off trajectory as projected rate for February 2014 was 0.38. A pan Lothian multidisciplinary effort is essential if target is to be achieved.
• support the Antimicrobial Team activities in relation to Antimicrobial Prescribing Review and reduction of antimicrobials associated with Clostridium difficile.
• encourage General Practitioners to share information associated with investigations of Community Healthcare associated Clostridium difficile.

3 Discussion of Key Issues

3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets March 2015
3.2 *Staphylococcus aureus* Bacteraemia: NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days by March 2015 with a current rate of 0.30. There were 21 episodes of *Staphylococcus aureus* Bacteraemia in February 2014 (1 Meticillin Resistant *Staphylococcus aureus*, 20 Meticillin Sensitive *Staphylococcus aureus*), compared to 16 in January 2014 (0 Meticillin Resistant *Staphylococcus aureus*, 16 Meticillin Sensitive *Staphylococcus aureus*).

3.2.1 Key actions to assist NHS Lothian to reduce *Staphylococcus aureus* Bacteraemia includes
- Education sessions are running at the three front door areas on blood culture sampling techniques.
- Currently awaiting procurement to approve a close system of blood culture collection that should reduce contamination rates.
- Vascular Access Devices poster for theatre staff has been developed, raising awareness and time and date cannula.
- Train the trainer arranged for SJH on vascular access devices.
- New mandatory NHS Lothian infection control learnpro is being developed in conduction with NES.
- Clinical guideline on aseptic technique is being developed currently for all staff.

3.3 *Clostridium difficile* Infection: NHS Lothian’s Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 total occupied bed days by March 2015 in patients aged 15 and over, with a current rate of 0.54. There were 33 episodes of *Clostridium difficile* Infection in patients aged 15 or over in February 2014, compared to 37 in January 2014. There are ongoing discussions with the Nurse Director and Medical Director about identifying improvements.

3.3.1 Key Actions to assist NHS Lothian to reduce *Clostridium difficile* includes
- On going multidisciplinary ward rounds to measure compliance with care bundle and antimicrobial prescribing.
- Regular updates to Chief Nurse and Clinical Director detailing the outcome of CDI ward round with key messages.
- Use of dedicated patient equipment in side room to limit the potential risk of transmission of infection.

3.4 Norovirus: NHS Lothian noted gradual increase in the incidence of Norovirus from October 2013. Infection Prevention and Control continue to work with Bed Management and Clinical Teams in an attempt to minimise disruption to service. Since October 2013 there have been 79 incidents of gastro-enteritis investigated in NHS Lothian, with 478 patients and 115 staff affected. In comparison for the same period for season 2012/13 there have been 130 incidents of gastro-enteritis investigated in NHS Lothian, with 906 patients and 235 staff affected.

3.5 Mandatory Surgical Site Infection (SSI) Surveillance: for the period 1st of October 2013 to 31st of December 2013, 1031 procedures were performed and 4 Surgical Site Infections were detected at a rate of 0.4%. SSI rates for caesarean section (inpatient and Post discharge to day 10) have improved this quarter from 2.2% to 0.4%. SSI rates for Repair of Neck of Femur fracture are improved on the last quarter from 1.9% to 0% and hip arthroplasty rates remain stable.

3.6 The Meticillin Resistant *Staphylococcus aureus* (MRSA) Screening Programme: all areas are being encouraged to improve and sustain compliance by adherence to
the national minimum target of 90% for both Clinical Risk Assessment and swabbing. A trial is being undertaken in wards 116 and 118 at the Royal Infirmary where the ordering of swabs and the Clinical Risk Assessment during the admission process will be linked. Additional improvement measures continue, including raising awareness of the screening programme and associated clinical risk assessment.

3.7 NHS Lothian Alert Antibiotic Policy: recent results from all three acute sites consistently show that approximately 50% usage of meropenem was for permitted indications while approximately 50% use was for non-permitted but approved by a microbiologist indications.

Antibiotic Prescribing indicators: the target level for compliance with the UHD Antimicrobial Prescribing Guidelines and documentation of antibiotic indication is 95%. In clinical areas where Empirical Prescribing Indicators are measured, against a target of 95% compliance with guidelines. St Johns Hospital and the Western General achieved 75% and 78% respectively. The Royal Infirmary of Edinburgh achieved 90%. Documentation of indication for antibiotic treatment was at or above the 95% target level for all three sites at 100%. Compliance with the Surgical Prophylaxis Policy was also 100% compliant.

Antimicrobial ward-rounds: antimicrobial ward-rounds reviewing patients receiving Intravenous antibiotics and alert antibiotics for greater than 48 hours have shown that approximately 50% of Intravenous antibiotic courses have been stopped or de-escalated to oral therapy. These results have been consistently achieved since the start of the pilot-study.

3.8 Healthcare Environmental Inspectorate: On 28th/29th of January 2014, the Healthcare Environmental Inspectorate carried out an announced community inspection at Astley Ainslie Hospital. The publication of the draft report and action plan is anticipated to be 3rd April 2014. NHS Lothian has been requested to submit their sixteen week post inspection action plan update to the Healthcare Environment Inspectors for the unannounced inspection carried out at the Royal Infirmary of Edinburgh on 2nd of October 2013 and the announced inspection at Liberton on 23rd/24th of October 2013.

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 trend for *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection NHS Lothian is not on target to achieve the set Health Efficiency Access Treatment Target.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register 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.

8.1.1 NHS Lothian has increased funding to provide an additional 3 Infection Prevention & Control Nurses to support the ongoing work to reduce healthcare associated infection

8.1.2 In addition NHS Lothian have resourced an Infection Prevention and Control Nurse for to support the HAI Scribe demands as result of the investment programmes in new building works and ongoing maintenance programmes across NHS Lothian.

Fiona Cameron
Head of Infection Prevention and Control Services
10 March 2014
fiona.cameron@nhslothian.scot.nhs.uk

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

NHS LOTHIAN

Staphylococcus aureus bacteraemia monthly case numbers

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Clostridium difficile infection monthly case numbers

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**Staphylococcus aureus** bacteraemia monthly case numbers

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WESTERN GENERAL HOSPITAL

Staphylococcus aureus bacteraemia monthly case numbers

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Clostridium difficile infection monthly case numbers

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**ST JOHNS HOSPITAL**

*Staphylococcus aureus* bacteraemia monthly case numbers

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*Clostridium difficile* infection monthly case numbers

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Estates Monitoring Compliance (%)

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### Clostridium difficile infection monthly case numbers

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## ROYAL HOSPITAL FOR SICK CHILDREN

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### Clostridium difficile infection monthly case numbers

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COMMUNITY HOSPITALS

The community hospitals covered in this report card include:

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

Staphylococcus aureus bacteraemia monthly case numbers

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Clostridium difficile infection monthly case numbers

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OUT OF HOSPITAL INFECTIONS

Staphylococcus aureus bacteraemia monthly case numbers

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Clostridium difficile infection monthly case numbers

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

- The purpose of this report is to invite the Board to review and approve revised Standing Orders.

- The Board approved the current Standing Orders on 24 March 2010 and they are due for review. The Audit & Risk Committee reviewed a draft of revised Standing Orders at its meeting of 10 February 2014. The Committee requested that some further changes be made (which has been completed) and agreed that the revised Standing Orders be recommended to the Board for its approval.

- The text relating to the conduct of Board meetings has been re-organised, which has allowed it to be reduced and simplified. The text now incorporates the recently introduced practice of the “consent agenda”.

- The review has included a detailed review of the section relating to Matters Reserved to the Board. This section is now clearer and updated to reflect other developments in governance.

Alan Payne
Corporate Governance Manager
12 March 2014
alan.payne@nhslothian.scot.nhs.uk
REVIEW OF THE STANDING ORDERS

1 Purpose of the Report

The purpose of this report is to invite the Board to review and approve revised Standing Orders. This is part of a larger programme of work to improve the Board’s corporate governance systems, and may have an impact on the delivery of all Corporate Objectives.

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

2 Recommendations

2.1 Review and agree to adopt the revised Standing Orders

3 Discussion of Key Issues

3.1 The Board approved the current Standing Orders on 24 March 2010 and they are due for review. The Audit & Risk Committee reviewed a draft of revised Standing Orders at its meeting of 10 February 2014. The Committee requested that some further changes be made (which has been completed) and agreed that the revised Standing Orders be recommended to the Board for its approval.

3.2 This review has revisited the Standing Orders from first principles. The following documents have been considered to inform the review: The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302) and The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2005 (2005 No. 108); the UK Code of Corporate Governance (September 2012); and ICSA Guidance on Matters Reserved to the Board (July 2013). Where possible, cross-references to other NHS Lothian policies and procedures have been introduced so as to clearly link the Standing Orders into the overall system of governance.

3.3 The Standing Orders focus on the conduct of Board meetings and which items of business must be considered at Board meetings. The current Standing Orders contain some redundant or unnecessary provisions. They refer to an extant Scottish Government circular on matters reserved to the Board which has been effectively superseded over the years by other developments.

3.4 The Regulations that underpin the Standing Orders go into detail on the appointment/disqualification and removal of Board members. Most of this detail has been removed from the Standing Orders as it has no bearing on the actual conduct of Board business.
3.5 The text relating to the conduct of Board meetings has been re-organised, which has allowed it to be reduced and simplified. The text now incorporates the recently introduced practice of the “consent agenda”.

3.6 At the request of the Audit & Risk Committee, the section on the calling and notice of Board meetings (Section 4) has been enhanced (at paragraphs 4.8 & 4.9) to clarify grounds when the Board may pass a resolution to meet in private.

3.7 The text relating to the personal conduct of Board members (Section 8) has been revised and simplified. The new text emphasises that it is the personal responsibility of each member to comply with the NHS Lothian Code of Conduct and reflects the provisions in the 2001 Regulations relating to interests.

3.8 A distinct element of this review was to consider the Matters Reserved to the Board (Section 6 of the revised version). The text in the current Standing Orders is a straight lift from the recommendations in MEL (1994) 80. However the MEL acknowledges that reserved decisions will differ for different types and sizes of bodies and may change over time. This section has been reviewed to recognise current practice and remove items that are not approved by the Board.

3.9 What has been added to the Matters Reserved is the approval of organisational values, risk management policy, risk appetite and tolerance – these are key aspects of corporate governance. Also it is stated that the Board shall directly approve its systems for responding to any civil, regulatory or criminal matters raised against it. The text has also been reviewed to provide further detail where required and to add links to other key documents.

3.10 Several subjects have been removed from Matters Reserved to reflect that alternative arrangements are in place. The Auditor General appoints the external auditor and the Audit & Risk Committee appoints the Chief Internal Auditor. The Scottish Government sets investment policy for exchequer funds. The Foundation Trustees govern charitable funds. Detailed text on property transactions has been removed and replaced with links to the Scheme of Delegation and the Property Transactions Handbook.

4 Key Risks

4.1 The key risk is that the Board does not function properly and that this compromises the whole system of governance.

5 Risk Register

5.1 This fundamental issue is relevant to all aspects of governance and all identified risks that are associated with it.

6 Impact on Inequality, Including Health Inequalities

6.1 A Rapid Impact Assessment (RIA) has not been performed for this paper. A Rapid Impact Assessment was conducted on the whole Standing Orders package that the Board approved in May 2010. No significant impacts were identified. The documents set the framework for governance and provide stability of working conditions and clarity about decision-making. Having this framework should bring overall
improvements in healthcare quality, but this depends on the content of the policies coming forward. There are no changes to the revisions to the Standing Orders that would require a further assessment to be done.

7 Involving People

7.1 Relevant Board members and managers have been consulted in the development of these Standing Orders. The Audit & Risk Committee has also reviewed the document.

8 Resource Implications

8.1 There are no resource implications.

Alan Payne
Corporate Governance Manager
12 March 2014
alan.payne@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Proposed Revised Standing Orders
1 General

1.1 These Standing Orders for regulation of the conduct and proceedings of Lothian NHS Board, the common name for Lothian Health Board, [the Board] and its Committees are made under the terms of The Health Boards (Membership and Procedure) (Scotland) Regulations 2001 (2001 No. 302) and The Health Boards (Membership and Procedure) (Scotland) Amendment Regulations 2005 (2005 No. 108).

1.2 The Scottish Ministers shall appoint the members of the Board. The Scottish Ministers shall also attend to any issues relating to the resignation, removal and disqualification of members in line with the above regulations. Any member of the Board may on reasonable cause shown be suspended from the Board or disqualified for taking part in any business of the Board in specified circumstances.

1.3 Board members are required to subscribe to and comply with the NHS Lothian Code of Conduct (Appendix 6 to the Standing Orders) which is made under the Ethical Standards in Public Life etc (Scotland) Act 2000.

1.4 Any statutory provision, regulation or direction by Scottish Ministers, shall have precedence if they are in conflict with these Standing Orders.

1.5 Any one or more of these Standing Orders may be varied or revoked at a meeting of the Board by a majority of members present and voting, provided the notice for the meeting at which the proposal is to be considered clearly states the extent of the proposed repeal, addition or amendment.

1.6 The Corporate Services Manager shall provide a copy of these Standing Orders to all members of the Board on appointment. A copy shall also be held on the Board’s intranet at CORPORATE > POLICIES > NHS_LOTHIAN_STANDING_ORDERS_PACK

2 Chair

2.1 The Scottish Ministers shall appoint the Chair of the Board and all other members of the Board.
3 **Vice-Chair**

3.1 The Board shall appoint a non-executive Board member to be Vice-Chair. Any person so appointed shall, so long as he or she remains a member of the Board, continue in office for such a period as the Board may decide.

3.2 The Vice Chair may at any time resign from that office by giving notice in writing to the Chair, and the Board may appoint another member as Vice-Chair.

3.3 Where the Chair has died, ceased to hold office, or is unable to perform his or her duties due to illness, absence from Scotland or for any other reason, the Vice-Chair shall assume the role of the Chair in the conduct of the business of the Board and references to the Chair shall, so long as there is no Chair able to perform the duties, be taken to include references to the Vice-Chair.

4 **Calling and Notice of Board Meetings**

4.1 The Chair may call a meeting of the Board at any time. The Board shall meet at least six times in the year and will annually approve a forward schedule of meeting dates.

4.2 A Board meeting may be called if one third of the whole number of members sign a requisition for that purpose. The requisition must specify the business proposed to be transacted. The Chair is required to call a meeting within 7 days of receiving the requisition. If the Chair does not do so, or simply refuses to call a meeting, those members who presented the requisition may call a meeting by signing an instruction to approve the notice calling the meeting. However no business shall be transacted at the meeting other than that specified in the requisition.

4.3 Before each meeting of the Board, a notice of the meeting (in the form of an agenda), specifying the time, place and business proposed to be transacted at it and approved by the Chair, or by a member authorised by the Chair to approve on that person’s behalf, shall be delivered to every member (e.g. sent by email) or sent by post to the usual place of residence of such members so as to be available to them at least three clear days before the meeting. The notice shall be distributed along with any papers for the meeting that are available at that point. The Board may exceptionally convene a meeting at shorter notice only if all members agree.

4.4 With regard to calculating clear days for the purpose of notice under 4.3 and 4.6, the period of notice excludes the day the notice is sent out and the day of the meeting itself. Working days and weekend days are counted. E.g. If a notice is sent out on Friday for a meeting to be held on the following Tuesday, three clear days notice will have been given.
4.5 Lack of service of the notice on any member shall not affect the validity of a meeting.

4.6 Board meetings shall be held in public. The Corporate Services Manager shall place a public notice of the time and place of the meeting at the Board’s offices at least three clear days before the meeting is held. If the meeting is held at shorter notice (see 4.3) then the public notice shall be placed at the same time that the shorter notice is served. The notice and the meeting papers shall also be placed on the Board’s website.

4.7 While the meeting is in public the Board may not exclude members of the public and the press (for the purpose of reporting the proceedings) from attending the meeting. However the Chair has the right to adjourn a meeting in the event of disorderly conduct or other misbehaviour at the meeting.

4.8 The Board may pass a resolution to meet in private in order to consider certain items of business. The Board may decide to do so on the following grounds:

- The Board is still in the process of developing proposals or its position on certain matters, and needs time for private deliberation.
- The business relates to the commercial interests of any person and confidentiality is required, e.g. when there is an ongoing tendering process or contract negotiation.
- The business necessarily involves reference to personal information, and requires to be discussed in private in order to uphold the Data Protection Principles.
- The Board is otherwise legally obliged to respect the confidentiality of the information being discussed.

4.9 The minutes of the meeting will reflect the reason(s) why the Board resolved to meet in private.

5 Conduct of Meetings

Authority of the Chair

5.1 The Chair shall preside at every meeting of the Board. The Vice-Chair shall preside if the Chair is absent. If both the Chair and Vice Chair are absent, the members present at the meeting shall choose a non-executive Board member to preside.

5.2 The duty of the person presiding at a meeting of the Board or one of its committees is to ensure that the Standing Orders or the Committee’s terms of reference are observed, to preserve order, to ensure fairness between members,
and to determine all questions of order and competence. The ruling of the person presiding shall be final and shall not be open to question or discussion.

5.3 The person presiding may direct that the meeting can be conducted in any way that allows members to participate, regardless of where they are physically located, e.g. video-conferencing, teleconferencing.

5.4 Any member who disregards the authority of the Chair, obstructs the meeting, or conducts himself/herself offensively shall be suspended for the remainder of the meeting, if a motion (which shall be determined without discussion) for his/her suspension is carried. Any person so suspended shall leave the meeting immediately and shall not return without the consent of the meeting.

**Quorum**

5.5 The Board will be deemed to meet only when there are present, and entitled to vote, a quorum of at least one third of the whole number of members, including at least five non-executive Board members. The quorum for committees will be set out in their terms of reference, however it can never be less than two Board members.

5.6 When a quorum is not present, the only actions that can be taken are to either adjourn to another time or abandon the meeting altogether and call another one. The quorum should be monitored throughout the conduct of the meeting in the event that a member leaves during a meeting, with no intention of returning. The Chair may set a time limit to permit the quorum to be achieved before electing to adjourn, abandon or bring a meeting that has started to a close. The Chair shall provide a report to the next meeting of the Board in the event of quorum not being reached.

5.7 In determining whether or not quorum is present the Chair must consider the effect any declared interests.

5.8 If a member, or an associate of the member, has any pecuniary or other interest in any contract, proposed contract or other matter under consideration by the Board or a committee, the member should declare that interest at the start of the meeting. This applies whether or not that interest is already recorded in the Board Members’ Register of Interests. Following such a declaration, the member shall be excluded from the Board or committee meeting when the item is under consideration, and should not be counted as participating in that meeting for quorum or voting purposes.

5.9 Paragraph 5.8 will not apply where a member’s interest in any company, body or person is so remote or insignificant that it cannot reasonably be regarded as likely to effect any influence in the consideration or discussion of any question with respect to that contract or matter.
5.10 If a question arises at a Board meeting as to the right of a member to participate in the meeting (or part of the meeting) for voting or quorum purposes, the question may, before the conclusion of the meeting be referred to the Chair. The Chair’s ruling in relation to any member other than the Chair is to be final and conclusive. If a question arises with regard to the participation of the Chair in the meeting (or part of the meeting) for voting or quorum purposes, the question is to be decided by a decision of the members at that meeting. For this latter purpose, the Chair is not to be counted for quorum or voting purposes.

5.11 Paragraphs 5.7-5.10 equally apply to members of any Board committees, whether or not they are also members of the Board, e.g. stakeholder representatives.

Adjournment

5.12 If it is necessary or expedient to do so for any reason, a meeting may be adjourned to another day, time and place. A meeting of the Board, or of a committee of the Board, may be adjourned by a motion, which shall be moved and seconded and be put to the meeting without discussion. If such a motion is carried, the meeting shall be adjourned to such day, time and place as may be specified in the motion.

Business of the Meeting

5.13 If a member wishes to add an item of business which is not in the notice of the meeting, he or she must make a request to the Chair at the start of the meeting. No business shall be transacted at any meeting of the Board other than that specified in the notice of the meeting except on grounds of urgency. Any request for the consideration of an additional item of business must be raised at the start of the meeting and the majority of members present must agree to the item being included on the agenda.

5.14 For Board meetings only, the Chair may propose within the notice of the meeting “items for approval” and “items for discussion”. The items for approval are not discussed at the meeting, but rather the members agree that the content and recommendations of the papers for such items are accepted, and that the minutes of the meeting should reflect this. The Board must approve the proposal as to which items should be in the “items for approval” section of the agenda. Any member (for any reason) may request that any item or items be removed from the “items for approval” section. If such a request is received, the Chair shall either move the item to the “items for discussion” section, or remove it from the agenda altogether.

5.15 The Board may reach consensus on an item of business without taking a formal vote. Where a vote is taken, every question at a meeting shall be determined by
a majority of votes of the members present and voting on the question. In the case of an equality of votes, the person presiding at the meeting shall have a second or casting vote. A vote may be taken by members by a show of hands, or by ballot, or any other method determined by the Chair.

5.16 Any member may move a motion or an amendment to a motion (a “motion”), and it is expected that members will notify the Chair in advance of the meeting. The Chair may require the motion to be reduced to writing. The member who moved the motion may speak to it. However, another member must second the motion before there is any further debate on it.

5.17 Any member may second the motion and may reserve his/her speech for a later period of the debate.

5.18 Once a motion has been seconded it shall not be withdrawn without the leave of the Board.

5.19 After debate, the mover of any original motion shall have the right to reply. In replying he/she shall not introduce any new matter, but shall confine himself/herself strictly to answering previous observations, and, immediately after his/her reply, the question shall be put by the Chair without further debate.

5.20 When more than one amendment is proposed, the Chair of the meeting shall decide the order in which amendments are put to the vote. All amendments carried shall be incorporated in the original motion which shall be put to the meeting as a substantive motion.

5.21 A motion to adjourn any debate on any question or for the closure of a debate shall be moved and seconded and put to the meeting without discussion. Unless otherwise specified in the motion, an adjournment of any debate shall be to the next meeting.

Minutes

5.22 The names of members present at a meeting of the Board, or of a committee of the Board, shall be recorded. The names of other persons in attendance shall also be recorded.

5.23 The Corporate Services Manager (or his/her authorised nominee) shall prepare the minutes of meetings of the Board and its committees. The Board or the committee shall receive and review the minutes at the following meeting.
6 Matters Reserved for the Board

Introduction

6.1 The Scottish Government retains the authority to approve certain items of business. There are other items of the business which can only be approved at a NHS Board meeting, due to either Scottish Government directions or a Board decision in the interests of good governance practice.

6.2 This section summarises the matters reserved to the Board.

Standing Orders

6.3 The Board shall approve its Standing Orders.

Committees

6.4 The Board shall approve the establishment of, and terms of reference of all of its committees.

6.5 The Board shall appoint all committee members.

Values

6.6 The Board shall approve organisational values.

Strategic Planning

6.7 The Board shall approve all strategies for all the functions that it has planning responsibility for. This is subject to any provisions for major service change which require Ministerial approval.

6.8 The Board shall review and approve the NHS Lothian contribution to Community Planning Partnerships through the Single Outcome Agreements.

6.9 The Board shall approve the Local Delivery Plan for submission to the Scottish Government for its approval.

6.10 The Board shall approve its Corporate Objectives.

Risk Management

6.11 The Board shall define its risk appetite and associated risk tolerance levels.

6.12 The Board shall approve its Risk Management Policy.
Health & Safety

6.13 The Board shall approve its Health & Safety Policy.

Finance

6.14 The Board shall approve its financial plan for the forthcoming year, and the opening revenue and capital budgets.

6.15 The Board shall approve Standing Financial Instructions and a Scheme of Delegation.

6.16 The Board shall approve its annual accounts and report.

Capital – Acquisitions and Disposals

6.17 The Board shall comply with the Scottish Capital Investment Manual. The Board shall review and approve any business case item that is beyond the scope of its delegated financial authority before it is presented to the Scottish Government for approval.

Other Organisational Policy

6.18 The approval of all other policies is delegated to committees and groups throughout NHS Lothian, and this is set out in the Procedure for the Development, Approval and Communication of NHS Lothian Policies & Procedures.

Performance Management

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

Criminal Prosecution/ Civil Litigation

6.20 The Board will approve its system for responding to any civil actions raised against the Board. The Board will approve its system for responding to any occasion where the Board is being investigated and / or prosecuted for a criminal or regulatory offence. Within these systems the Board may delegate some decision making to one or more executive Board members.

Other Items of Business

6.21 The Board may be required by law or Scottish Government direction to approve certain items of business, e.g. the Integration Plans for a local authority area.
6.22 The Board itself may resolve that other items of business be presented to it for approval.

7 Delegation of Authority by the Board

7.1 Except for the Matters Reserved to the Board, the Board may delegate authority to act on its behalf to committees, individual Board members, or other Board employees. In practice this is achieved primarily through the Board’s approval of the Standing Financial Instructions and the Scheme of Delegation.

7.2 The Board may delegate responsibility for certain matters to the Chair for action. In such circumstances, the Chair’s action should inform the Board of any decision or action subsequently taken on these matters.

7.3 The Board and its officers must comply with the NHS Scotland Property Transactions Handbook, and this is cross-referenced in sections 24 and 39 of the Scheme of Delegation.

7.4 The Board may, from time to time, request reports on any matter or may decide to reserve any particular decision for itself. The Board may withdraw any previous act of delegation to allow this.

8 Board Members – Ethical Conduct

8.1 Members have a personal responsibility to comply with the Lothian NHS Board Code of Conduct for Board Members. The Commissioner for Public Standards can investigate complaints about members who are alleged to have breached their Code of Conduct. The Corporate Services Manager shall maintain the Lothian NHS Board Register of Interests. When a member needs to update or amend his or her entry in the Register, he or she must notify the Corporate Services Manager of the need to change the entry within one month after the date the matter required to be registered.

8.2 The Corporate Services Manager shall ensure the Register is available for public inspection at the principal offices of the Board at all reasonable times and will be included on the Board’s website.

8.3 Members must always consider the relevance of any interests they may have to any business presented to the Board or one of its committees. Members must observe paragraphs 5.8 & 5.9 of these Standing Orders, and have regard to Section 5 of the Code of Conduct (Declaration of Interests).

8.4 In case of doubt as to whether any interest or matter should be declared, in the interests of transparency, members are advised to make a declaration.
8.5 Members shall make a declaration of any gifts or hospitality received in their capacity as a Board member. Such declarations shall be made to the Corporate Services Manager who shall make them available for public inspection at all reasonable times at the principal offices of the Board and on the Board’s website.

9 Common Seal and Execution of Documents

9.1 The Corporate Services Manager is responsible for the safe custody of the common seal of the Board, and for maintaining a register of the use of the seal.

9.2 Any document or proceeding requiring authentication by the Board by affixation of its Common Seal shall be subscribed by three Board members. Normally the Chair and the Director of Finance will be subscribers.

9.3 Where a document requires for the purpose of any enactment or rule of law relating to the authentication of documents under the Law of Scotland, or otherwise requires to be authenticated on behalf of the Board it shall be signed by an Executive Member of the Board or any person duly authorised to sign under the Scheme of Delegation in accordance with the provisions of the Requirements of Writing (Scotland) Act 1995. Before authenticating any document the person authenticating the document shall satisfy themselves that all necessary approvals in terms of the Board’s procedures have been satisfied. A document executed by the Board in accordance with this paragraph shall be self-proving for the purposes of the Requirements of Writing (Scotland) Act 1995.

9.4 Scottish Ministers shall direct which officers of the Board can sign on their behalf in relation to the acquisition, management and disposal of land.

9.5 Any authorisation to sign documents granted to an officer of the Board shall terminate upon that person ceasing (for whatever reason) from being an employee of the Board, without further intimation or action by the Board.

10 Committees

10.1 Subject to any direction issued by Scottish Ministers, the Board shall appoint such committees (and sub-committees) as it thinks fit. The Board shall appoint the chairs of these committees. The Board shall approve the terms of reference and membership of the committees and shall review these as and when required.

10.2 The Board shall appoint committee members to fill any vacancy in the membership as and when required. If a committee is required by regulation to be constituted with a particular membership, then the regulation must be followed.

10.3 Provided there is no Scottish Government instruction to the contrary, any non-executive Board member may replace a Committee member who is also a non-
executive Board member, if such a replacement is necessary to achieve the quorum of the committee.

10.4 The Board’s Standing Orders relating to the calling and notice of Board meetings, conduct of meetings, and conduct of Board members shall also be applied to committee meetings. The general exception is that committee meetings shall not be held in public and committee papers shall not be placed on the Board’s website.

10.5 The Board shall approve a calendar of meeting dates for its committees. The committee chair may call a meeting any time, and shall call a meeting when requested to do so by the Board.

10.6 The Board may authorise committees to co-opt members for a period up to one year, subject to the approval of both the Board and the Accountable Officer. A committee may decide this is necessary to enhance the knowledge, skills and experience within its membership to address a particular element of the committee’s business. A co-opted member is one who is not a member of Lothian NHS Board and is not to be counted when determining the committee’s quorum.

List of Appendices

Appendix 1 - Committees and Sub-Committees
Appendix 2 - Terms of Reference for Committees and Sub-Committees
Appendix 3 - Standing Financial Instructions
Appendix 4 - Scheme of Delegation
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Appendix 7 - Freedom of Information Code of Practice
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NHS LOTHIAN

Board Meeting
2 April 2014

Director of Public Health & Health Policy

**SUMMARY PAPER – SOUTH EAST SCOTLAND RESEARCH ETHICS COMMITTEES**

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

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

<table>
<thead>
<tr>
<th>Point</th>
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<tbody>
<tr>
<td>The Board appoints Research Ethics Committee members</td>
<td>3.1</td>
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<tr>
<td>A number of members have recently reached the end of their term</td>
<td>3.1</td>
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<tr>
<td>Six new members have been recruited and eight existing members reappointed</td>
<td>3.2</td>
</tr>
<tr>
<td>The Board is asked to agree to the revised membership of the South East Scotland Research Ethics Committees</td>
<td>2.1</td>
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Dr Alex Bailey
Scientific Officer
18 March 2014
alex.bailey@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
2 April 2014

Director of Public Health & Health Policy

SOUTH EAST SCOTLAND RESEARCH ETHICS COMMITTEES

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approves the revised membership of: South East Scotland Research Ethics Committee 01; South East Scotland Research Ethics Committee 02. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 The Board is asked to agree to the revised membership of the South East Scotland Research Ethics Committees, as detailed in Appendix 1.

3 Discussion of Key Issues

3.1 Whilst the appointment of Research Ethics Committees members is the responsibility of NHS Boards in Scotland, these Committees are part of the National Research Ethics Service. Therefore, the procedures for the recruitment and selection Research Ethics Committee members are laid down in guidance issued by the National Research Ethics Service. The maximum term that any one person can serve on a single Research Ethics Committee is two consecutive terms, or ten years. A number of members of the South East Scotland Research Ethics Committees have now reached this limit and will either transfer to another Research Ethics Committee or will step down from the Research Ethics Service.

3.2 As a consequence, six new members have been recruited to the South East Scotland Research Ethics Committees and eight existing members have been reappointed for a period of five years. This has resulted in a revised membership that requires Board approval. The revised membership is listed in Appendix 1.

3.3 All new members were recruited in accordance with the National Research Ethics Service guidelines, interviewed, offered induction training and, if appointed by the Board, will be added to the membership of South East Scotland Research Ethics Service. Both Research Ethics Committees continue to comply with the necessary requirements for Research Ethics Committee composition as outlined in The Governance Arrangements for Research Ethics Committees (A Harmonised Edition).

4 Key Risks

4.1 There are minimal risks attached to the recommendations. There is a risk that new members will fail to understand the role and remit of NHS Research Ethics Committees leading to inappropriate ethical opinions. There is a risk that the Committee does not retain adequate expertise and/or a sufficient number of lay...
4.2 These risks are mitigated by several processes. All new members have been interviewed, including a discussion about a research ethics application, by a panel including a Research Ethics Committee Chair and the Scientific Officer for the Research Ethics Service. All new members will undergo induction training and, in addition are required to undertake a minimum of one day of ethics-related training a year. All new members will be partnered with a mentor on the same Research Ethics Committee who will be available to provide advice and guidance about research ethics. The South East Scotland Research Ethics Committees undergo Quality Control Checks twice a year. This involves following a nationally-prescribed Quality Control checklist that reviews a selection of research ethics applications, meetings, membership and membership training, ensuring they all comply with current National Research Ethics Service standards. The National Research Ethics Service conducts regular independent audits of the Research Ethics Committees; passing the audit results in full accreditation. The audits include a review of the composition of the Research Ethics Committees including recommendations for the inclusion of more experts. The South East Scotland Research Ethics Committees were last audited on 03/07/2013 and remain fully accredited.

5 Risk Register

5.1 There is no requirement for risks to be added or removed from NHS Lothian’s Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 No impact assessment is required.

7 Involving People

7.1 The composition of NHS Research Ethics Committees is defined by the National Research Ethics Service Standard Operating Procedures. These Standard Operating Procedures state that to ensure that Research Ethics Committees reflect the currency of public opinion, at least a third of Research Ethics Committees members must be lay members. Both of the South East Scotland Research Ethics Committees comply with this requirement. Members are recruited by open advertisement, as per the Nolan principles.

8 Resource Implications

8.1 There are no resource implications arising from this report or recommendations.

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Scientific Officer
18 March 2014
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List of Appendices

Appendix 1: Revised membership of the South East Scotland Research Ethics Committees.
<table>
<thead>
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<th><strong>status</strong></th>
<th><strong>SESREC01</strong></th>
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<tbody>
<tr>
<td>Janet Andrews</td>
<td>Retired - Associate Medical Specialist</td>
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<tr>
<td>(Chair)</td>
<td></td>
<td>reappointment</td>
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<tr>
<td>Tan Chee-Wee (Vice-Chair)</td>
<td>Physiotherapist</td>
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<tr>
<td>Warwick Taylor</td>
<td>Retired</td>
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<tr>
<td>(Alternate Vice-Chair)</td>
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<tr>
<td>Christine Beadle</td>
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<td>Gail Corbett</td>
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<td>Helen Wright</td>
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Summary of Audit & Risk Committee Meeting of 10 February 2014

The Board is referred to the minutes of the meeting, but key items for noting by the Board in this report are:

**General**
- The meeting was quorate and well attended, including Internal Audit, Risk Management, Audit Scotland, CEO, CFO and the Board Chair
- The agenda and schedule of Committee business is now well established with excellent secretarial and governance support being received from Alan Payne.

**Risk Register / Risk Appetite**
Extensive discussion continued in respect of the Risk Register structure and reporting, and also the new Risk Appetite statements and reporting format, which we propose is represented to the Board together with “target and tolerances”.

The Board should note that at the current time most measures are OUTSIDE RISK APPETITE

**Internal Audit – Scopes and reporting**
Improvements have been implemented to ensure there is a more detailed scoping of audits communicated to the Committee as part of the Internal Audit Plan, the intent being to ensure the outcomes reviewed as part of the audit process better align with the expectations of Committee members, and thus improve the assurances obtained.

**Committee Membership**
The resignations of Committee Members Billy Peacock and Kay Blair, resulted in the need to appoint a new Committee member, and Julie Mcdowell was nominated to join the Committee

Jeremy Brettell
Committee Chairman: 10 February 2014.
(Next Meeting Scheduled April 2014)
Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 10 February 2014 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr J Brettell (in the Chair); Mr M Ash; Dr M Bryce; Councillor R Henderson and Councillor C Johnstone.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager); Mr G Curley (Director of Operations (Facilities)) (For items 4.2 and 7.1); Mr T Davison (Chief Executive); Mr D Gillan (Head of Catering and Logistics) (For items 4.2 and 7.1); Mrs S Goldsmith (Director of Finance); Ms D Howard (Head of Financial Control); Mr B Houston (Chairman); Mr D McConnell (Audit Scotland); Ms H Neilson (Modernisation Manager) (For item 7.5); Mr A Payne (Corporate Governance Manager); Mr A Perston (Audit Scotland); Mr D Proudfoot (Deputy Chief Internal Auditor); Mr D Woods (Chief Internal Auditor); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Ms K Blair, Councillor D Grant.

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

43 Internal Audit Report – Hospital Catering (September 2013) and Update on Action Taken in Response to Internal Audit Report on Catering.

43.1 Members noted that Mr Gillan, Catering and Logistic Manager and Mr Curley, Director of Operations (Facilities) were attending in response to Members’ request to receive explanation on what action had been taken to address management actions raised in the Internal Audit report on Hospital Catering.

43.2 Mr Gillan gave a detailed overview of actions taken so far. He highlighted that food provided to patients had now been fully analysed for nutritional adequacy and that previous concerns around calorific content had been resolved. Also, issues relating to mineral content, primarily sodium, were being addressed. In addition, analysis of nutritional adequacy has been undertaken for a standard patients’ snacks list, approved by Ms Douglas, Chair of Lothian Nutritional Care Group.

43.3 Mr Gillan advised that the recommended programme for monitoring food waste (untouched meals) had been implemented to improve consistency across NHS Lothian.

43.3 There was some discussion on the programme of re-investment for catering equipment and the timely appointment of a National Contract for Catering
Equipment Maintenance. Mr Gillan advised that an updated inventory of kitchen equipment would be complete by March 2014 and proposed that advice around food temperature recording at ward level be taken forward by the Lothian Nutritional Care Group.

43.4 Mr Gillan reported that compliance with the New Food Safety Assurance Manual by March 2014 would address the requirement to implement consistent cleaning documents and guidance throughout Catering.

43.5 Mr Woods confirmed that the action taken by Mr Gillan should address the issues raised by the Internal Audit of Catering Services. The Chair requested that a follow up report be submitted in April 2014 to advise the Committee of progress made against the outstanding actions, and thanked Mr Gillan and Mr Curley for attending.

Mr Gillan and Mr Curley left the meeting.

44 Minutes of the Previous Meeting

44.1 Minutes of the previous meeting held on 9 December 2013 – The Committee approved the circulated minutes as a correct record.

45 Matters Arising

45.1 Matters Arising from the Meeting of 9 December 2013 – the Committee received the paper detailing the matters arising from the Audit & Risk Committee meeting held on 9 December 2013, together with the action taken and the outcomes.

45.2 The Committee accepted that the actions detailed within the Running Action Note were complete or on track for completion by the intended target date.

46 Risk Management

46.1 Risk Register Update

46.1.1 Ms Bennett gave a detailed overview of the report. She drew the Committee’s attention to the review of the risk register, and the changes made to the register to address issues from the previous meeting. She went on to highlight the specific section on risk appetite and diagram therein.

46.1.2 The Chair advised that he would attend the next meeting of the Risk Management Steering Group to discuss NHS Lothian’s risk appetite. Once a way forward was agreed a report would be taken to the Board to ensure that all Board members have a shared understanding of Risk Appetite and how it relates to the Corporate Objectives. The Committee reviewed the diagrammatic representation of risk appetite that had been drafted and agreed
this was helpful as a way forward following the discussion at the last committee meeting.

46.1.3 Mr Davison acknowledged the importance of getting a clear understanding of the different levels of risk and how they related to a hierarchy of corporate objectives as the Board moves forward with risk appetite.

46.1.4 Following a brief discussion on the context of risk (3567) Health and Social Care Integration, it was agreed that Ms Bennett would revisit the wording with managers.

46.1.5 The Chair requested that Ms Bennett add a line to the risk register clarifying that risks are scored out of 25, and to review the register so that there is consistency throughout the “adequacy of control / risk rating” section of the risk register.

46.1.6 The Committee thanked Ms Bennett for the report and acknowledged the progress that had been made over the last year in developing the corporate risk register, the system of risk management and guidance on risk appetite.

47 Internal Audit & Counter Fraud Reports

47.1 Internal Audit – Progress Report January 2014

47.1.1 Mr Woods gave a brief overview of the report and highlighted that as at 27 January 2014, 4 audits were in fieldwork, 2 reports were draft, 11 reports were complete and 1 audit (year-end stock-taking) was in the planning stage. He highlighted that the recent improvement by management in implementing agreed actions was maintained.

47.1.2 The Committee accepted the Internal Audit Progress Report – January 2014.

47.2 Draft Internal Audit Plan 2014-15

47.2.1 Mr Woods introduced the draft internal audit plan detailing the proposed audits, scopes and quarters for the coming financial year along with tables showing the audit universe of 120 audit topics and how they are mapped with the Corporate Risk Register. He highlighted that scopes within the audit plan now listed the control objectives expected to be covered by the audits, before inviting members present to comment on the plan. The Chair noted it was vital for members to be comfortable with the more explicit scope detailed, as this was designed to ensure that the audit reports focussed also on ensuring the outcomes were reviewed to committee members satisfaction.

47.2.2 In response to a query from Dr Bryce, Mr Woods advised that although a stand alone audit of Staff Governance is not included in the audit plan, the topic features regularly in other audits. He advised that if control issues in relation to staff governance were identified during audits, then recommendations would be raised during those audits.
47.2.3 Dr Bryce asked if the scope of the Complaints audit would consider how the complaints process engages and affects people. Mr Woods explained that the current control objectives did not fully cover this and agreed to discuss with Dr Bryce any necessary amendments out with the meeting.

47.2.4 Mr Ash requested that in addition to Dr Bryce’s request for the Complaints audit, he would like the audit to consider how the organisation categorises, analyses and monitors complaints.

47.2.5 The Committee discussed the recent BBC programme on fraud in NHS Scotland and whether investigations highlighted by the programme had brought any other areas of fraud forward for consideration. Mr Woods advised that NHS Lothian was continuously working to identify new areas of fraud. He advised the Committee of work by the NHS Lothian’s Counter Fraud Action Group in applying the Fraud Risk Assessment Methodology developed by Counter Fraud Services and agreed to bring a report on this to the April meeting.

47.2.6 Following discussion around how the audit universe would include the prevention & detection of cyber attack in the internet / intranet, it was agreed that the Chair of the Information Governance Committee would be invited to attend and present a paper at the April meeting.

47.2.7 In response to a query from the Chair, Mr Woods assured the Chair that though a specific audit of Violence and Aggression had not been carried out since May 2007, the topic had been included in other audits such as Physical Security within this year’s audit plan.

47.2.8 The Committee approved the Internal Audit Plan 2014-15.

47.3 CFS – Referrals & Operations – January 2014

47.3.1 Mr Woods introduced the summary of CFS referrals and operations as at January 2013. He advised that 2 referrals and 7 operations were currently open.

47.3.2 In response to Councillor Henderson’s question about consistency on outcomes following investigations, Mr Woods advised that whether an employee was prosecuted was dependant on the level of evidence against them.

47.3.2 The Committee accepted the CFS – Referrals & Operations report.

48. External Audit Reports

48.1 NHS Lothian Annual Audit Plan 2013/14

48.1.1 Mr McConnell introduced the External Auditor’s Annual Audit Plan 2013/14. He gave a brief overview of the key risk areas under the two main headings:
financial statements audit, eg new accounting requirements for endowments and wider issues and risks, eg waiting times.

48.1.2 In response to a question, Mr McConnell advised that the way to address misrepresentation of the consolidation of the endowments funds would be in the accuracy and clarity of the narrative and notes of the annual accounts.

48.1.3 The Committee agreed to accept the Audit Scotland NHS Lothian Annual Audit Plan 2013/14.

49 Corporate Governance (Decision)

49.1 Overview of Tax Compliance risks in NHS Lothian

49.1.1 Mrs Howard gave an overview of the report that provided further information on NHS Lothian tax compliance risks. She highlighted that the main risks were associated with VAT for contracted-out services and business activities, and employment taxes (PAYE).

49.1.2 Mrs Howard advised that NHS Lothian was currently positioned at the top end of the acceptable level for inaccuracies for VAT recovery, however work is continuing to bring down the level of inaccuracies. It was noted that as a result of the processes in place, NHS Lothian did not experience any losses.

49.1.3 The Committee agreed to accept the report on Tax Compliance Risks in NHS Lothian.

49.2 Review of the Standing Orders

49.2.1 Mr Payne introduced the paper on the review of the standing orders. He advised that the review had two broad themes. The review has removed unnecessary material and re-ordered text in order to make the document as a whole flow better. Also the section on “matters reserved to the Board” has been revised.

49.2.2 Mr Payne agreed to look into the regulations surrounding private meetings, declaration of their purpose and disclosure of their papers before revising paragraph 4.8 of the draft standing orders.

49.2.3 Members agreed that the quorum of the Board should be amended to state that the ‘quorum of at least one third of the whole number of members, including at least five non-executive Board members.’

49.2.4 Mr Payne agreed to revise the last sentence of paragraph 5.16 of the draft standing orders so as to improve clarity.

49.2.5 The Committee agreed to recommend that the Board approves the standing orders, subject to the inclusion of the suggested changes.

49.3 Update on Actions Taken on Waiting Times Management
49.3.1 Ms Neilson gave a brief overview of the report that updated Committee Members on the progress of waiting time recommendations since the September meeting. She advised that appendix 1 summarised the changes to the assurance framework.

49.3.2 The Chair requested that Ms Neilson bring back an example of the forensic dashboard and a paper on the outcome of the sampling process to the April 2014 meeting of the Audit and Risk Committee.

49.3.3 The Committee agreed to accept the report on the actions taken on waiting times management.

49.4 Instructions on Governance Statement

49.4.1 Mr Payne introduced the paper on instructions on the governance statement. He highlighted that references to the UK Code of Corporate Governance have been removed from the guidance.

49.4.2 Mr Payne confirmed that any issues from directors' certificates of assurance and committee annual reports will be summarised and circulated to members before the June meeting.

49.4.3 The Committee agreed to accept the Instructions on the Governance Statement.

50 Items for information

50.1 Integration: Process and Update

50.1.1 The Committee noted the report on Integration: Process and Update for information.

50.1.3 The Committee noted the report for information.

51. Any Other Competent Business

51.1 Audit Scotland Reports

51.1.1 In response to Mr Ash question, Mr Payne advised members of the process for receipt of Audit Scotland reports. He agreed to bring forward a paper indicating whom reports had been passed to at future meetings.

52. Date of Next Meeting

52.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 7 April 2014 at 9:00 in Waverley Gate, Edinburgh.
Committee members only are asked to attend by 8.45 for the scheduled 15-minute pre-meeting.

Subsequent to the meeting, the Committee held a private meeting with Internal Audit, External Audit, and the Risk Manager.
Minutes of the Meeting of the Finance & Resources Committee held at 10am on Wednesday 22 January 2014 in the Seminar Room, Edinburgh Cancer Research Centre, Western General Hospital, Crewe Road South, Edinburgh.

Present: Mr B Houston (part Chair); Mr T Davison; Mrs S Goldsmith; Councillor R Henderson; Professor J Iredale and Mr J Brettell (part Chair).

In Attendance: Mr I Graham; Professor A McMahon; Mr C Marriott; Mr P Reith and Mr J Sherval.

Apologies for absence were received from Mr G Walker, Mrs K Blair, Dr D Farquharson, Ms M Johnson, Mr P Johnston, Mr J Crombie and Dr A K McCallum.

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.

53. Minutes of the Previous Meeting

53.1 The previously circulated minutes of the Finance & Resources Committee meeting held on 18 December 2013 were approved.

54. Action Note

54.1 The previously circulated running action note of the Finance & Resources Committee was noted:

- **Property and Asset Investment Programme 2012/13** – Mrs Goldsmith advised the committee that the focus of the master-planning presentation on the agenda was the potential capital implications of the work completed to date.

- **Self-Assessment Tool** – Mrs Goldsmith advised the committee that Mr Payne had prepared a draft paper which had been shared with the committee Chair and would be circulated around committee members in due course. Responses would support the completion of the Finance & Resources Committee’s Annual Report.

SG/GW
55. St John's Hospital Special Care Baby Unit Modernisation Project

55.1 Mrs Goldsmith introduced a previously circulated report giving an update on the approach being taken to address the opportunity to refurbish the St John's Hospital Special Care Baby Unit.

55.2 Mrs Goldsmith reminded members that the proposed approach had been agreed in principle at the previous meeting. Mrs Goldsmith commented that if a full business case for the upgrade of the unit was produced it would not get to the committee until the summer. Instead of this it was proposed to start the outlined enabling works at a cost of up to £½m at this meeting. The assessment of the risk involved was low and it was noted that this work was not included in a building maintenance budget but that the costs would be included in the business case.

55.3 Mr Brettell questioned whether the original piece of work on producing the business case for the Special Care Baby unit had been inadequately scoped and what the operational impact would be.

55.4 Mrs Goldsmith advised that the issue had been that the Birthing Centre at the Royal Infirmary had been launched with the maternity strategy and it had been agreed that a facility would also be required at St John's Hospital.

55.5 Mr Graham commented that a wider range risk assessment had been required and a number of lessons had been learned about the potential impact of such works on neighbouring facilities. The impact the additional vibration would have on a specialised Neonatal Unit had not been anticipated but the lesson learned would be applied to future such work.

55.6 Subject to Mr Brettell's comments, the committee agreed to note and approve the approach being taken to progress this project and agreed to delegate to the Director of Finance authority for the release of funding to support the enabling works of this project.

56. Matters Arising

56.1 Master-Planning and Strategic Capital Plan including the Draft Community Empowerment (Scotland) Bill – Mr Graham delivered a presentation on the master-planning and strategic capital plan covering the delivery governance hierarchy, the underlying requirements, the draft capital plan including the five year property and asset investment programme, primary care and integration, the master-plan for the Royal Edinburgh Hospital, the Edinburgh Bio Quarter and Royal Infirmary of Edinburgh, the Western General Hospital, St John's Hospital, the Lauriston Campus and other schemes.

56.1.1 Mrs Goldsmith suggested that some of the gaps in capacity within Lothian could be addressed with the creation of additional facilities at St John's Hospital. Also under consideration was the development of the Lauriston Campus including the Lauriston Building, Chalmers Hospital and the site of the Princess Alexandra Eye Pavilion.
56.1.2 Mr Davison commented that it might be possible to move a number of outpatient services to the Lauriston Building. Mrs Goldsmith commented that there was a need to rethink the clinical strategy in respect of where services were delivered and Professor Iredale noted that an isolated eye hospital was anachronism in modern medicine and there was a pressing need for it to be situated in close proximity to an acute hospital.

56.1.3 Mrs Goldsmith advised the Committee that dialogue was required with Scottish Government colleagues regarding availability of capital and the prioritisation process.

56.1.4 Mr Houston left the meeting. Mr Brettell took the Chair.

56.1.5 Mrs Goldsmith commented that the capital plan would be submitted to the next Finance & Resources Committee and it was her intention to seek a balanced capital plan for 2014/15 and 2015/16 and that the following three years would set out the proposed direction of travel.

56.1.6 Professor McMahon advised the committee that there would be a discussion on the draft Strategic Plan at the February Private Board meeting and Mr Davison emphasised the potential for the Edinburgh Bio-quarter site as an option for the further development of hospital services.

56.1.7 Professor Iredale suggested that the eye hospital could be relocated to the Edinburgh Bio-quarter.

56.1.8 The Committee noted the presentation and the current position in respect of the Master-plan and the Capital Plan.

56.2 Update on Step-down Beds in Care Homes – A previously circulated report from the Joint Director of Health & Social Care for the City of Edinburgh explaining the progress made on step-down beds in Edinburgh was received.

56.2.1 Mr Brettell commented that Edinburgh had the largest problem in Lothian in respect of the deficit of care home beds and Mrs Goldsmith advised that she and Mr Davison were involved in weekly discussions with the City of Edinburgh Council to resolve this. Councillor Henderson advised that one issue was that general practitioner records would not necessarily be available for patients using step-down beds. Professor McMahon advised that GP contracts could be examined to see if the issues of GP notes accessibility could be resolved and it was agreed that Mr Gabbitas should outline this problem in greater detail to the committee and identify how the problem could be resolved.

56.3 Process of Payment of Resources to Integration Joint Boards – Mrs Goldsmith advised the committee that it now seemed likely that there would be an agreed resource envelope for Integration Joint Boards and that whatever the financial framework, work on due diligence would be required.
56.3.1 The committee agreed that it would be willing to test the thinking on due diligence and scrutinise the proposals for the Board. It was agreed that this should also progress through the Audit & Risk Committee.

57. **Financial Position to 31 December 2013**

57.1 The committee received a previously circulated report giving an overview of the financial position to the end of December 2013 and an update on the year end forecast.

57.2 Mrs Goldsmith commented that the deterioration in the financial position had continued in December but to a lesser extent. Figures now showed a slight improvement although because the recruitment process was more efficient savings previously made through delays in recruitment were no longer appearing. There was an overspend on clinical supplies and the use of the independent sector had meant that NHS Lothian had been left with a higher proportion of more expensive complex cases.

57.3 Mrs Goldsmith commented that, barring further deterioration in the financial position, she could be positive about achieving financial break-even by the end of the financial year because of slippage on financial plan investments and other non-recurring items.

57.4 Mr Davison commented that any likely deficit would be within ½% of the allocation which would be within the Scottish Government's acceptable limits.

57.5 Mr Marriott advised that the underlying deficit arising from the non delivery of the local reinvestment plan was in the region of £4.2m and he would be looking at all aspects of flexibility to resolve this.

58. **Property and Asset Investment Programme 2013/14**

58.1 The committee received a previously circulated report giving an update on the Property and Asset Investment Programme for the current year.

58.2 The committee agreed to delegate authority to the Director of Finance to sign the amended supplemental agreement for the laboratory project and noted the financial performance to date with the highlighted key risks and issues from this programme of work.

59. **Property and Asset Investment Programme 2013/14 Business Case Monitor**

59.1 The committee noted a previously circulated business case monitor outlining the current position in respect of major reprovision projects, completed projects, business cases to be presented to the committee and projects on a capital plan under development.
60. Date and Time of Next Meeting

60.1 It was noted that the next meeting of the Finance & Resources Committee would be held on Wednesday 12 March 2014 at 9:00 a.m. in Meeting Room 7, Waverley Gate, Edinburgh.
Minutes of a Special Meeting of the Finance & Resources Committee held at 12.30 p.m. on Wednesday 5 March 2014 in the Boardroom, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr G Walker (Chair); Ms K Blair; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Ms M Johnson; Mr B Houston; Professor J Iredale and Mr J Brettell.

In Attendance: Mrs S Allan; Mrs A Mitchell; Dr R Williams; Mrs J McDowell; Mr G Warner; Councillor C Johnstone; Mr A Joyce; Mr A Boyter; Professor A McMahon; Mr B Currie, Mr I Graham; Mr A Orr; Mr R Cantlay; Mr M Pryor; Ms J Mackenzie and Mr P Reith.

An apology for absence was received from 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.

61. Royal Hospital for Sick Children and Department of Clinical Neurosciences, Little France, Project Procurement and Recommendation of Preferred Bidder

61.1 The Committee received a previously circulated report confirming completion of the evaluation of Final Tenders for the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France.

61.2 The Chair reminded members that the information being provided was commercially confidential and counted as “insider information” which could not be communicated to any third party without risking prosecution.

61.3 Mr Currie reminded members of the background to the project and the various steps leading to the recommendations made by the Project Team and endorsed by the Project Steering Board on 28 February 2014.

61.4 The Committee noted that the Scottish Futures Trust required that 60% of the evaluation of Final Tenders had to relate to commercial/cost and that 40% of the evaluation of Final Tenders had to relate to quality. This comprised 61 criteria divided into 3 sub-sections with a total of 40 marks available to bidders as part of the quality evaluation spread between the bidders' strategic and management approach (5 marks), design and construction approach (23 marks) and Facilities Management approach (12 marks). It was noted in
particular that the quality side of the evaluation was separated from the cost/commercial side of the evaluation.

61.5 Mr Graham commented that the cost/commercial side of the evaluation also included an evaluation of any commercial amendments made by bidders in respect of the legal framework, which consisted of a contract (this being the NPD Project Agreement) agreed in advance with the Scottish Futures Trust.

61.6 Mr Currie advised the Committee that the Project Steering Board now had a preferred bidder and he would be seeking the committee's endorsement of that recommendation.

61.7 Mr Pryor, representing Ernst and Young LLP, as Financial Advisers to the Project, advised that their evaluation had been carried out in accordance with the process set out in the Invitation to Participate in Dialogue and in the Invitation to Submit Final Tender issued on 16 December 2013. He confirmed that it had found that all of the construction costs were below the level of the Scottish Government cap as set at the point of issuing the Invitation to Submit Final Tender. He also confirmed that the life cycle costs had been compared to the amount indicated in the funding letter to the Board and all bidders were below this number. It was noted that the Facilities Management costs had been compared to the sum assumed in the Outline Business Case and that no bidders' cost exceeded this amount and that the provisional preferred bidder had the lowest capital cost and lowest subordinated debt coupon. He was satisfied that the processes had been completed in accordance with the requirements of the Scottish Futures Trust and the Scottish Government.

61.8 Mr Orr, representing MacRoberts LLP, as Legal Advisers to the Project, confirmed to the Committee that following the submissions of the Final Tenders from the three bidders, a legal review had been carried out and a report providing an overview of the legal documents submitted by each bidder in relation to the requirements of the Invitation to Submit Final Tenders had been provided to the Board.

61.9 Mr Orr confirmed that the procurement process followed by the Board had been consistent with other similar projects and the procurement followed by the Board had complied with relevant procurement regulations and best practice. The procurement had also followed the processes and procedures required by the Scottish Futures Trust.

61.10 Mr Cantlay, representing Mott MacDonald, advised the Committee that as technical advisors for the reprovision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences at Little France NDP project he believed from a technical perspective that the technical evaluation had been carried out in a manner consistent with the evaluation methodology. From their involvement in this process, the considered scores awarded for the technical evaluation criteria seemed to be correct and it appeared appropriate for the Board to conclude the evaluation process and appoint the bidder identified as having the most economically advantageous tender as the preferred bidder.
61.11 The Chair reminded the Committee that the purpose of the supplemental agreements with Consort were to ensure that whichever bidder was selected there were robust agreements in place to ensure that the enabling works relating to the shared areas between the Royal Infirmary of Edinburgh and the Royal Hospital for Sick Children and Department of Clinical Neurosciences could be completed without delay.

61.12 Mrs Goldsmith confirmed that the main risk implicit in relation to such supplemental agreements relating to the enabling works was in relation to ongoing issues in respect of the clinical enabling works.

61.13 Mr Graham confirmed that each bidder had tendered on the basis of a bidder specific NPD Project Agreement, that all sub-contractors had been required to submit references and visits to sites had been conducted by each bidder.

61.14 Mr Cantlay advised that the price proposed by the preferred bidder was a robust one based on an existing model and the process had been followed to the letter.

61.15 Councillor Johnstone left the meeting.

61.16 Mr Currie confirmed that all three bids had been of an acceptable quality and Mr Orr reassured the Committee that the scheme employed a new standard form contract, this being the NPD Project Agreement published by the Scottish Futures Trust, which ensured that returns to the private sector were capped and any surpluses came back to the public sector. Hard facilities management would be subject to a robust approach and the Payment Mechanism included appropriate penalties which could be used against the bidder in order to incentivise performance. Everything possible had been done to mitigate the risk of poor quality facilities and/or poor services being provided to NHS Lothian.

61.17 Mr Currie confirmed that the project had the potential to expand on the top floor, subject to obtaining town planning consent from The City of Edinburgh Council and the configuration of the ground floor could be altered to a limited degree if additional space was required.

61.18 Mr Currie also confirmed that all details had been clarified in the contract documentation and the Chair reminded the Committee that the Scottish Futures Trust had been members of the Project Board and signed off on all the processes (Key Stage Reviews).

61.19 Mr Orr confirmed that all the required legal processes were in place and documentation required by the Scottish Futures Trust had been used with any changes being made approved by the Scottish Futures Trust.

61.20 Mr Cantlay confirmed that the scores were all appropriate and he was happy with the evaluation and satisfied that the preferred bidder was in full accordance with the requirements.
61.21 Mrs Goldsmith advised that following the decision of the Committee there would be a full debriefing process with the two unsuccessful bidders.

61.22 The Chair sought confirmation that the price in the contract was fixed and Mr Orr confirmed that there would be a fixed price contract in place subject to any variations, agreed increases and other risks which remained with NHS Lothian.

61.23 The Committee agreed to note the outcome of the scored evaluation and the assurance statements provided by Legal, Technical and Financial Advisers along with the completion of the Key Stage Review (Appointment of Preferred Bidder) by the Scottish Futures Trust,

61.24 The Committee agreed unanimously, with no dissent from any members present, to approve the recommendation of the Project Team, as endorsed by the Project Steering Board, to appoint Integrated Health Solutions Lothian as the preferred bidder for the development of the Royal Hospital for Sick Children and Department of Clinical Neurosciences on the site at Little France and to authorise the Project Director to issue the formal Preferred Bidder Letter and the two associated unsuccessful bidder letters in order to formally commence the contract “standstill period” required under the relevant procurement regulations.

62. Date of Next Meeting

62.1 The Chair reminded members that the next full meeting of the Finance & Resources Committee would be held on Wednesday 12 March 2014 at 9:00 a.m. in Meeting Room 7, Waverley Gate, Edinburgh.
Summary of Healthcare Governance Committee Meeting of 21 January 2014

1.0 Key Issues Discussed

In addition to the enclosed minutes from the Healthcare Governance Committee meeting held on 21 January 2014 I would like to draw the attention of the Board to the following items:

1.1 Prison Healthcare

The Healthcare Governance Committee welcomed a comprehensive report on the Prison Healthcare Service with the HM Inspectorate of Prisons report on HMP Edinburgh. It was evident that considerable work had been undertaken since NHS Lothian assumed responsibility for the service.

1.2 Tissue Viability

The Healthcare Governance Committee received a very valuable presentation on Tissue Viability.

1.3 Stroke Care Standards

An insightful presentation on Stroke Care Standards was received, which highlighted the progress being made by working across sites as a single system, with the focus on care pathways for the individual patient. The presentation complemented the Quality Report’s focus on stroke care, compliance and improved trajectory on meeting these targets.

1.4 Research and Development Annual Report

The Research and Development Annual Report showed the depth of high quality research and illustrated the impact of research on the quality of patient care in Lothian.

Dr Morag Bryce
Chair of the Healthcare Governance Committee
05 February 2014
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.*

58. Patient Story

58.1 Ms Ballard-Smith read out a letter from a relative of a patient who described extremely good communication by staff both at the Royal Victoria Hospital and in Orthopaedics at the Royal Infirmary of Edinburgh to family members who were geographically distant. There was also a good example of person centred care as an effort was made to ensure the husband’s and wife’s needs as a couple were
considered as part of their individual care plans. Both the doctor and a student nurse were praised for caring and professional words as part of end of life care.

59. Committee Cumulative Action Note and Minutes from Previous Meeting (3 December 2013)

59.1 The updated cumulative action note had been previously circulated.

59.2 With one amendment to paragraph 48.1.5, the minutes of the meeting held on 3 December 2013 were approved as a correct record.

60. Matters Arising

60.1 Antimicrobial Team Resources

60.1.1 Dr Farquharson advised that Dr Wilks, Clinical Lead of the Antimicrobial Team, had produced a business case for 2.6 additional pharmacists and one additional consultant for the Antimicrobial Team. This was being reviewed and discussed.

61. Emerging Issues

61.1 Rapid Review of Safety and Quality of Care in NHS Lanarkshire

61.1.1 Dr Mackenzie declared an interest for this item, as he had been seconded as clinical lead for this project and was one of the authors of the report.

61.1.2 Dr Mackenzie noted that the recommendations in the report were for NHS Lanarkshire, but that they also applied in NHS Lothian and a position assessment was being carried out by the Board. A proposal would be submitted to the Board in February 2014 and progress would be reported in the Quality report thereafter. Dr Bryce also noted that a recent Board Development Day had focussed on this.

61.1.3 Ms Garrod noted that the recommendation on improving the complaints procedure so that it was consistent with a person-centred approach highlighted the need to ensure that patients could raise concerns when things went wrong.

61.1.4 Ms Scott Macfarlane noted that some of the areas mentioned in the report had been previously discussed at the Healthcare Governance Committee, including: day and night handovers; night, holiday and weekend cover; delayed or incorrect discharge letters; and medicines reconciliation.

61.2 Inspection Report on HMP Edinburgh

61.2.1 Councillor Toner declared an interest for this item, as he had a non-operational role on the Prisoners Visitors' Group at HMP Addiewell.

61.2.2 The Chair welcomed Ms MacDonald, Chief Nurse, East Lothian CHP, to the meeting. The HMP Edinburgh inspection report and covering paper had been previously circulated. Ms MacDonald noted that the report made three recommendations about GP access, raising orders for drugs, and the structure for reporting to Community Health Partnership Committees. Action had already been
taken towards making improvements in these areas. It was noted that the change towards prison healthcare staff being employed by the NHS had helped ensure appropriate training and appraisal was given.

61.2.3 A further improvement to access to healthcare for prisoners being considered was the use of video and telephone conferencing for communicating between the wings and the health centre, as any movement of prisoners was a security risk. Video conferencing was already being successfully used in the forensic unit at the Royal Edinburgh Hospital.

61.2.4 Ms Johnson commended the work done to improve healthcare for prisoners in the time since the NHS became responsible for prison healthcare and suggested that the Committee be updated annually to show work done and obtain support if required. This was agreed.

61.2.5 Ms Gormley suggested that it would useful to know outcomes of improvements made, for instance change in re-offending. Ms MacDonald noted that the National network had started work looking at outcomes, including long term.

61.2.6 Ms Garrod noted that the report mentioned that resources for prisoners with physical disabilities did not meet the demand and asked whether work was being done on providing a fair service to those with different equality needs. Ms MacDonald advised that care for patients with physical disabilities were currently considered on a case by case basis, but that there was a national focus on providing appropriate facilities for care of patients in prison who had specific needs, including care of the elderly, dementia and palliative care, care of bariatric patients, and care of patients with other disabilities.

62. Person Centred Care

62.1 Tissue Viability Update

62.1.1 The Chair welcomed Ms Ropper, Tissue Viability Nurse, to the meeting. Ms Ropper gave a presentation giving an update on the Tissue Viability Service. A paper had been previously circulated.

62.1.2 Professor McCallum noted that the Lothian Infection Control Advisory Committee received an annual report from the Tissue Viability Service due to the relationship between tissue viability and healthcare associated infection.

62.1.3 Dr Mackenzie suggested that in future reports numbers of patients should be noted next to percentages as this would associate the data more directly with the individual patients it represented.

62.1.4 In response to a question from Mr Campbell, Ms Ropper advised that although it was not mandatory, a pressure ulcer prevention eLearning module was available and was recommended for staff in high risk areas. Ms Ballard-Smith also noted that ward staff would be directed to this module and encouraged to complete it if an issue was identified.
Ms Bennett noted that increased reporting of pressure ulcers was beneficial but may not show a reduction in numbers at first. The project was being monitored through the quality report which reported to the Healthcare Governance Committee.

In response to a question from Ms Meiklejohn, Ms Ropper advised that at this stage costing work on a supply of appropriate cushions and mattresses had not been done, but that there was a good arrangement with Huntleigh who would supply appropriate mattresses as required. Ms Johnson noted that a number of studies across the UK showed that having a supply of appropriate cushions and mattresses was beneficial for patient experience and cost savings, but that a significant initial investment was required.

63. Safe Care

63.1 Healthcare Associated Infection Update

A report had been previously circulated.

63.2 Improving Management and System Learning from Significant Adverse Events

A report had been previously circulated. Ms Bennett noted that an improvement plan had been laid out for enabling staff to participate better in incident investigations and to receive feedback about the results of reviews.

Ms Bennett noted that an area for improvement was the need to involve patients and carers in incident reviews. This was clear in policy but not yet always in practice. Funds had been awarded to run a project aimed at education and improvement of staff confidence and ensuring processes were in place to allow involvement of patients and relatives. A trial would take place in maternity services where there were a high number of complaint. A clinical researcher had been appointed to do a baseline evaluation and look at improvement data to see what effect intervention had, as well as investigating how this would work if implemented across the organisation. The first meeting of the project team would be in the week beginning 27 January 2014.

63.3 Public Protection Update

A report had been previously circulated. Ms Ballard-Smith also noted that NHS Lothian was supporting the police investigation of a recent incident in Edinburgh involving the alleged murder of a 3 year old boy.

63.4 Update on Stroke Standards Compliance

The Chair welcomed Mr Briggs, Site Director, Western General Hospital and Professor Dennis, Consultant in Stroke Medicine, to the meeting. Mr Briggs and Professor Dennis gave a presentation on performance against stroke standards. A paper had been previously circulated.

In response to a question from Mr Wilson, Professor Dennis noted that for a stroke patient to be seen early, the ambulance staff needed to inform the Emergency
Department before the patient arrived. With a better organisation of resources figures showed that 60%-80% of patients could have stroke diagnosed before they reached the hospital.

63.4.3 Mr Briggs advised that the compliance with inpatient stroke standards was similar across sites, although there had previously been more variation. There was a focus on ensuring a single service across the three sites.

63.4.4 In response to a question from Professor McCallum, Professor Dennis explained that improvement in stroke standards compliance had been made by working together as a single structure across sites, and having a management focus on performance.

63.4.5 Miss Gillies noted that there was a risk when using compliance standards that artificially set targets could not be reached, which could have a negative effect on staff. Mr Briggs advised that for this reason targets were not set at 100%, and noted that improvements against the targets were still being made. Dr Mackenzie also noted that targets were a means to an end and that care should be taken that the outcome for the patients was kept in mind when considering compliance with targets. The Chair also felt that this should be presented in a way that was understandable to the general public.

63.4.6 Dr Mackenzie noted that system change was important when trying to change outcomes and that implemented systems should be consistent and not person dependent. He also suggested that benchmarking should be done against the best standard, and not by standards met by immediate neighbours if these also needed improvement.

63.4.7 In response to a question from Councillor Toner, Professor Dennis noted that eight to ten stroke clinics were currently run at St John’s Hospital and that it was hoped that a further consultant would be recruited so that clinics could be covered during leave.

63.4.8 Mr Houston commended the strategy of focusing on patient outcome rather than strategic management of the problem and noted that he would like to see more focus on patients over strategy.

63.4.9 Ms Johnson confirmed that the stroke strategy would also be discussed at the strategic planning committee.

64. Effective Care

64.1 Quality Report – Stroke

64.1.1 The report had been previously circulated.

64.2 Nursing and Midwifery Council Annual Report

64.2.1 The report had been previously circulated. Unfortunately Ms Bronksy was unable to attend the meeting, but had agreed to present the report at the next meeting on 25 March 2014.
64.3 Hip Fracture Report

64.3.1 A paper had been previously circulated. Miss Gillies noted that the audit report identified some areas where improvement was needed and some areas where expected standards were not being met. These were mainly related to timely access to theatre. NHS Lothian was an outlier compared to the average across Scotland on time to theatre for fracture patients. A clinical team based approach to improve standards was needed, admission and discharge processes needed to be considered and enough resources for theatre access needed to be available.

64.3.2 Miss Gillies also noted that there was a high incidence of fracture due to the aging population, and that the numbers would continue to increase. Preventative measures including promotion of bone health could help reduce this rate.

64.3.3 A further update on progress would be available in six months’ time. A second audit was likely to take place in the future, possibly in 2016.

64.3.4 The Committee noted and supported the recommendations in the paper.

65. Committee Effectiveness

65.1 A paper on assurance requirements for the Healthcare Governance Committee had been previously circulated. Ms Bennett noted that she would like the Healthcare Governance Committee to be more explicit about its assurance requirements. The paper outlined the areas of need and identified the Committee’s position.

65.2 A Committee Self-Assessment Tool for assurance was tabled. Ms Bennett asked that the Committee assess itself using this tool. This would be discussed again at the next meeting on 25 March 2014. Ms Bennett also agreed to organise a discussion session for the patient and public representatives and any other Member of the Committee who would find it useful, to help complete the self-assessment.

66. Exception Reporting

The Committee noted the following items for information:

66.1 St Columba’s Hospice, Edinburgh: Independent Healthcare Inspection;
66.2 Spire Murrayfield Hospital: Independent Healthcare Inspection;
66.3 Research and Development Annual Report.

67. Other Minutes Exception Reporting

The Committee noted the minutes from the following meetings:

67.1 NHS Lothian Health and Safety Committee, 26 November 2013;
67.2 Area Drug and Therapeutics Committee, 6 December 2013;
67.3 Clinical Management Group, 12 November 2013, 10 December 2013;
67.4 Lothian Infection Control Advisory Committee, 3 December 2013.
68. Date of Next Meeting

68.1 The next meeting of the Healthcare Governance Committee would be held from 9.00am – 11.30am on Tuesday 25 March 2014 in Room 7, Second Floor, Waverley Gate.

68.2 Further meetings would take place on the following dates in 2014:
- 27 May 2014;
- 22 July 2014;
- 23 September 2014;
Key Issues discussed included:

- A presentation on the Staff Survey results highlighting the NHS Lothian position in comparison to NHS Scotland and also the 2010 results. This presentation also looked at the areas of good practice identified across NHS Lothian and also the areas for improvement;

- The revised communications strategy;

- The new Staff Governance Standard Monitoring Framework for 2013/14 to be completed by 9 May 2014;

- A progress report on the retrospective checking for the Protection of Vulnerable Groups which requires to be completed by October 2015;

Key Issues on the horizon

- The Protection of Vulnerable Groups retrospective checking is currently off trajectory and additional actions are being put in place to try to address this. The committee will continue to closely monitor this position;

- The Staff Governance Action Plan for 2013/15 to be completed:

- The Staff Governance Self Assessment and Action Plan for 2014/15 to be submitted by 9 May 2015;

- Review of the Statement of Assurance needs for the Staff Governance Committee.

Alex Joyce
Chair
Minutes of the Meeting of the Staff Governance Committee held at 9.30am on Wednesday 29 January 2014 in the meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr A Joyce (Chair); Mr A Boyter; Dr D Farquharson; Councillor D Grant; Mrs J McDowell; Mr S McLauchlan and Mr R Wilson.

In Attendance: Mrs S Ballard-Smith; Mr J Crombie; Mrs R Kelly; Mrs L Khindria (for item 35); Mr P Reith and Mr S Wilson.

Apologies for absence were received from Ms M Johnson, Mr B Houston, Mrs A Meiklejohn, Mrs A Mitchell, 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.

31. Minutes of the Previous Meeting

31.1 The minutes of the previous Staff Governance Committee meeting held on 30 October 2013 were approved as a correct record.

32. Matters Arising

32.1 Management Culture Steering Group – In response to a question from Mrs McDowell, Mr Boyter advised that no response had yet been received from the Scottish Government in respect of the proposal to transfer the work of the Management Culture Steering Group to the Staff Governance Committee. Mr Boyter advised that he would contact the Scottish Government seeking a response.

32.2 NHS Scotland Staff Experience Project – Mrs Kelly advised the Committee that the presentation given at the Staff Governance Committee was being given to the Lothian Partnership Forum at their meeting on 11 March 2014 and following this decision would need to be taken with the Lothian partnership Forum about whether iMatters, Investors in People or other initiatives were pursued. Mr Boyter advised that the Scottish Government would no longer be funding iMatters and Boards would need to fund this from existing resources. It would not be sensible to fund both iMatters and Investors in People and a decision...
would require to be taken on which system best addressed NHS Lothian’s needs. The Committee noted that NHS Lothian had already made a substantial investment in Investors in People and had become Investors in Peoples’ biggest Scottish success. However, Investors in People accreditation was for a particular period of time and therefore an ongoing two year rolling programme of re-accreditation was being undertaken.

32.3 Mutuality and Equality Issues – Mrs McDowell commented on the need to follow up on the issues of mutuality and equality which had not been prevalent at the Staff Governance Committee since it had absorbed the former Equality and Diversity Committee. Mrs Kelly advised that routine reports on equality and diversity issues were being built into the agenda for the Staff Governance Committee and Mr Boyter confirmed this would be a regular agenda item with a report being brought back to the next meeting.

32.4 Staff Governance Committee Statement of Assurance Needs – In response to a question from Mrs McDowell, Mrs Kelly confirmed that she had spoken to Mr Glover concerning the appropriate reports in relation to equality and diversity and that these had now been included in the statement of assurance needs.

33. Staff Survey Results

33.1 Mrs Kelly gave a presentation on the staff survey results for 2013 comparing national results and NHS Lothian results. NHS Lothian's response rate was 23% compared to 19% in 2010 and was broadly midway in the range for teaching Boards. The highest response rate was from nursing and midwifery, administrative and clerical and allied health professions staff with a medium response rate from medical and dental, support services, scientific and technical and senior managers and the lowest response rate from other therapeutic staff, health promotion and doctors in training.

33.2 Mrs Kelly took the members of the Committee through the results of the Staff Survey highlighting areas of good practice and areas for development.

33.3 In terms of actions being taken to address the issues in the survey, Mrs Kelly advised that to date, revised partnership arrangements, including the establishment of an Estates / Facilities Partnership Forum separate from Corporate Services, had been agreed and revised management arrangements were in place for the Facilities function.

33.4 It was noted that “Our Values into Action” had been agreed by the Board, a revised Bullying and Harassment policy had been launched and a revised Whistle Blowing Policy had been launched. In addition, a national alert line had been set and published, the HR Online system had been implemented, revised performance management arrangements for senior managers focussing on behaviours were in place and a revision of the internal communication strategy had been undertaken.

33.5 Some further actions still remained to be taken including Our Values into Action to be implemented in all areas; Mediation Programme to be established to assist
in up-skilling managers in conflict resolution and managing difficult conversations; local partnership forums having staff governance improvement plans and the implementation of the revised internal communication strategy.

33.6 The Chair commented that there had been some problems in estates and maintenance with disputes between staff and management at the time of the survey and this might well have affected their responses.

33.7 The Committee noted that in respect of bullying and harassment, the work following the Bowles Report would not have had time to filter through at the time at which this survey was undertaken. It was also noted that the number of new questions in this survey made it difficult to make accurate comparisons with the previous year's survey.

33.8 Mr R Wilson commented that the statistics from the survey were all at a high level and it was difficult to get a feel of what was happening in practice in order to address the issues.

33.9 Mr McLauchlan commented that a proactive policy where shop stewards and managers went round staff with paper copies of the Staff Survey to encourage them to complete the survey had resulted in the response rate at the State Hospital at Carstairs rising from 30% to 60%. It was recognised that as a small organisation at a single site the logistics around this were easier. There was also a problem in the definition of bullying and when a number of instances had been investigated bullying had turned out to be staff being appropriately managed rather than bullied.

33.10 Mr Boyter agreed that interventions to address these problems could not simply be things that had been tried in the past and he informed the Committee that he would be meeting with the Committee Chair to discuss appropriate actions and these would be included in the Staff Governance Action Plan.

34. NHS Lothians Revised Communications Strategy

34.1 Mr S Wilson introduced the previously circulated revised communications strategy and advised the Committee that, after looking at the best practice in other NHS Boards, the Communications Team had been restructured to be more dynamic and address the issues.

34.2 Mr Crombie commented that part of the strategy should be the interface with staff and to achieve this, work was needed on creating improved access to the intranet.

34.3 Mr R Wilson suggested that the proposed actions to be taken in response to the Staff Survey should be publicised and should be explicit in the revised Communications Strategy.

34.4 It was agreed that further work was needed on the Communications Strategy, with more detailed actions. Given that the strategy covered both internal and external communications it was agreed this should be presented to the Board
meeting in April for approval. Mr S Wilson asked members to provide him with any particular comments or actions they would like to see included in the revised strategy.

35. **D J Bowles Report**

35.1 Mrs Khindria introduced a previously circulated report giving an update on how the recommendations within the David J Bowles and Associates Report and the Price Waterhouse Coopers Report into the management culture within NHS Lothian had been taken forward.

35.2 Mrs Khindria reminded the Committee that the Scottish Government had set up the Management Culture Steering Group under the Board Chairman, reporting directly to the Cabinet Secretary. Reports on progress had been given to the Board in the Chair’s report. An outside leadership organisation had been engaged to work with the Corporate Management Team and the Scottish Government had issued new guidelines for the performance management of Executive Directors.

35.3 Councillor Grant left the meeting.

35.4 Mrs Khindria advised that she was now working with the new teams for the Shadow Health & Social Care Partnerships and sessions had also been booked with the Scheduled and Unscheduled care teams.

35.5 Mr R Wilson commented that the timeframe for rolling out training to 25,000 staff seemed likely to take some years.

35.6 Mrs Khindria advised that the first step would be to refresh existing management skills and identify any skills gaps and she would be meeting with the Joint Chairs of the Partnership Groups to discuss this.

35.7 Mrs McDowell questioned whether there were sufficient resources for this work to be carried out and Mrs Khindria commented that there were some concerns about the impact of the Local Reinvestment Plan target of 10% for corporate services might have.

35.8 Mr Boyter confirmed that managers were working with relative decreasing budgets and continuing to have to meet robust targets. The Scottish Government required a reduced number of managers and there would be an ongoing requirement to continuously train managers to meet the challenges ahead.

35.9 The Committee agreed to note the recommendations and actions undertaken in response to the D J Bowles and PWC Report.

36. **Embedding NHS Lothian’s values into Action**

36.1 It was noted that this had been covered under item 34.
37. **Staff Governance Standard Monitoring Framework – Arrangements for 2013/14**

37.1 Mrs Kelly introduced a previously circulated report giving an update on the revised arrangements for the Staff Governance Standard Monitoring for 2013/14.

37.2 The Committee noted that the NHS Reform (Scotland) Act 2004 required NHS Scotland employers to deliver the key strategic agenda of ensuring the fair and effective management of staff. The Staff Governance Standards set out what each NHS Scotland employer must achieve to continuously improve in relation to the fair and effective management of staff.

37.3 It was noted that the Local Monitoring Template and Assessment Tool had been redesigned to be used at all levels through the organisation to assist in reviewing progress towards the Staff Governance Standard.

37.4 Mrs Kelly advised that it was not intended to duplicate work, and local implementation plans would be used to enable the Board to complete the National Annual Monitoring Return, providing the Scottish Government with a summary and assurance of the Board’s progress over the past year together with information on the priorities for action in the coming year via the Board’s Staff Governance Action Plan.

37.5 The Committee agreed to note the revised arrangements for the Staff Governance Standard Monitoring and noted that the monitoring return for NHS Lothian for 2013/14 would be presented at the Staff Governance Committee on 30 April 2014.

38. **Management of Violence and Aggression – Harm to Staff**

38.1 Mr Boyter introduced a previously circulated report giving an update on the actions undertaken to meet the requirements of the recent Health and Safety Executive Improvement Notice.

38.2 The Committee noted that the Health and Safety Executive was satisfied that the work done on the eleven areas inspected had been completed. On the assumption that other areas might have similar problems, these actions were being extended to the rest of the organisation to ensure compliance by the end of March.

38.3 Mr Boyter commented on the exemplary work of Amanda Langsley, Programme Lead for Safety and Compliance Education, and her team in driving this forward.

38.4 Mr McLauchlan commented that similar training was ongoing in primary care where client group changes were causing new problems.

38.5 The Committee agreed to note the contents of the report and support the planned actions in relation to improvement and reduction of harm to staff.

39.1 The Committee received a previously circulated report advising of the outcome of the review by Health Care Improvement Scotland of NHS Lothian’s progress on medical revalidation in 2012/13 and providing an update on progress with the improvement plan.

39.2 Dr Farquharson introduced the report and reminded members that medical revalidation had become a formal requirement in the UK in December 2012 and the General Medical Council would only renew a licence to practice if a doctor successfully completed medical revalidation, signed off by himself as the Responsible Officer. Medical revalidation took place every 5 years and required annual appraisal focussing on how the individual doctor at the organisation in which they worked could improve the quality of care provided.

39.3 Dr Farquharson advised that 20% of doctors had undergone the process and, with a deferral rate of 5 – 7%, NHS Lothian was just below the national average. The revalidation was being conducted on a rolling basis with twice as many doctors being revalidated in 2014/15 and the same again in 2015/16 to achieve 100% by 31 March 2016.

39.4 Mrs Ballard-Smith advised the Committee that the Nursing and Midwifery Council was looking at a similar process for nurses and a pilot study was planned.

39.5 The Committee agreed to note the outcome of the Health Improvement Scotland assessment in progress on medical revalidation for Lothian and for Scotland and noted the improvement plan which had been updated to include recommended actions points for the 2013 review and had been approved by the Health and Care Governance Committee in December 2013.

40. Partnership Agreement

40.1 Mrs Kelly introduced a previously circulated report giving an update on the revised arrangements for partnership working within NHS Lothian.

40.2 The Committee noted that Partnership Forums had been established for each of the Community Health (and Care) Partnerships, acute sites, Corporate Services and estates & Facilities and the Lothian Partnership Forum would be receiving minutes from all Local Partnership Forums.

40.3 The Committee noted the revised partnership arrangements outlined in the circulated partnership agreement.

41. Protection of Vulnerable Groups Progress Report

41.1 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.
41.2 Mrs Kelly advised that there was some concern that progress was continuing to fall short of the target. Forms had been issued to staff but were not coming back sufficiently quickly. Managers were being reminded that it would be illegal for staff to work in certain areas after 30 September 2015 unless they had been subject to a Protection of Vulnerable Groups check.

41.3 The Committee noted that the paperwork had been made as easy as possible although the actual form was produced by Disclosure Scotland and could not be changed. Monthly progress reports were being produced and managers and staff were being reminded of the importance of completing these checks before the deadline.

41.4 The Committee agreed that this issue should be highlighted in the summary to the Staff Governance Committee minutes going to the Board meeting and that this potential risk should be placed on the agenda for the Risk Management Steering Group.

41.5 Mr McLauchlan commented that of 156 reports received from Disclosure Scotland, 127 required no action as they had already been reported to management, risk assessed and deemed to be not relevant. The majority of issues being raised were matters such as failure to pay a TV licence, parking fines etc and were very minor. It was noted that there had been one dismissal over a failure to disclose previous convictions.

41.6 The Committee agreed to note the current progress with the protection of Vulnerable Groups retrospective checking and support the actions being taken to increase the return rate.

42. Staff Governance Committee – Statement of Assurance Needs

42.1 The Committee noted the previously circulated paper outlining the conclusions on the assurance needs of the Staff Governance Committee.

42.2 Mrs Kelly advised that there was a May deadline for the submission of the Statement of Assurance Needs and the final report would be considered by the Staff Governance Committee at its April meeting.

43. Frequency of Meetings

43.1 The Chair advised the Committee that the issue of frequency of meetings had been raised at a meeting of Board Committee Chairs. He noted that whilst most other Committees met six times a year, the Staff Governance Committee met four times a year.

43.2 After some discussion members unanimously agreed that the work could be adequately covered with quarterly meetings and that additional meetings could always be held if these proved necessary.
44. **Health and Safety Committee Minutes**

44.1 The Committee received for information the previously circulated minutes of the meetings of the NHS Lothian Health and Safety Committee held on 24 September and 26 November 2013.

45. **Lothian Partnership Forum**

45.1 The Committee received for information the previously circulated minutes of the meeting of the Lothian Partnership Forum held on 12 November 2013.

46. **Local Negotiating Committee**

46.1 The Committee received for information the previously circulated minutes of the Local Negotiating Committee held on 4 September 2013.

47. **Workforce Organisational Change Group**

47.1 The Committee received for information the previously circulated minutes of the Workforce Organisational Change Group meeting held on 2 December 2013.

48. **Date of Next Meeting**

48.1 It was noted that the next meeting of the Committee would be held on Wednesday 30 April 2014 at 9.30am in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
Minutes of the meeting of the Strategic Planning Committee of NHS Lothian held at 10am on Thursday, 13 February 2014 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston (Chairman); Mr A Boyter; Mr J Crombie; Mr T Davison; Ms P Eccles; Mrs S Goldsmith; Professor J Iredale; Ms M Johnson; Mrs A Meiklejohn; Professor A K McCallum; Professor A McMahon; Dr S Mackenzie (from 10.45am); Mr D A Small; Mr G Walker; Dr R Williams and Mr R Wilson.

In Attendance: Dr M Douglas (for item 52); Ms C Harris (for item 58); Mr M Hill; Mrs L Tait and Mr D Weir.

Apologies for absence were received from Ms J Anderson, Mrs S Ballard-Smith, Mrs K Blair, Mr J Brettell, Mr A Joyce, Ms D Milne and Mrs A Mitchell.

50. Declaration of Financial and Non Financial Interest

50.1 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.

51. Agenda Management

51.1 The Chairman sought and received permission to reorder the agenda to allow sufficient time at the end of the meeting to discuss in detail the draft strategic plan.

52. Draft Lothian Health and Inequalities Strategy

52.1 Dr Douglas provided the committee with a presentation detailing the background to the draft Health and Inequalities Strategy and how the development of this was being approached in Lothian.

52.2 The committee noted in respect of ‘heart disease early death by areas in Edinburgh for the under 75s’ that the gradient correlated with socioeconomic circumstances. Dr Douglas advised social status was a health determinant with the three key factors being employment, income and education. It was noted inequalities occurred across the gradient and not only in recognised deprived areas.
52.3 Dr Douglas explained the actions needed to:-

- Mitigate the consequences of Health and Inequalities
- Resist / prevent the impact of Health and Inequalities
- Undo underlying inequalities

52.4 The role of the NHS in delivering these actions was explained. It was reported there were differences between health improvement and health inequalities with it being noted the two were often confused.

52.5 Dr Douglas advised the approach to delivering the NHS Lothian strategy would include a review of previous approaches, identifying current actions to mitigate / prevent and undo inequalities, identify new actions with priorities to be available by the end of February, creating a delivery structure, indicators, monitoring and an overview of related partnership work.

52.6 The Chairman stressed for the Strategic Planning Committee there was a need to agree what to build into the strategic plan beyond what was already in place.

52.7 Dr Williams commented he welcomed the work underway and the GP Subcommittee was of the clear view that the issue was about more resource being available rather than diversion of resources from one area to another. He felt this should be referenced through the NHS Lothian strategy.

52.8 Mr Boyter commented the fundamental intention of the NHS was to help people who were unwell and to also prevent people getting unwell in the first instance. He suggested the key issue was around how brave people wanted to be about making choices. He reminded the Committee NHS was one of the biggest employers in the region and suggested more could be done to assist the Health and Inequalities agenda although if this were to be funded within existing resources consideration would need to be given to what was not done in its place.

52.9 Professor Iredale stressed the need not to underplay or neglect NHS Lothian’s role as either an advocate or employer as these were the two best ways to influence the Health and Inequalities agenda. He suggested beyond the Strategic Planning Committee it would be good to identify a champion to think about how the organisation could positively influence issues like deprivation.

52.10 Mr Walker agreed on the need to integrate this work with the planning strategy but stressed there was a need to consider what would have the biggest impact and in that regard he would welcome a narrower strategy as he would worry about attempting to do too many different things at the same time. Mr Walker commented it would be interesting to see data where targeting was already occurring.

52.11 Dr Douglas confirmed the intention was to initially identify a small number of areas to focus on. Dr Williams commented historically GPs had always targeted resources aligned to deprivation and needs. Mr Walker commented it would be helpful to see the detail of that process. Professor Iredale advised this remained a piece of unfinished work from the former Service Redesign Committee. Dr Williams
pointed out prescribing was undertaken predominantly on a needs basis although he questioned whether this was enough.

52.12 Mr Wilson questioned the progress of moving money out of secondary care into primary care and the community. The Chief Executive commented the majority of NHS spend was on pay, prescribing and the cost of facilities with the remainder of discretionary spend going towards meeting performance and treatment targets and this remained an ongoing challenge. He commented there would be merit in looking at existing developments and considering whether these could be appropriately assessed to reflect how they improved and impacted on health and inequality. He felt there was potential to do more around employment and income as currently much of the work was around the margins. The Chief Executive reported on discussions underway with the City of Edinburgh Council about moving the Social Care sector onto a living wage.

52.13 The Chairman commented the work underway to identify priorities fitted well with the strategic plan development timescale.

52.14 The Strategic Planning Committee noted and welcomed the progress in developing the draft Lothian Health and Inequalities Strategy.

52.15 Dr Douglas left the meeting.

53. Minutes of the Previous Meeting held on 9 January 2014

53.1 The minutes of the previous meeting held on 9 January 2014 were approved as a correct record.

54. Matters Arising from the Previous Meeting

54.1 Reshaping Older People’s and Continuing Care – Professor McMahon advised the Scottish Government had published papers on the above which changed the landscape and provided opportunities for improved performance moving forward.

55. Future Provision of Acute Stroke Services in Edinburgh

55.1 Ms Johnson commented the paper had originally been produced for the Corporate Management Team (CMT) where it had been decided it should be brought to the Strategic Planning Committee to keep members appraised of developments and progress. It was noted the CMT had agreed the proposals in the paper needed to be subjected to a detailed option appraisal. It was noted current performance against stroke targets was poor but improving with Lothian having the longest length of stay nationally.

55.2 The Committee noted the paper was about the future of stroke care which would adopt an appropriate focus on the first 24 hours of care and how best this could be provided for patients. It was noted currently 80% of patients were treated at the Royal Infirmary of Edinburgh (RIE). It was also noted neurosciences would move to
the RIE in the future and there would be benefit in having stroke aligned to the neurosciences department. It was stressed however the location of stroke services would be determined by the outcome of the full option appraisal.

55.3 The Chief Executive commented the future of stroke services linked closely to the work being undertaken around the future of the Western General Hospital (WGH). It was noted it was not a given that the WGH would remain configured as it currently was with there being a strong feeling there needed to be a new model created for that site.

55.4 Professor McCallum commented after a short acute intervention there was a need for more appropriate longer term rehabilitation. Professor McMahon commented there was a need to discuss with the Scottish Ambulance Service issues around Category A response and thrombolysis.

55.5 Ms Eccles noted there was no reference in the paper to community services being provided for rehabilitation. Ms Johnson advised on how this would be addressed through patient pathway modelling work.

55.6 Professor Iredale advised all of the internationally available evidence pointed towards simplifying treatment pathways through scanner diagnosis and appropriate downstream treatment. He reminded the committee the University of Edinburgh allowed the NHS to use one or its scanners based at the RIE when it was available. He felt therefore the best location for the acute stroke service was self evident although he acknowledged the need for a full option appraisal to be undertaken.

55.7 Mr Walker commented it would be important to address the points made by Professor Iredale by expediting the option appraisal process bearing in mind the need for due diligence. Ms Johnson advised the option appraisal needed to be concluded as rapidly as possible and within the timescale around the strategic plan.

55.8 It was noted in any event work would continue to reduce the length of stay for stroke patients and this would occur in tandem with the ongoing option appraisal work.

55.9 The committee noted the intention to include a proposition around stroke services in the draft strategic plan to be submitted for consideration to the Board in April. The need to undertake a full option appraisal to inform the proposition was agreed.

56. **Scheduled Care Strategy / Delivering for Patients**

56.1 Mr Crombie advised he had been keen for the Strategic Planning Committee to have sight of the paper approved at the Board. He advised delivering for patients was intrinsically linked to the strategic plan and would ensure the provision of evidence based care and safety of care. The delivery of treatment time guarantees would complement this process.

56.2 The committee noted the key issue was to move to implementation and put in place an infrastructure to allow movement away from reliance on external providers. He advised the Scottish Government were keen for NHS Lothian to accelerate the date
of recovery although he had a personal anxiety that delivery needed to be sustainable and discussions were ongoing with the Scottish Government. He stressed however the main vehicle to reducing the time to recovery was through the increased use of the independent sector.

56.3 Mr Crombie advised the document before the committee had been widely agreed with clinicians and this was important as the current paradigm could not continue.

56.4 The Chairman commented colleagues had seen the paper with it having been widely endorsed by the Board and he therefore did not feel there was a need to expose the paper to further discussion. He felt the granularity of the planning process was to be welcomed and that further exercises should mirror this approach.

56.5 The Chief Executive noted the debate mirrored that around the draft Health and Inequality Strategy. He reminded colleagues 93% of patients were treated within the guarantee time with £17m of recurring funding being expended trying to move this to a position of 100% compliance.

56.6 Mr Walker commented the paper represented an excellent piece of work and supported Mr Crombie in his quest for a sustainable solution.

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

57. **Draft Strategic Plan**

57.1 Mr Hill tabled a paper containing questions relating to the draft strategic plan advising he would welcome contributions from the committee in response to these in order to inform the next iteration. He advised the committee that following the Private Board meeting in February it had been agreed the Strategic Planning Committee would sign off the strategic plan and make recommendations to the Board about next steps. It would be important therefore to make best use of the available time.

57.2 Mr Hill tabled copies of a paper containing a number of questions he was seeking to discuss with the committee advising the responses to these would be fundamental to the way the final plan was constructed.

57.3 The committee noted the presumption was around transformational change as continuing to work at the margins would result in lost opportunities. Mr Wilson sought advice from the Chief Executive on how he thought this would resonate from an Executive perspective around the financial position.

57.4 The Chief Executive commented the system was being driven towards performance against targets. The national view was NHS funding was protected and therefore NHS Lothian received proper and adequate funding. Mr Hill stressed the importance of establishing whether there was a will to adopt a radical approach which would include a need to challenge how resources were currently being used.
Mr Crombie felt the role of the Board and the committee was to manage messages upwards and to manage the political environment both locally and beyond. He commented there was a need to consider in detail the engaging and influencing process. It was noted an important part of this process would be to engage down into the organisation in order to keep people appraised of developments.

Mr Boyter reminded colleagues in terms of the influencing agenda NHS Lothian was 1 of 22 Healthcare systems and this provided opportunities. He commented on the importance of alignment with the national 2020 Quality Strategy advising already 70% of the workforce needed in 2020 were already within the system or being trained. Mr Boyter reminded the committee the NHS currently operated on the basis of an assumption against Compulsory Redundancy and a No Detriment Organisational Change Protection Policy and in that regard NHS Lothian was part of NHS Scotland.

The Chairman commented he accepted the majority of the points made by colleagues although he felt the challenges around managing upwards were key roles for Non Executive Directors. He was clear if they felt the system was unable to deliver then it was their responsibility to step forward and say so to the appropriate audience.

Professor McCallum reminded the committee of the need to be reflective of the fact the Scottish Government Health and Social Care Directorate signed up to international priorities and the performance management implications of this needed to be considered. She reported in Australia there was evidence of public panels having a significant influence around public policy.

Dr Mackenzie felt the thrust of the paper should be around influencing upwards. He felt there was merit in creating a positive vision with other Health Boards and partners. Professor McMahon concurred advising the strategic and tactical approach was important and in that regard at the Health Board Chief Executive Group it had been agreed Chief Executive’s and their Local Authority counterparts would meet for local dialogue.

Professor McMahon felt strategic issues around finance were not yet as explicit as they needed to be and there was a need for a prioritisation process against the available resources. He felt efficiency, productivity and safety were all issues where proactive engagement could be held with clinicians.

It was noted by Professor Iredale in terms of managing upwards and downwards there was a need to put a premium on credibility and patient safety. In terms of credibility he fully concurred with the Chairman’s views about the role of Non Executive Directors as he felt quality, safety and patient experience were what would make the difference in credibility terms.

Mrs Goldsmith commented she did not yet fully understand the extent of the challenge moving forward with there being a need to assess whether the organisation could live within its existing resources. She noted in the past the NHS had generally managed to reinvent itself and issues like creating different patient pathways and ensuring service redesign might help the system to live within its resources.
57.13 The Chairman updated the committee on informal discussions he had held with a number of Non Executive’s where reservations had been raised about the reality of what was being planned within the context of the financial position. Mrs Goldsmith advised she personally did not think the current service configuration was correct and improvements in this area would start to improve the use of resources. Mr Hill stressed the importance of understanding the fact the Board would in due course be signing up to a strategy it would need to deliver upon.

57.14 Dr Mackenzie felt currently the system was overly focussed on buildings and it would be more appropriate to sell the strategy based on the benefits to future patients although challenges around timelines would need to be recognised. He undertook to provide Mrs Tait with a form of words for inclusion in the strategic document.

57.15 Mr Walker stressed the need for resource utilisation to feature and be reflected in the strategy. He felt a key issue in selling the strategy was to engage the support of senior operationally based clinicians as people who required to be influenced tended to listen to doctors. This would also help in closing the loop around the resource utilisation debate. Mrs Goldsmith agreed commenting patient focus was what would drive the process moving forward.

57.16 Dr Williams advised Professor McMahon had attended the GP Sub Committee where the direction of travel contained in the plan had been welcomed although questions had been raised around implementation and detail. It had been felt there was not enough focus on primary care although it was recognised the detail of this might possibly emerge through the establishment of the Health and Social Care Partnerships (HSCPs). He agreed appropriate patient pathways would be key moving forward.

57.17 Mrs Tait advised work continued around the four virtual patients and it was anticipated to use this as a tool to help to deliver services for patients in partnership with people including patients themselves. It was noted although the process was potentially difficult a good start had been made with there having been enthusiasm for focussed discussions.

57.18 Mrs Meiklejohn commented there had been excitement at the Area Clinical Forum about the development of patient stories and an enthusiasm to introduce a patient who was currently well and demonstrate how preventative resources could maintain this health status.

57.19 The Chief Executive commented building on Mr Boyter’s previous comments that there would be 22 Health Boards all experiencing increases in growth and reducing capacity. It would be important to consider how to engage and influence in order to move to a position of redefining some targets to release significant resources to divert to other parts of the health agenda. He added lobbying in this regard was already occurring at Executive and Non Executive level. He felt in terms of issues that could be done better that he would ensure there was a focus within the CMT around issues like the cost of deferrals: waste; failure to discharge patients on time; delayed discharge consequences of social care; outpatient clinics; prescribing and the use of facilities and overheads. It would be important that the CMT had a
proper focus in these areas by adopting a more radical approach than had been the case in the past.

57.20 Mr Small advised he also did not think the current service balance was correct and commented the Primary Care Forward Group was working on concrete proposals around primary and community care with issues around health visitors and dental nurse availability being considered.

57.21 Ms Eccles commented in respect of investing in training and development it was important to recognise this took time with there being a need to release staff to attend courses which was not always easy when the system was experiencing capacity issues.

57.22 Mr Wilson felt there was still not enough in the strategy about primary care services. He commented at the Edinburgh Partnership Committee an excellent presentation had been received on primary care and he felt this should be included in the plan. Professor McMahon advised it was the intention to ensure it was incorporated in the final version. Dr Williams commented on the need to expand the reference to reviewing GP numbers in the final iteration of the plan.

57.23 Mr Walker stated from his perspective the three things that were currently missing from the draft were resource utilisation, outcomes to be achieved over current aims and key milestones and measures to ensure the delivery of the strategy.

57.24 Mr Hill commented the guidance around the establishment of HSCPs meant the acute budget would be influenced by the new partnerships and this would potentially create a completely different dynamic. The Chief Executive explained the proposed financial model. It was noted the Health Board would approve the HSCPs Strategic Commissioning Plan.

57.25 The committee agreed that Mr Hill, in respect of the criteria for decision making, would test these against propositions to identify how robust they were. It was noted a fully tested set of priorities would not be available for the 2 April Board paper. Professor McMahon reminded the committee the proposal was now to include a consultation and engagement process and this would allow further development and clarity around priorities. Mrs Meiklejohn commented priorities needed to be weighted and this would be important in order to inform areas where investment / disinvestment would or should take place.

57.26 The Chief Executive suggested one possible approach would be to recognise at the April Board meeting that the LDP would also be presented for approval which would set out the LRP framework, headlines and targets. It would be possible to say therefore in year one the focus would be on these areas and beyond that the focus would be on areas like waste etc which would be reviewed by the CMT. This would allow ideas to be generated on how to make changes though the engagement process in a more radical manner. This approach was agreed.

57.27 The Chief Executive stressed when the draft strategic plan was presented to the Board it would need to be accompanied by an engagement plan.
58. **Communications Plan Update**

58.1 Ms Harris commented on the need to be clear what the system wanted to achieve out of the consultation process and how best to deliver this in terms of different audiences. Clarity was also needed around timescales.

58.2 The committee were advised the current timescale meant the Board paper would need to be discussed in stakeholder forums in advance of consideration by the Board itself if a proactive approach was to be adopted. Ms Harris commented in respect of the previous debate about the benefits of clinical engagement there would be a need to include within the timescale appropriate staff engagement opportunities. It was noted stakeholder engagement would include MSPs.

58.3 Ms Harris advised the draft timetable would be available by the end of the following week.

58.4 The Strategic Planning Committee noted the progress in respect of developing a communications plan.

59. **Date and Time of Next Meeting**

59.2 The next meeting of the Strategic Planning Committee would be held at 9.30am on Thursday 13 March 2014 in meeting room 7, Waverley Gate, 2 – 4 Waterloo Place Edinburgh.
Shadow Health and Social Care Partnership 14 February 2014 – Summary

Integration Programme Status Report

- The status report showed items which had formerly been green now showing as amber or red. This is a result of a range of HR, Legal and financial issues not being resolved as required for the integration scheme.

Professional Advisory Committee

- The PAC had held a workshop around ICT developments. It recognised the need for more rapid response to emerging issues.
- Ongoing engagement and responses could be formulated between its meetings.

Financial Monitoring

- Health & Social Care services had moved from a £690k overspend to project a balanced year end position. Pressures remained in domiciliary care, which has increased by 9% in the current financial year.
- The NHS final accounts would be prepared in April and May. There remained a requirement to find £3.3m of efficiencies and £0.25m of procurement efficiencies. Forecast falls in prescribing costs have not taken place, prescribing inflation of 3.3% has resulted in a £1.1m pressure.
- Capital to revenue transfers, procurement savings and reserves will bridge the shortfall and result in a balanced position by the year end for Edinburgh CHP.

Performance Overview

- The report now considers performance in the CHP, REAS and HSC. Sickness absence is short of target in all three organisations, though this is partly seasonal. The report now highlights key changes in performance.
- Performance improvements are needed in hospital discharge and discussed in detail below. Criminal Justice service indicators are demonstrate improved performance.

ICT Update

- Workshops to capture the Partnership’s requirements had been completed and would inform a roadmap of future development of the Portal.
- The Portal allows data from CEC and NHS systems to be presented on one screen for practitioners. The data would be stored only in the parent system. The most helpful arrangement of user views of data is currently being developed.
• A range of ICT improvements have been implemented, these allow CEC staff to access their systems from NHS offices and vice versa.
• The first phase of the Portal may be able to go live in April 2014. Future developments are being costed and will proceed where the business case suggests it is useful and resources are available.

NHS Lothian Strategic Plan
• Libby Tait and Alex McMahon presented the Plan, which addresses challenges of ageing workforce, population, funding pressures and multi-morbidity. The Plan proposes more services being delivered in patients’ homes and community settings, with hospital care provided from four sites.
• Radical change in the way services are delivered is proposed, coupled with equally radical change in the workforce. More of the same isn’t an option, how best to make the necessary transition is a key challenge.
• A communication plan and initiatives to engage with people affected are planned.

Unscheduled Care
• Significant increases in home care (13% last year and 9% this year) have not been sufficient to keep up with demand.
• A new contract for care at home is being prepared to address recruitment and retention issues.
• A Step-down capacity of 53 beds is being implemented and will be available by May. The Compass initiative is being extended city-wide.
• Additional spending to address unscheduled care has been identified: £700K re-ablement; £1.6m for care at home next year and £2m non-recurrent funding to free up resources currently tied up in more costly forms of care.
• Weekly progress meetings are being held and a full time project manager is in place to manage the implementation of initiatives.

Integration Plan/Scheme for Edinburgh
• The amended Public Bodies (Joint Working) (Scotland) Bill requires Integration Schemes to be submitted for ministerial approval. These were previously referred to as Integration Plans.
• The Scottish Government advises that Draft Integration Schemes cannot be consulted upon locally before the Scottish Government finalised its guidance.
• A draft schedule reflecting this was noted, which showed consultation taking place between December 2014 and April 2015 and being ratified by the parent bodies in May and June 2015.

Service User and Carer Engagement
• Two service user and two carer members would be recruited to ensure cover. The cost of reasonable expenses is estimated at £3,500.

Any other business
• It was agreed to consider a visits plan at the next meeting for 2014/15.
Minute of Meeting

Edinburgh Health and Social Care Partnership
City Chambers, Edinburgh 14 February 2014

Present:-
Councillors Ricky Henderson (Chair), Elaine Aitken, Cammy Day, Maggie Chapman, and Norman Work, Carl Bickler, Wanda Fairgrieve and Gordon Scott.

Also Present – Non Voting Members:- Kirsten Hay.

In Attendance, Monica Boyle, Lynda Cowie, Karen Dallas, Peter Gabbitas, Ian Mackay, Bob Martin, Vanessa Martin and Derek Masson.

Apologies:- Shulah Allan, Kay Blair, Michelle Miller, Tim Montgomery, Ella Simpson, Richard Williams and Robert Wilson

1 Welcome and Introduction

The Chair welcomed everyone to the meeting.

2 Minute

Decision

To approve the minute of the Health and Social Care Partnership of 20 December 2013 as a correct record.

3 ICT Update

Derek Masson and Vanessa Martin gave a presentation updating the Partnership on the work underway to enhance Partnership working using technology.

Details were provided of the following:-

- The progress on requirements gathering
- The interagency portal
- The project team
• Activity to date
• High level milestones
• Examples of data sharing
• Recent developments
• The next steps, and
• The key risks.

Decision

1) To note the progress around developing shared ICT which had already taken place.

2) To note that a strategy and road map was now in development.

3) That a further report detailing priorities and what could be collectively funded together with detailed costings of the proposals be submitted to the next meeting.

4 Integration Programme Status Report

The integration programme status report for the period December 2013 to January 2014 was presented. The report included Red/Amber/Green Status on work streams and forthcoming milestones.

Peter Gabbitas advised that the planned deadline of April for the integration had now been extended to December 2014 which would reduce the proximity of the risks highlighted in the report, however very little progress had been made towards integrating the legal, financial and HR arrangements of the organisations. Rules in relation to finance, legal and HR, that both organisations were comfortable with, required to be agreed by all the relevant bodies within the NHS Lothian and the City of Edinburgh Council.

Decision

1) To note the status report.

2) To note that the deadline for Integration had been extended to December 2014.

3) To note that little progress had been made towards integrating the legal, financial and HR arrangements of each organisation.

(Reference – report by the Programme Team, submitted.)
5 **Professional Advisory Committee - Minute**

The minutes of the meeting of the Professional Advisory Committee (PAC) held on 17 December 2013 were presented.

**Decision**

To note the minutes of the PAC.

(Reference – minute of the PAC 17 December 2013, submitted)

6 **Financial Monitoring – Month 9**

The first joint monitoring report outlining the nine month aligned budgetary position of the Edinburgh Health and Social Care Partnership was presented.

**Decision**

1) To note the report.

2) To note that a further report would be submitted to the next meeting of the Partnership.

(Reference – joint report by the Acting Principal Finance Manager (CEC) and Head of Finance, Edinburgh CHP, submitted)

7 **Performance Overview**

A summary was provided of performance across the Health and Social Care Partnership together with an update on progress towards the development of a performance framework to support the Health and Social Care Partnership.

The report was based on a selection of key performance indicators from Health and Social Care, Edinburgh CHP and REAS and provided a high level overview of key areas.

An overview of performance trends was provided in Appendix 1 and summaries of the key performance topics were provided in appendices 2, 3 and 4 to the report.

**Decision**

1) To note the ongoing work to develop a performance framework to support the Health and Social Care Partnership.

2) To note the performance report for December 2013.

(Reference – report by the Chief Social Work Officer, submitted.)
8 NHS Lothian Strategic Plan

The Partnership received a presentation from Alex McMahon and Libby Tait on “Our Health Our Future” the NHS Lothian Strategic Plan for 2014-2024.

The purpose of the plan was to set out a clear direction to achieve the aims of NHS Lothian through prioritised strategic actions across the Lothian health and social care system by:

- Determining where we need to be
- Clarifying evidence base and assumptions
- Progressing existing plans to deliver
- Developing plans where change was needed
- Addressing interdependencies
- Ensuring alignment of corporate strategies with clinical priorities

It was intended that the Health Board would approve the draft Strategy for consultation on 2 April 2014 and that a consultation with public and stakeholders would take place from April to June 2014.

During discussion the following points were raised:

- The compass model and hospital at home was a priority
- Much more detail to be included
- Not more of the same
- Needs to win hearts and minds of the public

Decision

1) To note the presentation.

2) To note that the Partnership would submit a response to the consultation.

(Reference – presentation, submitted.)

9 Unscheduled Care

Details were provided of meetings which had been held between NHS Lothian and the City of Edinburgh Council to find joint solutions to address delayed discharges and improve unscheduled care performance. The weekly meetings, chaired by the Chief Executives of each organization, had been instigated as a result of an increase in demand for Health and
Social care services which, when combined with capacity issues had contributed to a decline in unscheduled care performance.

A number of actions had already been implemented to tackle these issues. A draft project plan had also been developed to further reduce the demand for hospital admission, make the discharge process more efficient, increase capacity in existing services, and enhance community capacity. Further short term and long term actions to address the situation were detailed.

**Decision**

1) To note the report.

2) To support the approach being taken to improve unscheduled care performance.

3) That a further report be submitted to the next meeting.

(Reference – report by the Director of Health and Social Care, submitted.)

**10 Integration Plan/Scheme for Edinburgh**

An update was provided on the proposed timeline for production and sign off of the Draft Integration Plan/Scheme to establish the Edinburgh Integration Authority.

**Decision**

1) To note that the Public Bodies (Joint Working)(Scotland) Bill was scheduled to progress to Stage 3 commencing 24 February 2014

2) To note the revised timeline for the production and approval of the Draft Integration Plan/Scheme.

3) To note the different arrangements and lead in times for approval within the parent bodies.

(Reference – report by the Integration Programme Manager, submitted.)

**11 Service User and Carer Engagement**

An update was provided on the recruitment of service users and carers as members of the Health and Social Care Partnership

**Decision**

1) To note the progress made on recruitment of the service user and carer members

2) To agree to recruit two service users and two carer members
3) To retain the previously recommended scheme of payment to meet reasonable expenses, based on the Edinburgh Partnership arrangements and PPF procedure.

4) That the selection take place in mid February with a panel comprising Shulah Allan, Ella Simpson, and one officer from City of Edinburgh Council and the Edinburgh Community Health Partnership.

5) That a report on the selection be submitted to the meeting of the Partnership in March.

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

12 Visits by the Partnership

Decision

To note that the Director of Health and Social Care would produce a programme of visits to be considered at the next meeting of the Partnership.
PRESENTATION

Our Health, Our Care, Our Future 2014 – 2024
PJ welcomed Libby Tait who delivered the above as a presentation. This was followed by an opportunity for open questions from the committee. Feed-back from this was encouraged in order that these could be fed into the final plan.

Items for Discussion
- A Sense of Belonging 2011 – 2016 Implementation update
  The Sub-Committee considered a verbal report at the meeting given by EMc.

- Childrens Services Inspection Report
  Alison MacDonald, Chief Nurse and Sally Egan presented the findings and recommendations from the report and discussed in detail with the committee members.

Performance Reports
A range of routine performance reports were received.

  Joint Directors Report
  Staff Governance
  Finance Report
  Clinical Directors Report
  AHP Managers Report

Careers Forum Report

Promoting Peer Support

Public Partnership Forum

Peter Johnson on behalf of the committee thanked Sue Edmonds for all of her contributions to the above over the last seven years. Sue is leaving her post in Lothian and her role as Chairman of the PPF.

Peter Johnston
Chairman, Midlothian CHP
26 February 2014
1.0 Apologies and Welcome

PJ noted the apologies as above.

PJ also highlighted to the committee that SE is now leaving her role as Chair of the Public Partnership Forum as she is relocating to South. He acknowledged her very significant contribution to the NHS throughout the 7 years representing PPF. PJ also thanked her on behalf of the committee and the wider Midlothian public.

PJ also welcomed Libby Tait (LT) who was delivering a presentation on “Our Health, Our Care, Our Future 2014-2024”.

2.0 Minutes & Summary Notes from Previous Meeting

Please find attached summary notes at the end of the minutes.

3.0 Action Note from Previous Meeting

As agreed previously these are included within the summary at end of minutes. One amendment was noted.

4.0 Items for Decision

None for consideration.

5.0 Items for Discussion
5.1 **NHS Lothian Draft Strategic Plan “Our Health, Our Care, Our Future 2014-2024”**

LT highlighted the challenges that have been considered in respect of bringing together and developing this Strategy. However, she also highlighted the opportunity this brings specifically to address demographic growth and the capacity and demand issue that faces all Hospital and Primary Care Services.

The draft plan for sign off by the Health Board is being prepared and must be ready for April 2014.

LT is looking for feedback and a view on the plan in order that this can feed into the plan. A copy of the presentation is available, members were asked to please contact LT direct if you require any further information.

The strategic plan uses case studies, focussing on people and following a journey through to understand their care pathways and to demonstrate how the plan will meet their health care needs.

It was highlighted to LT that these plans are taking into account the work of the “family carers” in supporting patients. LT replied that the case studies should capture this in the pathways that are being tested.

HR suggested this is positive, and it is what we are all striving for in respect of meeting capacity and demand for the future. However, he suggested that resource transfer is required to Primary Care. He also spoke of the delivery of Cancer Care and that there a real desire for a transfer of cancer treatments to be provided from Midlothian Community Hospital (MCH). HR asked LT to take this on board and feed this into the strategy, thus ensuring that the infrastructure in respect of nursing, pharmacy etc is provided to support this initiative.

DK asked that consideration should be given to the NHS Strategic Plan supporting the delivery the strategic plans developed by the H&SC Partnerships rather than vice versa as is proposed.

EMcH highlighted the importance of the plan supporting the shift to new ways of working that focuses the delivery of health care to individuals in the context of their communities rather than as patients in hospital. In order to do this the plan needs to support the shift in focus that is required around the delivery of healthcare and the requirement to support the workforce to develop new skills and change cultures.

LT acknowledged changing hearts and minds is the way forward, but this is what presents a big challenge for all of us.

SE on admissions avoidance, there does require to be resource transfer in order to provide additional care for this from the GPs in Primary Care. SE asked whether the development of this plan would use real people, but supported the theory of using fictional patients. LT is working with Lesley Baxter to identify real patients for future testing.

PJ thanked LT for the presentation and asked how comments will be fed-back into the plan. She hopes this will be a succinct plan including an action plan for local areas to include actions such as mentioned above to be bespoke to each H&SCP.
A Sense of Belonging 2011 - 2016 Implementation update

This is a Lothian wide Mental Health and Wellbeing Strategy aimed improving mental health and well being through all stages of life, from young children to older people. The strands include:-

- Tackling health inequalities;
- Building on health and wellbeing;
- Embedding recovery;
- Improving services.

Significant progress has been made in supporting people with mental health difficulties to gain employment, social prescribing and peer support as well the redesign of housing support services.

Members were asked to note the report

5.2 Children’s Services Inspection Report

The Joint Inspection of Services for Children and Young People in Midlothian.

AMcD presented the recent “Care Inspectorate Report” on Midlothian Children’s Services. The final report was published on the Care Inspectorate website on 13 January 2014. The report recognises the quality of services provided for children and young people across the Midlothian Community Planning Partnership. Particular strengths identified include, meaningful involvement of children and young people to shape policies and services, creative approaches to encourage physical, social and emotional wellbeing and highly effective and helpful support to improve parenting.

The report also notes that leaders have made significant improvements to services for children whose wellbeing is at risk and children who are in need of protection from abuse are kept safe and experience positive outcomes as a result of the help they receive. The report states that inspectors are confident that services will be able to make the necessary improvements in the light of the inspection findings. There are four recommendations outlined in the report, which notes that the Midlothian Community Planning Partnership and the Getting it Right for Every Midlothian Child Board should take account of the need to:-

1. Provide readily available support for all children, young people and families to ensure they get the help they need at the right time;
2. Continue to improve the quality of assessment and planning for all children and young people;
3. Implement a comprehensive and effective joint commissioning strategy for services for children and young people; and
4. Maintain strong leadership and clear direction for integration and continuous improvement in order to realise the vision and aspirations for children and young people.

An action plan to respond to these recommendations is in development aligned with the “Single Midlothian Plan”.

SAE reported that having read the report, it indeed was a really positive report and felt this has not been reflected in the grading which is a little disappointing.
She urged members to read the report which gives positive messages about the strength of leadership in Midlothian. She suggested that Midlothian does bear well in respect of the positive work across services and this was reflected at a National Forum she attended recently where early years collaborative developments in Midlothian was being used as a national exemplar. She would be happy to share the VT with members at another Committee meeting in the future if desired.

EMcH believes that the detail within the report does actually reflect the good work done in Children’s Services and the many strengths that services have going forward.

GW asked about the proposed future consideration of Children’s Services being included in the Health and Social care Partnership and the implications of such a move for close working relationships between Children’s Services and Education. EMcH confirmed that active consideration is being given to including Children’s Services in the Partnership but careful consideration would need to be given to maintaining good working relationships between Children’s Services and education services in any future arrangements.

Members were asked to note the report.

### 6.0 Performance Reports

#### 6.1 Joint Director’s Report

EMcH highlighted the progress in the partnership to date, and the work currently ongoing, in developing the Integration and Strategic Plan. This links positively with the presentation LT gave.

Active consideration is being given to the inclusion of both Children’s services and Criminal Justice services within the scope of the partnership.

Members were asked to note the report.

EMcH formally reported to the committee that Rob Packham was leaving his post as Head of Health and she wanted to thank him for his contribution in the early stages of the development of the Midlothian Partnership. There is a gap in respect of the AHP Lead for East Lothian and Midlothian, but discussions are ongoing and a resolution is being sought.

EMcH reported that delayed discharges are very challenging across Lothian. There is increased activity allied to some challenges within care home places reducing availability of places. This is creating significant difficulties. There are currently concerns about one particular Care Home in Midlothian. However, this is being managed carefully. The Midlothian Partnership is again reporting no delays over 4 weeks.

SE asked if there are any particular issues with the Home Care in the Penicuik area. EMcH confirmed that she was not aware of specific concerns in relation to availability of care at home packages.

SAE left the meeting

#### 6.2 Staff Governance Report

Staff Governance report highlighted Midlothian is performing well in relation to staff absences.
AMcD asked the committee to note that the drop in staff numbers are as a result of the changes in structure and the move of hosted services out of the partnership.

Members were asked to note the report.

6.3 Finance Report

Break-even this current financial year. This is a positive position in respect of the prescribing challenges this year.

The important thing to note from this report is to ensure that the position for 2014/15 is now discussed and forecasted. There has been a need to put together an efficiency plan which is currently in draft.

Members were asked to note the report.

6.4 Chief Nurse’s Report

AMcD highlighted the following from her report:-

Health Visitor availability, Midlothian are in a good position with no vacancies and sickness absence being back-filled currently. Developing teams and roles is ongoing and consideration being given to the improvement plan from the Inspectorate report.

Frailty Project is experiencing difficulties in recruiting advanced practitioner nurses.

Care home advisor is in post in Midlothian which can help to support issues in respect of quality in Care Homes. The considerable benefits of this post were noted.

Members were asked to note the report.

6.5 Clinical Director’s Report

HR highlighted the key issues from his report:-

SE said the Coaguchek sounds very positive and will reduce any patient anxiety. She asked about what would happen if a machine breaks down. HR replied that there will be one spare machine per geographic area. SE also asked about the possibility of home testing, but this is more problematic. However, this may be something in the future, but not in this first implementation period.

MG asked if this can be self done like diabetic testing. HR replied that there are some quality and governance issues around this, although patients could buy machines themselves, but he would not encourage this.

Members were asked to note the report.

6.5.1 Agreement

Service level Agreement for Coaguchek template was attached to paper

Members were asked to note this.
6.6 **AHP Manager’s Report**

RP highlighted the following from his report:-

Physiotherapy is no longer a red risk in respect of recruitment, which is really good news as this had been featuring as a risk for quite some time.

OT therapy increase in vacancies and this is being looked at currently along with secondary colleagues.

Members were asked to note the report.

6.7 **Joint Health Improvement Partnership**

MMcK reported that key pieces of work recently included :-

The Physical Activity and Health Alliance are considering a local response to the new national Physical Activity strategy. The priorities of which include workplace, environment, health and social care. Recent discussions with Midlothian JMT regarding promoting understanding of physical activity and preventative role in dementia and frailty.

Continued work to mitigate the impact of welfare reform on staff and the population of Midlothian. Tracy McLeod leads this work on behalf of JHIP and is working closely with Midlothian Financial Inclusion Network and their Hardship Co-ordinator.

Helen Yewdall has joined Midlothian as the Public Health Practitioner. Helen is based at the Esk Centre in Musselburgh.

Members were asked to note the report.

7.0 **Carers Forum**

Jane Cuthbert reported the following on behalf of Julie Gardner:-

Carer Parliament - consultation on carers and carer right.

Next meeting to be dedicated to ensure Carers have their say.

A concentrated effort to contact ethnic minorities and ensure involvement.

Copy report to be attached to note of this meeting.

Additionally Julie had sent in a late paper, which was tabled but also is attached for perusal and update.

8.0 **Public Partnership Forum**

SE reported the following:-

Transport meeting has been organised in February and SE extends an invitation to all to attend or be represented. She asked that the flyer be circulated through our networks, this was agreed. She also asked members to highlight any issues with patient transport in order that these could be raised at the event or sent to Catherine Evans in advance.

Quality training for reception staff ongoing across Lothian. This is welcomed as this
group of staff are the first to face the patients and often feature in patient complaints.

Access panel also discussing disabled access across sites.

Some concerns that Delayed Discharges were as a result of house repairs. EMcH reported that this remains a priority but some adaptations take time and especially if bathrooms are requiring to be created. EMcH asked for any concerns to be highlighted directly to her.

SE highlighted that Red Cross are keen to and could assist with support. RP said we would welcome any other partners providing support for patients at home and this should and may already be captured in the strategic plans.

SE thanked all for the support she has had over the last seven years.

9.0 Promoting Peer Support

EMcH wanted the committee to be aware of developments in relation to peer support and welfare reform. Forward Mid have set up a Welfare Reform Peer Support Group. MG asked members to circulate this information throughout their networks.

GW said we have done well in Midlothian to bring in support, but there are still real desperate situations out there and specifically for young males. MG also was concerned about the impact of welfare reform on people who have Mental Health issues.

Outcome focus plan requires to be developed locally to highlight how we are taking this forward.

JC highlighted the CAB sessions for family carers which are available to support people impacted by the Welfare Reform.

Consideration to SE’s replacement is taking place.

Alistair Short has been offered the post of Head of Health and should take up position as early as 24 March 2014.

10.0 AOCB

None

11.0 Date and Time of Next Meeting

Thursday 20 March 2014 at 14.00 - 17:00
Council Chambers | Midlothian House | Buccleuch Street | Dalkeith

Meeting finished at 16.09

Summary of actions on next page
### SUMMARY OF ACTIONS

<table>
<thead>
<tr>
<th>DOM</th>
<th>Topic</th>
<th>Decision</th>
<th>Progress/Status</th>
<th>Action</th>
<th>Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>30.01.14</td>
<td>Stroke Pathway</td>
<td>The Chair noted that it maybe helpful to have a presentation at a future meeting of the CHP Sub Committee on the new Lothian Stroke Pathway. (From the meeting of 26.05.11)</td>
<td>Mark Smith to be confirmed for meeting in March 2014 for presentation of updated paper March/April</td>
<td>HA</td>
<td>Ongoing</td>
</tr>
<tr>
<td>25.07.13</td>
<td>Children's Strategy</td>
<td>The Children's Strategy will conclude by 31 January 2014, The final draft of the Strategy due back to Midlothian CHP Sub Committee in March, prior to being submitted to Lothian NHS Board in April. Mike Massaro-Mallinson.</td>
<td>MMM</td>
<td>Mar 14</td>
<td></td>
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</tbody>
</table>

### Midlothian CHP SUB Committee Group - Meetings 2014

<table>
<thead>
<tr>
<th>DATE</th>
<th>DAY</th>
<th>TIME</th>
<th>VENUE</th>
</tr>
</thead>
<tbody>
<tr>
<td>20.03.14</td>
<td>Thursday</td>
<td>14.00 - 17.00</td>
<td>Council Chambers, Midlothian Council, Buccleuch Street, Dalkeith</td>
</tr>
<tr>
<td>15.05.14</td>
<td>Thursday</td>
<td>14.00 - 17.00</td>
<td>Council Chambers, Midlothian Council, Buccleuch Street, Dalkeith</td>
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<tr>
<td>17.07.14</td>
<td>Thursday</td>
<td>14.00 - 17.00</td>
<td>Council Chambers, Midlothian Council, Buccleuch Street, Dalkeith</td>
</tr>
<tr>
<td>18.09.14</td>
<td>Thursday</td>
<td>14.00 - 17.00</td>
<td>Council Chambers, Midlothian Council, Buccleuch Street, Dalkeith</td>
</tr>
<tr>
<td>20.11.14</td>
<td>Thursday</td>
<td>14.00 - 17.00</td>
<td>Council Chambers, Midlothian Council, Buccleuch Street, Dalkeith</td>
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<tr>
<td>MEETING</td>
<td>KEY ISSUES</td>
<td>ACTION</td>
<td></td>
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<td>----------------------------------------------</td>
<td>------------------------------------------------</td>
<td>------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>West Lothian CHCP Sub-Committee 6(^{th}) February 2014</td>
<td>Presentation on Carers of West Lothian</td>
<td>Noted presentation and happy to continue to support the work of the Carers of West Lothian</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reducing Re Offending Strategy</td>
<td>Noted paper providing an update on the progress on implementing strategy.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Reducing Re-Offending Performance Reporting</td>
<td>Noted paper providing an update on the performance reporting procedures.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Community Planning Audit</td>
<td>A self assessment in preparation of the audit was carried out. The recommendations were accepted</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Working Towards our Single Outcome Agreement – themed Agenda 2014</td>
<td>The thematic agenda for 2014 was agreed, basing the agenda around the 4 SOA outcomes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Future Meeting dates for 2014/15</td>
<td>All dates were agreed.</td>
<td></td>
</tr>
</tbody>
</table>
Minutes of the West Lothian Sub Committee held on 6 February 2013, 1400 – 1600, Strathbrock Partnership Centre.

Present  
Frank Toner (FT)  Chair, West Lothian CHCP  
Jim Forrest (JF)  Director, West Lothian CHCP  
Marion Christie (MC)  Head of Health / General Manager, WLCHCP  
Jennifer Scott (JS)  Head of Social Policy, WLC  
Mary-Denise McKernan (MMc)  Manager, Carers of West Lothian  
Lorraine Gillies (LG)  Community Planning Development Manager  
Andreas Kelch (AK)  GP PCCF Rep  
Anne Greig (AG)  CPO, Education  
Tim Ward (TW)  Senior Manager, Young People & Public Protection  
Jane Houston (JH)  Partnership Lead  
Jane Kellock (JK)  Senior Manager, Children & Early Intervention  
Alan Bell (AB)  Senior Manager, Community Care Support & Services  
John Richardson (JR)  Public Partnership Forum Rep  
Lindsay Seywright (LS)  West Lothian College

Apologies  
Gill Cottrell (GC)  Chief Nurse  
Pat Donald (PD)  Acting AHP Manager  
Chris Stirling (CS)  SJH Site Director  
John Jackson (JJ)  
Alistair Shaw (AS)  Head of Service  
Alison Mitchell (AM)  Non-Executive Member, NHS Lothian

In Attendance  
Marjory Brisbane  Admin Manager

Declaration of Financial and Non-Financial Interest  
The Chairman reminded members they should declare any financial and non-financial interests they had in the items of business for consideration. FT declared he is chair of the CHCP and non executive member of NHS Lothian

Welcome and Introductions  
Due to adverse weather and the subsequent cancellation of the Sub Committee meeting on the 5th December the agenda includes items from the previous meeting and has been split in to 2 sections due to the number of items on the agenda detailing items for approval and items for discussion. The chair requested the committee to advise whether any items should move from the approval to the discussion section of the agenda. The Committee were satisfied that all items under approval were appropriate.

1.0. ITEMS FOR APPROVAL

1.1. Draft Minute of CHCP Sub-Committee held on 17 October 2013  
The minutes were approved as an accurate record.
1.2. **Confirmation of Action Points**  
Action note was approved

1.3. **Minutes of PPF Meeting dated 3rd October and 21st November 2013**  
The minutes of the PPF were noted

1.4. **Draft Minute of Primary Care Joint Management Group dated 10th October 2013**  
The minutes of the PCJMG were noted

1.5. **Working Towards Our Single Outcome Agreement**  
The report was noted

1.6. **Consultation on Redesigning the Community Justice System**  
The report was noted

1.7. **West Lothian Offender Profile**  
The report was noted

1.8. **Suicide Statistics 2012**  
The report was noted

1.9. **Suicide Prevention Week**  
The report was noted

1.10. **Launching the New Single Outcome Agreement (SOA) - Achieving Positive Outcomes**  
The report was noted

1.11. **Local Community Planning**  
The report was noted

2.0. **ITEMS FOR DISCUSSION**

2.1. **Carers of West Lothian**

MDMc provided a presentation on the work being undertaken by Carers of West Lothian providing information, support and listening to over 3,700 unpaid carers in West Lothian. The presentation provided an informative session including the key areas of service provision and key relationship with core services including hospital services, dementia carer support, older people services, young carers’ service and local networks. Carers of West Lothian are currently reviewing its strategy and looking at the development of carers’ services to meet future demands as a result of increasing carers’ numbers and complexity of carers’ roles.

AK requested information on the work around supporting carers re Power of Attorney.

The Sub Committee are happy to continue to support the work of the Carers of West Lothian.

2.2. **Reducing Re-offending Strategy**

TW talked to the report providing an update on the progress on implementing the West Lothian Reducing Re-offending Strategy. This is the first plan of its kind in West Lothian and Scotland and represent the commitment of all partners to work together to address the six identified priorities within it. To ensure structures were established to oversee and facilitate the work a committee has been set up supported by four sub committee with specific areas of responsibilities, Offender Management Sub Committee,
Violence Against Woman Strategic Committee, Youth Crime Sub Committee and Offender Engagement Sub Committee. TW gave a summary of the activities which have been undertaken including redesign work with Alcohol and Drugs Partnership and the work around reducing the frequency of re-offending.

The Sub Committee noted the report.

2.3. **Reducing Re-offending Performance Reporting**

TW talked to the report providing an update on the performance reporting procedures in place for Reducing Re offending within West Lothian. The four sub committee mentioned under the Reducing Re offending strategy has a suite of indicators who report in to the reducing re-offending committee. There are a total of 13 indicators capturing the main focus of the groups. There are robust reporting and governance structures in place to monitor and analyse performance. TW talked to the Reducing Re-offending committee summary report discussing and highlighting some of the measures and targets identified.

The Sub Committee noted the performance measures and reporting structures.

2.4. **Community Planning Audit**

LG talked to the paper which supports the preparation for the forthcoming audit by supporting the CHCP by self assessing their role within West Lothian Community Planning Partnership. The self assessment framework has been circulated to all CHCP partners asking them to populate the template by 27th January. LG collated the responses and pulled together a mini self assessment. The self assessment was discussed at the meeting and additional comments were discussed. LG asked if all additional comments could be sent to her for inclusion in the self assessment and an action plan including recommendations will be developed.

The Sub Committee accepted the recommendations.

2.5. **Working Towards our Single Outcome Agreement – Themed Workplan 2014**

JK talked to the paper providing a thematic workplan for 2014 for the monitoring of the revised SOA outcomes. There are eight outcomes of the SOA of which the Sub Committee have responsibility of delivering four. The six Sub Committee meeting in 2014 will be scheduled as:

- Meeting 1 Agree themed workplan
- Meeting 2 Our Children have the best start in life and are ready to succeed
- Meeting 3 Older people are able to live independently in the community with an improved quality of life
- Meeting 4 We live, longer, healthier lives and have reduced inequalities
- Meeting 5 People most at risk are protected and supported to achieve improved life chances
- Meeting 6 Review of themed agenda

For each relevant meeting each sub/group/lead officer will take responsibility for presenting a performance report drawn from Covalent. The majority of the agenda items will be related to the theme and will be agreed at the CHCP Sub Committee agenda setting meeting. This will enable the Sub Committee to fulfil its responsibilities as a Community Planning Partnership.

The Sub Committee agreed the thematic workplan for 2014.
2.6. Future Meeting Dates for the CHCP Sub Committee

JF talked to the report providing future dates for the Sub Committee in 2014 and 2015.

The Sub committee agreed the dates of the meetings

No other business was discussed

3.0 NEXT SUB-COMMITTEE MEETING

Thursday 10 April 2014 at 2 pm, held in Strathbrock Partnership Centre, Broxburn

4.0 MATTERS ARISING

There were no matters arising.

5.0 ANY OTHER COMPETENT BUSINESS

Meeting closed at 3pm
<table>
<thead>
<tr>
<th>MEETING</th>
<th>KEY ISSUES</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>West Lothian CHCP Board 28 January 2014</td>
<td>National Dental Inspection Programme for Scotland 2013 Primary 7</td>
<td>Agreed to continue to support the Childsmile Programme in schools and nurseries.</td>
</tr>
<tr>
<td>Public Dental Service</td>
<td></td>
<td>Noted merger of Community Dental Service and Salaried General Dental Practitioner Service and new service to be known as Public Dental Service.</td>
</tr>
<tr>
<td>Risk Management</td>
<td></td>
<td>CHCP risk register noted.</td>
</tr>
<tr>
<td>Care Governance</td>
<td>1. Crofthead House Nursing Home</td>
<td>Noted application of enhancement in the quality element of the National Care Home Contract fee.</td>
</tr>
<tr>
<td></td>
<td>2. Livingston Nursing Home</td>
<td>Noted that the Care Inspectorate had extended the period for some parts of the Improvement Notice applicable to Livingston Nursing Home and that further visits would take place in early February.</td>
</tr>
<tr>
<td>Staff Governance</td>
<td></td>
<td>Noted the work being undertaken to develop a unified systematic approach to managing Health and Safety and establish an integrated governance framework and congratulated staff on NHSL reaccreditation against the Investors In People Standard in</td>
</tr>
<tr>
<td>Director’s Report</td>
<td>Noted the opening of a new early years and family resource for Armadale, the development of the Roots of Empathy programme, the opening of a new courtyard at Limecroft Care Home and update on Blackburn Partnership Centre.</td>
<td>November 2013.</td>
</tr>
</tbody>
</table>
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 28 JANUARY 2014.

Present – Frank Toner (Chair), Jane Houston, John McGinty, Angela Moohan (substituting for Anne McMillan), Ed Russell-Smith

Apologies – Janet Campbell, Brian Houston, Anne McMillan, Alison Mitchell

In Attendance – Jim Forrest (CHCP Director) Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), Carol Mitchell (Assistant Director of Finance, NHS Lothian), Alan Bell (Senior Manager Communities and Information – West Lothian Council), Sharon Leitch (Auditor - West Lothian Council) Carol Bebbington (Primary Care Manager – NHS Lothian), Robert Naysmith (Clinical Director, Public Dental Service), John Richardson (PPF)

Apologies – Gill Cottrell (Chief Nurse – 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 26 November 2013 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 PRIMARY CARE JOINT MANAGEMENT GROUP

The Board noted the minute of the Primary Care Joint Management Group meeting on 14 November 2013.

5. NOTE MINUTE OF MEETING OF THE PRIMARY CARE JOINT MANAGEMENT GROUP
The Board noted the minute of the Primary Care Joint Management Group meeting on 12 December 2013.

6. NOTE MINUTE OF MEETING OF THE PRIMARY CARE FORWARD GROUP

The Board noted the minute of the Primary Care Joint Management Group meeting on 6 June 2013.

7. NATIONAL DENTAL INSPECTION PROGRAMME FOR SCOTLAND 2013 PRIMARY 7 -

The Board considered a report and presentation (copies of which had been circulated) by the Clinical Director - Public Dental Service providing details of the recently published national report into the dental health of Primary 7 Children in Scotland, which showed that the proportion of P7 children in Lothian with no obvious tooth decay had increased from 72% in 2011 to 77% in 2013. Appendix 1 to the report contained details of the National Dental Inspection Programme 2013.

The report advised that detailed dental inspections of children were carried out in state schools across Scotland annually, alternating between children in primary 1 and primary 7 classes. In Lothian 9.5% of Primary 7 children were in private education and these children did not receive a dental inspection.

Information gathered from inspections was used to:-

- Monitor dental health of school children over time.
- Inform parents of their child’s dental health status and promote regular attendance at the dentist.
- Inform local Health and Education authorities of the dental health of children in their area.

The report went on to advise that in previous years detailed analysis of the results across Scotland showed that children in more deprived areas had higher levels of dental disease, and the converse was true. Because 9.5% of Lothian’s P7 population were in private education and were not inspected the positive effect of this sub-population on Lothian’s headline figure was lost.

The report explained that a steady improvement could be seen from 2005, reflecting the benefits of both the nursery and school toothbrushing programmes. It was also advised that 98.5% (target 100%) of Lothian nurseries and 36% (Target 20%) of primary schools now participated in toothbrushing programmes.

In conclusion the report advised that a study carried out by the University
of Glasgow and published by the Scottish Government showed that for the year 2009/10 an investment of £1.8m in providing Childsmile toothbrushing programmes across Scotland avoided just over £6m of cost in providing dental treatments to children. Although this was good economic news the major benefit was that many Scottish children avoided pain, filings, extractions and general anaesthetics for dental problems.

Decision

1. To note the contents of the report.

2. To continue to support the Childsmile Programme in schools and nurseries.

3. To note the presentation in relation to National Dental Inspection Programme for Scotland 2013 and its relevance to West Lothian

4. To provide Board members with information about the apparently low rate of Primary 7 inspections in West Lothian.

8. PUBLIC DENTAL SERVICE

The Board considered a report (copies of which had been circulated) by the Clinical Director - Public Dental Service advising that West Lothian CHCP hosted the Salaried Primary Care Dental Service which was made up of two elements; the Community Dental Service and the Salaried General Dental Practitioner Service. On 28 November 2013 a Scottish Government letter to Board Chief Executives announced the merger of the two dental services from 1 January 2014 and that this new service would be known as the Public Dental Service.

The report explained that most Boards in Scotland provided dental services to priority groups in their local population using staff working in the Community Dental Services. Community dental staff worked under CDS terms and conditions, and as well as providing dental treatment undertook the National Dental Inspection Programme.

Since 2000 the remit of Salaried General Dental Practitioners expanded so that they began to treat patients who, for a variety of reasons were unable to attend an independent GDP. For example this could be that the patient had a complex medical condition, were particularly anxious about attending a dentist or required specialist care. The salaried General Dental Practitioner Service was funded through the non cash limited GDS budget.

In Lothian these two services had always been managed as one service and had been known as the Salaried Primary Care Dental Service.

The report went on to advise that in 2006 the Chief Dental Officer commissioned a report that recommended merging the two services so that there was a consistent level of care for patients.

All dentists in the Public Dental Service would work under GDS
regulations and unless a patient was included in an exemption category, the patient would pay 80% of the cost of treatment up to a maximum of £384.

The report provided a list of non-GDS work which would incur no charges to the patient.

In conclusion the report advised that as from 1 April 2014 the non cash limited GDS budget had become cash limited and the allocation was negotiated annually with the Scottish Government.

**Decision**

To note the information in relation to the merger of the Community Dental Service and the Salaried General Dental Practitioner Service from 1 January 2014.

9. **RISK MANAGEMENT**

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director providing an update on the review of the CHCP risk register. Appendix 1 to the report provided details of CHCP Risks and Risk Action Progress.

The report advised that the CHCP risk register was reviewed and updated in June 2013 and the risks were now recorded in West Lothian Council’s Covalent system and the NHS Lothian’s Datix system.

The purpose of the register was to provide a record of the high level risks to the CHCP which, should they occur, threaten the ability of the CHCP to achieve its objectives. The recording of the risk register ensured that management had identified and considered risks and were satisfied that they were either appropriately controlled or had planned actions in place to mitigate the risks further.

The CHCP Director explained that the risk register was reviewed by the CHCP Senior Management Team in January 2014, and that had involved a review of risks, their scores and associated risk actions. The review resulted in a number of changes which were detailed in the report.

In conclusion the report advised that the CHCP risks had been reviewed and updated to more accurately reflect the current risks to the CHCP and the actions required to further mitigate these risks. Progress in implementing risk actions were now monitored through Covalent.

**Decision**

1. To note and agree the updated CHCP risk register.

2. To agree that future reports should identify clearly risks which remained on the register but in relation to which Action Plans had been completed with no outstanding work required to mitigate the risk.
10. **SCHEDULE OF DATES FOR FUTURE CHCP BOARD MEETINGS**

The Board considered a report (copies of which had been circulated) by the Community Health and Care Partnership Director outlining the proposed schedule of meetings for the Board until June 2015.

The report advised that Standing Orders for the Proceedings and Business of West Lothian Community Health and Care Partnership stipulated that “The Board shall normally meet every 6 weeks but not less than 6 times in a year, in accordance with a timetable of meetings fixed annually by the Board and amended from time to time by the Board”.

The CHCP Board generally met on a six-eight weekly basis on Tuesdays in Strathbrock Partnership Centre from 2.00pm – 4.00pm. Meeting dates had been agreed until May 2014. The following dates were therefore proposed for meetings until June 2015:-

12 August 2014
7 October 2014
9 December 2014
3 February 2015
7 April 2015
2 June 2015

**Decision**

To agree the proposed schedule of meetings until June 2015.

11. **CARE GOVERNANCE -**

(A) **CROFTHEAD HOUSE NURSING HOME - REPORT BY HEAD OF SOCIAL POLICY (HEREWITH).**

The Board considered a report (copies of which had been circulated) by the Head of Council Services advising of the application of an enhancement in the quality element of the National Care Home Contract fee to one private provider who had been awarded a Grade 5 by the Care Commission in the category Quality of Care and Support.

The Head of Council Services explained that in April 2007 the National Care Home Contract for Older People Care Homes was implemented in West Lothian and across Scotland. The aim of the contract was to provide a consistent approach to the quality of care and the national fee for the provision of Older People Care Home beds in the private sector.
In April 2008 a report was presented to the Council Executive to seeking agreement on the implementation of the updated contract 08/09, its quality requirements and the national increase in fee. In April 2009, April 2010 and April 2011 reports were delivered to the Social Policy PDSP advising of the quality aspects of the continuing contract and national fee increase.

The Head of Council Services went on to advise that a key performance indicator in the contract 2013/2014 was the use of the quality assurance framework currently in use by The Care Inspectorate. Its officers undertook inspections of the Older People Care homes and awarded grades in relation to the Quality of Care & Support, Quality of Environment, Quality of Staffing and Quality of Management and Leadership.

It was stipulated by the contract that, as part of the contract quality agenda for Care Homes with nursing, an additional £2.00 per resident per week would be available if a QAF grade of 5 or 6 was achieved in Quality of Care and Support and a minimum of grade 3 in other categories. A further £1.00 per resident per week would be available to homes that achieved QAF grade 5 or 6 in Quality of Care and Support and a minimum of 5 in any one other category.

In October 2013, Crofthead Nursing Home was awarded QAF grade 5 in the category Quality of Care and Support, QAF grade 4 in the category Quality of Environment, QAF grade 5 in the category Quality of Management and Leadership and QAF grade 5 in the category of Quality of Staffing. Appendix 1 to the report contained the Care Service Inspection report.

The report concluded that the National Care Home Contract required West Lothian Council to apply the enhancement under the quality element of the contract. The enhancement for Crofthead Nursing Home calculated to an additional £3 per resident per week backdated to 30 October 2014.

Decision

To note the application of enhancement in the quality element of the National Care Home Contract fee to the private provider at Crofthead Nursing Home.

(B) LIVINGSTON NURSING HOME

The Board considered a report (copies of which had been circulated) by the Head of Council Services advising of the continued suspension of admissions to Livingston Nursing Home as a result of the Improvement Notice requirements issued by the Care Inspectorate and the current status of the ongoing investigation.

The Head of Council Services explained that Livingston Nursing Home was registered to care for 58 older people. Currently there were 42
places in this nursing home with 16 vacancies. West Lothian Council had responsibility for 27 of the 42 residents. The remaining 15 residents had been placed by and remained the responsibility of other local authorities.

In July 2013 a formal complaint was raised with the Care Inspectorate who subsequently carried out an unannounced inspection. West Lothian Council took the decision to suspend purchasing of new placements and all other local authorities were advised through the Association of Directors of Social Work (ADSW) communication channels.

A further inspection of the home in September 2013 resulted in a further downgrade to 1 in all four categories and the issue of an Improvement Notice by the Care Inspectorate.

It was advised that a multi agency working group had met regularly and at a meeting held on 12 December 2013 the Care Inspectorate advised that they had visited the home on three occasions in November and found firm evidence that improvements were being made but some elements of the Improvement Notice which should have been completed in October 2013 had been extended to January 2014.

At the multi agency meeting on 12 December 2013 Police Scotland advised that two members of staff from the Livingston Nursing Home had been charged under Section 315 of the Mental Health Care and Treatment (Scotland) Act 2004, and a further two staff remained suspended pending further police investigations.

It was explained that if the Care Inspectorate concluded that there was no organisational capacity to improve grades within a reasonable time frame, the council would need to consider alternatives.

In conclusion the report advised that the council was discharging its statutory duties under the Adult Support and Protection (Scotland) Act 2007 by fulfilling the duty to inquire. Meetings were convened under the West Lothian Adult Protection Committee’s Large Scale Investigation Protocol and a further meeting to determine whether a full Large Scale Investigation was required would be held on 16 January 2014.

**Decision**

1. To note that the Care Inspectorate had extended the period for some parts of the Improvement Notice applicable to Livingston Nursing Home and that further visits would take place in early February.

2. To note the ongoing monitoring which was being undertaken by the multi agency working group and senior representative group which ensured the council and partner agencies were discharging their statutory duties.

3. To note that admissions to Livingston Nursing Home continued to be suspended.

4. To agree that officers should ensure that procedures for passing
on nursing home inspection scores to GPs were being following through the Primary Care Joint Management Group and to advise the Board accordingly.

12. **STAFF GOVERNANCE**

The Board considered a report (copies of which had been circulated) by the Head of Council Services and the Head of Health Services providing an update on staff issues within the CHCP.

The report advised that Health and Safety was an essential element in implementation of NHS Staff Governance Standards which stipulated that staff were entitled to be:-

- Well Informed
- Appropriately trained
- Involved in decision which affect them
- Treated fairly and consistently
- Provided with an improved and safe working environment.

Currently CHCP staff worked within Health and Safety policies and procedures of their respective employer and each organisation had different approaches and structures in place to support their delivery of this statutory requirement.

The report explained that it recognised the benefits of developing a more consistent approach, guidance and support to staff particularly where they were/would be working in integrated teams. Therefore it was advised that work was at an early stage to scope out the requirements for a more integrated approach to the management of health and safety.

The report went on to advise that West Lothian CHCP underwent reassessment against the Investors in People Standard in November 2013. The assessment process was carried out in accordance with the guidelines provided by the UK Commission for Employment and Skills (UKCES) with the outcome that West Lothian CHCP continued to meet the requirements.

Recommendations made for continuous improvement were linked to key priorities and included improving feedback to staff on achievements and impact of activities, realising the potential of the new values through embedding these in practice and developing manager coaching skills to enable a more consistent leadership style.

In conclusion the report advised that the CHCP Investors In People Team would use the feedback to develop an improvement plan and would continue to liaise with the IIP Specialist to support continuous improvement.
Decision

1. To note the work being undertaken to develop a unified systematic approach to managing Health and Safety and establish an integrated governance framework.

2. To note and to congratulate staff on the Health Board’s reaccreditation against the Investors In People Standard in November 2013.

13. DIRECTOR’S REPORT

The Board heard a report by the CHCP Director providing an update on key areas of work in which the partnership had been involved in since the last meeting of the Board.

Decision

To note the information and work undertaken in relation to:-

a) The opening of a new early years and family resource for Armadale.

b) The development of the Roots of Empathy programme.

c) The opening of a new courtyard at Limecroft.

d) Blackburn Partnership Centre.
The key points of the paper are summarised here.

| The draft strategic plan is presented for endorsement to commence public consultation and engagement on the propositions to deliver the Board’s strategic aims in line with the 2020 Vision for Health and Care. | 3.1-3.3 |
| A summary only of some of the key propositions is provided in the Board paper, the rest are detailed in the Strategic Plan itself. | 3.3 |
| The process undertaken to develop the plan has been led by the Strategic Planning Committee. | 3.5 |
| A strategy for Primary and Community Care is appended to the Strategic Plan for the Board’s endorsement. | 3.5 |
| The Communication and Engagement Plan for the draft Strategic Plan is appended for the Board’s endorsement. | 3.5 |
| There are a number of key plans which support and contribute to the delivery of the Strategic Plan which are being or will be considered separately by the Board. | 3.7, 3.8 |
| The timetable for consultation and engagement is April to August 2014, and the final plan will be presented to the Board in October 2014. | 3.10 |

Libby Tait  
Associate Director Strategic Planning  
21 March 2014  
Libby.tait@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 The purpose of this report is to present the consultation version of the Strategic Plan to the Board for consideration and approval.

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

2 Recommendations:

2.1 Consider and endorse the draft Strategic Plan as attached (Appendix 1) and agree support for its content as the basis for further consultation and engagement

2.2 Agree the content of the Strategy for Primary and Community Care, as discussed at the Strategic Planning Committee on 13 March 2014 (Appendices 2, 3, 4)

2.3 Agree that the plan with the supporting suite of information listed will be the basis for wide consultation and engagement over the period April to August 2014.

2.4 Agree the process detailed in the Communication and Engagement Plan (Appendix 5).

2.5 Support the recommendation that the final version of the strategic plan is brought back to the Health Board in October 2014, along with an implementation plan.

3 Summary

3.1 In February 2013 the Board approved the Strategic Clinical Framework “Our Health, Our Future” which identified six strategic aims to ensure we can deliver safe effective and person-centred health and social care. Following this the Board decided that that a ten year strategic plan should be developed, to set out the specific actions to be taken to achieve these aims. Also in 2013 the Scottish Government set out the triple aims for achieving the 2020 Vision for Health and Social Care: “Improving the quality of care, improving the health of the population and securing value and financial sustainability” and these have been used to structure this Strategic Plan.

3.2 The plan sets out the demographic, health inequalities, population health, economic and workforce challenges which NHS Lothian requires to plan for and describes what we propose to do over the coming decade to address these, while providing a high quality and sustainable healthcare system for our citizens. The improvements and necessary changes will be delivered through new ways of working by staff and independent contractors, as well as through working differently with key partners- particularly the four local authorities, the third sector and patients and carers.
3.3 A wide range of propositions has been developed and will be debated and firmed up through consultation and engagement over the coming months; many of these are essential in order to deliver the 2020 Vision, including the following:-

- a radical shift away from a traditional, incremental approach to development based on services and specialties to a patient-centred, whole-system, pathways approach, focussing much more explicitly on the needs and experiences of people who use NHS Lothian’s services;
- pursue the ten safety essentials and nine point of care priorities in the Scottish Patient Safety Programme, including infrastructure for building quality improvement capacity and capability, the strategic prioritisation of safety in acute care, the safe management of medicines and the prevention of falls;
- improving services for the significant, and growing, number of people with multiple conditions, by developing and delivering Lothian’s multimorbidity action plan, in concert with the national programme to deliver excellence through:-
  - care planning and consultations that help people have control over their conditions, care and support and to achieve their personal outcomes;
  - integrated care and support that builds on community assets and promotes independence, wellbeing and resilience;
  - whole system pathways that are designed around multimorbidity and to reduce health inequalities;
  - providing visible leadership and using research, innovation and improvement approaches to improve the quality of care for people with multimorbidity;
- ending ‘silo working’, through closer interdependence and integration of community and hospital based services and across the public sector, through the establishment of Health and Social Care Partnerships in 2015 for Edinburgh, West Lothian, Midlothian and East Lothian, in accordance with Government legislation;
- improving access to primary care, through an increase in the number and capacity of general practices and community teams to meet increased demand arising from the population growth, extended life expectancy and the consequent increase in multi-morbidities; develop primary care premises, wherever possible, as integral parts of multipurpose facilities providing health, social care, voluntary and other community-based services; develop a Lothian-wide approach to sharing and benchmarking of primary care information at general practice and partnership level;
- urgently reducing to a maximum of 2 weeks by April 2015 and eventually eliminating altogether delays in patients’ discharge from hospitals;
- improving the care for older people by adapting and modernising the role of all current continuing care provision across Lothian to create a seamless spectrum of care from hospital based complex clinical care through to residential home care and care at home;
- improving arrangements for the residential care of older people, including assessment of the potential for the creation of a new ‘care village’ concept on the Royal Victoria Hospital and Liberton Hospital sites, replacing old and out of date hospital facilities with new purpose-built facilities, allowing social care to be provided in local communities, with NHS support provided on an inreach basis, as required; this is in line with recent policy developments following reviews of residential care and the future of NHS inpatient continuing care;
- developing a new East Lothian Community Hospital and adapting the use of Midlothian Community Hospital, to provide ‘step up’ and ‘step down’ care for
older people, to prevent inappropriate admission to acute hospitals in Edinburgh and to provide a wide range of community services for people closer to home;

• continuing to develop community mental health services to better support people at home, and to modernise acute mental health services by redeveloping the Royal Edinburgh Hospital, with phase one expected to be complete by 2016;

• delivering a wide range of improvements in children’s services, including the construction of a new Royal Hospital for Sick Children on the Royal Infirmary of Edinburgh campus, with completion expected by 2017;

• building a new, Regional Cancer Centre, fit for the 21st century, at the Western General Hospital, and integrating within a patient pathway designed to keep patients as close to home for treatment as possible;

• revising the model of emergency care at the Western General Hospital to improve the quality of service and the experience for patients and staff, and which is sustainable; to review acute receiving and assessment capacity at the Royal Infirmary of Edinburgh to meet the growing demand for more generalist services that can respond to the needs of older, frailer patients, often with multiple conditions and many with dementia;

• improving the quality and sustainability of specialist hospital services, through a new configuration of acute inpatient services at the Royal Infirmary of Edinburgh, Western General Hospital and St John’s Hospital, Livingston, including the development of a specialist clinical neurosciences centre at RIE, reviewing the model for Dermatology care and concentrating inpatient orthopaedics and trauma at RIE, stroke services at either the RIE or WGH and ophthalmology at RIE, WGH or SJH.

• improving patient services by widening the scope and scale of operative procedures undertaken on a day case basis and developing additional day surgery facilities at WGH and/or SJH;

• radically reviewing the future requirement for outpatient services and introducing more convenient, safe and innovative alternatives to routine outpatient attendance and follow-up;

• rebalancing investment between acute hospitals and primary and community services, as well as urgent action on areas for disinvestment, recognising the need to improve service quality while generating up to £40m cash-releasing savings each year;

• developing our human resources strategy to ensure a capable, integrated and sustainable workforce, within a healthy organisational culture which will support high quality health and social care

• driving an innovative and radical approach to creating opportunities for improving the value of all (not just new) investment in facilities and services, identifying those which do not contribute to the health of the population, in order to free up the funds and capacity to deliver a higher quality, more modern and more sustainable health and care service in line with this plan.

3.4 This is a dynamic document and, as such, it sets a ‘direction of travel’ for NHS Lothian in the years ahead. Firm commitments and priorities will be determined through further detailed engagement with the public, with our staff, with GPs and other independent practitioners and with our many other partners.

3.5 The Plan was developed during 2013/14 under the direction of the Strategic Planning Committee and with leadership from the Strategic Plan Programme Board. All NHS Lothian Executive Directors and the four Joint Directors of Health and Social Care are members of this Programme Board and they and their teams have contributed to the development of the Strategic Plan. The Strategic Planning Committee considered the
draft Strategic Plan, along with the Strategy for Primary and Community Care which has been developed in parallel, and the Communication and Engagement Plan, and agreed that these documents, with revisions made to take account of the Committee’s comments, should be recommended to the full Board for approval.

3.6 There are a number of supporting documents associated with the Strategic Plan which provide more detailed information on the context, specific programme strategies, resourcing strategies and planning and delivery processes. There is a full list of these documents on page 48 of the Plan, and all of these are available at www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/OurHealthOurCareOurFuture

3.7 Two of the service strategy appendices are separately on the agenda of the Board for approval:
- Draft NHS Lothian Strategy for Children and Young People 2013-2020
- Better Cancer Outcomes in Lothian - A Strategy for Cancer 2015-2020

3.8 Further work aligned to the development of the Strategic Plan is being taken forward in respect of site masterplanning; Human Resources and Organisational Development Strategy; 5 year finance plans, capital plan and efficiency and productivity plans which will also come to the Board over the course of 2014/15.

3.9 It is intended that the Strategic Plan will be finalised in the Autumn of 2014, in order to set a context for consultation on the four Integration Plans and to inform the development of each of the Health and Social Care Partnership’s Strategic commissioning Plans, later in 2014 and into 2015.

3.10 To achieve that, the proposed outline timetable following Board approval is:-

April, May 2014 - “Our Health, Our Care, Our Future” is published on NHS Lothian website and distributed widely for comments and feedback.

May, June, July, August 2014 – meetings with patients groups, staff, independent contractors, partnerships, Councils, Scottish Government and other stakeholders to analyse patent pathways, consider options and develop specific proposals, including workforce, capital and other resource implications.

October 2014 – NHS Lothian Board receive a refined and more definitive Strategic Plan for approval.

Detailed consultation and meaningful engagement with an extensive range of affected stakeholders will be necessary to convert the propositions into deliverable commitments. There will also be a specific programme of engagement to review and redesign patient pathways.

A number of general questions have been posed in order to facilitate and focus the dialogue with staff, partners and the public and allow responses to be considered and reflected in the submission to the Board in October 2014.

4 Risk Register

The strategic plan is intended to set out the key challenges, opportunities and actions that NHS Lothian will take forward to achieve our aims. As such it will impact on all of the corporate risks of the organisation.
A key risk is that the planned actions do not gain stakeholder support. Discussion of the draft plan with Scottish Government colleagues, Local Authority and community planning partners has already started, and the plan will be issued as a consultation and engagement draft to seek wide public and stakeholder support and feedback.

5 Impact on Inequality, Including Health Inequalities

The plan sets out actions to improve health and includes the commitment to implement the draft NHS Lothian Health Inequalities Strategy. The consultation and engagement plan will also enable consultation on that specific strategy.

A rapid impact assessment of the draft strategy has been undertaken and has identified a number of key issues to be considered as the propositions are developed. The plans for communication and engagement will be designed to ensure opportunities for wide inclusion are provided, and that the views of affected groups, including patients, carers, staff, partners and carers are considered.

6 Involving People

The plan has been developed to respond to government policy and with input from a range of internal and external stakeholders. The consultation and engagement plan sets out the process for involving people over the next four months. The patient pathway approach will provide a major focus for staff, patient, carer and 3rd sector involvement in planning future care models for Hannah, Callum, Scott and Sophie.

7 Resource Implications

The expected resource issues for NHS Lothian over the 10 year period are set out in section 7 of the plan. The specific resource implications of each proposition will be developed, within the context of the need to reduce waste, improve efficiency and increase productivity and deliver affordable health and care. The implementation plan will be developed and resource implications identified for the priority actions during the consultation and engagement period.

Libby Tait
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21 March 2014
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List of Appendices:

Appendix 1: NHS Lothian Strategic Plan 2014 -2024 V7.3
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Appendix 4: Primary Care Premises - A Strategic Overview
Appendix 5: Engagement and Communication Plan
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Policy Context

In 2011, the Scottish Government set out the strategic challenge for the NHS in Scotland, thus:-

Our ‘2020 Vision’

Our vision is that by 2020 everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

Lothian Today

There have been many significant improvements in healthcare in NHS Lothian in recent times; mental health services are being transformed, following the development of community and intensive home treatment teams, reducing the need for hospitalisation; a Lothian wide service to support people with COPD and pulmonary rehabilitation is delivering benefits in patients’ quality of life, in their ability to live more independently and in reducing admissions and re-admissions to hospital; there are improvements in sexual health services following redevelopment of the Chalmers Hospital; the Edinburgh Cardiac Centre has been designated as a national provider of trans-aortic transplant implementation; work with the Change Fund for Older People has seen significant investment into the community including joint community teams to support patients on discharge from hospital and additional carer support.

In addition to the many improvements in particular services, more people are also being seen and treated more rapidly than ever before.

While acknowledging these and many other changes, NHS Lothian is nonetheless committed to continuous improvement across all of our services and we have identified, through this draft plan, key areas where further development is needed to achieve the 2020 vision. We also recognise that, against a background of rising quality aspirations, major demographic challenges and resource constraints, delivering these changes will not be achieved without radical change, accelerating innovation and changing mindsets:-

- Our current systems are not geared to deliver the outcomes that matter most to people with multiple conditions - coordination and continuity of care, accessible information and advice and good communication with, and between, staff at all times;
• General medical services (GP practices) and community services are already stretched and face increasing workload demands from a growing and ageing population, together with the consequences of the policy shift from hospital to home based care;

• Waiting times for some patients are still too long and fall outwith the Scottish Government’s targets and guarantees;

• The number of people whose discharges from hospital to residential care in Edinburgh is delayed, is increasing rather than decreasing;

• We lack the capacity to treat all NHS patients requiring hospital treatment within NHS Lothian facilities and remain dependent on other providers, including the private sector;

• Many of our buildings are old and not fit for purpose;

• Our costs and spending are higher than our anticipated income;

• Some of our systems of working are outmoded, stressed and struggling to cope with today’s demands, let alone those of a larger and older population expected in the years ahead.

There is an increasing risk, unless we fundamentally change the ways we currently work and organise our services, that the quality of patient care will deteriorate and that we will fall short of meeting the needs and expectations of the people that we are here to serve.

**Lothian’s Future**

**Lothian population projections**

The National Records of Scotland projections for 2010 to 2025 show a 15% increase in total Lothian population from 836,711 to 965,007 :-

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2025</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Lothian</td>
<td>97,500</td>
<td>103,315</td>
<td>109,263</td>
<td>115,933</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>486,120</td>
<td>517,222</td>
<td>543,785</td>
<td>568,200</td>
</tr>
<tr>
<td>Midlothian</td>
<td>81,140</td>
<td>83,412</td>
<td>85,553</td>
<td>87,649</td>
</tr>
<tr>
<td>West Lothian</td>
<td>172,080</td>
<td>179,912</td>
<td>186,735</td>
<td>193,354</td>
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<tr>
<td>NHS Lothian</td>
<td>836,711</td>
<td>883,732</td>
<td>925,207</td>
<td>965,007</td>
</tr>
</tbody>
</table>


NHS Lothian's Vision for Services

Our vision is that services will be safe, effective and patient centred. We aim to deliver the right care, at the right time in the right place i.e. to be both caring and productive.

We will only achieve this by thinking and working differently and being more willing to innovate than we are currently.

<table>
<thead>
<tr>
<th>Current System</th>
<th>Future System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Geared towards acute / single condition</td>
<td>Designed around people with multiple conditions</td>
</tr>
<tr>
<td>Hospital - centred</td>
<td>Located in local communities and their assets</td>
</tr>
<tr>
<td>Doctor dependent</td>
<td>Multi-professional and team - based care</td>
</tr>
<tr>
<td>Episodic care</td>
<td>Continuous care and support when needed</td>
</tr>
<tr>
<td>Disjointed care</td>
<td>Coordinated and integrated health and care</td>
</tr>
<tr>
<td>Reactive care</td>
<td>Preventive and anticipatory care</td>
</tr>
<tr>
<td>Patient as passive recipient</td>
<td>Informed, empowered patients and clients</td>
</tr>
<tr>
<td>Self-care infrequent</td>
<td>Self-management / self-directed support</td>
</tr>
<tr>
<td>Carers undervalued</td>
<td>Carers are supported as full partners</td>
</tr>
<tr>
<td>Low tech</td>
<td>Technology enables choice and control</td>
</tr>
</tbody>
</table>

The Plan

This plan describes what NHS Lothian proposes to do over the coming decade to address these challenges and provide a high quality and sustainable healthcare system for the people of Lothian. The improvements and necessary changes will be delivered through new ways of working by our staff and independent contractors, as well as by working differently with our key partners through the four local authorities, the third sector and with patients and carers.

We will put patient safety, quality and transparency truly at the heart of what we do. This will include full involvement in national programmes including the Scottish Patient Safety Programme, Person Centred Care and Leading Better Care. We will undertake a programme of patient pathway redesign taking a whole system approach involving patients, staff and partners to transform our services around the needs of those who use them.

A wide range of propositions has been developed and will be debated and firmed up through consultation and engagement over the coming months; many of these are essential in order to deliver the 2020 Vision, including the following:-
NHS Lothian
Our Health, Our Care, Our Future

- a radical shift away from a traditional, incremental approach to development based on services and specialties to a patient-centred, whole-system, pathways approach, focussing much more explicitly on the needs and experiences of people who use NHS Lothian’s services;

- pursue the ten safety essentials and nine point of care priorities in the Scottish Patient Safety Programme, including infrastructure for building quality improvement capacity and capability, the strategic prioritisation of safety in acute care, the safe management of medicines and the prevention of falls

- improving services for the significant, and growing, number of people with multiple conditions, by developing and delivering Lothian’s multimorbidity action plan, in concert with the national programme to deliver excellence through:-
  - care planning and consultations that help people have control over their conditions, care and support and to achieve their personal outcomes;
  - integrated care and support that builds on community assets and promotes independence, wellbeing and resilience;
  - whole system pathways that are designed around multimorbidity and to reduce health inequalities;
  - providing visible leadership and using research, innovation and improvement approaches to improve the quality of care for people with multimorbidity;

- ending ‘silo working’, through closer interdependence and integration of community and hospital based services and across the public sector, through the establishment of Health and Social Care Partnerships in 2015 for Edinburgh, West Lothian, Midlothian and East Lothian, in accordance with Government legislation;

- improving access to primary care, through an increase in the number and capacity of general practices and community teams to meet increased demand arising from the population growth, extended life expectancy and the consequent increase in multi-morbidities;

- develop primary care premises, wherever possible, as integral parts of multipurpose facilities providing health, social care, voluntary and other community-based services; develop a Lothian-wide approach to sharing and benchmarking of primary care information at general practice and partnership level;

- urgently reducing to a maximum of two weeks by April 2015 and eventually eliminating altogether delays in patients’ discharge from hospitals;

- improving the care for older people by adapting and modernising the role of all current continuing care provision across Lothian to create a seamless spectrum of care from hospital based complex clinical care through to residential home care and care at home;
• improving arrangements for the residential care of older people, including assessment of the potential for the creation of a new ‘care village’ concept on the Royal Victoria Hospital and Liberton Hospital sites, replacing old and out of date hospital facilities with new purpose-built facilities, allowing social care to be provided in local communities, with NHS support provided on an inreach basis, as required; this is in line with recent policy developments following reviews of residential care and the future of NHS inpatient continuing care;

• developing a new East Lothian Community Hospital and adapting the use of Midlothian Community Hospital, to provide ‘step up’ and ‘step down’ care for older people, to prevent inappropriate admission to acute hospitals in Edinburgh and to provide a wide range of community services for people closer to home;

• continuing to develop community mental health services to better support people at home, and to modernise acute mental health services by redeveloping the Royal Edinburgh Hospital, with phase one expected to be complete by 2016;

• delivering a wide range of improvements in children’s services, including the construction of a replacement for the Royal Hospital for Sick Children on the Royal Infirmary of Edinburgh campus, with completion expected by 2017;

• creating a new, Regional Cancer Centre, fit for the 21st century, at the Western General Hospital, and integrating within a patient pathway designed to keep patients as close to home for treatment as possible;

• revising the model of emergency care at the Western General Hospital to improve the quality of service and the experience for patients and staff, and which is sustainable; to review acute receiving and assessment capacity at the Royal Infirmary of Edinburgh to meet the growing demand for more generalist services that can respond to the needs of older, frailer patients, often with multiple conditions and many with dementia;

• improving the quality and sustainability of specialist hospital services, through a new configuration of acute inpatient services at the Royal Infirmary of Edinburgh (RIE), Western General Hospital (WGH) and St John’s Hospital, Livingston (SJH), including the development of a specialist clinical neurosciences centre at RIE, reviewing the model for Dermatology care, concentrating inpatient orthopaedics and trauma at RIE, stroke services at either the RIE or WGH and ophthalmology at RIE, WGH or SJH.

• improving patient services by widening the scope and scale of operative procedures undertaken on a day case basis and developing additional day surgery facilities at WGH and/or SJH;
• radically reviewing the future requirement for **outpatient services** and introducing more convenient, safe and innovative alternatives to routine outpatient attendance and follow-up;

• developing our human resources strategy to ensure a **capable, integrated and sustainable workforce**, within a healthy organisational culture which will support high quality health and social care;

• rebalancing investment between acute hospitals and primary and community services, as well as **urgent action on areas for disinvestment**, recognising the need to improve service quality while generating up to £40m cash-releasing savings each year;

• driving an innovative and radical approach to creating opportunities for **improving the value** of all (not just new) investment in facilities and services, identifying those which do not contribute to the health of the population, in order to free up the funds and capacity to deliver a higher quality, more modern and more sustainable health and care service in line with this plan.

This is a consultation document and, as such, it sets a 'direction of travel' for NHS Lothian in the years ahead. Firm commitments and priorities will not be determined without further detailed engagement with the public, with our staff, with GPs and other independent practitioners and with our many other partners.

It is essential that the plan supports innovative and modern clinical practice in ways that make it easier for clinical and other staff to provide the best care to patients. It is equally important that all clinicians and managers engage positively with the planning process and commit to supporting the outcome. This will only be achieved through facilitative management and effective clinical leadership which do more to break down the barriers to the best care and focus on developing new ways of working through integrating, not just health and social care, but primary, community and hospital care to deliver a seamless patient’s journey.

A definitive strategic plan, which firms up the propositions and detail around the actions, timelines and implications for patients, staff and funding will not be presented to the Health Board for approval before the autumn of 2014, reflecting the outcome – and importance - of an extensive consultation and engagement process.
1. **Outcomes to be achieved**

   ‘Our Health, Our Future’

   In 2013, Lothian NHS Board approved a Strategic Clinical Framework which identified six aims to ensure we can deliver safe, effective and person-centred health and social care:

   1. Prioritise prevention, reduce inequalities and promote longer healthier lives for all
   2. Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
   3. Ensure that care is evidence-based, incorporates best practice, fosters innovation and achieves safe, seamless and sustainable care pathways for patients
   4. Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
   5. Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families
   6. Use the resources we have – skilled people, technology, buildings and equipment - efficiently and effectively

   ‘A Route Map to the 2020 Vision for Health and Social Care’

   Also in 2013, the Scottish Government set out the triple aims for achieving the 2020 Vision and these have been used to structure this plan. They are:-

   - **Further improving the quality of the care** we provide with a particular focus on:
     - increasing the role of primary care
     - integrating health and social care
     - accelerating our programme to improve safety in all healthcare environments
     - improving the way we deliver unscheduled and emergency care
     - people-powered health and care services
     - improving our approach to supporting and treating people who have multiple and chronic illnesses

   - **Improving the health of the population** with a particular focus on:-
     - early years
     - reducing health inequalities
     - preventative measures on alcohol, tobacco, dental health, physical activity and early detection of cancer

   - **Securing the value and financial sustainability of the health and care services** we provide:-

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SP draft V7.2 190314
- establish a vision for the health and social care workforce for 2020, and setting out a clear plan of actions which will have an immediate effect
- increase our investment in new innovations which both increase quality of care, and reduce costs and simultaneously provide growth in the Scottish economy
- increase efficiency and productivity through more effective use of unified approaches coupled with local solutions and decision making where appropriate

The NHS Lothian outcomes and measurement framework is being developed to ensure that we monitor progress against these aims and ambitions.

2. The Challenges

Demography, Inequalities and Ill Health

Health services in Lothian have been designed or have evolved historically to serve much smaller numbers of people and a different age profile than is now predicted.

While the overall health of people is improving, the incidence and prevalence of some diseases is increasing; also, rates of health improvement are lower in poorer parts of our communities. While health is improving overall, with fewer deaths, for example, from coronary heart disease and stroke, there remains a significant difference in the rate of premature death from heart disease between the richest and the poorest sections of our community:-
Much of the attention of the NHS is spent on responding to the needs of people when they are unwell or unable to cope on their own. This will always be a major mission of the health and care services, but needs to be increasingly balanced by proactive interventions by people themselves, supported as necessary by health and care professionals, to avoid or delay the onset of illness. People also expect to be able to manage their own health conditions themselves to a greater degree than ever before and the health and care services must ensure that information and knowledge, along with specialist advice and equipment is made accessible to support people effectively in their own self-care.

In Scotland there are significant inequalities in health between people who are socially and economically well off, and those who are socially disadvantaged. In Lothian this means, for example, that people living in the most affluent communities in Lothian can expect to live 21 years longer than people living in the most deprived communities. People living in the most deprived communities also have poorer physical and mental health throughout their lives. However, health inequalities are not related to socio-economic status alone. People who are disadvantaged by race, disability, gender and other factors also have poorer health.

A common approach to tackling health inequalities is to target support and interventions to the geographical areas identified as being deprived, commonly the most deprived 15% of areas measured by the Scottish Index of Multiple Deprivation (SIMD). There are several reasons why this approach cannot reduce health inequalities on its own, not least because
many disadvantaged people do not live in these deprived areas – only about half of people who are income deprived live in the 15% most deprived areas by SIMD. So if an intervention is provided only to people living in targeted areas, other equally needy people will miss out.

**Multimorbidity**

The risk of people suffering from a complex mix of long term conditions (multimorbidity) increases with age and lower socioeconomic status. **The overall prevalence of cancer is expected to rise by 8% every five years, and the prevalence of dementia to increase by up to 70% in the next twenty years.** New ways need to be found of tackling the causes of issues such as obesity, poor diet and limited physical activity, smoking and excessive consumption of alcohol, which are closely associated with long term conditions such as cardiovascular disease and diabetes.

We know that people living in deprived communities develop multimorbidity ten to fifteen years earlier than the least deprived. We also know that, while most over-65s have two or more conditions, and most 75+ have three or more conditions, multimorbidity is not just experienced by older people. There are more people in total aged under sixty-five with multimorbidity than over sixty-five.

New and innovative ways need to be found – and quickly - of reducing ill health and, following its onset, of treating and supporting people to be able to enjoy an acceptable quality of life.

*Average number of conditions, by age group*
Health Service Demand

The National Records of Scotland projections for 2010 to 2025 show a 15% increase in total Lothian population from 836,711 to 965,007. East Lothian’s population increases by 19%, Edinburgh by 18%, West Lothian by 12% and Midlothian by 8% over this period. Overall, the Lothian population increases by 15%, or 128,296 people.

The over 65s represent 18.2% (up from 14.8% in 2010) of the total population in 2025 and account for 40% of the total increase of 128,296 between 2010 and 2025. It should be noted that the proportion of young people stays constant over the period.

**Lothian population age projections, 2010-2025**

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<thead>
<tr>
<th></th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
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<td>NHS Lothian</td>
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<tr>
<td>0-15</td>
<td>16.9</td>
<td>16.7</td>
<td>17.0</td>
<td>16.7</td>
<td>17.3</td>
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<td>68.3</td>
<td>67.4</td>
<td>66.2</td>
<td>65.2</td>
<td>61.4</td>
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<tr>
<td>65-74</td>
<td>7.8</td>
<td>8.6</td>
<td>9.0</td>
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<td>10.8</td>
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<td>5.1</td>
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<td>6.2</td>
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<tr>
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<td>1.9</td>
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<td>2.4</td>
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Growth in the population and rising demand for services in recent years has not been matched by equivalent growth in the numbers of staff, largely due to improvements in efficient working and acceptance of more intensive working patterns. However, particular pressures on GP and practice staffing and on health visiting and district nursing need to be addressed early in the life of this plan, if the rising expectations on primary and community based services to support more patients and more complex conditions at home or in homely settings is to be realised.

As people get older they are also more likely to be admitted into hospital. In 2012/13 the rate of all emergency bed days for patients aged 75+ (per 1000 patients was 5,220. This is the equivalent of 5.22 bed days used by each person in Lothian aged 75+.

Some admissions are avoidable and there are many established services and pilots in place across Lothian to reduce the number of avoidable admission by increasing the capacity and effectiveness of community services to support people at home. These include care homes, home care and district nursing services which work alongside shorter term ‘intermediate’ services such as reablement, rehabilitation and step down services in hospitals and care homes. Activity in all of these services has grown or remained stable throughout 2013. There have however been particular issues in Edinburgh due to concerns about quality of care in care homes, which has resulted in a suspension of admissions to a number of larger care homes, approximately 15% of the capacity in Edinburgh. A number of actions are currently underway to mitigate the impact of this on the patient population, but more is required.
The Rate of Emergency Admission Bed Days for patients aged 75+ is decreasing in Lothian, but is higher than the Scottish average. To be able to cope with future demands within the current beds, the admission rate would need to reduce very significantly, as illustrated below:

The definitive version of this plan will be informed by Scottish Government policy, both established and emerging, including the modernisation of the system of care for people who would traditionally have looked to either NHS continuing care or Local Authority or independent residential care provision for ongoing support, in pursuit of the long term policy goal to shift the balance of care from institutional settings to more homely settings in the community. Recent reports of the Residential Care Task Force and Continuing Healthcare Review offer a vision of care which has been translated by NHS Lothian into innovative propositions in this draft plan, including the creation of “care villages” on the Liberton and Royal Victoria hospital sites.

Tighter Finances

The economic outlook for health, local government and the voluntary sector remains extremely tight and the global economic downturn means that real terms growth in public spending is not expected to return to the level of 2009/10 until 2025, so we have to deliver better health and healthcare while making best use of limited public resources.
For NHS Lothian, **this means having to find cash releasing savings of around £40M in each of the next three years**, even before consideration of the investment required to deliver much of this plan. Restrictions in available growth funding and savings targets mean that the investment necessary to support more people appropriately at home or in homely, rather than hospital surroundings, will require a rebalancing of investment from hospital to primary and community services. Action will also be required on areas for disinvestment - the elimination of tasks and actions that consume staff time and other resources without delivering benefit for patients, freeing up those resources to help deliver the priorities in this plan.

On current funding assumptions, **there is no capacity for discretionary investment until at least 2017**. Therefore, the only way to support the levels of investment required to deliver this plan is to generate funding by freeing up existing resources through much more efficient working, redesign and through disinvestment from services which are no longer appropriate or fit for a modern high quality health system in the 21st century. This is going to require renewed levels of commitment and effective leadership from clinicians and senior managers working even more closely together.

**There is a duty on the Health Board and its partners to ensure that it public money is spent in ways which deliver the greatest health benefit and the highest quality of care to the population.** It would be irresponsible, and not in the public’s best interest, to continue to spend on the things that we have always done, without maximising the benefits in terms of healthcare. We will therefore review not only decisions about where to invest in new services, but also how we spend our money today on current premises, systems, medicines and...
practices to ensure that they are effective and adding value to the outcomes in this plan. Premises which are no longer fit for purpose will be declared surplus to requirements, subject to disposal and the gains from sale reinvested in the delivery of modern services and other changes set out in this plan.

It is important to ensure that any decisions about where to invest or disinvest public funds are taken in a properly considered way. Decisions on priorities and choices will therefore be determined through a transparent process of engagement which will require clinical leadership and will include weighing up of various dimensions of quality, consistent with NHS and Scottish Government policy as objectively as possible. The criteria will include equity, efficiency, effectiveness, safety, person-centredness and timeliness.

3. Developing Lothian’s Health Services

Developing Primary and Community Services

The overarching aims of Primary and Community Services are to be able to meet public expectations by ensuring timely consultation with an appropriate health care professional, involve the patient and carer in decision making about their healthcare choices, deliver access to safe and effective treatment, give clear and accessible information and experience an efficient, approachable and responsive service. *Primary Care and Community Services provide the first point of contact between an individual and a healthcare professional in more than 90% of contacts with health care services.*

Within primary care there are four practitioner services; medical, dental, pharmaceutical and optical. These practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Contracts are negotiated on a national basis, however NHS Boards have some scope to negotiate local contracts or employ practitioners directly as salaried NHS employees.

Each year, there are over 5 million contacts with general medical practices, 1.5 million contacts with community services and 136,000 contacts with the Lothian Unscheduled Care Service (Out of Hours General Medical Service). There are 127 GP practices in Lothian (excluding the challenging behaviour GP practice) supported by a total of 1,601 general practitioners. The Primary Care and Community Services healthcare team consists of general medical practitioners, practice nurses, managers and reception staff working together with Health Visitors, District Nurses and Health Care Assistants, Community Midwives, Phlebotomists, Community Psychiatric Nurses and Allied Health Care Professionals.

In order to support the shift in the balance of care from secondary to primary and community care services at the same time as providing for the growth in numbers and the ageing in Lothian’s population, and meet all the aspirations of a sustainable and high quality service
(e.g. with patients waiting no longer than 48 hours for a non-urgent appointment to see a GP or practice nurse), we need to increase the capacity of our primary care and community services.

The rate of population growth and its impact on primary care is described in the diagram below:-

The propositions in this draft plan are designed to strengthen the capacity and capability of locally based teams in primary, community and social care. This will enable them to better support patients and to deliver the kind of anticipatory care and interventions which will maintain people at home and so avoid unnecessary emergency admission to an acute hospital, with all the inevitable stress and inconvenience that that entails. They also recognise the need for appropriate input to a residential sector focused on prevention and rehabilitation (step-up / step-down care) and a more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs.

**Developing Acute Hospital Services**

Acute hospitals provide a focus for specialist secondary and tertiary care, bringing together highly specialised expertise, with specially designed equipment and premises operating 24 hours a day, 7 days a week, assessing, diagnosing and treating patients. Their main role is focused around the clinical assessment and interventions required to return people to a state of health where they can return home, or to a more homely setting, as soon as possible and
without unnecessary delay. Same-day treatment, without the need for an overnight stay in hospital, is the norm for an increasing number of conditions and planned procedures and should always be preferable, where it is safe to do so. Where the specialist, secondary or tertiary care services uniquely available within an acute hospital are not required, patients should not have to go there and more appropriate assessment, treatment and care arrangements should be provided at home or in the community.

So far as hospital services in Lothian are concerned, we see almost 1 million outpatients, carry out around 100,000 planned surgical interventions and more than 240,000 people attend our accident and emergency departments every year. NHS Lothian hospitals admitted more than 100,000 inpatients last year. The following graphs show the projected activity changes based on population growth, assuming that care delivery follows current trends and remains unchanged:

*Projections for A&E attendances, based on population changes*
Projections for Unplanned Inpatient Admissions, based on population changes
Increasingly, acute hospitals are not simply responding to the acute health needs of patients, but are providing an essential element of specialist support to frail, older people with a complex range of conditions on a continuous basis as part of an integrated pathway of care. These arrangements need to be further strengthened by hospital-based physicians and other specialists working more closely with GP and community based clinicians and care professionals to provide expertise and support to patients with increasingly complex conditions living at home or in care homes in the community. This will involve hospital based clinicians working more on an ‘outreach’ basis to patients at home, and GPs and other community based clinicians working on an ‘inreach’ basis to inform appropriate care in hospital when this is unavoidable.

Although we remain fully committed to shifting the balance of care from acute hospital to care at home or in the community where this is appropriate, we also need to deliver the right capacity in the hospital system which is able to efficiently meet the acute needs of the population and to better respond to the growing demands of an ageing population.
Unscheduled care

Key elements of our strategic approach to Unscheduled Care include:-

- Providing alternatives to emergency care in hospitals;
- Improving emergency care access and treatment across all main hospitals;
- Enhancing joint working with primary, community and social care and other agencies to improve patient pathways of care;
- Reducing delayed discharges

There is also considerable disparity between emergency hospital admission rates of people living in the poorest and the wealthiest areas of Lothian:-

![Bar chart showing emergency admissions rates by deprivation level]

In the short term, there is a real issue about frail older people with complex care needs being accommodated as inpatients in acute hospitals, having been admitted to hospital as emergencies, sometimes because of the lack of more appropriate arrangements, or remaining in hospital following assessment and treatment, when no longer clinically necessary, but again due to a lack of community support to allow them to return home. While the acute hospital is often seen as a ‘place of safety’ for frail patients in need of urgent care, particularly out of hours, alternative arrangements which are more appropriate and which would allow patients to remain at home, or at least to stay in more homely surroundings with appropriate healthcare support determined by a properly designed pathway of care, are being developed, but too slowly.

While delays in patients being discharged from hospital are reducing across Scotland, the position in Lothian is not improving as rapidly. This plan addresses particular challenges due to lack of community care capacity in the City of Edinburgh and East Lothian. Successful collaboration with local authority partners to improve our performance on this will make a
significant impact on improving both the lives of patients and on the more efficient use of hospital resources.

Currently the unscheduled care system in NHS Lothian is not meeting the demand being placed on it, particularly in its accident and emergency departments and its minor injury units and is not helped by the unique, hybrid arrangements for acute receiving which have developed in recent years at The Western General Hospital. This means that too many people are waiting longer than they should i.e. longer than current targets, before being seen, treated, transferred or discharged.

The current situation, characterised by pressures on services and failure to deliver best care, is far from ideal and can also compromise the ability of staff to deliver high quality care.

Scheduled care

Many people continue to wait too long for their hospital appointment, and there are disparate arrangements across the specialties for additional operating and outpatient capacity, both within NHS Lothian hospitals and across the wider NHS and private sector. This is being urgently addressed, with immediate but sustainable actions to deliver reductions in waiting times that are acceptable to patients and that meet and better national targets.

Key elements of our strategic approach to scheduled care include:-

- Improve capacity for patients to be admitted on a day case basis and for inpatient theatre provision
- Deliver benchmarked performance to reduce unnecessary reliance on inpatient beds
- Reduce unnecessary reliance on out of hours junior doctors
- Patients admitted on the day of surgery, as the norm
- Enhanced recovery, as norm
- Extended working day/extended working week

Careful attention needs to be given to issues affecting the quality and efficiency of patient services, especially given that specialist, acute hospital services are relatively scarce and extremely expensive. Increasing demand on the current pattern and organisation of acute hospital services generates unacceptable waiting times and delays; without radical change and targeted investment in ‘upstream’ anticipatory, primary and social care, demographic and other pressures will create unsustainable demand well before the expiry of this plan. Radical action will therefore be required to deliver the Scottish Government’s 2020 vision.

Such radical actions need to include consideration of:-

- more flexible working e.g. evenings and weekends, to make best use of staffing and facilities and meet patient needs for planned outpatient and elective treatment or care;
- the current state and fitness for purpose of our buildings and estate to improve patient and staff safety and to reduce the incidence of healthcare associated infections;
- how services can best be organised on each of our acute hospital sites to improve service quality and sustainability to meet current and future demand, taking account of patient needs and efficient use of resources.

**The Estate**

NHS Lothian has too many buildings and more than it needs to provide a modern and effective health service for the population. A number of these are underused, unoccupied or in the wrong place. In reducing the overall number, we will ensure that the buildings retained are fit for purpose and, along with any new developments, meet future demand and are suitable for the delivery of high quality healthcare in the 21st century. This needs to include the modernisation of supporting infrastructure.

Work is underway to review in detail the demand and capacity of every hospital specialty, in light of population and any known technological changes during the period of this plan. In addition to considering the best contemporary models of patient care, capacity constraints on the RIE site and the age and condition profile of buildings on the WGH and other sites are being taken into account in determining the best location for patient services in any reconfiguration. These have been mapped to site plans according to current and proposed specialty configurations.

We have identified a number of our property assets as “stakes in the ground” and our masterplanning work is initially concentrated on these four sites:
- Royal Infirmary of Edinburgh – the re-provision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences being part of the Edinburgh BioQuarter are future reference points;
- St John’s Hospital in Livingston;
- Western General Hospital – a reprovision of the Regional Cancer Centre is a major development requirement;
- Royal Edinburgh Hospital Campus – the phased redevelopment is already being planned.
At this stage, NHS Lothian has developed the site masterplans as an in house technical assessment of the physical site assets looking at the condition of the buildings and infrastructure. The potential to develop accommodation on each site, through demolitions and extensions has been identified.

This will support consideration of options for future development or reprovision of services and inform individual business cases. Only the masterplan for the Royal Edinburgh Hospital Campus has been submitted for Town Planning consent at this point. This application supports the Business Case for the initial phase of Mental Health reprovision on the Campus in fit for purpose accommodation, linked to a longer term redevelopment of the whole site. There are a number of underlying requirements and developments that influence site specific masterplans:

A number of supporting plans are also under development to provide a similar framework or address the future planning developments including the integration requirements for Health and Social Care. These include:

- Lauriston Campus which consists of the Lauriston Building, Chalmers Centre, and the Princess Alexandria Eye Pavilion
- Royal Victoria Hospital site which has the opportunity for an innovative mix of health and social care facilities
- East Lothian Community Hospital which includes the related hospital provisions in East Lothian
- Liberton Hospital where the adjoining land is subject to redevelopment proposals as the Scottish National Blood Transfusion Service relocates to a new facility in 2017.
- Primary care premises requirements are being reviewed, across NHS Lothian, to establish priorities for future investment and support to this part of the wider healthcare estate.

As part of the financial planning for the next five years, we are assessing the capital plan implications of the masterplans in line with future programmes of investment to address backlog maintenance and anticipated service demands. As such the masterplans are seen as a longer term framework, within which individual service projects can be developed.

4. Planning Approach

Transforming our services - Putting patients at the centre of our plans

For a long time, and in common with much of the rest of the UK, we have planned the way we deliver health services separately in different parts of our system (primary care, acute care, NHS, local councils). We have also tended to plan around buildings, or around individual services.

What is proposed here is a radical shift away from this ‘traditional’ approach to a patient-centred, whole-system approach, focussing much more explicitly on the needs of people who use NHS Lothian’s services.

This plan is predicated on the need for radical redesign to deliver sustainable improvements in health and care services in Lothian. A central tenet of service redesign is to focus on the patients’ journey and experience, to help identify where service improvements are necessary and to involve a wide range of service users and providers in analysing and redesigning patient pathways.

Using intelligence and evidence, we have identified representative patients with varying degrees of care needs: we have called these patients Callum, Hannah, Scott and Sophie. These patients are not representative of all NHS Lothian patients, but are examples to illustrate pathways of care and to help us understand a range of typical patients’ care needs, how their care needs are currently being met and to agree how these can be met more effectively and efficiently in radically different ways. This is being conducted through a designed and managed process of engagement during 2014 and will inform large and significant parts of the final plan.

Some urgent redesign work is currently ongoing and will continue, in order to meet the most pressing and immediate challenges that we face. However, alongside that, a number of new
work streams will be initiated with the aim of redesigning healthcare across whole pathways. These need to use innovative methods which will lead to rapid cycle change and review.

**Who are Callum, Hannah, Scott and Sophie?**

We have identified four names to represent four groups of patients. These groups have been chosen because their current use of health services suggests that those services could be provided in a better way and because these patients’ pathways impact upon the majority of healthcare that is currently delivered across NHS Lothian.

The four groups are represented by Callum, Hannah, Scott and Sophie. Their current pattern of use of health services has been summarised in a risk prediction tool called SPARRA (Scottish Patients at Risk of Readmission and Admission). The tool predicts the risk of emergency admission in the following year for each patient in Scotland. It looks at previous use of health services by analysing activity such as number of drugs prescribed by GPs, A&E attendances, hospital admissions and out-patient appointments.

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**Callum**

Callum represents an adult patient between 16 to 55 years of age. The group he represents is likely to have mental health problems such as anxiety or depression, a history of alcohol and drug misuse and typically presents frequently to A&E.

Approximately 41,000 or 5% of people in Lothian are in this patient group. They account for 11% of the adult patients who experience at least one emergency admission each year.

As well as being frequent A&E attenders, patients in this group are likely to make use of primary care, community mental health services, specialist drug and alcohol services and a range of local authority and voluntary sector services. Patients represented by Callum are also more likely to be involved with the criminal justice system.

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**Hannah**

Hannah represents an adult patient aged between 16 and 74. The group she represents is likely to have one or more long term conditions such as diabetes, COPD and heart failure.

Approximately 440,000 or 49% of people in Lothian are in this patient group and they account for 56% of the adult patients who experience at least one emergency admission each year.

Depending on the number and type of long term conditions each patient has, and how long they have had the conditions, these patients are likely to make use of primary care and specialist community care services, attend A&E, be admitted as an emergency and receive a range of local authority and voluntary sector services.
Scott

Scott represents an adult patient aged over 74. The group he represents is likely to be frail and may have a range of long term conditions or may not have any specific diagnosis.

Approximately 59,000 or 7% of people in Lothian are in this patient group and they account for 33% of the adult patients who experience at least one emergency admission each year.

Patients in this group are likely to make use of primary care and specialist community care services, attend A&E, be admitted as an emergency and receive a range of local authority and voluntary sector services

Sophie

Sophie represents a child patient aged under 16. The group she represents may have at least one long term condition.

Approximately 103,000 or 11% of people in Lothian are in this patient group.

Patients in this group are likely to make use of primary care and specialist community care services, attend A&E, be admitted as an emergency and receive a range of local authority and voluntary sector services

What happens now and how could we give Callum, Hannah, Scott and Sophie better care?

The first step in the redesign process will be for the ‘Hannah’ work stream to map the care that Hannah receives. We will do this using data, the experience of people like Hannah who use our services and the experience of those who provide care and treatment for people like Hannah. The same will take place for the ‘Callum’, ‘Scott’ and ‘Sophie’ work streams.

Having identified what currently happens, we will work with patients, carers, staff, GPs, social care and 3rd sector colleagues to come up with a better way of doing things, in line with our aims and ambitions. Once we have agreed a better way of doing things, we will decide how best to deliver this in terms of services, buildings, staff, IT and the other infrastructure needed.

This is expected to lead to quite different working patterns and arrangements for clinical and other staff e.g. making the expertise currently located exclusively in hospitals more accessible to people in their own homes, or providing some services available at different times of the day or week, as we better match our services to patients' needs.
5. **The Draft Plan**

Many of the propositions in the final version of NHS Lothian’s Strategic Plan will be informed by the radical redesign of patient pathways described above, as well as by the wider consultation and engagement process throughout 2014 with the people of Lothian, with staff and with those organisations in the public, private and third sectors with an interest in the work of NHS Lothian. **This plan must, therefore, be regarded as a dynamic document, rather than a definitive answer to all of the challenges and opportunities of the coming decade.**

However, we need to be clear about the direction of travel and this section expands on the main strategic areas for action that NHS Lothian intends to pursue during the plan period, in order to deliver the outcomes listed in section 1 above. Some propositions are reasonably clear and firm, while others are less clear and will require further debate and investigation and, in some case, detailed option appraisal to firm up. The propositions are not yet listed in order of priority, although indicative timescales will be shown on the final plan.

It is intended that the Strategic Plan will be finalised in the Autumn of 2014, in order to set a context for consultation on the four Integration Plans and to inform the development of each of the Health and Social Care Partnership Board’s Strategic commissioning Plans, later in 2014 and into 2015.

Under each of the three aims, are listed short term **ST** (years 1-3) and longer term **LT** (years 4-10) actions. A detailed schedule is being developed to include estimates of headline resource implications, in terms of staffing, capital and buildings, revenue funding and enabling technologies.

5.1 **Improving the Quality of Care**

**Developing Person-centred Primary and Community Services**

**Propositions**

5.1.1 To **engage people** in making decisions about their care taking into account their preferences, values and coping skills, to improve quality and reduce ‘waste’ associated with unattended appointments, unused medication or unnecessary investigations **ST**

5.1.2 To develop Lothian’s **multimorbidity action plan**, alongside the national programme to deliver excellence through:-
- care planning and consultations that help people have control over their conditions, care and support and to achieve their personal outcomes;
- integrated care and support that builds on community assets and promotes independence, wellbeing and resilience;
- whole system pathways that are designed around multimorbidity and to reduce health inequalities;
- providing visible leadership and using research, innovation and improvement approaches to improve the quality of care for people with multimorbidity. **ST/LT**

5.1.3 To develop the business case during 2014 to enhance the community-based model of services for people requiring **palliative care**, maximising the time spent in people’s preferred place of care, minimising emergency admissions where these can be avoided, and supporting choice of place of death where this can be realistically achieved; all in accordance with the NHS Lothian Palliative Care Strategy and proposed 3-year redesign/delivery programme **ST**

5.1.4 To transform the role of primary care through active participation in the Scottish Government’s **Primary Care Modernisation** Programme 2013-2020, aimed at better integrating primary and secondary care as well as health, social and other community care; develop a more outcomes-focused GP contract linked to opportunities for an expanded role of other healthcare professionals and assets within local communities **LT**

5.1.5 To deliver on the new GP contract 2014/15, including the new QOF ‘Quality and Safety Domain’ relating to integration liaison, review of access, continuous quality improvement and anticipatory care plans **ST**

5.1.6 To fully explore the potential of the GP contract enhanced service model to better support integrated pathways of care, including extending the scope of **anticipatory care** to cover frail older patients living in their own homes, ensuring that a lead practice is identified for all Care Homes and that there is a consistent approach to **polypharmacy** medication reviews in conjunction with community pharmacists. **ST**

5.1.7 To review General Practitioner numbers and workforce support, locations and suitability of premises used by **GP practices**; consider additional requirements in the light of population and demographic changes as well as the growing need to support older people with complex needs living at home with chronic disease and complex multi morbidity; the resource shift required to support the transformation of primary care will be assessed as work progresses across a number of work streams such as the redesign of pathways of care, provision of local ‘step up’ and ‘step down’ beds, expansion of primary care premises and development of primary care workforce plans. **ST/LT**

5.1.8 To review **GP practice premises** requirements, recognising that 38 practices (some 30%) have been identified as requiring premises solutions to meet current capacity, compliance or quality issues and to address the future population growth **ST/LT**

5.1.9 To develop specific propositions to support the **shift in the balance of care** and workload from hospitals to primary care across a range of services including near-patient testing, enhanced diabetes services, community speciality nursing and the consequences of outpatient review; improve the sharing and rapid transfer of **information** between primary and secondary care services to better coordinate care. **ST**
5.1.10 To accelerate the development of services for people at risk and suffering from **diabetes**, which impairs the quality and length of people’s lives as well as accounting for a very significant and fast-growing proportion of healthcare costs **ST**

5.1.11 In light of significant growth in the numbers of people who will have **dementia**, develop the role of dementia link workers, complete patient registration and support skills training for acute and other staff to better manage pathways of care for people with dementia **ST**

5.1.12 To develop a strategy (including e-strategy) and fully integrated pathways of care for patients with **neurological conditions**, head injury, sensory impairment, epilepsy, Huntington’s and other rare conditions requiring physical and complex care **ST/LT**

5.1.13 To improve **dental and oral health** and strengthen dental services, through increasing registration for those aged up to 2 years, improving access to specialist dental services by integrating and aligning the public dental service with the Edinburgh Dental Institute, continuing to deliver Scottish Government funded prevention programmes and raise awareness of signs and symptoms of oral cancer particularly amongst younger people, ensuring access to specialist services for oral cancer **ST/LT**

5.1.14 To implement the recommendations in “Prescription for Excellence” published in 2013 which outlines a vision and action plan for the delivery of **pharmacy services** across Scotland to support people living in the community, receiving care at home, living in care homes and those receiving hospital / specialist hospital care at home; establish a framework for joint working and information sharing between primary and secondary care pharmacists and other members of the multidisciplinary team. **ST/LT**

5.1.15 To recognise **optometry services** as the first point of contact for individuals who are experiencing eye problems; to implement legislative and pathway changes which support improved joint working and a shift in the balance of care, through e.g. independent prescribing rights for optometrists and optometrist direct referral to hospital ophthalmology services. **ST/LT**

5.1.16 To improve care and reduce acute hospital emergency admissions and readmissions by rapidly developing suitable alternatives delivered in the community. By the end of 2014, we will have robust models of integrated care and demand management within the Health and Social Care Partnerships’ Strategic Commissioning Plans, including integrated assessment and rehabilitation services for frail older people (e.g. REACT/COMPASS/ELSIE/MIDcare). **ST**

5.1.17 To urgently reduce to a maximum of two weeks by April 2015 and eventually eliminate altogether **delays in patients’ discharge** from hospitals; through joint modelling, develop a mix of care home and home support packages to facilitate rapid discharge whenever clinically appropriate; explore innovative models of care home and homecare commissioning to address particular market conditions in Edinburgh; expand provision of community-based reablement capacity, step up/step down beds in care homes, a Discharge Hub on each hospital site and increase challenging behaviour capacity in care homes **ST**
5.1.18 To improve the care for older people by adapting and modernising the role and functioning of NHS Lothian inpatient continuing care so that NHS beds are focused on the care of people with the most complex needs, in line with Scottish Government guidance; to review the future role for all current continuing care provision across Lothian to create a seamless spectrum of care from Hospital Based Complex Clinical Care through to residential home care and care at home ST

5.1.19 To develop the concept of a ‘care village’ on the Royal Victoria Hospital and Liberton Hospital sites, remodelling or replacing old and out of date hospital facilities with new purpose-designed residential care facilities for older people, including those with a range of complex conditions, strengthening social care provision in local communities, with NHS support provided on an inreach basis; this could involve replacing existing NHS continuing care hospital systems and buildings with a range of sheltered housing and residential care home facilities for ongoing care and support, able to respond to changing needs. ST/LT

5.1.20 To continue to develop community mental health services to better support people at home, and to modernise acute mental health services by redeveloping the Royal Edinburgh Hospital, with phase one expected to be complete by 2016, in accordance with the joint strategy “A Sense of Belonging” ST/LT

5.1.21 To improve the quality and best ways of delivering care in the future, develop jointly with local authority partners, a community and residential support service for people with learning disability, autism spectrum disorder and challenging behaviour; to shift to integrated models of community rehabilitation, enabling residential provision to be modernised and inpatient capacity reduced and including a 12 space development for those with the most complex and challenging care needs in the community LT

5.1.22 To develop a new East Lothian Community Hospital, replacing Roodlands and Herdmanflat Hospitals, with modern accommodation and capacity to treat more East Lothian residents locally, including the repatriation of some services currently provided elsewhere, and to provide ‘step up’ and ‘step down’ care for older people, to prevent inappropriate admission to and facilitate earlier discharge from acute hospitals in Edinburgh ST/LT

5.1.23 To adapt the use of Midlothian Community Hospital to maximise its potential to meet the health care needs of the Midlothian population. This will include the provision of ‘step up’ and ‘step down’ care for older people, to prevent inappropriate admission to acute hospitals in Edinburgh and facilitate early discharge. This redesign will entail the repatriation of some services to East Lothian ST/LT

5.1.24 To review the operation and design of the Lothian Unscheduled Care Service (LUCS) in the face of increasing numbers of patients with complex needs being seen out of hours, the increase in direct access to out of hours primary care advice through our professional to professional telephone line, (a 25% increase since 2010/11) and the additional demands out of hours, over and above the normal core work e.g. public health ST
Developing Person-centred Hospital Services

Propositions - Unscheduled care

5.1.25 To urgently develop an integrated care pathway, including a new model of ambulatory care as well as rapid assessment beds and diagnostics availability designed to avoid delays in patient flow so that more than 80% of patients can be discharged home, or to specialist rehabilitation/step down facility off-site within 48-hours ST

5.1.26 To urgently explore the considerable potential to improve patient outcomes in stroke services, including options to concentrate inpatient stroke provision at either RIE or WGH and at SJH. ST

5.1.27 To review the model of emergency care at the Western General Hospital with arrangements for medical receiving which improve care, improves the experience of patients and staff and which is sustainable; to similarly review provision for surgical admission of patients to WGH-based surgical and cancer specialties; to work with senior clinical and managerial staff at the hospital, general practitioners and social work partners to look closely at the model of care offered by the hospital and to redesign the way in which patients are received, assessed, admitted and discharged ST

5.1.28 To expand acute receiving and assessment capacity at the Royal Infirmary of Edinburgh to meet the growing demand for more generalist services that can respond to the needs of older, frailer patients, often with multiple conditions and many with dementia; ST

5.1.29 To explore opportunities to improve hospital throughput and avoid inappropriate ‘boarding-out’ of patients, by various means including extending specialist capacity to seven day working, to facilitate more rapid and appropriate assessment and discharge, including conversion of patients presenting for unscheduled, out of hours care to scheduled, in hours care. ST

5.1.30 To realise the quality and clinical safety benefits of re-locating the Royal Hospital for Sick Children to purpose-built accommodation on the RIE site, co-located with adult specialist services, with direct links between maternity and paediatrics supporting mothers and new born babies; and of the transfer of the department of clinical neurosciences to RIE linking with major A&E trauma unit and other key trauma specialties.ST/LT

5.1.31 To implement the Lothian High Demand Service, an innovative service model, which aims to bring individualised patient-centred care to the 1,500 to 2,000 patients at highest risk of emergency hospital admission; to work with each patient to draw up their own, personal anticipatory care plan to ensure that all of the patient’s care needs are met in a way that is coordinated, consistent and effective ST
Propositions - Scheduled Care

5.1.32 To pursue the ten safety essentials and nine point of care priorities in the Scottish Patient Safety Programme, including the two strategic priorities in acute care, i.e. infrastructure for building quality improvement capacity and capability and the strategic prioritisation of safety; two major areas for further attention are the safe management of medicines and the prevention of patient falls ST/LT

5.1.33 To continue to develop demand and capacity models for all key specialties to deliver sustainable compliance with Government waiting time targets, including orthopaedics, ophthalmology, rheumatology, urology and general surgery ST

5.1.34 To review efficiency and productivity of current arrangements, including pathways, booking processes, job planning and opportunities for skills substitution, in the light of relevant benchmarking with a view to achieving upper quartile system performance ST/LT

5.1.35 To develop a new configuration of general acute inpatient hospital services at the Royal Infirmary of Edinburgh, Western General Hospital and St John’s Hospital, Livingston, concentrating inpatient orthopaedics and trauma at RIE, and ophthalmology within the Lauriston Building ST

5.1.36 To increase day surgery capacity on WGH and/or SJH site, redirecting elective day cases from RIE site and providing dedicated multi-specialty day case centres supporting efficient and effective use of specialist surgical staff and facilities; planned procedures should be carried out on a day-case basis wherever possible, with the aim of upper quartile performance as the minimum. ST

5.1.37 To change the model of delivery for outpatient services to ensure that the maximum clinical benefit is derived from direct patient contact time, for example one stop clinics, more complex procedures on an out-patient basis; avoid unnecessary out-patient attendances by using innovative alternatives to hospital attendance which ensure patient centred access to specialist assessment and follow-up care where necessary. ST/LT

5.1.38 To radically review options for the provision of modern facilities for outpatient assessment, consultation and treatment, which will include the acute hospital sites (RIE, WGH and St John’s) and the Lauriston Building for ambulatory care provision. ST

5.1.39 To keep under review the capacity for delivery of maternity care across the facilities at RIE and St John’s, recognising the need to have flexibility to increase capacity and utilization as the birth rate fluctuates ST/LT

5.1.40 To implement the NHS Lothian laboratories strategy, as an essential diagnostic resource for both primary and specialist hospital care, delivering more efficient diagnostic facilities, investing in automation, workforce redesign and capital infrastructure in blood sciences, genetics and molecular sciences. LT

5.1.41 To maximise systems, such as the patient reminder service, to significantly reduce ‘did not attends’ and so improve clinic resource utilisation ST
5.2 Improving Health and Tackling Inequality

Propositions

5.2.1 To promote the value and importance of patients’ experience in reviewing and designing services **ST**

5.2.2 To develop and implement the NHS Lothian Health Inequalities Strategy detailing the role of NHS Lothian to reduce and mitigate health inequalities. This will include both delivery of appropriately targeted clinical services, and the wider impact, for example relating to procurement, HR policies and NHS Lothian as an advocate for wider actions by partners **ST/LT**

5.2.3 To implement the NHS Lothian strategy for children and young people 2013 – 2020, “Improving the Health and Wellbeing of Lothian’s Children and Young People”; Implement the requirements from the Children’s Bill that NHS Boards provide a named person for every child from zero to 5 years, requiring the recruitment of additional Health Visitors and School Nurses; drive the work generated by the Lothian strategy and the Bill through utilisation of the Early Years Change Fund and the Early Years Collaborative to ensure that we and our partners achieve the local and national ambition for every child to have the best start in life **ST/LT**

5.2.4 To work with community planning partners and through the Single Outcome Agreements to realise the Christie Commission’s vision of harnessing wider community resources; develop plans and policies that address the underlying causes of health inequalities. This may include actions to reduce poverty and income inequality, ensure high quality education and lifelong learning, and provide employment opportunities and employability support **ST**

5.2.5 To ensure health improvement initiatives such as the early years collaborative, healthy eating, physical activity and weight management are implemented to standards of best practice, and are appropriately targeted and tailored to meet the needs of the most vulnerable populations as well as achieving a population impact. **ST**

5.2.6 To explore and develop combined telehealth and telecare solutions such as ‘Living it Up’ to support people living in their own homes or in care homes in assisted living for independence; continue development and implement the ‘patient portal’ enabling patients to access information and their own health records, email clinicians and review their clinical results.**ST**

5.2.7 To ensure engagement of and effective working with the third sector through integrated patient pathways and as partners in Health and Social Care Partnerships, at all points in the patients’ pathway and spanning all sectors and programmes of care **ST**

5.2.8 To assist patients to manage their own health condition by developing an integrated service model for people with chronic obstructive pulmonary disease (COPD), thereby
improving the quality and sustainability of care and reducing the numbers of patients requiring admission to hospital. ST

5.3 Securing Value and Financial Sustainability

Propositions

5.3.1 To develop and implement a system wide capacity planning and bed modelling approach which ensures the health and care system can regularly identify, for each Health and Care partnership, the capacity needed in terms of specialist hospital beds, community based step down care, care home and care at home capacity to meet the needs of local populations ST

5.3.2 To develop Lothian’s inpatient services within a new configuration in order to achieve gains in both quality of patient services and efficiency of provision; this includes specialties which require a ‘critical mass’ of patients to deliver the best quality of care and should therefore be concentrated on a single NHS Lothian hospital site. Changes may be subject to further option appraisal, including services to be provided on a pan-Lothian, single site basis, including reviewing the model for Dermatology care, specialist laboratory functions at WGH and RIE, with the blood sciences training school at SJH. ST/LT

5.3.3 To develop the business case for a new Regional Cancer Centre, to be sited at the Western General Hospital, in accordance with NHS Lothian’s agreed strategy; review patient pathways designed to strengthen early detection, radiotherapy and primary and community support; ensure sustainable arrangements for complex pelvic cancer surgery through multi-specialty team working ST

5.3.4 To replace the ophthalmology service currently provided in the Princess Alexandra Eye Pavilion, a building which is no longer fit for purpose, following growth in demand for eye care and the need to improve the quality of experience; appraise options for the provision of a modern ambulatory and day case facility on RIE, Lauriston Campus, SJH or WGH site, with the proposed timescales being developed during 2014. ST/LT

5.3.5 To maintain a one site model for Orthopaedic inpatients and trauma at the RIE, whilst repatriating independent sector capacity ST

5.3.6 Develop and implement our catering strategy in line with proposed service changes, while ensuring delivery of quality services meeting patient food and nutrition standards ST

6. Making it Happen: Delivering the Changes

This section describes the key enabling actions which need to be put in place to deliver the propositions in section 5 and achieve the outcomes in section 1 above.

Measures of successful achievement, or key performance indicators, will be identified for each of the propositions and the final action plan during consultation, so that there is
transparency of the improvements sought. Active management of the Plan implementation and routine monitoring of progress will be incorporated into NHS Lothian’s measurement framework and ‘balanced scorecard’ approach to performance management.

**Leadership**

In committing to the vision of a better future set out in this plan, NHS Lothian needs to provide the resources, including the leadership and management capability to deliver it. This is not a simple task and will involve working closely with partners on a reallocation of current resources – budgets, professional and supporting staff and managers, and capital assets – to be working differently throughout the life of the plan.

It is essential that the plan supports innovative and modern clinical practice in ways that make it easier for clinical and other staff to provide the best care to patients. It is equally important that all clinicians engage positively with the planning process and commit to supporting the outcome. This will only be achieved through strong and effective clinical leadership.

**A different relationship with patients and the public.**

Patients and the public expect to be treated with respect and dignity and giving people a voice and demonstrating responsiveness are essential to improving care. What being involved means can vary – from being made to feel welcome, to being able to share anxieties, to weighing the pros and cons of treatments.

Surveys by the Picker Institute, Europe show that the UK has a more paternalistic approach than other countries; we have comparatively good levels of doctor-patient relationship and provider continuity, but low scores for choice, involvement and information.

The following list represents what patients want from their relationship with the NHS:-

- Relational aspects of care – found in individual consultations and in team working.
- Continuity of care, smooth transitions which require planning and coordination.
- Fast access, effective treatment, respect for their preferences, support for self-care and the involvement of family and carers.
- Patients want organisations not to argue and to be consistent. They expect professionals to work together as a ‘team around the patient’.
- They want obvious inefficiencies to be addressed – not least in making the best use of their own time.
- Knowledge of the patient/service user/carer as a person.
- Knowledge of their relevant conditions and all options to treat manage and support, including support services available elsewhere.
Addressing these issues will be key challenges in our patient pathway transformation programme.

**Person Centred Health and Care Programme**

The national Person Centred Health and Care Programme (PCHC) was launched by the Scottish Government in November 2012 with the aim of developing health and care services that are centred on the people who use our services. This programme builds on the work that NHS Lothian has done to date and gives us a further emphasis on how we use the experiences of patients, families and carers to improve our care and services.

In addition to the national improvement programme, we will also consider other sources of patient feedback and information such as patient stories. We will use a range of approaches to ensure that the patient's voice and their experiences are used to drive improvements so that care and services are provided safely, effectively and in a person centred way.

It is proposed that a series of workshops are held starting in 2014, including our staff and people from communities and organisations across Lothian to inform our ongoing involving people activity and the requirements for the emerging integrated partnerships. In the meantime, we will continue to involve people using effective, meaningful and outcome focused methods in service improvement, development and redesign of health services, strategies and policies.

**Integrating Health and Social Care Systems**

Health, social care and other public services across Scotland have been working increasingly closely for many years, including in Lothian, but this has not been sufficient to deliver the seamlessness and efficiency required for high quality care for everyone. Further significant changes will therefore be made during the early years of this plan when NHS Lothian will work with its four local authority partners and the people of Lothian to establish four new Health and Social Care Partnerships, covering the communities of Edinburgh, East Lothian, Midlothian and West Lothian. Each of the four new Health and Social Care Partnership areas in Lothian will be developing methods of involving people to reflect local variations in the Community Planning Partnerships and Health and Social Care Partnerships.

Aligned to the development of this plan will be the development of four integration plans describing how NHS Lothian will work with its four Council partners. These integration plans will be consulted on within a timeframe consistent with the Scottish Government’s legislative programme during 2014, with a view to the new Partnerships becoming operational in 2015.

These changes are expected to fully integrate services with the prime purpose of delivering improvements in patient care. They will also affect the governance, leadership and management arrangements, all of which are essential for successful delivery of this plan. It will therefore be a priority for NHS Lothian and its partners, not only to avoid structural concerns of integration becoming a diversion or a hindrance to change, but rather to ensure that the process of integration is designed and enacted in ways which most effectively deliver the necessary changes at a pan Lothian, partnership, locality and neighbourhood level.
Integration, therefore, is not simply an important contextual matter, but is an essential enabler, generating a new dynamic and creating exciting opportunities for NHS Lothian and its partners to work differently - and more efficiently - to realise the ambitions of this plan.

**Workforce**

The imperative in this plan is to deliver the best quality of patient care and to do this safely, for an ageing population, recognising financial resources and recruitment challenges, particularly for doctors. Whilst acknowledging the high quality of care our staff is delivering in the vast majority of cases, there are occasions when care falls short of the standards or the quality of experience that we should all expect at every stage of the patient journey, e.g. in meeting waiting time targets, or in timeously enabling hospital patients to return home.

The shape of our workforce is changing and there are exciting opportunities to develop and use the skills of many staff groups and professional disciplines differently and more effectively. Where we are unable to recruit the doctors' skills needed in specialist areas of care, e.g. in emergency medicine, paediatrics and in smaller surgical specialities, these may be concentrated, to ensure that services remain at the highest quality and are safe.

The demographic change in the population as a whole is also reflected within the NHS Lothian workforce, e.g. between 2006 and 2011 the proportion of registered nurses aged more than 50 years old has increased from 19% to 27%:-

We need to balance the positive aim to provide family friendly working conditions for staff with the need to extend the working hours of our services. Extended days and 7 day working already apply in many areas, but extending the availability of other important staff groups who support diagnosis, treatment, rehabilitation and care at home will be required to ensure we can provide services when needed and make best use of our resources.

We also need to improve workforce efficiency and productivity whilst improving quality. The development of new and innovative roles is required, to enable services to be provided to a growing population at a lower unit cost and to a higher standard.
We will review the quantitative and qualitative information used for both management and governance at all levels of the organisation and ensure that the knowledge and skills to make use of these are developed.

For the benefits to be realised in full, greater attention also needs to be paid to the 10 patient safety essentials (CEL19(2013)), particularly to standards of practice and care and to the identification and elimination of variation which compromises the quality of outcome for the patient. This means that leaders and managers must apply a consistent approach to performance monitoring and a firm but supportive and developmental response to the identification of areas for improvement. It is important to distinguish between the range and scope of services, which may differ across communities and neighbourhoods according to their needs, and the quality standards to which these services are provided, which must aim to consistently reflect best practice and should not vary.

This will be achieved through embedding the NHS Scotland and NHS Lothian values of quality, dignity and respect, care and compassion, openness, honesty, responsibility and teamwork in all that it does. Living these values and behaving in ways consistent with them at all times are essential to achieve the engaged workforce and organisational culture we need to respond to the changes and challenges we face.

Organisational Development

Our vision is to have a healthy organisational culture, a sustainable and capable workforce. Working in an integrated manner with our partners, we will demonstrate effective leadership and management of our people, conducted in a manner that improves staff experience and lets us demonstrate that we have put our values into action. The cornerstone of employee relations in NHS Scotland is to work in partnership with the trades unions/professional organisations.

The human resource strategy will be delivered through five priorities for action:

**Healthy Organisational Culture:** by developing and sustaining a healthy organisational culture we will create the conditions for high quality health and social care:

- Incorporate behavioural competencies (which reflect our values) within recruitment, development and appraisal processes
- We will take action to ensure that staff are clear about the values and behaviours expected of them
- Engage and involve staff in decisions that affect them
- Develop a strategy for tackling the health and wellbeing issues associated with an ageing workforce.
**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 Clinical Framework:-

- 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 behaviors, decisions and actions reflect our shared values.
- Improve the confidence, capability and capacity of everyone involved in leading and practicing quality improvement
- Work collaboratively with other Health Boards to develop training programmes for small occupational groups e.g. Oncology, Medical Physics, and Perfusionists.

**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 provide the health and well-being of the existing workforce and prepare them to meet future service needs:-

- Ensure Consultant job plans match service demand and support 24/7 delivery; Consider extending the use of job plans to other staff who manage caseloads (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
- 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, working with the Colleges of Education to have job ready employees
- Maximise opportunities for youth employment and socially responsible recruitment through academies, placement schemes and recruitment campaigns, working with voluntary and other public sector partners.
**Effective Leadership and Management:** Our managers and leaders are part of the workforce and have a key role to play in being innovative in driving service and culture change. They also need to be valued, supported and developed:

- 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
- 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
- Develop and implement a Leadership Framework

**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:

- Develop a joint workforce/organisational plan that aims to have a fully integrated workforce by 2020 for each Health and Social Care Partnership
- Explore and maximise opportunities for shared services across NHS Scotland and with other public sector partners

**Better use of Information**

The NHS has been slow to develop whole-system information systems and to adopt the technologies which, in many cases already exist and are necessary to inform service improvements. This is due in part to the costs involved, even though the proportion of total budgets spent on new technologies by other industries tend to be much higher. It is also due, in part, to the fragmented nature of services which this plan intends to address through service integration and the pathway approach to patient service delivery. Clinical informatics and a more modern approach to the capture, analysis, sharing and use of routine clinical and other data will therefore be essential in redesigning treatment and co-ordinating care.

However, much can be achieved in the meantime by more focussed and accurate use of existing IT systems, but only through universal clinical engagement, flexibility, and commitment to work through the issues.
eHealth

eHealth needs to be central to the delivery of the care journey from planning, delivery, and evaluation across primary care, hospital care, and preventative service. eHealth is crucial to the delivery of safe, efficient, effective, quality and patient-centred care as outlined in the NHS Scotland Healthcare Quality Strategy and supported by the six eHealth strategic aims outlined in the associated eHealth Strategy.

Key eHealth actions will be establishing service delivery in a paper-light environment, and where possible paper-free by providing systems and access mechanisms to electronic information, which are "digital by default". This includes scanning of existing paper documents and ensuring that these are an integral part of the wider patient record, with future transactions being electronic. The provision of hand held and mobile technology to create and access patient information is also key, ensuring that information is "virtually" available at the point of care, and also where patients or staff are remote from NHS premises.

This includes fully integrated and secure patient and staff access to the necessary information and video/voice services for care planning and delivery. This supports virtual as well as face to face communication, enabling services to be delivered in the location of choice and a more mobile workforce - including communication with patients at home and staff working from home or other care settings. The use of 'portaling' technologies ensures that information that requires to be securely shared across organisational boundaries is available, making the services seamless to the patient. This includes interoperable messaging within NHS Scotland healthcare and for communication with other agencies, including social services, education, police and voluntary sector, and an accompanying real time access to service management information for service planning and monitoring.

Propositions - Delivering the Changes

6.1 To establish Health and Social Care Partnerships for Edinburgh, West Lothian, Midlothian and East Lothian, working with the local authorities, local communities and other stakeholders, in shadow form during 2014 and operational by April 2015; review the remaining governance arrangements within NHS Lothian in the light of the establishment of Partnerships. ST

6.2 That the four Lothian Health and Social Care Partnerships develop Strategic Commissioning Plans supported by a number of Joint Commissioning Plans such as those for older people, mental health, learning disability, addiction and criminal justice services, in ways which ensure local ownership and support from the Primary Care Contractor Organisation. ST

6.3 To implement NHS Lothian’s 2013 values, through local engagement events with managers and staff across each of our main management units and sites including the four Community Health and Care Partnerships, the major hospital sites, the scheduled care directorates and corporate services, by:-

- extensive use in internal and external communications
embedding in HR processes including recruitment and induction
incorporation in staff and management competencies, behavioural training, development and appraisal
to be the cornerstone of our organisational development plan ST/LT

6.4 To strengthen leadership and management and systems of governance to reflect the priorities in this plan and the need to deliver continuous improvement, better use of information systems and a balanced scorecard in the performance of NHS Lothian services ST/LT

6.5 To create dynamic, new fora for clinical engagement across the hospital and community interface; to promote initiatives to develop medical and other clinical leadership arrangements that facilitate the engagement of frontline staff and that position clinicians as leaders delivering change ST

6.6 To modernise and train the workforce, reflecting efficient and innovative use of knowledge and skills and challenging outmoded systems of working; to develop and publish a workforce plan ST/LT

6.7 To develop new models of working with staff groups and partnership support which allow utilisation of our hospital facilities such as operating theatres and out-patient departments for scheduled care over extended (three session) days and 7 days per week to maximise capacity and productivity ST

6.8 To make optimum use of managed clinical networks and other organisations to engage clinical and other service providers with citizens and to focus attention of services on patient-centred priorities and pathway redesign ST/LT

6.9 To make full use of new technologies e.g. wireless communications, telehealth/telecare and other digital systems such as paperless processes to enable service modernisation and efficiency improvements; make better use of existing IT systems and further develop clinical informatics and other ways that NHS Lothian will achieve NHS Scotland’s six strategic eHealth aims (set out in the eHealth Strategy 2011-2017) ST :-
- Efficient working practices
- Assisting patients to manage own health
- Support people with long term conditions
- Providing information and tools for staff to effectively improve quality
- Medicines safety
- Real time management information

6.10 To drive forward the innovation agenda; the priorities of the programme board will be to develop a culture of innovation across the whole organisation and to implement the agreed action plan, in particular addressing:-

- the demands that will be placed upon healthcare services, as the result of the over 75 population doubling in number over the next 20 years.
- The need to reduce the levels of hospital admissions.
- Reducing the number of clinic based outpatient appointments.
- Reducing the cost base by up to 5% each year. ST
7. Managing the Finances

The principal aim of this plan is to continue to improve the quality, accessibility and effectiveness of healthcare services for the people of Lothian and the real driver of change is the prospect of improving health and health services. However, the challenging financial context makes the pursuit of efficiency and excellence all the more imperative, so that NHS Lothian is also able to demonstrate maximum value for the public purse.

We are projecting a £400m total efficiency challenge over the next 10 years. This is based on the assumption that we will need to continue to deliver a minimum of a 3% cash efficiency target each year. The ever rising demands on our health budget over the next decade are increases in the population, demography, quality improvements, increases in the cost of providing care and developments in medical technology. Although there are projected increases in healthcare funding, these are not at the same level as the last decade and are not expected to be sufficient to cover the increased costs of demand from an expanding ageing population. The organisational challenge will therefore need to focus on better understanding and maximising the value and benefit from the 100% of expenditure rather than focusing on the annual 3% efficiency challenge.

Future investment and disinvestment decisions will be the outcome of strategic service choices. These decisions will be based in part on changing health care needs, wants and desires, but also on changes in the unit costs of providing care relative to inflation in the economy as a whole and the capacity of our health system to generate productivity gains. It is recognised that improvements in productivity should enable improved value from the level of funding that is deemed affordable. However it is likely that a gap will open up between the resources available and the demands over the next decade.

This plan highlights an ambitious programme of change for NHS Lothian. To support delivery of such a change programme it is important that efficiency and innovation are recognised as core building blocks for a sustainable financial future. Our focus will be on reducing waste and inefficiency and driving through productivity improvements, although these principles alone will not be sufficient to bridge the £400m NHS Lothian efficiency challenge.

The financial challenges are not confined to NHS Lothian, but are also being faced by local authority partners. To address the financial challenge it is important that NHS Lothian together with our local authority partners, through the Health and Social Care Partnerships, embrace the opportunity to modernise our service and strive to make them more cost effective and resilient in the process.

Patient safety and quality will be at the heart of the measures taken to address the £400m challenge. Some of the tools that we will seek to employ will include:

- Benchmarking our services against national and international comparators, constantly striving for improvement.
• Seeking out and reducing unnecessary variation in clinical practice and quality outcomes.
• Utilising any major change agenda as an opportunity to improve our service provision and cost effectiveness. e.g. integration, capital investments, service strategies.
• Encouraging the public to take greater ownership for their health care needs and assist in reducing avoidable demand.

The radical transformation of our services to meet service and financial challenges can only be delivered through rigorous engagement with all of our stakeholders - staff, patients and partner organisations. This open conversation needs to recognise the combination of a tightened financial settlement, an ever increasing demand for healthcare and rising expectations of standards and quality. Our current model is not sustainable within the current service configuration.

Property and Asset Management Investment Programme

To develop a programme which aligns with and supports this strategy, masterplans have been commissioned for all major sites. Each of these masterplans is at a different stage of development and the draft five year programme captures the agreed and emerging priorities.

The draft programme for 2014/15 onwards is summarised in the table below. This shows a potential over commitment for next financial year and a significant over commitment thereafter. Ensuring a balanced position is achieved will require a combination of prioritisation of unapproved projects via the masterplanning process, reviewing the timing of unapproved projects, exploration of potential funding routes with SGHSCD, Scottish Futures Trust (SFT) and council partners and detailed consideration of the revenue consequences of capital build aspirations that support the strategy.

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### Summary Five Year Property and Asset Management Investment Programme

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<td></td>
<td>£m</td>
<td>£m</td>
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<td></td>
<td>£m</td>
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The table shows a formula funding gap of up to £10m for the next two years. This is considered to be manageable. The large funding gap in the years 2016 – 2019 is due to large capital schemes that have not yet received approval from the SGHSCD, and which therefore do not have specific funding agreed. This five year plan has been submitted to the SGHSCD as part of the draft LDP for 2014/15 – 2018/19.

8. **Next Steps - Engagement Process**

It is intended that the Strategic Plan will be finalised in the Autumn of 2014, in order to set a context for consultation on the four Integration Plans and to inform the development of each of the Health and Social Care Partnership’s Strategic commissioning Plans, later in 2014 and into 2015.

To achieve that, the following outline timetable is proposed:-

- **2 April 2014** – Lothian NHS Board approve this document as the basis for further consultation and engagement and as a framework for completion of a definitive Strategic Plan

- **April, May 2014** - “Our Health, Our Care, Our Future” is published on NHS Lothian website and distributed widely for comments and feedback

- **May, June, July, August 2014** – meetings with patients groups, staff, independent contractors, partnerships, Councils, Scottish Government and other stakeholders to analyse patent pathways, consider options and develop specific proposals, including workforce, capital and other resource implications

- **October 2014** – Lothian NHS Board receive a refined and more definitive Strategic Plan for approval

Detailed consultation and meaningful engagement with an extensive range of affected stakeholders will be necessary to convert the list of propositions into a prioritised set of deliverable commitments. There will also be a specific programme of engagement to analyse and redesign patient pathways to take forward the work outlined in section 4 above.

However, in addition, a number of general questions have been posed in order to facilitate and focus the dialogue with staff, partners and the public and the aggregated responses reflected in the submission to the Board in October 2014. Details have been specified in the Communications Plan as to how respondents may submit their comments (e.g. electronic, paper, telephone) and confirmation that they are content for their comments to be published where appropriate.
Consultation Questions

Q1. Does this plan address the most important issues?

Q2. Have we missed anything that is really significant? If so, what is it?

Q3. Do the propositions in the Summary, taken together, reflect the right priorities?

Q4. Are the criteria for making decisions the right ones?

Q5. Which of the criteria do you think are the most important and what weighting would you give to each criterion?

Q6. Is there anything else you would like to tell us before finalising our Strategic Plan?
Supporting Documents (available via weblink)

Context
1. Lothian’s changing population and trends in disease incidence and prevalence
2. Health Inequalities Strategy

Programme Strategies
3. Developing Person-centred Primary and Community Services
4. Children and Young People’s Strategy 2014-2020
5. Mental Health Strategy
6. Learning Disability Strategy
7. Cancer Strategy
8. Action Plan for Unscheduled Care Services
9. Delivering for Patients - Plan for Scheduled Care Services

Resource Strategies
10. Workforce Plan
11b. Property and Asset Management Investment Programme 14/15-2018/19

Planning and Delivery Processes
12. Integration of Health and Social Care
13. Engagement and Communication Plan
14. Key Outcomes and Measurement Framework
15. Involving People Framework 2014-17
16. Decision Criteria
17. Integrated Pathways of Care
DEVELOPING PERSON-CENTRED PRIMARY AND COMMUNITY SERVICES
Contents

1. Introduction and Background

2. Challenges For Primary and Community Services 2014 – 2024

3. Primary and Community Services Propositions
   3.1 Engage with Individuals in Making Decisions About Their Care
   3.2 Develop Lothian’s Multimorbidity Action Plan
   3.3 Enhanced Palliative Care Community Model
   3.4 Scottish Government Modernisation Programme
   3.5 New GP Contract 2014/15
   3.6 Anticipatory Care and Polypharmacy
   3.7 Review of General Practitioner Numbers and Practices
   3.8 Shifting the Balance of Care
   3.9 Services for People at Risk and Suffering from Diabetes
   3.10 Dementia Link Workers
   3.11 Patients with Neurological Conditions and Sensory Impairment
   3.12 Improvements in Dental and Oral Health
   3.13 Pharmacy Services
   3.14 Optometry Services
   3.15 Services for Frail Older People
   3.16 Reduction and Elimination of Delayed Discharge
   3.17 Review of Role and Function of NHS Inpatient Continuing Care
   3.18 Access the Potential for New ‘Care Village’ Concept
   3.19 Redevelopment of the Royal Edinburgh Hospital
   3.20 Development of Joint Community Services for People with Learning Disability
   3.21 Develop a New East Lothian Community Hospital
   3.22 Redesign of Midlothian Community Hospital
   3.23 Lothian Unscheduled Care Service

4. Supporting Delivery of NHS Lothian Strategic Plans
   4.1 Better Cancer Outcomes in Lothian 2015-2020
   4.2 Strategy for Children and Young People 2013-2020
   4.3 Sexual Health and HIV Strategy 2011-2016
   4.4 Substance Misuse

5. Delivering the Propositions

Appendix 1 NHS Lothian Primary Care Strategy
       Demand – Capacity – Access

Appendix 2 NHS Lothian Primary Care Premises Strategy
1. INTRODUCTION AND BACKGROUND

Primary Care and Community Services provide the first point of contact between an individual and a healthcare professional in approximately 90% of contacts with health care services.

Within primary care there are 4 practitioner services; medical, dental, pharmaceutical and optical. These practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Contracts are negotiated on a national basis, however NHS Boards have some scope to negotiate local contracts or employ practitioners directly as salaried NHS employees.

The key role of primary care services is to:

- Provide a first point of contact with healthcare services
- Offer continuity of care (diagnosis, prescribing and care management)
- Provide a universal service
- Co-ordination of care 24 hours a day, 7 days per week across primary, secondary and social care systems
- Improve the health of the population through health promotion and primary prevention

Each year, there are over 5 million contacts with general practices, 1.5 million contacts with community services and 136,000 contacts with the Lothian Unscheduled Care Service (Out of Hours General Medical Service).

1.1 General Practice

There are 127 GP practices in Lothian (excluding the challenging behaviour GP practice) supported by a total of 1,601 general practitioners. Around 10% of the practice population access their general practice each week in Lothian.

The Primary Care and Community Services healthcare team consists of general medical practitioners, practice nurses, managers and reception staff working together with Health Visitors, District Nurses and Health Care Assistants, Community Midwives, Phlebotomists, Community Psychiatric Nurses and Allied Health Care Professionals.

General practitioners and community teams are central to lifelong patient care and therefore there is a need to recognise this primary healthcare team needs to be accessible and adequately resourced to deliver a vast majority of NHS interventions and ensure their specialist role in co-production.
1.2 **Dental Services**

NHS General Dental Services are provided by dental practitioners under a national contract between themselves and NHS Boards with the aim to improve oral health.

There are 172 dental practices in Lothian, both independent contractors and salaried dentists working in the Public Dental Service, supported by 532 dentists. As of 30 September 2013, 83% of children and 75% of adults of the Lothian population are registered with a dentist\(^1\).

1.3 **Optometry Services**

The general ophthalmic services contract ensures a comprehensive eye examination, appropriate to individual need, symptoms and general health.

There are 114 optician premises in Lothian supported by 665 optometrists. In the year ending March 2013, 299,014 primary NHS eye examinations were undertaken in Lothian (34.5% of the Lothian population)\(^2\).

1.4 **Pharmacy Services**

There are 182 pharmacy premises in Lothian supported by circa 400 community pharmacists who dispense 11.7 million prescriptions every year, the cost of prescribing in primary care is in the region of £132 million per year.

It is estimated 94% of the population in Lothian access a pharmacy each year and 67% of the population visit a community pharmacy each month.

2. **CHALLENGES FOR PRIMARY AND COMMUNITY SERVICES 2014 – 2024**

2.1 As outlined within the NHS Lothian Strategic Plan 2014 – 2024 there are a number of recognised key challenges facing primary and community services.

- The population growth, extended life expectancy and the consequent increase in multi-morbidities that have contributed to the increased demand for access to primary care and community services without commensurate increases in capacity
- The need to address the existing and future capacity short-fall to meet the above increased, and increasing, demand upon Primary and Community services through the review of premises capacity and suitability, the need for additional GP Practices and work-force planning issues associated with GPs and community health teams particularly health visitors and district nurses

\(^1\) ISD, MIDAS 30 September 2013
\(^2\) ISD, OPTIX, August 2013
Access and the need to consider different models to support access to appointments within general practice, and alternatives to direct GP access to ensure our population wait no longer than 48 hours for a non-urgent appointment to see a GP or appropriate alternate healthcare professional.

Demand, Capacity and Access – An Overview (Appendix 1) summarises the current position across Lothian and provides comment on the future impact associated with the population growth.

Meet public expectations by ensuring timely consultation with an appropriate health care professional, patient and/or carer involvement in decision making about their healthcare choices, access to safe and effective treatment, clear and accessible information and experience of an efficient, approachable and responsive service.

Ensuring co-ordination of the care and support needed by patients across primary care, community health and social care and hospital based services which may all have a part to play in meeting individual’s health needs.

Support the shift in the balance of care from secondary to primary and community care services and ensure this transfer of care is appropriately resourced.

The need for further development of information technology to support timely communication and transfer of information between primary care contractors, hospital and social care services.

Increasing demands and issues associated with recruitment and retention of the out of hours workforce which is impacting significantly on delivery of the Lothian Unscheduled Care Service (LUCS).

3. DELIVERING THE PRIMARY AND COMMUNITY SERVICES PROPOSITIONS

There are a number of propositions outlined within NHS Lothian’s Strategic Plan 2014-2024 which require be further developed and implemented over lifetime of the plan.

The sections below provide additional information on the propositions and include details of how delivery of these propositions will be taken forward.

3.1 Engage with Individuals in Making Decisions about Their Care

There is a need to develop a new relationship between the NHS and the Lothian population to ensure individuals are clear on the limitations of medicine and to ensure individuals are supported to take responsibility for self care and self management (such as via long term conditions education programmes and self management plans e.g. diabetes, COPD and asthma). There is also a need for our patient population to recognise not all treatments are possible and there is a need for NHS Lothian to cease treatments for which there is no clinical evidence.

This engagement programme could be supported through development of an NHS Lothian’s Patient Charter which should outline not only the rights of our patients but also to set out the limitations of our services.
3.2 **Develop Lothian’s Multimorbidity Action Plan**

A national programme is being developed to support NHS Boards in developing a multimorbidity action plan. This will ensure healthcare is designed around the needs of people.

The development of plans will be driven through the pathway developments outlined within the strategic plan, the managed clinical networks in supporting individuals to self manage their care via promotion of the use of self management plans, and co-production to ensure co-ordination of care around the needs of individuals.

3.3 **Enhanced Palliative Care Community Based Model**

A Lothian Palliative Care Redesign Programme Board was established in February 2013. Representation is in place from carers/families, NHS Lothian services, City of Edinburgh Council, Midlothian Council, Independent Care Home providers, Edinburgh University, St. Columba’s Hospice and West Lothian partnership; arrangements are being finalised with the other three partnerships.

The programme aims to improve the community-based model of end-of-life care across Lothian. This would allow people to spend more time in their preferred place of care, minimise emergency admissions where avoidable, and support choice in place of death. Specifically, the programme objectives are to:

- increase capabilities to identify patients and to plan care in anticipation, and in advance, of needs;
- improve coordination of care, within and across settings, to support patients and families with complex and unstable palliative and end-of-life care needs;
- increase community-based care service provision, and accelerate progress in shifting the balance of end-of-life care towards greater community-based care; and
- increase public awareness of, and community involvement in, the issues related to death, dying and bereavement.

During 2013 palliative care services in West Lothian have been reviewed, with consideration in particular of the service model required for the future. NHS Lothian, Marie Cure Cancer Care and Macmillan Cancer Support will jointly provide specialist palliative care community services in West Lothian, in all care settings. Overseen by a steering group with membership from senior service and clinical management, the ‘West Lothian Palliative Care Service’ will have 3 stages of implementation in the first half of the 2014: community specialist palliative care service (March); start date for Consultant in palliative medicine (April); and palliative care day and outpatient services (June). West Lothian is also participating in the redesign work, which will help to chart a
course for the longer-term development on West Lothian palliative care services.

Throughout 2013, the redesign programme has conducted a review of the current evidence base and a series of workshops with a wide range of stakeholders, including patient and carer representatives, to identify options for transformational change of palliative care and support services in all settings. This has produced in excess of 800 ideas which have been distilled through two stages of options assessment to around 20 potential ‘capabilities’ including: a range of Health Promoting Palliative Care events and resources; a care home centre of excellence; a 24/7 rapid response service; and a community volunteer support service. By summer 2014, a business case and programme plan for the delivery of the preferred configuration of services and initiatives will be signed off by the Programme Board.

3.4 Scottish Government Modernisation Programme

The Scottish Government have outlined four key elements necessary for the transformation of primary care in order to achieve the 2020 Vision. These are:

- Development of new models of integrated care that better meets the needs of the changing population and that engages with and meets the needs of local people

NHS Lothian’s review and redesign of pathways of care around the needs of high users of our health and social care services (Callum, Hannah, Scott and Sophie) will support the development and resource shifts required to deliver the future models of integrated care.

- Involve General Practitioners to develop a ‘more Scottish’ GP contract as part of continuing effort in Scotland to deliver excellence in primary care and to ensure a clear focus of health and social care integration

General Practitioners are seen as a key to the delivery of the integration of health and social care services, this key contribution is recognised in the 2014-15 Scottish GP Contract in that:

- Each GP practice will nominate a practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership
- Engagement with the evolving local Health and Social Care partnerships, and input to developments/decision-making will be led through these GPs as appropriate. Any additional consequential workload will be agreed

NHS Lothian and its partners will be taking these actions forward within our wider primary care actions aligned with our strategic and integration plans.

- Improve the quality and usefulness of primary care data as a tool for improvement
NHS Lothian’s Primary Care Data Group has a role to co-ordinate support to primary care services to make informed decisions on strategic and operational issues through collating existing data and information; analysing the data, reviewing the evidence; writing reports; and conducting ad hoc surveys where appropriate.

Strategic priorities have been identified as:
- Support the NHS Lothian’s Strategic Plan which is inextricably linked to the integration of health and social care
- Ensure co-ordination of information supporting primary and secondary care initiatives relevant to the strategic plan, in particular those which affect the interface between primary and secondary care

The operational priority is considered to be:
- Primary care benchmarking to ensure a Lothian wide approach to sharing and benchmarking of primary care information at general practice and partnership level
- NHS Boards are required to make medium term assessments of the strengths and weaknesses in delivering the 2020 vision for primary care. This assessment should include detail of the shift in resource to support the transformation of primary care

The resource shift required to support the transformation of primary care will be assessed as work progresses across a number of work streams such as the redesign of pathways of care, provision of local ‘step up’ and ‘step down’ beds, expansion of primary care premises and development of primary care and community care workforce plans.

NHS Lothian will continue to contribute to this Scottish Government primary care modernisation agenda through active participation at the Scottish Government Primary Care Strategic Forum.

3.5 New GP Contract 2014/15

Development of the Scottish GP contract in 2014/15 will contribute to delivery of the key priority areas outlined in the 2020 vision route map in terms of further reducing bureaucracy and creating a stable funding environment for general practice over the coming years. A further 264 Quality & Outcome Framework (QOF) points are being transferred into the global sum under core standard arrangements leaving a balance of 659 points for 2014/15. The main area of innovation in QOF is in relation to the quality and safety indicators:
Integration:

- A requirement for a designated practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership and fully engage with the evolving integration agenda.

Quality Improvement:

- A new continuous quality improvement indicator requiring a quality report reflecting relevant activity in the previous year, plus participation in a 3 year rolling programme of formative and supportive peer review visits. The practice visits are intended to allow constructive discussion, identify areas of priority and support the sharing of best practice.

Patient Access:

- An annual review (involving patients) of current patient demand, focusing on both met and unmet needs; ‘Patient Access Action Report’ to be submitted to the Board for discussion at a formative and supportive quality review visit. This data will be key to our understanding of the current pressures on GP practices and improving the response times for patient appointments by the sharing of best practice.

Anticipatory Care / Key Information Summaries:

- Continuing the current work on developing anticipatory care plans / Key Information Summary (KIS) (including a polypharmacy review) for those patients predicted (from SPARRA data) to be most at risk of emergency admission or unscheduled care; requirement for quarterly multidisciplinary practice meetings focusing on this cohort of patients. There is a good evidence base for this work in primary care and over 10,000 KIS records were created in Lothian this year.

Patient Safety:

- Two patient safety indicators are retained in QOF requiring practices to conduct a safety climate survey and two case note reviews using validated tools to detect safety incidents, discuss the results as a team and share a reflective report with the Board. This work will be complemented by a comprehensive enhanced service (ES) which will focus on improving outpatient communication in 2014/15. Previous work by practices in relation to Warfarin monitoring and medicines reconciliation has already produced excellent results and contributed to a material culture change in general practice as part of the Scottish Patient Safety Programme in Primary Care.
3.6 *Anticipatory Care and Polypharmacy*

A local enhanced service has been established which aims to facilitate a joint polypharmacy review between the pharmacist and the patient’s general practitioner. These reviews link with Anticipatory Care Plans (ACPs).

- Year 1 (2012-13) – reviews were offered to all GP practices with patients in care homes in addition to frail elderly patients identified at high risk (over 75 years and on 10 or more medicines)
- Year 2 (2013-14) – co-horts of patients were identified for review using the SPARRA risk prediction tool
- Year 3 (2014-15) – continue to invite all practices with patients in care homes to be offered review and practices will be invited to identify patients who are at risk of readmission. Community pharmacists will continue to jointly lead reviews with general practitioners.

3.7 *Review of General Practitioner Numbers and Practices*

Population growth in Lothian, as predicted by National Records of Scotland (NRS) will be an average of circa 9,000 per annum between 2010 and 2020, or circa 8,000 per annum between 2015 and 2020. It should be noted however that, historically, there is a significant disparity between the NRS predicted population estimates and the GP lists size, across Lothian and within each locality.

Graph 1 – Population Trends in Lothian 2010 - 2024

![Population Projections](image)
Demographics in Lothian are predicted (NRS) to change significantly with the number of people over the age of 65 increasing by circa 25% between 2010 and 2020, as demonstrated in the table below.

**Table 1 : National Records Scotland Population Predictions (1,000's) 2010 based**

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* 2012 NRS estimate based on 2011 Census data

It is difficult to predict the growth of the elderly population, at a locality or practice level, which is where this will impact on GP Practices capacity.

There are 127 GP Practices across NHS Lothian. Although the number of practices has grown this has been the result of existing practices sub-dividing using existing premises capacity and with their relevant practice populations. The last new and additional practice was created over a decade ago.

Mapping of General Practice, General Dental Practice and Pharmacy locations has been completed and shared with each Community Health Partnership (CHP). Work is underway to identify the localities and individual practices experiencing, or predicted to experience, specific population pressures and map these to the relevant current General Practice boundaries.

Each CHP will then develop general practice capacity plans within their locality, and in partnership across CHP boundaries where appropriate, to address these capacity issues, including the development of existing practice premises and the identification of where new and additional practices will be required. (See Appendix 2)

As well as facilities, these capacity plans should also address practice manpower planning, Community Services resource levels, new ways of working and the potentials provided through advances in information technology.

Work is underway to consider a replacement mechanism for the former Initial Practice Allowance (part of the previous General Medical Services Contract) to facilitate the creation of new and additional General Practices in Lothian.

### 3.8 Shifting the Balance of Care

We continue to evaluate the GP enhanced services programme (circa £13 million GMS investment) on an annual basis to ensure best strategic fit, effectiveness and value for money.

Recent examples of enhanced service developments include:
• Domiciliary Phlebotomy

Primary care services have seen an increased demand for domiciliary phlebotomy services (carried out in a patient’s home) as a result of 3 broad drivers:

- increased requirements associated with remuneration frameworks such as QOF;
- population growth
- clinical change, where requirements for disease monitoring or treatment have been altered and the resource has not necessarily been provided to reflect this change in clinical practice

To meet future demand, a domiciliary phlebotomy service has been established supported by recurring investment of £350,000.

• General Practice Support to Care Homes

The current local enhanced service (LES) which allows practice teams to provide additional care to patients in care homes for older people is under review. The anticipatory care LES provides for a single practice to take ‘lead practice’ responsibilities for each care home in Lothian. This has proved a successful model although there are currently four care homes where we continue to seek a practice to take on lead status and this requires further development and investment in the region of £300,000.

• Models of Care for Frail Elderly

There is a clear identified need to better support integrated pathways of care for frail, older people living at home. Development work on a new model of care focusing on service redesign to cover complex frail elderly patients in the community is underway. This will cover patients in care homes and also those living in their own homes. Information transfer between primary care and acute services will be improved, together with a consistent approach to polypharmacy medication reviews.

A number of initiatives have already been developed to support the shift the balance of care from hospital based to community services.

• Near Patient Testing (Warfarin)

A recent example of this shift is the provision of Near Patent Testing for warfarin in East and Midlothian which allows general practices to provide safe, effective and convenient access to testing with immediate results and thus avoids patients having to wait for results and for changes to medications. This initiative is supported through local investment of circa £60,000.
Looking forward, NHS Lothian will continue to regularly review existing local enhanced services, have identified current local enhances services which require further development and will consider new local enhanced service proposals.

3.9 Services for People at Risk and Suffering from Diabetes

Diabetes represents a rapidly expanding workload with circa 2,200 individuals in Lothian diagnosed with type 2 diabetes each year, a prevalence of (at least) 4.7% in the Lothian population (35,288 in 2012) and (at least) a 9% share of the NHS Lothian prescribing budget.

Secondary care diabetes services need to focus specialist skills on individuals with type 1 diabetes and those with type 2 who are complex or developing complications.

Historically, most patients with diabetes were referred to hospital at the time of diagnosis, though many are subsequently discharged back to the care of the General Practitioner once their initial assessment and management plans are in place and their condition stabilised.

An enhanced service would provide the resource for this initial assessment and ongoing care to be undertaken in general practice and would reflect the well established rise in prevalence and complexity. In order to support this proposal, investment of circa £300,000 is required.

Whilst the proposal service outlined above will provide support for those newly diagnosed with type 2 diabetes, a number of gaps and areas for improvement have been identified:

- discharge planning
- earlier supported discharge
- follow up of type 1 diabetes who do not attend hospital appointments
- GP practice support
- review of late stage type 2 diabetes with polypharmacy
- community support for those with long term stable type 2 diabetes on insulin.

In order to further enhance and bridge the gap between primary and community services, there is a need to develop a community diabetes specialist nurse (CDSN) service across Lothian. The benefits of provision of these posts will support the gaps / service improvements which have been outlined, has the potential to reduce readmissions and diabetic ketoacidosis (DKA) admissions, relieve pressure on secondary care clinic capacity, support the avoidance of travel for some stable, elderly patients to hospital services, provide support in the implementation of the national and local diabetes prescribing strategies and support the cross pollination of good practice and a more patient centred pathway of care.
3.10 **Dementia Link Workers**

Scotland’s National Dementia Strategy 2013-16\(^3\) outlines the importance of increasing the availability, consistency and quality of post-diagnostic support to people with dementia. It is expected that everyone diagnosed from April 2013 should be offered post diagnostic support.

- **Provision of Link Workers**

NHS Lothian, Local Authorities in City of Edinburgh, West Lothian and Midlothian have secured change fund monies to establish Alzheimer’s Scotland Post Diagnostic link workers. The link worker service will complement existing post diagnostic support (PDS) services currently available through community mental health teams and are aligned to local geographical areas. Discussions are underway in East Lothian for a proposed PDS service.

- **Developing the 8 Pillars Model**

The 8 Pillars Model will build the resilience of people with dementia and their carers to enable them to live in the community for as long as possible. It builds on the one year post-diagnostic support guarantee, to ensure the impact of the investment in early intervention is not lost. Midlothian is a Scottish Government test site for the 8 pillars model.

North West Edinburgh Integrated model is working with NW Section 17c GPs in partnership improve the outcomes and experience for people diagnosed with dementia, their families and carers by providing a continuum of integrated support throughout their dementia journey.

- **Dementia Awareness**

A joint dementia awareness campaign was launched in Edinburgh in January 2014, providing information and encouraging people to seek help for a diagnosis if they were worried about their memory. This is being developed into making Edinburgh a dementia friendly city; a local example is Barnton and Cramond dementia friendly community and the work is being led in this area by a local pharmacist.

3.11 **Patients with Neurological Conditions and Sensory Impairment**

3.11.1 **Lothian Neurological Care Improvement Plan**

It is estimated that round 17% of general practice consultations in Lothian (918,000 consultations each year) are for neurological symptoms such as dizziness, seizures, paralysis, headache and sensory symptoms\(^4\).

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\(^3\) Scotland’s National Dementia Strategy 2013 – 2016, Scottish Government, 30 May 2013

\(^4\) Functional and dissociative neurological symptoms : a patient’s guide J Stone

www.neurosymptoms.org
Neurological conditions include epilepsy, seizures, chronic headache and migraine, Parkinson’s disease, multiple sclerosis, acquired brain injury, Huntington’s disease, dystonia, functional neurological symptoms, cerebral palsy, motor neurone disease and muscular dystrophy.

In Lothian, there is an estimated 53,480 people living with a neurological condition, of whom 5,348 will be disabled by the condition and 1,872 will require assistance with tasks of daily living.

Each year, there is circa 8,489 individuals in Lothian who receive a new diagnosis of a neurological condition. Having a neurological condition is the most likely reason for experiencing complex and physical disability for people aged under 65 years.

NHS Lothian and partners, through the Neurological Care Improvement Group are developing a Lothian Neurological Care Improvement Plan 2014 - 2017 which will set out a vision for and actions to deliver improvements in care and support for people with neurological conditions. High level themes and issues outlined within the draft plan include:

- Seek to build shared patient records and a single point of contact to support an infrastructure to deliver co-ordination of care
- Review of neurological pathways to ensure these are fully integrated across all tiers of health, social care and the voluntary sector
- Clear designated clinical leadership for each neurological pathway
- Development of a neurological care eHealth strategy which supports effective use of existing systems to support the co-ordination of clinical care and to support engagement with patients

3.11.2 National Sensory Impairment Strategy

The Scottish Government have indicated a national sensory impairment strategy, ‘See Hear’, will be published by the end of April 2014. NHS Lothian and our partners will take forward work to support implementation of the strategy recommendations. It is anticipated the themes of the national strategy recommendations will relate to audit of spend, basic sensory screening, sensory awareness training, local partnership work, local information and the Equality Act.

The work streams outlined above will be taken forward under the guidance of the Lothian Physical and Complex Disability Programme Board.

3.12 Improvements in Dental and Oral Health

The key strategic priorities relating to dental care for the next 10 years have been identified as:

- Increase registration for those aged up to 2 years
As at 30 September 2013, 41% of 0 to 2 year olds were registered with an NHS dentist compared to 47% registration rate across Scotland. NHS Boards in the West of Scotland that began Childsmile Practice earlier than the East of Scotland NHS Boards, show better registration. NHS Greater Glasgow and Clyde have 52% of 0 – 2 year olds registered. By 2024, NHS Lothian should aim for 70% of 0 to 2 year olds registered.

- Improve access to specialist dental services by integrating and aligning the Public Dental Service (PDS) with the Edinburgh Dental Institute (EDI)

By redesigning services provided by the PDS and EDI agree a single point of referral for suitable services. This will mean that referrers have an easy route to access specialist services, and that patients will be seen by the most appropriate clinician in a location as close to their home as is practicable in as timely a way as possible.

- Continue with Scottish Government funded prevention programmes - Childsmile and Caring for Smiles aimed at improving oral health for young and older people

Childsmile is a national dental prevention programme delivered locally by each NHS Board. All children in nursery provision are offered the opportunity to participate in a tooth brushing programme. Children attending nursery located in the SIMD most deprived quintile are offered the opportunity to participate in the Childsmile Fluoride Varnish Programme. The proportion of Primary One children with no obvious dental decay in Lothian has risen from 50% to 70% since the Childsmile Programmes began. By 2024, we should aim for 80% of Primary One children in Lothian with no obvious decay.

Caring for Smiles resource was launched in 2010 in partnership with NHS Health Scotland and the National Older People’s Oral Health Improvement Group. This resource provides a guide for oral health professionals to deliver training for staff in care homes and enable carers to provide a high standard of oral care for dependent older people. The training highlights to care staff that good oral health is important for overall general health and it also encourages carers to consider that oral care should be an integral part of personal care.

3.13 Pharmacy Services

The key priority for pharmaceutical services is to implement the recommendations outlined in Prescription for Excellence published in 2013 which outlines a vision and action plan for the delivery of pharmacy services across Scotland to support people living in the community, receiving care at home, living in care homes and those receiving hospital / specialist hospital care at home.

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5 Prescription for Excellence, A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation, Scottish Government Health Department, September 2013.
The recommendations will be implemented through establishing a framework for joint working and information sharing between primary and secondary care pharmacist and other members of the multidisciplinary team.

3.14 **Optometry Services**

Optometry services should be recognised as the first point of contact for individuals who are experiencing eye problems. Since 2006 the General Ophthalmic Services contract has been in place to allow community optometrists to provide a comprehensive patient-specific examination and any necessary follow-up appointments for accurate diagnosis or monitoring of conditions.

There are a number of optometry legislative and pathway changes which support improved joint working and a shift in the balance of care, these will be the focus for development over the coming years.

- **Independent Prescribing Rights to Optometrists**

In 2013, new legislation was introduced to extend NHS prescribing to optometrists who are recognised by the General Ophthalmic Council (GOC) as appropriately qualified. All optometrists in Scotland, who have completed a GOC approved training course and are entered on the GOC Register as an Independent Prescriber, to provide NHS prescriptions for conditions affecting the eye and tissues surrounding the eye. This legislation will assist to shift demand from general practice as individuals do not have to visit their general practitioner to request eye prescriptions and can access specialist eye services in the community.

- **Optometrist Direct Referral to Hospital Ophthalmology Services**

In 2014 all community optometry practices will have access to SCI Gateway for referrals to the Hospital Eye Service. This will provide more detailed information (particularly retinal photographs) to the hospital allowing them to triage accurately. Referral guidance is available on the Lothian Referral Guideline website and there are plans to develop guidelines for additional ophthalmic and systemic conditions.

3.15 **Services for Frail Older People**

There are a number of health and social care integrated teams providing assessment and rehabilitation services for frail older people available across Lothian. The continuation of these services and resources to support further development of this type of model of care is essential when supporting the shift in the balance of care. Examples of integrated teams for frail older people are described below.

- Edinburgh – COMPrehansive Assessment (COMPASS)
This model supports a new way of working which aims to provide more integrated care for frail older people in Edinburgh. A key component of the COMPASS model is regular multidisciplinary team meetings whose role is to identify older people at risk of hospital admission. The aim of the meetings is to deliver better outcomes for older people and their carers through improved understanding and communication across teams and professionals.

The COMPASS pilot began in South East Edinburgh in April 2012 and rollout out further to North West Edinburgh in April 2013. There are plans to roll out the COMPASS model across all areas in Edinburgh.

• East Lothian - Integrated Service for the Elderly (ELSIE) and Midlothian MIDCare

These services are integrated co-located services which provide urgent assessment, rapid response (health and social care), rehabilitation and re-enablement for frail older people at time of crisis. Both services benefit from medical and nursing input (medicine of elderly consultant and advanced nurse practitioners) with access to Allied Health Professionals, social care and crisis care services.

East and Mid Lothian partnerships plan to further develop ‘frailty models’ and further enhance local rapid response services.

• West Lothian - Rapid Elderly Assessment and Care Team (REACT)

The REACT service provides better care for elderly patients at home by providing alternatives to hospital admission.

- Phase 1 – Hospital at Home

Currently comprising a team of nurse practitioners, consultant geriatricians, specialty doctors, a community pharmacist and an administrator, the Hospital at Home service accepts daily acute referrals for urgent assessment of older patients to prevent unnecessary admissions to hospital and to maintain individuals in their own homes where possible. The team work closely with the physiotherapists and occupational therapists to provide rapid intervention as required.

- Phase 2 – Intermediate Care Team

The Intermediate Care Team comprises physiotherapists, occupational therapists and speech therapist. They provide rehabilitation within the patient’s own home and accept referrals from the hospital wards facilitating an early supported discharge, direct from the community or from the hospital at home team. They also support Phase 1 Hospital at Home patients providing rapid assessment and intervention as required.

- Future Development of REACT In-Reach Team
The appointment of Specialist Nurses to assess frail elderly at the front door and downstream wards will facilitate the most appropriate pathway including accessing relevant community services. These nurses will work closely with the duty Consultant Geriatrician who will also be the single point of contact available to GPs and other clinicians. The team will also include senior physiotherapist and occupational therapist pulling patients back out into the community for assessments and interventions in their own home.

3.16 **Reduction and Elimination of Delayed Discharge**

In April 2008, a National Standard was introduced, that no patient should wait more than 6 weeks for discharge from hospital after being declared medical fit to do so. This standard was strengthened by the Scottish Government to be 4 weeks in April 2013 and 2 weeks in April 2015.

Across Lothian achieving these standards has been a challenge. The Partnerships of West Lothian and Midlothian have managed to keep pace with the National standards and are on a path that will see them achieve the impending April 2015 target. City of Edinburgh and East Lothian are experiencing challenges associated with the availability and affordability of Care Homes, and increasingly workforce shortages in the care at home market. Whilst both have achieved the 6 week standard, the 4 week standard is more challenging.

The partnerships across Lothian have identified short and long term actions to support the reduction and eventual elimination of delayed discharge.

**City of Edinburgh**

The City of Edinburgh partnership have already undertaken a number of actions to support a reduction in delayed discharge in Edinburgh. This includes:

- an increase in domiciliary care capacity
- development of 42 'step down' beds.

A draft project plan has been developed to further reduce the demand for hospital admission, make the discharge process more efficient, increase capacity in existing services and enhance community capacity.

In the short term, this plan includes:

- an additional 2,500 domiciliary care hours to be provided by April 2014
- the roll out of COMPASS to all quadrants of the city
- investment in re-ablement to clear the current backlog
In the long term, this plan includes:

- the re-tender of the care at home contract which expires in October 2014
- commissioning additional ‘step-down’ beds
- establishing a discharge hub on each hospital site to increase the efficiency of the discharge process.

**East Lothian**

The East Lothian partnership will reduce the total number of delayed discharges and meet the 4 week and 2 week targets through:

- establishment of step down capacity
- the introduction of new contracts for care at home
- supporting a social enterprise model to provide care to specific cohorts of patients and service users
- implementation of a ‘frailty model’
- enhancement of the emergency care service

**Midlothian**

The Midlothian partnership have identified a number of key actions to address delayed discharge which will be to:

- explore ways of strengthening the Midlothian In-Reach service which involves Midlothian staff working in the acute hospital settings)
- implement the ‘Frailty Model’ through an enhanced Rapid Response Service
- extend the provision of assessment and intermediate care beds the Highbank care facility
- review care home provision in Midlothian and further develop extra-care housing
- refresh the workforce development strategy in Primary Care to support ‘Shifting the Balance of Care’
- Continue to strengthen working links between Midlothian Partnership and the Acute sector
- From April 2014 begin to shadow the two week target for delayed discharge (this approach was adopted for when the 4 week target was introduced)

**West Lothian**

The West Lothian Partnership has a diverse range of initiatives in place to support the reduction and elimination of delayed discharges through:

- Reducing demand for hospital admission:
  - REACT,
  - Crisis Care,
- Integrated Care Pathways development supported through Interface Group and Primary Care Work Plan
- Additional capacity for falls coordination and further development of robust falls pathway
- Currently over 4000 households benefit from telecare services with access to 24 hour Careline

• Making the discharge process more efficient.
- Integrated Discharge Planning Pathway
- Multidisciplinary and multiagency involvement in early identification of patients needs and discharge requirements
- Increased capacity to facilitate early supported discharge through REACT intermediate care team, re-ablement service and mental health Older People Acute Care Team

• Increasing capacity in existing services.
- The development of step up and step down model in St Michaels Hospital
- Universal re-ablement services
- Redesign of domiciliary physiotherapy service
- Development of integrated workforce plan
- Continuing development and delivery of care home education programme
- Expansion of inpatient physiotherapy and occupational therapy services to 7 day working
- Working with independent sector on their demand and capacity plans to support care at home and care home provision

• Enhancing community capacity.
- Development of an additional housing with care complex In Bathgate
- Further investment in telecare
- Telehealth research with focus on providing care at home
- Ensuring capacity in health and social care services to support 7 day discharge model

3.17 Review of Role and Function of NHS Inpatient Continuing Care

The NHS Lothian Strategic Plan and the requirement to rebalance care from hospital and community settings require the Board to have a strategic plan for the future model and provision of inpatient complex care (IPCC) beds across Lothian. NHS Continuing Care is a package of healthcare provided and solely funded by the NHS. Patients normally receive NHS Continuing Healthcare in a hospital ward, hospice or a contracted inpatient bed within an independent sector provided e.g. Care Home.

The purpose of the review is to identify the factors that will affect future demand and need for inpatient continuing care and to propose a strategy to
meet the care needs of the ageing population. The main factors are; increasing demand from an ageing population, reducing demand because community services can increasingly provide for people with higher care needs, and evolving national eligibility guidance for IPCC.

The first stage of the review will conclude by end of February 2014 and will describe an emerging strategic plan for future IPCC provision. This will be incorporated into the NHS Lothian Strategic Plan for consultation.

3.18 Assess the Potential for a new ‘Care Village’ Concept

The Edinburgh partnership will host a workshop in April 2014 to begin initial discussions and assess the potential for this concept.

3.19 Redevelopment of the Royal Edinburgh Hospital

NHS Lothian and its partners, through the current mental health strategy: A Sense of Belonging 2011 - 2016; sets out plans for the redevelopment of the Royal Edinburgh Hospital and the required investments and developments in community services.

For the past 8 years, mental health services have had clear agreed strategic direction and clear plans are outlined for the remainder of the current strategy. These plans have delivered significant bed reductions compensated by investments in community services such as the intensive treatment teams and crisis intervention services.

Similarly, the number of sites from which acute mental health inpatient services are delivered has reduced from 4 to 2 sites during this period. This has resulted in significant shifts in the balance of care from hospital to community and clinical service functions providing safe, supportive assessments and treatments to patients at home who were previously admitted to hospital.

NHS Lothian’s mental health strategies and resulting community developments have been agreed and developed in partnership with local authorities and Third Sector organisations and this continued partnership will be key to the success of the plans for the redevelopment of the Royal Edinburgh Hospital. A Sense of Belonging outlines how the redevelopment will be delivered including service redesign, investments in community services and associated improvements in reduced inpatient services to provide a better quality of inpatient care for individuals who cannot be safely or appropriately supported at home.

Phase 1 of the Royal Edinburgh Hospital campus redevelopment will focus on providing inpatient mental health assessment, treatment and rehabilitation facilities and the re-provision of the national brain injury unit. The construction associated with the Phase 1 redevelopment is estimated to be completed in November 2016.
3.20 Develop jointly with Local Authority partners a community and residential support service for people with learning disability

A number of strategic developments and work streams are being progressed across Lothian to ensure that specialist learning disability services are of high quality, effective and fit for purpose. Key work streams relate to:

- Reprovision of Learning Disability Inpatient Service.

The final stage of benchmarking and service model development will be complete by April 2014. This will inform the clinical brief for the business case for Phase 2 of the Royal Edinburgh Hospital reprovision.

- Repatriation of Out of Scotland Patients.

The national learning disability strategy requires that repatriation of patients is concluded by 2018. This will be included in the work above.

- Support Discharge of Long Stay Patients

This work stream has the potential to deliver community based opportunities for 16 individuals.

- Development of a Joint Community Facility for Autism and Learning Disability

A project to support this development is planned for 2016/17. A revised Initial Agreement will be considered in April 2014.

- Develop a New Model of Care Fit for Future Learning Disability Inpatient Services

To support this new model of care, patient pathways will be revised across all levels of the health and social care system.

Development of a Model of Care and Delivery of Services for People with Profound and Multiple Disabilities

A working group will be set up to take forward this initiative.

- Development of a Health Inequality Strategy Building on the Interim Lothian Action Plan and National Strategy; The Keys To Life within the overarching framework of NHS Lothian’s Health Inequality Strategy, the learning disability programme will detail health promoting actions specific to the needs and wishes of people with learning disability and their families.

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6 The Keys to Life – Improving Quality of Life for People with Learning Disability, Scottish Government Health Department, June 2013

Developing Person-Centred Primary and Community Services
3.21 **Develop a new East Lothian Community Hospital**

We will develop a new East Lothian Community Hospital to replace Roodlands and Herdmanflat Hospitals with modern accommodation and increase capacity to treat more East Lothian residents locally, it is anticipated the new community hospital will open in late 2017.

The provision of this local community hospital will ensure that more patients can be admitted directly and more can be discharged quickly from Edinburgh hospitals for post acute care through increasing the capacity for step-up/step-down provision for older people.

The new hospital will also increase capacity for day surgery and outpatients so that more East Lothian residents can be treated locally in line with the Lothian wide scheduled care capacity plans.

3.22 **Redesign of Midlothian Community Hospital**

The Midlothian partnership is at an early stage of developing a project plan to support the redesign of Midlothian Community Hospital. The key actions at this stage will be to:

- strengthen the Midlothian in-reach service
- implement the ‘frailty’ model through an enhanced Rapid Response Service
- extend the provision of assessment and intermediate care beds at the Highbank care facility

The main challenge in Midlothian is the limited availability of care home beds, however in the interim, the partnership will continue with the development and provision of extra care housing.

3.23 **Lothian Unscheduled Care Service (LUCS)**

LUCS has a mixture of salaried and ad hoc General Practitioners working within it, the split of shifts covered is approximately 50/50 salaried and ad hoc. It also employs Emergency Nurse Practitioners and paramedics via a Memorandum of Understanding with the Scottish Ambulance Service.

The service is based across 5 bases within Lothian, 3 are open until midnight and the other 2 are open overnight. LUCS covers 118 hours per week, two thirds of the week.
Over the last eighteen months the national shortage of doctors has severely impacted on the ability of LUCS to cover its rotas. Out of hours (OOH) work is not popular among General Practitioners. This is due to a number of factors outlined below:

- European Working Time Directive
- Busier day time practice
- Busier out of hours shifts
- Recruitment and retention of salaried medical staff has been difficult and those that transferred into the new system in 2004 are now aging and the new doctors are looking for a work life balance that does not put Out of Hours in the forefront of roles they would be seeking to do

Since 2005/06 (first full year of operation) to 2012/2013 the demand on the service has increased by 18%. With the current move to maintain higher numbers of complex patients in the community and to manage flow through the hospital sector 7 days a week there are increasing demands on LUCS. The increase in LUCS activity from 2004 is outlined in the graph below.

**LUCS Activity 2004-05 to 2012-13**

![LUCS activity graph](image)

In meeting this demand, a number of new initiatives and other ability of LUCS to maintain core work:

- The services are seeing an increase in the level of complex patients seen in OOHs (particularly the frail elderly, care homes and palliative patients).
- There was an increase in the direct access to OOHs through our professional to professional telephone line, a 25% increase since 2010/2011 and patients using LUCS as a walk in service.
In addition to the current pressures of demand, there are a number of challenges facing LUCS such as new initiatives and other increasingly complex areas of work and this will impact on the ability for the service to maintain core work. Key challenges relate to:

- the increase in level of complex patients seen in OOH, particularly the frail elderly, care home and palliative patients
- the increase in direct access to OOH through our professional to professional telephone line, a 25% increase since 2010/11
- the additional demands on OOH over and above the normal core work e.g. public health
- information sharing through anticipatory care plans is leading to longer home visits (expected to increase further due to the Key Information Summary and QOF)

LUCS will undertake a service review as part of addressing these challenges.

4. SUPPORTING DELIVERY OF OTHER NHS LOTHIAN STRATEGIC PLANS

In addition to the reference in Section 3 above, outlining the key role primary care and community services play in supporting delivery of NHS Lothian’s mental health, older people, learning disability and palliative care strategies. NHS Lothian also has an existing sexual health strategy and is also refreshing the children and young people and cancer strategies for which primary care and community services play a key role.

4.1 Better Cancer Outcomes in Lothian 2015 - 2020

A number of areas have been outlined within the cancer strategy where primary care and community teams have a pivotal role. These have been identified as:

- Participation in the Detect Cancer Early (DCE) Programme at local and national level including developing and implementing specific Lothian initiatives
- Improving access to diagnostic services to support earlier detection, including scoping the potential for pathway redesign and working alongside national improvement programmes
- Assist practices in improving their screening programme uptake, in particular supporting the bowel screening Scottish Quality and Outcomes programme initiative in 2013/14 and 2014/15
- Supporting the improvement of cancer referral guidelines by working locally and nationally, and supporting their local implementation in liaison with referrals advisors and others
- Supporting the palliative care programme including supporting learning and development associated with the Palliative Care Directed Enhanced Service (DES), and supporting the Lothian Palliative Care Redesign Programme
• Assessment of redesign potential to improve follow-up, and participation in the Lothian Transforming Care After Treatment programme

Work has already begun to support the DCE programme which aims to achieve earlier diagnosis of cancer with an initial focus on breast, colorectal and lung cancers.

NHS Lothian has commenced a pilot with 10 practices to explore different models of improving GP engagement to improve breast and bowel screening rates supported by a £60,000 investment from local DCE programme funding.

To support roll out of the DCE programme; NHS Boards have been allocated ‘6 QOF points equivalent’ funding to support the development of a Local Enhanced Service. An enhanced service specification will be developed in conjunction with NHS Lothian’s Detect Cancer Early Programme Board.

Further development of the work streams outlined above will be supported via NHS Lothian and Macmillan Cancer Care support a GP Lead post and a Nurse Consultant post for Cancer and Palliative Care. This team will work with colleagues across the healthcare system to manage this programme of work. There is a need to establish an appropriate forum straddling both primary and secondary care to discuss the how best primary care services can support the redesign of pathways and services and identify resource requirements to meet the aspirations of the cancer strategy.

4.2 Strategy for Children and Young People 2013 – 2020

A recent consultation has been undertaken to refresh NHS Lothian’s Strategy for Children and Young People 2013-2020. The strategy focuses on achieving the following outcomes:

• Every child and young person will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity
• Disabled children and young people will have their additional needs met
• Children, young people and their families will be involved in decisions that affect their health and wellbeing
• NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services
• To improve health and resilience in those more vulnerable to poor health NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions (Article 24 UNCRC)
• The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services, and the development of services at St John’s Hospital
NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population of children and young people (Article 42 UNCRC)

Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy (Articles 43 - 54 UNCRC)

In 2013, A Vision for General Practice in the Future NHS\(^7\) was published. This vision outlines the changing landscape in which an understanding of high-quality health care is changing. It recognises the move towards a twenty-first-century system of integrated care, where clinicians work closely together in flexible teams, formed around the needs of the patient and not driven by professional convenience or historic location. It is therefore crucial that GPs are involved in the development of plans for the integration of children’s services.

Furthermore, the report states that GPs in 2022 will need expert generalist clinical skills, particularly in the context of managing children with complex medical conditions and that, “They will be able to respond to both urgent and routine needs, providing first-contact services to the majority of children.....”. It is therefore important that GPs generally have opportunities to maintain their knowledge and skills.

NHS Lothian’s Strategic Plan 2014 - 2024 outlines the need to review GP numbers and workforce support in light of the population and demographic changes. In addition, to support GP training in the management of children and young people, GPs are encouraged to access programmes such as the Lothian Fellowship Programme for paediatrics and the National Education for Scotland Paediatric Scholarships, which are particularly aimed at GPs with a special interest or wanting to take a lead in the practice.

4.3 Sexual Health and HIV Strategy 2011 – 2016

Primary Care has a crucial role to support the delivery of this strategy as the majority individuals contact primary care services for matters relating to sexual health.

A number of key ambitions for primary care are outlined within the strategy as follows:

- Increase uptake of long acting reversible contraception (LARC) through the local enhanced service
- Increase testing for HIV for higher-risk populations
- Reduce demand for routine sexual health interventions in the specialist service by signposting patients to primary care and developing clear referral guidelines for primary care

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\(^7\) The 2022 GP - A Vision for General Practice in the Future NHS, Royal College of General Practitioners, May 2013
The strategy for Blood Borne Virus (BBV) is outlined through the Hepatitis Managed Clinical Network (MCN) work plan and the Sexual Health and HIV Strategy.

Ambitions for primary care relate to:

- Provide sterile injecting equipment to people who inject drugs, and educate people who inject drugs to use sterile equipment on each occasion.
- Increase testing for HCV and HIV through primary care, particularly for the populations at higher risk (a Local Enhanced Service for BBVs supports this objective) and improve access into specialist services for antiviral treatment
- Increase vaccination rate for Hepatitis B for higher risk populations

4.4 **Substance Misuse**

There are strategies in the four Alcohol and Drug Partnership which emphasise prevention, access to treatment and support to recover. Primary care services, health and social care partnerships and the voluntary sector have a key function in the delivery of this work. The ambitions for primary care outlined within the partnership plans relate to:

- Increase number of Alcohol Brief Interventions (ABIs) in primary care, reduce current variation of uptake between practices and establish ABIs as routine
- Support and increase the quality and effectiveness of the service provided through the National Enhanced Service (NES) for Drug Misuse (circa 4000 patients receive treatment from their GP for opiate dependency)
- Increase the opportunities for people receiving treatment through the NES to achieve recovery within a substitute prescription

5. **DELIVERING THE PRIMARY CARE AND COMMUNITY SERVICE PROPOSITIONS**

The four Lothian Health and Social Care Partnerships are to develop a Strategic Plan supported by a number of Joint Commissioning Plans such as those for older people, mental health, learning disability, addiction and criminal justice services.

In order for the aspirations outlined in this plan to be met, these need to be reflected within the partnerships strategic plans to ensure local ownership.

There is a need to continue to support existing and establish new forums across primary, secondary and social care services to support the redesign of pathways and services outlined within NHS Lothian’s Strategic Plan. There is a need to agree a mechanism to ensure representation in these forums from primary care services.
The developments associated with the primary care contractors will be taken forward with support from the Primary Care Contractor Organisation (PCCO).
NHS Lothian
Primary Care Strategy
Demand, Capacity and Access
An Overview
Introduction

Primary Care Services consist of four distinct professional groups, these are:

General Medical Practices (GP practices)
General Dental Practices
Community Pharmacy Services
Optometry Services

All the above services are provided, in the main, by practitioners operating as or within independent businesses.

It is therefore difficult for the NHS to prescribe what range and quantity of resources each should provide to deliver the services contracted for, or to ascertain what resources each has in place.

Demand, Capacity and Access issues will differ markedly between localities and between providers within the same locality.

The main drivers for the above differences centre on local population growth, deprivation, demographics, the impacts of Shifting the Balance of Care, availability of adequate resources in Community Services, the efficiency of the structure (man-power/staff mix), systems and processes internal to the individual provider and the suitability and capacity of premises.

Each of the above will have its own impact and, where more than one factor is present; will have as minimum a cumulative, if not an exponential, impact.
**Demand**

The growth in demand on Primary Care Services is affected by numerous factors, few of which can be immediately influenced by Practices or the NHS.

These include:

Population Growth in locality (impact on Practice lists size)

Demographics of Practice population (particularly those impacts related to a growing elderly population, in terms of consultation frequency, complexity and duration, and the increase in the incidence of domiciliary visits.

Nationality (where patient communication difficulties impact on length of consultation and cultural expectations)

Deprivation Levels/Volume (historically high-end users of health services, particularly Primary Care)

Housing Development Plans (impacts of recent and future housing developments on population growth, practices list sizes and thereby demand)

The movement of condition specific patient care into the Primary Care setting and the further expectations of "Shifting the Balance of Care" from the acute sector into the Primary Care and Community setting.

The reduction in Community Services (Health Visitors, District Nurses, AHPs etc) over time has increased the need for patients to access GP services.

**Population Growth**

Determining what the population growth in Lothian has been and projecting what it may be in the future is subject to a number of data variables, dependant upon the source of the data in question.

Traditionally, most planning assumptions for public services, including the NHS, have been based on General Registrar Office (GRO) [now National Records Scotland (NRS)] data and information.

To inform the production of this document and in addition to the NRS data, various other data and information sources were examined to obtain a broader picture, with a significant degree variance becoming apparent.

This included Local Authorities Housing Land Audits, which predict the level of house completions by locality each year, from which the rise in population for an area and therefore for Primary Care services can be calculated.

The other source of information examined was that produced by the Practitioner Services Division (PSD) of National Services Scotland (NSS). This data reports the size of General Practice lists as of 1st April each year.
Table 1 below demonstrates the variance between NRS projections and the actual size of GP patient lists over time.

<table>
<thead>
<tr>
<th>1000’s</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRS Projections</td>
<td>856.20</td>
<td>865.86</td>
<td>875.18</td>
<td>883.86</td>
<td>892.43</td>
<td>900.69</td>
<td>908.96</td>
</tr>
<tr>
<td>Lothian List Size</td>
<td>894.50</td>
<td>903.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total HLA Impact</td>
<td>6.59</td>
<td>6.91</td>
<td>7.76</td>
<td>7.31</td>
<td>6.85</td>
<td>7.43</td>
<td></td>
</tr>
<tr>
<td>NRS 2013+Housing</td>
<td>856.20</td>
<td>872.45</td>
<td>882.08</td>
<td>891.62</td>
<td>899.73</td>
<td>907.55</td>
<td>916.39</td>
</tr>
<tr>
<td>Lists 2013+Housing</td>
<td>894.50</td>
<td>909.75</td>
<td>916.66</td>
<td>924.42</td>
<td>931.72</td>
<td>938.58</td>
<td>946.01</td>
</tr>
</tbody>
</table>

**Table 1:** Comparison between NRS projections\(^1\) and cumulative GP Lists\(^2\) with population impacts of Lothian Local Authorities’ Housing Land Audits

Graph 1: Lothian Population Projections

The graph above clearly demonstrates the disparity between NRS (GRO) projections and the apparent reality at GP practice level. Whilst it is accepted that there will be a degree of churn in practice list sizes the data from each practice, as of 1\(^{ST}\) April each year, is compared and validated against the NHS Central Register (NHSCR) Demographic Extract.

Using 2012 as a common point of origin (NRS estimate based on 2011 Census and GP lists size for that year), the population impacts of the Lothian local authorities Housing Land Audits has also been projected.

The full pan-Lothian population projections are available in Appendix 1 to this document.

\(^1\) [http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm](http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm)

\(^2\) Source: National Services Scotland, Practitioner Services Division
Since 2009/10 Practice list sizes, across NHS Lothian, have grown by circa 29k, the equivalent of circa 6 good sized practices. In 2013 there has been an increase in the incidence of practices reporting their patient lists as full or restricted, albeit still open, within Edinburgh City (see Appendix 5), whilst practices in other Health and Social Care Partnerships (HSCPs) report growing pressures.

This is at variance with the projections forecast by NRS as, at 2012; there was a gap of circa 38,000 between the reported cumulative NHS Lothian list size and the NRS population estimate for that year.

Factors to be considered when looking at this disparity include cross-boundary (external to Lothian) residents registered with Lothian practices, non-notification of emigration and unreported deaths occurring abroad.

One conclusion that could be drawn from the above is that the practice list size is the stronger determinant of the demand upon an individual practice and that this should form the basis of any planning for the future.

It would, however, be equally important to take cognisance of the projected growth in population for the South-East of Scotland and the Lothian area in particular, combined with the changing demographic profile of that population.

**Demographics**

It has been long accepted that the changing demographics across Scotland will have a significant impact upon all NHS services, over time. This is particularly true of Primary Care and Community services and increasingly so when ‘Shifting the Balance of Care’ is factored into planning for the future.

The aging population and non-UK immigration are the two main demographic factors high-lighted by GPs as impacting upon their capacity.

The growing, elderly, population across Lothian brings with it issues of increasing numbers of patients with multi-morbidity and frailty. This patient group frequently requires a disproportionate time for each consultation and access GP services with greater frequency than younger patients. Visits, either to homes or care homes, are particularly time consuming and more likely in this group for both practice and community services.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2010-20</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>836.7</td>
<td>883.7</td>
<td>925.2</td>
<td>88.5</td>
<td>10.58%</td>
</tr>
<tr>
<td>0-15</td>
<td>141.4</td>
<td>147.4</td>
<td>157.1</td>
<td>15.7</td>
<td>11.10%</td>
</tr>
<tr>
<td>16-64</td>
<td>571.4</td>
<td>595.5</td>
<td>613</td>
<td>41.6</td>
<td>7.28%</td>
</tr>
<tr>
<td>65+</td>
<td>124</td>
<td>140.8</td>
<td>155.3</td>
<td>31.3</td>
<td>25.24%</td>
</tr>
</tbody>
</table>

**Table 2:** Change in Population by Age Group 2010 to 2020

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3 http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm
Graph 2: Projected Demographic Change in Lothian 2010 to 2020
Data Source: http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm

Of the Lothian wide increase (25.24%) the projected proportional increase, for each HSCP, in aging populations (+65) in the time period above, across Lothian are:

West Lothian (36.17%)
Midlothian (27.74%)
East Lothian (24.43%)
Edinburgh (20.61%)

Although Edinburgh shows the least, proportionate, increase it is worthy of note that this represents a potential increase of over 14,000 in its elderly population.

The percentage increases in the aging populations above help to illustrate the proportional increase in demand that will impact on both Primary and Community services, particularly where concentrations of care homes and sheltered housing occur.
The full projections by Local Authority and Age Group are demonstrated in Appendix 2.

**Non-UK In-Migration**

There has been a large influx of non-UK immigrants over recent years and this is projected to continue. The larger proportion of these has been from former Eastern European countries, post EEC membership and is anticipated to increase as more countries take up EEC membership. There has also been a rise in the proportion of the, relatively stable, student population who are foreign nationals.

Migration is the most difficult element of population change to estimate as, unlike births and deaths, there no comprehensive system of registration of movement to and from the rest of the world, nor moves within the UK.

A number of information sources must be brought together with the NRS estimates of migration to create a fuller picture.

Accepting this, in-migration has fluctuated over the years although the trend continues to be upward and out-migration has shown a gradual decline.

This has resulted in an average, between 2006 and 2011, net in-migration of circa 7,000 per annum, i.e. more than a GP Practice worth of new patients.

**Deprivation Levels and Inequality**

At the end of 2012/13, there were fifteen practices in which more than a third of the practice population lived in one of the 20% most deprived areas of Scotland, measured by SIMD. (See Appendix 3)

At a Scotland level the impact of deprivation inequalities are stark, including:

- Average life expectancy of men in the most deprived areas is **70.1 years**, in the least deprived areas it is **81 years**;
- For women it is **76.8 years** in the most deprived areas, in the least deprived areas it is **84.2 years**;
- Exclusive breastfeeding rate at 6-8 weeks is **15%** in the most deprived areas, in the least deprived areas it is **40%**;
- GP consultations for anxiety per 1,000 patients is **62** in the most deprived areas, in the least deprived areas it is **28**; and
- Alcohol-related hospital admissions per 100,000 of population in the most deprived areas are **1,621**, in the least deprived areas it is **214**.

People in more deprived areas have higher rates of vascular disease, mental health problems, obesity, alcohol and drug misuse problems, diabetes and most types of cancer. Children in deprived areas have significantly worse health than those in more affluent areas. For example, they have lower
average birth weights and breastfeeding rates, have poorer dental health and are more likely to be obese.

GPs working in deprived areas will have a workload that reflects the prevalence of multi-morbidity in their population. Their population will also have a higher need for support with other social needs, which often impacts on their use of healthcare services. As well as high need for primary medical care, their patients will have greater need for other community health and social care services.

However, although Scotland has a higher ratio of GPs to people compared with every other UK country, the distribution of GPs does not necessarily reflect the respective needs of people according to the level of deprivation in their area.

From the perspective inequity of access, the distribution of primary care services across Lothian does not fully reflect the higher levels of ill health and wider needs found in deprived areas, or the need for more preventative health care. The distribution of other primary health care services, such as pharmacies, is more closely matched to need.

The Deep End group of practices, which serve the most deprived populations in Scotland, argues for better integrated care for these patients. The group has made the following recommendations to meet their enhanced needs:

- Provide extra time for consultations and best use of serial encounters for patients in the most deprived areas.
- Provide additional clinical capacity, equivalent to one additional GP per 1000 patients in the most deprived areas.
- Develop a stepped approach to engagement for attached workers in general practice.
- Provide attached alcohol workers.
- Develop a National Enhanced Service for Vulnerable Families (NES).
- Recruit practice attached community link workers.
- Enhancements to GP training to give GP trainees experience of work in deprived areas.

**Shifting the Balance of Care**

Shifting the Balance of Care has moved demand out of the acute sector into the Primary and Community care sectors. This has impacted most upon GP practices and Community Services (see Demand section below).

The effect of this shift has been to impact on the resources, already stretched through the drivers mentioned above, available within GP Practices.
Further planned shifts of activity from the acute sector to the Primary and Community setting will need to be defined, the resource impacts explicitly identified and the required resource transfer and structural changes put in place, before any relocation of activity takes place.

**Housing Developments**

The South East of Scotland and Lothian in particular, have been identified as the area that will see the greatest growth in population over the next 20 years.

The period up to 2020 will be no exception to this with a projected average increase in Lothian population of circa 7,000 per annum. This is based on the 2012 Housing Land Audits (HLs) from each of the, Lothian, Local Authorities (LA). HLA’s however do not portray the full measure of population growth although their impact will be contributory.

The Housing Land Audits provide clarity as to where and how many houses are planned to be built and the population impact on the local practice, or practices, can be calculated from this.

In Graph 1 on page 3 above and in Appendix 1, and using 2012 as a common point of origin, the projected population impacts of the cumulative data from the Lothian local authorities Housing Land Audits have been demonstrated.

The projections in the Housing Land Audits mentioned above (See Appendix 1) are based on land, and its housing capacity, identified for this purpose by each local authority in their local development plans.

The decision on when to commence building and at what rate, for individual housing developments, is a purely commercial one and therefore subject to fluctuating market conditions.

**Resource Levels in Community Services**

The work and work-load of Primary Care services, and specifically General Practice, is directly affected by the movement in the levels, types and capacity of services available to support them in the community.

The reduction and/or lack of these services will result in increased patient demand for General Practice services which, in turn often translates into increased demand upon Out-of-Hours, acute hospital beds and A&E services.

**Capacity**

The capacity of Primary Care services can be affected by a range of factors, not all within the control of primary care service providers. The area of Primary Care that reports significant capacity issues is that of General Practice (GP).
There is now an acute crisis of capacity, many practices having already expanded and adapted to their limits and patients may now have to access several practices before being accepted.

Edinburgh CHP has identified a non-recurring, short term payment scheme to help practices grow by 500 patients, known as List Extension Growth Uplift (LEGUP). Funding is being sought from NHS Lothian to enable a pilot to progress in Edinburgh.

**General Medical Practices**

- The number, whole time equivalents (WTE) and status of GPs within a practice i.e. partner, salaried, long-term/short-term locum.

- GP practices now have a mainly female, part time, profile. Many are younger GPs, who do not aspire to partnership status may not wish to work full time and are often more interested in salaried posts.

- Practices are not obliged to provide information on their GP staffing nor the WTE GPs in a practice. As a result it is impossible to estimate the true ratio of GP resource available against a practice list size.

- Although the Primary Care Workforce Survey (PCWS) 2013 estimates that the GP WTE has risen to 610, from the 590 estimate in 2009, these calculations are based on a much reduced return rate for 2013. It is interesting to note that, at variance to the above, the estimated sessional commitment has reduced from 634, in 2009, to 520 in 2013.

- The number, WTE and status of practice nursing staff, all of which determines how much and what GPs can, or cannot, appropriately delegate/sign-post to for care. The PCWS 2013 count of nurses employed in practices was carried out in a very different way, than that undertaken in 2009, so no direct correlation can be made.

- The number, grades, experience and abilities of Practice Managers and administrative staff to deal with first contact from patients, ensure procedures are efficient and implemented effectively and that policies and procedures are regularly reviewed and updated.

- The capacity of community services (District Nursing, Health Visitors and School Nursing etc) to reduce the need for patients to contact a practice in the first instance and to deal with patients within the community avoiding condition exacerbation and repeat access to GP services, and maintaining independence.

- The capacity of Social Services to provide services and equipment for patients to aid recovery and re-enablement, avoiding condition exacerbation and maintaining independence.

- Demography, particularly the rapidly growing elderly population, levels and volume of local deprivation and in-migration also impact upon the capacity of general practice. This is due to the additional time these patients require, albeit for different reasons i.e. medical condition and
physical communication disability, chaotic life-styles or second language communication issues and cultural expectations.

- The application of appropriate and/or innovative activities, processes and procedures ensuring efficient practices are in place, avoiding negative and seeking positive impacts on the capacity of the practice and patient access to its services.

- Other factors which have had a negative effect on GP practice capacity include:
  - increase in IT requirements, with some degradation in consultation functionality including prescribing;
  - increase in QOF requirements for a flat resource;
  - increase in GP training requirements, again with a flat resource;
  - more care home patients;
  - shift of ‘tasks’ from secondary care, not formally recognised;
  - the impact of welfare and benefit reforms (both consultations and administrative time, again under-resourced)

- Premises – the suitability and capacity of facilities to support the activity required to deal appropriately with the volume of patient contacts.

**General Dental Services**

There are a known number of practices who are taking on new NHS patients but, at the current time, no capacity issues have been identified.

**Community Pharmacy Services**

There are no known capacity issues, for Community Pharmacy Services, within Lothian

**General Ophthalmic Services**

There are no known capacity issues, for Ophthalmic Services, within Lothian

**Community Services**

There has been erosion in the numbers of ‘trained’ nursing staff (Health Visitors, Community Nurses and School Nurses) in the community, off-set to a degree by an increase in community Health Care Assistants (HCA).

However, whilst the WTE of community ‘nursing’ staff between 2009 and 2013 has risen over-all, by 1.34% (13.19 wte), practice list size has increased by over 3% ( circa 29,000).

Preparedness for Vision 20:20 would indicate a need for more, rather than fewer community nurses. This is particularly important if community-based palliative care is to be maintained or increased.
**Access**

The quality of access to Primary Care services is, for most patients, determined by the immediacy of that access to a service, or range of services, suitable to address their need.

Pharmacy services are provided by high street retailers to which the public and patients have immediate access when their services are open.

General Practitioner, General Dental and Optometry services normally operate an appointment system, the latter two through negotiation between the practice and the patient.

General Practices have historically operated a first-come-first-served system of one kind or another, although there are good examples where practices are moving away from this to address demand, capacity and access issues.

**Dentistry**

The decision whether or not to register with any, or a particular, Dental Practitioner is solely the choice of the individual patient. The registration status available to the patient, NHS or private, and whether they are accepted will be determined by the Dental Practitioner.

Data on the number of purely private registrations with Dental Practitioners is not available; therefore the information below is confined to patients registered with a NHS General Dental Service (NHS GDS) Dentist.

The level of the Scottish population (all ages) registered with an NHS GDS dentist was 81.8% as at 31st March 2013, up from 79.8% as at 30th September 2012. Within the 6-12 and 13-17 age groups, over 99% of the population was registered with an NHS GDS dentist.

However, as will be seen in Table 3 below, Lothian falls short of the above by a significant margin and appear in the lower half of Health Boards, for both children and adults, for the proportion of registrations against population. This should be viewed with the caveat that a significant, but unknown, number of the Lothian population will be registered as private patients.

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Number of children</th>
<th>% of child population</th>
<th>Number of adults</th>
<th>% of adult population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shetland</td>
<td>4,574</td>
<td>94.80</td>
<td>13,497</td>
<td>76.40</td>
</tr>
<tr>
<td>Orkney</td>
<td>3,647</td>
<td>93.10</td>
<td>10,529</td>
<td>64.80</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>212,316</td>
<td>89.90</td>
<td>817,023</td>
<td>83.90</td>
</tr>
<tr>
<td>Scotland</td>
<td>927,330</td>
<td>89.50</td>
<td>3,370,982</td>
<td>79.90</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>64,112</td>
<td>89.00</td>
<td>253,188</td>
<td>85.90</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>24,743</td>
<td>88.70</td>
<td>90,603</td>
<td>75.40</td>
</tr>
<tr>
<td>Highland</td>
<td>53,017</td>
<td>87.80</td>
<td>161,885</td>
<td>64.40</td>
</tr>
<tr>
<td>Area</td>
<td>Induction Loop</td>
<td>Wheelchair Access</td>
<td>Private Consulting Area or Room</td>
<td></td>
</tr>
<tr>
<td>--------------------</td>
<td>----------------</td>
<td>-------------------</td>
<td>---------------------------------</td>
<td></td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>146 (80%)</td>
<td>165 (91%)</td>
<td>165 (91%)</td>
<td></td>
</tr>
<tr>
<td>East Lothian</td>
<td>20 (87%)</td>
<td>21 (91%)</td>
<td>19 (82%)</td>
<td></td>
</tr>
<tr>
<td>Midlothian</td>
<td>16 (80%)</td>
<td>17 (85%)</td>
<td>19 (95%)</td>
<td></td>
</tr>
<tr>
<td>Edinburgh</td>
<td>85 (79%)</td>
<td>97 (91%)</td>
<td>98 (92%)</td>
<td></td>
</tr>
<tr>
<td>West Lothian</td>
<td>25 (78%)</td>
<td>30 (91%)</td>
<td>29 (88%)</td>
<td></td>
</tr>
</tbody>
</table>

Table 5: Physical Access Resources Provided by Lothian Pharmacies

The new community pharmacy contract replaces one where NHS pharmacy services mainly related to dispensing of medication. The new contract aims to use the skills and knowledge of pharmacists better.

Pharmacists now graduate at a Masters level of degree education. The location and facilities of pharmacies could be better utilised to meet the needs of patients.

All pharmacies are required to provide 4 core pharmaceutical care services:
• Chronic Medication Service
• Acute Medication Service
• Minor Ailment Service
• Public Health Service.

Full descriptions of these services, together with the extended services provided by some pharmacies, are described in more detail in the document “Provision of Pharmaceutical Care Services Delivered via Community Pharmacy 1st April 2013 FINAL”.

In terms of access there appear to be no significant issues. This is not the GP impression in some areas, where pharmacies are unable to provide dosette boxes or other interval prescribing due to pressures. Again, deprivation may have a disproportionate effect – where much methadone / drug misuse prescribing, high levels of interval prescribing and so on.

However, chronic medication is the final core service to be implemented in pharmacies and the demand and workload has not yet been established. It may be useful in the future to assess the capacity in existing pharmacies and any changes to staffing skill mix that may help meet increasing demands.

**Optometry**

On 1st April 2006, a new NHS eye examination was introduced and free NHS eye examinations were extended to all in Scotland.

The traditional NHS sight test was replaced with a comprehensive eye examination appropriate to the patient’s needs. An initial eye examination is carried out (primary eye examination) and where necessary a second eye examination (supplementary eye examination).

<table>
<thead>
<tr>
<th>Lothian NHS eye examinations (total)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>At 31st March</strong></td>
</tr>
<tr>
<td>000's</td>
</tr>
<tr>
<td>Annual Change</td>
</tr>
<tr>
<td>% Change</td>
</tr>
</tbody>
</table>

Table 6: Total Eye Examinations per year Source: ISD August 2013

Approximately 35% of the Lothian population received an eye test during the year 2012/13. Given that the vast majority of these are primary eye examinations, and the population percentage receiving eye examinations has remained consistently over 30% per annum since 2009, there would appear to be no access issues to these services.

Traditionally, within the NHS, the first point of contact for most patients with an ocular or visual problem has been their GP. With the introduction of the NHS eye examination optometrists/ophthalmic medical practitioners should now be
promoted as the first point of contact for patients with eye related problems. This message is still not getting through to many patients resulting in many, unnecessary, GP consultations

**General Practice**

Improving access, for patients who need to interact with General Practices is a key issue in ensuring the patient's experience of the NHS is improved.

This includes improved access to a wider range of services, increasing core capacity, redesigning services by making full and effective use of professional skills, and harnessing information, technology and communications.

In practice this means, NHS Boards and primary care teams working together to improve access through, for example:

- increased capacity
- fit for purpose premises
- service redesign
- skill-mix
- development and more effective use of the skills of all primary care staff
- direct access to the full range of primary care staff
- local protocols for interdisciplinary referrals within primary care
- local protocols for interdisciplinary referrals to Community Services i.e. Community Nursing, CPN’s, Health Visitors, AHP services, OT and Social Services etc
- Fully resourced work transfer from secondary care
- information to local people about how to access and make the best use of services
- telephone triage arrangements
- use of NHS24 (08454 24 24 24)

A number of practices across Lothian are struggling to maintain the 48 hour access target, set by the QOF requirements. This is due to the increased demand they are experiencing and poor access to GP services remains the main point of concern for most patients.

GP practices in Lothian overall see around 10% of their entire practice weekly, which offers an extremely high level of access but which continues to be outstripped by rising demand.
Community Services

Access to Community Services is restricted by manpower availability and skill-mix within all the professional groups under this heading.

As mentioned above, under Capacity, whilst the WTE of community ‘nursing’ staff between 2009 and 2013 has risen over-all, by 1.34% (13.19 wte), practice list size has increased by 3.42% (C29k), 2 ½ times the rate of increase in (non-Psychiatric) nursing staff in the community.

This has led to the range of services delivered by these staff to become increasingly reduced with consequent impact on patient care and practices.

This will have a domino effect upon Out-of-Hours services and, inevitably, on A&E services and unscheduled admissions.

The reduction is particularly noticed in the care of patients who are frail, have multiple morbidity or palliative needs where spare capacity is required to manage unexpected clinical events.

Primary Care Premises

Primary Care Premises is dealt with under its own heading as the issues involved impact on both Capacity and Access, in part driven by Demand but by other factors also.

There are currently 94 premises providing accommodation for 127 GP Practices. These range from NHS owned health centres, GP owned medical centres and developer owned medical centres and premises leased from private landlords.

The quality of these premises range from relatively new facilities that accommodate Primary Care, NHS community and Council services, to GP practices based in converted residential premises such as Gullane Surgery, in East Lothian, currently being re-provided through a joint project with East Lothian Council. The maps in Appendix 5 show the distribution of GP premises across Lothian.

There are also NHS Community services provided from a range of GP premises and from NHS premises. These face the same range of issues as the GP services. Some GP premises cannot accommodate NHS staff.

There are 164 premises providing General Dental Services and 9 premises in which the Public Dental Service operate. There are some “state of the art” premises, but also some premises that will never fully comply with legislation or decontamination requirements in their current premises.
The Salaried Primary Care Dental Service is managed by West Lothian Health and Social Care Partnership (HSCP), but all HSCPs also have some responsibilities since some of the services are located in shared premises.

There are major issues of Disability Discrimination Act (DDA) compliance and functional suitability with some. GP/GDP owned, developer owned and private landlord owned premises range from modern compliant multipurpose buildings to old, non-compliant single purpose buildings.

Attached at Appendix 4 is the NHS Lothian GP premises development priorities list based on condition, compliance and functional suitability.

In dentistry there are two key issues with some practices being unable to achieve DDA compliance and decontamination standards. Primary Care Contractors Organisation (PCCO) is actively engaging Dental Practices to bring all facilities up to the “Glennie” standards for decontamination. PCCO is also the enforcement arm for the comprehensive three yearly GDP practice inspection regime.

Wherever possible and as opportunities present, the HSCPs and the relevant Council should develop multipurpose joint facilities to bring together a range of NHS and Council services in communities; the recently completed Wester Hailes project being an example.

Wester Hailes Healthy Living Centre provides new accommodation for over 300 NHS Lothian and Edinburgh Council and voluntary sector staff. This includes accommodation for the Wester Hailes Medical Practice and a wide range of other community health services including:

- Physiotherapy
- Salaried Primary Care Dental Service
- Podiatry
- Midwifery
- Learning Disabilities
- Community Child Health
- Mental Health
- Speech and Language Therapy

At various times in the week, other NHS outreach services will conduct clinics in the new Centre.

Council services located in the building consist of the Health and Social Care, Children and Families and Criminal Justice social work teams. The Centre will also accommodate the Wester Hailes Health Agency and the Wester Haven Cancer support Project.
The Health Agency will provide a range of therapeutic services, such as counselling, massage and relaxation as well as group activities such as walking groups, exercise classes and volunteering opportunities.

Another example, although not including council services is Musselburgh Primary Care Centre, completed in 2012, providing accommodation for:

**Three GP practices;**
- Inveresk Medical Practice
- Riverside Practice
- Eskbridge Medical Centre

**Children Health Services;**
- Speech and Language Therapy
- Occupational Therapy
- Physiotherapy
- School Nurses
- Community Child Health

**Together with;**
- Salaried Primary Care Dental Service
- Podiatry
- Outpatients
- District Nurses and Health Visitors
- Midwives
- Clinical Psychology
- Adult Psychiatry
- Adult Physiotherapy
- Dietetics

Facilities, such as above, could provide services for a whole community such as GP practices and practice based community health services, mental health services, social work services and day services and other public and voluntary sector services as appropriate to the locality.

These facilities would deliver all or some of the following benefits:

a. Allow the NHS and the Council to significantly improve some of their worst premises and ensure compliance with legislation.

b. Improve access to services for those communities.

c. Support NHS and shared strategies by providing space for shifting the balance of care where critical mass justifies the location of services.

d. Improve services through the co-location of NHS and Council teams.

e. Maximise efficiency in use of capital and revenue by sharing space and through joint procurement.

f. Provide physical capacity to allow general practices to register extra patients in the areas of population growth

g. Provide space for other independent contractor services, particularly pharmacy and dentistry.

NHS Lothian should continue to facilitate the re-provision of premises for GP
practices that are on the premises priority list (see Appendix 4), but which are not placed to take advantage of joint working opportunities. Within this priority the HSCPs should seek to reduce the number of separate premises and encourage small practices to share facilities.

These facilities would deliver the following benefits:

a. Allow the NHS and GPs to significantly improve the worst premises and ensure compliance with legislation.
b. Allow existing GP practices to expand to provide the capacity needed to accommodate population growth.
c. Allow GP practices to support Shifting the Balance of Care.

In improving premises for Community Services HSCPs should seek to incorporate as much NHS and Council owned estate into these developments wherever possible. Some could be incorporated into the proposed joint facilities discussed above.

This could facilitate the merging of NHS and Council teams and the disposal of assets to support the capital programme. These facilities would deliver the benefits described above.

Of note, there have not been any new, additional, practices in Lothian for a decade although there have been cases of practices sub-dividing, such as in the case of Durham Road and Niddrie Medical Practices, where the existing list was shared.

Edinburgh CHP has also identified a significant number of practices, city wide, who could increase their capacity by using a modest investment to internally reorganise rooms or build an extension, rather than address their needs by re-providing their premises. By linking this to an agreed increase in practice list size, population growth as well as premises constraints could be accommodated.
APPENDICES
### APPENDIX 1: Population Projections and GP List Size

<table>
<thead>
<tr>
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<td>865.86</td>
<td>875.18</td>
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<td>925.34</td>
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Data Source: NRS Projections population by Council and NHS Board area (2010-based), 2010-2035

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<tr>
<th>GP List Sizes by CH(C)P @ October Each Year</th>
<th>List Increase</th>
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<td>1000's</td>
<td>2009-13 Ave' PA</td>
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</tr>
<tr>
<td>Midlothian</td>
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</tr>
<tr>
<td>West Lothian</td>
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</tr>
<tr>
<td>Lothian</td>
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</tr>
<tr>
<td>Year on Year</td>
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Data Source: ISD GP List Sizes at October Each Year, Published December 2013

### Housing Land Audits (HLA) Estimated Population Impact

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<td>1.94</td>
<td>2.06</td>
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<td>1.72</td>
<td>1.91</td>
<td>1.86</td>
<td>1.74</td>
<td>1.58</td>
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<td>Total</td>
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<td>7.76</td>
<td>7.31</td>
<td>6.85</td>
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Data Source: Local Authority Latest Housing Land Audits

### Summary

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<td>846.23</td>
<td>856.20</td>
<td>865.86</td>
<td>875.18</td>
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<td>892.43</td>
<td>900.69</td>
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<td>917.17</td>
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<td>933.45</td>
<td>941.50</td>
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<td>957.35</td>
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<td>894.50</td>
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<tr>
<td>Total HLA Impact</td>
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<td>6.91</td>
<td>7.76</td>
<td>7.31</td>
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<td>7.43</td>
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<td>NRS 2013+Housing</td>
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<td>907.55</td>
<td>916.39</td>
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<tr>
<td>Lists 2013+Housing</td>
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<td>909.75</td>
<td>916.66</td>
<td>924.42</td>
<td>931.72</td>
<td>938.58</td>
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## APPENDIX 2: Projected Population Growth by Local Authority and Age Group

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<th>Age Group</th>
<th>0000's</th>
<th>Projected Change</th>
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<tr>
<td></td>
<td>2010</td>
<td>2015</td>
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<tr>
<td><strong>SCOTLAND</strong></td>
<td></td>
<td></td>
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<tr>
<td>All Ages</td>
<td>5,222.10</td>
<td>5,365.40</td>
</tr>
<tr>
<td>0-15</td>
<td>911.8</td>
<td>922.3</td>
</tr>
<tr>
<td>16-64</td>
<td>3430.8</td>
<td>3457.2</td>
</tr>
<tr>
<td>65+</td>
<td>879.5</td>
<td>985.8</td>
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</table>

| **Lothian** |      |      |      |         |      |
| 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% |
| 65+       | 124    | 140.8 | 155.3  | 31.3     | 25.24%|

| **East Lothian** |      |      |      |         |      |
| All Ages  | 97.5  | 103.3 | 109.3 | 11.8     | 12.10%|
| 0-15      | 18.8  | 19    | 20.4  | 1.6      | 8.51% |
| 16-64     | 61.2  | 64.4  | 67    | 5.8      | 9.48% |
| 65+       | 17.6  | 19.9  | 21.9  | 4.3      | 24.43%|

| **Edinburgh** |      |      |      |         |      |
| All Ages  | 486.1 | 517.2 | 543.8 | 57.7     | 11.87%|
| 0-15      | 72.3  | 77.8  | 84.2  | 11.9     | 16.46%|
| 16-64     | 344.3 | 362.6 | 375.8 | 31.5     | 9.15% |
| 65+       | 69.4  | 76.9  | 83.7  | 14.3     | 20.61%|

| **Midlothian** |      |      |      |         |      |
| All Ages  | 81.1  | 83.4  | 85.6  | 4.5      | 5.55% |
| 0-15      | 15.5  | 15.4  | 15.9  | 0.4      | 2.58% |
| 16-64     | 52    | 52.2  | 52.1  | 0.1      | 0.19% |
| 65+       | 13.7  | 15.9  | 17.5  | 3.8      | 27.74%|

| **West Lothian** |      |      |      |         |      |
| All Ages  | 172.1 | 179.9 | 186.7 | 14.6     | 8.48% |
| 0-15      | 34.9  | 35.3  | 36.6  | 1.7      | 4.87% |
| 16-64     | 113.7 | 116.4 | 118   | 4.3      | 3.78% |
| 65+       | 23.5  | 28.1  | 32    | 8.5      | 36.17%|

http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm
APPENDIX 3: Lothian Practices Ranked by % of List in Deprivation Quintile 1

Data Source: SIMD 2012 Data Base & CHI Data Base

<table>
<thead>
<tr>
<th>Practice</th>
<th>Practice Name</th>
<th>LHP</th>
<th>Q1 SIMD (most deprived)</th>
<th>% in Quintile 1</th>
<th>List Size</th>
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<tbody>
<tr>
<td>70215</td>
<td>Craigmillar Medical Group</td>
<td>SE</td>
<td>6,675</td>
<td>75.9%</td>
<td>8,790</td>
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<tr>
<td>70978</td>
<td>Wester Hailes Health Centre</td>
<td>SW</td>
<td>4,903</td>
<td>72.0%</td>
<td>6,805</td>
</tr>
<tr>
<td>70662</td>
<td>Muirhouse Medical Group</td>
<td>NW</td>
<td>7,638</td>
<td>63.1%</td>
<td>12,110</td>
</tr>
<tr>
<td>70573</td>
<td>Crewe Medical Centre</td>
<td>NW</td>
<td>4,177</td>
<td>52.9%</td>
<td>7,896</td>
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<td>70516</td>
<td>Gracemount Medical Practice</td>
<td>SE</td>
<td>3,573</td>
<td>50.6%</td>
<td>7,059</td>
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<tr>
<td>78311</td>
<td>The Craighall Partnership</td>
<td>WL</td>
<td>4,087</td>
<td>47.7%</td>
<td>8,573</td>
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<td>70911</td>
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<td>3,666</td>
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<tr>
<td>70906</td>
<td>Drs Sharpe, Putta &amp; Burns Practice</td>
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<td>1,352</td>
<td>42.1%</td>
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<td>70959</td>
<td>Dr Guy Johnson And Dr Helga Rhein</td>
<td>SW</td>
<td>628</td>
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<td>70605</td>
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<td>78043</td>
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<td>70427</td>
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<td>% in Quintile 1</td>
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<td>14,246</td>
<td>14.3%</td>
<td>99,711</td>
</tr>
<tr>
<td>North West Edinburgh</td>
<td>15,563</td>
<td>10.9%</td>
<td>142,940</td>
</tr>
<tr>
<td>South Central Edinburgh</td>
<td>3,062</td>
<td>3.4%</td>
<td>89,111</td>
</tr>
<tr>
<td>South East Edinburgh</td>
<td>23,402</td>
<td>21.2%</td>
<td>110,316</td>
</tr>
<tr>
<td>South West Edinburgh</td>
<td>15,694</td>
<td>19.9%</td>
<td>79,055</td>
</tr>
<tr>
<td>Lothian Total</td>
<td>114,561</td>
<td>12.8%</td>
<td>897,526</td>
</tr>
</tbody>
</table>
### Appendix 4: NHS Lothian Draft Primary Care Premises Priority List

<table>
<thead>
<tr>
<th>Rank</th>
<th>Existing Premises</th>
<th>CHP/CHCP</th>
<th>Priority Score</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Leith Walk Surgery</td>
<td>Edin</td>
<td>26</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Southside Surgery</td>
<td>Edin</td>
<td>24</td>
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<tr>
<td>5</td>
<td>Brunton Place Surgery</td>
<td>Edin</td>
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<tr>
<td>5</td>
<td>Granton Waterfront Development</td>
<td>Edin</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Dalkeith Road Surgery</td>
<td>Edin</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Ferniehill Surgery</td>
<td>Edin</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Southern Medical Group</td>
<td>Edin</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Edinburgh Homeless Practice, Cowgate</td>
<td>Edin</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Meadows Surgery</td>
<td>Edin</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Hermitage Terrace Surgery</td>
<td>Edin</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Edinburgh University Health Centre</td>
<td>Edin</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Morningside Surgery</td>
<td>Edin</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Polwarth Surgery</td>
<td>Edin</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Rose Garden Surgery</td>
<td>Edin</td>
<td>9</td>
<td></td>
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<tr>
<td>18</td>
<td>Durham Road Surgery</td>
<td>Edin</td>
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<td></td>
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<tr>
<td>20</td>
<td>New Leith Practice</td>
<td>Edin</td>
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<td></td>
</tr>
<tr>
<td>4</td>
<td>Blindwells Development</td>
<td>East</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Prestonpans Health Centre</td>
<td>East</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Cockenzie Health Centre</td>
<td>East</td>
<td>15</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>North Berwick Health Centre</td>
<td>East</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Tranent Health Centre</td>
<td>East</td>
<td>14</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Newton Port Surgery, Haddington</td>
<td>East</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>East Linton Surgery</td>
<td>East</td>
<td>7</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Shawfair Development</td>
<td>Mid</td>
<td>23</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Gorebridge Surgery</td>
<td>Mid</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Sutherland House, Loanhead</td>
<td>Mid</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Danderhall Surgery</td>
<td>Mid</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Loanhead Surgery</td>
<td>Mid</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Armadale Medical Centre</td>
<td>West</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>East Calder Health Centre</td>
<td>West</td>
<td>28</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Linlithgow Health Centre</td>
<td>West</td>
<td>22</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Winchburgh Health Centre</td>
<td>West</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Murieston Health Centre</td>
<td>West</td>
<td>20</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Dedridge Health Centre</td>
<td>West</td>
<td>19</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Carmondean Health Centre</td>
<td>West</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Whitburn Health Centre</td>
<td>West</td>
<td>17</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Craigshill Health Centre</td>
<td>West</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Bathgate Primary Care Centre</td>
<td>West</td>
<td>11</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Boghall Clinic</td>
<td>West</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>Howden Health Centre</td>
<td>West</td>
<td>10</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>Stoneyburn Health Centre</td>
<td>West</td>
<td>9</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>Blackridge Health Centre</td>
<td>West</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Kirkliston Health Centre</td>
<td>West</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>20</td>
<td>Strathbrock Centre</td>
<td>West</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>Fauldhouse Partnership Centre</td>
<td>West</td>
<td>4</td>
<td></td>
</tr>
<tr>
<td>21</td>
<td>West Calder Medical Centre</td>
<td>West</td>
<td>4</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 5: Lothian GP Premises and List Status (November 2013)
Primary Care Premises – A Strategic Over-View

1. EXECUTIVE SUMMARY

1.1 This document describes, at Health and Social Care Partnership level (HSCP), a series of recommended actions to adjust the existing Primary Care Infrastructure to the needs of the increasing demand driven, in significant part, by the steadily growing Lothian population and the under provision of suitable Primary Care premises.

1.2 Primary Care has, historically, demonstrated flexibility in absorbing the pressure of additional demand.

1.3 Within this document there has been a presumption against the establishment of new Practices, in favour of facilitating existing Practices to absorb new population, except where there is evidence of overwhelming need or a strategic opportunity. There has also been a presumption to support the development of infrastructure which allows Practices to share services with relevant partners.

1.4 The HSCP strategic plans, currently in development, will include a detailed strategy to address the Primary and Community premises issues highlighted in the attached appendices. These Premises Strategies will be updated annually and discussed at local GP Representative Meetings across Lothian, to establish a clear set of funded strategic actions to match infrastructure to population growth, up to and beyond 2024.

1.5 There is a need to establish Primary Care Population Growth funds which will facilitate practices to grow their list sizes. This would focus on practice manpower and any opportunities there may be to increase list size without investment in premises, see 2.7 below. There is also a need to establish a funding mechanism, based on the previous Initial Practice Allowance, to facilitate and support the establishment of new (additional) practices, where these are the only option available.

1.6 It is recognised that premises, GMS income and associated funding streams are only part of the Primary and Community services capacity which needs to be developed to meet the national and local strategic goals. This will have workforce planning implications, in addition to those of premises associated capital and revenue funding.
2. BACKGROUND

2.1 Over the period 2010 to 2030 the population of Lothian is expected to grow by approximately 165,718\(^1\) (from Circa 837,000 to Circa 1,000,000). This increase equates to 33 additional practices of 5,000 patients each, or 1.5 per year.

2.2 It should be noted, however, that there is a significant disparity between NRS population projections and actual practice list size, as reported for any given year. In 2012 this equated to the GP list population being Circa 38,000 more than the NRS projected population.

<table>
<thead>
<tr>
<th>Year</th>
<th>NRS Projections</th>
<th>GP List Sizes</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2010</td>
<td>2011</td>
</tr>
<tr>
<td>Year</td>
<td>836.84</td>
<td>856.20</td>
</tr>
<tr>
<td>GP List Sizes</td>
<td>881.66</td>
<td>885.93</td>
</tr>
</tbody>
</table>

Table 1: NRS/GP List Variance\(^{1,2}\)

2.3 Since 2009, the GP list size in Lothian\(^2\) has had an established growth rate of Circa 7,200 per year. However, historically, the linkage of premises development to population growth has been largely opportunistic, being driven by a response to the poor state of existing premises, the capacity of individual Practices to raise awareness of their particular issues and the opportunities created by sites becoming available.

<table>
<thead>
<tr>
<th>CH(C)P</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
<th>2009-13</th>
<th>Average PA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Edinburgh</td>
<td>508.54</td>
<td>513.97</td>
<td>515.21</td>
<td>522.58</td>
<td>528.12</td>
<td>19.58</td>
<td>4.90</td>
</tr>
<tr>
<td>East Lothian</td>
<td>101.59</td>
<td>102.15</td>
<td>103.96</td>
<td>103.39</td>
<td>104.22</td>
<td>2.63</td>
<td>0.66</td>
</tr>
<tr>
<td>Midlothian</td>
<td>85.73</td>
<td>86.13</td>
<td>86.59</td>
<td>87.61</td>
<td>88.40</td>
<td>2.67</td>
<td>0.67</td>
</tr>
<tr>
<td>West Lothian</td>
<td>178.50</td>
<td>179.41</td>
<td>180.17</td>
<td>180.93</td>
<td>182.42</td>
<td>3.92</td>
<td>0.98</td>
</tr>
<tr>
<td>Lothian</td>
<td>874.35</td>
<td>881.66</td>
<td>885.93</td>
<td>894.50</td>
<td>903.16</td>
<td>28.80</td>
<td>7.20</td>
</tr>
</tbody>
</table>

Table 2: Lothian GP List Size by CH(C)P\(^2\)

2.4 19 of Lothian’s 127 general practices, currently all in Edinburgh City but with similar pressures elsewhere in Lothian, are declaring their lists full or restricted at any given time. This is a substantial increase on five

---

\(^{1}\) NRS Population Projections, 2010 based
\(^{2}\) Trend of GP practice populations by gender and age-group as at 01 October 1999 – 2013 (ISD 2013.12.17)
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years ago when this status was used only in exceptional circumstances as a mechanism for recognition of capacity pressures.

2.5 This creates a ripple effect on neighbouring practices, as patients are required to register further afield and in turn creates capacity issues for those practices who may have been managing their list size satisfactorily.

2.6 GPs have emphasised, as part of this exercise, their reluctance to restrict their lists in this way and their willingness to work with NHS Lothian to address the imbalance between population growth and Primary Care capacity.

2.7 In late 2012, a short term measure was designed and proposed, by Edinburgh CHP, the Edinburgh List Extension Grant Uplift (LEGUP), to help with the immediate pressure. This was intended to help Practices who could extend their list sizes to do so, and release pressure from surrounding Practices. It is not the solution to the mismatch between infrastructure and population growth.

3. STRATEGIC PLANS

3.1 Across Lothian, 38 practices have been identified as requiring premises solutions to current capacity, compliance or quality issues and to address the future population growth.

3.2 The capital costs, of the above developments, are estimated to be between Circa £64m and Circa £84m. Whatever the final solution identified for development, in each individual case, there will be significant revenue implications for both Primary and Community services.

3.3 The scale and cost of these projects will vary from small amounts, for relatively minor alterations to increase physical capacity, to larger amounts for premises re-provision for existing practices or new premises for additional practices.

3.4 Each HSCP will continue to work on these, currently high-level, plans to produce detailed Primary Care Premises Strategies as part of their HSCP Strategic Plans.

3.5 High-level summaries of the identified needs addressing population/capacity issues, by HSCP, is provided in the appendices to this document together with the NHS Lothian Premises Prioritisation List, which deals, primarily, with the quality and suitability of the current physical infrastructure.

3.6 Primary Care Premises planning will also need to factor in significant additional accommodation and manpower resources for community services to address the increasing population numbers, changing
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demographics, “Shifting the Balance of Care”, the integration of Health
and Social Care and changing models of care, to provide the capacity
required and enable the delivery of core services.
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Appendix 1: Edinburgh HSCP Summary

Numerically, the majority of the Lothian-wide population increase has, and will continue, to take place within the City of Edinburgh.

<table>
<thead>
<tr>
<th>GP List Sizes by CH(C)P @ October Each Year</th>
<th>List Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000's</td>
<td>2009</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>508.54</td>
</tr>
</tbody>
</table>

Data Source: ISD GP List Sizes at October Each Year, Published December 2013

The trend of annual list size increases, demonstrated above, precedes the period in planning although NRS projections suggest that this will continue, if not increase.

NRS projections suggest that the Edinburgh population will increase by Circa 52,000 over the next ten years, equivalent to one new GP practice per year through to 2024.

There has been a significant level of practice facilities development within Edinburgh HSCP and this is on-going. Current developments will increase list capacity, in Edinburgh by Circa 6,500.

Further work has been, and is being, undertaken to develop mechanisms to address the continuing population expansion within Edinburgh and the capacity pressures this is creating for GP Practices.

These developments do not focus on premises in isolation (i.e. LEGUP see 2.7 above) and look to increase capacity within existing practices, where this is possible. However this, within the physical capacity of the current premises, will not address the population increases indicated above.

The current Edinburgh HSCP premises development plan looks at a range of options from relatively minor works, to improve space utilisation, the extension or re-provision of individual practice premises, the re-provision of multiple practices within single buildings and the need to create new and additional practices within Edinburgh.

The capital build costs involved in building new practice premises, or extending existing, vary considerably. As an outline guide, each 1,000 patients require approximately 90sqm of space so a practice of 5,000 will have an associated build at a cost of Circa £2m and associated revenue costs.

This development plan affects 19 (27%) of the 71 GP practices (17 premises) within Edinburgh HSCP, over the short, medium and long term and the overall costs are estimated to be between Circa £25m and Circa £30m capital and £100k and £150k p.a. revenue.
Appendix 2: East Lothian HSCP Summary

The mixed rural and township nature of East Lothian amplifies the impact of house building, and/or inward migration for other reasons, on individual practices, many of which are the only practice in a locality.

Overall, between 2010 and 2013, the GP list population has increased sufficiently to justify the creation of a single practice.

<table>
<thead>
<tr>
<th>GP List Sizes by CH(C)P @ October Each Year</th>
<th>List Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000’s</td>
<td>2009</td>
</tr>
<tr>
<td>East Lothian</td>
<td>101.59</td>
</tr>
</tbody>
</table>

Data Source: ISD GP List Sizes at October Each Year, Published December 2013

NRS projections suggest that the East Lothian population will increase by Circa 12,000 over the next ten years. However, the Housing Land Audit projected house building to 2020 (c4,000), suggests a minimum population increase of Circa 8,000 in that period.

Extrapolated through to 2024, this would equate to Circa 6,000 additional dwellings with an estimated additional population, to that of 2014, of 13,000. The latter indicates the need for two or three, new and additional GP practices through to 2024, or the significant expansion of existing practice and their facilities.

Of note is the NRS projection that East Lothian will also experience a 25% increase in their elderly population over the same period, with the increased demand this will place on GP and Community services.

There will be significant pressures on practices in East Lothian in addition to that addressed in response to previous population expansions. This will rapidly outstrip the current capacity and/or the suitability of practice premises, including:

- Haddington (3 practices, facilities and population),
- North Berwick (facilities and population),
- Prestonpans (high deprivation and population)
- Cockenzie and Port Seton (facilities)
- Ormiston (facilities and population)

The current framework does not address the potential of the Blindwells development, the initial phase of which would deliver Circa 1600 houses with an additional population of Circa 3,500. A new practice will be required to address this.
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The capital build costs involved in building new practice premises, or extending existing, vary considerably. As an outline guide, each 1,000 patients require approximately 90sqm of space so a practice of 5,000 will have an associated build at a cost of Circa £2m and associated revenue costs.

The overall costs are estimated to be between Circa £6m and Circa £9m capital and £100k and £150k p.a. revenue.

Appendix 3: Midlothian HSCP Summary

The mixed rural and township nature of Midlothian amplifies the impact of house building, and/or inward migration for other reasons, on individual practices, many of which are the only practice in a locality.

Overall, between 2010 and 2013, the GP list population has increased sufficiently to justify the creation of a single practice.

<table>
<thead>
<tr>
<th>GP List Sizes by CH(C)P @ October Each Year</th>
<th>List Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000's</td>
<td>2009</td>
</tr>
<tr>
<td>Midlothian</td>
<td>85.73</td>
</tr>
</tbody>
</table>

Data Source: ISD GP List Sizes at October Each Year, Published December 2013

National Records Scotland (NRS) projections suggest that the Midlothian population will increase by Circa 4,000 over the next ten years.

The Housing Land Audit projected house building to 2020 (Circa 6,000), suggests a minimum population increase of Circa 15,000 in that period. Extrapolated through to 2024, this would equate to Circa 9,000 additional dwellings with an estimated additional population, to that of 2014, of 21,000.

This latter would be the equivalent to 4 or 5, new and additional GP practices through to 2024 or the significant expansion of existing practices and their facilities.

Given the above there will be significant pressures on practices in Midlothian not having previously experienced capacity issues and in addition to that addressed in response to previous Local Development Plans. This will rapidly outstrip the current capacity and/or the suitability of practice premises.

The priorities within Midlothian, driven by the above, include:

- Loanhead (re-provision)
- Mayfield (re-provision)
- Gorebridge (extension)
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- Dalkeith, Bonnyrigg and Newtongrange triangle (new Practice) to relieve pressures created by completed and anticipated additional housing
- Danderhall (upgrade and extension)

The current framework does not address all of the potential of the Shawfair development which may deliver circa 4,000 houses with an additional population of circa 9,000.

The overall costs, to address the immediate capacity issues are estimated to be between £10m and £15m capital and £50k and £100k p.a. revenue but need to be subject to a detailed review.

Appendix 4: West Lothian HSCP Summary

Between 2009 and 2013, the West Lothian GP list population has increased by 3,920, equivalent to an additional 2 partner GP practice. This has been absorbed by existing practices expanding their lists and increasing manpower.

<table>
<thead>
<tr>
<th>GP List Sizes by CH(C)P @ October Each Year</th>
<th>List Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>1000's</td>
<td>2009</td>
</tr>
<tr>
<td>West Lothian</td>
<td>178.50</td>
</tr>
</tbody>
</table>

Data Source: ISD GP List Sizes at October Each Year, Published December 2013

There are significant core development areas, within the Local Development Plan, already impacting on GP and Community provision. As these develop further, demand will quickly outstrip capacity in terms of both.

West Lothian population has grown by 10% in the last 10 years to 175,990 (GRO Scotland mid-2012 population estimates). It is anticipated that the population will continue to grow to around 208,285 over the next 10 years, an increase of approximately 20% (33,295). This takes account of GRO projections and Housing Land Audit housing completions estimates.

The projected population increase above will require the equivalent of an additional 6 GP practices with average list sizes of 5,500.

The CHCP have undertaken an audit of practices and existing premises and have identified the following priorities for development to manage service integration and capacity issues.

- Armadale Partnership Centre: This will include development of a new GP Practice and re-provision of community health and council services.
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- East Calder Partnership Centre: This will enable expansion of existing GP and community provision in the core development area, along with development of Council based services
- Linlithgow Partnership Centre: This will enable expansion of existing GP and community provision
- Winchburgh Partnership Centre: This will enable expansion of existing GP and community provision in core development area, along with development of Council based services
- Murieston Medical Practice: This is only new practice to be established in last 10 years and is currently in temporary accommodation.

The Health Centre stock in West Lothian is aging and the following have been identified as needing refurbishment to ensure statutory compliance and meet required standards and demand.

- Dedridge Health Centre:
- Carmondean Health Centre
- Whitburn Health Centre

The overall capital and revenue costs, to address the immediate and long term capacity issues are still to be determined.
### Developing Person-Centred Primary and Community Services

#### Appendix 5: NHS Lothian Draft Primary Care Premises Prioritisation List

<table>
<thead>
<tr>
<th>Rank</th>
<th>Existing Premises</th>
<th>HSCP</th>
<th>Priority Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>Leith Walk Surgery</td>
<td>Edin</td>
<td>26</td>
</tr>
<tr>
<td>3</td>
<td>Southside Surgery</td>
<td>Edin</td>
<td>24</td>
</tr>
<tr>
<td>5</td>
<td>Brunton Place Surgery</td>
<td>Edin</td>
<td>22</td>
</tr>
<tr>
<td>5</td>
<td>Granton Waterfront Development</td>
<td>Edin</td>
<td>22</td>
</tr>
<tr>
<td>6</td>
<td>Dalkeith Road Surgery</td>
<td>Edin</td>
<td>21</td>
</tr>
<tr>
<td>7</td>
<td>Ferniehill Surgery</td>
<td>Edin</td>
<td>20</td>
</tr>
<tr>
<td>7</td>
<td>Southern Medical Group</td>
<td>Edin</td>
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Our Health, Our Care, Our Future

NHS Lothian Draft Strategic Plan 2014-2024

Engagement and Communication Plan

April, 2014
1. Introduction

The purpose of this document is to set out the engagement and communication plan to support the development of NHS Lothian’s strategic plan for 2014 – 2020.

A draft of the strategic plan is to be presented to the NHS Lothian Board in April 2014. The plan makes the case for change, signals the direction of change and contains a range of propositions.

The first phase of our engagement and communications activity has been designed to help the people of Lothian understand the need for change and raise awareness of our approach to delivering the Scottish Government’s 2020 Vision for achieving sustainable, quality healthcare services and a healthier future for everyone.

We will spend a minimum of three months engaging with stakeholders on the draft plan. This will allow us to initiate a conversation on the need for change, the propositions and direction.

Because the plan is broad and at the draft stage we will use phase one to clarify and help shape the strategic plan, including identifying which, if any of the propositions, require formal consultation. It will also enable us to refine our approach to the next phase of communications once the final plan has been approved by the NHS Lothian board.

A co-ordinated approach will be taken to internal and external communications, including all media relations, in order to ensure consistency in communication of key messages.

2. Communications Aims

- To start a conversation with stakeholders around the need for change and the propositions set out in the strategic plan
- To give the people of Lothian the opportunity to influence and shape the strategic plan and to recognise and record the impact of this
- To explain what decisions have already been taken and why to ensure stakeholders have a clear understanding of what they can influence
- To encourage people to respond and give their views
- To explain the consultation and engagement process for taking forward the propositions as a result of the plan being agreed.
In order to achieve the communication aims, a wide range of options for the people of Lothian to view and comment on the plan will be developed including, face to face, online and print.

The number of people accessing and responding through these different mediums will be recorded and their views fed into the development of the final plan. Media relations will be evaluated through the amount of coverage, its tone and position in publications.

3. Key Messages

- To continue to provide safe, effective person-centered healthcare for the people of Lothian, we need to do things differently.

- Our population is changing. This plan sets our approach to developing our health and care services to meet the changing needs of the people of Lothian and the current economic environment.

- The improvements and necessary changes will be delivered through NHS staff working in partnership with local authorities, the third sector and with patients and their carers.

- We want your views on whether the overall approach, set out by our propositions, reflects the right priorities.

- Through our patient pathway approach, we want you to tell us what we should do more of, what we should do differently and what we should stop doing to ensure we can continue to meet the healthcare needs of the people in Lothian.

- By getting involved and giving your views you can help shape the future of health and care in Lothian.

- Further specific consultation and engagement around the individual propositions contained in the plan will be carried out once the plan has been agreed.

4. Target Audiences

There is a wide and varied audience for this engagement process. Both NHS Lothian staff and the people of Lothian need to understand that the future will be different and to offer ideas and solutions for how this can be achieved.
Internal audiences
NHS Lothian staff including:
- The Board
- Joint Management Team
- Senior Managers and Senior Clinical Leaders
- Frontline staff

Health and Social Care Partnerships

External audiences
Patient and Public groups and networks (including hospital based forums)
Councillors
MSPs and MPs
Local authorities
Community Planning Partnerships
Community Councils
Patients
Carers
Members of the public
Third sector and community groups
Scottish Government Health Department
Media outlets

5. Engagement programme/timetable

The engagement programme will run from Monday 21 April 2014 to Monday 21 July 2014. During this time stakeholders and the general public will be encouraged to review the plan and give their feedback.

The general public
The engagement programme will utilise existing networks within communities to start conversations around what the future looks like for health care in Lothian.

A full and a summary version of the plan will be produced and will be available on the NHS Lothian website. A paper copy of both documents will be available on request.

The summary version of the plan will present the context and challenges, our vision and the high level propositions. It will be widely distributed across Lothian including hospital sites, GP surgeries, pharmacies, community centres etc. It will highlight the questions we are looking for the public to respond to and ask them to complete a short on-line survey, e-mail or write to us with their comments. This document will also direct people to the NHS Lothian website for the full version of the plan.
The people of Lothian will be encouraged to participate in the engagement programme through existing communication channels such as Health Link and social media. A poster will also be produced and distributed to key community sites.

**Communities and interested parties**
Community groups and Third Sector organisations will be invited to send representatives to attend presentations and discussions about the draft Strategic Plan in each of the four Lothian local authority areas. As well as being given an opportunity to feed in their views at these local meetings, the representatives will be asked to discuss the plan, evaluation criteria and weightings with their wider membership and to send in their views on a feedback template. We will also be happy to receive requests to speak to groups and organisations.

Where possible, key clinicians will be invited to support the strategic planning team in delivering these sessions.

Briefings for other interested parties such as MSPs and local councillors will be provided as required.

**Staff**
NHS Lothian staff will play a key role in delivering the strategic plan. Understanding the case for change and being engaged in the development of the plan and the specific propositions will be instrumental in its success. Building on the work that has already been done to highlight the strategic framework, staff will be encouraged to take the time to read the plan and give their views.

The plan will be available on the intranet and will be promoted through the regular internal communications channels. A briefing for managers will encourage them to engage their teams in discussing the plan, what it means for them and how they can contribute. It will also encourage staff to review and respond to the questions around the evaluation criteria and weightings.

A series of open meetings will be held at key hospital sites as well as in community and primary care and professional networks such as the GP Sub Committee, advisory groups for nurses, dentists and community pharmacists and also the Area Clinical Forum.

**Media**
Some of the ground work for the plan has already been done through the media coverage of the strategic framework. A press release will be issued to the national and local media to coincide with the publication of the plan on the NHS
Lothian website. A programme of media activity will be planned to support the community meetings and to encourage participation in the engagement process. Further media activity will be planned for when the final version of the plan is presented to the board.

6. Roles and Responsibilities and Resources

The Communication and Public Affairs Team will be responsible for overseeing the delivery of the engagement and communications plan working closely with the Strategic Planning Directorate.

In order to achieve the aims of this plan a detailed action plan is being drawn up covering a wide range of activities. The initial activities are detailed in Appendix 1. This will be developed as the plans for engagement and communication progress and the detail and timescales will be agreed and finalised by the Strategic Planning Communications Sub Group.

Non Executive Directors
NHS Lothian Executive Directors will be asked to present the vision and lead discussions about the plan at staff and community meetings.

Clinical Leadership
Key clinicians will be identified who are in a position to make the case for change and to engage with communities about the need and benefits. A series of short interviews will be filmed and can be used in meetings and on the NHS Lothian website.

7. Evaluation

The feedback received during the engagement period will be collated, reviewed and used to shape the final version of the Strategic Plan. A summary of the feedback will be produced which will explain what has changed, or not and why, as a result of the engagement process. This will be published on the website and sent to those groups who participated in the process.
# Appendix 1

## Engagement and Communication Action Plan

<table>
<thead>
<tr>
<th>DATE</th>
<th>AUDIENCE</th>
<th>ACTION</th>
<th>AIM AND DESCRIPTION</th>
<th>LEAD</th>
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<tr>
<td>Mon 14 March</td>
<td>Clinical Directors</td>
<td>Presentation</td>
<td>Overview of the plan to ensure teams are aware of the areas that may impact them before the plan is made public.</td>
<td>Strategic Planning</td>
</tr>
<tr>
<td>Mon 24 March</td>
<td>NHSL key clinicians and managers</td>
<td>Briefing document/powerpoint to be cascaded by Directors</td>
<td>Overview of the plan to ensure teams are aware of the areas that may impact them before the plan is made public.</td>
<td>Strategic Planning/Comms</td>
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<td>General Public/Media</td>
<td>Press release – linking to plan published on website as part of board papers.</td>
<td>Press release highlighting the content of the plan and setting out the programme for engagement.</td>
<td>Comms</td>
</tr>
<tr>
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<td></td>
<td>Latest news on the intranet.</td>
<td>To ensure staff are aware before reading in the media.</td>
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<tr>
<td></td>
<td></td>
<td>All staff email with link to website.</td>
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</tr>
<tr>
<td>Communities</td>
<td></td>
<td>Email to community networks</td>
<td>Based on press release and highlighting plans for engagement.</td>
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<tr>
<td>MSPs, local councillors</td>
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</tr>
<tr>
<td>Date</td>
<td>Audience</td>
<td>Activity Description</td>
<td>Department</td>
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<td>Wed 2 April</td>
<td>Board Meeting</td>
<td>Approval of draft plan and engagement activity.</td>
<td>Strategic Planning</td>
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<tr>
<td>W/c 7 March</td>
<td>General public</td>
<td>Media interviews</td>
<td>Comms</td>
<td></td>
</tr>
<tr>
<td>W/c 7 April</td>
<td>General Public</td>
<td>Health Link published including article on the Strategic Plan and engagement programme. Present vision for the future and prepare the public for conversation around the future of healthcare in Lothian.</td>
<td>Comms</td>
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<tr>
<td>Mon 21 April</td>
<td>(End July)</td>
<td>Launch of engagement. Distribution of summary document and posters. Website updated with summary document and survey monkey. Email to community networks. Encourage the people of Lothian to give their views.</td>
<td>Comms</td>
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</table>
SUMMARY PAPER - LOCAL DELIVERY PLAN

This paper aims to summarise the key points.

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

<table>
<thead>
<tr>
<th>Point</th>
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<tr>
<td>The Board is recommended to approve the final version of the Local</td>
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<tr>
<td>Feedback was received from the Scottish Government following</td>
<td>3.1</td>
</tr>
<tr>
<td>submission of the first draft on 14 February 2014. This has been</td>
<td></td>
</tr>
<tr>
<td>incorporated into the latest version of the LDP.</td>
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<tr>
<td>The NHS Lothian Local Delivery Plan is aligned to the NHS Lothian</td>
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<tr>
<td>Strategic Plan, and the four Integration Schemes that are currently</td>
<td></td>
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<tr>
<td>being developed.</td>
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<tr>
<td>That the 2014/15 Corporate Objectives are also aligned with the key</td>
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<tr>
<td>aspects of the LDP including the triple aims and 12 priority areas</td>
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<td>in the 2020 Route Map</td>
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</table>

Moray Joslyn
Programme Manager
18 March 2014
moray.joslyn@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning

alex.mcmahon@nhslothian.scot.nhs.uk
1  Purpose of the Report

1.1  The purpose of this report is to request that the Board approve the final version of the Local Delivery Plan 2014-15.

2  Recommendations

2.1  The Board is recommended to approve this latest version of the Local Delivery Plan 2014-15, and the plans within the appendices.

2.2  Note that the LDP is the delivery contract between Scottish Government and NHS Boards in Scotland, and sets out how Boards will meet HEAT targets and other national priorities.

2.3  Note that this final version of the LDP was submitted to the Scottish Government on 14 March 2014 in line with the national LDP development process.

2.4  Note that the 12 priorities within the 2020 Route Map have also been used to inform the development of this year's Corporate Objectives alongside the triple aims.

3  Discussion of Key Issues

3.1  Feedback was received from the Scottish Government following submission of the first draft on 14 February 2014. The main areas of feedback are highlighted in section 4 below.

3.2  The NHS Lothian Local Delivery Plan is aligned to the NHS Lothian Strategic Plan, and the four Integration Schemes that are currently being developed.

3.3  The Scottish Government is viewing 2014/15 as a transitional year for the LDP. Transitional plans will be further developed during the year as integration progresses.

4  Key Risks and areas to highlight:

4.1  Following submission of the first draft of the LDP to the Scottish Government on 14 February 2014, feedback was received on the following topics:

   •  Introduction to the LDP from the Chief Executive
   •  Named Executive Leads for each of the 12 priorities within the 2020 Route Map
   •  Map of key local plans (operational / thematic) against the 12 priorities within the 2020 Route
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.

6 Impact on Inequality, Including Health Inequalities

6.1 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.

7 Involving People

7.1 The involvement of people is outlined within the Improvement and Co-Production Plan.

8 Resource Implications

8.1 Resource implications are outlined within the HEAT Target Risk Management Plan.

Moray Joslyn
Programme Manager
18 March 2014
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Alex McMahon
Director of Strategic Planning
alex.mcmahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Improvement & Co-production Plan
Appendix 2: NHS Board Contribution to Community Planning Partnership Plan
Appendix 3: HEAT risk management plans
Appendix 4: HEAT delivery trajectories
Appendix 5: Workforce Plan
# NHS Lothian Local Delivery Plan 2014/15
## Improvement and Co-Production Plan

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<td>Introduction from the Chief Executive</td>
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<td>1.2</td>
<td>Executive Lead Contacts for the 12 priorities within the 2020 Route Map</td>
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<td>1.3</td>
<td>Map of Key Local Plans</td>
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<td>Care for Multiple and Chronic Illnesses</td>
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<td>4.9</td>
<td>- Strategic Clinical Framework</td>
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<td>4.10</td>
<td>- Multi Morbidity Action Plan</td>
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<td>- Chronic Pain</td>
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<td>Early Years</td>
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<td>4.15</td>
<td>Prevention</td>
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<td>Workforce</td>
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1.1 Introduction from the Chief Executive

As we look forward to 2014/15, NHS Lothian is progressing a number of priority actions to deliver the 2020 Vision. Work has commenced on many of these actions in 2013/14 and will continue in 2014/15. This work has been developed through engagement in national discussions on all the priorities set out in the Route Map, and involves co-production with staff, patients, public and partners.

We are currently developing our Strategic Plan for 2014-2024 and through this our aims and ambitions are being aligned to the aspirations of the 2020 Vision. The Draft Strategic Plan is being submitted to the NHS Lothian Board on the 2nd April for approval. From there the propositions that we set out will be taken forward for consultation, engagement and further development as appropriate.

The plan outlines how we will deliver health and care across the whole system, including primary and community care and acute hospital services. It considers the whole system and our proposals to transform patient pathways for those with complex needs and co-morbidities. It builds on our aspirations in respect of integration and the need to shift the balance of care to provide care at home and in the community whenever possible. We will review what activity is currently undertaken across our physical estate in order to ensure maximisation of space and our workforce. In doing so we are committed to retaining our four acute sites. These being the Royal Infirmary of Edinburgh, the Western General Hospital, St John’s Hospital and the Royal Edinburgh Hospital.

In addition, we will explore options to improve the quality and safety of hospital facilities. This will include re-providing complex care beds from Corstorphine Hospital, some from Astley Ainslie Hospital in upgraded accommodation at the Royal Victoria Hospital, and the long term use of the Royal Victoria Hospital.

With Edinburgh Council a priority for 2014/15 is to explore the future role of the Royal Victoria Hospital and Liberton Hospital to meet the care needs of older people. This will include the potential development of care villages. The options for both the Lauriston Building and the Princess Alexandra Eye Pavilion sites will also be reviewed. We will consider better utilisation of the Midlothian Community Hospital and the development of the new East Lothian Community Hospital for older people’s care. We have also restated our ambition to reprovide the Edinburgh Cancer Centre on the Western General site. These, along with other propositions will be set out within the final Strategic Plan which we will forward to you once the plan has been approved by the Board.

Tim Davison
Chief Executive
### Executive Lead Contacts for the 12 priorities within the 2020 Route Map

<table>
<thead>
<tr>
<th>Priority</th>
<th>Contact Name</th>
<th>Position</th>
</tr>
</thead>
<tbody>
<tr>
<td>Person-centred Care</td>
<td>Melanie Johnson</td>
<td>Director of Nursing, AHPs and Unscheduled Care</td>
</tr>
<tr>
<td>Safe Care</td>
<td>David Farquharson</td>
<td>Medical Director</td>
</tr>
<tr>
<td>Primary Care</td>
<td>David Small</td>
<td>Director of Health &amp; Social Care Partnership East Lothian</td>
</tr>
<tr>
<td>Unscheduled and Emergency Care</td>
<td>Melanie Johnson</td>
<td>Director of Nursing, AHPs and Unscheduled Care</td>
</tr>
<tr>
<td>Integrated Care</td>
<td>Alex McMahon</td>
<td>Director of Strategic Planning, Performance Reporting and Information</td>
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<tr>
<td>Care for Multiple and Chronic Illnesses</td>
<td>Alex McMahon</td>
<td>Director of Strategic Planning, Performance Reporting and Information</td>
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<td>Early Years</td>
<td>Alex McMahon</td>
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<td>Workforce</td>
<td>Alan Boyter</td>
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<td>Efficiency and Productivity</td>
<td>Susan Goldsmith</td>
<td>Director of Finance</td>
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### 1.3 Map of Key Local Plans

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<tr>
<td>Safe Care</td>
<td>• NHS Lothian Primary Care Strategy Demand-Capacity-Access</td>
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<td>• NHS Lothian Primary Care Premises Strategy</td>
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<td>• NHS Lothian Strategic Plan Appendix - Developing Primary and Community Services</td>
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<td>Primary Care</td>
<td>• NHS Lothian Local Unscheduled Care Action Plan</td>
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<tr>
<td>Integrated Care</td>
<td>• Integration Schedules x4 (in progress)</td>
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<td>• Delivering for Patients - NHS Lothian's Commitment to meet and sustain the Treatment Time Guarantee and Outpatient Standards</td>
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<td>• Joint Older People’s Plans x 4</td>
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<td>• NHS Lothian Mental Health and Wellbeing Plan</td>
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<tr>
<td>Unscheduled and Emergency Care</td>
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<td>• NHS Lothian Multi-Morbidity Action Plan</td>
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<td>Early Years</td>
<td>• Improving the Health and Wellbeing of Lothian's Children and Young People - Draft NHS Lothian strategy for children and young people 2013 – 2020</td>
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<td>• NHS Lothian Children and Young People’s Strategy 2014 – 2020 - Improving the Health and Well-being of Lothian’s Children and Young People - Draft Implementation Plan</td>
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<td>• 4x Integrated Children’s Services Plans</td>
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<td>• NHS Lothian Learning Disabilities One Year Interim Plan</td>
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<td>• Draft NHS Lothian 5 Year Property and Asset Management Investment Programme 2014/15 - 2018/19</td>
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<td>• Draft NHS Lothian Financial Plan for the period 2014/15 – 2018/19</td>
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2. Person-centred

Person-centred Care
For a long time, and in common with much of the rest of the UK, we have planned the way we deliver health services separately in different parts of our system (primary care, acute care, NHS, local councils). We have also tended to plan around buildings, or around individual services.

What is proposed here is a radical shift away from this ‘traditional’ approach to a patient-centred, whole-system approach, focussing much more explicitly on the needs of people who use NHS Lothian’s services.

Our Strategic Plan is predicated on the need for redesign to deliver improvements in health and care services in Lothian. A central tenet of service redesign is to focus on the patients’ journey and experience, to help identify where service improvements are necessary and to involve a wide range of service users and providers in analysing and redesigning improved patient pathways.

Using intelligence and evidence, we have identified representative patients with varying degrees of care needs. We then use these patients as examples to illustrate their pathways of care, understand their care needs, how their care needs are currently being met and agree how these can be met more effectively and efficiently in radically different ways. This is being conducted through a designed and managed process of engagement during 2014 and is expected to inform large and significant parts of the final plan.

Person Centred Health & Care Programme

The national Person Centred Health & Care Programme (PCHC) was launched by the Cabinet Secretary in November 2012 with the aim of developing health and care services that are centred on the people who use our services. This programme build on the work that NHS Lothian has done to date and gives us a further emphasis on how we use the experiences of patients, families and carers to improve our care and services.

There are five elements that as an organisation we should consider when speaking with patients and service users

- What matters to you?
- Who matters to you?
- What information do you need?
- Personalised contact
- Involved in discussions and communication about your care
In addition to this national improvement programme, NHS Lothian will also consider other sources of patient feedback and information such as patient stories. We will use a range of approaches to ensure that the patient's voice and their experiences are used to drive improvements so that care and services are provided safely, effectively and in a person centred way. This work also builds on our organisational values of care and compassion, dignity and respect, quality, teamwork, openness, honesty and responsibility.

2.1 Co-Production

The Scottish Government and CoSLA are of the view that using ‘assets-based approaches’ such as co-production are instrumental if we are to successfully shift the balance of health and social care and develop public services that are focused on prevention and independence (Governance International 2013). Co-production recognises that people have ‘assets’ such as knowledge, skills, characteristics, experience, friends, family, colleagues, and communities. These assets can be brought to bear to support their health and well-being. Co-production begins and ends with the person, placing them at the heart of any given service and involving them in it, from the creation and commissioning of that service through to its design and delivery, its assessment and sometimes, where appropriate, its end.

NHS Lothian uses co-production across a range of initiatives and health topics from the development of self-directed support, to the development of Public Social Partnerships around the Royal Edinburgh campus redevelopment programme.

Examples of Co-production

Self-Directed Support

The Social Care (Self-directed Support)(Scotland) Bill was passed by parliament on 28th November 2012, with Royal Assent granted in January 2013. The Self-directed Support Act (2013) will commence on 1st April 2014. In preparation for this NHS Lothian became an SDS test site to explore a re-ablement / self-management approach, where participants agreed and put in place a non-NHS intervention(s) to meet identified health outcomes, with the support of their key health professional.

The individual held a small budget (direct payment) and purchase this intervention themselves, with the effectiveness of the intervention, in achieving the identified health outcomes, being reviewed by their health professional. Individuals supported by specific staff teams or services around the following long-term conditions were recruited as test site participants:
The test sites found that fairly small (financial) interventions can achieve quite a lot in terms of positive outcomes and experience for patients, and that for some service users the opportunity to direct their support brings real health benefits. There is also potential to reduce the level of health service inputs for some service users through this model of re-enablement.

In 2014/15 NHS Lothian will continue to support self-directed support, and the commencement of the Bill. This agenda will be further strengthened by closer working through the integration of Health and Social Care.

**Public Social Partnerships**

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.

Recognising that services provided by public bodies have a social purpose at their core. PSPs enable the public and third sectors to work together to enhance services for the public and our communities. Overall responsibility for services in a social and community context will continue to be the legal responsibility of public bodies under statutory regimes. PSPs are about matching public service commissioners and the resources, knowledge and experiences of those within the public sector with the knowledge, experience and resources of the third sector.

PSPs are essentially about outcomes and results: focusing on innovation in service design and delivery; better understanding of service user requirements; maximising resources and efficiency and effectiveness in delivery, amongst others.

If the new services prove that they make a real difference to service users, their family and carers through piloting the new service, then NHS Lothian and the statutory agencies will consider what the best approach is to embedding the new service as part of four core service delivery.

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

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.

The 3rd sector has a strong record of innovative working and creative problem solving underpinned by a strong values base. Lothian’s Joint Mental Health and wellbeing strategy set out a number of priority actions to support transformational change which have greatly assisted in ensuring that all partners are committed to a shared value base.

With support and guidance from the consortium Ready for Business, to date three PSP work-streams have been identified to pilot the use of the PSP approach by NHS Lothian and the City of Edinburgh Council.

**Wayfinder**

A Knowledge Transfer Partnership (KTP) project which is focused on the redesign of rehabilitation for people with multiple and complex mental health needs. It is one of a number of change projects currently underway under the umbrella of the ‘Transformation Station’ which is a unique health and academic collaboration between NHS Lothian and Queen Margaret University. The first stakeholder event for this PSP will take place on 22 August and will consider how a community resource with capacity to provide safe and secure community living environment for people with multiple and complex needs can be designed and delivered. This is part of the implementation of the new Rehabilitation Pathway which has been developed with stakeholders over the last few months.
**Gateway**
The project is focused on developing the approach to outcome planning, signposting and navigation for people with neurological conditions, their families and carers. The Gateway will develop pathways of self-management and or / self-directed support, while providing opportunities to access accurate and tailored information. This function is a critical component in helping individuals to self-manage effectively and to direct the way in which their support is provided.

**Green space: Art space**
Inpatient accommodation will be re-provided in fit for purpose new buildings with some of the older buildings, due to their historical significance, being kept for support services. The campus, which has lots of trees and woodland most of which will be preserved, provides a great opportunity for a truly therapeutic and green environment to be created. The first stakeholder event for this PSP will take place on 30 August.

Each of the three PSPs to date have an explicit focus on addressing inequalities ad health inequalities in line with the social value approach embedded with the royal Edinburgh Campus Programme. Green space: art space offers a unique opportunity to shape the outside environment to support health gain for patients and wider communities. Each PS work-strand will build on the exciting 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.

Within Wayfinder a number of Change Champions within the various organisations and services have been identified, these were staff that understood the goals of the project and could not only input to the design process but champion the change within their respective areas. Together they can represent and influence all parts of the future patient journey from referral to rehabilitation.

The Wayfinder and Gateway PSP developments will be funded by existing budgets or proposals to support specific developments will be made to NHS Lothian and partner public sector agencies. The Green Space: Art Space PSP will most likely result in a comprehensive application to the Health Foundation.

**Scottish Neurological Alliance**
As part of the Scottish Neurological Alliance national initiative, NHS Lothian provides support and funding for the Lothian Neurological Voices Group. The membership of this group includes patients and carers, voluntary sector, local authority and NHS Lothian representatives who are committed to working
together to improve care and services for individuals with neurological conditions in Lothian.

The role of patients and carers involved in this group is to draw upon their experiences of services provided in Lothian and to consider, reflect and offer opinions on issues affecting patient care.

The purpose of the Group is to work in partnership with NHS Lothian and potentially other organisations to provide advice, constructive criticism, views and experiences of people living with a range of neurological conditions in order to:

- Shape and inform the neurological service development plans and priorities for Lothian
- Identify gaps in service provision
- Ensure that plans and developments focus on patient and carer needs
- Review and comment as requested on policy documents, patient information leaflets and any neurological service matter in which user input might be helpful.

Five neurological care development priorities have been identified by the group for focus, these are:

1. Development of specialist nurse / neuro-rehabilitation nurses as a bridge between hospital and community services
2. Importance of clear pathways for neurological care
3. Rapid access to services when required
4. Care needs to be patient focused
5. Training for Care Givers

These priorities will be reflected within NHS Lothian’s Neurological Improvement Plan which is currently being developed.

3. Safe

3.1 Complaints

NHS Lothian receives contacts from all sources via one centralised point, the Customer Relations and Feedback Team (CRaFT) although local clinical and management teams will resolve issues on site at the time.

The information received by CRaFT is triaged to be actioned and answered right away or sent to the pertinent personnel for the information required to answer
the query. Responses are channelled through CRaFT and all information is entered to a database.

CRaFT sends weekly reports to the clinical teams and managers in the service so that they are aware of current issues. This report allows the team to be aware of the current issues, worrying complainants and allows them to identify real-time trends for immediate action.

Monthly, quarterly and annual reports are also sent but these are retrospective and mainly indicate to the clinical teams how they have performed against the government targets for responding to complaints and against their previous performance.

A Quality report is produced by CRaFT each quarter and, as well as being circulated, this is discussed at the NHS Board meeting. This report highlights the most common reasons for complaints and the actions taken by the clinical teams to resolve them.

During 2014 it is proposed to add a new team to CRaFT who will objectively investigate the most complex or re-opened complaints and involve the complainant in the process and resolution. It is hoped that this new team will be in place by the middle of 2014.

4. Effective

4.1 Primary Care

Strategic Assessment of Primary Care

NHS Lothian recognises the need to expand the role for primary care and general practice to support delivery of the 2020 vision. To support this, engagement has taken place in recent months involving the Strategic Planning Committee and Primary Care Forward Group with further engagement events planned within the Lothian Health and Social Care Partnerships and other primary care contractors to support development of NHS Lothian’s Strategic Plan for Primary Care and to ensure plans are embedded with the Health and Social Care Partnerships’ Strategic Commissioning Plans which will be developed during 2014.

We also noted the actions with the letter published in December 2013 in respect of the GP contract in Scotland that in relation to the Integration agenda that GPs are seen as key to the delivery of integrated Health and Social care services and that:
• Each GP practice will nominate a practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership.

• Engagement with the evolving local Health and Social Care partnerships, and input to developments/decision-making will be led through these GPs as appropriate. Any additional consequential workload will be agreed.

We will clearly be taking these actions forward within our wider primary care actions aligned with our strategic and integration plans.

In Lothian, the key challenges relating to primary care are associated with anticipated population growth and the impact of this growth on demand for primary care services, implications for general practice and premises, capacity and workload, access to primary care services and meeting the expectations of the public to deliver efficient and responsive services.

In facing these challenges, NHS Lothian will focus on supporting a review and development of plans relating to:

- our community and primary care workforce
- primary care premises
- development of locality and team working supported by our Health and Social Care Partnerships,
- shifting the balance of care through review of the use of community hospitals, further development of intermediate care (step up / down) and increased home support
- tackle inequalities through locality planning and a targeted approach in focussing on areas of deprivation
- use of technology to support improved timely communication across health and social care and the interface between primary and secondary care and to support electronic communication between primary care contractors

NHS Lothian’s draft Primary Care Strategic Plan and supporting appendices are attached in Appendix 1. This draft plan will be discussed at the meeting of NHS Lothian Board on 2 April 2014 following which a period of public consultation will be undertaken.

An overview of demand, capacity and access across localities in Lothian and a discussion paper to review the current arrangements for medical services for frail elderly patients in community settings in Lothian with a view to explore alternative models of care is being developed.

NHS Lothian will undertake further assessment of the themes outlined within the Scottish Government Strategic Assessment of Primary Care circulated on 23 December 2013 via a number of established groups such as the Primary Care
Forward Group, Enhanced Services Review Group, Primary Care Data Group and Health and Social Care Partnerships in line with the guidance issued.

Focus on Keeping People Healthy in the Community

NHS Lothian plans to undertake a review of long term conditions pathways of care to incorporate preventative measures in communities of identified risk through regular specialist and supported self-care and appropriate rehabilitation.

Initiatives are already underway such as the COPD Invest to Save Project in Edinburgh which aims to create an integrated COPD service model within Edinburgh to improve patient experience and journey, reduce the number and severity of COPD exacerbations and subsequent hospital readmissions and allow more people to confidently self-manage their condition at home. If successful the model will be rolled out across Lothian.

There are a number of efficiency and productivity work streams relating to diabetes which includes diabetes prevention. The Enhanced Services Review Group is considering an enhanced service to support a shift in the management of type 2 diabetes to general practice.

Resource Shift to Deliver the Objectives of the Strategic Assessment of Primary Care

At this stage, it is too early to be able to quantify the resource shift required to deliver aspirations and strategic objectives for primary care.

The development of NHS Lothian’s Strategic Plan 2014 – 2024 and the Health and Social Care Partnership Strategic Commissioning Plans and will inform future resource requirements.

4.2 Unscheduled and Emergency Care

NHS Lothian and its partner organisations recognise the importance of providing safe, sustainable and quality unscheduled care for its local population. Unscheduled Care represents one of the priority areas for NHS Lothian and is explicitly linked to “Our Health, Our Future, The NHS Lothian Strategic Clinical Framework for 2013-2020”.

The Local Unscheduled Care Action Plan (LUCAP) has been produced in response to a request from Scottish Government to all Health Boards in Scotland that they should submit a quarterly plan setting out how they will achieve the 4 hour emergency care standard for patients. The plan address necessary improvements to the whole system rather than just within hospital to reflect the two strands of work from the national unscheduled care plan (out of
the acute hospital/community and within the acute hospital) and the complexity of the whole health and social care system.

It should be noted that the existing investments related to capacity have been informed by detailed capacity modelling. This was based on agreeing an optimal clinical model in 2011 with unscheduled care teams and the optimal flow measures and capacity to deliver that model. The LUCAP is therefore not starting from a blank sheet of paper and builds on many previous and existing work-streams. The LUCAP was approved by the NHS Lothian Board on 26th June 2013. NHS Lothian’s LUCAP was subsequently commended by Scottish Government in terms of its quality and transparency.

The following key achievements have already been met:

**Key Achievements**

- NHS Lothian’s LUCAP was submitted to the Scottish Government following approval by NHS Lothian Board
- A total of £1,022,317 has been allocated to NHS Lothian in support of the LUCAP for 2014/15 and 2015/16
- For 2013/14 a total of £1,331,545 has been allocated, including £125,000 set aside as HEAT T10 funding.
- In 2013/14 NHS Lothian is investing circa £14.14 million overall in unscheduled care (including winter).
- A review and update of NHS Lothian’s LUCAP was undertaken and submitted to the Scottish Government in December 2013
- A total of 48 actions were reported covering:
  1. Flow and the Acute Hospital (Right Time)
  2. Effective and safe CARE 24/7 at Hospital front door (Right Care)
  3. Making the Community the right place, and
  4. Developing the primary care response.
- Examples of initiatives spawned via the LUCAP include:
  1. The development of step-down and step-up beds,
  2. The development of frailty models across the community
  3. The adoption of 7 day working,
  4. The development of Alcohol Related Brain Disease (ARBD) pathways.
- Additional winter capacity has also been established with an additional 152 beds created as at December 2013, rising to 249 in March 2014.
- These additional beds will be supported by appropriate staffing models.
- Plans are in place to scale down these additional beds after the winter period (Jan-Mar) to avoid downstream consequences around service provision and financial management issues.
- The issues of delayed discharge remains a key pressure on the system.

Direct leadership focus is being developed via weekly meetings with
Chief Executives from both NHS Lothian and City of Edinburgh Council, along with other executive colleagues.

- New infrastructure headed by Hospital Site Directors, are now in place to drive and lead the necessary changes highlighted via the LUCAP.
- The achievement of the 4 hour target remains challenging. However performance is showing signs of improvement. The YTD monthly average performance for the period April –December 2013 was 93.5% against a target of 95%. This compares to 91.8% for the same period in 2012.
- Further support has been agreed with the Scottish Government to review systems and performance at The Western General Hospital. Specifically this will involve data analysis and process mapping and the production of an improvement plan to support us going forward into 2014/15.
- It is anticipated that NHS Lothian’s Unscheduled Care Board will continue to identify and support the roll out of further action to support our overall performance.

Going forward into 2014/15 a number of actions will be required. These include:

**Key Factors Going Forward**

- Delivery of the actions contained within the current LUCAP into 2014/15
- Review and update the LUCAP for 2014/15 with a particular focus on key strategic issues such as enhancing step-down bed provision as well as enhancing new frailty models of care.
- Following the Scottish Government’s review of the Western General Hospital, look to mainstream the findings from their implementation plan to support patient flow and performance.
- We will continue to work in tandem with other key stakeholders, in particular City of Edinburgh Council to develop our position with regards to delayed discharge.
- An additional 31 beds will become available at RIE from mid-February that will support issues of capacity and demand. We will also create a bigger planned assessment area, including additional bed capacity
- We will plan and oversee the scaling down of winter beds from March 2014, mindful of the issues of financial and workforce resources.
- Future workforce challenges are likely to continue, particularly to ensure we are able to recruit a workforce with suitable skills and competencies across a number of job families and specialties appropriate to unscheduled care (eg Stroke, MoE, ARBD etc.)
- We anticipate further investment to developing a sustainable workforce across sites. Including enhancing site management as appropriate.

Further detail is provided in Appendix 4 – Unscheduled Care.
4.2.2 Stroke

Plans are underway to increase Stroke medical cover at St John’s Hospital and to ensure a robust stroke service continues to develop at both the Western General Hospital site and the Royal Infirmary of Edinburgh. A consistent Stroke Outreach service across each of the three acute sites will be achieved so that Stroke Standards are delivered consistently across all of Lothian. Further work will be completed to improve the Thrombolysis pathway, with a pre-alert system to be trialled in partnership with the Scottish Ambulance Service. Better linking of Stroke Standard compliance to staff training is planned and several members of our acute teams are to be trained to deliver STAT training, improving NHS Lothian’s ability to up skill staff across the entire hospital Stroke pathway.

In 2014/15, to deliver the Stroke Bundle NHS Lothian will undertake the following actions:

- Exception reporting improvement methodology will continue across each of the acute Stroke Units. By looking at every patient’s journey and by examining all component parts of the bundle, using the established exception reporting framework, and taking appropriate action when there is any deviation.
- Education will be better linked to performance against the Stroke Standards targeting improvement efforts and training towards areas of weakness.
- Uptake of STAT train-the-trainer training will enable acute services to deliver in-house Stroke training.
- CT Scan performance will be maintained.
- Training and use of exception reporting methodology will continue to drive improvements in Aspirin prescribing and Swallow screening.

In relation to Access to a Stroke unit, NHS Lothian will:

- Explore new models of acute Stroke care aimed at improving patient experience and performance against each of the Stroke Standards.
- Develop the Stroke Outreach model, further ensuring more patients are pulled into Stroke Units earlier.
- Develop better links with downstream community rehabilitation to ensure effective stroke flow enables timely access to Stroke units.
4.3 Integrated Care

4.3.1 Integration

Health, social care and other public services across Scotland have been working increasingly closely for many years, including in Lothian. However, they will undergo further, significant changes particularly during the next two years when NHS Lothian will work with its four local authority partners and the citizens of Lothian to establish four new Health and Social Care Partnerships, covering the communities of Edinburgh, East Lothian, Midlothian and West Lothian.

Aligned to the development NHS Lothian’s Strategic Plan will be the development of four integration plans (or Schedules) describing how NHS Lothian will work with its four Council partners. The timeline to develop Integration Plans and establish Integration Joint Boards is informed by national timeline for the Bill to become legal and for regulations to be produced by Scottish Government.

NHS Lothian will develop Integration Plans in partnership with Local Authorities during 2014. Draft Integration Plans will be presented to the NHS Lothian Board in December 2014 for approval to consult. Our ambition is for the new Integration Joints Boards to be established in April 2015 but acknowledge that this timeframe is driven by the guidance in the Scottish Government regulations.

These changes, which are expected to fully integrate services with the prime purpose of delivering improvements, will affect the governance, leadership and management arrangements, all of which are essential for successful delivery of this plan. It will therefore be a priority for NHS Lothian and its partners, not only to avoid structural concerns of integration becoming a diversion or a hindrance to change, but rather to ensure that the process of integration is designed and enacted in ways which most effectively deliver the necessary changes at a pan Lothian, partnership, locality and neighbourhood level.

Integration is an essential enabler, which will generate a new dynamic, creating opportunities for NHS Lothian and its partners to realise the outcomes highlighted in our strategic plan.

There is an established culture of joint-working between NHS Lothian and the four Local Authorities which provides a firm foundation to develop the Integration Schedules as required in the Public Bodies (Joint Working)(Scotland) Bill. There is a joint director in post for each of the four Integration Joint Board areas and shadow health and social care partnerships have been established to lead the development of draft strategic plans.

The key objectives during 2014/15 are:
• To produce and consult on the four Integration Schedules required in the Bill.
• To develop the systems and controls to delegate functions to the Integration Joint Boards
• To develop the role of Shadow Health and Social Care Partnerships
• To agree the localities that will be used for the Integration Joint Boards' Strategic Plans.
• To progress the strategic needs assessments in each Local Authority area to inform the Strategic Plans.

4.3.2 Innovation

NHS Lothian’s delivery of the 2020 Vision for Innovation – An “Outcome Needs” led approach

NHS Lothian has a strong tradition of leading on healthcare innovations, which it continues to build upon with a very effective Research and Development Programme, which sees NHS Lothian receive nearly half of the Scottish allocation of the Research & Development budget (5.1% of the 11.5% allocation to Scotland).

This is closely aligned with the collaborative work that NHS Lothian is involved in as part of the Bio Quarter development.

NHS Lothian has been at the forefront of the development of Telehealthcare, particularly in relation to the self-management of long term conditions. This having been reflected in NHS Lothian being one of the five NHS Boards involved in the Living It Up Programme.

NHS Lothian has also been at the forefront of the introduction of the “Lean methodology approach” to the NHS, which has at its core, the redesign of patient pathways and processes by frontline staff through identifying constraints and problems to achieving optimum care, and designing and implementing changes required to address these.

In addition, the NHS Lothian Efficiency and Productivity programme has, supported locally developed ideas to improve service delivery, through “invest to save” resources, and the implementation of the NHS Lothian 5x5x5 service redesign programme.

Through its Strategic Clinical Framework: Our Health, Our Future, NHS Lothian has committed itself to six key Outcomes:
1. Enhancing prevention, reducing inequalities and promoting longer, healthier lives.
2. Delivering integrated care across primary, secondary and social care.
3. Introducing evidence-based best practice and innovation from other healthcare systems to deliver safe and sustainable care for patients.
4. Delivering care at the right time in the most appropriate setting.
5. Supporting people to manage their own health and wellbeing and that of their families.
6. Use the resources we have – skilled people, technology, buildings and equipment – efficiently and effectively.

With these aims to be delivered against a challenging financial background where the cost of healthcare is rising at a rate in excess of GDP growth, innovative approaches to the future provision of healthcare services will be required, rather than simply doing more of the same thing.

At its Innovation Event in October 2013, NHS Lothian identified the following four priority needs for the identification and subsequent adoption of innovative solutions:

A. Meeting the increase in demands that will be placed on health services as a consequence of the over 75 population doubling in number in the next 20 years.
B. The need to reduce acute hospital admissions – when care can be more appropriately provided elsewhere.
C. Reducing the number of out-patient appointments provided in hospital clinic settings.
D. Reducing the cost baseline for health care services by 5% per annum, through work-streams such as the NHS Lothian Efficiency and Productivity Programme, which as previously mentioned has strong stakeholder engagement.

This approach will ensure that the NHS Lothian innovation work stream will be “Outcome Needs” led rather than simply starting from a “Technology Led” perspective.

Innovation Co-Production

The success for NHS Lothian’s innovation programme will come as the result of effective collaboration with our staff, other NHS organisations, our local authority partners (particularly in support of the integration agenda), further education institutions, the third sector, research-based industries, and most importantly of all, the public and healthcare service users.
The greatest knowledge of how healthcare services are provided rests with patients (their relatives and friends) and NHS Lothian staff providing care in response to their healthcare needs. With this knowledge comes a range of ideas as to how these services can be improved in ways that better meet local and specific identified needs, moving away from “one size fits all” models of care, to more person centred options.

These “tailored” models of care are a means to better support individuals in the prevention and management of their illness, with a greater emphasis on providing them with informed choice, rather than only looking for their informed consent.

In support of this approach, the NHS Lothian Strategic Plan 2014-2024, includes plans to redesign care around four “fictional” patient pathways, based on current data on healthcare utilisation. Based on the needs of each “patient”, discussions involving patients and staff across the whole health and social care system will identify the innovative service delivery changes required in the future, to enable NHS Lothian and its partners to achieve the government’s 2020 vision for health and healthcare.

Patients and our staff will be at the core of all that NHS Lothian will do in the development and planning of innovative solutions to meet it’s “Outcome Needs”. The engagement of them in the innovative process, as with the other stakeholders will be enabled through their continued involvement in the implementation of the NHS Lothian Innovation Action Plan.

The Innovation Action Plan will result in:

- Workshop sessions to:
  - consider the “Needs” identified by NHS Lothian in its Clinical Strategy, and from there identify the “Outcomes” that patients, clinicians and other stakeholders have defined as being the measures as to evidence of their delivery.
  - Utilise the experience of service users and those responsible for delivering services to identify what innovative solutions will be required as the only means through which NHS Lothian will achieve its agreed outcome measures.
  - Set out the design for future service provision that will incorporate the agreed innovative solution – and the development of an evaluation process to be used to determine its effectiveness and efficiency in achieving the agreed outcome measures.

- The creation of an Innovation Intranet / Internet page that will enable two way communication re the posting of the “Needs” of NHS Lothian along with the seeking of innovative solutions. This will also act as a resource to highlight innovation and report progress on innovative solutions being
implemented in NHS Lothian, and to provide examples from other healthcare systems of innovative approaches, that staff /stakeholders may wish to consider for adoption in Lothian.

- Ensuring that those who have developed the endorsed innovative solutions are then empowered to implement them, with an acknowledgement that not all of these will be successful.

**Innovation Collaboration with Industry and co-creation of new products.**

In line with the Scottish Government vision for innovation, NHS Lothian will develop collaborative partnerships with organisations such as the Scottish Lifesciences Association, the Bio Quarter and the Digital Health Institute in the development and evaluation of new products that will better meet the healthcare needs of the population.

For the wealth of the nation, this will provide the opportunity for industry to develop products that will have strong market potential, that will stimulate growth and with that employment opportunities, encouraging them to further innovate.

4.3.2 **Use of the Independent Health Care Sector for Acute Hospital Care**

NHS Lothian recognises that the use of the independent sector should only be used to support short-term capacity issues within the service. However, over the past 18 months, in order to address significant backlogs in inpatient and outpatient waiting lists, the independent sector has been used to support clinical services in order to create additional capacity.

NHS Lothian has additional NHS capacity at Golden Jubilee National Hospital for Orthopaedics, Plastic Surgery, Ophthalmology and General Surgery. Utilisation of this has been variable and revised pathways have been developed to optimise the use of this capacity, including a more robust patient transport system to make this option more attractive for patients.

NHS Lothian currently has agreements in place with four independent sector providers – Spire Healthcare, The Edinburgh Clinic, Nuffield Hospital, Glasgow and Ross Hall Hospital. These agreements ensure that NHS Lothian can access capacity for agreed see and treat pathways and also for treat only patients across a range of specialties including Urology, General Surgery, Ophthalmology, ENT, Plastic Surgery and Orthopaedic Surgery and that those providers provide a quality of service that is in line with the quality standards that patients treated within NHS Lothian comply with. Further work is underway with external providers to enhance monitoring and reporting arrangements in place for clinical quality standards.
NHS Lothian uses Medinet routinely to run clinics and theatre lists for a range of surgical specialties. The coordination of patients treated through Medinet clinics and lists is managed by NHS Lothian staff. Medinet has been used to provide additional capacity for Urology, Colorectal, Gastrointestinal, General surgery, Ophthalmology, Neurology, Plastic surgery, Dermatology, Maxillo-facial and ENT. All services provided to date have been for adults.

Over the past year, new processes have been put in place with each of the independent sector providers to ensure that appropriate patients are transferred to those providers in a standardised and consistent manner and that that patients are offered appointment opportunities in line with NHS Scotland waiting times processes. Those processes also ensure that NHS Lothian receives regular updates on the booked status of those patients.

NHS Lothian is in the throes of a significant investment plan to enhance local clinical capacity and therefore reduce reliance on the independent sector. Clinical Management Teams within NHS Lothian are updating capacity plans currently and are predicting either a phased reduction or no requirement for capacity in the independent sector in 2014/15. The impact of local investment is already evident as the volume of patients being identified and offered treatment out with the NHS is now reducing in a number of specialties.

Capacity plans for all specialties are expected to be finalised by March 2014. From these, shortfalls in internal capacity will be identified, resulting in a new round of negotiation with independent providers, using the new National Procurement framework, to agree activity volumes for 2014/15.

Also in 2014/15, governance arrangements with independent providers will focus on complementing the monitoring and scrutiny programme delivered through Health Improvement Scotland (HIS).

External Contractors

Investment plans are predicated on the goal of achieving a sustainable internal NHS Lothian service to meet on-going demand; however there are areas where this will not be possible in 2014/15 and a degree of reliance on the independent sector will continue.

The agreement of phasing plans for implementation of the additional capacity requirements outlined above will determine the requirement for use of external capacity. A general provision of £9M has been made for additional capacity to support delivery of targets including TTG during the implementation phase. This general provision represents a 50% reduction with non-NHS providers against the level of spend forecast in 2013/14. Any further requirement will be managed against slippage on the investment plan.
4.4 Care for Multiple and Chronic Illnesses

4.4.1 Strategic Clinical Framework

NHS Lothian agreed a Strategic Clinical Framework in February 2013 to guide the vision, plans and transformational change we need for the future. It is based on our values which are in line with those of NHS Scotland, and the associated behaviours we have developed with staff.

NHS Lothian has also confirmed its core purpose- to deliver safe, effective person centred healthcare and healthier lives for all.

The framework sets out six strategic aims which we need to deliver to achieve the Scottish Government’s 2020 vision for health and healthcare:

- Prioritise prevention, reduce inequalities and promote longer healthier lives for all
- Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care
- Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for patients
- Design our health care systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting
- Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of families
- Use the resources we have – skilled people, technology, buildings and equipment – efficiently and effectively

We are now using this framework as we develop an integrated set of strategic plans for transforming our services which will be presented to the Health Board in April 2014. Our Strategic Plan will cover the period 2014-2024 and will cover the following themes:

- Delivering a different relationship with patients and the public
- Integrating health and social care systems
- Designing integrated pathways of care
- Developing primary and community services
- Developing acute hospital services
- Making it happen: delivery and change management
- Managing the finances

The Plan with set out the changes needed to meet our strategic aims and our plans and proposals in each of these areas, which will be further developed through public consultation in the first half of 2014/15. This consultation will take
place alongside the engagement and consultation on the integration plans of theour Lothian Health and Care Partnerships. The achievement of our aims is
integ rall y linked and dependent on the ability of partnerships to deliver more
integrated health and care for their populations at partnership and
neighbourhood level.

4.4.2 Multi Morbidity Action Plan

The Multi Morbidity Action Plan which addresses the 2020 Route Map priority to
improve care for people with Multimorbidity (2 or more long-term conditions) was
discussed at the NHS Chief Executives' Business Meeting on 15 January 2014.
During 2014/15 NHS Lothian will progress the following 'Top Ten Actions for
Boards and Partnerships':

- Adopt Year of Care model in GP practices and spread personal outcomes
  approaches in community teams.
- Design holistic GP practice and outpatient appointments for people with
  multiple conditions.
- Scale up Anticipatory Care Planning in primary care and use of Key
  Information Summaries in unscheduled care.
- Roll out Pharmaceutical Care Planning and reviews.
- Introduce practice attached support workers / community navigators and
  simplify access to local community support.
- Scale up use of digital information, guided self-help, remote monitoring
  and consultation.
- Extend health coaching and health promoting interventions to all care
  settings.
- Develop roles, job shadowing and action learning to enhance generalist
  skills in specialist care and specialist expertise in community workforce.
- MCNs develop Single point of access / ICT enabled decision support for
  Multimorbidity at key points in local pathways.
- Identify practice populations with Multimorbidity and deliver care
  management using a tiered model of peer, Third sector, technology and
  professional support tailored to complexity.

4.4.3 Chronic Pain

At an operational level, plans to streamline the patient pathway over the service
have proved useful in determining on-going service peaks and troughs. Further
work is needed to identify how this will be best utilised to make better use of the
existing resource and plan for future service requirements. Underpinning this
work has been the development of a single point of referral into the service
which is currently based at the Western General Hospital, under the direction of
a consultant Anaesthetist. Current new patient numbers reflect an on year
referral increase of 8% which generates a new to review ratio of 1:1.7. As this is
out with current capacity, additional work will be required to refined referral pathways and streamline the current multi-site/service provision into a single service provision thus reducing inappropriate refers into the service. Initiatives such as Patient focused booking, External provider and WLI clinics are under review to ensure governance, best practice and patient benefit. Future work will need to include the impact of any extra new patient capacity generated against the capability to provide appropriate follow up or review capacity.

As part of the Scottish Government National initiative for Chronic Pain, a service improvement manager was appointed in 2013 to lead the development and restructure of the Chronic Pain Service. There has been a recent development of a strategic Service Improvement Group (SIG) which will oversee operational and tactical initiatives to completion. The membership of the group consists of medical consultants, voluntary sector representatives, patient representatives, local authority and NHS Lothian representatives.

Key objectives of the SIG are to define a service delivery structure in line with the Scottish Model for Chronic Pain, and ensure that the NHS Lothian service delivery model is compliant with the recently published SIGN guidelines.

In 2014/15 the Chronic Pain Service will undertake the following action plan to help reduce service pressure, streamline resource capability and increase capacity headroom.

- Move the core service to a single site within NHS Lothian.
- Ensure service capacity and demand awareness by completing a detailed demand and capacity review with recommendations.
- Educate the local GP population to help them understand the specific needs of patients with Chronic Pain.
- Look to employ an additional nurse specialist to reduce the impact of review patients on consultant time.
- Reduce the number of inappropriate referrals into the service.
- Engage with third sector partners (Scottish Pain Association) to instate a service level agreement so that patients from the pain management programme, currently sites at the Astley Ainslie Hospital, may be better cater for on an individual basis.
- Develop satellite clinics in both East and West Lothian
- Develop a single management structure

4.5 Early Years

During 2014/15 NHS Lothian will approve and drive forward the implementation of the NHS Lothian strategy for children and young people 2014 – 2020, “Improving the Health and Wellbeing of Lothian’s Children and Young People” at an (eventual) additional annual cost of £1.4M.
We will implement the requirements from the Children and Young People (Scotland) Bill that NHS Boards provide a named person for every child from zero to 5 years, requiring the recruitment of additional Health Visitors and School Nurses. This is estimated to have an additional cost of £2.5m.

We will drive the work generated by the Lothian strategy and the Bill through utilisation of the Early Years Change Fund and the Early Years Collaborative to ensure that we and our partners achieve the local and national ambition for every child to have the best start in life.

In response to the Scottish Government’s comments:

1. At the time of drafting the LDP, the fourth EYC stretch aim had not been finalised. At the EYC Learning Session in January, NHS Lothian fully engaged across the 3 Lothian CPP Collaboratives and have committed to participating in the new stretch aim. This new aim will be incorporated into the local Integrated Children Service Plans, however it is early days and plans have not yet been fully developed.

2. Key actions that NHS Lothian are focusing on, in collaboration with our partners, include:
   - Ways to further improve access to maternity services
   - Improving uptake of Healthy Vitamins and Healthy Start Vouchers
   - Improving uptake of the 27-30 month review

3. The 3 actions outlined above and those identified within our LDP are all preventative approaches and could be included within the Prevention section of the LDP. Our Children and Young People Strategy, which is being taken to the Board for approval in April 2014 has a strong focus on early intervention and outlines how we will work in partnership with community planning partners to ensure that children have the best start in life and grow up being healthy confident and resilient.

4.6 Health Inequalities

Health inequalities are systematic, unfair differences in the health of the population that occur across social classes or population groups. People living in the most affluent communities in Lothian can expect to live twenty-one years longer than people living in the most deprived communities. Health inequalities do not just affect the most deprived communities and individuals - for almost every health indicator there is a clear gradient showing progressively poorer health with decreasing affluence. Nor are health inequalities only related to socio-economic status - people who are disadvantaged by race, disability, gender and other factors also have poorer health. Health inequalities cannot be
attributed to a single clinical or behavioural risk factor. They are the result of social circumstances and reflect the underlying distribution of power and resources in the population.

Three types of action are needed to address health inequalities:

- Actions that mitigate the health and social consequences of social inequalities. People who are socially disadvantaged have higher health needs and the level and nature of service provision should reflect that.
- Actions that help prevent inequality affecting people’s health and well-being. These include targeted health improvement activities, community development activities that increase social capital in deprived areas and improvements to the physical environment in deprived areas.
- Actions that undo the underlying structural inequalities in power and resources. These are the most challenging to implement and include the provision of high quality universal services such as education, housing, employment and improved environments, particularly in the most deprived areas. However, undoing structural inequalities also requires fundamental socio-economic and political measures. These may include economic policies that support social mobility and prevent high wage differentials; income maximisation services; reducing the democratic deficit across the social spectrum; increasing the number of people on the electoral roll. The key policy areas where action is most likely to reduce social and health inequalities are employment, income and education.

Addressing health inequalities requires a multi-sectoral response. Each of the four Lothian Community Planning Partnerships includes indicators of health inequalities within the Single Outcome Agreement and has a partnership group leading on health improvement and reducing health inequalities. In Edinburgh there is also a cross-partnership group that aims to identify actions to reduce poverty and inequality in the city. Within NHS Lothian we are currently working on a health inequalities strategy that will form part of the Strategic Plan. The health inequalities strategy is considering the potential for NHS Lothian to help reduce inequalities in the following ways: through procurement policies; as a large employer; through the delivery of clinical services; through partnership work.

4.6.1 Learning Disabilities

Tackling the health inequalities faced by people with learning disabilities

NHS Lothian has a well-established Steering Group which, for the past 4+ years has focused on addressing the health inequalities of people with learning disabilities. This has recently expanded to include a wider representation of stakeholders including representation from all local authorities/ health and social
care partnerships. This group is well placed, in partnership with NHS Lothian Public Health, to lead on the work and delivery of the 2020 LD Guidance.

**Component 1**
The Director of Public Health has identified a PH Consultant to work in partnership with the LD programme to address health inequalities faced by people with LD.

**Component 2**
Generation and Verification of a secure LD database for NHS Lothian.
There are a number of existing data sources that will provide NHS Lothian, and partners with the means of establishing a robust baseline. These include Lothian GP practices. Currently across 125 practices in within Lothian, we have a register of the number of adults with learning disabilities from the QOF LD register. From 2012/13 there were 4351 patients with LD known to Lothian practices, which represents 0.49% of the population, aged 18+. The Scottish average for the LD population known to GP practices is 0.48%. This register will be held until March 2014 under QOF requirements. It is not however a database of patient identifiable information that can be shared out-with each separate general practice.

Data comparison and merging between the 4 Lothian local authorities and NHS Lothian.
According to the most recently available ESAY (electronic Same As You) statistics from 2012, there are 5,261 adults known to the 4 Lothian local authorities in total. We need to undertake a comparison exercise across these two sources to identify any shared data, and identify individuals known only to one or other organisation, i.e. NHS Lothian or the local authority. LD in total should represent 2% of the population, including both adults and children.

We have also identified the following opportunities to ensure we develop and maintain an accurate database on-going. These include identification and analysis of the needs of children with learning disability known to the NHS Lothian SNS (Special Needs system) data base.

Longer term work will include developing and maximising the outcome measure from the 4 Single Outcome Agreements/ early years initiative measures:

- By 2016: To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child’s 27-30 month child health review: we will seek to maximise this opportunity to identify those young children with learning disability.
- By 2017: To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school: We will seek to maximise this opportunity identify those children with a learning disability.
Component 3
Lothian LD SESP: Since 2007 the enhanced service has supported improvements in the care of people with learning disabilities provided by primary care and has enable information to be collated. We hold detailed information of co-morbidities experienced by the Adult LD population in Lothian gathered from comorbidity profiles from participating practices for the last 3 years, as shown on table below:

(The 113 practices that completed the profiles of co-morbidity of their ALD patients had a total of 4119 patients on their registers)

![2012-13 chronic disease prevalence chart]

Should the Lothian LD enhanced service continue to be funded in 2014/15 the proposed areas of development would be to encourage completion of Key Information Summaries (KIS) for adults with learning disabilities. This is in accordance with Recommendation 13 Keys to Life (2013).
KIS is an electronic method by which information is shared from GP practices to end-users such as the Out of hours service, the ambulance service and Accident & Emergency. KIS can be used to share different levels and details of information, from a very straightforward “special note” to a more detailed “anticipatory care plan”. Adults with LD may experience barriers when accessing health services, such as communication difficulties, which can be overcome when key information is shared. This would aid the identification of LD patients who contact NHS 24 services or ambulance services as suggested in the Local Delivery Plan.

Through the LD Health Inequalities Steering Group, noted above, we are currently, in partnership with Public Health, local authorities and the health and social care partnerships working to develop a Lothian LD health inequalities strategy. This will
enable us to identify, develop and deliver improvements in partnership with health promoting services, Health Improvement Teams and other stakeholders to reduce the health inequalities faced by people with learning disabilities and improve their health outcomes.

Based on the NHS Scotland Health Inequalities framework, this will identify and deliver against the 3 areas of: mitigation, prevention and undoing.

Through the established Community Planning Partnerships and Single Outcome Agreements we will build on locality analysis to develop and enhance our understanding of the health experienced by people with learning disability, and the comparison with the general local populations.

Through the established Lothian LD Primary Care Steering Group, we will have the opportunity to identify analyse and develop the support available to GP practices and primary care through liaison nurses, Community LD teams and Local Area Coordination.

Training
NHS Lothian has a well-established e-learning system which already includes 4 modules regarding the needs of people with learning disabilities. We will use the analysis of the uptake of these modules to inform further training needs analysis and CPD development opportunities.

With regard to the development of the wider NHS Lothian systems, processes and practices, we will seek to establish a process where there is routine audit of Equality impact assessments to capture any positive and/or negative impacts on the health inequalities faced by people with learning disability, and use this information to deliver continuous system improvements.

4.7 Prevention

Reducing and Responding to teenage pregnancy in Lothian
Reducing teenage pregnancy requires a complex approach including the delivery of high quality information, education and services, set within a context of action to impact on wider health inequalities, improve early intervention and youth development, and ensure the adoption of a holistic approach to young people’s health. While some aspects of this work sit within sexual health structures, much of it should be driven by GIRFEC Boards and appear in Integrated Children’s Service Plans (ICSPs).

A recent document has been designed in partnership with a range of agencies and comprises three key elements which are designed to support local delivery of actions: A prevention logic model linking prevention activity to improved outcomes, early intervention approaches to supporting young people at risk of pregnancy or
with a suspected pregnancy, and finally pregnancy pathways, to be completed locally, which define the roles and responsibilities of all professionals involved when a young woman becomes pregnant.

**Lothian Reproductive Health Services (LRHS) young people’s development**
This process has involved transferring the clinical services from Caledonia Youth into Chalmers to develop ‘young people friendly’ drop-ins services from 1st April 2014 and the development of 4 peripheral sites in areas of deprivation designed for young people, including young LGBT young people, to improve sexual health outcomes.

**HIV prevention with men who have sex with men (MSM)**
Following a comprehensive Needs Assessment by NHS Lothian and NHS Greater Glasgow and Clyde, the Recommendations of the Report will be implemented across Lothian and included in local delivery plans. This includes reaching vulnerable men and should include assessment for other overlapping vulnerabilities experienced, including problematic alcohol use, mental health problems and experience of violence and childhood sexual abuse.
Culture and Society must also be addressed as Gay, Bisexual and MSM experience discrimination and prejudice throughout their lives. When this results in feelings of isolation and powerlessness, it impacts on all aspects of life including decision making and risk relating to sex and relationships. Men living with HIV bear an additional burden of rejection, stigma and discrimination. HIV prevention, treatment and care must also address the cultural context within which men live their lives.

**Tackling Obesity**
This will be a key area and we will continue to build on the good work done so far aligned to the Child Healthy Weight HEAT Target as well as local initiatives for both children and adults re exercise and diet. As well as providing a Tiered Care service.
4.8 Workforce

Healthy Organisational Change
NHS Lothian now have an agreed set of organisational values which have been derived from 3000 staff attending over 80 workshops and from the national work on values. We are now working with our Local Partnership Forums to develop an Organisational Development Plan which will be based on a "bottom up" approach as opposed to a “top down” approach on how we embed these values. The plan will be ready by the end of March 2014, although some work has commenced in specific areas in order to enhance team working and leadership development.

Sustainable Workforce
In partnership we are developing a Workforce Plan which will support the delivery of our corporate objectives and the implementation of our clinical strategy. The key actions being taken forward are:

- additional Advanced Practitioners being developed for specific specializations where we are experiencing medical staff pressures;
- the development and implementation of a Band 1-4 workforce that will allow for a career structure for Clinical Support Workers. This involves working in partnership with Edinburgh College to ensure job ready support workers;
- working closer with services to gain a better understanding of their demand for staff and the type of new roles that may provide an effective and efficient workforce.

Capable Workforce
We have completed a review of our Learning and Development Strategy to ensure it takes into account our priorities and it enhances our capacity and capability to be able to improve the quality of care. The six strategic aims within our strategy are:

1. Enable Fitness to Practice.
2. Improve governance and accountability.
3. Equip and support our leaders and managers to succeed.
4. Improve access and create career opportunities.
5. Embed quality into our education and training activity.
6. Support innovative practice and encourage technological opportunities.

To be able to take forward these aims meaningfully one significant core action will be the important dialogue between managers and staff through Personal Development and Review. Assurances of progress will be provided to the Staff Governance on a regular basis.
Integrated Workforce
With the establishment and implementation of the Health and Social Care Partnerships within NHS Lothian, we intend to develop integrated Workforce Plans. These will outline areas where roles can be merged or new roles can be created in order to be more person-centred. We will also be ensuring that our plans focus on the steps we need to take to ensure a fully integrated workforce by 2020.

Effective Leadership and Management
We will be developing a Leadership Development Programme to ensure all leaders and managers are equipped for the challenges of managing change. The challenge of managing integrated teams who will be employed by two employees, or more, will require dedicated support for Team Leaders. In addition, integration will require enhanced team working to ensure we provide the right care at the right time consistently for the people in Lothian.
5 Appendices

Appendix 1 - NHS Lothian’s draft Primary Care Strategic Plan
Appendix 2 - Developing Primary and Community Services
Appendix 3 - NHS Lothian Primary Care Strategy Demand, Capacity and Access
Appendix 4 – Unscheduled Care
Developing Primary and Community Services

1. Introduction and Background

Primary Care and Community Services provide the first point of contact between an individual and a healthcare professional in approximately 90% of contacts with health care services.

Within primary care there are 4 practitioner services; medical, dental, pharmaceutical and optical. These practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Contracts are negotiated on a national basis, however NHS Boards have some scope to negotiate local contracts or employ practitioners directly as salaried NHS employees.

The key role of primary care services is to:

- Provide a first point of contact with healthcare services
- Offer continuity of care
- Provide a universal service
- Co-ordination of care 24 hours a day, 7 days per week across primary, secondary and social care systems
- Improve the health of the population

Each year, there are over 5 million contacts with general practices, 1.5 million contacts with community services and 136,000 contacts with the Lothian Unscheduled Care Service (Out of Hours General Medical Service).

1.1 General Practice

There are 127 GP practices in Lothian (excluding the challenging behaviour GP practice) supported by a total of 1,601 general practitioners.

The Primary Care and Community Services healthcare team consists of general medical practitioners, practice nurses, managers and reception staff working together with Health Visitors, District Nurses and Health Care Assistants, Community Midwives, Phlebotomists, Community Psychiatric Nurses and Allied Health Care Professionals.

1.2 Dental Services

NHS General Dental Services are provided by dental practitioners under a national contract between themselves and NHS Boards with the aim to improve oral health.

There are 172 dental practices in Lothian supported by 532 dentists. As of 30 September 2013, 83% of children and 75% of adults of the Lothian population are registered with a dentist\(^1\).

\(^1\) ISD, MIDAS 30 September 2013
1.3 Optometry

The general ophthalmic services contract ensures a comprehensive eye examination, appropriate to individual need, symptoms and general health.

There are 114 optician premises in Lothian supported by 665 optometrists. In the year ending March 2013, 299,014 primary NHS eye examinations were undertaken in Lothian (34.5% of the Lothian population)\(^2\).

1.4 Pharmacy

There are 182 pharmacy premises in Lothian supported by circa 400 community pharmacists who dispense 11.7 million prescriptions every year, the cost of prescribing in primary care is in the region of £132 million per year.

It is estimated 94% of the population in Lothian access a pharmacy each year and 67% of the population visit a community pharmacy each month.

2. Challenges for Primary and Community Services 2014 – 2024

As outlined within the NHS Lothian Strategic Plan 2014 – 2024 there are a number of recognised key challenges facing primary and community services.

- The population growth, extended life expectancy and the consequent increase in multi-morbidities that have contributed to the increased demand for access to Primary Care and Community Services without commensurate increases in capacity.

- The need to address the existing and future capacity short-fall to meet the above increased, and increasing, demand upon Primary and Community services through the review of premises capacity and suitability, the need for additional GP Practices and work-force planning.

- Access and the need to consider different models to support access to appointments within general practice, and alternatives to direct GP access to ensure our population wait no longer than 48 hours for a non-urgent appointment to see a GP or appropriate alternate healthcare professional.

Demand, Capacity and Access – An Overview (Appendix 1) summarises the current position across Lothian and provides comment on the future impact associated with the population growth.

- Meet public expectations by ensuring timely consultation with an appropriate health care professional, patient and/or carer involvement in decision making about their healthcare choices, access to safe and effective treatment, clear and accessible information and experience of an efficient, approachable and responsive service

- Ensuring co-ordination of the care and support needed by patients across primary care, community health and social care and hospital based

\(^2\) ISD, OPTIX, August 2013
services which may all have a part to play in meeting individual’s health needs

- Support the shift in the balance of care from secondary to primary and community care services and ensure this transfer of care is appropriately resourced

- Increasing demands and issues associated with recruitment and retention of the out of hours workforce which is impacting significantly on delivery of the Lothian Unscheduled Care Service (LUCS)

3. Delivering the Primary and Community Services Propositions

There are a number of propositions outlined within NHS Lothian’s Strategic Plan 2014-2024 which require be further developed and implemented over lifetime of the plan.

The sections below provide additional information on the propositions and include details of how delivery of these propositions will be taken forward.

3.1 Scottish Government Modernisation Programme

The Scottish Government have outlined four key elements necessary for the transformation of primary care in order to achieve the 2020 Vision. These are:

- Development of new models of integrated care that better meets the needs of the changing population and that engages with and meets the needs of local people

NHS Lothian’s review and redesign of pathways of care around the needs of high users of our health and social care services (Callum, Hannah, Scott and Sophie) will support the development and resource shifts required to deliver the future models of integrated care.

- Involve General Practitioners to develop a ‘more Scottish’ GP contract as part of continuing effort in Scotland to deliver excellence in primary care and to ensure a clear focus of health and social care integration

General Practitioners are seen as a key to the delivery of the integration of health and social care services, this key contribution is recognised in the 2014-15 Scottish GP Contract in that:

- Each GP practice will nominate a practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership

- Engagement with the evolving local Health and Social Care partnerships, and input to developments/decision-making will be led through these GPs as appropriate. Any additional consequential workload will be agreed

NHS Lothian and its partners will be taking these actions forward within our wider primary care actions aligned with our strategic and integration plans.
• Improve the quality and usefulness of primary care data as a tool for improvement

NHS Lothian’s Primary Care Data Group has a role to co-ordinate support to primary care services to make informed decisions on strategic and operational issues through collating existing data and information; analysing the data, reviewing the evidence; writing reports; and conducting ad hoc surveys where appropriate.

Strategic priorities have been identified as:

- Support the NHS Lothian’s Strategic Plan which is inextricably linked to the integration of health and social care
- Ensure co-ordination of information supporting primary and secondary care initiatives relevant to the strategic plan, in particular those which affect the interface between primary and secondary care

The operational priority is considered to be:

- Primary care benchmarking to ensure a Lothian wide approach to sharing and benchmarking of primary care information at general practice and partnership level

• NHS Boards are required to make medium term assessments of the strengths and weaknesses in delivering the 2020 vision for primary care. This assessment should include detail of the shift in resource to support the transformation of primary care

The resource shift required to support the transformation of primary care will be assessed as work progresses across a number of work streams such as the redesign of pathways of care, provision of local ‘step up’ and ‘step down’ beds, expansion of primary care premises and development of primary care and community care workforce plans.

NHS Lothian will continue to contribute to this Scottish Government primary care modernisation agenda through active participation at the Scottish Government Primary Care Strategic Forum.

3.2 New GP Contract 2014/15

Development of the Scottish GP contract in 2014/15 will contribute to delivery of the key priority areas outlined in the 2020 vision route map in terms of further reducing bureaucracy and creating a stable funding environment for general practice over the coming years. A further 264 Quality & Outcome Framework (QOF) points are being transferred into the global sum under core standard arrangements leaving a balance of 659 points for 2014/15. The main area of innovation in QOF is in relation to the quality and safety indicators:
Integration:

- A requirement for a designated practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership and fully engage with the evolving integration agenda.

Quality Improvement:

- A new continuous quality improvement indicator requiring a quality report reflecting relevant activity in the previous year, plus participation in a 3 year rolling programme of formative and supportive peer review visits. The practice visits are intended to allow constructive discussion, identify areas of priority and support the sharing of best practice.

Patient Access:

- An annual review (involving patients) of current patient demand, focusing on both met and unmet needs; ‘Patient Access Action Report’ to be submitted to the Board for discussion at a formative and supportive quality review visit. This data will be key to our understanding of the current pressures on GP practices and improving the response times for patient appointments by the sharing of best practice.

Anticipatory Care / Key Information Summaries:

- Continuing the current work on developing anticipatory care plans / Key Information Summary (KIS) (including a polypharmacy review) for those patients predicted (from SPARRA data) to be most at risk of emergency admission or unscheduled care; requirement for quarterly multidisciplinary practice meetings focusing on this cohort of patients. There is a good evidence base for this work in primary care and over 10,000 KIS records were created in Lothian this year.

Patient Safety:

- Two patient safety indicators are retained in QOF requiring practices to conduct a safety climate survey and two case note reviews using validated tools to detect safety incidents, discuss the results as a team and share a reflective report with the Board. This work will be complemented by a comprehensive enhanced service (ES) which will focus on improving outpatient communication in 2014/15. Previous work by practices in relation to Warfarin monitoring and medicines reconciliation has already produced excellent results and contributed to a material culture change in general practice as part of the Scottish Patient Safety Programme in Primary Care.

3.3 Review of General Practitioner Numbers and Practices

Population growth in Lothian, as predicted by National Records of Scotland (NRS) will be an average of circa 9,000 per annum between 2010 and 2020, or circa 8,000 per annum between 2015 and 2020. It should be noted however that, historically, there is a significant disparity between the NRS predicted population estimates and the GP lists size, across Lothian and within each locality.
Demographics in Lothian are predicted (NRS) to change significantly with the number of people over the age of 65 increasing by circa 25% between 2010 and 2020, as demonstrated in the table below.

**Table 1 : National Records Scotland Population Predictions (1,000's) 2010 based**

<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All NRS</td>
<td>836.70</td>
<td>843.73</td>
<td>883.70</td>
<td>925.20</td>
<td>88.50</td>
<td>10.58%</td>
</tr>
<tr>
<td>0-15</td>
<td>141.40</td>
<td>143.36</td>
<td>147.40</td>
<td>157.10</td>
<td>5.70</td>
<td>11.10%</td>
</tr>
<tr>
<td>16-64</td>
<td>571.40</td>
<td>571.00</td>
<td>595.50</td>
<td>613.00</td>
<td>41.60</td>
<td>7.28%</td>
</tr>
<tr>
<td>65+</td>
<td>124.00</td>
<td>129.37</td>
<td>140.80</td>
<td>155.30</td>
<td>31.30</td>
<td>25.24%</td>
</tr>
</tbody>
</table>

* 2012 NRS estimate based on 2011 Census data

It is difficult to predict the growth of the elderly population, at a locality or practice level, which is where this will impact on GP Practices capacity.

There are 127 GP Practices across NHS Lothian. Although the number of practices has grown this has been the result of existing practices sub-dividing using existing premises capacity and with their relevant practice populations. The last new and additional practice was created over a decade ago.
Mapping of General Practice, General Dental Practice and Pharmacy locations has been completed and shared with each Community Health Partnership (CHP). Work is underway to identify the localities and individual practices experiencing, or predicted to experience, specific population pressures and map these to the relevant current General Practice boundaries.

Each CHP will then develop general practice capacity plans within their locality, and in partnership across CHP boundaries where appropriate, to address these capacity issues, including the development of existing practice premises and the identification of where new and additional practices will be required. (See Appendix 2)

As well as facilities, these capacity plans should also address practice manpower planning, Community Services resource levels, new ways of working and the potentials provided through advances in information technology.

Work is underway to consider a replacement mechanism for the former Initial Practice Allowance (part of the previous General Medical Services Contract) to facilitate the creation of new and additional General Practices in Lothian.

3.4 General Practice Enhanced Services and Shifting the Balance of Care

We continue to evaluate the GP enhanced services programme (circa £13 million GMS investment) on an annual basis to ensure best strategic fit, effectiveness and value for money.

Recent examples of enhanced service developments include:

- **Domiciliary Phlebotomy**
  Primary care services have seen an increased demand for domiciliary phlebotomy services (carried out in a patient’s home) as a result of 3 broad drivers:
  - increased requirements associated with remuneration frameworks such as QOF;
  - population growth
  - clinical change, where requirements for disease monitoring or treatment have been altered and the resource has not necessarily been provided to reflect this change in clinical practice

To meet future demand, a domiciliary phlebotomy service has been established supported by recurring investment of £350,000.

- **Polypharmacy Review**
  This enhanced service, aims to facilitate a joint polypharmacy review between the pharmacist and the patient’s general practitioner. These reviews link with Anticipatory Care Plans (ACPs).

  - **Year 1 (2012-13)** – reviews were offered to all GP practices with patients in care homes in addition to frail elderly patients identified at high risk (over 75 years and on 10 or more medicines)
- Year 2 (2013-14) – co-horts of patients were identified for review using the SPARRA risk prediction tool
- Year 3 (2014-15) – continue to invite all practices with patients in care homes to be offered review and practices will be invited to identify patients who are at risk of readmission. Community pharmacists will continue to jointly lead reviews with general practitioners.

Looking forward, NHS Lothian will continue to regularly review existing local enhanced services, have identified current local enhanced services which require further development and will consider new local enhanced service proposals.

- **General Practice Support to Care Home**
The current local enhanced service (LES) which allows practice teams to provide additional care to patients in care homes for older people is under review. The anticipatory care LES provides for a single practice to take ‘lead practice’ responsibilities for each care home in Lothian. This has proved a successful model although there are currently four care homes where we continue to seek a practice to take on lead status and this requires further development and investment in the region of £300,000.

- **Models of Care for Frail Elderly**
There is a clear identified need to better support integrated pathways of care for frail, older people living at home. Development work on a new model of care focusing on service redesign to cover complex frail elderly patients in the community is underway. This will cover patients in care homes and also those living in their own homes. Information transfer between primary care and acute services will be improved, together with a consistent approach to polypharmacy medication reviews.

A number of initiatives have already been developed to support the shift the balance of care from hospital based to community services.

- **Near Patient Testing (Warfarin)**
A recent example of this shift is the provision of Near Patient Testing for warfarin in East and Midlothian which allows general practices to provide safe, effective and convenient access to testing with immediate results and thus avoids patients having to wait for results and for changes to medications. This initiative is supported through local investment of circa £60,000.

A further example of a current proposal to support the shift in the balance of care relates to a type 2 diabetes enhanced service.

- **Type 2 Diabetes Pathway**
Diabetes represents a rapidly expanding workload with circa 2,200 individuals in Lothian diagnosed with type 2 diabetes each year, a prevalence of (at least) 4.7% in the Lothian population (35,288 in 2012) and (at least) a 9% share of the NHS Lothian prescribing budget.

Secondary care diabetes services need to focus specialist skills on individuals with type 1 diabetes and those with type 2 who are complex or developing complications.
Historically, most patients with diabetes were referred to hospital at the time of diagnosis, though many are subsequently discharged back to the care of the General Practitioner once their initial assessment and management plans are in place and their condition stabilised.

An enhanced service would provide the resource for this initial assessment and ongoing care to be undertaken in general practice and would reflect the well established rise in prevalence and complexity. In order to support this proposal, investment of circa £300,000 is required.

Whilst the proposal service outlined above will provide support for those newly diagnosed with type 2 diabetes, a number of gaps and areas for improvement have been identified:

- discharge planning
- earlier supported discharge
- follow up of type 1 diabetes who do not attend hospital appointments
- GP practice support
- review of late stage type 2 diabetes with polypharmacy
- community support for those with long term stable type 2 diabetes on insulin.

In order to further enhance and bridge the gap between primary and community services, there is a need to develop a community diabetes specialist nurse (CDSN) service across Lothian. The benefits of provision of these posts will support the gaps / service improvements which have been outlined, has the potential to reduce readmissions and diabetic ketoacidosis (DKA) admissions, relieve pressure on secondary care clinic capacity, support the avoidance of travel for some stable, elderly patients to hospital services, provide support in the implementation of the national and local diabetes prescribing strategies and support the cross pollination of good practice and a more patient centred pathway of care.

### 3.5 Community based Pharmacy, Dental and Optometry Services

#### 3.5.1 Pharmacy Services

The key priority for pharmaceutical services is to implement the recommendations outlined in Prescription for Excellence published in 2013 which outlines a vision and action plan for the delivery of pharmacy services across Scotland to support people living in the community, receiving care at home, living in care homes and those receiving hospital / specialist hospital care at home.

The recommendations will be implemented through establishing a framework for joint working and information sharing between primary and secondary care pharmacist and other members of the multidisciplinary team.

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3 Prescription for Excellence, A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation, Scottish Government Health Department, September 2013.
3.5.2 Dental Services

The key strategic priorities relating to dental care for the next 10 years have been identified as:

- **Increase registration for those aged up to 2 years**
  
  As at 30 September 2013, 41% of 0 to 2 year olds were registered with an NHS dentist compared to 47% registration rate across Scotland. NHS Boards in the West of Scotland that began Childsmile Practice earlier than the East of Scotland NHS Boards, show better registration. NHS Greater Glasgow and Clyde have 52% of 0 – 2 year olds registered. By 2024, NHS Lothian should aim for 70% of 0 to 2 year olds registered.

- **Improve access to specialist dental services by integrating and aligning the Public Dental Service (PDS) with the Edinburgh Dental Institute (EDI)**
  
  By redesigning services provided by the PDS and EDI agree a single point of referral for suitable services. This will mean that referrers have an easy route to access specialist services, and that patients will be seen by the most appropriate clinician in a location as close to their home as is practicable in a as timely a way as possible.

- **Continue with Scottish Government funded prevention programmes - Childsmile and Caring for Smiles aimed at improving oral health for young and older people**

  Childsmile is a national dental prevention programme delivered locally by each NHS Board. All children in nursery provision are offered the opportunity to participate in a tooth brushing programme. Children attending nursery located in the SIMD most deprived quintile are offered the opportunity to participate in the Childsmile Fluoride Varnish Programme. The proportion of Primary One children with no obvious dental decay in Lothian has risen from 50% to 70% since the Childsmile Programmes began. By 2024, we should aim for 80% of Primary One children in Lothian with no obvious decay.

3.5.3 Optometry Services

Optometry services should be recognised as the first point of contact for individuals who are experiencing eye problems. Since 2006 the General Ophthalmic Services contract has been in place to allow community optometrists to provide a comprehensive patient-specific examination and any necessary follow-up appointments for accurate diagnosis or monitoring of conditions.

There are a number of optometry legislative and pathway changes which support improved joint working and a shift in the balance of care, these will be the focus for development over the coming years.
• **Independent Prescribing Rights to Optometrists**

In 2013, new legislation was introduced to extend NHS prescribing to optometrists who are recognised by the General Ophthalmic Council (GOC) as appropriately qualified. All optometrists in Scotland, who have completed a GOC approved training course and are entered on the GOC Register as an Independent Prescriber, to provide NHS prescriptions for conditions affecting the eye and tissues surrounding the eye. This legislation will assist to shift demand from general practice as individuals do not have to visit their general practitioner to request eye prescriptions and can access specialist eye services in the community.

• **Optometrist Direct Referral to Hospital Ophthalmology Services**

In 2014 all community optometry practices will have access to SCI Gateway for referrals to the Hospital Eye Service. This will provide more detailed information (particularly retinal photographs) to the hospital allowing them to triage accurately. Referral guidance is available on the Lothian Referral Guideline website and there are plans to develop guidelines for additional ophthalmic and systemic conditions.

### 3.6 Integrated Assessment and Rehabilitation Services for Frail Older People

There are a number of health and social care integrated teams providing assessment and rehabilitation services for frail older people available across Lothian. The continuation of these services and resources to support further development of this type of model of care is essential when supporting the shift in the balance of care. Examples of integrated teams for frail older people are described below.

• **Edinburgh – COMPrehansive Assessment (COMPASS)**

This model supports a new way of working which aims to provide more integrated care for frail older people in Edinburgh. A key component of the COMPASS model is regular multidisciplinary team meetings whose role is to identify older people at risk of hospital admission. The aim of the meetings is to delivery better outcomes for older people and their carers through improved understanding and communication across teams and professionals.

The COMPASS pilot began in South East Edinburgh in April 2012 and rollout out further to North West Edinburgh in April 2013. There are plans to roll out the COMPASS model across all areas in Edinburgh.
• East Lothian - Integrated Service for the Elderly (ELSIE) and Midlothian MIDCare
These services are integrated co-located services which provide urgent assessment, rapid response (health and social care), rehabilitation and re-ablement for frail older people at time of crisis. Both services benefit from medical and nursing input (medicine of elderly consultant and advanced nurse practitioners) with access to Allied Health Professionals, social care and crisis care services.

East and Mid Lothian partnerships plan to further develop ‘frailty models’ and further enhance local rapid response services.

• West Lothian - Rapid Elderly Assessment and Care Team (REACT)
The REACT service provides better care for elderly patients at home by providing alternatives to hospital admission.

- Phase 1 – Hospital at Home
Currently comprising a team of nurse practitioners, consultant geriatricians, specialty doctors, a community pharmacist and an administrator, the Hospital at Home service accepts daily acute referrals for urgent assessment of older patients to prevent unnecessary admissions to hospital and to maintain individuals in their own homes where possible. The team work closely with the physiotherapists and occupational therapists to provide rapid intervention as required.

- Phase 2 – Intermediate Care Team
The Intermediate Care Team comprises physiotherapists, occupational therapists and speech therapist. They provide rehabilitation within the patient’s own home and accept referrals from the hospital wards facilitating an early supported discharge, direct from the community or from the hospital at home team. They also support Phase 1 Hospital at Home patients providing rapid assessment and intervention as required.

- Future Development of REACT In-Reach Team
The appointment of Specialist Nurses to assess frail elderly at the front door and downstream wards will facilitate the most appropriate pathway including accessing relevant community services. These nurses will work closely with the duty Consultant Geriatrician who will also be the single point of contact available to GPs and other clinicians. The team will also include senior physiotherapist and occupational therapist pulling patients back out into the community for assessments and interventions in their own home.

3.7 Reduction and Elimination of Delayed Discharge
In April 2008, a National Standard was introduced, that no patient should wait more than 6 weeks for discharge from hospital after being declared medical fit to do so. This standard was strengthened by the Scottish Government to be 4 weeks in April 2013 and 2 weeks in April 2015.
Across Lothian achieving these standards has been a challenge. The Partnerships of West Lothian and Midlothian have managed to keep pace with the National standards and are on a path that will see them achieve the impending April 2015 target. City of Edinburgh and East Lothian are experiencing challenges associated with the availability and affordability of Care Homes, and increasingly workforce shortages in the care at home market. Whilst both have achieved the 6 week standard, the 4 week standard is more challenging.

The partnerships across Lothian have identified short and long term actions to support the reduction and eventual elimination of delayed discharge.

**City of Edinburgh**

The City of Edinburgh partnership have already undertaken a number of actions to support a reduction in delayed discharge in Edinburgh. This includes:

- an increase in domiciliary care capacity
- development of 42 ‘step down’ beds.

A draft project plan has been developed to further reduce the demand for hospital admission, make the discharge process more efficient, increase capacity in existing services and enhance community capacity.

In the short term, this plan includes:

- an additional 2,500 domiciliary care hours to be provided by April 2014
- the roll out of COMPASS to all quadrants of the city
- investment in re-ablement to clear the current backlog

In the long term, this plan includes:

- the re-tender of the care at home contract which expires in October 2014
- commissioning additional ‘step-down’ beds
- establishing a discharge hub on each hospital site to increase the efficiency of the discharge process.

**East Lothian**

The East Lothian partnership will reduce the total number of delayed discharges and meet the 4 week and 2 week targets through:

- establishment of step down capacity
- the introduction of new contracts for care at home
- supporting a social enterprise model to provide care to specific cohorts of patients and service users
- implementation of a ‘frailty model’
- enhancement of the emergency care service

**Midlothian**

The Midlothian partnership have identified a number of key actions to address delayed discharge which will be to:
• explore ways of strengthening the Midlothian In-Reach service which involves Midlothian staff working in the acute hospital settings
• implement the ‘Frailty Model’ through an enhanced Rapid Response Service
• extend the provision of assessment and intermediate care beds the Highbank care facility
• review care home provision in Midlothian and further develop extra-care housing
• refresh the workforce development strategy in Primary Care to support ‘Shifting the Balance of Care’
• Continue to strengthen working links between Midlothian Partnership and the Acute sector
• From April 2014 begin to shadow the two week target for delayed discharge (this approach was adopted for when the 4 week target was introduced)

West Lothian

The West Lothian Partnership has a diverse range of initiatives in place to support the reduction and elimination of delayed discharges through:

• Reducing demand for hospital admission:
  - REACT,
  - Crisis Care,
  - Integrated Care Pathways development supported through Interface Group and Primary Care Work Plan
  - Additional capacity for falls coordination and further development of robust falls pathway
  - Currently over 4000 households benefit from telecare services with access to 24 hour Careline

• Making the discharge process more efficient
  - Integrated Discharge Planning Pathway
  - Multidisciplinary and multiagency involvement in early identification of patients needs and discharge requirements
  - Increased capacity to facilitate early supported discharge through REACT intermediate care team, re-ablement service and mental health Older People Acute Care Team

• Increasing capacity in existing services
  - The development of step up and step down model in St Michaels Hospital
  - Universal re-ablement services
  - Redesign of domiciliary physiotherapy service
  - Development of integrated workforce plan
  - Continuing development and delivery of care home education programme
  - Expansion of inpatient physiotherapy and occupational therapy services to 7 day working
  - Working with independent sector on their demand and capacity plans to support care at home and care home provision
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Our Health, Our Care, Our Future

• Enhancing community capacity.
  - Development of an additional housing with care complex In Bathgate
  - Further investment in telecare
  - Telehealth research with focus on providing care at home
  - Ensuring capacity in health and social care services to support 7 day discharge model

3.8 Review of Role and Function of NHS Continuing Care

The NHS Lothian Strategic Plan and the requirement to rebalance care from hospital and community settings require the Board to have a strategic plan for the future model and provision of inpatient complex care (IPCC) beds across Lothian. NHS Continuing Care is a package of healthcare provided and solely funded by the NHS. Patients normally receive NHS Continuing Healthcare in a hospital ward, hospice or a contracted inpatient bed within an independent sector provided e.g. Care Home.

The purpose of the review is to identify the factors that will affect future demand and need for inpatient continuing care and to propose a strategy to meet the care needs of the ageing population. The main factors are; increasing demand from an ageing population, reducing demand because community services can increasingly provide for people with higher care needs, and evolving national eligibility guidance for IPCC.

The first stage of the review will conclude by end of February 2014 and will describe an emerging strategic plan for future IPCC provision. This will be incorporated into the NHS Lothian Strategic Plan for consultation.

3.9 Redevelopment of the Royal Edinburgh Hospital

NHS Lothian and its partners, through the current mental health strategy: A Sense of Belonging 2011 - 2016; sets out plans for the redevelopment of the Royal Edinburgh Hospital and the required investments and developments in community services.

For the past 8 years, mental health services have had clear agreed strategic direction and clear plans are outlined for the remainder of the current strategy. These plans have delivered significant bed reductions compensated by investments in community services such as the intensive treatment teams and crisis intervention services.

Similarly, the number of sites from which acute mental health inpatient services are delivered has reduced from 4 to 2 sites during this period. This has resulted in significant shifts in the balance of care from hospital to community and clinical service functions providing safe, supportive assessments and treatments to patients at home who were previously admitted to hospital.

NHS Lothian’s mental health strategies and resulting community developments have been agreed and developed in partnership with local authorities and Third Sector organisations and this continued partnership will be key to the success of the plans for the redevelopment of the Royal Edinburgh Hospital. A Sense of
Belonging outlines how the redevelopment will be delivered including service redesign, investments in community services and associated improvements in reduced inpatient services to provide a better quality of inpatient care for individuals who cannot be safely or appropriately supported at home.

Phase 1 of the Royal Edinburgh Hospital campus redevelopment will focus on providing inpatient mental health assessment, treatment and rehabilitation facilities and the re-provision of the national brain injury unit. The completion of construction associated with the Phase 1 redevelopment is estimated to be completed in November 2016.

3.10 Develop Jointly with Local Authority partners a community and residential support service for people with learning disability

A number of strategic developments and work streams are being progressed across Lothian to ensure that specialist learning disability services are of high quality, effective and fit for purpose. Key work streams relate to:

- Reprovision of Learning Disability Inpatient Service
  The final stage of benchmarking against national and international practice is due for completion in April 2014. The service is concluding negotiations with NHS Borders relating to commissioning of assessment and treatment services for people with learning disability. This work will inform the clinical brief which is being developed by the Royal Edinburgh Hospital Reprovision team and this will inform the business case for Phase 2 of the reprovision.

- Repatriation of Out of Scotland Patients
  The national learning disability strategy requires that repatriation of patients is concluded by 2018. This strand of work forms part of the overall modernisation of learning disability services, including the Royal Edinburgh Hospital redevelopment.

- Support Discharge of Long Stay Patients
  The service is entering negotiations with the respective local authorities to identify and agree community destinations for individuals who did not benefit from the original repovisioning of the long stay institutions. This work stream has the potential to deliver community based opportunities for 16 individuals.

- Development of a Joint Community Facility for Autism and Learning Disability
  A project to support this development is planned for 2016/17 and is a key element of the planned shift in the balance of care, and the up streaming of services from the hospital campus into community resources. A revised Initial Agreement will be considered by the Lothian Capital Investment Group on 8 April 2014.

- Develop a New Model of Care Fit for Future Learning Disability Inpatient Services
  To support this new model of care, patient pathways will be revised across all levels of the health and social care system. Stakeholder engagement is now underway to discuss and consult on the future model of care.
This will inform the Royal Edinburgh Hospital Outline Business Case and other
elements of redesign, both of which will inform the development of the
integration plans, joint commissioning plans and the overall Lothian Joint
Strategy for Learning Disability which will be concluded in 2014/15.

- Development of a Model of Care and Delivery of Services for People with
  Profound and Multiple Disabilities
  A working group will be set up to take forward this initiative.

- Development of a Health Inequality Strategy Building on the Interim
  Lothian Action Plan and National Strategy; The Keys To Life
  Within the overarching framework of NHS Lothian’s Health Inequality
  Strategy, the learning disability programme is undertaking local engagement
  events throughout February 2014 which, once concluded will detail health
  promoting actions specific to the needs and wishes of people with learning
disability and their families.

3.11 Assess the Potential for a new ‘Care Village’ Concept

The Edinburgh partnership will host a workshop in April 2014 to begin initial
discussions and assess the potential for this concept.

3.12 Develop a new East Lothian Community Hospital (replacing
  Roodlands Hospital)

We will develop a new East Lothian Community Hospital to replace Roodlands
and Herdmanflat Hospitals with modern accommodation and increase capacity to
treat more East Lothian residents locally, it is anticipated the new community
hospital will open in late 2017.

The provision of this local community hospital will ensure that more patients can
be admitted directly and more can be discharged quickly from Edinburgh
hospitals for post acute care through increasing the capacity for step-up/step-
down provision for older people.

The new hospital will also increase capacity for day surgery and outpatients so
that more East Lothian residents can be treated locally in line with the Lothian
wide scheduled care capacity plans.

3.13 Provision of ‘Step Up’ and ‘Step Down’ Care in Midlothian
  Community Hospital

The Midlothian partnership is at an early stage of developing a project plan to
support the redesign of Midlothian Community Hospital. The key actions at this
stage will be to:

- strengthen the Midlothian in-reach service
- implement the ‘frailty’ model through an enhanced Rapid Response Service

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4 The Keys to Life – Improving Quality of Life for People with Learning Disability, Scottish Government
Health Department, June 2013
extend the provision of assessment and intermediate care beds at the Highbank care facility

The main challenge in Midlothian is the limited availability of care home beds, however in the interim the partnership will continue with the development and provision of extra care housing.

3.14 Lothian Unscheduled Care Service (LUCS)

LUCS has a mixture of salaried and ad hoc General Practitioners working within it, the split of shifts covered is approximately 50/50 salaried and ad hoc. It also employs Emergency Nurse Practitioners and paramedics via a Memorandum of Understanding with the Scottish Ambulance Service.

The service is based across 5 bases within Lothian, 3 are open until midnight and the other 2 are open overnight. LUCS covers 118 hours per week, two thirds of the week.

Over the last eighteen months the national shortage of doctors has severely impacted on the ability of LUCS to cover its rotas. Out of hours (OOH) work is not popular among General Practitioners. This is due to a number of factors outlined below:

- European Working Time Directive
- Busier day time practice
- Busier out of hours shifts
- Recruitment and retention of salaried medical staff has been difficult and those that transferred into the new system in 2004 are now aging and the new doctors are looking for a work life balance that does not put Out of Hours in the forefront of roles they would be seeking to do

Since 2005/06 (first full year of operation) to 2012/2013 the demand on the service has increased by 18%. With the current move to maintain higher numbers of complex patients in the community and to manage flow through the hospital sector 7 days a week there are increasing demands on LUCS. The increase in LUCS activity from 2004 is outlined in the graph below.

**LUCS Activity 2004-05 to 2012-13**
There was an increase in the direct access to OOHs through our professional to professional telephone line, a 25% increase since 2010/2011 and patients using LUCS as a walk

In addition to the current pressures of demand, there are a number of challenges facing LUCS such as new initiatives and other increasingly complex areas of work and this will impact on the ability for the service to maintain core work. Key challenges relate to:

- the increase in level of complex patients seen in OOH, particularly the frail elderly, care home and palliative patients
- the increase in direct access to OOH through our professional to professional telephone line, a 25% increase since 2010/11
- the additional demands on OOH over and above the normal core work e.g. public health
- information sharing through anticipatory care plans is leading to longer home visits (expected to increase further due to the Key Information Summary and QOF)

LUCS will undertake a service review as part of addressing these challenges.

4. Delivering the Propositions for Primary and Community Services

The four Lothian Health and Social Care Partnerships are to develop a Strategic Commissioning Plan supported by a number of Joint Commissioning Plans such as those for older people, mental health, learning disability, addition and criminal justice services.

In order for the aspirations outlined in this plan to be met, these need to be reflected within the partnerships strategic commissioning plans to ensure local ownership.

The developments associated with the primary care contractors will be taken forward with support from the Primary Care Contractor Organisation (PCCO).
Appendix 2 Developing Primary and Community Services

1. Introduction and Background

Primary Care and Community Services provide the first point of contact between an individual and a healthcare professional in approximately 90% of contacts with health care services.

Within primary care there are 4 practitioner services; medical, dental, pharmaceutical and optical. These practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Contracts are negotiated on a national basis, however NHS Boards have some scope to negotiate local contracts or employ practitioners directly as salaried NHS employees.

The key role of primary care services is to:

- Provide a first point of contact with healthcare services
- Offer continuity of care
- Provide a universal service
- Co-ordination of care 24 hours a day, 7 days per week across primary, secondary and social care systems
- Improve the health of the population

Each year, there are over 5 million contacts with general practices, 1.5 million contacts with community services and 136,000 contacts with the Lothian Unscheduled Care Service (Out of Hours General Medical Service).

1.1 General Practice

There are 127 GP practices in Lothian (excluding the challenging behaviour GP practice) supported by a total of 1,601 general practitioners.

The Primary Care and Community Services healthcare team consists of general medical practitioners, practice nurses, managers and reception staff working together with Health Visitors, District Nurses and Health Care Assistants, Community Midwives, Phlebotomists, Community Psychiatric Nurses and Allied Health Care Professionals.

1.2 Dental Services

NHS General Dental Services are provided by dental practitioners under a national contract between themselves and NHS Boards with the aim to improve oral health.

There are 172 dental practices in Lothian supported by 532 dentists. As of 30 September 2013, 83% of children and 75% of adults of the Lothian population are registered with a dentist.¹

¹ ISD, MIDAS 30 September 2013
1.3 Optometry

The general ophthalmic services contract ensures a comprehensive eye examination, appropriate to individual need, symptoms and general health.

There are 114 optician premises in Lothian supported by 665 optometrists. In the year ending March 2013, 299,014 primary NHS eye examinations were undertaken in Lothian (34.5% of the Lothian population).2

1.4 Pharmacy

There are 182 pharmacy premises in Lothian supported by circa 400 community pharmacists who dispense 11.7 million prescriptions every year, the cost of prescribing in primary care is in the region of £132 million per year.

It is estimated 94% of the population in Lothian access a pharmacy each year and 67% of the population visit a community pharmacy each month.

2. Challenges for Primary and Community Services 2014 – 2024

As outlined within the NHS Lothian Strategic Plan 2014 – 2024 there are a number of recognised key challenges facing primary and community services.

- The population growth, extended life expectancy and the consequent increase in multi-morbidities that have contributed to the increased demand for access to Primary Care and Community Services without commensurate increases in capacity.

- The need to address the existing and future capacity short-fall to meet the above increased, and increasing, demand upon Primary and Community services through the review of premises capacity and suitability, the need for additional GP Practices and work-force planning.

- Access and the need to consider different models to support access to appointments within general practice, and alternatives to direct GP access to ensure our population wait no longer than 48 hours for a non-urgent appointment to see a GP or appropriate alternate healthcare professional.

Demand, Capacity and Access – An Overview (Appendix 1) summarises the current position across Lothian and provides comment on the future impact associated with the population growth.

- Meet public expectations by ensuring timely consultation with an appropriate health care professional, patient and/or carer involvement in decision making about their healthcare choices, access to safe and effective treatment, clear and accessible information and experience of an efficient, approachable and responsive service.

- Ensuring co-ordination of the care and support needed by patients across primary care, community health and social care and hospital based

2 ISD, OPTIX, August 2013
services which may all have a part to play in meeting individual’s health needs

- Support the shift in the balance of care from secondary to primary and community care services and ensure this transfer of care is appropriately resourced

- Increasing demands and issues associated with recruitment and retention of the out of hours workforce which is impacting significantly on delivery of the Lothian Unscheduled Care Service (LUCS)

3. Delivering the Primary and Community Services Propositions

There are a number of propositions outlined within NHS Lothian’s Strategic Plan 2014-2024 which require be further developed and implemented over lifetime of the plan.

The sections below provide additional information on the propositions and include details of how delivery of these propositions will be taken forward.

3.1 Scottish Government Modernisation Programme

The Scottish Government have outlined four key elements necessary for the transformation of primary care in order to achieve the 2020 Vision. These are:

- Development of new models of integrated care that better meets the needs of the changing population and that engages with and meets the needs of local people

NHS Lothian’s review and redesign of pathways of care around the needs of high users of our health and social care services (Callum, Hannah, Scott and Sophie) will support the development and resource shifts required to deliver the future models of integrated care.

- Involve General Practitioners to develop a ‘more Scottish’ GP contract as part of continuing effort in Scotland to deliver excellence in primary care and to ensure a clear focus of health and social care integration

General Practitioners are seen as a key to the delivery of the integration of health and social care services, this key contribution is recognised in the 2014-15 Scottish GP Contract in that:

- Each GP practice will nominate a practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership

- Engagement with the evolving local Health and Social Care partnerships, and input to developments/decision-making will be led through these GPs as appropriate. Any additional consequential workload will be agreed

NHS Lothian and its partners will be taking these actions forward within our wider primary care actions aligned with our strategic and integration plans.
• Improve the quality and usefulness of primary care data as a tool for improvement

NHS Lothian’s Primary Care Data Group has a role to co-ordinate support to primary care services to make informed decisions on strategic and operational issues through collating existing data and information; analysing the data, reviewing the evidence; writing reports; and conducting ad hoc surveys where appropriate.

Strategic priorities have been identified as:

- Support the NHS Lothian’s Strategic Plan which is inextricably linked to the integration of health and social care
- Ensure co-ordination of information supporting primary and secondary care initiatives relevant to the strategic plan, in particular those which affect the interface between primary and secondary care

The operational priority is considered to be:

- Primary care benchmarking to ensure a Lothian wide approach to sharing and benchmarking of primary care information at general practice and partnership level

• NHS Boards are required to make medium term assessments of the strengths and weaknesses in delivering the 2020 vision for primary care. This assessment should include detail of the shift in resource to support the transformation of primary care

The resource shift required to support the transformation of primary care will be assessed as work progresses across a number of work streams such as the redesign of pathways of care, provision of local ‘step up’ and ‘step down’ beds, expansion of primary care premises and development of primary care and community care workforce plans.

NHS Lothian will continue to contribute to this Scottish Government primary care modernisation agenda through active participation at the Scottish Government Primary Care Strategic Forum.

3.2 New GP Contract 2014/15

Development of the Scottish GP contract in 2014/15 will contribute to delivery of the key priority areas outlined in the 2020 vision route map in terms of further reducing bureaucracy and creating a stable funding environment for general practice over the coming years. A further 264 Quality & Outcome Framework (QOF) points are being transferred into the global sum under core standard arrangements leaving a balance of 659 points for 2014/15. The main area of innovation in QOF is in relation to the quality and safety indicators:
Integration:

- A requirement for a designated practice-based liaison GP to link to a specified liaison person from the Health and Social Care Partnership and fully engage with the evolving integration agenda.

Quality Improvement:

- A new continuous quality improvement indicator requiring a quality report reflecting relevant activity in the previous year, plus participation in a 3 year rolling programme of formative and supportive peer review visits. The practice visits are intended to allow constructive discussion, identify areas of priority and support the sharing of best practice.

Patient Access:

- An annual review (involving patients) of current patient demand, focusing on both met and unmet needs; ‘Patient Access Action Report’ to be submitted to the Board for discussion at a formative and supportive quality review visit. This data will be key to our understanding of the current pressures on GP practices and improving the response times for patient appointments by the sharing of best practice.

Anticipatory Care / Key Information Summaries:

- Continuing the current work on developing anticipatory care plans / Key Information Summary (KIS) (including a polypharmacy review) for those patients predicted (from SPARRA data) to be most at risk of emergency admission or unscheduled care; requirement for quarterly multidisciplinary practice meetings focusing on this cohort of patients. There is a good evidence base for this work in primary care and over 10,000 KIS records were created in Lothian this year.

Patient Safety:

- Two patient safety indicators are retained in QOF requiring practices to conduct a safety climate survey and two case note reviews using validated tools to detect safety incidents, discuss the results as a team and share a reflective report with the Board. This work will be complemented by a comprehensive enhanced service (ES) which will focus on improving outpatient communication in 2014/15. Previous work by practices in relation to Warfarin monitoring and medicines reconciliation has already produced excellent results and contributed to a material culture change in general practice as part of the Scottish Patient Safety Programme in Primary Care.

3.3 Review of General Practitioner Numbers and Practices

Population growth in Lothian, as predicted by National Records of Scotland (NRS) will be an average of circa 9,000 per annum between 2010 and 2020, or circa 8,000 per annum between 2015 and 2020. It should be noted however that, historically, there is a significant disparity between the NRS predicted population estimates and the GP lists size, across Lothian and within each locality.
Demographics in Lothian are predicted (NRS) to change significantly with the number of people over the age of 65 increasing by circa 25% between 2010 and 2020, as demonstrated in the table below.

**Table 1: National Records Scotland Population Predictions (1,000's) 2010 based**

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<tbody>
<tr>
<td>All NRS</td>
<td>836.70</td>
<td>843.73</td>
<td>883.70</td>
<td>925.20</td>
<td>88.50 10.58%</td>
<td>41.50 4.70%</td>
</tr>
<tr>
<td>0-15</td>
<td>141.40</td>
<td>143.36</td>
<td>147.40</td>
<td>157.10</td>
<td>15.70 11.10%</td>
<td>9.70 6.58%</td>
</tr>
<tr>
<td>16-64</td>
<td>571.40</td>
<td>571.00</td>
<td>595.50</td>
<td>613.00</td>
<td>41.60 7.28%</td>
<td>17.50 2.94%</td>
</tr>
<tr>
<td>65+</td>
<td>124.00</td>
<td>129.37</td>
<td>140.80</td>
<td>155.30</td>
<td>31.30 25.24%</td>
<td>14.50 10.30%</td>
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* 2012 NRS estimate based on 2011 Census data

It is difficult to predict the growth of the elderly population, at a locality or practice level, which is where this will impact on GP Practices capacity.

There are 127 GP Practices across NHS Lothian. Although the number of practices has grown this has been the result of existing practices sub-dividing using existing premises capacity and with their relevant practice populations. The last new and additional practice was created over a decade ago.
Mapping of General Practice, General Dental Practice and Pharmacy locations has been completed and shared with each Community Health Partnership (CHP). Work is underway to identify the localities and individual practices experiencing, or predicted to experience, specific population pressures and map these to the relevant current General Practice boundaries.

Each CHP will then develop general practice capacity plans within their locality, and in partnership across CHP boundaries where appropriate, to address these capacity issues, including the development of existing practice premises and the identification of where new and additional practices will be required. (See Appendix 2)

As well as facilities, these capacity plans should also address practice manpower planning, Community Services resource levels, new ways of working and the potentials provided through advances in information technology.

Work is underway to consider a replacement mechanism for the former Initial Practice Allowance (part of the previous General Medical Services Contract) to facilitate the creation of new and additional General Practices in Lothian.

3.4 General Practice Enhanced Services and Shifting the Balance of Care

We continue to evaluate the GP enhanced services programme (circa £13 million GMS investment) on an annual basis to ensure best strategic fit, effectiveness and value for money.

Recent examples of enhanced service developments include:

- **Domiciliary Phlebotomy**
  Primary care services have seen an increased demand for domiciliary phlebotomy services (carried out in a patient's home) as a result of 3 broad drivers:
  - increased requirements associated with remuneration frameworks such as QOF;
  - population growth
  - clinical change, where requirements for disease monitoring or treatment have been altered and the resource has not necessarily been provided to reflect this change in clinical practice

To meet future demand, a domiciliary phlebotomy service has been established supported by recurring investment of £350,000.

- **Polypharmacy Review**
  This enhanced service, aims to facilitate a joint polypharmacy review between the pharmacist and the patient’s general practitioner. These reviews link with Anticipatory Care Plans (ACPs).
  - Year 1 (2012-13) – reviews were offered to all GP practices with patients in care homes in addition to frail elderly patients identified at high risk (over 75 years and on 10 or more medicines)
- Year 2 (2013-14) – co-horts of patients were identified for review using the SPARRA risk prediction tool
- Year 3 (2014-15) – continue to invite all practices with patients in care homes to be offered review and practices will be invited to identify patients who are at risk of readmission. Community pharmacists will continue to jointly lead reviews with general practitioners.

Looking forward, NHS Lothian will continue to regularly review existing local enhanced services, have identified current local enhanced services which require further development and will consider new local enhanced service proposals.

- General Practice Support to Care Home
  The current local enhanced service (LES) which allows practice teams to provide additional care to patients in care homes for older people is under review. The anticipatory care LES provides for a single practice to take 'lead practice' responsibilities for each care home in Lothian. This has proved a successful model although there are currently four care homes where we continue to seek a practice to take on lead status and this requires further development and investment in the region of £300,000.

- Models of Care for Frail Elderly
  There is a clear identified need to better support integrated pathways of care for frail, older people living at home. Development work on a new model of care focusing on service redesign to cover complex frail elderly patients in the community is underway. This will cover patients in care homes and also those living in their own homes. Information transfer between primary care and acute services will be improved, together with a consistent approach to polypharmacy medication reviews.

A number of initiatives have already been developed to support the shift the balance of care from hospital based to community services.

- Near Patient Testing (Warfarin)
  A recent example of this shift is the provision of Near Patent Testing for warfarin in East and Midlothian which allows general practices to provide safe, effective and convenient access to testing with immediate results and thus avoids patients having to wait for results and for changes to medications. This initiative is supported through local investment of circa £60,000.

A further example of a current proposal to support the shift in the balance of care relates to a type 2 diabetes enhanced service.

- Type 2 Diabetes Pathway
  Diabetes represents a rapidly expanding workload with circa 2,200 individuals in Lothian diagnosed with type 2 diabetes each year, a prevalence of (at least) 4.7% in the Lothian population (35,288 in 2012) and (at least) a 9% share of the NHS Lothian prescribing budget.

Secondary care diabetes services need to focus specialist skills on individuals with type 1 diabetes and those with type 2 who are complex or developing complications.
Historically, most patients with diabetes were referred to hospital at the time of diagnosis, though many are subsequently discharged back to the care of the General Practitioner once their initial assessment and management plans are in place and their condition stabilised.

An enhanced service would provide the resource for this initial assessment and ongoing care to be undertaken in general practice and would reflect the well established rise in prevalence and complexity. In order to support this proposal, investment of circa £300,000 is required.

Whilst the proposal service outlined above will provide support for those newly diagnosed with type 2 diabetes, a number of gaps and areas for improvement have been identified:

- discharge planning
- earlier supported discharge
- follow up of type 1 diabetes who do not attend hospital appointments
- GP practice support
- review of late stage type 2 diabetes with polypharmacy
- community support for those with long term stable type 2 diabetes on insulin.

In order to further enhance and bridge the gap between primary and community services, there is a need to develop a community diabetes specialist nurse (CDSN) service across Lothian. The benefits of provision of these posts will support the gaps / service improvements which have been outlined, has the potential to reduce readmissions and diabetic ketoacidosis (DKA) admissions, relieve pressure on secondary care clinic capacity, support the avoidance of travel for some stable, elderly patients to hospital services, provide support in the implementation of the national and local diabetes prescribing strategies and support the cross pollination of good practice and a more patient centred pathway of care.

### 3.5 Community based Pharmacy, Dental and Optometry Services

#### 3.5.1 Pharmacy Services

The key priority for pharmaceutical services is to implement the recommendations outlined in Prescription for Excellence³ published in 2013 which outlines a vision and action plan for the delivery of pharmacy services across Scotland to support people living in the community, receiving care at home, living in care homes and those receiving hospital / specialist hospital care at home.

The recommendations will be implemented through establishing a framework for joint working and information sharing between primary and secondary care pharmacist and other members of the multidisciplinary team.

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³ Prescription for Excellence, A Vision and Action Plan for the right pharmaceutical care through integrated partnerships and innovation, Scottish Government Health Department, September 2013.
3.5.2 Dental Services

The key strategic priorities relating to dental care for the next 10 years have been identified as:

- Increase registration for those aged up to 2 years

As at 30 September 2013, 41% of 0 to 2 year olds were registered with an NHS dentist compared to 47% registration rate across Scotland. NHS Boards in the West of Scotland that began Childsmile Practice earlier than the East of Scotland NHS Boards, show better registration. NHS Greater Glasgow and Clyde have 52% of 0 – 2 year olds registered. By 2024, NHS Lothian should aim for 70% of 0 to 2 year olds registered.

- Improve access to specialist dental services by integrating and aligning the Public Dental Service (PDS) with the Edinburgh Dental Institute (EDI)

By redesigning services provided by the PDS and EDI agree a single point of referral for suitable services. This will mean that referrers have an easy route to access specialist services, and that patients will be seen by the most appropriate clinician in a location as close to their home as is practicable in a timely way as possible.

- Continue with Scottish Government funded prevention programmes - Childsmile and Caring for Smiles aimed at improving oral health for young and older people

Childsmile is a national dental prevention programme delivered locally by each NHS Board. All children in nursery provision are offered the opportunity to participate in a tooth brushing programme. Children attending nursery located in the SIMD most deprived quintile are offered the opportunity to participate in the Childsmile Fluoride Varnish Programme. The proportion of Primary One children with no obvious dental decay in Lothian has risen from 50% to 70% since the Childsmile Programmes began. By 2024, we should aim for 80% of Primary One children in Lothian with no obvious decay.

3.5.3 Optometry Services

Optometry services should be recognised as the first point of contact for individuals who are experiencing eye problems. Since 2006 the General Ophthalmic Services contract has been in place to allow community optometrists to provide a comprehensive patient-specific examination and any necessary follow-up appointments for accurate diagnosis or monitoring of conditions.

There are a number of optometry legislative and pathway changes which support improved joint working and a shift in the balance of care, these will be the focus for development over the coming years.
• Independent Prescribing Rights to Optometrists

In 2013, new legislation was introduced to extend NHS prescribing to optometrists who are recognised by the General Ophthalmic Council (GOC) as appropriately qualified. All optometrists in Scotland, who have completed a GOC approved training course and are entered on the GOC Register as an Independent Prescriber, to provide NHS prescriptions for conditions affecting the eye and tissues surrounding the eye. This legislation will assist to shift demand from general practice as individuals do not have to visit their general practitioner to request eye prescriptions and can access specialist eye services in the community.

• Optometrist Direct Referral to Hospital Ophthalmology Services

In 2014 all community optometry practices will have access to SCI Gateway for referrals to the Hospital Eye Service. This will provide more detailed information (particularly retinal photographs) to the hospital allowing them to triage accurately. Referral guidance is available on the Lothian Referral Guideline website and there are plans to develop guidelines for additional ophthalmic and systemic conditions.

3.6 Integrated Assessment and Rehabilitation Services for Frail Older People

There are a number of health and social care integrated teams providing assessment and rehabilitation services for frail older people available across Lothian. The continuation of these services and resources to support further development of this type of model of care is essential when supporting the shift in the balance of care. Examples of integrated teams for frail older people are described below.

• Edinburgh – COMPrehansive Assessment (COMPASS)

This model supports a new way of working which aims to provide more integrated care for frail older people in Edinburgh. A key component of the COMPASS model is regular multidisciplinary team meetings whose role is to identify older people at risk of hospital admission. The aim of the meetings is to deliver better outcomes for older people and their carers through improved understanding and communication across teams and professionals.

The COMPASS pilot began in South East Edinburgh in April 2012 and rollout out further to North West Edinburgh in April 2013. There are plans to roll out the COMPASS model across all areas in Edinburgh.
• East Lothian - Integrated Service for the Elderly (ELSIE) and Midlothian MIDCare
These services are integrated co-located services which provide urgent assessment, rapid response (health and social care), rehabilitation and re-enablement for frail older people at time of crisis. Both services benefit from medical and nursing input (medicine of elderly consultant and advanced nurse practitioners) with access to Allied Health Professionals, social care and crisis care services.

East and Mid Lothian partnerships plan to further develop ‘frailty models’ and further enhance local rapid response services.

• West Lothian - Rapid Elderly Assessment and Care Team (REACT)
The REACT service provides better care for elderly patients at home by providing alternatives to hospital admission.

- Phase 1 – Hospital at Home
Currently comprising a team of nurse practitioners, consultant geriatricians, specialty doctors, a community pharmacist and an administrator, the Hospital at Home service accepts daily acute referrals for urgent assessment of older patients to prevent unnecessary admissions to hospital and to maintain individuals in their own homes where possible. The team work closely with the physiotherapists and occupational therapists to provide rapid intervention as required.

- Phase 2 – Intermediate Care Team
The Intermediate Care Team comprises physiotherapists, occupational therapists and speech therapist. They provide rehabilitation within the patient’s own home and accept referrals from the hospital wards facilitating an early supported discharge, direct from the community or from the hospital at home team. They also support Phase 1 Hospital at Home patients providing rapid assessment and intervention as required.

- Future Development of REACT In-Reach Team
The appointment of Specialist Nurses to assess frail elderly at the front door and downstream wards will facilitate the most appropriate pathway including accessing relevant community services. These nurses will work closely with the duty Consultant Geriatrician who will also be the single point of contact available to GPs and other clinicians. The team will also include senior physiotherapist and occupational therapist pulling patients back out into the community for assessments and interventions in their own home.

3.7 Reduction and Elimination of Delayed Discharge
In April 2008, a National Standard was introduced, that no patient should wait more than 6 weeks for discharge from hospital after being declared medical fit to do so. This standard was strengthened by the Scottish Government to be 4 weeks in April 2013 and 2 weeks in April 2015.
Across Lothian achieving these standards has been a challenge. The Partnerships of West Lothian and Midlothian have managed to keep pace with the National standards and are on a path that will see them achieve the impending April 2015 target. City of Edinburgh and East Lothian are experiencing challenges associated with the availability and affordability of Care Homes, and increasingly workforce shortages in the care at home market. Whilst both have achieved the 6 week standard, the 4 week standard is more challenging.

The partnerships across Lothian have identified short and long term actions to support the reduction and eventual elimination of delayed discharge.

**City of Edinburgh**

The City of Edinburgh partnership have already undertaken a number of actions to support a reduction in delayed discharge in Edinburgh. This includes:

- an increase in domiciliary care capacity
- development of 42 ‘step down’ beds.

A draft project plan has been developed to further reduce the demand for hospital admission, make the discharge process more efficient, increase capacity in existing services and enhance community capacity.

In the short term, this plan includes:

- an additional 2,500 domiciliary care hours to be provided by April 2014
- the roll out of COMPASS to all quadrants of the city
- investment in re-ablement to clear the current backlog

In the long term, this plan includes:

- the re-tender of the care at home contract which expires in October 2014
- commissioning additional ‘step-down’ beds
- establishing a discharge hub on each hospital site to increase the efficiency of the discharge process.

**East Lothian**

The East Lothian partnership will reduce the total number of delayed discharges and meet the 4 week and 2 week targets through:

- establishment of step down capacity
- the introduction of new contracts for care at home
- supporting a social enterprise model to provide care to specific cohorts of patients and service users
- implementation of a ‘frailty model’
- enhancement of the emergency care service

**Midlothian**

The Midlothian partnership have identified a number of key actions to address delayed discharge which will be to:
explore ways of strengthening the Midlothian In-Reach service which involves Midlothian staff working in the acute hospital settings)
- implement the ‘Frailty Model’ through an enhanced Rapid Response Service
- extend the provision of assessment and intermediate care beds the Highbank care facility
- review care home provision in Midlothian and further develop extra-care housing
- refresh the workforce development strategy in Primary Care to support ‘Shifting the Balance of Care’
- Continue to strengthen working links between Midlothian Partnership and the Acute sector
- From April 2014 begin to shadow the two week target for delayed discharge (this approach was adopted for when the 4 week target was introduced)

West Lothian

The West Lothian Partnership has a diverse range of initiatives in place to support the reduction and elimination of delayed discharges through:

- Reducing demand for hospital admission:
  - REACT,
  - Crisis Care,
  - Integrated Care Pathways development supported through Interface Group and Primary Care Work Plan
  - Additional capacity for falls coordination and further development of robust falls pathway
  - Currently over 4000 households benefit from telecare services with access to 24 hour Careline

- Making the discharge process more efficient
  - Integrated Discharge Planning Pathway
  - Multidisciplinary and multiagency involvement in early identification of patients needs and discharge requirements
  - Increased capacity to facilitate early supported discharge through REACT intermediate care team, re-ablement service and mental health Older People Acute Care Team

- Increasing capacity in existing services
  - The development of step up and step down model in St Michaels Hospital
  - Universal re-ablement services
  - Redesign of domiciliary physiotherapy service
  - Development of integrated workforce plan
  - Continuing development and delivery of care home education programme
  - Expansion of inpatient physiotherapy and occupational therapy services to 7 day working
  - Working with independent sector on their demand and capacity plans to support care at home and care home provision
• Enhancing community capacity.
  - Development of an additional housing with care complex in Bathgate
  - Further investment in telecare
  - Telehealth research with focus on providing care at home
  - Ensuring capacity in health and social care services to support 7 day discharge model

3.8 Review of Role and Function of NHS Continuing Care

The NHS Lothian Strategic Plan and the requirement to rebalance care from hospital and community settings require the Board to have a strategic plan for the future model and provision of inpatient complex care (IPCC) beds across Lothian. NHS Continuing Care is a package of healthcare provided and solely funded by the NHS. Patients normally receive NHS Continuing Healthcare in a hospital ward, hospice or a contracted inpatient bed within an independent sector provided e.g. Care Home.

The purpose of the review is to identify the factors that will affect future demand and need for inpatient continuing care and to propose a strategy to meet the care needs of the ageing population. The main factors are; increasing demand from an ageing population, reducing demand because community services can increasingly provide for people with higher care needs, and evolving national eligibility guidance for IPCC.

The first stage of the review will conclude by end of February 2014 and will describe an emerging strategic plan for future IPCC provision. This will be incorporated into the NHS Lothian Strategic Plan for consultation.

3.9 Redevelopment of the Royal Edinburgh Hospital

NHS Lothian and its partners, through the current mental health strategy: A Sense of Belonging 2011 - 2016; sets out plans for the redevelopment of the Royal Edinburgh Hospital and the required investments and developments in community services.

For the past 8 years, mental health services have had clear agreed strategic direction and clear plans are outlined for the remainder of the current strategy. These plans have delivered significant bed reductions compensated by investments in community services such as the intensive treatment teams and crisis intervention services.

Similarly, the number of sites from which acute mental health inpatient services are delivered has reduced from 4 to 2 sites during this period. This has resulted in significant shifts in the balance of care from hospital to community and clinical service functions providing safe, supportive assessments and treatments to patients at home who were previously admitted to hospital.

NHS Lothian’s mental health strategies and resulting community developments have been agreed and developed in partnership with local authorities and Third Sector organisations and this continued partnership will be key to the success of the plans for the redevelopment of the Royal Edinburgh Hospital. A Sense of
Belonging outlines how the redevelopment will be delivered including service redesign, investments in community services and associated improvements in reduced inpatient services to provide a better quality of inpatient care for individuals who cannot be safely or appropriately supported at home.

Phase 1 of the Royal Edinburgh Hospital campus redevelopment will focus on providing inpatient mental health assessment, treatment and rehabilitation facilities and the re-provision of the national brain injury unit. The completion of construction associated with the Phase 1 redevelopment is estimated to be completed in November 2016.

3.10 Develop Jointly with Local Authority partners a community and residential support service for people with learning disability

A number of strategic developments and work streams are being progressed across Lothian to ensure that specialist learning disability services are of high quality, effective and fit for purpose. Key work streams relate to:

- Reprovision of Learning Disability Inpatient Service
  The final stage of benchmarking against national and international practice is due for completion in April 2014. The service is concluding negotiations with NHS Borders relating to commissioning of assessment and treatment services for people with learning disability. This work will inform the clinical brief which is being developed by the Royal Edinburgh Hospital Reprovision team and this will inform the business case for Phase 2 of the reprovision.

- Repatriation of Out of Scotland Patients
  The national learning disability strategy requires that repatriation of patients is concluded by 2018. This strand of work forms part of the overall modernisation of learning disability services, including the Royal Edinburgh Hospital redevelopment.

- Support Discharge of Long Stay Patients
  The service is entering negotiations with the respective local authorities to identify and agree community destinations for individuals who did not benefit from the original repovisioning of the long stay institutions. This work stream has the potential to deliver community based opportunities for 16 individuals.

- Development of a Joint Community Facility for Autism and Learning Disability
  A project to support this development is planned for 2016/17 and is a key element of the planned shift in the balance of care, and the up streaming of services from the hospital campus into community resources. A revised Initial Agreement will be considered by the Lothian Capital Investment Group on 8 April 2014.

- Develop a New Model of Care Fit for Future Learning Disability Inpatient Services
  To support this new model of care, patient pathways will be revised across all levels of the health and social care system. Stakeholder engagement is now underway to discuss and consult on the future model of care.
This will inform the Royal Edinburgh Hospital Outline Business Case and other elements of redesign, both of which will inform the development of the integration plans, joint commissioning plans and the overall Lothian Joint Strategy for Learning Disability which will be concluded in 2014/15.

- Development of a Model of Care and Delivery of Services for People with Profound and Multiple Disabilities
  A working group will be set up to take forward this initiative.

- Development of a Health Inequality Strategy Building on the Interim Lothian Action Plan and National Strategy; The Keys To Life
  Within the overarching framework of NHS Lothian’s Health Inequality Strategy, the learning disability programme is undertaking local engagement events throughout February 2014 which, once concluded will detail health promoting actions specific to the needs and wishes of people with learning disability and their families.

3.11 Assess the Potential for a new ‘Care Village’ Concept

The Edinburgh partnership will host a workshop in April 2014 to begin initial discussions and assess the potential for this concept.

3.12 Develop a new East Lothian Community Hospital (replacing Roodlands Hospital)

We will develop a new East Lothian Community Hospital to replace Roodlands and Herdmanflat Hospitals with modern accommodation and increase capacity to treat more East Lothian residents locally, it is anticipated the new community hospital will open in late 2017.

The provision of this local community hospital will ensure that more patients can be admitted directly and more can be discharged quickly from Edinburgh hospitals for post acute care through increasing the capacity for step-up/step-down provision for older people.

The new hospital will also increase capacity for day surgery and outpatients so that more East Lothian residents can be treated locally in line with the Lothian wide scheduled care capacity plans.

3.13 Provision of ‘Step Up’ and ‘Step Down’ Care in Midlothian Community Hospital

The Midlothian partnership is at an early stage of developing a project plan to support the redesign of Midlothian Community Hospital. The key actions at this stage will be to:

- strengthen the Midlothian in-reach service
- implement the ‘frailty’ model through an enhanced Rapid Response Service

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4 The Keys to Life – Improving Quality of Life for People with Learning Disability, Scottish Government Health Department, June 2013
extend the provision of assessment and intermediate care beds at the Highbank care facility

The main challenge in Midlothian is the limited availability of care home beds, however in the interim the partnership will continue with the development and provision of extra care housing.

3.14 Lothian Unscheduled Care Service (LUCS)

LUCS has a mixture of salaried and ad hoc General Practitioners working within it, the split of shifts covered is approximately 50/50 salaried and ad hoc. It also employs Emergency Nurse Practitioners and paramedics via a Memorandum of Understanding with the Scottish Ambulance Service.

The service is based across 5 bases within Lothian, 3 are open until midnight and the other 2 are open overnight. LUCS covers 118 hours per week, two thirds of the week.

Over the last eighteen months the national shortage of doctors has severely impacted on the ability of LUCS to cover its rotas. Out of hours (OOH) work is not popular among General Practitioners. This is due to a number of factors outlined below:

- European Working Time Directive
- Busier day time practice
- Busier out of hours shifts
- Recruitment and retention of salaried medical staff has been difficult and those that transferred into the new system in 2004 are now aging and the new doctors are looking for a work life balance that does not put Out of Hours in the forefront of roles they would be seeking to do

Since 2005/06 (first full year of operation) to 2012/2013 the demand on the service has increased by 18%. With the current move to maintain higher numbers of complex patients in the community and to manage flow through the hospital sector 7 days a week there are increasing demands on LUCS. The increase in LUCS activity from 2004 is outlined in the graph below.

LUCS Activity 2004-05 to 2012-13
There was an increase in the direct access to OOHs through our professional to professional telephone line, a 25% increase since 2010/2011 and patients using LUCS as a walk.

In addition to the current pressures of demand, there are a number of challenges facing LUCS such as new initiatives and other increasingly complex areas of work and this will impact on the ability for the service to maintain core work. Key challenges relate to:

- the increase in level of complex patients seen in OOH, particularly the frail elderly, care home and palliative patients
- the increase in direct access to OOH through our professional to professional telephone line, a 25% increase since 2010/11
- the additional demands on OOH over and above the normal core work e.g. public health
- information sharing through anticipatory care plans is leading to longer home visits (expected to increase further due to the Key Information Summary and QOF)

LUCS will undertake a service review as part of addressing these challenges.

4. Delivering the Propositions for Primary and Community Services

The four Lothian Health and Social Care Partnerships are to develop a Strategic Commissioning Plan supported by a number of Joint Commissioning Plans such as those for older people, mental health, learning disability, addition and criminal justice services.

In order for the aspirations outlined in this plan to be met, these need to be reflected within the partnerships strategic commissioning plans to ensure local ownership.

The developments associated with the primary care contractors will be taken forward with support from the Primary Care Contractor Organisation (PCCO).
Appendix 3:

NHS Lothian
Primary Care Strategy
Demand, Capacity and Access
An Overview
Appendix 3:

**Introduction**

Primary Care Services consist of four distinct professional groups, these are:

- General Medical Practices (GP practices)
- General Dental Practices
- Community Pharmacy Services
- Optometry Services

All the above services are provided, in the main, by practitioners operating as or within independent businesses.

It is therefore difficult for the NHS to prescribe what range and quantity of resources each should provide to deliver the services contracted for, or to ascertain what resources each has in place.

Demand, Capacity and Access issues will differ markedly between localities and between providers within the same locality.

The main drivers for the above differences centre on local population growth, deprivation, demographics, the impacts of Shifting the Balance of Care, availability of adequate resources in Community Services, the efficiency of the structure (man-power/staff mix), systems and processes internal to the individual provider and the suitability and capacity of premises.

Each of the above will have its own impact and, where more than one factor is present; will have as minimum a cumulative, if not an exponential, impact.
**Demand**

The growth in demand on Primary Care Services is affected by numerous factors, few of which can be immediately influenced by Practices or the NHS.

These include:

Population Growth in locality (impact on Practice lists size)

Demographics of Practice population (particularly those impacts related to a growing elderly population, in terms of consultation frequency, complexity and duration, and the increase in the incidence of domiciliary visits.

Nationality (where patient communication difficulties impact on length of consultation and cultural expectations)

Deprivation Levels/Volume (historically high-end users of health services, particularly Primary Care)

Housing Development Plans (impacts of recent and future housing developments on population growth, practices list sizes and thereby demand)

The movement of condition specific patient care into the Primary Care setting and the further expectations of “Shifting the Balance of Care” from the acute sector into the Primary Care and Community setting.

The reduction in Community Services (Health Visitors, District Nurses, AHPs etc) over time has increased the need for patients to access GP services.

**Population Growth**

Determining what the population growth in Lothian has been and projecting what it may be in the future is subject to a number of data variables, dependant upon the source of the data in question.

Traditionally, most planning assumptions for public services, including the NHS, have been based on General Registrar Office (GRO) [now National Records Scotland (NRS)] data and information.

To inform the production of this document and in addition to the NRS data, various other data and information sources were examined to obtain a broader picture, with a significant degree variance becoming apparent.

This included Local Authorities Housing Land Audits, which predict the level of house completions by locality each year, from which the rise in population for an area and therefore for Primary Care services can be calculated.

The other source of information examined was that produced by the Practitioner Services Division (PSD) of National Services Scotland (NSS). This data reports the size of General Practice lists as of 1st April each year.
Table 1 below demonstrates the variance between NRS projections and the actual size of GP patient lists over time.

<table>
<thead>
<tr>
<th>1000’s</th>
<th>2012</th>
<th>2013</th>
<th>2014</th>
<th>2015</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>NRS Projections</td>
<td>856.20</td>
<td>865.86</td>
<td>875.18</td>
<td>883.86</td>
<td>892.43</td>
<td>900.69</td>
<td>908.96</td>
</tr>
<tr>
<td>Lothian List Size</td>
<td>894.50</td>
<td>903.16</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total HLA Impact</td>
<td>6.59</td>
<td>6.91</td>
<td>7.76</td>
<td>7.31</td>
<td>6.85</td>
<td>7.43</td>
<td></td>
</tr>
<tr>
<td>NRS 2013+Housing</td>
<td>856.20</td>
<td>872.45</td>
<td>882.08</td>
<td>891.62</td>
<td>899.73</td>
<td>907.55</td>
<td>916.39</td>
</tr>
<tr>
<td>Lists 2013+Housing</td>
<td>894.50</td>
<td>909.75</td>
<td>916.66</td>
<td>924.42</td>
<td>931.72</td>
<td>938.58</td>
<td>946.01</td>
</tr>
</tbody>
</table>

**Table 1:** Comparison between NRS projections¹ and cumulative GP Lists² with population impacts of Lothian Local Authorities’ Housing Land Audits

Graph 1: Lothian Population Projections

The graph above clearly demonstrates the disparity between NRS (GRO) projections and the apparent reality at GP practice level. Whilst it is accepted that there will be a degree of churn in practice list sizes the data from each practice, as of 1ST April each year, is compared and validated against the NHS Central Register (NHSCR) Demographic Extract.

Using 2012 as a common point of origin (NRS estimate based on 2011 Census and GP lists size for that year), the population impacts of the Lothian local authorities Housing Land Audits has also been projected.

The full pan-Lothian population projections are available in Appendix 1 to this document.

¹ [http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm](http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm)

² Source: National Services Scotland, Practitioner Services Division
Since 2009/10 Practice list sizes, across NHS Lothian, have grown by C29k, the equivalent of c6 good sized practices. In 2013 there has been an increase in the incidence of practices reporting their patient lists as full or restricted, albeit still open, within Edinburgh City (see Appendix 5), whilst practices in other HSCPs report growing pressures.

This is at variance with the projections forecast by NRS as, at 2012; there was a gap of C38k between the reported cumulative NHS Lothian list size and the NRS population estimate for that year.

Factors to be considered when looking at this disparity include cross-boundary (external to Lothian) residents registered with Lothian practices, non-notification of emigration and unreported deaths occurring abroad.

One conclusion that could be drawn from the above is that the practice list size is the stronger determinant of the demand upon an individual practice and that this should form the basis of any planning for the future.

It would, however, be equally important to take cognisance of the projected growth in population for the South-East of Scotland and the Lothian area in particular, combined with the changing demographic profile of that population.

**Demographics**

It has been long accepted that the changing demographics across Scotland will have a significant impact upon all NHS services, over time. This is particularly true of Primary Care and Community services and increasingly so when ‘Shifting the Balance of Care’ is factored into planning for the future.

The aging population and non-UK immigration are the two main demographic factors high-lighted by GPs as impacting upon their capacity.

The growing, elderly, population across Lothian brings with it issues of increasing numbers of patients with multi-morbidity and frailty. This patient group frequently requires a disproportionate time for each consultation and access GP services with greater frequency than younger patients. Visits, either to homes or care homes, are particularly time consuming and more likely in this group for both practice and community services.

<table>
<thead>
<tr>
<th>Age Group</th>
<th>2010</th>
<th>2015</th>
<th>2020</th>
<th>2010-20</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Ages</td>
<td>836.7</td>
<td>883.7</td>
<td>925.2</td>
<td>88.5</td>
<td>10.58%</td>
</tr>
<tr>
<td>0-15</td>
<td>141.4</td>
<td>147.4</td>
<td>157.1</td>
<td>15.7</td>
<td>11.10%</td>
</tr>
<tr>
<td>16-64</td>
<td>571.4</td>
<td>595.5</td>
<td>613</td>
<td>41.6</td>
<td>7.28%</td>
</tr>
<tr>
<td>65+</td>
<td>124</td>
<td>140.8</td>
<td>155.3</td>
<td>31.3</td>
<td>25.24%</td>
</tr>
</tbody>
</table>

**Table 2:** Change in Population by Age Group 2010 to 2020

3 http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm
Of the Lothian wide increase (25.24%) the projected proportional increase, for each HSCP, in aging populations (+65) in the time period above, across Lothian are:

- West Lothian (36.17%)
- Midlothian (27.74%)
- East Lothian (24.43%)
- Edinburgh (20.61%)

Although Edinburgh shows the least, proportionate, increase it is worthy of note that this represents a potential increase of over 14,000 in its elderly population.

The percentage increases in the aging populations above help to illustrate the proportional increase in demand that will impact on both Primary and Community services, particularly where concentrations of care homes and sheltered housing occur.

The full projections by Local Authority and Age Group are demonstrated in Appendix 2.
Non-UK In-Migration

There has been a large influx of non-UK immigrants over recent years and this is projected to continue. The larger proportion of these has been from former Eastern European countries, post EEC membership and is anticipated to increase as more countries take up EEC membership. There has also been a rise in the proportion of the, relatively stable, student population who are foreign nationals.

Migration is the most difficult element of population change to estimate as, unlike births and deaths, there no comprehensive system of registration of movement to and from the rest of the world, nor moves within the UK.

A number of information sources must be brought together with the NRS estimates of migration to create a fuller picture.

Accepting this, in-migration has fluctuated over the years although the trend continues to be upward and out-migration has shown a gradual decline.

This has resulted in an average, between 2006 and 2011, net in-migration of C7,000 per annum, i.e. more than a GP Practice worth of new patients.

Deprivation Levels and Inequality

At the end of 2012/13, there were fifteen practices in which more than a third of the practice population lived in one of the 20% most deprived areas of Scotland, measured by SIMD. (See Appendix 3)

At a Scotland level the impact of deprivation inequalities are stark, including:

- Average life expectancy of men in the most deprived areas is 70.1 years, in the least deprived areas it is 81 years;
- For women it is 76.8 years in the most deprived areas, in the least deprived areas it is 84.2 years;
- Exclusive breastfeeding rate at 6-8 weeks is 15% in the most deprived areas, in the least deprived areas it is 40%;
- GP consultations for anxiety per 1,000 patients is 62 in the most deprived areas, in the least deprived areas it is 28; and
- Alcohol-related hospital admissions per 100,000 of population in the most deprived areas are 1,621, in the least deprived areas it is 214.

People in more deprived areas have higher rates of vascular disease, mental health problems, obesity, alcohol and drug misuse problems, diabetes and most types of cancer. Children in deprived areas have significantly worse health than those in more affluent areas. For example, they have lower average birth weights and breastfeeding rates, have poorer dental health and are more likely to be obese.
GPs working in deprived areas will have a workload that reflects the prevalence of multi-morbidity in their population. Their population will also have a higher need for support with other social needs, which often impacts on their use of healthcare services. As well as high need for primary medical care, their patients will have greater need for other community health and social care services.

However, although Scotland has a higher ratio of GPs to people compared with every other UK country, the distribution of GPs does not necessarily reflect the respective needs of people according to the level of deprivation in their area.

From the perspective inequity of access, the distribution of primary care services across Lothian does not fully reflect the higher levels of ill health and wider needs found in deprived areas, or the need for more preventative health care. The distribution of other primary health care services, such as pharmacies, is more closely matched to need.

The Deep End group of practices, which serve the most deprived populations in Scotland, argues for better integrated care for these patients. The group has made the following recommendations to meet their enhanced needs:

- Provide extra time for consultations and best use of serial encounters for patients in the most deprived areas.
- Provide additional clinical capacity, equivalent to one additional GP per 1000 patients in the most deprived areas.
- Develop a stepped approach to engagement for attached workers in general practice.
- Provide attached alcohol workers.
- Develop a National Enhanced Service for Vulnerable Families (NES).
- Recruit practice attached community link workers.
- Enhancements to GP training to give GP trainees experience of work in deprived areas.

**Shifting the Balance of Care**

Shifting the Balance of Care has moved demand out of the acute sector into the Primary and Community care sectors. This has impacted most upon GP practices and Community Services (see Demand section below).

The effect of this shift has been to impact on the resources, already stretched through the drivers mentioned above, available with GP Practices.

Further planned shifts of activity from the acute sector to the Primary and Community setting will need to be defined, the resource impacts explicitly identified and the required resource transfer and structural changes put in place, before any relocation of activity takes place.
Housing Developments

The South East of Scotland and Lothian in particular, has been identified as the area that will see the greatest growth in population over the next 20 years.

The period up to 2020 will be no exception to this with a projected average increase in Lothian population of c7k per annum. This is based on the 2012 Housing Land Audits from each of the, Lothian, Local Authorities (LA). HLA’s however do not portray the full measure of population growth although their impact will be contributory.

The Housing Land Audits provide clarity as to where and how many houses are planned to be built and the population impact on the local practice, or practices, can be calculated from this.

In Graph 1 on page 3 above and in Appendix 1, and using 2012 as a common point of origin, the projected population impacts of the cumulative data from the Lothian local authorities Housing Land Audits have been demonstrated.

The projections in the Housing Land Audits mentioned above (See Appendix 1) are based on land, and its housing capacity, identified for this purpose by each local authority in their local development plans.

The decision on when to commence building and at what rate, for individual housing developments, is a purely commercial one and therefore subject to fluctuating market conditions.

Resource Levels in Community Services

The work and work-load of Primary Care services, and specifically General Practice, is directly affected by the movement in the levels, types and capacity of services available to support them in the community.

The reduction and/or lack of these services will result in increased patient demand for General Practice services which, in turn often translates into increased demand upon Out-of-Hours, acute hospital beds and A&E services.
Capacity

The capacity of Primary Care services can be affected by a range of factors, not all within the control of primary care service providers. The area of Primary Care that reports significant capacity issues is that of General Practice (GP).

There is now an acute crisis of capacity, many practices having already expanded and adapted to their limits and Patients may now have to access several practices before being accepted.

Edinburgh CHP has identified a non–recurring, short term payment scheme to help practices grow by 500 patients, known as List Extension Growth Uplift (LEGUP). Funding is being sought from NHS Lothian to enable a pilot to progress in Edinburgh.

General Medical Practices

- The number, whole time equivalents (WTE) and status of GPs within a practice i.e. partner, salaried, long-term/short-term locum.
- GP practices now have a mainly female, part time, profile. Many are younger GPs, who do not aspire to partnership status may not wish to work full time and are often more interested in salaried posts.
- Practices are not obliged to provide information on their GP staffing nor the WTE GPs in a practice. As a result it is impossible to estimate the true ratio of GP resource available against a practice list size.
- Although the Primary Care Workforce Survey (PCWS) 2013 estimates that the GP WTE has risen to 610, from the 590 estimate in 2009, these calculations are based on a much reduced return rate for 2013. It is interesting to note that, at variance to the above, the estimated sessional commitment has reduced from 634, in 2009, to 520 in 2013.
- The number, WTE and status of practice nursing staff, all of which determines how much and what GPs can, or cannot, appropriately delegate/sign-post to for care. The PCWS 2013 count of nurses employed in practices was carried out in a very different way, than that undertaken in 2009, so no direct correlation can be made.
- The number, grades, experience and abilities of Practice Managers and administrative staff to deal with first contact from patients, ensure procedures are efficient and implemented effectively and that policies and procedures are regularly reviewed and updated.
- The capacity of community services (District Nursing, Health Visitors and School Nursing etc) to reduce the need for patients to contact a practice in the first instance and to deal with patients within the community avoiding condition exacerbation and repeat access to GP services, and maintaining independence.
- The capacity of Social Services to provide services and equipment for patients to aid recovery and re-enablement, avoiding condition exacerbation and maintaining independence.
• Demography, particularly the rapidly growing elderly population, levels and volume of local deprivation and in-migration also impact upon the capacity of general practice. This is due to the additional time these patients require, albeit for different reasons i.e. medical condition and physical communication disability, chaotic life-styles or second language communication issues and cultural expectations.

• The application of appropriate and/or innovative activities, processes and procedures ensuring efficient practices are in place, avoiding negative and seeking positive impacts on the capacity of the practice and patient access to its services.

• Other factors which have had a negative effect on GP practice capacity include:
  o increase in IT requirements, with some degradation in consultation functionality including prescribing;
  o increase in QOF requirements for a flat resource;
  o increase in GP training requirements, again with a flat resource;
  o more care home patients;
  o shift of ‘tasks’ from secondary care, not formally recognised;
  o the impact of welfare and benefit reforms (both consultations and administrative time, again under-resourced)

• Premises – the suitability and capacity of facilities to support the activity required to deal appropriately with the volume of patient contacts.

General Dental Services
There are a known number of practices who are taking on new NHS patients but, at the current time, no capacity issues have been identified.

Community Pharmacy Services
There are no known capacity issues, for Community Pharmacy Services, within Lothian.

General Ophthalmic Services
There are no known capacity issues, for Ophthalmic Services, within Lothian.

Community Services
There has been erosion in the numbers of ‘trained’ nursing staff (Health Visitors, Community Nurses and School Nurses) in the community, off-set to a degree by an increase in community Health Care Assistants (HCA).

However, whilst the WTE of community ‘nursing’ staff between 2009 and 2013 has risen over-all, by 1.34% (13.19 wte), practice list size has increased by over 3% (c29k).
Preparedness for Vision 20:20 would indicate a need for more, rather than fewer community nurses. This is particularly important if community-based palliative care is to be maintained or increased.

**Access**

The quality of access to Primary Care services is, for most patients, determined by the immediacy of that access to a service, or range of services, suitable to address their need.

Pharmacy services are provided by high street retailers to which the public and patients have immediate access when their services are open.

General Practitioner, General Dental and Optometry services normally operate an appointment system, the latter two through negotiation between the practice and the patient.

General Practices have historically operated a first-come-first-served system of one kind or another, although there are good examples where practices are moving away from this to address demand, capacity and access issues.

**Dentistry**

The decision whether or not to register with any, or a particular, Dental Practitioner is solely the choice of the individual patient. The registration status available to the patient, NHS or private, and whether they are accepted will be determined by the Dental Practitioner.

Data on the number of purely private registrations with Dental Practitioners is not available; therefore the information below is confined to patients registered with a NHS General Dental Service (NHS GDS) Dentist.

The level of the Scottish population (all ages) registered with an NHS GDS dentist was 81.8% as at 31st March 2013, up from 79.8% as at 30th September 2012. Within the 6-12 and 13-17 age groups, over 99% of the population was registered with an NHS GDS dentist.

However, as will be seen in Table 3 below, Lothian falls short of the above by a significant margin and appear in the lower half of Health Boards, for both children and adults, for the proportion of registrations against population. This should be viewed with the caveat that a significant, but unknown, number of the Lothian population will be registered as private patients.

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Number of children</th>
<th>% of child population</th>
<th>Number of adults</th>
<th>% of adult population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Shetland</td>
<td>4,574</td>
<td>94.80</td>
<td>13,497</td>
<td>76.40</td>
</tr>
<tr>
<td>Orkney</td>
<td>3,647</td>
<td>93.10</td>
<td>10,529</td>
<td>64.80</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>212,316</td>
<td>89.90</td>
<td>817,023</td>
<td>83.90</td>
</tr>
<tr>
<td>Scotland</td>
<td>927,330</td>
<td>89.50</td>
<td>3,370,982</td>
<td>79.90</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>64,112</td>
<td>89.00</td>
<td>253,188</td>
<td>85.90</td>
</tr>
<tr>
<td>Area</td>
<td>Number</td>
<td>Open until 6pm</td>
<td>Open between 6pm-10pm</td>
<td>Open on Saturdays AM</td>
</tr>
<tr>
<td>-----------------------</td>
<td>--------</td>
<td>----------------</td>
<td>-----------------------</td>
<td>----------------------</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>182</td>
<td>23</td>
<td>23</td>
<td>90</td>
</tr>
<tr>
<td>East Lothian</td>
<td>159</td>
<td>23</td>
<td>0</td>
<td>90</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>107</td>
<td>0</td>
<td>17</td>
<td>90</td>
</tr>
<tr>
<td>Midlothian</td>
<td>20</td>
<td>0</td>
<td>2</td>
<td>17</td>
</tr>
</tbody>
</table>

Table 4: Community Pharmacy Opening Hours in NHS Lothian Source: Provision of Pharmaceutical Care Services Delivered via Community Pharmacy 1st April 2013 FINAL

<table>
<thead>
<tr>
<th>Area</th>
<th>Induction Loop</th>
<th>Wheelchair Access</th>
<th>Private Consulting Area or Room</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian</td>
<td>146 (80%)</td>
<td>165 (91%)</td>
<td>165 (91%)</td>
</tr>
<tr>
<td>East Lothian</td>
<td>20 (87%)</td>
<td>21 (91%)</td>
<td>19 (82%)</td>
</tr>
<tr>
<td>Midlothian</td>
<td>16 (80%)</td>
<td>17 (85%)</td>
<td>19 (95%)</td>
</tr>
<tr>
<td>Edinburgh</td>
<td>85 (79%)</td>
<td>97 (91%)</td>
<td>98 (92%)</td>
</tr>
<tr>
<td>West Lothian</td>
<td>25 (78%)</td>
<td>30 (91%)</td>
<td>29 (88%)</td>
</tr>
</tbody>
</table>

Table 5: Physical Access Resources Provided by Lothian Pharmacies

The new community pharmacy contract replaces one where NHS pharmacy services mainly related to dispensing of medication. The new contract aims to use the skills and knowledge of pharmacists better.
Pharmacists now graduate at a Masters level of degree education. The location and facilities of pharmacies could be better utilised to meet the needs of patients.

All pharmacies are required to provide 4 core pharmaceutical care services:

- Chronic Medication Service
- Acute Medication Service
- Minor Ailment Service
- Public Health Service.

Full descriptions of these services, together with the extended services provided by some pharmacies, are described in more detail in the document “Provision of Pharmaceutical Care Services Delivered via Community Pharmacy 1st April 2013 FINAL”.

In terms of access there appear to be no significant issues. This is not the GP impression in some areas, where pharmacies are unable to provide dosette boxes or other interval prescribing due to pressures. Again, deprivation may have a disproportionate effect? – where much methadone / drug misuse prescribing, high levels of interval prescribing and so on.

However, chronic medication is the final core service to be implemented in pharmacies and the demand and workload has not yet been established. It may be useful in the future to assess the capacity in existing pharmacies and any changes to staffing skill mix that may help meet increasing demands.

Optometry

On 1st April 2006, a new NHS eye examination was introduced and free NHS eye examinations were extended to all in Scotland.

The traditional NHS sight test was replaced with a comprehensive eye examination appropriate to the patient’s needs. An initial eye examination is carried out (primary eye examination) and where necessary a second eye examination (supplementary eye examination).

<table>
<thead>
<tr>
<th>Lothian NHS eye examinations (total)</th>
</tr>
</thead>
<tbody>
<tr>
<td>At 31st March</td>
</tr>
<tr>
<td>000's</td>
</tr>
<tr>
<td>Annual Change</td>
</tr>
<tr>
<td>% Change</td>
</tr>
</tbody>
</table>

Table 6: Total Eye Examinations per year Source: ISD August 2013

Approximately 35% of the Lothian population received an eye test during the year 2012/13. Given that the vast majority of these are primary eye examinations, and the population percentage receiving eye examinations has
remained consistently over 30% per annum since 2009, there would appear to be no access issues to these services.

Traditionally, within the NHS, the first point of contact for most patients with an ocular or visual problem has been their GP. With the introduction of the NHS eye examination optometrists/ophthalmic medical practitioners should now be promoted as the first point of contact for patients with eye related problems. This message is still not getting through to many patients resulting in many, unnecessary, GP consultations

General Practice

Improving access, for patients who need to interact with General Practices is a key issue in ensuring the patient's experience of the NHS is improved.

This includes improved access to a wider range of services, increasing core capacity, redesigning services by making full and effective use of professional skills, and harnessing information, technology and communications.

In practice this means, NHS Boards and primary care teams working together to improve access through, for example:

- increased capacity
- fit for purpose premises
- service redesign
- skill-mix
- development and more effective use of the skills of all primary care staff
- direct access to the full range of primary care staff
- local protocols for interdisciplinary referrals within primary care
- local protocols for interdisciplinary referrals to Community Services i.e. Community Nursing, CPN's, Health Visitors, AHP services, OT and Social Services etc
- Fully resourced work transfer from secondary care
- information to local people about how to access and make the best use of services
- telephone triage arrangements
- use of NHS24 (08454 24 24 24)

A number of practices across Lothian are struggling to maintain the 48 hour access target, set by the QOF requirements. This is due to the increased demand they are experiencing and poor access to GP services remains the main point of concern for most patients.
GP practices in Lothian overall see around 10% of their entire practice weekly, which offers an extremely high level of access but which continues to be outstripped by rising demand.

Community Services

Access to Community Services is restricted by manpower availability and skill-mix within all the professional groups under this heading.

As mentioned above, under Capacity, whilst the WTE of community ‘nursing’ staff between 2009 and 2013 has risen over-all, by 1.34% (13.19 wte), practice list size has increased by 3.42% (C29k), 2 ½ times the rate of increase in (non-Psychiatric) nursing staff in the community.

This has led to the range of services delivered by these staff to become increasingly reduced with consequent impact on patient care and practices.

This will have a domino effect upon Out-of-Hours services and, inevitably, on A&E services and unscheduled admissions.

The reduction is particularly noticed in the care of patients who are frail, have multiple morbidity or palliative needs where spare capacity is required to manage unexpected clinical events.

Primary Care Premises

Primary Care Premises is dealt with under its own heading as the issues involved impact on both Capacity and Access, in part driven by Demand but by other factors also.

There are currently 94 premises providing accommodation for 127 GP Practices. These range from NHS owned health centres, GP owned medical centres and developer owned medical centres and premises leased from private landlords.

The quality of these premises range from relatively new facilities that accommodate Primary Care, NHS community and Council services, to GP practices based in converted residential premises such as Gullane Surgery, in East Lothian, currently being re-provided through a joint project with East Lothian Council. The maps in Appendix 5 show the distribution of GP premises across Lothian.

There are also NHS Community services provided from a range of GP premises and from NHS premises. These face the same range of issues as the GP services. Some GP premises cannot accommodate NHS staff.

There are 164 premises providing General Dental Services and 9 premises in which the Public Dental Service operate. There are some “state of the art” premises, but also some premises that will never fully comply with legislation or decontamination requirements in their current premises.
The Salaried Primary Care Dental Service is managed by West Lothian Health and Social Care Partnership (HSCP), but all HSCPs also have some responsibilities since some of the services are located in shared premises.

There are major issues of DDA compliance and functional suitability with some. GP/GDP owned, developer owned and private landlord owned premises range from modern compliant multipurpose buildings to old, non-compliant single purpose buildings.

Attached at Appendix 4 is the NHS Lothian GP premises development priorities list based on condition, compliance and functional suitability.

In dentistry there are two key issues with some practices being unable to achieve DDA compliance and decontamination standards. Primary Care Contractors Organisation (PCCO) is actively engaging Dental Practices to bring all facilities up to the “Glennie” standards for decontamination. PCCO is also the enforcement arm for the comprehensive three yearly GDP practice inspection regime.

Wherever possible and as opportunities present, the HSCPs and the relevant Council should develop multipurpose joint facilities to bring together a range of NHS and Council services in communities; the recently completed Wester Hailes project being an example.

Wester Hailes Healthy Living Centre provides new accommodation for over 300 NHS Lothian and Edinburgh Council and voluntary sector staff. This includes accommodation for the Wester Hailes Medical Practice and a wide range of other community health services including:

- Physiotherapy
- Salaried Primary Care Dental Service
- Podiatry
- Midwifery
- Learning Disabilities
- Community Child Health
- Mental Health
- Speech and Language Therapy

At various times in the week, other NHS outreach services will conduct clinics in the new Centre.

Council services located in the building consist of the Health and Social Care, Children and Families and Criminal Justice social work teams. The Centre will also accommodate the Wester Hailes Health Agency and the Wester Haven Cancer support Project.
The Health Agency will provide a range of therapeutic services, such as counselling, massage and relaxation as well as group activities such as walking groups, exercise classes and volunteering opportunities.

Another example, although not including council services is Musselburgh Primary Care Centre, completed in 2012, providing accommodation for:

**Three GP practices;**
- Inveresk Medical Practice
- Riverside Practice
- Eskbridge Medical Centre

**Children Health Services;**
- Speech and Language Therapy
- Occupational Therapy
- Physiotherapy
- School Nurses
- Community Child Health

**Together with;**
- Salaried Primary Care Dental Service
- Podiatry
- Outpatients
- District Nurses and Health Visitors
- Midwives
- Clinical Psychology
- Adult Psychiatry
- Adult Physiotherapy
- Dietetics

Facilities, such as above, could provide services for a whole community such as GP practices and practice based community health services, mental health services, social work services and day services and other public and voluntary sector services as appropriate to the locality.

These facilities would deliver all or some of the following benefits:

a. Allow the NHS and the Council to significantly improve some of their worst premises and ensure compliance with legislation.
b. Improve access to services for those communities.
c. Support NHS and shared strategies by providing space for shifting the balance of care where critical mass justifies the location of services.
d. Improve services through the co-location of NHS and Council teams.
e. Maximise efficiency in use of capital and revenue by sharing space and through joint procurement.
f. Provide physical capacity to allow general practices to register extra patients in the areas of population growth
g. Provide space for other independent contractor services, particularly pharmacy and dentistry.

NHS Lothian should continue to facilitate the re-provision of premises for GP
practices that are on the premises priority list (see Appendix 4), but which are not placed to take advantage of joint working opportunities. Within this priority the HSCPs should seek to reduce the number of separate premises and encourage small practices to share facilities.

These facilities would deliver the following benefits:

a. Allow the NHS and GPs to significantly improve the worst premises and ensure compliance with legislation.

b. Allow existing GP practices to expand to provide the capacity needed to accommodate population growth.

c. Allow GP practices to support Shifting the Balance of Care.

In improving premises for Community Services HSCPs should seek to incorporate as much NHS and Council owned estate into these developments wherever possible. Some could be incorporated into the proposed joint facilities discussed above.

This could facilitate the merging of NHS and Council teams and the disposal of assets to support the capital programme. These facilities would deliver the benefits described above.

Of note, there have not been any new, additional, practices in Lothian for a decade although there have been cases of practices sub-dividing, such as in the case of Durham Road and Niddrie Medical Practices, where the existing list was shared.

Edinburgh CHP has also identified a significant number of practices, city wide, who could increase their capacity by using a modest investment to internally reorganise rooms or build an extension, rather than address their needs by re-providing their premises. By linking this to an agreed increase in practice list size, population growth as well as premises constraints could be accommodated.
APPENDIX 1: Population Projections and GP List Size

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Data Source: NRS population by Council and NRS Board area (2010-based), 2010-2035

GP List Sizes by CH(C)P @ October Each Year

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Data Source: ISD GP List Sizes at October Each Year, Published December 2013

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Data Source: Local Authority Latest Housing Land Audits

Summary

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### APPENDIX 2: Projected Population Growth by Local Authority and Age Group

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http://www.gro-scotland.gov.uk/files2/stats/population-projections/scottish-areas-2010-based/j21704310.htm
**APPENDIX 3:** Lothian Practices Ranked by % of List in Deprivation Quintile 1  
Data Source: SIMD 2012 Data Base & CHI Data Base

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<th>Practice</th>
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<th>% in Quintile 1</th>
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<td>LHP</td>
<td>Q1 SIMD (most deprived)</td>
<td>% in Quintile 1</td>
<td>List Size</td>
</tr>
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<td>Dr J W Paterson &amp; Partners</td>
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<td>1,567</td>
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<td>10,608</td>
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<td>Q1 SIMD (most deprived)</td>
<td>% in Quintile 1</td>
<td>List Size</td>
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### Appendix 4: NHS Lothian Primary Care Premises Priority List

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<tr>
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<td>Tranent Health Centre</td>
<td>East</td>
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<tr>
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<td>Newton Port Surgery, Haddington</td>
<td>East</td>
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<td>19</td>
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<td>8</td>
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<tr>
<td>9</td>
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<td>Mid</td>
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<td>16</td>
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<td>16</td>
<td>Howden Health Centre</td>
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<td>17</td>
<td>Stoneyburn Health Centre</td>
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<td>21</td>
<td>West Calder Medical Centre</td>
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Appendix 5: Lothian GP Premises and List Status (November 2013)
Unscheduled Care

Evidence of action to support sustainability e.g increased weekend / early in day discharge;

NHS Lothian is sponsoring a range of activities in support of sustainability. Some examples are noted below

Pharmacy services continue to evolve to provide a more sustainable service. Notable changes include the changes to the weekend service as well as the introduction of twilight hours sessions (Mon –Fri). Extended opening hours over the winter period have also been put in place.

Pharmacy and technical staff are now deployed more flexibly to support ward staff on discharge during particular pressured or key parts of the day. This change to service delivery has had a number of benefits namely:

- Improved communications,
- Act on/push or facilitate known /planned discharges (EDD, Criteria led DC if available)
- Medicine reconciliation at point of admission (supports safer process at point of discharge)
- Review of discharge prescription 'arrival times' to ensure resource is deployed to meet activity peaks.

As part of the winter plan we have operated with an additional consultant on at weekends to increase frequency of medical review. A proposal is currently being considered by NHS Lothian to allow the consultant resource to be increased to allow this to be undertaken throughout the year. It is anticipated this would deliver increased weekend discharges.

Additional AHP resource has been deployed over the winter period at weekends to facilitate flow and reduce delays for AHP assessment.

Following a successful pilot, the Hospital at Weekend development at St John’s Hospital, which was supported by the Unscheduled care Group, has been implemented from December 2013. This will continue to support improved patient safety, patient flow and discharge profile over the weekend.

Longer terms plans

Planning is underway to develop a Discharge Hub for SJH/West Lothian. Following advice from the Scottish Government, West Lothian staff have visited NHS Fife to learn from their successful implementation of this model. This is now likely to be implemented during 2014/15.
We will continue to focus on EDD’s, ensuring effective use of the discharge lounge for early in the day discharge. More effective use of community and integrated resources such as the West Lothian frailty model “REACT” whose membership attend the daily morning site meeting (St Johns) will also help facilitate improved performance on discharges/transfers.

Other notable developments include:

- The appointment of Alan Boyter, HR Director, as the strategic lead for 7 day working in NS Lothian.
- The piloting of AHP 7day working has already commenced across NHS Lothian, led by Lynne Douglas, AHP Director.

These and other initiatives will be developed further and noted in the next iteration of NHS Lothian’s LUCAP for 2014/15.

Evidence of whole system approach to achieve sustainable 95/98% compliance e.g. linking of Unscheduled Care and Change fund initiatives to ensure optimum patient care outcomes;

NHS Lothian has and continues to undertake a series of actions that reflect a whole systems approach to unscheduled care. Not only does this involve working in partnership with a range of healthcare partners, it also involves reviewing aspects of service delivery including front door performance, internal patient flow mechanisms and appropriate discharge – all of which are critical to establishing effective systems wide performance.

Additional capacity to support front door services has been created. Examples include:

- Increased Consultant presence in the evening and weekend to improve senior decision making and to manage boarding more effectively in support of assessment models.
- Increased nurse staffing to maximise medical capacity that improves flow, eg time to first assessment etc.

The Change Fund has allowed for investment in a range of community services in helping to prevent unnecessary admission to hospital as well as to assist with issues of delayed discharge. Examples include:

- New models of care such as REACT (West Lothian) and COMPASS (Edinburgh) are in place offering day hospital and community rehab provision with the goal of reducing the numbers of elderly patients attending Emergency Departments and subsequent admission to hospital.
- Support and investment to support the better management of COPD and to reduce the number of patients attending ED (Edinburgh CHCP).
• The appointment of a GP to the Hospital Associate Medical Director role at St Johns will also allow for a greater focus reducing medical re-admissions and the development of improved pathways for multimorbidity patients.
• Ambulatory Care developments within assessment areas are also supporting alternatives to ED attendance.

Issues of delayed discharge are also being tackled on a site by site basis involving partnership engagement with our health and social care partners. More detail is outlined below.

Evidence of effective working with partners e.g. with social work / LA to avoid delayed discharge build ups at key points throughout the year;

Strategic partnership arrangements are currently in place, eg Unscheduled Care Board for Lothian is co-chaired by the Director for Health and Social Care at City of Edinburgh Council and by the Director for Unscheduled Care at NHS Lothian.

Weekly meetings of the Chief Executives of both CEC and NHS Lothian, involving executive leads to critically focus on the issue of delayed discharge.

As a direct result, the Royal Victoria Hospital (RVH) Transition plan was agreed jointly in support of delayed discharge and creating more effective patient flow – see below.

As part of the solution to tackling issues of Delayed Discharge and patient flow, 42 Step Down beds have been jointly commissioned by CEC and NHS Lothian - of which 32 are currently open with the remaining opening during March 2014.

In addition circa £2m additional funding has been released by CEC to support packages of care as part of tackling the issue of Delayed Discharge.

All of the above are fluid and ongoing and will be referenced in the new LUCAP following receipt of Scottish Govt guidance and templates,
Consideration of review of internal patient flow / capacity management processes on an individual site by site basis;

Scottish Govt invited to review performance at the WGH. Following receipt of their report a series of actions are being undertaken to radically review the future models across sites and services – as noted below.

We have proactively managed capacity during winter with additional beds being made available to deal with demand, particularly on the RVH site.

The joint development of the RVH transition plan will have a wider impact on peripheral hospitals such as the Astley Ainslie and Corstorphine Hospitals. Not only will this plan allow us to tackle delayed discharge beds on all three sites, it will ultimately allow for the transfer of 66 IPCC beds from AA and Corstorphine to the RVH. The move from will also reduce the risks related to Healthcare Acquired Infection (HAI) and improved patient and staff safety.

Further capacity to support issues of delayed discharge will come from additional Care Home beds (40), investment of £700k in Re-ablement services; increased budget for Home Care/ Care at Home services (to increase capacity by 2,600 hours).

As a result of the internal building works and the enabling works which are taking place on the RIE site to support the Reprovision of the Royal Hospital for Sick Children (RHSC) and Department of Neurosciences (DCN), we have seen some reduction in bed capacity over the winter. However we have been able to secure an additional 31 beds on the RIE site form 17th February.

Looking ahead we also plan to expand the Acute Assessment footprint, with works planned to take place in 2015.

Priority actions required to improve HB / Specific hospital site unscheduled care performance;

Assistance was sought from the Scottish Government to review the Western General Hospital in terms of patient flow and how this can aid our overall performance across NHS Lothian. A brief report highlighting key messages has now been received.

Building on this piece of work, a series of workshops have been organised to consider the required future model of Unscheduled Care in Lothian. Any proposals to improve unscheduled care will also form a vital component of NHS Lothian’s evolving strategic plan, ‘Our Health, Our Care, Our Future, 2014-24’.
These multi-agency workshops will consider a range of ‘big ticket’ issues such as the future model of care at the Western General Hospital, process improvement work being led at the Emergency Department at RIE, as well as to consider pan-Lothian models of service delivery for Stroke.

A further action planning session is also proposed for 27th June 2014. These sessions are being led by the Chief Executive and the Director for Unscheduled Care.

Any agreed outcomes will be centred on improved performance and efficiency as well as heightening the patient experience.

Summary of current position, and confirmation that the HB will reach trajectory by year ending September 2014.

Transparent communication, in the form of briefings on performance, are submitted to the Scottish Government on a weekly basis.

As at the end of February, NHS Lothian’s performance for the 4 hour standard was 92.4% against the agreed LUCAP February 2014 trajectory of 93.2%.

This performance compares to 91.1% for the same period last year.

There were 8 twelve hour breaches during February.

The national target is to achieve a minimal compliance rate of 95% as at September 2014 and 98% thereafter.
# NHS Lothian Local Delivery Plan 2014/15

## NHS Board Contribution to Community Planning Partnerships

### Contents

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<th></th>
<th>Introduction</th>
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<td>Priority: Safer and stronger communities, and offending</td>
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<td>Priority: Employment</td>
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1. **Introduction**

NHS Lothian, through CH(C)Ps supported by Strategic Planning and Public Health colleagues, continues to be actively involved in community planning across East Lothian, Edinburgh, Midlothian and West Lothian. CH(C)Ps are actively engaged in leading the development and delivery of the health related outcomes within each of the four SOAs in Lothian, with clear performance processes in place to demonstrate progress.

Development of the local SOAs for 2013 onwards had significant involvement from NHS staff, particularly CH(C)P, Strategic Planning, Performance Reporting & Information and Public Health & Health Policy. This involved reviewing previous outcomes and indicators in previous SOAs, participation in local consultation events and membership of and engagement with various themed groups. Communication across NHS staff engaged in development of the four SOAs has reinforced NHS Lothian’s Strategic Clinical Framework priorities, which include prioritising prevention and reducing inequalities in health.

Where possible, there has been willingness to identify common outcomes and indicators across Lothian to enable opportunities for benchmarking and provide continuity for recording data, especially for Lothian-wide services. This has mainly been achieved across the four CPPs, however, there is some local variation due to this being a locally focused process. Examples of high level outcomes being considered across the CPPs include:

- Our Children have the best start in life and are ready to succeed
- Older people are able to live independently in the community with an improved quality of life
- We live healthier, more active and independent lives
- Citizens experience improved health and wellbeing, with reduced inequalities in health.
- Safer and stronger communities, and reducing reoffending

This submission outlines contributions that NHS Lothian makes to Community Planning and the 6 key themes that are core to Single Outcome Agreements. Examples of activity across Lothian in Community Planning Partnerships are provided.

It is also underpinned by a joint event that NHS Lothian and its four Joint Directors facilitated on 2nd December 2013 to look at how closer working and alignment can be achieved in respect of community planning to maximise the outcomes for local communities. Scottish Government colleagues aligned to the partnerships also joined the session.

It was felt that new ways of working requires new ways of measuring performance. In particular, we need a better balance between hard and soft outcomes.
There was recognition that sharing power with communities requires a very significant cultural shift for the public sector. Senior managers need to be prepared to take the risk. We are still some way away from good information on the impact of all preventative services. Where there is no evidence to support preventative activities, we need to be better at monitoring progress to measure the impact on short, medium and the long term. While we create new evidence and develop innovation, some investment will require a considerable leap of faith.

There was recognition that there needed to be a better understanding and definition of local/locality planning versus community planning. In the same vein there also needed to be a better understanding of community planning and community development. It was felt that these two issues could benefit from some further definition or guidance to support partners in taking their thinking forward in light of the emergent integration agenda.

Partnership Boards need to be more proactive in engaging with the workforce through what is going to be a time of disinvestments and service reductions.

Agreed actions are:

- The budget processes between health and social care need to be aligned as a minimum for 2014/15. There was recognition that in terms of timing there was not much difference but the process is different and it is as much about the process and the culture around making budgets public that needs to be reconciled.
- Improve our understanding of assets at a community and locality level and begin to get a “place” based understanding that will start to shape service delivery.
- Start shaping our definition and understanding of community engagement and locality versus community planning and where working well, share good practice.
- Meet later in the spring in this forum to take stock of progress.
- Use the Local Delivery Plan process to get better alignment between the NHS Board and the four partnerships around the financial and workforce plans in addition to the community planning and co-production agenda. And align this work with the ambitions around integration and the NHS Lothian Strategic Plan that will go to our Board on the 2nd April 2014.
2. Priority: Early years and early intervention

NHS Lothian Contribution during 2013/14

Early Years

In October 2013, NHS Lothian began a public consultation on our draft Children and Young People’s Strategy, which outlines NHS Lothian’s vision that every child should have the best start in life and grow up being healthy, confident and resilient.

This draft strategy sets out a clear vision, principles and approach for how NHS Lothian will work with children and young people, their families, the public, the voluntary sector and the four local authorities across Lothian to improve the physical and emotional health and well-being of children and young people across Lothian. A performance framework is currently being developed to support its implementation.

Based on an understanding of our child population and what we know from children and young people accessing services, this strategy builds on the commitments NHS Lothian has already made in the four Integrated Children’s Services Plans and Single Outcome Agreements for East Lothian, Edinburgh, Midlothian and West Lothian.

Within each Community Planning area, NHS Lothian has worked with our local authority, Police Scotland and voluntary sector partners to establish local Early Years Collaboratives (EYCs) – for Edinburgh, West Lothian and a joint EYC for East Lothian and Midlothian. To ensure a clear line of sight between national and local outcomes and indicators, each SOA in Lothian has included the outcome; *Our Children have the best start in life and are ready to succeed*. To evidence progress against these outcomes, each SOA in Lothian also includes the 3 stretch aims of the EYC:

- To ensure that women experience positive pregnancies which result in the birth of more healthy babies as evidenced by a reduction of 15% in the rates of stillbirths (from 4.9 per 1,000 births in 2010 to 4.3 per 1,000 births in 2015) and infant mortality (from 3.7 per 1,000 live births in 2010 to 3.1 per 1,000 live births in 2015)
- To ensure that 85% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time of the child’s 27-30 month child health review, by end-2016.
- To ensure that 90% of all children within each Community Planning Partnership have reached all of the expected developmental milestones at the time the child starts primary school, by end-2017.

To help achieve the second stretch aim, NHS Lothian reintroduced the 27 – 30 month health check in April 2013 for all children across East Lothian, Edinburgh,
Midlothian and West Lothian, using an ages and stages questionnaire. Data published in December 2013 shows that in Lothian 67.1% of those children reviewed have reached the expected developmental milestones. Local CPP data is currently being used to develop incremental targets for 2014 – 2016 in collaboration with CPP partners.

An example of NHS Lothian’s contribution to leading health related early intervention projects within a CPP would be within West Lothian. Within West Lothian, NHS Lothian leads on Childsmile, involving circulation of dental packs to children aged under 5, as well as supervised teeth-brushing sessions at pre-school establishments and fluoride varnishing for identified children living within the most deprived areas (as measured by SIMD indices). Child Healthy Weight initiatives include BMI measurements for Primary 1 children, supported by a range of child healthy weight interventions co-ordinated through the Health Improvement Team including breakfast clubs and healthy eating tuck shops. Maternal and Infant Nutrition is supported through the Healthy Start Vitamins pilot project and breast feeding promotion. A peer supporter network (23 active supporters) continues to support women breast feeding throughout West Lothian, and NHS Lothian is also working towards the UNICEF Baby Friendly award. Meanwhile, local Surestart projects have also been established in West Lothian to work with identified vulnerable young mothers and families following referral from midwifery services.

Over the past year, NHS Lothian has actively contributed to the inspections of services for children and young people in Edinburgh, East Lothian and Midlothian. As we learn from each Inspection, we are working with our community planning partners during 2014 to refresh our Integrated Children’s Service Plans and ensure that improvement plans are developed that reflect the level of improvement required to ensure we get it right for every child. The learning from inspections will also be a driver for plans to integrate children’s services across Lothian. Beginning with Lothian, initial plans to strengthen joint working and ensure strong governance are:

- To establish a Joint Board of Governance for Edinburgh’s Children’s Services within the Edinburgh Community Planning Partnership
- To strengthen management arrangements of children’s health services in Edinburgh through the establishment of a Director of Health for Children and Young People
- To establish five neighbourhood multidisciplinary children’s services management teams across Edinburgh to ensure the oversight and delivery of integrated children services
- To extend the Total Craigroyston approach to the other school clusters across the city
- To ensure the consistent implementation of Getting it Right for Every Child for all children and families
- To develop integrated city wide services for children with additional support needs /disabilities
Examples of local indicators routinely monitored and included within SOAs/Integrated Children’s Services Plan that NHS Lothian are leading on across Lothian include:

- % of women in each Scottish Index of Multiple Deprivation quintile booked for antenatal care by the 12th week of gestation;
- % of children exclusively breast-fed at 6-8 weeks;
- % of all East Lothian children aged 3-5 registered with a dentist (by postcode);
- % of Looked After Children and Young People offered a health assessment within 4 weeks of referral being received by NHS Lothian;
- % of children in P1 who are above the 95th centile of BMI (Body Mass Index).

**Early Intervention**

NHS Lothian is actively involved in undertaking early intervention work across a range of initiatives. An example of this can be demonstrated through NHS Lothian’s contribution to preventing alcohol misuse as a member of the three Alcohol and Drug Partnerships (ADPs) across Lothian.

We know that Scots across all ages and socio-economic groups continue to drink at harmful levels. The resultant health and social harms from problematic alcohol are evident across Lothian and place a heavy burden on us all, including costs to health and social work services, crime, loss of productive capacity and wider social costs such as mortality and family breakdown. Drinking is also a major contributory factor to crime rates in Scotland, with 50% of prisoners reporting being drunk at the time of their offence (77% for young offenders) and 70% of assaults requiring treatment in A&E are thought to involve alcohol.

**Alcohol Brief Interventions (ABIs)** are structured conversations between a professional and an individual about their drinking, which aim to motivate and empower them to change their behaviour. ABIs have a significant impact on people who are drinking enough for it to be causing health, personal or social problems but are not (presently) so severely affected to need treatment. They are a highly effective and inexpensive way to encourage heavy (but non-dependent) drinkers to reduce their consumption. Opportunistically intervening with those who would never present to specialist services can have a dramatic and enduring effect on individuals, and the effect of a programme of these is potentially significant in reducing the total amount of alcohol consumed in the community.

The delivery of Alcohol Brief Interventions is a performance management standard (HEAT) for Scottish Government. NHS Lothian is targeted with delivering 9,938 ABIs annually, 90% in the priority settings of Primary Care, Antenatal and A&E with 10% in wider settings.
Consistently within Lothian, performance has exceeded the nationally set target and in 2012 - 2013 delivered 18,275 ABIs (184% of the target) continuing to be one of three top performing boards in Scotland and is well on the way to a similar delivery in 2013-2014. This performance is recognised within Lothian’s ADPs as a key contributor to preventing alcohol misuse within the wider alcohol prevention context.

In 2014/2015 NHS Lothian will continue to work with our local ADPs partners, including local authorities and 3rd sector agencies to sustain the delivery of ABIs in Lothian in priority settings and support the development of the delivery in wider settings, embedding ABIs into all clinical practice.

In 2012, working in partnership with Edinburgh Lothian Counsel on Alcohol, a pilot was developed to deliver ABIs to inmates of HMP Edinburgh & HMP Addiewell. This follows a needs assessment by the Scottish Government which identified that a possible 36% of prisoners had alcohol dependency problems, representing 566 prisoners on these 2 sites, and in particular prisoners on remand and short stay were often unable to access ABIs, counselling and support due to the shortness of their residency. This pilot delivered by ELCA has had a very positive uptake in both prisons, a full range of advice & information, screening for alcohol problems, delivering ABIs plus counselling and support programmes are now available to prisoners on remand as well as short and long term prisoners. Following an ABI prisoners are encouraged to engage in a more formal programme of counselling and support to address their alcohol issues and this support continues to be available from the same service after release from Prison.

In year 1, 454 prisoners across the 2 sites accessed the drop in service and of that number 50% represented prisoners on remand – in the past this group were often unable to use such services. 326 prisoners progressed into formal counselling programmes and again, as many as 25% achieved this support whilst on remand.

As we approach the last quarter of year 2, numbers accessing services continue to be of a similar level. All the services/partners available within the prisons and after release continue to work together to raise awareness of problem drinking and help to reduce the levels of dependency amongst the prison population.
3. **Priority: Safer and stronger communities, and offending**

**NHS Board Contribution in 2013/14**

In Lothian, partners from across public and 3rd sector agencies have come together to create Re:D. Re:D is a collaborative venture which aims to improve outcomes and the lived experience of people with multiple and complex needs, many of whom will have problems with drugs, alcohol or mental health issues and will have offended, reoffended or be at risk of offending.

The ethos reflects the priorities and recommendations of the Christie Commission. Partners are challenged to consider – “If we were able to re-orientate the criminal justice system to focus on reducing reoffending behaviour by understanding the motivations for offending, which often stem from a complex mix of personal experience and circumstances, mental health conditions, drug and alcohol abuse and peer influence, would this begin to lessen the health inequalities experienced by a significant part of Scottish society?”

**Progress and Work being taking forward**

**Interpersonal Therapy for Women in contact with the Criminal Justice System**

Pilot the use of interpersonal therapy with women who are committing low tariff offences.

Enhance the psychological mindfulness of staff working in prison settings

£182,484 p.a. for two years concept test funded by the Mental Health Division, Scottish Government

Key Partners include Edinburgh Prison, Police Scotland, Criminal Justice Social Work, Mental Health Services, Substance Misuse Services, the Willow Service, Forensic Custody Services and Judiciary.

**Improving the care, treatment and support of women with personality disorders in prison settings**

The provision of Mentalisation training to Prison Personel and individual and group psychological therapy to women with a diagnosis of personality disorder

£105,345 p.a. for two years concept test funded by the Mental Health Division, Scottish Government

Key Partners include Edinburgh Prison, Cortonvale Prison, the Orchard Clinic, Mental Health and Substance Misuse Services and the Willow Service.
Willow
Establishment of Community Justice centre(s) for women in Lothian using Willow model as a starting point Hub and spoke model covering Lothian and Borders (Two Health Board and five Local Authority areas)
£604,000 total cost for concept test commenced June 2013 to March 2015

Key Partners Partners include (Lead Partner) Health and Social Care Partnership Edinburgh, the Willow Service, Mental Health and Substance Misuse Services, Alcohol and Drug Partnerships, Police Scotland and Judiciary.

Re:D Peer Programme: Males with mental ealth health a dn substance misues problems wo have had contact with the Criminal Justice System
Re:D Peer Programme is a public social partnership (PSP) comprising of Edinburgh. The partnership has been developed to explore innovative and collaborative responses to reducing reoffending through peer mentoring.

Following a period of research and development the partnership has secured funding to pilot a Peer Mentoring Project over 12 months. The project will involve employing peer workers who have a lived experience of criminal justice system providing support to adult males living in Leith.
£48,000 for one year concept test funded by NHS Lothian

Partners include the Cyrenians (lead partner), EVOC, NHS Lothian, Scottish Churches Housing Action, Health in Mind and Volunteer Development East Lothian.

Each Re:D initiative will have a developed logic model detailing the inputs, activities and outputs which will contribute to the national 9 Offender Outcomes. Evaluation will also focus on “Distance Travelled” - a measurement term that refers to the progress that a person makes towards harder outcomes like employment or ceasing reoffending. This can include differences in feelings, attitudes, perceptions or skills over time, using self-reporting and observation methods.
4. Priority: Health inequalities and physical activity

NHS Board Contribution in 2014/15

All SOAs in Lothian include indicators relating to health improvement and health inequalities. Within each of our four CPPs, members of NHS Lothian staff lead a Health Improvement Partnership that focuses strongly on actions to mitigate and reduce health inequalities.

The East Lothian Health Improvement Alliance is currently developing a Health Inequalities Strategy. The Alliance held a stakeholders event in September and is now developing actions to address the priority issues that were identified.

In Edinburgh, NHS Lothian has been involved in the Poverty and Inequalities Theme Group, which over the past year has developed a profile of poverty in the city, held a series of workshops to identify actions to reduce poverty and inequalities, has consulted with strategic partnerships to prioritise these actions and held a successful city conference to gain support for this work in November.

We are also developing a NHS Lothian Health Inequalities Strategy that will identify the role that NHS Lothian can play to mitigate and reduce health inequalities. This will include both delivery of appropriately targeted clinical services, and our wider impact, e.g. relating to procurement and HR policies. This will be implemented through an action plan that will form part of the NHS Lothian Strategic Plan.

NHS Lothian has chosen to develop patient pathways to inform the development of the Strategic Plan. The patient pathways represent fictitious patients called Callum, Hannah, Scott and Sophie. Callum represents patients who may have alcohol and drug problems who frequently attend A&E. Hannah represents patients with multimorbidities. Scott represents the frail elderly population and Sophie is a child with complex health needs. The intention is to use a series of multi-disciplinary workshops (with strong patient representation) to map the current care pathways of these representative patients and redesign that pathway across the full range of health and social care services. The work will be led by a senior clinician and be fully integrated with Integration Plans and Strategic Commissioning Plans. Many of the issues identified will be associated with deprivation. For example it is known that patients develop multimorbidity 10 to 15 years earlier in the most deprived areas than the least deprived. The Strategic Plan will identify key process and outcome measures for each patient pathway which will be shared with CPPs. It will also take account of key guidance documents such as the recently published Scottish Government Multimorbidity Action Plan which discusses development of key outcomes and indicators.

NHS Lothian also leads a Lothian wide Learning Disability health inequalities steering group, in partnership with all community planning partners. Work being
driven by this group is both Lothian wide and local, for example; an initiative within Midlothian, a collaborative between Midlothian Social Work, Midlothian Leisure and NHS Lothian to develop and deliver accessible targeted physical exercise programmes for older adults with learning disability. The learning from this will be made available to the other Lothian community planning partners to inform local developments in each of the areas.

The overarching steering group is currently developing a specific health inequalities strategy to drive local actions that will address health inequalities experienced by people with learning disability.

Alongside this are the evolving actions within the Local Delivery Plan 2020 which aims to tackle health inequalities faced by people with learning disability. In partnership with community planning partners Lothian will identify the learning disability population across children and adults, which will subsequently enable partners to more effectively evidence improvements in the health and wellbeing of people with learning disabilities locally.

NHS Lothian is also leading partnership work with the 4 community planning partners to address inequalities faced by people with learning disability and significant additional needs. The planning partners are working to develop a community based service in Lothian to enable people with this level of need to be safely and successfully supported in the community.

The Scottish Government’s overarching vision for physical activity is, ‘The people of Scotland will enjoy more active and healthier lives’. Work in Lothian will be both led by, and contribute to, the National Physical Activity Implementation Plan (PAIP) and the Walking Strategy.

Demonstrating how NHS Lothian’s contribution to community planning continues to develop, NHS Lothian are currently leading a programme of work to support improvement in sensory impairment pathways, the NHS Lothian audiology service through their patient focus group has identified the need to provide access to replacement batteries for hearing aids within local communities to avoid individuals having to travel to the audiology department in central Edinburgh to obtain batteries. The NHS Lothian audiology manager is working with our local authority partners to support the distribution of replacement batteries at local libraries across Lothian. This activity will help CPPs evidence progress towards local outcomes such as ‘Edinburgh’s citizens experience improved health and wellbeing, with reduced inequalities in health’ and in Midlothian to ‘Enhance social inclusive and personalised services’.

The local multiagency alliances, led by strategic input from the Senior Health Promotion Specialist, and with support from the locality based Public Health Practitioner, and with AHP representation, will be mapping out existing services in
each local authority area against the national PAIP to identify gap areas of delivery and to strategically plan areas of work. The PAIP is in line with CPP SOA priorities.

**Lothian Wide**

Across Lothian, five HIF (Health Improvement Fund) physical activity projects are funded from NHS Lothian monies, with a specific aim to increase physical activity levels in target populations. The HIF oversight group met this year to oversee Lothian wide recommendations for allocations of HIF monies for the next 3 year funding round. All of the funded physical activity projects directly relate to addressing health inequalities.

2014–15 is the first year of the three year funding round, and all of the five HIF funded specific physical activity projects in Lothian will be undergoing action plan development in Q4 of 2014 to develop plans for 2014–2017. All plans must undergo a Rapid Impact Assessment (RIA) and collect equalities data.

The NHS Lothian Senior Health Promotion Specialist (SHPS Physical Activity) is the link officer for all of the key Physical Activity HIF funded projects and is a member of the National NHS Health Scotland Physical Activity Special Interest Group, the NHS Lothian Physical Activity and Patient Pathway Strategic group, a sub group of CEL 01/ Health Promoting Health Service has representation from MCN leads, Public Health, AHPs and Community Groups across Lothian. The SHPS is a key driver for all four of the CPP multi agency physical activity and health alliances, which also has representation from Public Health and AHP leads.

HIF Physical Activity project development is informed by, and reports to, the multi-agency alliances in each of the CPP areas and are integrated into the strategic development and CPP planning structures.

HIF programmes across Lothian:

**East Lothian:** The Active Choices East Lothian (ACE) programme, co-funded by HIF and from Health and Social Care Shadow Board/ East Lothian CHP. The main aim of the project is to support health improvement and reduce health inequalities specifically with people with long term conditions. The majority of people accessing the project are above 60 years old.

**West Lothian:** West Lothian on the Move’s key outcomes are to:
- Maintain and develop the West Lothian Health Improvement and Health Inequalities Alliance (HIHIA) and support and develop all subgroups to achieve their action plans.
- Increase access to, and promote the small grant scheme for community organisations
• Increase physical activity across life stages and settings a) early years and school aged children b) young people in transition and adults of working age c) older people d) environment e) NHS f) promotion and training

Edinburgh: The Edinburgh Physical Activity and Health Alliance is planning a ‘Year of Walking’ which will integrate activities across all of the five priority National Physical Activity Implementation Plan areas, and be informed by HIF funded community based organisations and other key partners. There are three HIF funded projects in Edinburgh, and they will integrate activities to support local walking within all of their 3 year action plans.

NHS Lothian (Senior Health Promotion Specialist, Public Health Practitioner, Public Health Consultant) has also been a contributing partner to the development of:

• Edinburgh Physical Activity and Sport Strategy (soon to be launched)
• Edinburgh Active Travel Action Plan (ATAP)
• Edinburgh Road Safety Strategy – Streets Ahead

Examples of indicators and current performance includes the following:

The Ageing Well project in Edinburgh (AWE) is a partnership between NHSL Health Promotion Service & Edinburgh Leisure and Pilmeny Development Project. Opportunities developed by the project currently include an allotment project, buddy swimming, chair based exercise and walking groups. Additional targeted work takes place with, for example, falls prevention groups, men’s groups, day care centres, older adults with learning disabilities, COPD and Dementia groups.

The project currently engages 52 volunteers. The most recent quarterly report shows that:

• 2,418 people attended AWE activities over a 3 month period
• 75% & 100% participants from 2 activities reported that their health & wellbeing had improved as a result.

West Lothian – Walking (Put your West Foot Forward)

Of 67 walkers who have joined in 2013, at least 10 who have learning difficulties and 20 were previously inactive which equates to 29.8%. There are 14 walks per week, with an average attendance on each walk of 11, so on average, there are 154 walkers each week. In addition, a closed walk has been piloted with a dementia café. To date, 9 new walkers have attended and service users have requested the walks become a regular monthly event.

Walking profile: A profile of the 201 newly registered walkers assessed from a questionnaire, indicates that the walks are reaching people to whom walking is of particular benefit.

See additional NHS Lothian activity under the ‘Early Years and Early Intervention’ section.
5. **Priority: Economic recovery and growth**

**NHS Board Contribution in 2014/15**

NHS Lothian is a main employer in and around Lothian. We are collaborating fully with East Lothian, Edinburgh Midlothan and West Lothian Community Planning partners in driving forward the economic recovery in the area as well as looking at innovative ways of working and supporting people through a range or developments and initiatives. Many of these may be through the work that we are and will do in developing our clinical services and in developing and redeveloping our ‘physical’ capital developments in the shape of new hospitals and community and primary care premises. We also contribute to this through the work of our Workplace Health Promotion Team that provides Occupational Health & Safety support and training to SMEs and workplace health support and training to both large and small organisations within Lothian.

Using the example of developing the Midlothian Single Plan, CPP partners have recognised the key future challenges being the national, and our locally based, response to the continuing economic downturn which was sparked by the 2007/8 financial crisis and subsequent global recession. This has given rise to, for example, severe cutbacks in public expenditure, the current and future challenges posed by public sector reform and the on-going impact of welfare reform. Put together, these challenges are impacting, and will continue to impact, on our communities, businesses and local people living in Midlothian. In order to ensure local economies such as Midlothian can continue to take advantage of economic opportunities and address growing problems, NHS Lothian and CPP partners recognise the need for greater partnership working and that joint solutions are more important than ever.

To address the challenges faced it is essential that partners work collaboratively and innovatively to grow Midlothian’s economic potential and, in turn, support people into employment. The focus of our partnership work is geared to meeting these challenges and in supporting the effective delivery of our local economic outcomes. A key area of work in this regard is the development of an Economic Recovery Plan for Midlothian. NHS Lothian is currently leading a Rapid Impact Assessment (RIA) on the Economic Recovery Plan, with the Economic Forum as part of delivering the JHIP objective, *to provide support and advice to key partnerships regarding the reduction of health inequalities.*

See additional NHS Lothian activity under the ‘employment’ section.
6. **Priority: Older people**

**NHS Board Contribution in 2014/15**

NHS Lothian has continued in 2013/14 to work closely with local authorities and third sector organisations to reshape care for Older People. There are strong multi-organisational groups overseeing the application of the Change Fund budget to shift the balance of care to communities and supporting individuals to reduce demand on services in the future.

In 2013/14 a range of new innovative projects were funded across Lothian and examples of these are summarised below.

In 2014/15 the pressure of meeting the care needs of the older population will continue to rise and NHS Lothian will continue to work closely with other organisations, testing new models of care, and scrutinise the impact of the established projects. The integration of health and social care will require the learning from projects to be disseminated across Lothian so that new systems of care can be developed at the scale and pace required to exceed rising demands.

The metrics show that NHS Lothian and its partners are having a positive impact on hospital utilisation rates and improving outcomes for older people. For example, the Joint Improvement Team published a progress report in November 2013 which highlighted that the Rates of All Emergency Admission Bed Days for people aged 75+ following an emergency admission are down by 10.7% from 2009/10 to 2012/13 In Lothian the Emergency Admission Bed Day rate has decreased by 11.5% during the same period.

Examples of projects in 2013/14 from the Edinburgh Change Fund

- Edinburgh Step-Down provides intensive rehabilitation and a period of extended assessment for people who were in hospital and were being considered for a care home place. The objective is to support people to return home, where possible by enhancing their level of independence

- Community Medication Review: The investment provides additional capacity within community pharmacy to review medication packages, targeting older people who receive regular home visits to dispense medication. The project pharmacist took up post in late September 2012. Activity levels have increased markedly: by 25 March 2013, 57 medication reviews had been completed; over the six months ending 30 September 2013, this had increased to 560. This most common benefit to patients was to reduce unnecessary drug therapy, followed by reduction of ineffective drug usage:
Additional funding for telecare services and equipment was made to support people with health and social care needs in the community. Telecare continues to be fundamental to the preventative strategy. The service continues to support customers to remain at home following an alarm call. 63% of all Telecare customers are aged over 75 years. 85% of all emergency response visits were to people aged 65 and over. The additional funding has met targets by helping to support 1200 extra people through Telecare since 2010/11, from 8,492 to 9692 in 2012/13 (a 12.4% increase). At the end of September 2013 there were 6,334 people aged 65 and over supported through Telecare.

East Lothian projects funded from the 2013/14 Change Fund:

East Lothian Council and NHS Lothian have supported the allocation of funding from the change fund to support 20 innovative third sector projects. The main elements to these are:

- Greater support to informal carers
- Information, practical support and preventative services
- Increased capacity of small charities to support older people with more complex needs
- Greater capacity and development of volunteers and volunteering in supporting older people and their carers, and
- Greater capacity in local communities to work together to support older people.

An independent sector project aimed at developing greater links within the independent sector organisations locally has also been supported from the change fund. This has been in conjunction with the active inclusion of independent sector organisations in workforce development projects and the development of dementia specific equipment and activities across all sectors to improve the day to day environment and experiences of individuals with dementia.

The focus of spend in the statutory sectors has focused on supporting redesign of existing services and collaborative/ co-located projects aimed at improving the service user/patient pathway across health and social care services. The Change Fund has enabled the early development of a community response and rehabilitation service across the CHP and Adult well-being with a one number rapid access to care, Social Work and AHP services. This links to our wider vision a holistic community response team with the addition of nursing and medical support.

The emphasis on innovation and prevention has resulted in our anticipated spend on the Preventative and Anticipatory Care work-stream being increased from 24% identified in the Change Plan to 34%.

In 2014 East Lothian will be developing up to 20 Intermediate Care Beds to address Delayed Discharge targets. In addition to this, we are developing models of integrated “wraparound” care to support older people at time of medical crisis, preventing avoidable hospital admissions.
West Lothian

Examples of patient centred projects established in West Lothian and contributing to reducing avoidably admissions to hospitals and facilitating timely discharge

Dementia Home Support Team

The Dementia Home Support team offers specialist intensive support at home to facilitate an earlier discharge from hospital into their own home where an outcomes focussed assessment will more accurately identify the skills and abilities of the service user and how they can be supported to remain at home.

OPACT

The Older Peoples Acute Care & Treatment (OPACT) team shifts the balance of care from the acute inpatient psychiatry of old age hospital provision to a community based service through provision of intensive treatment and support over a 6-8 week period. The team provide a comprehensive assessment and treatment with a range of therapies for both user and family/carers, which include:

- problem solving
- stress management
- brief supportive counselling
- Intervention aimed at maintaining and improving social networks.

Medication – Compliance assessment and short term prescribing if needed

66% of clients have been direct referrals with admission successfully prevented and 34% early supported discharge from the acute inpatient unit. The service has enabled the successful reduction of acute inpatient psychiatry of old age beds.

Midlothian

Midlothian has committed the majority of the change fund to preventative activity. This has included, for example:

- Low level supports through voluntary agencies
- Carer support and information through partnership arrangements with the voluntary organisations
- Hospital In reach and delaying admissions to hospital and care homes.

These investments are planned to reduce the length of stay in care homes and avoiding unnecessary hospital admissions and reducing time spent in hospital by offering intermediate care at home and at Highbank care home.

The Change Fund supports a number of statutory services in service re-design for example placing local authority Occupational Therapists in the independent care at home providers to introduce and train staff in Reablement. A small percentage £50,000 (4.5%) has been spent within the institutional spectrum on day treatment and medical equipment for the day hospital.
An example of the projects that have been developed in partnership in Midlothian is the **Hospital In-Reach team**: 

A hospital in-reach team was established. The service consists of Social Workers and Occupational Therapists who work in close partnership with the Rapid Response Team (RRT) based in Highbank care home to facilitate earlier discharge. Each member of the team is affiliated with a specific hospital which includes Royal Infirmary of Edinburgh, Western General Hospital, Liberton, Astley Ainsley and the Midlothian Community Hospital working closely with hospital ward staff and Allied Health Professionals for Midlothian residents.

The outcomes from this project are:

- Facilitates early discharge (consistently achieving the four week delayed discharge target and working towards two weeks).

- Speedier needs led assessment.

- A significant increase in percentage of people returning home with a package of care and support, who might previously have been admitted to care home from hospital.

- Decrease in care home admissions direct from hospital from 75% down to 45%.

- Shorter length of stay.
7. **Priority: Employment**

**NHS Board Contribution in 2014/15**

NHS Lothian is the first Health Board in Scotland to have developed an outcome focussed framework to support the planning, delivery and evaluation of its contribution to the Scottish Government’s Health Works strategy. NHS Lothian continues to deliver this framework in partnership with CPPs across Lothian. In 2013 NHS Lothian was awarded funding by the Scottish Government to assess its impact on delivering Health Works in Lothian and this assessment is due for publication in April 2014.

An example of NHS Lothian working with partners to deliver on the economic development and employability agenda is through the Edinburgh CPP. NHS Lothian is actively involved in Edinburgh CPP’s Joined up for Jobs Strategy where we are a key delivery agent for those services that focus on supporting people with disabilities and long term health conditions, including a mental health problem, to move into and progress in employment. For example, ‘The Works’ is an evidenced based employability service run by Occupational Therapy (mental health) to support those with mental health problems in secondary care to return to and retain mainstream employment.

NHS Lothian has also run a very successful workshop with employability partners and cancer specialists on vocational rehabilitation and people with cancer - this programme of work will now be incorporated into the service delivered by Working Health Services NHS Lothian.

Also via Edinburgh CPP, NHS Lothian is a key partner in an evidenced based employability programme for young people with learning disabilities called Project Search – NHS Lothian will be providing work placements for the young people involved in this initiative.

A key driver for the UK Government’s Welfare Reform Programme is employability therefore NHS Lothian has developed a number of actions in response to this to ensure NHS Lothian staff understands the impact and their role in supporting those affected by welfare reform. These actions have included:

- Training programmes for frontline health & social care staff and implementation of an e-learning module
- Establishing referral processes between NHS and employability & welfare rights services delivered by partner organisations
- Developing further welfare rights advisors in GP practices, all advisors trained in delivering employability support
- Supporting NHS staff affected by the welfare reform programme by working towards ensuring they have the digital and financial literacy skills required in preparation for Universal Credit.
Health Board: Lothian

Use of Risk Management Plan

Boards should, as in previous years, use the LDP Risk Management Plan to provide contextual information on key risks to the delivery of each target and how the risks are being managed. Within the template, the description of the key risk should be provided in the first column and detail on how the risk is being managed should be provided in the second column. Cross-reference to local plans should be made where necessary.

- **Delivery and Improvement**: briefly highlight local issues and risks that may impact on the achievement of targets and/or the planned performance trajectories towards targets and **how these risks will be managed**.

- **Workforce**: brief narrative on the workforce implications of each of the HEAT targets **where appropriate and relevant**. This should include an assessment of staff availability to deliver the target, the need for any training and development to ensure staff have the competency levels required, and consideration of affordability cross referenced to the Financial Plan.

- **Finance**: Where applicable boards should identify and explain any specific issues, e.g. cost pressures or financial dependencies specifically related to achieving the target. There is **no need to repeat generic financial risks** that apply to all targets.

- **Equalities**: Where applicable, boards should outline any risks that the delivery of the target could create unequal health outcomes for people with protected characteristics, and/or for people living in socio-economic disadvantage; and how these risks are being managed.
HEATS TARGETS FOR 2013/14

- To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015.
- 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.
- NHS Boards to operate within their agreed revenue resource limit; operate within their capital resource limit; meet their cash requirement.
- NHSScotland to reduce energy-based carbon dioxide emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.
- 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; and 18 weeks referral to treatment for Psychological Therapies from December 2014.
- 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.
- No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013; followed by a 14 day maximum wait from April 2015.
- 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.
- Eligible patients will commence IVF treatment within 12 months by 31 March 2015.
- Further reduce healthcare associated infections so that by March 2014/15 NHS Boards’ Staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.32 cases or less per 1000 total occupied bed days.
- 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.
- NHSScotland 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 the one year ending March 2015.
To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25%, by 2014/15

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<tr>
<th>Risk</th>
<th>Management of Risk</th>
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<tbody>
<tr>
<td>That we will not be able to significantly increase the proportion of stage 1 cancers detected by the breast and bowel screening programmes.</td>
<td>Detailed analysis of screening programme performance and forecast performance levels against anticipated yield (additional cancers detected and stage) has been undertaken and is being used to guide planning with the services involved.</td>
</tr>
<tr>
<td>Failure to focus the local programme onto targeted approaches to address known cancer inequalities in access and uptake, with enough time to achieve a sustainable impact on performance.</td>
<td>The South East of Scotland Breast Screening Programme is developing plans to support further targeting and increased uptake of screening, with support from the Lothian DCE Programme Board including the Public Health Breast Screening Programme co-ordinator.</td>
</tr>
<tr>
<td></td>
<td>Across the planning, public health and regional screening service the planning and development work of the DCE and national Breast Screening Review programmes are being integrated to ensure local implementation best supports equity of access and maximises uptake.</td>
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<td></td>
<td>Ten Lothian General Practices are participating in a Lothian DCE programme pilot scheme to support better uptake of screening in both the breast and bowel programmes.</td>
</tr>
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<td></td>
<td>Across NHS Lothian there is excellent uptake of the Bowel Screening SQoF scheme. NHS Lothian is also now providing bowel screening non-responder information to Lothian practices to aid the further development and implementation of local bowel screening SQoF action plans, which focus on improving uptake.</td>
</tr>
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<td></td>
<td>The NHS Lothian DCE Programme Board is developing proposals for the next phase of DCE investment. The targeted schemes, particularly for breast screening, should be ready in April. We have established a strategic group and initial work undertaken. The SGHD is also convening screening meetings and discussing further direct investment.</td>
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<td></td>
<td>Further support will be provided to the service in 2014-2015 to ensure local health intelligence continues to underpin targeted plans, the evidence base is better understood, and support is given to</td>
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translate targeted plans into local action.

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<th>Workforce</th>
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<td><strong>Risk</strong></td>
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<tr>
<td>Potential difficulty matching colonoscopists to the screening / symptomatic scope service</td>
<td>Working with the service to develop more flexible capacity, maximise the capacity from accredited nurse endoscopists for screening, and integrated booking across all Lothian sites.</td>
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<th>Finance</th>
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<td><strong>Risk</strong></td>
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<tr>
<td>Uncertainty in financial planning associated with unknown exact allocations for NHS Lothian in years 3 (14/15) and 4 (15/16) of the national programme.</td>
<td>Programme Manager, Strategic Planning, to liaise with the SGHD DCE lead closely and incorporate estimates available into the Lothian DCE investment plan.</td>
</tr>
<tr>
<td>There is a requirement to carry over DCE allocated sums for use in 14/15 and beyond.</td>
<td>Ongoing planning with finance to agree an outline plan and mechanism which supports the overall DCE Programme aim and allows the programme to invest in targeted approaches. Without the ability to apply the funds allocated to the programme, Lothian’s contribution to the national target will need to be reconsidered or funds withdrawn from elsewhere in cancer services.</td>
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<th>Equalities</th>
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<td><strong>Risk</strong></td>
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<tr>
<td>DCE is intended to reduce the socioeconomic, ethnic and disability gradient in stage at presentation and 5 year survival from primary cancer. Current routine data collection systems are not set up to monitor progress at a level that enables refocusing and realignment where progress is slower.</td>
<td>The Scottish Additional Needs Task Force is building on the achievements of the ethnic coding task force and the cancer team is involved in piloting equity standards as part of a wider initiative.</td>
</tr>
<tr>
<td>The implementation of revised referral guidelines for urgent suspected cancer could, unsupported, worsen the ratio of referrals / diagnostic investigations to the number of cancers detected. This would have the consequence of transferring resources from the socioeconomic, ethnic and disabilities groups that DCE was intended to help to more affluent ‘worried well’</td>
<td>Referral guideline implementation is being supported by guideline incorporation into ref help and Gateway. This work is being supported directly by the clinical leads in bowel, breast and lung cancer.</td>
</tr>
<tr>
<td>Practice Profiles will be published by ISD, and once available, will also be used as appropriate.</td>
<td>For lung cancer, the leadership of the lung cancer service and associated pathway development has been placed with the Royal Infirmary of Edinburgh respiratory team. This team now includes a new DCE funded respiratory medicine consultant, which increases the focus on the lung cancer pathway and</td>
</tr>
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</table>
its continuous development. The RIE team, in collaboration with the respiratory teams at the Western General Hospital and St John’s Hospital will ensure that pathways and protocols for lung cancer access and performance, including DCE, are standardised across all sites, as appropriate.
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

**NHS BOARD LEAD:**

Prof Alex McMahon  
Director of Strategic Planning, Performance Reporting & Information

### Delivery and Improvement

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<th>Risk</th>
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| Women from quintiles 4 & 5 and the hard to reach groups (e.g. vulnerable women, families, teenage pregnancy, substance using parents, women from areas of high deprivation who may not present to GP/ Midwife) who self pregnancy test may not always know or appreciate the importance of early booking within the 10-12 week window. | - Promotion of new NHS Scotland publicity in NHS Lothian and the four local authority areas, e.g. leaflets/posters re centralised bookings in all shops, environments, etc. who stock pregnancy tests. Liaison with Children and Family Centres by end of March 2014.  
- Maternity Services continue to work with GPs to improve referral before 12 weeks.  
- Maternity Services are education all groups of staff and other statutory and voluntary agencies on the target and importance of early booking before 12 weeks, specifically services working with vulnerable women.  
- Children’s Partnerships monitor Children and Young Peoples Integrated Children’s Services Plans to ensure no unintended consequences of other activity on delivery of target.  
- The community midwifery teams are being realigned to match the Health visiting boundaries to enable better joint working in Edinburgh.  
- Education of young women within family planning services, schools and colleges / universities in the importance of early booking and antenatal assessment and care.  
- Explore the use of drop in clinics in hard to reach areas/access points. |
| Women with Long Term Conditions, i.e. diabetes, obesity related asthma, etc. may not present within 10-12 weeks and therefore also need to be identified within the at risk group. | - As above, increased publicity in NHS Lothian and the four Local Authority areas, e.g. leaflets/posters re centralised bookings in all shops, environments, etc. who stock pregnancy tests. Liaison with Children and Family Centres.  
- Build on good links with medical services and joint clinics for women with co-morbidities already in existence. |
| Data reported by ISD, not consistent with locally reported data | - Meeting held with ISD and ensured local data reporting and published reports is consistent. NHS Lothian is currently monitoring local data and published reports to ensure consistency. |

### Workforce

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<td>Capacity unavailable within the Centralised Booking Office to achieve a 70% response within 24 hours to telephone booking requests.</td>
<td>- In conjunction with eHealth &amp; Medical Records continue to ensure a robust system and process and appropriate establishment within the Centralised Booking Office to ensure all</td>
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telephone contacts to arrange booking appointments are responded to timeously.

- We have used some of the Refreshed Maternity Framework allocation to increase administrative support by 1wte.

**Review of midwifery workforce in terms of impact of GIRFEC and managing unpredictable workloads on labour ward.**

- An internal Staffing Review of Community Midwifery Services has started to ensure equity in case load size across Lothian. Skill mix and the Maternity Care Assistant role are also being looked at to allow for cost effective, safe services. We are also continuing to work with community groups in an effort to find solutions that might improve access with hard to reach groups, i.e. access to community centres.

- Maternity Services are currently piloting a new model of care in Leith community midwifery team which will help define midwifery case loads better, improve case load management and continuity and increase midwifery workforce flexibility.

**Lack of workforce capability in relation to health and social care assessment at the booking appointment.**

- We have, through maternity framework funding, invested in an additional member of the administrative staff team at central booking office to enable efficient throughput of the women to ensure assessment and screening by the named midwife at the earliest opportunity and by 12 weeks gestation. As part of this process we also have electronic SCI gateway communication with woman’s named GPs requesting a referral from GP with woman’s history and known risk factors (Medical and social) communicated back to central booking office.

- All our midwives are undergoing/have undergone GIRFEC training in conjunction with Public Health Nursing and others in the four CH(C)P/Local Authority Partnerships. NHS Lothian has acted as an early implementer for this work and is monitoring the successes in key teams before continuing with a programme to roll out across Lothian. This will be reviewed in terms of midwifery booking processes to reduce duplication.

- Our Maternity TRAK electronic assessment is very comprehensive and having included the GIRFEC Practice Model within it. Parent Education is currently leading work to map the Principles of GIRFEC (safe, healthy, achieving, nurtured, active, respected, responsible and included).

- A GIRFEC midwife lead has been appointed to progress the GIRFEC implementation plan for maternity services.

**Finance**

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<td>Costs of the publicity campaign</td>
<td>Costs will be set against the refreshed Maternity Framework allocation</td>
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Framework Scottish Government financial allocation for implementation – will also make effective use of the national campaign resources.

- Funding expenditure will continue to be monitored by Refreshed Maternity Framework Implementation group.

### Equalities

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| As above, women from the hard to reach groups (e.g. vulnerable women, families, teenage pregnancy, substance using parents, women from areas of high deprivation who may not present to GP/ Midwife) who self pregnancy test may not always know or appreciate the importance of early booking within the 10-12 week window. | - A Rapid Impact Assessment has already been completed on the Centralised Booking Service and actions highlighted from that are included below.  
- Rapid impact assessment has been completed on the boundary review and will be completed in relation to the pilot change to the model of midwifery care  
- Increased publicity in NHS Lothian and the four local authority areas. Leaflets/posters re centralised bookings in all shops, environments etc who stock pregnancy tests. Liaison with Children and Family Centres.  
- Work to be continued on identifying the needs of women during early pregnancy through epidemiological and qualitative work (interviews and questionnaires) in order to maximise the take up of early booking. |
| Women from minority ethnic groups unable to easily access the centralised booking service. | - A telephone interpreter service is available to women who phone in to the central number.  
- Women can book an interpreter through the system for the midwife appointment and ultrasound scan.  
- Interpreters continue to be booked in advance of booking appointments, reducing the need to cancel booking appointments awaiting interpreters. The centralised booking system staff have access to phone interpreting services when booking appointments for women whose' first language is not English on the phone. |
| Lack of equitability in offer and uptake of appointments. | - Active monitoring of appointments offered and subsequent uptake by disadvantaged groups.  
- Maternity services will monitor compliance monthly for all quintiles against access targets. |
NHSScotland 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 the one year ending March 2015.

NHS BOARD LEAD: Prof Alison McCallum
Director of Public Health and Health Policy

### Delivery and Improvement

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<td>Meeting the target requires 1,765 successful outcomes at 12 weeks post quit date in 40% most-deprived areas in Lothian over the target period. Activity needs to engage smokers from these hard to reach areas and as in previous years we will focus on: pregnant women, people with mental health issues, and people with chronic disease. These groups historically are both difficult to attract to services and keep in services and this has been compounded by the increase in availability and use of e-cigarettes. By focusing on these groups there is a risk that we may not be able to attract the required numbers into services. Additionally there is also a significant challenge in providing the level of support necessary to obtain abstinence and sustain contact over a 12 week period in those who do engage with services.</td>
<td>The smoking cessation service continues to review their services for pregnant women and mental health services and make adjustments as required. This will ensure we can deliver the required number of successful outcomes. Those clients with chronic disease continue to be targeted by focusing on hospital based cessation for both out and inpatients. Cessation interventions will focus on their specific chronic disease management, ensuring that cessation is fully integrated into bundles of care for specific diseases. This should enhance successful outcomes. Our Health Promoting Health Service Group monitor these outcomes.</td>
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<tr>
<td>We will also increase our activity in our 2 prisons and have already have 1wte staff member providing support both to prisoners and their visitors. It is anticipated this will contribute to the inequalities agenda.</td>
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<td>Carbon monoxide measurement at booking is now fully implemented in NHS Lothian and together with the introduction of an opt out service has resulted in an increase in the number of pregnant women being referred to cessation services.</td>
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<td>We plan to implement smoke free hospital grounds from May 2014 and this should help attract patients to the service. A comprehensive communication strategy is being developed which will ensure service users are aware of our Policy and sign post our cessation services.</td>
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<td>Numbers of cessation staff based in hospital setting has been increased.</td>
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<td>Support to quit continues to be available to our own staff (including nightshift workers) and No Smoking Day activity will continue to specifically target NHS and Local Authority staff. This will aid role modeling.</td>
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<td>Interventions will be available at visiting times at our hospitals to give ready access to services to those visiting our premises</td>
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<td>Community pharmacy services will be promoted to attract more smokers. A publicity campaign is planned in partnership with the Evening News which will specifically promote this service.</td>
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<tr>
<td>The review of NHS Lothian services planned will</td>
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While our aim is to increase our level of activity as anticipated as prevalence reduces those remaining smoking will be more heavily addicted and have more complex lives. Subsequently smokers are become both harder to reach and keep engaged in services. The numbers being attracted into services and successfully followed up at 12 weeks will need to increase significantly to achieve the targets set.

- We will continue to promote the service to our local employers utilising our Healthy Working Lives teams including our four local authorities and our own NHS staff. We have designed services to give our own staff easy access during their working hours. In addition to the contribution to their own health as patients, staff who have successfully quit using the service will then go onto act as ambassadors for our service and this will help promote the service and contribute to achieving our target.
- We have already taken account of the challenges and our planned trajectory takes account of previous year’s patterns of activity.

### Workforce

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| As the target groups become more challenging staff will require both retaining existing and acquiring new skills to meet the additional challenges of providing an effective service. | - We continue to adjust the skill mix of our cessation team to increase the numbers of staff providing face to face support to smokers to ensure the required number of outcomes is achieved.  
- In addition to encouraging staff to undertake nationally accredited training, we will continue to provide a robust in-house education programme. This will continue to improve expertise and support staff to manage the expected challenging caseloads particularly pregnant women.  
- We will increase the skills of stop smoking service staff by providing access to motivational interviewing and other behaviour change training. |

### Finance

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<td>There is a need to ensure the budget allocated will be able to deliver the requisite number of increasingly complex interventions at a time when pay and prices are increasing.</td>
<td>- We continue to review the skill mix of staff to ensure staff costs do not increase.</td>
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### Equalities

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| Services may not attract the numbers of clients required to achieve the target. As prevalence reduces it becomes increasing challenging attracting smokers into services. Additionally, the impact of the economic downturn on tobacco misuse may be significant. In a recession, aspects of people’s lifestyle | - NHS Lothian plans to continue with its strategy of increasing accessibility to its ‘stop smoking services’ and in particular targeting services to those most in need, e.g. pregnant women, those with mental health issues and chronic disease.  
- NHS Lothian continues with an advertising strategy that includes leaflets and posters, press and bus advertising. We anticipate that this will |
can change in unpredictable ways and have a direct impact on self-esteem, mental health and general well-being all of which can affect tobacco use and lead to less motivation to change.

continue to increase the numbers accessing our pharmacy services. We also carry out recruiting activity in local shopping centres and supermarkets, targeting those used most frequently by those form disadvantaged groups with high smoking rates.

• We continue to provide raising the issue of smoking training to all healthcare professionals and local authorities to encourage referrals to the service.

• Motivational interviewing and other behaviour change training will be made available for our healthcare staff to access. A motivational interviewing e-module has been added to ‘Learn-pro modules available to all NHS Lothian staff.
NHSScotland to reduce energy-based carbon emissions and to continue a reduction in energy consumption to contribute to the greenhouse gas emissions reduction targets set in the Climate Change (Scotland) Act 2009.

**NHS BOARD LEAD:**
Mr Alan Boyter  
Director of Human Resources and Organisational Development

### Delivery and Improvement

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<tr>
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<tr>
<td>Time to deliver.</td>
<td>Identify measures to save energy and develop an investment programme.</td>
</tr>
<tr>
<td>Capital finance needs to be sufficient to support achievement of that target.</td>
<td>Availability of Capital – recommend Scottish Government ring fenced funding be used to support this.</td>
</tr>
<tr>
<td>Severe weather, e.g. extreme, continues making savings difficult.</td>
<td>Availability of revenue to support 'invest to save' proposal. Reinvest a proportion of savings in energy efficiency projects instead of tagging as LRP efficiency savings.</td>
</tr>
<tr>
<td>Grant support for renewable / low carbon technologies is unreliable.</td>
<td>Capital developments adhere to low carbon / BREEAM Healthcare requirement.</td>
</tr>
<tr>
<td>Old buildings cannot be upgraded within normal financial constraints to achieve long term target.</td>
<td>Dispose of old and functionally unsuitable buildings as part of the Boards agreed strategy.</td>
</tr>
<tr>
<td>Develop the CEF project at St John's including boiler replacement.</td>
<td>Develop updated Carbon Management Plan 2014 with investment program designed to achieve HEAT target.</td>
</tr>
<tr>
<td>Develop Scottish Governments new Energy Audit Programme.</td>
<td>Include simplified contract variations within new PFI contracts to promote the adoption of retrofit programmes within contract “life cycle”.</td>
</tr>
<tr>
<td>PFI hospital contracts not structured to allow simple adoption of retrofit projects without difficult negotiation.</td>
<td>Health Facility Scotland has raised the energy and Carbon reduction trajectory problems in a paper to Scottish Government with the intention of replacement after 2015.</td>
</tr>
<tr>
<td>Energy and Carbon reduction trajectories based on only 30-35% of the Board’s buildings, emissions from electricity consumed omitted, Combined Heat &amp; Power systems not correctly accounted for, base year change disadvantaged NHSL ignoring benefits gained from early actions and does not give full allowance for changes in the hospital estate or CO2 reductions as consequence of site closures.</td>
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### Workforce

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<tr>
<td>Conflicting pressures for estates staff needs to continue to be managed.</td>
<td>Staff training to identify and manage low carbon projects.</td>
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<tr>
<td>General staff - their engagement and ownership.</td>
<td>Support from Resource Efficient Scotland in revised Carbon Management Plan.</td>
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<td>Corporate Communications staff to develop their awareness programme and investment in staff initiatives.</td>
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### Finance

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<td>Management of budgets to take</td>
<td>Clarity of accountability of Managers.</td>
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account of any overspend of existing budgets due to increased exposure to high energy tariffs.

- Increased exposure to taxation of carbon emissions – EUETS, CRC, CCL and others in pipeline

- Automated Building Management System and other automated systems response to alert and or correct failure of equipment.

- Procurement – review procurement of goods and services with a view to reducing carbon costs these would take place at the agreed procurement notice date and at least in advance of the contract renewal notice. A strategic review of services within this are is to be established.

### Equalities

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<td>Not Applicable.</td>
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Deliver faster access to mental health services by delivering 26 weeks referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS) from March 2013; reducing to 18 weeks by December 2014; and 18 weeks referral to treatment for Psychological Therapies from December 2014

NHS BOARD LEAD:  
Jim Forrest  
Director of Health & Social Care West Lothian

### Delivery and Improvement

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| Develop sufficient Capacity to deal with current and future demand | • Improve patient flow through full implementation of the Choice and Partnership model (CAPA)  
• Using DCAQ to identify improvement opportunities.  
• Monitor 1\textsuperscript{st} and 2\textsuperscript{nd} appt DNA rates.  
• Implementation of reminder systems to improve DNA rates  
• Maximise the opportunities for joint working with other agencies for less complex patients.  
• Ensure full compliance with GIRFEC.  
• Provide consultation and advice services in addition to face to face contacts.  
• Adhere to redesigned pathways using matched care model.  
• Ensure timeous recruitment of vacancies.  
• Develop DCAQ dashboards to provide services with relevant data to monitor performance and identify improvement opportunities |
| Dealing with greater levels of case complexity in patients being referred | • Ensure staff are using evidence based treatments and psychological therapies.  
• Ensure there are regular case reviews  
• Ensure staff are appropriately supervised. |
| Growing numbers of referrals | • Work with referrers to CAMHS Tier 3 where the majority of referrals are made, to ensure that there is Pre-referral assessment, prior to referral.  
• Ensure active dialogue with GPs to ensure shared understanding of referral criteria and of matched care models i.e. wider service delivery.  
• Continue to develop level One & Two Child and Adolescent Mental Health Services to meet any increase in referrals.  
• Increase access to low levels interventions which can be accessed via self referral |
| Ensuring that patients are matched to the appropriate psychological therapy to meet their needs | • Using matched care models and integrated care pathways to ensure patients are matched to appropriate therapy. |
| Increased demand for psychological therapies | • Promote the evidence base of “what works for whom” and promote compliance with it.  
• Implement recording of “primary focus of treatment” (initial diagnosis) to ensure application of effective evidence based treatment |
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<tr>
<td>Providing time for professional development</td>
<td>• All staff have agreed job plan including appropriate PDP element.</td>
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| Avoid the focus on service improvement being seen as only about delivering the access targets | • Ensure staff morale for service improvement is maintained through regular staff supervision and support and feedback on improvements achieved and feedback from service users.  
• Ensure staff are involved in considering service improvement. |
| Ensure staff have the necessary competencies and supervision to deliver psychological therapies | • Training and supervision needs identified as part of all staff’s PDPs. |
| Staff feeling pressurised due to increased demand with no increase in capacity | • Ensure staff are engaged with service improvement methodologies and that clinical time is maximised.  
• Ensure health care staff are aware of the role that other agencies play in delivering alternatives which may then impact on referral rates and demand.  
• Ensure that clear operational policies and standard operational procedures are in place to support staff to deliver care within agreed standards (eg. Applying consistent DNA policies)  
• Ensure that there is sufficient admin time in order that clinicians are not taking on non clinical admin duties which detract from clinical work. |
### Finance

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<tr>
<td>Availability of funding to sustain additional capacity</td>
<td>• Continued monitoring of available resources and maximising their use.</td>
</tr>
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<td>• Maintaining a flexible workforce of full and part-time staff and qualified and unqualified staff.</td>
</tr>
<tr>
<td>Any potential reduction in funding by partner agencies involved in providing services</td>
<td>• Continuing to work with partner organisations to identify those opportunities where improved closer working can deliver efficiencies.</td>
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<td>• Ensure full risk assessment is provided where funding reduction is being considered and the implications are understood both strategically and operationally.</td>
</tr>
<tr>
<td>Loss of funding to 3rd sector through other funding sources</td>
<td>• Continue to ensure integrated planning and delivery across health, local authorities and 3rd sector.</td>
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### Equalities

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<tr>
<td>Ensuring that disadvantaged groups have equal access to service provision</td>
<td>• Continuing to review waiting times and DNA data on access to services to ensure that patients from disadvantaged groups have the same level of access to services, as other patient groups.</td>
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<td></td>
<td>• Rapid Impact Assessment is always carried out where service change is being considered.</td>
</tr>
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<td>Equitability in offer and uptake of psychological therapies across equality groups</td>
<td>• Active monitoring of therapies offered and subsequent uptake.</td>
</tr>
<tr>
<td>Vulnerable people may not attend appointments</td>
<td>• Use different means to engage with groups rather than standard appointment letters.</td>
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<td>• Introduce greater flexibility around appointment times and clinical hours.</td>
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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

NHS BOARD LEAD:
Ms Melanie Johnson
Director of Nursing, AHPs and Unscheduled Care

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| NHS Lothian has indicated a stretched target of 21% reduction from the 2009/10 baseline of 6,003 to 4,709 by March 2015. | • Robust mechanisms of joint planning and performance management in each of the four partnerships.  
• Shared data between local authorities and NHS Lothian aids identification of areas of pressure. |
| The system wide Reshaping Care for Older People work streams need to deliver the required changes to support the reduction of inpatient bed day rate. | • Change Fund allocations to March 2015 will provide a catalyst for sustainable change and review of progress against the target needs to be a key metric for all partnerships.  
• Joint commissioning plans agreed across all four partnerships. |
| Flexible Capacity Required for pressures through the winter / escalation periods, increases capacity and subsequent rate of bed days. | • Robust discharge plans and enhanced community services to ensure demand is met.  
• New models of care such as COMPASS and roll out of care home beds as step down beds.  
• Apply the radical system change associated with NHS inpatient complex care to allow flexible beds for surge activity. |

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| Requirement to make savings across both health and social care may see reduction in workforce to deliver alternatives to hospital bed days in the wider community; the impact of this requires on-going management across both systems. | • Work with Workforce colleagues in both NHSL and Councils to ensure systems do not impede progress.  
• Through the Reshaping care and Change Fund work streams continue to test and explore new ways of working with the voluntary and private sectors to ensure value for money and effective delivery of services. |
| Recruitment challenges to allied health professional posts in hospital will have an adverse impact on preparing people for discharge as far as rehabilitation and discharge planning is concerned | • Through unscheduled care group, have AHP leads make representation of different/better ways of working, with the in reach of Intermediate Care Teams to hospitals enabling appropriate and timely discharge. |
| Good and evidence based Discharge Planning processes not being adhered to owing to pressures of work | • Recognise where there might be pressure, and work with teams to improve discharge planning.  
• Ensure best use of the patient transport system through the Scottish Ambulance Service to arrange discharges timely.  
• Live updating of hospital systems ensures vacant beds are identified, making best use of current capacity. |
### Finance

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| Ability to release funds from services for reinvestment needs to support productivity and efficiency requirements. | • Ensure an integrated approach is taken with resource utilisation being more transparent through the Integrated Resource Framework utilisation, and the planning for future services being integrated through the Joint Commissioning Plan being submitted for March 2013 across the four Lothian partnerships.  
• Develop partnership agreements in line with the legislative intent associated with Integration of Adult Health and Social Care. |

### Equalities

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| Access to all groups and communities should not be adversely impacted with the implementation of the change fund and reshaping older people work streams, with more opportunities to live as independent lives as possible at home, or in a homely setting being the key aim in line with the national philosophy. | • Continue to develop community services to ensure older people are supported at home or in a homely setting for as long as possible, through the on-going Change Fund Plans, and Joint Commissioning Plans.  
• The Shadow Integrated Health & Social Care Partnerships will ensure equalities are addressed through on-going joint plans, the Single Outcome Agreements and working better together. |
No people will wait more than 28 days to be discharged from hospital into a more appropriate care setting, once treatment is complete from April 2013, followed by a 14 day maximum wait from April 2015

**NHS BOARD LEAD:** Ms Melanie Johnson, Director of Nursing, AHPs and Unscheduled Care and Joint Directors of Health and Social Care x 4

### Delivery and Improvement

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| The delivery of the impending National target of 28 days is currently proving challenging to some of the Councils in the Lothian Partnership. With an ageing population, we need to ensure that we continue to work in partnership across health and social care to reduce pressure on the system. | • The reduction in the number of patients delayed, supported through more timely discharge is a key aim for the Local Transformation Plans, which are resourced by the Change Fund and have been signed off by Community Planning Partnerships.  
• An increased focus on providing preventative care interventions to reduce unnecessary admissions to hospital along with community-based support to facilitate earlier discharge will be necessary in order to achieve the planned reductions in the length of stay.  
• The range of actions through the NHS Lothian Strategic Plan will address the wider issue of patient flow across the health and social care system, which will positively impact on reducing the number of delays.  
• The commitment to move towards integration between health and social care will support the development of integrated budgets, with the focus on the patient rather than the service.  
• The need to continually review all delays but also to focus on those patients waiting for packages of care of less than 14 hours; care at home as well as those on the rehabilitation list who could be supported at home. In addition we will continue to focus on the reduction in the length of time to process complex cases, including guardianship cases.  
• New models of care such as COMPASS and care home beds being used for step down as well as behaviour support beds being created in the community.  
• The publication of CEL(2013)32 in December 2013 provides clarification of the guidance on what Boards and patients / carers / relatives are required to do in relation to leaving hospital and moving to a care home. This will reduce inequalities and ensure patients move to the best place to meet their on-going care needs in a timely manner. Action plan to support the effective implementation of this is being developed. |

### Workforce
### Risk Management of Risk

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| The workforce issues reach across both health and social care staff, with health staff needing to begin discharge planning at the earliest opportunity and for social work staff to ensure timely assessment of patient’s needs. | • The implementation of the new discharge planning checklist will enable early identification of estimated discharge dates by health staff.  
• The continued close working between health and social work staff will ensure appropriate assessment and discharge planning can be put in place.  
• Early engagement and involvement of the family in the discharge arrangements will also contribute to a reduction in delays. |
| Whilst there is good knowledge of community-based services by clinical staff, there is a need to ensure this is consistent across all hospital sites. | • Engagement with clinical staff on the range of services available locally to support patients being cared for at home or in a community setting. |

### Finance

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| The Change Fund is supporting initiatives to deliver the necessary shift in the balance of care. We need to ensure that these are embedded and become normal practise | • The performance metrics in place through the Change Fund plans will be used to determine the impact and effectiveness of the interventions through the Local Transformation Plans.  
• Change Fund, £11.2m for 13/14. Development and sign off of Joint Commissioning Plans that build on this work for 31st March 2013.  
• The Delayed Discharge team within NHS Lothian will closely monitor delays over 2014/15 to ensure they remain on trajectory and provide analysis to support any proposed changes required to address performance. |
| We need to manage the integrations of costs for patients between health and social care. | • The development of the Integrated Resource Framework will provide clarity on the total spend across health and social care, which will support more effective service planning, with the patient at the centre. |

### Equalities

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<td>The right level of care and treatment needs to be provided in the most appropriate environment.</td>
<td>• Delivery of the new national standard will ensure timely discharge from hospital to ensure appropriate care and treatment can be delivered both in hospital and the community.</td>
</tr>
<tr>
<td>The impact of delays needs to be managed to ensure all patients will be able to access a hospital bed for treatment.</td>
<td>• Delivery of the new national standard will ensure timely discharge from hospital to ensure appropriate care and treatment can be delivered both in hospital and the community.</td>
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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.

**NHS BOARD LEAD:**  
Mr Jim Forrest  
Director of West Lothian CHCP

### Delivery and Improvement

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<tr>
<td>That the target is not owned by health and social care and the 3rd sector.</td>
<td>Ensure that delivery on this target is owned by all stakeholders.</td>
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<td></td>
<td>Ensure that the role of link worker is understood as a role that workers from a wide set of professions and agencies can take on.</td>
</tr>
<tr>
<td>Only health interventions are identified due to difficulties of tracking patients and constraints of I M and T systems</td>
<td>Learn from models in place which ensure that all sectors’ activities can be collated e.g. the A11 Drug and Alcohol Waiting times standard.</td>
</tr>
<tr>
<td>Link worker role is not understood</td>
<td>Use learning from pilots and evidence base to inform new service models.</td>
</tr>
<tr>
<td>Importance of wider staff groups other than consultant psychiatrists being able to diagnose dementia</td>
<td>Training for medical staff in diagnosis of dementia.</td>
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### Workforce

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<td>The introduction of named link workers does not impact on staff’s ability to work intensively with those clients who require it</td>
<td>Recognise and plan service provision accordingly – i.e. not all people will require or want the same degree and intensity of support.</td>
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### Finance

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<tr>
<td>Resources are directed at first year of support rather than at those points at an individual’s pathway where support is most needed</td>
<td>Ensure there is understanding across all services of how all staff members can contribute to post diagnostic support including fulfilling the role of link-worker.</td>
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### Equalities

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<tr>
<td>People from vulnerable groups may not seek help from their GP.</td>
<td>• Ensure full rapid impact assessment is undertaken and the findings are implemented and monitored.</td>
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<tr>
<td>Different cultural perceptions of aging</td>
<td>• Ensure cultural competency training is delivered to staff.</td>
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<td>• Ensure a focus on the importance of working with and building on a person’s social and family networks of support.</td>
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Eligible patients will commence IVF treatment within 12 months by 31 March 2015

NHS BOARD LEAD: Mr Jim Crombie
Director of Scheduled Care

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<td><strong>Risk</strong></td>
<td><strong>Management of Risk</strong></td>
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<tr>
<td>NHS Lothian is currently close to</td>
<td>Self-funding capacity is to be flexed to enable the appropriate number of [fresh] cycles to be used. Requirements for 2013/14 will be based upon projections provided to the National Infertility Group by University of Glasgow.</td>
</tr>
<tr>
<td>meeting the 12 month guarantee as</td>
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<td>measured locally. However, additional capacity is required to sustain this.</td>
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<tr>
<td>National definitions for measure-</td>
<td>Commence collecting key dates for patients so waiting time can be reported as far as practicable against final definitions. National group has outlined proposals. Consideration required here on the measurement of patient unavailability on waiting time performance.</td>
</tr>
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<td>ment require confirmation. Possibility that waits reported locally will be inconsistent with those required nationally.</td>
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<tr>
<td>Reliable measurement of waiting</td>
<td>While there may be merit in a national solution here, local consideration is required to identify suitable options.</td>
</tr>
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<td>times required.</td>
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<tr>
<td>Capacity for frozen cycle treat-</td>
<td>Plan not only for the increased fresh cycles in University of Glasgow’s projections, but also for associated frozen requirements for 2013/14</td>
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<td>ment capacity and infrastructure.</td>
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<tr>
<td>Frozen cycles are not currently reimbursed by NHS Lothian, but these cycles do incur a cost. The change in treatment pattern in 2010 in Lothian, shifting towards a presumption of elective Single Embryo Transfer (eSET), has resulted in a higher number of frozen transfers.</td>
<td></td>
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<tr>
<td>Eligibility criteria/pathway out-</td>
<td>Collect information on those patients joining the waiting list to enable ready assessment of impact depending upon acceptance of national group’s recommendations. The similarity between the national recommendations and current practice may be merit a retrospective review of referrals at this point.</td>
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<td>lined nationally may be inconsistent with current practice locally.</td>
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<tr>
<td>Staff already in post, but capacity</td>
<td>Plan earlier delivery to allow for “headroom” later against trajectory.</td>
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<td>will be impacted by any deficit.</td>
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<td>Currently contingency arrangements are in place with Dundee if difficulties arise in the unit. These will be reconfirmed in light of additional volumes both units will be undertaking.</td>
<td></td>
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<tr>
<td>Generating staffing headroom in consultant job plans (gynae to EFREC). Appointment of lab, medical, nursing and laboratory staff is under consideration.</td>
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<tr>
<td>Costs will fall outside the national</td>
<td>This risk is being taken into account in the costing for</td>
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funding available to support this target and require sustainability beyond the March 2015. the business case with implications for 2015/16 onwards being submitted to the board financial plan.

### Equalities

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<tr>
<td>Displacement of self-funding patients will impact on groups outside of national criteria.</td>
<td>Demonstrate adherence to national criteria with clear communication in place with patients</td>
</tr>
<tr>
<td>Lack of donor insemination service in Lothian particularly impacts on same sex couples/single women</td>
<td>Donor Insemination aspects, although only partially overlapping with IVF, are to be included in business case.</td>
</tr>
<tr>
<td>Smoking and BMI criteria exclude certain groups.</td>
<td>Pathways in place to smoking cessation and health weight support.</td>
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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.

NHS BOARD LEAD: Melanie Johnson, Executive Director of Nursing, AHP and Unscheduled Care

### Delivery and Improvement

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<tr>
<td>Delayed discharge numbers affected unscheduled care flow and 4 hour performance.</td>
<td>• Focus on reducing total numbers of delays and length of delays.</td>
</tr>
<tr>
<td>Hospital processes require improvement to support safe, effective and reliable unscheduled care flow.</td>
<td>• Development of Change Fund supported solutions to service delivery and implementation of new joint hospital and CHP/social care structures through the Integration agenda.</td>
</tr>
<tr>
<td>Increasing demand particularly from frail elderly patients with increased complexity of needs and co-morbidity.</td>
<td>• Direct leadership focus in the form of weekly meetings with Chief Executives of both NHS Lothian and City of Edinburgh council, along with other executive colleagues.</td>
</tr>
<tr>
<td>Unscheduled and Elective capacity pressures conflict for available resource and capacity</td>
<td>• Undertake capacity review of social care service provision to identify areas where service provision can be improved to match demand more closely.</td>
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<tr>
<td>Insufficient capacity within hospital system.</td>
<td>• Joint chairing of unscheduled care group for Health &amp; Social care partners.</td>
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<td>• Focus on additional social care package of care capacity and alternative providers’ e.g. intermediate care.</td>
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<td></td>
<td>• Hospital Site management will focus on improvements to time of discharge, pathways for specialty admission, matching capacity to demand, increased provision of 7 day working, increased senior decision-making at the front door.</td>
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<td></td>
<td>• Development of frailty models as alternatives to hospital admission.</td>
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<td></td>
<td>• Continued development of urgent ambulatory care, OPAT and ERAS schemes to reduce preventable hospital bed days.</td>
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<td>• Additional nursing home capacity introduced to the system.</td>
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<td>• DCAQ undertaken with QuEST to support recovery of elective position to be linked to capacity shortfall in acute assessment and medical ward areas.</td>
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<td>• Additional 31 beds commissioned for RIE from mid-February 2014. Business case to expand acute assessment footprint at RIE with work anticipated to commence in 2015. Additional</td>
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Norovirus and related HAI affecting unscheduled care flow.

- Review of HAI management of Liberton Hospital and related flow issues with goal of reducing risk of repeated loss of capacity.

### Workforce

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<tr>
<td>Recruitment of workforce with appropriate skills and competencies across a number of job families and specialty areas</td>
<td>- Investment in additional consultant, specialty doctor, GP with ED training, Emergency Nurse Practitioner and staff nurse posts as part of an overall Emergency medicine workforce plan to sustain safe provision of 24-hour emergency departments at RIE, RHSC and SJH.</td>
</tr>
<tr>
<td>Recruitment of staff for frailty models and front door models will be delayed / prolonged.</td>
<td>- Focus on accelerating the recruitment process and supporting acting up arrangements were safe and practical to do so.</td>
</tr>
<tr>
<td>Recruitment / retention of Social Care staff for Intermediate Care / Reablement / Change Fund supported services will be difficult to maintain due to market rates.</td>
<td>- Enhanced Elderly Care Assessment Team (ECAT) established to support frail elderly patients.</td>
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<td>- Social care to review rates of payment to produce vacancy rates.</td>
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<td>- Executive team will continue to review the ED Workforce plan to plan the appropriate workforce capacity needs aligned to changes in demand at front door and elsewhere.</td>
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### Finance

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<td>Sustainability of investment required for additional hospital capacity and alternatives to admission.</td>
<td>- Unscheduled Care Group will approve a financial plan which links to NHS Lothian’s overall Financial Plan.</td>
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<td>- Scale of investment being made across Unscheduled Care and Elective agenda in NHS Lothian creates potential for delays in commencement or implementation of schemes and therefore potential risk of slippage which can add to flexibility of available resource.</td>
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<td>- Significant investment for unscheduled care will be offset by savings elsewhere.</td>
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<tr>
<td>Performance in unscheduled care below trajectory risks inequity of access with other pathways e.g. elective.</td>
<td>• Effective capacity management and flow management should reduce the risk of boarding and elective cancellations.</td>
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Further reduce healthcare associated infections so that by March 2015 NHS Boards' Staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.32 cases or less per 1000 total occupied bed days.

| NHS BOARD LEAD: | Melanie Johnson  
Executive Director of Nursing, AHP and Unscheduled Care |

### Delivery and Improvement

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| There is a risk of harm to patients through essential clinical interventions | • The application of care bundles related to Healthcare Associated Infection, for example for insertion and maintenance of central venous lines, peripheral cannula and urinary tract catheters will assist in reducing the risk of bacteraemia.  
• Compliance with Antimicrobial prescribing guidelines to reduce the risk of antimicrobial associated Clostridium difficile infection (CDI) and use of CDI Care bundle to prevent cross infection |
| Ownership of the target at clinical level within acute and community services is key to success and needs to be universal. | • Data is fed back on a regular basis to clinical teams; weekly and monthly reports are published on the Infection Prevention and Control Team (IPCT) Intranet page and displayed at local and clinical level. The monthly reports provide guidance to directorates on local trajectories and managers should take appropriate action supporting interventions for local reductions in HAI.  
• The IPCT will provide advice and support. Monitoring of data by the Infection Prevention and Control Committee and relevant clinical/management team meetings.  
• Rapid impact assessment of all SABs should be undertaken by clinical teams with support from IPCT within two working days. The aim of the RIA is to identify health care factors which may have contributed to the acquisition. Clinical teams should utilise the information from the RIA to assist improvement in local practice and outcomes guiding education and practice development within the department/service.  
• In addition Pareto and statistical process charts should be available to focus work on areas of greater risk. Support is available for education through the appointment of a temporary Practice Education Facilitator to the IPCT funded by Scottish Government.  
• Clinical Teams should continue to engage with Scottish Patient Safety Programme in the use of care bundles and improvement methodology for practice.  
• All staff should have HAI objective within their annual work plan and linked practice |
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| Development activity in their personal development plan             | - A standard operating procedure (SOP) has been developed for staff to utilise when obtaining samples for blood culture. Staff competency should be assessed and monitored to reduce false positives through the consistent application of the SOP.  
- Clinical teams to ensure implementation of care bundles is audited and quality assured taking the necessary actions to improve compliance where SPSP data indicates not achieving target of 95% compliance.  
- Chairs of infection prevention and control committees, Nurse Director, Deputy Nurse Director and Divisional Medical Director to support the Head of Service in promoting HAI agenda and associated actions.  
- Clinical teams to utilise Infection Prevention and Control data to inform improvement plans and practices to reduce incidence of Healthcare Associated Infection.  
- Collaborative working with Health Protection Scotland to continue to improve Infection Prevention and Control practice. |
| There is a risk that as the level is based on a non-comparable health boards achievements and that the 2015 target will not be met. | - Investigation of patients testing positive within 48hrs of admission should include a retrospective review of previous healthcare contact. Where a link is found action should be taken by the relevant healthcare department to investigate and address practice issues which may have contributed to acquisition.  
- Work with primary care and third sector partners, to continue to optimise early intervention in the community to reduce the risk of healthcare associated infection acquisition eg prevention of pressure sores, optimum management of diabetic ulcers, implementation of bundles to prevent catheter associated infections. |
| There needs to be consistency of focus across all healthcare settings. | - Funding by SGHD has been utilised to support education and promotion of Clinical Risk assessment. Regular compliance audits are undertaken by SGHD funded Support Workers within IPCT. Current compliance levels are varied between 45%-100%.  
- Areas undertake a higher level of actual screening than compliance with CRA which provides an assurance that colonisation with MRSA is identified.  
- A works request and TRAK specification has been submitted to change the CRA from an optional to a mandatory field.  
- Monthly reports are provided to clinical teams Chief Nurses and the Nurse Director. Compliance |
rates are discussed at Chief Nurse and Nurse Director Meetings as well as Infection Control Committee

| Sustained compliance with hand hygiene at 95% or above | • An escalation process for failure to comply with hand hygiene practice was introduced in December 2012.  
• The escalation process has 4 stages and supports staff to take appropriate action when a staff member fails to attain satisfactory level of compliance on audit. Actions range from immediate advice and feedback to the individual, education and support through to investigation with potential disciplinary  
• 4 audits of 30 opportunities/observations per audit will be completed every quarter to provide assurance that our measuring and monitoring process is robust.  
• Members of the Infection Prevention and Control Team (IPCT) will identify respective wards/departments based on hand hygiene compliance reports via QIDS and incidence of HAI.  
• Two wards will be selected from audits which consistently report 95-100% compliance with hand hygiene, and two will be selected from wards measuring below 90%. |

**Workforce**

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| Healthcare practice can contribute to the acquisition of SAB and CDI. | • There is a need for clinical staff to recognise the importance of prompt analysis and implementation of recommendations.  
• The impacts of compliance with bundles and interventions recommended are key to reduction in incidence.  
• Staff will require time to investigate contributory factors and implement change.  
• Infection prevention and control and patient safety are available to provide support.  
• Collaborative working and monitoring of progress through quality improvement and infection prevention and control committees.  
• Application of root cause analysis for all SAB and CDI requires support of the multidisciplinary team.  
• High patient throughput and staffing levels can result in pressures and reduced adherence to standard infection control precautions |
| There is potential for lack of knowledge or understanding of HAI matters in individual staff members. | • Staff are required to undertake mandatory induction and updates on infection control.  
• HAI education strategy establishes learning matrix for clinical groups.  
• All staff should have HAI related activity within personal development plans and objectives which |
should be monitored through the appraisal process.
- There is an active education programme for Cleanliness Champions.
- Work is on-going to link actions required following incidence of infection to staff development through exiting e-learning packages.
- HAI education strategy establishes learning matrix for clinical groups.

### Increasing and competing demands on core IPCT members.

Reduction in staff availability in core hours with the introduction of weekend working.

- The establishment did not provide the flexibility to meet the fluctuations in capacity and resulting demand within the Infection Prevention and Control Team nor ensure sustainable business continuity in the absence of a team member.
- Continuity of the service was compromised during 2013 as a consequence absence levels. This was a combination of sickness and unprecedented levels of bereavements for staff member resulted in and absence level of approximately 42% for several months. The annual average sickness rate is currently estimated at 5%.
- A business case was supported by Nurse Director and HAI Executive Lead to increase baseline establishment for IPCT.
- Recruitment is in progress for 3 additional Band 6 staff. This will provide the base line level of 1:250.
- There is a high demand on provision of support to Estates, Capital Planning to support new building developments, refurbishments, backlog and current maintenance programmes for prevention of infection in the built environment guidance.
- The business case also include a Band 7 experienced IPCN to support this work and this has been filled through internal staff moves promotions.
- The risk for 2014 is due to combination of staff retirement, resignation and moves the ratio of trained to untrained staff will average 50%.
- All new staff will be required to undertake specialist qualification to Post Graduate Diploma level.

### Finance

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<tbody>
<tr>
<td>Failure to deliver LRP for financial year 2014-2015.</td>
<td>- IPCT resource is mainly staffing. Requirement to reduce staffing to meet LRP will compromise the baseline required provision of 1:250</td>
</tr>
<tr>
<td></td>
<td>- Whilst staff changes have reduced the level of salary protection, there are 2 staff remaining on protection within the service and 1 staff member who left the service under organisational change to redeployment requiring sustained protection.</td>
</tr>
<tr>
<td>Antimicrobial prescribing cost of alternatives to high risk medications.</td>
<td>- Substitution of high risk antimicrobial agents for CDI infection (i.e. broad spectrum antibiotics) with</td>
</tr>
</tbody>
</table>
lower risk antimicrobials is anticipated to be cost neutral. In addition, implementation of the CDI Reduction Programme and adherence to the revised Antibiotic Prescribing Guidelines will result in a reduction in use of antibiotics as both of these measures promote prudent antibiotic prescribing.

- As part of the surveillance of antibiotic use in NHS Lothian, the AMT monitoring and report on antibiotic usage and expenditure.

<table>
<thead>
<tr>
<th>Risk</th>
<th>Management of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Potential for competing priorities versus available resources to fail to fully meet service.</td>
<td>Through monitoring and reporting priority areas can be identified to target resources to maximise impact and reduce the risk.</td>
</tr>
</tbody>
</table>
| There is a need to manage patient and public anxiety over the risk of acquiring Healthcare Associated Infection. | Enhance public confidence through patient public representatives being actively involved with the HAI agenda.  
- Public representatives on relevant committees’ e.g. Healthcare Environment Inspectorate Steering Group. Infection Control Committees (Lothian Infection Control Advisory Committee, Acute and Community).  
- Involvement of public representative in Patient experience Quality Indicator Inspections.  
- Staff awareness of HEI and ensuring maintenance of standards. |
### Reduction in emergency bed days for patients aged 75+

<table>
<thead>
<tr>
<th>Year Ending</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mar-10</td>
<td>5,091</td>
<td>6,112</td>
<td>5,314</td>
<td>4,251</td>
<td>4,076</td>
<td>5,047</td>
<td>6,256</td>
<td>5,462</td>
<td>5,068</td>
<td>6,003</td>
<td>4,711</td>
<td>3,892</td>
<td>4,927</td>
<td>7,177</td>
</tr>
<tr>
<td>Mar-11</td>
<td>4,806</td>
<td>5,543</td>
<td>5,254</td>
<td>4,279</td>
<td>4,053</td>
<td>4,811</td>
<td>6,350</td>
<td>4,989</td>
<td>4,730</td>
<td>5,531</td>
<td>4,773</td>
<td>3,314</td>
<td>4,623</td>
<td>7,447</td>
</tr>
<tr>
<td>Mar-12</td>
<td>4,609</td>
<td>4,935</td>
<td>4,637</td>
<td>4,222</td>
<td>4,157</td>
<td>4,561</td>
<td>6,349</td>
<td>4,480</td>
<td>4,379</td>
<td>5,501</td>
<td>4,118</td>
<td>4,386</td>
<td>4,504</td>
<td>6,210</td>
</tr>
<tr>
<td>Mar-13</td>
<td>5,071</td>
<td>3,661</td>
<td>4,458</td>
<td>4,247</td>
<td>4,318</td>
<td>4,071</td>
<td>5,867</td>
<td>4,380</td>
<td>4,009</td>
<td>5,341</td>
<td>4,323</td>
<td>4,461</td>
<td>4,672</td>
<td>5,275</td>
</tr>
<tr>
<td>Apr-14</td>
<td>4,259</td>
<td>4,741</td>
<td>4,155</td>
<td>4,296</td>
<td>3,992</td>
<td>3,975</td>
<td>5,759</td>
<td>4,681</td>
<td>4,349</td>
<td>4,867</td>
<td>4,116</td>
<td>3,840</td>
<td>4,173</td>
<td>5,180</td>
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<tr>
<td>May-14</td>
<td>4,243</td>
<td>4,733</td>
<td>4,142</td>
<td>4,274</td>
<td>3,990</td>
<td>3,922</td>
<td>5,747</td>
<td>4,667</td>
<td>4,357</td>
<td>4,852</td>
<td>4,104</td>
<td>3,800</td>
<td>4,152</td>
<td>5,160</td>
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<tr>
<td>Aug-14</td>
<td>4,192</td>
<td>4,711</td>
<td>4,102</td>
<td>4,209</td>
<td>3,983</td>
<td>3,763</td>
<td>5,712</td>
<td>4,623</td>
<td>4,179</td>
<td>4,806</td>
<td>4,070</td>
<td>3,680</td>
<td>4,088</td>
<td>5,100</td>
</tr>
<tr>
<td>Sep-14</td>
<td>4,175</td>
<td>4,695</td>
<td>4,089</td>
<td>4,188</td>
<td>3,980</td>
<td>3,710</td>
<td>5,700</td>
<td>4,608</td>
<td>4,167</td>
<td>4,791</td>
<td>4,058</td>
<td>3,640</td>
<td>4,067</td>
<td>5,080</td>
</tr>
<tr>
<td>Oct-14</td>
<td>4,158</td>
<td>4,687</td>
<td>4,076</td>
<td>4,076</td>
<td>3,978</td>
<td>3,657</td>
<td>5,688</td>
<td>4,593</td>
<td>4,155</td>
<td>4,775</td>
<td>4,047</td>
<td>3,600</td>
<td>4,046</td>
<td>5,060</td>
</tr>
<tr>
<td>Nov-14</td>
<td>4,141</td>
<td>4,689</td>
<td>4,063</td>
<td>4,144</td>
<td>3,976</td>
<td>3,604</td>
<td>5,677</td>
<td>4,578</td>
<td>4,144</td>
<td>4,760</td>
<td>4,035</td>
<td>3,560</td>
<td>4,025</td>
<td>5,045</td>
</tr>
<tr>
<td>Dec-14</td>
<td>4,124</td>
<td>4,682</td>
<td>4,049</td>
<td>4,123</td>
<td>3,973</td>
<td>3,604</td>
<td>5,665</td>
<td>4,564</td>
<td>4,132</td>
<td>4,745</td>
<td>4,024</td>
<td>3,520</td>
<td>4,003</td>
<td>5,030</td>
</tr>
<tr>
<td>Feb-15</td>
<td>4,090</td>
<td>4,667</td>
<td>4,023</td>
<td>4,080</td>
<td>3,968</td>
<td>3,581</td>
<td>5,642</td>
<td>4,534</td>
<td>4,109</td>
<td>4,714</td>
<td>4,001</td>
<td>3,440</td>
<td>3,961</td>
<td>5,010</td>
</tr>
<tr>
<td>Mar-15</td>
<td>4,073</td>
<td>4,660</td>
<td>4,010</td>
<td>4,058</td>
<td>3,966</td>
<td>3,548</td>
<td>5,630</td>
<td>4,520</td>
<td>4,097</td>
<td>4,709</td>
<td>3,989</td>
<td>3,425</td>
<td>3,942</td>
<td>5,000</td>
</tr>
</tbody>
</table>

**Notes:**
1. Boards submitted 3-year trajectories for emergency bed days in the 2012/13 LDPs. These are provided in the table above (along with any amendments since then).
2. The data are the number of emergency bed days in a year per 1,000 population.
3. Boards have access to more recent performance management information.
# 2020 LDP HEAT DELIVERY TRAJECTORIES

## Version 1.1

This document is to be used by NHS Boards to complete HEAT Delivery Trajectories.

**Colour Coding Key:**

<table>
<thead>
<tr>
<th>Performance required to achieve target</th>
<th>Colour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline position or latest published data</td>
<td></td>
</tr>
<tr>
<td>Requested trajectories from April 2014 to achieve target delivery (Boards to complete)</td>
<td></td>
</tr>
</tbody>
</table>

NHS Scotland Resilience and Business Management Team  
Health Workforce and Performance Directorate  
Scottish Government
2014/15 HEAT Targets

Detect Cancer Early

Early Access to Antenatal Services

Smoking Cessation (SIMD)

Reduce carbon emissions

Reduce energy consumption

Faster access to CAMHS

Faster access to psychological therapies

IVF Treatment Waiting Times*

Accident & Emergency Waiting Times*

Dementia Post Diagnostic Support*

Reduction in emergency bed days for patients aged 75+

14 Days Delayed Discharge

MRSA/MSSA Bacterium

Clostridium difficile infections

* Please see target details in accompanying Methods and Sources Document
## Detect Cancer Early

### Proportion of Colorectal, Lung and Breast Cancer Patients Diagnosed at First Stage of Disease

<table>
<thead>
<tr>
<th></th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2010/2011</strong></td>
<td>24.7%</td>
<td>26.2%</td>
<td>19.1%</td>
<td>23.2%</td>
<td>26.0%</td>
<td>20.4%</td>
<td>22.4%</td>
<td>25.4%</td>
<td>23.9%</td>
<td>22.6%</td>
<td>20.3%</td>
<td>19.8%</td>
<td>21.6%</td>
<td>27.6%</td>
</tr>
<tr>
<td><strong>2013/2014</strong></td>
<td>27.0%</td>
<td>28.1%</td>
<td>24.0%</td>
<td>27.6%</td>
<td>27.0%</td>
<td>27.9%</td>
<td>26.8%</td>
<td>27.8%</td>
<td>27.0%</td>
<td>25.6%</td>
<td>26.0%</td>
<td>26.0%</td>
<td>24.0%</td>
<td>28.0%</td>
</tr>
<tr>
<td><strong>2014/2015</strong></td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
<td>29.0%</td>
</tr>
</tbody>
</table>

**Notes:**
1. Data based on sets of 2 calendar years.
2. Performance in 2014/2015 should be at least 29%
# Early Access to Antenatal Services

## Percentage of Pregnant Women Booked for Antenatal Care by 12th Week of Gestation in the worst performing quintile

<table>
<thead>
<tr>
<th>Region</th>
<th>2010/11</th>
<th>2011/12</th>
<th>Apr-Jun 14</th>
<th>Jul-Sep 14</th>
<th>Oct-Dec 14</th>
<th>Jan-Mar 15</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>69.0%</td>
<td>82.9%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Borders</td>
<td>79.1%</td>
<td>85.0%</td>
<td>87.5%</td>
<td>88.0%</td>
<td>89.0%</td>
<td>90.0%</td>
</tr>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>83.8%</td>
<td>81.5%</td>
<td>83.5%</td>
<td>83.5%</td>
<td>83.5%</td>
<td>83.5%</td>
</tr>
<tr>
<td>Fife</td>
<td>1.0%</td>
<td>16.2%</td>
<td>74.0%</td>
<td>76.0%</td>
<td>78.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>44.4%</td>
<td>84.6%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Grampian</td>
<td>81.9%</td>
<td>84.6%</td>
<td>79.0%</td>
<td>79.0%</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>55.7%</td>
<td>54.4%</td>
<td>73.6%</td>
<td>75.7%</td>
<td>77.9%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Highland</td>
<td>76.3%</td>
<td>80.9%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>70.2%</td>
<td>73.6%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Lothian</td>
<td>53.2%</td>
<td>80.2%</td>
<td>76.9%</td>
<td>76.0%</td>
<td>78.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Orkney</td>
<td>68.3%</td>
<td>76.9%</td>
<td>39.0%</td>
<td>77.5%</td>
<td>79.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Shetland</td>
<td>25.9%</td>
<td>39.0%</td>
<td>65.9%</td>
<td>76.7%</td>
<td>79.0%</td>
<td>80.0%</td>
</tr>
<tr>
<td>Tayside</td>
<td>61.7%</td>
<td>65.9%</td>
<td>56.9%</td>
<td>82.7%</td>
<td>78.2%</td>
<td>83.9%</td>
</tr>
<tr>
<td>Western Isles</td>
<td>65.2%</td>
<td>81.6%</td>
<td>81.6%</td>
<td>82.7%</td>
<td>83.9%</td>
<td>85.0%</td>
</tr>
</tbody>
</table>

**Notes:**
1. Boards submitted 3-year trajectories for number of interventions in the 2012/13 LDPs. These are provided in the table above (along with any amendments since then).
2. Performance in Jan-Mar 2015 should be at least 80%
# Smoking Cessation (SIMD)

<table>
<thead>
<tr>
<th>Cumulative total</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 14 - Jun 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr 14 - Sep 14</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Apr 14 - Dec 14</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Apr 14 - Mar 15</td>
<td>814</td>
<td>227</td>
<td>353</td>
<td>761</td>
<td>607</td>
<td>1634</td>
<td>2823</td>
<td>582</td>
<td>1391</td>
<td>1765</td>
<td>36</td>
<td>35</td>
<td>884</td>
<td>93</td>
</tr>
</tbody>
</table>

Notes:
1. Number of successful quits at 12 weeks post quit in the 40% most deprived within-board SIMD areas i.e the bottom two local SIMD quintiles (60% for island health boards i.e. the bottom three local SIMD quintiles) over the 1 year ending March 2015.
## Reduce carbon emissions

<table>
<thead>
<tr>
<th>Year</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Moray</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
<th>National Waiting Times Centre</th>
<th>State Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>10,704</td>
<td>3,358</td>
<td>5,875</td>
<td>11,775</td>
<td>5,600</td>
<td>12,225</td>
<td>60,617</td>
<td>14,677</td>
<td>11,262</td>
<td>30,271</td>
<td>844</td>
<td>400</td>
<td>21,794</td>
<td>1,977</td>
<td>4,400</td>
<td>2,674</td>
<td></td>
</tr>
<tr>
<td>2012/13</td>
<td>8,440</td>
<td>3,041</td>
<td>4,600</td>
<td>10,624</td>
<td>4,241</td>
<td>11,836</td>
<td>57,709</td>
<td>13,158</td>
<td>11,348</td>
<td>29,640</td>
<td>832</td>
<td>302</td>
<td>19,391</td>
<td>1,903</td>
<td>4,379</td>
<td>854</td>
<td></td>
</tr>
<tr>
<td>2013/14</td>
<td>9,476</td>
<td>2,973</td>
<td>5,201</td>
<td>11,115</td>
<td>6,217</td>
<td>20,914</td>
<td>52,363</td>
<td>12,671</td>
<td>10,218</td>
<td>26,532</td>
<td>748</td>
<td>464</td>
<td>20,430</td>
<td>1,750</td>
<td>3,895</td>
<td>2,427</td>
<td></td>
</tr>
<tr>
<td>2014/15</td>
<td>9,191</td>
<td>2,883</td>
<td>5,044</td>
<td>10,781</td>
<td>6,030</td>
<td>20,285</td>
<td>50,790</td>
<td>12,484</td>
<td>9,911</td>
<td>25,734</td>
<td>725</td>
<td>450</td>
<td>19,817</td>
<td>1,697</td>
<td>3,778</td>
<td>2,354</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. Values are in tonnes of CO2
2. Information for 2009/10 (baseline) and published data for 2012/13 is included in table
3. For future years, the baseline amounts may be revised to account for site closures/openings or weather correction. Trajectories have been based on the current baseline amounts. Actual targets may vary.
### Reduce energy consumption

<table>
<thead>
<tr>
<th>Year</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
<th>National Waiting Times Centre</th>
<th>State Hospital</th>
</tr>
</thead>
<tbody>
<tr>
<td>2009/10</td>
<td>293,518</td>
<td>95,061</td>
<td>183,151</td>
<td>307,414</td>
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<td>1,746,424</td>
<td>279,245</td>
<td>330,377</td>
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<tr>
<td>2013/14</td>
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<td>164,055</td>
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<td>1,475,860</td>
<td>255,635</td>
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<td>15,660</td>
<td>565,943</td>
<td>32,398</td>
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Notes:
1. Values are in GJ.
2. Information for 2009/10 (baseline) and published data for 2012/13 is included in table.
3. For future years, the baseline amounts may be revised to account for site closures/openings or weather correction. Trajectories have been based on the current baseline amounts. Actual targets may vary.
### Faster access to CAMHS

<table>
<thead>
<tr>
<th>Patients who started treatment within 18 weeks of referral: Quarter of Treatment</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
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</tr>
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<tbody>
<tr>
<td>Jul-Sep 13</td>
<td>55.4%</td>
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<td>94.6%</td>
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<td>87.0%</td>
<td>90.0%</td>
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<td>100.0%</td>
<td>83.3%</td>
<td>90.0%</td>
<td>85.0%</td>
<td>100.0%</td>
<td>90.0%</td>
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<tr>
<td>Jul-Sep 14</td>
<td>80.0%</td>
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<tr>
<td>Oct-Dec 14</td>
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</tr>
<tr>
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1. Percentage of patients who started treatment within 18 weeks of referral
2. Based on Patients seen during each quarter (Adjusted)
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<thead>
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<th>Orkney</th>
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<th>Tayside</th>
<th>Western Isles</th>
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</thead>
<tbody>
<tr>
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<td>84.0%</td>
<td>83.0%</td>
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<td>Oct-Dec 14</td>
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<td>Jan-Mar 15</td>
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<td>90.0%</td>
<td>90.0%</td>
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Notes:
1. Percentage of patients who started treatment within 18 weeks of referral
2. Based on Patients seen during each quarter (Adjusted)
* - Published Data not available for Ayrshire & Arran
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<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
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<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
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<th>National Waiting Times Centre</th>
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Notes:
1. Number of NHS Delayed Discharges above 14 Days (2 Weeks)
2. Census night in October 2013 is included in the table
<table>
<thead>
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<th>Fife</th>
<th>Forth Valley</th>
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<th>Lothian</th>
<th>Orkney</th>
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<th>Tayside</th>
<th>Western Isles</th>
<th>National Waiting Times Centre</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jun-13</td>
<td>0.25</td>
<td>0.34</td>
<td>0.29</td>
<td>0.43</td>
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<td>0.13</td>
<td>0.27</td>
<td>0.36</td>
<td>0.04</td>
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<tr>
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<td>0.22</td>
<td>0.36</td>
<td>0.28</td>
<td>0.25</td>
<td>0.26</td>
<td>0.24</td>
<td>0.25</td>
<td>0.26</td>
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<td>0.14</td>
<td>0.12</td>
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<td>Sep-14</td>
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<td>0.27</td>
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<td>0.14</td>
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</tr>
<tr>
<td>Dec-14</td>
<td>0.24</td>
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<td>0.22</td>
<td>0.28</td>
<td>0.26</td>
<td>0.24</td>
<td>0.24</td>
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<td>0.26</td>
<td>0.14</td>
<td>0.12</td>
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</tr>
<tr>
<td>Mar-15</td>
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<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
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<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
<td>0.24</td>
<td></td>
</tr>
</tbody>
</table>

Notes:
1. Boards are expected to achieve a rate of 0.24 cases per 1,000 acute occupied bed days or lower by year ending March 2015. Boards currently with a rate of less than 0.24 are expected to at least maintain this, as reflected in their trajectories.
2. Boards will be held to account against the 0.24 rate.
3. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
4. Information for year ending June 2013 is included in the table.
## Clostridium difficile infections

<table>
<thead>
<tr>
<th>Year Ending</th>
<th>Ayrshire &amp; Arran</th>
<th>Borders</th>
<th>Dumfries &amp; Galloway</th>
<th>Fife</th>
<th>Forth Valley</th>
<th>Grampian</th>
<th>Greater Glasgow &amp; Clyde</th>
<th>Highland</th>
<th>Lanarkshire</th>
<th>Lothian</th>
<th>Orkney</th>
<th>Shetland</th>
<th>Tayside</th>
<th>Western Isles</th>
<th>National Waiting Times Centre</th>
</tr>
</thead>
</table>
| Jun-13      | 0.46             | 0.45    | 0.45                | 0.29 | 0.15         | 0.26     | 0.29                     | 0.41     | 0.43         | 0.53    | 0.47   | 0.02     | 0.46    | 0.45         | 0.45
| Jun-14      | 0.40             | 0.37    | 0.36                | 0.32 | 0.25         | 0.32     | 0.31                     | 0.37     | 0.32         | 0.32    | 0.36   | 0.39     | 0.37    | 0.37         | 0.10
| Sep-14      | 0.37             | 0.35    | 0.35                | 0.32 | 0.25         | 0.32     | 0.31                     | 0.37     | 0.32         | 0.32    | 0.35   | 0.37     | 0.37    | 0.35         | 0.10
| Dec-14      | 0.34             | 0.33    | 0.34                | 0.32 | 0.29         | 0.32     | 0.31                     | 0.34     | 0.32         | 0.32    | 0.34   | 0.35     | 0.34    | 0.35         | 0.10
| Mar-15      | 0.32             | 0.32    | 0.32                | 0.32 | 0.32         | 0.32     | 0.32                     | 0.32     | 0.32         | 0.32    | 0.32   | 0.32     | 0.32    | 0.32         | 0.32

Notes:
1. Boards are expected to achieve a rate of 0.32 cases per 1,000 occupied bed days by year ending March 2015. This relates to people aged 15 and over. Boards currently with a rate of less than 0.32 are expected to at least maintain this, as reflected in their trajectories.
2. Boards will be held to account against the 0.32 rate.
3. It is acknowledged that there are particular issues with island board targets given that very small changes in case numbers will have a disproportionate impact on rates. This will be taken into account when assessing whether these boards have effectively delivered their target; but the expectation of zero tolerance of preventable infections will continue to apply.
4. Information for year ending June 2013 is included in the table
5. Based on C Difficile Infection (CDI) data from Health Protection Scotland
## Workforce Plan

Contents:

1. Workforce pressures and risks ........................................... P2-10
2. Application of nursing and midwifery workload and workforce planning tools ........................................... P10-12
1. Existing/Planned Service Areas with Particular Pressures

1.1 Medical Workforce Pressures

In the face of mounting pressures within a number of areas a medical workforce risk assessment tool and process has been developed and rolled out across all specialties/services in NHS Lothian. The 2013/14 LDP Workforce Section detailed the findings from initial priority areas of Paediatrics, Emergency Medicine and Obstetrics and Gynaecology (O&G). The process has now been completed for all Specialties/Services, this section will outline the key areas of risk that have emerged and provided an update on the situation within the priority areas.

The risk assessment tool has been developed within NHS Lothian to provide a comprehensive assessment of risk across the range of medical specialties and to mitigate against these as appropriate. The tool that has been developed includes three categories of risk covering:

- training grade medical workforce
- trained medical workforce
- non-medical replacement workforce

Within these three categories there are a number of individual risks, which are given a scoring based on the NHSiS national scoring system; 1-5 rating for impact and 1-5 for likelihood. These scorings are developed following discussion with the relevant Clinical Director and will in turn help build up a comprehensive risk profile within specialties across both Sites and Boards.

1.2 Medical Workforce Risk Assessment

The following are the risks that are reviewed as part of the assessment:

**Training Grade Medical Workforce Risks**

- Potential reduction in trainee numbers resulting from Reshaping the Medical Workforce Programme (SGHD/NES trainee numbers)
- Difficulties in sustaining trainee rotas - this may be linked to reductions identified the risk above.
- The results from the annual GMC Trainee survey and in particular the identification of any 'red flags', which may reflect issues of training quality (GMC survey results on website)
- Gaps in trained medical workforce.
- Gaps in rotas resulting from OOP due to research, maternity leave, etc.
- Gaps resulting from recruitment difficulties, including the recruitment of LAT/LAS.
- Any other factor affecting the medical trainee workforce.

**Trained Medical Workforce risks**

- Difficulties in recruitment of trained medical workforce
- Gaps in trained medical workforce resulting from absence sickness, maternity, study leave, etc
- OOH commitments and impact upon morale/retention, etc
Staff shortages resulting in lack of capacity as evidenced by waiting times/lists, etc
- Productivity does not meet planned or benchmarked levels expected
- Demographic issues such as aging workforce or increased feminisation that are anticipated to lead to staffing issues over next 1-3 years
- Single handed specialist or skills shortage within the team
- Level of EPAs is too high/unsustainable - services would be unsustainable without individuals working a high number of EPAs
- Financial impact of additional payments i.e. to cover Waiting List payments/resident OOH working, etc
- Any other factor affecting Trained Medical workforce

Non-Medical Workforce risks

- Availability of appropriately trained staff
- Can they be trained within the required timescale
- Is there funding available to train alternative non-medical workforce
- Is the non medical workforce as productive as the medical workforce?
- Retention/turnover of non medical workforce
- Gaps in non medical workforce resulting from absence (sickness, maternity, study leave, etc)
- Any other factor affecting Non Medical workforce

1.3 Key risks identified through the assessment process

1.3.1 Reduction in trainee numbers

Whilst the majority of the areas covered to date represent ‘paused specialties’ within the national reshaping of the medical workforce a significant number of areas considered that there was still a significant risk associated with further reductions until such time as the policy is revised. This was considered to represent a very high 'red' risk within:

- Emergency Medicine on all sites
- Paediatrics at RIE-SMMP
- Obstetrics and Gynaecology at both the RIE-SMMP and St John’s
- Hospital at Night

Within all these areas there are plans in place to try and recruit and/or grow both medical and non-medical replacements, however given the recent recruitment experience these may also carry a significant element of risk.

Whilst in almost all cases there has not been a reduction in trainees a number of areas highlighted reductions in the number of trainees as there have been changes in the numbers within the different stages of training, for example there may be more trainees in core training, working in different specialties or spending more time at other locations in the SE Region to gain required experience.

This variability in trainee numbers often at very short notice can make it difficult for services such as Medicine for Elderly to plan sustainable rotas and maintain patient throughput. Further reductions in overall numbers and variability in numbers will make sustaining Hospital at Night and potentially extending it to the weekend challenging as it is reliant on trainees from a range of specialties, who may be unable to release them.
1.3.2 Loss of Service Delivery

The majority of areas rated rota sustainability as either a high or very high risk. This reflected the fact that the restrictions associated with European Working Time Regulations (EWTR) and Modernising Medical Careers (MMC) meant trainees were spending less time undertaking service delivery as a proportion of their working week. These changes in conjunction with other factors such as emerging gaps and an inability to recruit meant rota compliance was often ‘on the brink’ and were consequently often reliant on temporary bank/agency staffing.

1.3.3 Training v Service

MMC has meant that the placement of trainees is based on training requirements and trainees can be moved at short notice to gain certain training and experience. Whilst this has always been the case the loss of service delivery from trainees, as described above, means that this can make it difficult for areas to plan service delivery and ensure rotas remain compliant. There was however recognition of the importance of high quality training and pointed to positive GMC trainee survey feedback as evidence of this. Many training programmes in the South-east region are considered to be amongst the best in the UK and as such have the highest fill rates of all the Deaneries in Scotland. It is anticipated that the proposals of the Shape of Training Independent Review led by Professor David Greenway review if implemented will help in the medium term.

1.3.4 Maternity Leave, Less Than Full-time Training and Out of Programme Research

All Clinical Directors covered by the assessments to date have indicated that the significantly increasing proportion of female trainees has led to an increasing number of gaps emerging throughout the year. The levels of maternity leave can be high as experienced within paediatrics and it can be difficult/impossible to recruit a Locum Appointed for Training (LAT) or Specialty Doctor to fill gaps and as a consequence there is a growing reliance on bank or agency staffing.

Many trainees return from maternity leave on a less than full-time basis, often on a 0.6 whole time equivalent. In many instances it is very difficult to fill the remainder of the post as this would be unattractive given the low hours. Consequently many services are heavily reliant on the use of band or agency locums. There was also concern there may be a knock on impact in terms of individuals asking to opt out of out of hours cover for family reasons. There is a clear need to consider requests for less than full time training in light of the need to sustain services.

Within a number of specialties there are a significant number of trainees who undertake out of programme research such as MDs or PhDs which can take 3 years to complete. Whilst this is very positive from a training perspective, reflects the high quality of trainees and maintains the high status of the SE programmes it can leave services with gaps that can be difficult to fill.

Gaps associated with the above reasons were considered to represent a very high ‘red’ risk within the following services/specialties:
• Anaesthetics
• Medicine for the elderly/Geriatric Medicine
• Haematology
• Paediatrics – St John’s Hospital
• Obstetrics and Gynaecology
• Acute medicine

1.3.5 Trained doctor recruitment

Across Scotland the solution to many of the challenges associated with losing trainee service contribution has been to expand the trained medical workforce. This has in most cases been the consultant workforce given the relative unattractiveness of specialty doctor posts and the changes in the ability of Boards to recruit overseas doctors. The biggest concern that has emerged out of the assessments to date has been around the ability to recruit specialty doctor posts and also now consultant posts. Within Medicine for the Elderly (MOE) and Anaesthetics there are recent examples of where they have been unable to recruit to a number of posts. This is a matter of significant concern as it suggests financial investment alone will not provide the required additional capacity. As a result of the recruitment difficulties in MOE it is unable to implement a revised service model aimed at improving patient throughput.

It has become clear that NHS Lothian can no longer assume that it’s location and international standing is suffice to easily attract applicants. This has been a significant problem within Paediatrics at St John’s Hospital where gaps in out of hours cover led to a nationally supported very comprehensive international recruitment campaign, which has resulted in the appointment of 2 overseas doctors. Whilst this campaign was partially successful it was both expensive and complex. In recognition of the challenging recruitment market more concentrated recruitment campaigns have also been launched in other at risk areas such as anaesthetics.

There is little national detailed information and analysis available currently on trained doctor recruitment performance i.e. analysis of numbers of notes of interest, by country, numbers of applications, numbers of candidates interviewed and appointable, offers made and accepted, etc.

1.3.6 Work intensity

Increased work intensity was also raised by a number of areas and in particular Emergency Medicine and O&G. It was felt that the intensity of work for trained doctors was particularly intense with fewer trainees meaning more service delivery. A number of areas also highlighted that intensity within on-call periods had also increased, where in the past training grade doctors would have been more independent as they were more experienced. Feedback from trainees suggested that seeing the intensity of work within the trained workforce was making these specialties unattractive.

1.3.7 Non-medical replacement
There were a range of views in relation to whether a non-medical workforce replacement was a viable option. There were broadly three categories of response:

- Specialties/Services such as O&G where a non-medical replacement to cover registrars was not viable or appropriate.
- Other Specialties/Services felt non-medical roles were unlikely to be a direct replacement for a registrar. However there was a contribution that was being made/could be made in future towards supporting specialist areas. This was considered to be less applicable in complex clinical decision making. This was also a theme in terms of Hospital at Night where the team based approach was very successful; however the non-medical element of the workforce was not anticipated to replace registrar level doctors.
- Specialties/Services such as Critical Care where there has been significant investment in advanced critical care practitioners who operate highly effectively on the registrar rota. These staff were considered to be as productive and were well accepted by medical staff and had been trained by local clinicians.

There were also a number of smaller Specialties/Services where the number of gaps was not sufficient to provide the justification for developing a cohort of non-medical staff. It was also commented that to do so may replace one workforce supply risk with another.

All areas indicated the lead in time for such roles was up to 3 years as the academic learning also needed to be accompanied by supervised time building up experience. The costs of such roles were also noted as being a potential concern given the need for double running.

The development of advanced practice roles within a range of areas continues to increase with 51 within training in February 2014 increasing to 71 in April 2015.

1.4 Actions taken to control and reduce risk

1.4.1 Paediatrics

Gaps in middle grade registrar rotas caused by maternity leave, less than full time training and out of programme research continue to affect all paediatric and neonatal rotas in Lothian. These have been partially mitigated by recruitment of a combination of fixed term and substantive staff. These include an additional consultant and specialty doctor at St John’s in addition to two new consultants appointed in 2012, two senior Clinical Fellows and two advanced neonatal nurse practitioners in neonatology at RIE, two junior Clinical Fellows shared between RHSC and RIE, a Clinical Fellow in Paediatric Intensive Care at RHSC and the consolidation into clinical practice of two advanced nurse practitioners in the paediatric intensive care unit at RHSC. An advanced nurse practitioner in paediatric and an advanced neonatal nurse practitioner are now established in the middle grade rota at St John’s.

In order to cover out of hours commitments at St John’s an international recruitment drive was undertaken and resulted in four doctors from Myanmar being made offers of whom 2 have ultimately commenced employment. In order to fill the two gaps left two specialty doctor posts have been advertised, however there have been little or no applicants to specialty doctor posts in the last four years. One of the consultant paediatricians recruited last year will be leaving in February, recruitment is currently underway to fill this post.
All of the rotas are however more robust than they were earlier in the year.

A key medium term action that has been identified at a local and national level has been the development of advanced nurse practitioners. Five members of the nursing staff at RHSC are now enrolled on the nationally sponsored Paediatric advanced nurse paediatric course, which commenced in September, which will take between two and three years to complete depending on whether study is full or part time. These roles will not therefore support service sustainability in the short term.

The Community Child Health Service is also facing staffing shortages in coming months mostly due to sickness, retirements and difficulties in recruiting. This service provides most of the medical input in to child protection services in Lothian. This situation is particularly difficult in West Lothian. The service managed to recruit a consultant and a specialty doctor who started work in September. Two further consultant posts have been advertised. Recent interviews were held for two specialty doctors to replace retirements, however only one (0.6 WTE) appointment was made.

In recognition of the significant pressures associated with the very high level of out of programme and retiralrs within community child health in coming years across Scotland a recommendation has been accepted by the National Reshaping Medical Workforce Board to increase paediatrics training numbers nationally by 10 trainees per year. The funding in relation to such an increase has yet to be identified at a national level.

1.4.2 Emergency Medicine (EM)

It became clear in 2010 that there were going to be substantial challenges in sustaining the Emergency Medicine medical workforce as a result of the reduction in trainee doctors as part of the National Reshaping of the Medical Workforce initiative. Consequently a 3 year workforce plan was developed around the changes required within the workforce both in terms of numbers and the introduction of new roles.

A significant element within the plan was the recruitment of specialty doctors to cover the out of hours period, which had previously been covered by trainees. However only half of these posts could be filled and the response to efforts to recruit GPs to cover a gap of 100 hours per week at St John’s (that had been covered by trainees). Following the unsuccessful recruitment to Specialty Doctors and GPs a Clinical Development Fellow (CDF) role was developed which targeted individuals that had completed foundation training and wished to build up further experience before entering higher specialty training whilst working through an MSc qualification. Recruitment was successful to 6 CDF posts.

There situation resulted in a significant risk to the sustainability of out of hours services at St John’s and a group of senior clinicians and senior managers was been established to agree an action plan and contingency arrangement. Following detailed consideration of appropriate options a decision was taken to update the model of care within the Emergency Department (ED) at St John’s of which the key elements were:

- Increase in junior doctor numbers through the development of Clinical Development Fellows roles in overnight period 7/7
- Ensure ENP presence in department 24/7
- Extension of Emergency Medicine consultant presence to 2300hrs 7/7
LIowered threshold for critical care call in period 2300-0700hrs to provide additional support
• no change to the pre-existing diversion protocol that has been in place successfully with the Scottish Ambulance Service for several years

An audit of the revised model highlighted no areas of concern and the revised model of care has consequently been adopted on an on-going basis, the audit process will however continue. Whilst these moves have helped ensure short term sustainability the following measures are in place to sustain service provision in the medium term:

➢ Continued promotion of specialty and region.
➢ Commitment to further cohort CDFs for Academic Year 2014-15.
➢ Ensure Foundation Year support and development with possible review of allocation.
➢ Commitment to further EM Consultant recruitment (3 x posts) for 2014-15 to support late evening and weekend consultant presence.

1.4.3 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. The numbers of gaps varies on a month by month basis. The service has been heavily dependant upon locums to sustain Out of Hours (OOH) rotas, with currently 8-9 WTE gaps out of a minimum of 39 trainee slots locums employed across the region. This situation at RIE has deteriorated recently with an inability to find competent external locums and unanticipated sickness absence. This has resulted in increased internal locum usage and consultants covering resident middle grade OOH shifts several times a month with a consequent impact on day time availability.

In 2012 NHS Lothian funded and appointed two new consultants (RIE) and two new specialty doctor posts (St John’s) followed by a further three consultant posts at RIE in 2013 (these posts include out of hours resident shifts to compensate for loss of experienced trainees). Other recent appointments include a consultant gynaecologist at the RIE who will take up post in March 2014 and a further consultant in obstetrics and gynaecology working between St John's and RIE who will also commence in March 2014. Two further consultant posts and two further specialty doctor posts (all with resident out of hours shifts in the job plans) have also been advertised for RIE. These posts were approved in response to acute and potentially destabilising staff shortages. This is in the context of a competitive recruitment situation with widespread recruitment to new consultant posts across Scotland and the UK and not all the posts have been filled. The Scottish headcount of consultants has increased by 4.6% between March 2012 and March 2013.

In the longer term further career grade expansion will be required and in order to coordinate the Medical and Midwifery staffing a Short Life Working Group has now been set up in Women's Services, to bring together the Medical and Midwifery workforce plans and agree a coordinated plan which meets the changing needs of the service and incorporates workforce modernisation.

For the foreseeable future rotas at RIE will continue to be dependent on a mix of internal locums, external agency locums and consultants covering middle grade slots. Should
there be deterioration at the RIE then consultants would be required to cover any OOH gaps with the corresponding adverse impact upon in hours work.

A recent review of the training programme by the Deanery at the Simpson Centre for Reproductive Health Centre (SCRH) at the RIE has highlighted that whilst the quality of the training programme was high the trainees found the intensity of work very demanding. This was especially the case for consultants, which made it difficult for them to provide the required level of support for trainees. Whilst rating the training highly trainees indicated that the high level of work intensity would put them off working at the SCRH. This also highlighted that doctors in training are having to undertake a wide range of tasks such as routine phlebotomy, which should be undertaken by other members of the clinical team. This will be addressed in the integrated Maternity services workforce plan. Midwives are already being trained to undertake the Examination of the Newborn, which reduces reliance on paediatric trainees to do this and speeds up the discharge home of women and their babies. Another development which is currently being pursued is the training of Midwives to dispense discharge medication, again speeding up discharge home by reducing reliance on doctors to do this.

Given the importance of sustaining services at the SCRH for both Edinburgh and the South-East Scotland as a whole a regional short life working group has been established to examine ways in which a regional approach could be taken to expand the trained workforce across the region considering sources in addition to local CCT holders and avoiding competition between Boards for a limited group of specialists. The initial meeting of the working group took place in early October and has identified a number of options to be taken forward. Further information will be detailed in future papers.

Following a period of stability St John’s now faces two maternity leave gaps in the middle grade registrar rota from early 2014 and two gaps in the GPST cohort. Plans for the recruitment of locums to fill these gaps are under development; however previous experience shows that it is not always possible to recruit competent locums for these posts.

1.5 Regional working

Given that medical trainees are planned and managed on a regional basis there is a need to work as a region to identify problems and potential solutions. There are regional working groups for each of these high priority areas in order to try and support sustainability within each Board.

1.6 Board reporting

Since the introduction of the medical workforce risk assessment process the NHS Lothian Board has been provided with a comprehensive briefing on key areas of risk and the actions underway to manage and reduce risk levels.

1.7 Other shortage occupational groups
In the 2013 Local Delivery Plan Workforce Section detail was provided of challenges in sustaining the radiotherapy and oncology medical physics workforce in the face of increasing demand and significant demographic challenges. There has been significant work done locally and regionally around detailing these challenges and there has been a national event looking at ways of sustaining these workforces. This work is now being taken forward at a national level by the Scottish Government through by the Radiotherapy Project Group.

A national Scottish Government Small Occupational Group has been established to review areas where workforce sustainability issues have been identified; including the areas above it is also reviewing Sonography, Maxillo-facial Prothetists, Prothetists, Audiologists and Perfusionists. Given the size of these specialist areas and the difficulties in accessing appropriate training it is considered that these areas are best tackled at a national level.

2. Application of nursing and midwifery workload and workforce planning tools

2.1 Rollout Approach

The Assistant Director (Nursing Workforce & Business Support) is the nominated lead for all work around the NMWWPP project and is responsible for ensuring that each area is scheduled to complete the relevant speciality tool and Professional Judgement tool on an annual basis. Chief Nurses are responsible for delivery of this within their clinical area. Reports within the SSTS / BOXI environment will be used to evidence use of the tools.

NHS Lothian has a well established Nursing and Midwifery Workforce Group led by the Assistant Director (Nursing Workforce & Business Support). The Workforce Planning team and partnership colleagues have representation on this group. This group have a remit to co-ordinate Board wide runs of the Nursing and Midwifery Workload and Workforce Planning tools. Governance around the delivery of the CEL is via this group and the findings / evaluation of Board wide runs of the tool will be reported through professional lines and to the Joint Management Team. There is a regular update on the nurse and midwifery staffing position and the use of the national tools via a quarterly Department of Nursing update that is available to all staff via the intranet. Professional approval of all nursing and midwifery establishments rests with the Nurse Director.

A masterclass for Charge Nurses and Clinical Nurse Managers was held in 2012 to ensure that a wide group of senior nurses have a detailed understanding of the workload and workforce tools. All Senior Charge Nurses have access to the relevant workforce tools via SSTS for their roster location(s). The recent release of reporting functionality to access the data will be rolled out to the Chief Nurses and Clinical Nurse Managers to enable local analysis. In September 2013 a Board wide run of the speciality tools and professional judgement was completed for all in patient areas. Going forward Board wide runs will be scheduled across a speciality on an annual basis. Additionally all new developments and service redesign include a ratification process against the agreed Board position.

NHS Lothian has a system (MIDAS) to record a range of quality indicators. The data from this system and the feeder systems for areas not linked to MIDAS is being used as part of the triangulation process, together with financial data and the local context. Chief Nurses and Clinical Nurse Managers have been involved in agreeing Board wide principles around nursing and midwifery staffing. In addition any incidents reported relating to staffing levels
are reported on a weekly basis to the Nurse Director and Medical Director and Chief Nurses.

2.2 Application of tools

The following tools have been applied across all in-patient areas (as appropriate to the roster location) as part of the skill mix review.

- Professional Judgement (2 week run September 2013)
- Adult Acute (2 week run September 2013)
- Small Wards (2 week run September 2013)
- Mental Health/Learning Disability (2 week run September 2013)
- SCAMPS™ (being used twice daily)
- Neonatal (being used twice daily)

Additionally the following tools have been used to inform local staffing debate and/or to comply with national testing of tools.

- Maternity
- Perioperative (national run)
- Emergency Department / Emergency Medicine (national run)
- Community Nursing Workload Assessment (national run)

The following tools have not been run during 2013, it however anticipated that they will be run in 2014-15.

- Clinical Nurse Specialist
- Community Nursing Benchmarking Profile
- Community Children's and Specialist Nurse

2.3 Communication with key stakeholders

A paper taken to JMT in November 2013 detailed the initial findings of a skill mix and staffing levels review across all in patient facilities. The initial work has demonstrated that midwifery services and in patient continuing care are of the most significant risk to the organisation.

Funding has been awarded to midwifery services to increase the midwife staffing within Labour Ward by 5 wte which will enable the service to assure 1:1 care during birth on 90% of days.

The Strategic Planning Committee have agreed to take forward a review of the options for provision of in patient continuing care across Lothian.

Further work is being taken forward to determine specific areas of priority to be included in the financial plan. The analysis is taking account of the outcome of professional judgement, speciality specific nationally mandated nursing and midwifery workload and workforce tools, quality indicators and the local context, including the current financial envelope.
The output of the nursing tools provide an assessment of the workforce demand within each of the services and areas and highlights areas there may be risk. There are also other areas of potential challenge associated with workforce supply such as the ageing of the workforce and reliance on supplementary staffing. During 2014-15 the monthly Board paper around medical workforce risk assessment will be widened out to cover the areas of pressure within the workforce as a whole and set out the work being undertaken to reduce levels of risk. This is also an action set out by the Scottish Government in Everyone Matters: 2020 Workforce Vision Implementation Framework and Plan. Further detail will also be provided within the 2014/15 Workforce Plan.

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extensive consultation has been undertaken over three months with children, young people, communities and staff across the NHS, local authorities and voluntary sector. The final strategy reflects the main themes to emerge from consultation.</td>
<td>3.1</td>
</tr>
<tr>
<td>This consultation builds on a series of meetings and presentations since May 2013 to ensure that staff across NHS Lothian representing different disciplines and services had the opportunities to engage with the development of the strategy prior to consultation. It has also been discussed with local authority colleagues to ensure consistency with our integrated children’s services plans.</td>
<td>7.1</td>
</tr>
<tr>
<td>There were over 170 responses to the public consultation from adults and 315 responses from children and young people between the age of 3 and 25. Appendix 1 summarises the process of the consultation and the teams/services that helped us engage children and young people during the consultation</td>
<td>3.3 and Appendix 1</td>
</tr>
<tr>
<td>A programme of work is being led by the Nurse Director to increase capacity within the Health Visiting Service. In March 2014, CMT agreed to fund an additional 10 nurses to undertake HV training for 2014/15. A further paper will be submitted to CMT in July / August 2014 with a detailed plan of actions required to be undertaken in response to the national review of Health Visiting (and school nursing), which is taking into account the implications of the Children and Young People (Scotland) Bill</td>
<td>3.6</td>
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<tr>
<td>An implementation plan has been drafted and outlines the actions and indicators that will show progress towards the strategy’s outcomes. This is an evolving document as some developments are at an early stage and indicators have not yet been identified</td>
<td>Appendix 3</td>
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Mike Massaro-Mallinson  
Strategic Programme Manager  
20 March 2014  
mike.massaro-mallinson@nhslothian.scot.nhs.uk
1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to approve, in line with the Strategic Plan, the draft NHS Lothian Children and Young People’s Strategy.

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

2 Recommendations

2.1 Approve the draft Children and Young People’s Strategy.

2.2 Note that the draft Children and Young People’s Strategy was discussed at the meeting of the Strategic Planning Committee on 13 March and was broadly supported.

2.3 Acknowledge the extensive consultation that was undertaken over three months and that the final strategy reflects the main themes to emerge from consultation.

2.4 Note the key indicators that will enable us to demonstrate progress towards the strategy’s outcomes and that these will be further developed through the course of the year.

3 Discussion of Key Issues

3.1 A draft Children and Young People’s Strategy was approved for public consultation at the NHS Lothian Board in October 2013. The subsequent consultation ran for over three months and consisted of an online survey, presentations to multi agency and single agency stakeholder groups across Lothian and a Lothian-wide event focusing on the needs of children with a learning disability and challenging behaviours.

3.2 The Children’s Parliament was commissioned to develop a consultation tool to engage children and young people. In collaboration with NHS Lothian officers, staff from the Children’s Parliament trained 35 staff across NHS Lothian, the four local authorities and the voluntary sector to help us engage children and young people about what is important to them regarding their health and what they expect from NHS services.

3.3 There were over 170 responses to the public consultation from adults and 315 responses from children and young people between the age of 3 and 25. Appendix 1 summarises the process of the consultation and the teams/services that helped us engage children and young people during the consultation.
3.4 The strongest theme to emerge from written comments and meetings with staff/professional groups was broad support for the direction of travel proposed in the draft strategy. Over 90% of those that completed the online survey agreed with the outcomes identified in the strategy and 85% agreed that the proposed actions will help lead to the children and young people of Lothian having the best start in life.

3.5 Some concern was raised by respondents and particularly by the GP Sub Committee about the impact of the Children and Young People (Scotland) Bill and on the capacity of Health Visitors as the Named Person, as identified within the Bill.

3.6 A programme of work is being led by the Nurse Director to increase capacity within the Health Visiting Service. In March 2014, CMT agreed to fund an additional 10 nurses to undertake HV training for 2014/15. This would mean a total of 16 Health Visitors completing the programme in September 2015. A further paper will be submitted to CMT in July / August 2014 with a detailed plan of actions required to be undertaken in response to the national review of Health Visiting (and school nursing), which is taking into account the implications of the Children and Young People (Scotland) Bill.

3.7 The following table summarises the views of the 315 children and young people who fed back

<table>
<thead>
<tr>
<th>% of children and young people agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and young people should get medical care when they need it</td>
</tr>
<tr>
<td>Children and young people should have access to information to keep them healthy</td>
</tr>
<tr>
<td>Children with a disability should get the care and support they need to live a full and healthy life</td>
</tr>
<tr>
<td>Children and young people should have a say in decisions that affect their health</td>
</tr>
<tr>
<td>When NHS staff are making decisions about the healthcare of children and young people, they should have the child or young person’s best interests in mind.</td>
</tr>
<tr>
<td>NHS Lothian should work to improve the health and wellbeing of the children and young people who are most vulnerable.</td>
</tr>
<tr>
<td>NHS Lothian should improve the quality and types of healthcare services for children and young people.</td>
</tr>
<tr>
<td>NHS Lothian should have staff who are knowledgeable and skilled and who know about children’s human rights.</td>
</tr>
<tr>
<td>NHS Lothian should have a plan to check that healthcare services for children and young people are as good as they can be.</td>
</tr>
</tbody>
</table>

3.8 The attached strategy (Appendix 2) has taken into account the themes that emerged from the public consultation. There is a wealth of information, views and opinions that have been fed back by children and young people in the form of written responses and artwork. The Children’s Parliament has agreed to write up a full report and develop an exhibition using the artwork submitted, that will be launched at a Children and Young People’s Conference in September and presented to NHS Lothian Children’s Services over the autumn.
3.9 An implementation plan (appendix 3) has been drafted and outlines the actions and indicators that will show progress towards the strategy’s outcomes. This is an evolving document as some developments are at an early stage and indicators have not yet been identified. Work has been undertaken to align this plan with local Children’s Partnership’s Integrated Children’s Services Plans. This approach has been welcomed by partner agencies across the four Community Planning Partnerships.

3.10 It is important that the Children and Young People’s Health and Wellbeing Programme Board can measure and demonstrate progress towards achieving the outcomes achieved below:

- Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity
- Children with disabilities will have their additional needs met
- NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health and resilience in those more vulnerable to poor health
- Children, young people and their families will be involved in decisions that affect their health

4 Key Risks

4.1 The main risk aligned with implementing this strategy relates to the Children and Young People (Scotland) Bill and implementing the role of the Named Person. NHS Lothian has responded to the Financial Committee outlining our concerns of having to find up to £2.8 million to develop the necessary capacity within Midwifery and Health Visiting Services to implement the Bill. Agreeing to fund an additional 10 nurses to undertake Health Visitor training for 2014/15 is the initial step taken to mitigate this risk. The paper being submitted to CMT in July / August 2014 in response to the national review will provide a detailed plan of further actions to mitigate risks.

5 Risk Register

5.1 It is proposed that the shortage of Health Visitors is added to the NHS Lothian corporate risk register. The key mitigating action is increasing places at Queen Margaret University. The risk register should be reviewed in light of the outcome of the national review of health visiting and school nursing.

6 Impact on Inequality, Including Health Inequalities

6.1 A Rapid Equality Impact Assessment was carried out on 21 August 2013. The assessment recognised that addressing inequalities in health is a specific focus and outcome for the strategy, particularly noting the positive impacts of children’s rights and rolling out Children’s Rights Impact Assessments. The EIA concluded that the consultation process should specifically target children and young people with protected characteristics to gain their views.

6.2 Staff were therefore trained from the Minority Ethnic Health Improvement Service (MEHIS), LGBT Youth, CAMHS and local authorities to help us engage different
groups of children and young people. The following table outlines percentages of children with protected characteristics that responded.

<table>
<thead>
<tr>
<th>Protected characteristics</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethnic origin (other than white Scottish)</td>
<td>13%</td>
</tr>
<tr>
<td>Disabled Children and Young People</td>
<td>8%</td>
</tr>
<tr>
<td>Looked After Children</td>
<td>25%</td>
</tr>
<tr>
<td>LGBT</td>
<td>7%</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Gender</th>
<th>Male</th>
<th>Female</th>
<th>Transgender</th>
<th>Undisclosed</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>45%</td>
<td>49%</td>
<td>1%</td>
<td>5%</td>
</tr>
</tbody>
</table>

6.3 The comments made by children and young people with protected characteristics were, in the main, the same as other children and young people. The main feedback focused on the importance of being listened to and talked to directly rather than through their parents/carers. Some young people did comment on the stigma they receive from health professionals. This was particularly the case for LGBT young people and looked after children.

6.4 A second Equality Impact Assessment was undertaken on 5 March 2014 and considered the consultation responses and particularly comments made by children and young people with protected characteristics. The EIA concluded that this strategy would have a positive impact for children and young people, including those with protected characteristics.

7 Involving People

7.1 This consultation builds on a series of meetings and presentations since May 2013 to ensure that staff across NHS Lothian representing different disciplines and services had the opportunities to engage with the development of the strategy prior to consultation. It has also been discussed with local authority colleagues to ensure consistency with our integrated children’s services plans.

7.2 The strategy is a result of direct input from senior staff within Strategic Planning, Performance Reporting & Information, Public Health & Health Policy, Royal Sick Children’s Hospital Services, CH(C)Ps, Maternity Services, Health Promotion Service, Organisational Development, Finance and the RSCH Reprovision Team.

8 Resource Implications

8.1 This NHS Lothian Children and Young People’s Strategy is key to improving outcomes for children and reducing upward and future pressure on budgets for Looked After Children, Child and Adolescent Mental Health and Adult Health and Social Care / Criminal Justice Services.

8.2 The strategy outlines baseline financial information regarding the investment NHS Lothian makes in Children’s Services in Lothian. It also highlights the increased investment from 2012 that is supporting the roll out of the 27-30 month review and implementation of health assessments for all looked after children (CEL 16).

8.3 As outlined within section 4 and 5 of this report, the main resource implications aligned with implementing this strategy relates to the Children and Young People (Scotland)
Bill and implementing the role of the Named Person. NHS Lothian has responded to the Financial Committee outlining our concerns of having to find up to £2.8 million to develop the necessary capacity within Midwifery and Health Visiting Services to implement the Bill.

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20 March 2014

List of Appendices

Appendix 1: NHS Lothian Children and Young People’s Strategy: Consultation Methodology
Appendix 2: Improving the Health and Well-being of Lothian’s Children and Young People
Appendix 3: Draft Implementation Plan
NHS Lothian Children and Young People’s Strategy: Consultation Methodology

1. Background of the draft Children and Young People’s Strategy Consultation Process

The draft strategy was presented to the NHS Lothian Board in October 2013 at which the intention to consult on the draft strategy with children and young people, NHS staff, voluntary organisations and communities was stated. The aim of the consultation was to ensure that they had the opportunity to be involved in the further consideration and development of the NHS Lothian Children and Young People’s Strategy.

The draft strategy built on the previous evidence and views obtained in the engagement stage of the development of the draft strategy. This had included presentations to a series of planning groups and operational services across Lothian, including NHS staff, voluntary organisations and users of services. The plan for the consultation was discussed and agreed with the Scottish Health Council.

2. Materials to Support the Consultation with NHS staff, voluntary organisations and communities

A number of materials were prepared to support the consultation process, these included:

- The full draft strategy and a summary document were produced. The latter contained questions about the draft strategy. The summary version also contained contact details (phone, postal address, website and email) where people could obtain more information and the next steps following consultation.
- Information was placed online including the full version of the strategy and the summary document. A link to the page was placed on the NHS Lothian homepage of the website. If people wanted hard copies of any of the documents, these were posted out on request.
- The online information also contained a link to an online survey, which asked the same questions as those contained in the summary document.
- Information was highlighted during the consultation on the NHS Lothian’s Facebook and Twitter pages, where people could also give feedback.

3. Consultation with Children and Young People

To ensure that children and young people were fully engaged in the consultation, we commissioned the Children’s Parliament to help us gather the views of what children and young people think is important about their health and what they look for from health services.

The Children’s Parliament created a toolkit for staff that work with children and young people to use with their groups so that their voices could be heard. The toolkit included activities for children and young people aged 8 to 18 as an
engaging way to involve them in the consultation on the draft strategy. The activities could be delivered as a series of linked workshops or lessons over a period of days or as a one-off process.

The activities included in the pack could be used with or adapted to suit all children and young people. Staff were encouraged to adapt them to suit the age, stage and needs of children and young people they worked with. Further details on the consultation activities can be found at the following link: http://childrensparliament.org.uk/nhs-lothian-consultation.html

4. How the consultation exercise with children and young people was completed

Communication was disseminated via e-mail to staff in services that work with children and young people across Lothian inviting them to support the consultation process and to attend a workshop that would:

- Explain the purpose of the consultation
- Outline the tools that could be used with children and young people to gather their views on the strategy
- Equip staff to use the tools with children and young people
- Outline how children and young people’s views could be fed back to children and young people.

Two workshops were held in Edinburgh and in West Lothian with 35 staff that work with children and young people across NHS Lothian, the four local authorities in Lothian and the voluntary sector. Attendees were trained by NHS Lothian staff from Strategic Planning and the Health Promotion Service and staff from the Children’s Parliament. All attendees committed to engage children and young people that used their services.

5. Analysis of the Responses

315 children and young people between the ages of 3 and 25 provided responses through facilitated sessions using the Children’s Parliament Toolkit. These were through 18 children and young people’s services (Annex 1).

Responses were provided through a mixture of agree/disagree statements, comments made during discussion, cartoons and pictures. These responses have been analysed looking at the questions that were developed as part of the consultation process.

Overall the Draft Children and Young People’s Strategy was well received with overall agreement on the vision and outcomes.

The following table reflects the responses of those children that undertook the agree/disagree statements that were created around the outcomes of the strategy.
Table 1:

<table>
<thead>
<tr>
<th></th>
<th>% of children and young people agree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children and young people should get medical care when they need it</td>
<td>100%</td>
</tr>
<tr>
<td>Children and young people should have access to information to keep them healthy</td>
<td>92%</td>
</tr>
<tr>
<td>Children with a disability should get the care and support they need to live a full and healthy life</td>
<td>96%</td>
</tr>
<tr>
<td>Children and young people should have a say in decisions that affect their health</td>
<td>86%</td>
</tr>
<tr>
<td>When NHS staff are making decisions about the healthcare of children and young people, they should have the child or young person’s best interests in mind.</td>
<td>90%</td>
</tr>
<tr>
<td>NHS Lothian should work to improve the health and wellbeing of the children and young people who are most vulnerable.</td>
<td>91%</td>
</tr>
<tr>
<td>NHS Lothian should improve the quality and types of healthcare services for children and young people.</td>
<td>68%*</td>
</tr>
<tr>
<td>NHS Lothian should have staff who are knowledgeable and skilled and who know about children’s human rights.</td>
<td>89%</td>
</tr>
<tr>
<td>NHS Lothian should have a plan to check that healthcare services for children and young people are as good as they can be.</td>
<td>82%</td>
</tr>
</tbody>
</table>

*While this was the statement that least children agreed with, it was also the statement with the highest score for children neither agreeing nor disagreeing.

Through looking through the written responses, cartoons and pictures, there were 3 key themes identified in the consultation responses from children and young people. These were:

- How we engage children and young people in their care and treatment
- Recognising how children and young people feel
- Access to health Information and health services

Further details of these themes and quotes made by children and young people have now been included directly in the strategy.

What was clear from what children and young people told us is that there is a great deal of good work to build on. Many told us that they like the services they use and they like the people that provide their care. There is, however, more that we can do to ensure that we consistently include them in decisions about their healthcare; respect them for who and what they are and; acknowledge how they feel.

To fully acknowledge the contribution children and young people have made, we will launch an exhibition of the artwork at a Lothian wide children and young people’s event in September. We will then share what children and young people have told us, including the artwork and present it to Children’s Services teams within NHS Lothian. Children’s Services Quality Improvement
Teams can then consider the specific issues for their service. We will also present the report to the Children’s Partnerships across Lothian so that we can share the learning with our partner agencies.

Feedback from those staff that undertook the consultation exercise with children and young people was that it was a beneficial exercise and that they enjoyed it (both the children and the staff). To demonstrate our ongoing commitment to engaging children and young people, we will seek to undertake an annual consultation activity with children and young people and continue feeding back what they tell us to staff across NHS Lothian. This will be in addition to the large number of small consultation exercises that take place with children and young people through our services already.

6. How the Consultation Exercise with NHS staff, voluntary organisations and communities was completed

6.1 Consultation with the users, carers, voluntary organisations and communities:
- Information on the draft strategy and how to access it on the NHS Lothian website was distributed to groups with a particular interest and remit for supporting children and young people. In addition it was sent to Community Planning Partnerships who posted details on local websites and disseminated details to their local groups and services. This included schools, voluntary organisations and children and families services.

6.2 Consultation with Health and Social Care Professionals
The email containing links to the consultation summary paper, full paper and the online survey was distributed widely across health and social care professionals including: Primary Care, Children’s Services in both Hospitals and Communities, NHS Board, Strategic Planning (including Managers with responsibilities for Mental Health, Learning Disabilities, Primary Care and Cancer), Public Health and local multi-agency Children’s Planning Groups.

- The strategy and details of how to complete the consultation questionnaire was communicated at, and presented to, a series of multi-agency and single agency meetings throughout Lothian. These groups included:
  o Children’s Clinical Management Team
  o NHS Lothian Partnership Forum
  o GP Sub Committee
  o Lothian Allied Health Professions Committee
  o West Lothian Children and Families Management Group
  o East Lothian GIRFECYP Group
  o Midlothian GIRFEMC Group
  o Edinburgh Children’s Partnership
  o East and Midlothian Public Health Nurses Forum
  o Children and Young People Strategic Planning Group (SEAT)
  o Primary Care Forward Group
Maternity Services Liaison Committee  
Edinburgh Health Visitors Team Managers Meeting  
CAMHS Executive Meeting  
Community Child Health Executive Team  

This built on a series of presentations prior to the formal consultation with:  
  o Early Years Framework Group\(^1\)  
  o Clinical Area Forum  
  o Edinburgh CH(C)P Sub Committee  
  o Midlothian CH(C)P Sub Committee  
  o East Lothian CH(C)P Sub Committee  
  o West Lothian CH(C)P Sub Committee  

The deadline for the consultation responses was 17 January 2014. However there is commitment to ensuring the process of engagement continues during the implementation of the strategy.

7. Analysis of the Responses

A total of 172 online responses were submitted with an additional 9 hard copies received from individuals and groups.

A detailed report on every comment submitted within the consultation has been considered by the NHS Lothian Children and Young People Strategic Planning and Modernisation Group. As some comments related to operational delivery, these have been directed to service managers to provide a response. All responses will be documented and reviewed at the first meeting of the newly formed, Children and Young People’s Health and Wellbeing Programme Board.

Overall the Draft Children and Young People’s Strategy was well received. Of those that answered the online questions, over 90% agreed with the proposed outcomes identified within the strategy and 85% agreed with the proposed actions.

Themes identified through analysing the responses are as follows:

- The need for a robust Implementation Plan and more clarity on how we will monitor and measure the achievement of outcomes;
- Ideas on how to consult more effectively with children, young people and families;
- The need for more data and information, especially for children with learning disabilities and autism;
- Workforce/staff issues – especially around the named person role and impact of the Children and Young People (Scotland) Bill;
- How we improve communication amongst services and make sure they are more joined up

\(^1\) with representation from Partnership Forum, Strategic Planning, CH(C)Ps, Public Health, Allied Health Professionals and Health Promotions Service
These themes have all been considered with the following actions taken:

- An implementation plan has been drafted. Delivery of this plan will be overseen by the Children and Young People’s Health and Wellbeing Programme Board.

- The strategy has been updated to include how we will further engage children and young people. We will also take the learning to Children’s Partnership Groups across Lothian for further collaborative action.

- We have updated the strategy to included data from the Special Needs System. We do recognise that more data is needed. This is recognised in the Implementation Plan, where addressing the needs of children with a disability requires most development.

- A plan is currently being developed to improve capacity within the Health Visiting workforce with first steps being taken to Lothian NHS Board alongside the Children and Young People’s Strategy.

- How we ‘join-up’ services is the foundation of the integration agenda, plans for which are progressing across Lothian. The direction of travel for how we plan to integrate children’s services is also being taken to Lothian NHS Board in April 2014 alongside this strategy.

8. Evaluation and Future Work

An evaluation of the consultation process will be completed in April 2014 and will report to the Children and Young People’s Health and Wellbeing Programme Board and with subsequent dissemination to lead staff within Strategic Planning and Modernisation to share good practice.

All those who participated in the consultation will receive information on the outcome of the strategy consultation and how implementation of the strategy will be taken forward. A short newsletter will be collated outlining comments received, what we are taking forward in the Strategy and its implementation.
Annex 1
List of Services/Organisations that responded

BLES training
Bridges Project, East Lothian
Campie Primary School, East Lothian
Children's Parliament
City of Edinburgh, Children and Families - Support to children and young people residential services
East Lothian Looked after Young People Group
East Lothian Youth Council
Holy Cross After School Club, Edinburgh
LGBT Youth Scotland
Lothian Child and Adolescent Mental Health Service/Early Psychosis Support Service
MEHIS
North Edinburgh Childcare
Pirniehall Primary School
Through Care Group
Trinity & Victoria After School Club
West Lothian Youth Action Project
West Lothian Youth Congress
Women's Aid East and Midlothian
IMPROVING THE HEALTH AND WELL-BEING OF LOTHIAN’S CHILDREN AND YOUNG PEOPLE

The NHS Lothian Strategy for Children and Young People 2014 - 2020
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11. Workforce Planning: Ensuring that we have a workforce that is fit to meet the demands of a growing population
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3. Key Messages from Fair Society, Healthy Lives, Marmot Review
1. Introduction

NHS Lothian believes that every child should have the best start in life and grow up being healthy, confident and resilient.

This strategy sets out a clear vision, principles and approach for how NHS Lothian will work with children and young people, their families, the public, the voluntary sector and the four local authorities across Lothian to improve the physical and emotional health and well-being of children and young people across Lothian.

Based on an understanding of our child population and what we know from children and young people accessing services, this strategy builds on the commitments NHS Lothian has already made in the four Integrated Children’s Services Plans for East Lothian, Edinburgh, Midlothian and West Lothian. It also builds on our existing assets, especially:

- Our services – that are life saving, safe, evidence based, efficient and fast to respond when we know children and young people need help
- Our partners – including children, young people, their families, the public, the voluntary sector and the four local authorities across Lothian, all who have a wealth of knowledge, skills and expertise
- Our Staff – who are highly motivated, passionate, knowledgeable and experienced
- Our values – such as respecting our diverse child and young population, their background, culture, environment, abilities and needs.

Getting it Right For Every Child (GIRFEC), the national policy which underpins this strategy and the new Children and Young People (Scotland) Bill which incorporates the principles of the United Nations Convention on the Rights of the Child (UNCRC), has evidenced that to improve the life chances and well-being of all children and young people in Scotland, we must focus on keeping children Safe; Healthy; Achieving; Nurtured; Active; Respected; Responsible and Included (also known as the well-being indicators). We know we cannot do this alone and therefore rely on our strong working relationships with partners, children and parents to ensure children’s needs and rights are met.

We shall continue to respond to health needs when they are presented. We must also have a trained, effective workforce that has the capacity to respond to the current needs of children and young people and be ready for emerging trends.

However, if we are to seriously improve the longer term health needs of not only children, but our future adult population, then we must get better at focusing on prevention and early interventions. That means we start with reducing inequalities during pregnancy and continue to reduce inequalities throughout the lifecourse. The Early Years Change Fund, introduced by the Scottish Government in 2013, is one mechanism for helping us consider how we shift the balance of emphasis, mindset and physical resource towards prevention activities.
2. What children and young people have told us

**Outcome this section covers:**
Children, young people and their families will be involved in decisions that affect their health and wellbeing

In developing this strategy, staff across the NHS and within local authorities and the voluntary sector helped us gather the views of children and young people from across Lothian about what was important to them about the health services they use and need. We received comments from over 300 children and young people between the age of 3 and 25 in the form of photos, cartoons and completed questionnaires. The main themes identified in the responses are as follows:

### 2.1 How we engage children and young people in their care and treatment

The strongest message that came from those we consulted was the importance of how we involve children and young people. This was in relation to individual care and in relation to improving services. Many children and young people had positive experiences of how healthcare staff involved them and spoke to them about what was happening. Some however felt that staff spoke to their parents or carers rather than them directly and they didn’t like that.

One child said, “I think you should have children’s surveys too. My mum does surveys when she’s at the doctors but I have never been asked to do one.” Another young person said, “Good services ask us what we think is good.”

Suggestions to help improve how we involve children and young people included:

“*speak to us, not at us or our carers*”

“*not make decisions without us*”

“*Could probably answer some of the questions about ourselves better than mum or dad. You could ask us first then if we don’t know ask mum or dad*”

“*children and young people should be involved in deciding what should be checked when evaluating services and how they could be improved.*”

“*NHS should be thinking of ways of supporting individual young people not see them as one group*”

### 2.2 Recognising how children and young people feel

Many children and young people commented on their feelings about speaking to healthcare staff or going into hospital. Because they did not know what to
expect, they felt nervous or scared. For some, they commented on waiting long times to be seen and commented on the environment. There were many comments from children and young people about staff being nice and how that helped them feel better, e.g. “I was worried and they were nice” and, “Nurses are nice people. They look after everybody and know all about special medicines to make you feel better”

Suggestions for how we could make improvements included:

“by looking at me, listening and helping. So that I know what happens”

“all doctors and nurse should remember to tell us what is going to happen to us”

“when I go to hospital I feel a bit worried and they could do things that are kind or comforting to make me not feel bad”

“Tell me in a nice way that you will be ok”

“They could have more good books to read when you have to wait”

“Having clocks that I can read, like the ones with just the numbers and not the hands, then I would know what time it is”

Related to the above were comments made by specific groups of young people:

“for marginalised groups like asylum seekers / refugees or specific things in relation legislation or relevant health provision, the level of awareness and understanding is completely different with each service”

“As soon as you come out as LGB or T to a staff member, any issues you may be struggling with in relation to mental health are attributed to your sexual orientation and / or gender identity.”

The issue of feeling labelled also came from other children, including Looked After Children and young people with a mental health problem. One young person suggested that there would be value in educating teachers on depression so that they could have been supported earlier.

**2.3 Access to health Information and health services**

One comment from a young person summed up the views of others - “If you don’t know something then how can you be expected to make good choices and be healthy?”

Some suggestions made by children and young people included:

“You need to know stuff so that you know what to do and where to go in case something bad happens”

“Health drop ins should be open more, more places open in school holidays”
“some services should be focused on to stop illness in the future, things such as dental care / mental health before problems start”

2.4 What we will do next

What was clear from what children and young people told us is that there is a great deal of good work to build on. Many told us how that they like the services they use and they like the people that provide their care. There is, however, more that we can do to ensure that we consistently include them in decisions about their healthcare; respect them for who and what they are and; acknowledge how they feel.

To fully acknowledge the contribution children and young people have made, we will share what children and young people have told us, including the artwork and present it to Children’s Services teams within NHS Lothian. Children’s Services Quality Improvement Teams can then consider the specific issues for their service. We will also present the report to the Children’s Partnerships across Lothian so that we can share the learning with our partner agencies.

Feedback from those staff that undertook the consultation exercise with children and young people was that it was a beneficial exercise and that they enjoyed it (both the children and the staff). To demonstrate our ongoing commitment to engaging children and young people, we will seek to undertake an annual consultation activity with children and young people and continue feeding back what they tell us to staff across NHS Lothian. This will be in addition to the large number of small consultation exercises that take place with children and young people through our services already.
3. Scope of Improving the Health and Well-being of Lothian’s Children and Young People

The scope of this NHS Lothian strategy is far reaching. It has the potential to affect not only services for children and young people but all adult services that work with parents or carers. This strategy therefore aims to create a child-centred ethos within NHS Lothian alongside identifying the specific services it will provide for children and young people.

This strategy will not duplicate or rewrite existing Lothian strategies, frameworks and plans that are already in existence. It will support the delivery of the NHS Lothian Strategic Clinical Framework which prioritises prevention and reducing inequalities – the foundation of this strategy. It compliments the Refreshed Maternity Framework, A Sense of Belonging: A Joint Strategy for Improving the Mental health and Wellbeing of Lothian’s population, the 2011 – 2016 Lothian Sexual Health Strategy and the (draft) NHS Lothian Strategic Plan – Our Health, Our Care, Our Future. Improving the Health and Well-being of Lothian’s Children and Young People brings together the key components of these strategies to help articulate NHS Lothian’s overall strategic approach to improving children and young people’s health.

This strategy will focus on achieving the following outcomes, aligned with the Rights of the United Nations Convention on the Rights of the Child (UNCRC):

- Every child and young person will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity (Article 24 UNCRC)

- Disabled children and young people will have their additional needs met (Article 23 UNCRC)

- Children, young people and their families will be involved in decisions that affect their health and wellbeing (Article 12 UNCRC)

- NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services (Article 3 UNCRC)

- To improve health and resilience in those more vulnerable to poor health NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions (Article 24 UNCRC)

- The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services, and the development of services at St John’s Hospital (Articles 24 & 42 UNCRC)
• NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population of children and young people (Article 42 UNCRC)

• Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy (Articles 43 -54 UNCRC)

_improving the health and well-being of lothian’s children and young people_will focus on NHS Lothian’s contribution to achieving these outcomes and will seek continued support from our partners to make progress towards outcomes that cannot be solely achieved by NHS Lothian.

We think that the best way to explain our strategy is through a ‘life stages’ approach, in line with NHS universal service provision. We can therefore describe this as:

<table>
<thead>
<tr>
<th>Early Years</th>
<th>School age</th>
<th>Young people in transition</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternity (Conception to 1 month)</td>
<td>5 – 11 years (primary)</td>
<td>16 – 25 years, for young people that require specific services e.g. young people with a disability and young people leaving residential care</td>
</tr>
<tr>
<td>1 month – 4 years (pre-school)</td>
<td>12 – 18 years (secondary)</td>
<td></td>
</tr>
</tbody>
</table>

Explaining our strategy in this way enables us to articulate the different approaches and interventions that children may need growing up to become healthy, confident and resilient adults.

As this approach ensures that the needs of children and young people are considered from conception through to adulthood, this strategy recommends that any new strategies or frameworks being developed by NHS Lothian take into account the life stages identified above. This will also ensure that issues relating to transition from children’s to adult services will be considered.
4. Understanding the health needs of children and young people in Lothian

Outcome this section covers:
NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services.

Information available locally and nationally has been used to build up a profile of the health and well-being of children and young people in Lothian. This section provides an overall picture/snapshot whilst appendix 2 provides links to national data sources used for this section which, in some but not all cases contain information at CHP level.

4.1 Current and Future Profile of Children and Young People in Lothian

Current Population

Chart 1 shows the most recent numbers of children and young people in Lothian compared to Scotland. There are a total of 265,833 under 25s in Lothian just over 30% of the total population for Lothian. Edinburgh City has the fewest proportion of young people aged 18 and under (59%) compared to 73% in East Lothian and West Lothian. The figure for Lothian as a whole is 65 per cent slightly less than the Scotland figure (68%).
Projected Populations for 2017 and 2022

Chart 2 shows that by 2017 the population of Lothian children in the age group 5-11 will increase by 13% to 67,606. This is greater than the percentage increase in Scotland for the same age group (8%). The largest increase will be in City of Edinburgh (20%).

The ten year population projections paint a slightly different picture in Lothian particularly in the 12 – 18 age group. In contrast to the five year projection all CHPs (apart from Midlothian) and Lothian as a whole will see an increase in numbers. The largest increase will be in City of Edinburgh (11%). For Lothian as a whole the largest projected increase will be in the 5 -11 age group, an increase of 17%.
While the NRS projections for Lothian show a slight increase to 2030, the figures recorded by maternity services in Lothian show a levelling off and perhaps evidence of a slight decline.

4.2 Information About the Health and Well Being of Children and Young People in Lothian

Key Points

- The percentage of babies with a healthy birth weight in Lothian was 90.1 in year ending March 2011, above the Scottish Average (89.9%). This percentage has remained relatively stable over the last five years. In Scotland as a whole, rates of healthy birth weight are lower in the most deprived areas, however the figures are less marked in Lothian according to latest figures. Birth weight that is not within normal ranges has a strong association with poor health outcomes in infancy, childhood and across the whole life course, including long term conditions such as diabetes and coronary heart disease.

- In Lothian the most common age for starting a family in the area of lowest deprivation is 30-34, the equivalent figure is 20-24 in the area of highest deprivation.

- The teenage pregnancy rate (16 and under) in Lothian has fallen over recent years and is similar to the Scottish Average (5.6 per 1000 in NHS Lothian, 5.7, Scotland average).
• In Lothian in 2012 the overall percentage of women who reported smoking at the time of their first antenatal booking was 17.7% which is less than the Scottish average of 19.3%. It should be noted that there is known to be considerable under-reporting of smoking by pregnant women.

• Over 45% of pregnant women in Lothian are overweight or obese at time of booking. Maternal weight out with the normal boundaries is associated with complications in pregnancy for both the mother and child including an increased likelihood of stillbirth and neonatal death. Data from Lothian in 2011/12 confirms this increased risk with pregnant women who are obese approximately twice as likely to suffer a stillbirth or neonatal death.

• The prevalence of overall and exclusive breastfeeding at the 6-8 week review has remained static across both Scotland (36.5% and 26.2% respectively in 2012) and Lothian (48.7% and 34.6% respectively in 2012) over the last five years. There are a number of personal, social and cultural issues that are strongly associated with the likelihood of breastfeeding including maternal age, deprivation and smoking status. Scotland wide figures show that mothers in the least deprived areas are nearly three times as likely to exclusively breastfeed at 6-8 weeks compared with mothers in the most deprived areas. Within Lothian figures range from Edinburgh CHP which has the highest rates (58.6% overall & 41.4 exclusive) to West Lothian which has the lowest rates (33.3% overall & 23.4% exclusive).

• There are currently around 560 children aged 15 and under on the child protection register in Lothian.

• There were 2,289 looked after and accommodated children/young people (including kinship care) in Lothian in 2012.

• There are currently 58 children in Lothian who have been identified as having exceptional healthcare needs (CEN). The best estimate of the overall prevalence of CEN currently available is around 30 per 100,000 in Scotland. The figure for Lothian is very similar to the Scottish Average (34).

• NHS Lothian currently has 1,395 children with a learning disability present at last assessment on the Support Needs System (SNS).

• Around one in five births in Lothian is to a mother born outside the UK.

• NHS Lothian had 0.8% new vision concerns at 27-30 month review between April and September 2013, and 1% new hearing concerns during the same time period.

• Official UK Statistics estimate one in ten children between the ages of one and 15 has a mental health disorder. Many mental health problems
start early in life. Half of those with lifetime mental health problems first experience symptoms by the age of 14.

- In the quarter ending September 2013, 1,014 referrals were made to the Children and Adolescent Mental Health services. The referral rate per 1,000 people under 18 for Lothian was 6.8, slightly higher than the figure for Scotland (5.3).

- In Scotland the target of the national immunisation programme is for 95% of children to complete courses of the following childhood immunisations by 24 months of age: Diptheria, Pertussis, Tetanus, Polio and Hib. An additional national target of 95% uptake of one dose of the Measles, Mumps and Rubella (MMR) vaccine by five years of age (with a supplementary measure at 24 months) was introduced in 2006 to focus efforts on reducing the number of susceptible children entering primary school. Latest data published shows that in Lothian 94.8% of children are immunised against MMR, slightly lower than the Scottish Average. 97.9% of babies were immunised against Diptheria, Pertussis, Tetanus, Polio and Hib. The figure for Scotland is 98.2%.

- The levels of Primary one children who are classed as being overweight or obese using epidemiological categorisation is very similar to the Scottish average: 21.7% in Lothian compared to 21.9%. Data for 2011/12 show that Scotland wide the prevalence of unhealthy weight amongst children in Primary 1 increases with deprivation.

- Latest dental inspection figures found that 76.9% of P7 children and 69.8% of P1 children in Lothian have no obvious decay experience. These are slightly higher than the Scottish figures (72.8% & 66.3% respectively). Scotland wide figures show that there are clear inequalities in terms of dental disease looking at deprivation categories. Although all categories have shown an improvement since 2009, there is still a large difference in levels of P7 children with no obvious decay experience in the most deprived group (60.7%) and the least deprived group (81.5%).

- The age groups with the highest rates per population attending Accident and Emergency are for those aged four and under. In the year ending March 2013 29,394 children aged 4 and under attended Accident and Emergency. 17% were admitted as inpatients.

- There were 41,546 Accident & Emergency attendances in the year ending December 2013 at the Royal Hospital for Sick Children, 14% were admitted as inpatients.

- The latest SALSUS figures for substance use show, overall, that 72% of 15 year old pupils report not using any substances regularly or recently; 5% of pupils are using all three (cigarettes, alcohol and drugs) and 8% are using two types. Alcohol is the most commonly used substance on a regular basis (21% vs 13% regular smokers (usually one or more cigarettes per week) and 12% using drugs in last month).
The number of domestic abuse incidents recorded by The Police in Lothian is around 5,300 incidents per year, of which 45% of incidents were witnessed by children and young people. This figure is considered to be an underestimate and evidence shows that witnessing and/or experiencing domestic abuse represents a serious mental, physical and psychological risk to our young people.
5. Policy Context

The Scottish Government’s ambition is that Scotland should be the best place in the world for children and young people to grow up. There are a number of national policies and local strategies that we link with to help achieve this ambition and ensure that children and young people who live in Lothian will have the best possible start in life and achieve the best outcomes.

The Refreshed Maternity Framework (2011) has been designed to address all care from conception, throughout pregnancy and during the postnatal phase. This document clearly outlines the strategic direction for maternity services in Scotland and NHS Lothian is delivering on this Framework.

Similarly, the Neonatal Care in Scotland: A Quality Framework, (2013) outlines the approach required to deliver high quality care for neonates and their families across Scotland. The South East of Scotland and Tayside (SEAT) Managed Clinical Network for Neonatal Services, of which NHS Lothian is a key member, has an approved work plan that drives local delivery of this Framework.

Recognising the plethora of national policy related to children and young people, the Scottish Government published a summary of Scottish Government policy, titled Supporting Young People’s Health & Wellbeing in March 2013. This document brings together key policies from across a range of Scottish Government Directorates and helpfully provides a broad overview of the national context in which NHS Lothian operates.

This document also outlines the key themes of the Children and Young People (Scotland) Bill recent, which was passed by the Scottish Parliament in February 2014. This legislation combines proposals to improve the delivery of children’s rights and services for children and young people. It is wide-ranging in its focus, building on the foundations of Getting it Right for Every Child (GIRFEC) and has implications for NHS Lothian, particularly with the responsibilities outlined for the Named Person. We will therefore be working with our partner organisations to:

- Embed children’s rights in the design and delivery of local policies and services (as outlined within the UNCRC)
- Improve the way our services support children and families by ensuring every child and young person has a single point of contact through the role of the Named Person
- Ensure better permanence planning for Looked After Children by extending support to young people leaving care for longer, i.e. up to the age of 25
6. Our vision and principles

NHS Lothian’s vision is that **Every child should have the best start in life and grow up being healthy, confident and resilient.**

This vision will only be achieved by building on the capacities and assets of our staff working jointly with local people living and working in our communities. Achieving this vision requires collective action to:

- Focus on our relationships with children, young people and their families and our partner organisations.
- Enable local people to be part of the solution to the challenges we face
- Focus on our strengths
- Indentify ways that we make best use of our skills, knowledge and resources

The following diagram, developed by an organisation called Brighter Future Together, outlines the many assets that can be found within local communities and helps us articulate who our partners are that we will be working with to achieve our vision.
6.1 Principles of Getting It Right For Every Child (GIRFEC)

NHS Lothian has worked to ensure that the national principles and indicators of Getting it Right for Every Child (GIRFEC) are at the heart of all services working directly with children, young people, their families and carers. The following diagram, often described as the Well-being Wheel, demonstrates what NHS Lothian is committed to making a reality. We know that we cannot do this alone, which is why we are working with all our partners to implement it.
7. Meeting the health needs of children and young people in Lothian

Outcomes this section covers:

- NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those more vulnerable to poor health
- Every child and young person will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity
- Children and young people with disabilities will have their additional needs met
- Children, young people and their families will be involved in decisions that affect their health and wellbeing

From the time that a woman finds out she is pregnant, through to birth, NHS Lothian has a maternity service across Lothian that supports the family to ensure that the child comes into the world as healthy as possible. Where extra support is required, we have a flagship neonatal unit and targeted initiatives such as PrePare (for pregnant women with a drug or alcohol problem) and Family Nurse Partnership (for teenage mothers) that are held in high regard.

When a child is born through to age five, the first point of contact for support is through the Health Visiting Service with responsibility transferring to the School Nurse from the time a child starts school. Throughout this time, GPs will also play a key role when a parent identifies a health care need for their child. Appendix 1 shows the contact that all children will have with NHS Lothian services and includes specialist services for those children that have additional support needs or are more vulnerable.

Addressing the needs of vulnerable children can only be achieved where services work together. The recent inspections of children’s services in Edinburgh, Midlothian and East Lothian evidenced that NHS Lothian has strengths in protecting children and keeping them safe, however, we know that we can always do better. Where we have to focus more of our energies is in relation to increased prevention activities, helping prevent situations where children are at risk and where they are in difficult situations, have the resilience to manage them. This agenda will therefore continue to remain a priority for NHS Lothian and our local authority and voluntary sector partners within the four Integrated Children’s Services Plans.

7.1 Transforming our services - Putting children’s services at the centre of our plans

For a long time, and in common with much of the rest of the UK, we have planned the way we deliver health services separately in different parts of our system (primary care, acute care, NHS, local councils). We have also tended to plan around buildings, or around individual services. Our Health, Our Care, Our
Future, the NHS Lothian Strategic Plan 2014 – 2024 proposes a radical shift away from this 'traditional' approach to a patient-centred, whole-system approach, focusing much more explicitly on the needs of people who use NHS Lothian's services.

This plan is predicated on the need for radical redesign to deliver sustainable improvements in health and care services in Lothian. A central tenet of service redesign is to focus on the patients' journey and experience, to help identify where service improvements are necessary and to involve a wide range of service users and providers in analysing and redesigning patient pathways.

Using intelligence and evidence, we are identifying representative children with varying degrees of care needs. These children will be examples to illustrate pathways of care and to help us understand their care needs, how their care needs are currently being met and to agree how these can be met more effectively and efficiently in radically different ways.

This is being conducted through a designed and managed process of engagement during 2014 and will inform significant parts of the final plan.

To bring all this work together, an plan will be developed to support implementation of this strategy. It will include a suite of performance measures that will demonstrate NHS Lothian’s progress towards achieving our vision.
8. Addressing health inequalities

**Outcome this section covers:**

NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health or resilience in those more vulnerable to poor health.

Michael Marmot’s review of health inequalities (2010) provides the most comprehensive summary of the impact of health inequalities and approaches to reducing health inequalities.

Marmot notes that:

- people from different socioeconomic groups experience avoidable differences in health, well-being and length of life and that this is unfair and unacceptable
- these differences are strongly influenced by inequalities in experiences of daily life that are typically mediated through differences in education, occupation, income, gender, ethnicity and race
- these differences are also influenced by an overarching socio-political and cultural and social context.

Health inequalities can be observed in the distribution of many diseases and risk factors. Health inequalities have become more pronounced in the UK over the past thirty years. The difference in life expectancy at birth by socioeconomic status provides a stark and incontestable reminder of this fact. The differences by income are even further accentuated for disability free life expectancy. Similar gradients are observed for maternal smoking, breastfeeding, childhood obesity, childhood accidents and many other key risk factors and conditions.

Marmot’s report also summarises the current evidence and recommendations for tackling health inequalities in the United Kingdom. These recommendations, the culmination of decades of research, are consistent with earlier reports on health inequalities. However, what sets the Marmot report apart is the particular focus on maternal and child health (the early years), early intervention and parenting (see appendix 3 for a more detailed list of key messages).

The Marmot report also notes that “focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage” referring to this as “proportionate universalism”. This has clear relevance to discussion on universalism and targeting. The approach of offering a comprehensive programme of child health reviews and interventions (e.g. vaccination) for all children in Lothian is an example of a universal approach.
To address and reduce health inequalities requires three types of action:

- Actions to **mitigate** the health and social consequences of social inequalities.
- Actions to help individuals and communities **resist** the effects of inequality on health and wellbeing.
- Actions to **undo** the underlying inequalities in power and resources. Key areas are *employment, income and education*.

### 8.1 Current NHS Lothian approach

NHS Lothian has adopted a ‘whole system approach’ that recognises three strands to the role of health services in addressing health inequalities. The three strands of work are:

- Ensuring mainstream services are accessible to and appropriate for all groups in the population – using tools like impact assessment and equity audit
- Providing additional support and targeted services for disadvantaged groups whose needs cannot be fully met by mainstream services – for example the Homelessness and Health Team, Family Nurse Partnerships, Looked After Children’s’ Nurses and Throughcare and Aftercare Nurses
- Working with partners to address underlying causes of health inequalities

These approaches will be integral to the delivery of the Children and Young People’s Strategy.
9. Working in Partnership and Community Planning

Outcomes this section covers:

NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions to improve health and resilience in those more vulnerable to poor health.

Partnership working is a “must do” for children and young people’s services for a range of practical and financial reasons:

- Taking a holistic approach to improving children and young people’s health and reducing health inequalities is complex, with a range of different agencies involved (including health care, children and families services, voluntary sector and youth services)
- Many children and young people are vulnerable or have limited ability to negotiate complex bureaucracies. They therefore need services that are well integrated at the point of contact, are easy to negotiate and are focused on their needs
- Partnership working can help minimise bureaucracy and duplication as well as maximise integration for service users and staff
- Resources are scarce, but the task is broad. It therefore makes sense for us to work together, strategically and operationally, to make best use of the knowledge, experience and skills we have that will make sure we achieve our collective vision for children and young people

Effective partnership working is essential for children, young people and their families, who can often experience fragmented services, a lack of continuity and conflicting information in situations where local agencies fail to collaborate effectively.

There are strong examples of good partnership working between NHS Lothian and our community planning partners, as evidenced in the recent inspections of Children’s Services in Edinburgh, Midlothian and East Lothian, for example:

- A clear strategy for integrating children’s services, including strong involvement of the voluntary sector
- Meaningful involvement of children and young people to shape policies and services
- Strong partnership working and promotion of team working across services

For partnership working to happen effectively across services, it should be demonstrated through leadership. NHS Lothian is actively engaged strategically and operationally within each of the four Community Planning Partnerships (CPPs) which demonstrate that leadership across Lothian. Each CPP has a focus on early years outlined in its Single Outcome Agreement, with a children
and young people’s sub group and Children’s Integrated Services Plan driving delivery and partnership working.

All partners in the four CPPs in Lothian have signed up to the high level outcome, ‘Every child has the best start in life and is ready to succeed’. Details of how this outcome will be achieved are outlined in each of the local plans and takes into account the needs of all children, while recognising the specific needs pertaining to local communities in that CPP area. This includes the crucial role that parents play in giving children the best start in life and the additional support some parents need with bringing up their children.

Ensuring that children and young people are protected from emotional and physical harm is a priority for NHS Lothian and our local authority partners. The commitment, approach and actions to be taken are clearly outlined in the Interagency Child Protection Procedures, Edinburgh and the Lothian’s. Our commitment to keeping children safe can be demonstrated through a range of prevention activities that take place and through specialist services including a consultant delivered 24/7 service for medical examinations of children where concerns about physical abuse or neglect have been raised. Keeping children safe from harm is also an integral component of the four Integrated Children’s Services Plans that NHS Lothian helped develop and is currently helping to implement.

NHS Lothian is also committed to driving the work of the Early Years Collaborative and is heavily involved in testing new approaches across the three work streams (conception to one year, one year to three years and three years to five years), using the Plan, Do, Study, Act methodology. With a principle of ‘think big, start small, scale fast’, early years staff have been encouraged to move quickly, using the ‘tests of change’ model of improvement, record the tests they are making and measure the progress that is being made. NHS Lothian staff will continue to work with our community planning partners through the Early Years Collaborative to encourage a culture that supports innovation and using data to drive improvement.

There is also an opportunity to improve shared learning and good practice across Lothian. To this end, it is proposed that a new Lothian Children and Young People’s Programme Board be formed with representation from NHS Lothian, the four local authorities, General Practice and the voluntary sector to share good practice. Further details of the remit of this group are discussed in section 11.
10. Reprovision of the Royal Hospital for Sick Children

Outcome this section covers:

The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children and young people’s services and the development of services at St John’s Hospital.

We are committed to maintaining Edinburgh’s reputation as a world-class facility for healthcare and research. Our work to re-provide services from the Royal Hospital for Sick Children (RHSC), Child and Adolescent Mental Health Service (CAMHS) and the Department of Clinical Neurosciences on the Little France site will help us to provide children and their families with facilities and services that ensure they receive the highest possible standards of care and provide a safe, spacious, light and comforting environment which promotes recovery and meets the needs of children, young people and their carers.

The benefits of having children’s, maternity and adult services on the same site are well documented. This new building will bring the pieces of the jigsaw together to create a new centre of excellence at Little France. Having paediatric care, specialist neonatal care, adult neurosciences and children’s and adult emergency departments all on one site will ensure that teams can share experience and expertise for the benefit of children and their families as well as adult patients.
The existing RHSC provides a comprehensive range of dedicated children’s services, caring for over 100,000 children, up to the age of 13, and to age 18 in certain cases, from across Lothian and beyond. Services include accident and emergency, acute medical and surgical care, specialist surgical and medical care, haematology and oncology, neurosciences, day care, and critical care. The busy outpatients department cares for more than 34,000 patients a year. A number of regional and national services are hosted by RHSC, including the Paediatric Intensive Care Unit and the national Scoliosis service.

The hospital has been based at its current site in the centre of Edinburgh for almost 120 years. A three floor extension was added in 1995 and the vacated wards created a new Paediatric Intensive Care unit. Based on current projections, the emergency department for children and young people will expect to see around 50,000 attendances a year by 2016. The hospital is also expected to admit 9,500 inpatients, treat 8,000 day cases and see 64,000 outpatients under 18 years of age.

Plans for this project have been developed over a number of years. Specific factors driving the need for change in children’s and young people’s services and clinical neurosciences are:

- the age and limitations of the current premises
- the need to deliver sustainable specialist services whilst meeting the challenge of relatively small numbers of patients and small numbers of clinical experts
- the national policy for Paediatric Intensive Care Units in Scotland, which have been commissioned under NHS National Services since 2007, sited in two hospitals for children and young people
- the need to provide care for young people up to 16 years of age, and up to 18 in some cases, in an age appropriate facilities

Clinical benefits of integrating the services into one building, supporting the Board’s and national strategic ambitions include:

- the ability to deliver paediatric and adult neurosurgery in the same theatre suite, maximising the utilisation of specialist equipment (e.g. intra-operative MRI) and expert staff, with direct internal access to age-appropriate critical care wards
- mental health services on the same site as acute hospital services for children and young people, supporting their physical and psychological care
- joint-working and economies of scale in high-cost specialist clinical areas such as theatres and radiology
- the opportunity to improve emergency access to services by incorporating a helipad on the roof of the new build.

The Reprovision of the new facility brings about opportunities for redesign of services and work has already commenced in this area with a focus on patient pathways and models of care.

Extensive public consultation has taken place in the development of the proposals for this project utilising existing stakeholder groups and in addition,
specific stakeholder groups have been set up to ensure that patients and partner organisations have an understanding and input into the project.

The project will co-locate services currently provided at the existing Royal Hospital for Sick Children based in Sciennes, Edinburgh and CAMHS based at the Royal Edinburgh Hospital, Morningside with the adult clinical neuroscience services currently provided out of the Western General Hospital on Crewe Road South, Edinburgh, on the existing RIE site adjacent to the RIE Hospital at Little France.

Linked to the RHSC reprovision, we will also continue to look for opportunities to develop specialist outpatient services and more day surgery/programmed investigation services at St John’s Hospital, to meet the needs of the population in West Lothian by providing these services more locally, wherever possible.
11. Workforce Planning: Ensuring that we have a workforce that is fit to meet the demands of a growing population of children and young people

Outcomes this section covers:

NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population.

The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services and the development of services at St John’s Hospital.

11.1 Workforce Planning: An Overview

NHS Lothian is committed to working closely with staff, the NHS Lothian Partnership Forum and the population in aligning workforce capacity to meet the needs of children, young people and their families for today and tomorrow, across all NHS services.

In taking forward workforce planning across those services working with children and young people, NHS Lothian endorses the nationally sponsored 6 step workforce planning methodology.

Workforce planning should be developed on an integrated basis that makes clear connections with service planning and financial planning. Such plans should also be able to respond to emerging issues and developments.

11.2 Workforce Planning: Child and Maternal Health Services

NHS Lothian’s greatest asset is undoubtedly its workforce, operating across a wide range of settings in the delivery of a vast array of services, many of which are provided on a 24 hour/7 days a week basis. NHS Lothian is therefore committed to ensuring that its workforce has the right skills and is in the right place to provide the high quality, safe, effective, person centred care that children, young people and their families deserve.

The development of The NHS Lothian Strategy for Children and Young People, 2013 -2020 is therefore crucial to supporting the formulation of robust child and maternal health workforce plans that deliver for the short, medium and long term.

There are a number of significant challenges within child and maternal health services in Lothian. This section sets out some of the key issues that need to be addressed. It also highlights where a robust and integrated workforce
planning approach can ensure that we are able to provide a workforce that is fit for a leading 21st century public sector health provider.

These challenges, and NHS Lothian’s collective responses, will form part of a wider Child and Maternal Health Implementation Plan, an element of which will reflect the ongoing workforce planning activity across a range of specific service areas. This Action Plan, addressing issues outlined below, will be driven by a Workforce Planning subgroup of the Lothian Children and Young People’s Programme Board.

11.3 Key Issues

Implications of the Children & Young People (Scotland) Bill for Midwives and Health Visitors

NHS Lothian welcomes the Scottish Government’s move towards prevention and early intervention through the Named Person, as set out in the Children and Young People (Scotland) Bill. For NHS Lothian, this means that we have increased duties to promote well-being of children and be the first point of contact for providing support and responding to concerns.

The Scottish Government has estimated the additional resource implications of introducing the named person to routine Midwifery and Health Visiting Services and that this equates to over £16 million for Scotland.

Based on the number of live births (9,794) and numbers of 0-5 year old children (48,980 - 2011 census), NHS Lothian estimates that this will place additional demand for workforce resource, particularly across Maternity and Health Visiting services.

The Scottish Government is also currently leading a national review of the Health Visiting Service and will report during 2014, in response to the national shortage of trained Health Visitors.

While it is recognised that changes as a result of the Bill and the national review are not likely to come into effect until 2016, there are two main challenges facing NHS Lothian, namely:

- Funding any additional capacity recognised within the Bill; and
- The feasibility of being able to develop and/or recruit to midwifery and health visiting roles in order to make a step change within our current workforce.

Such changes will require innovative planning across a range of key stakeholders in order to meet the requirements of the Bill. This may involve elements of service re-design, options for new ways of working as well as a review of skill mix across teams. As a matter of priority, we have also committed to fund an additional 10 nurses to undertake Health Visitor training for 2014/15 with a view to reviewing training needs in response to the national review. This will be a priority action during the first year of the strategy.
11.4 Maternity Services

The opening of the Lothian Birth Centre has been an unprecedented success within NHS Lothian, with over 1,500 midwife led births during 2012-13. However, this move of low risk births out of the main labour ward has highlighted more clearly the increasingly high percentage of complex cases going through the labour ward. There has also been a corresponding increase in length of stay within the postnatal wards, despite an increase of 10 postnatal beds within the SCRH with the opening of the birth centre. This in turn impacts on patients moving through services, leading to capacity and staffing pressures at SCRH and an increasing number of times that patients are diverted to St John’s Hospital at short notice.

The service has already developed an internal improvement plan and has recently implemented the National Maternity Patient Safety Programme, which aims to reduce avoidable harm by 30% (including post partum haemorrhage), reduce stillbirth by 15%, address safety culture within the organisation and improve women’s satisfaction with care by 2015. There is centrally funded midwifery time in Simpsons and St Johns to lead the programme of work that will achieve these aims.

Maternity services have also worked closely with the National Gender Based Violence programme to ensure midwives receive training and support on the introduction of routine enquiry of domestic abuse to pregnant women. Responses and interventions following disclosure are recorded centrally and community midwives are identifying an approximate disclosure rate of 8-10%. Close working relationships with Police, Child Protection Advisers, Health Visitors and specialist voluntary sector services has resulted in improving the health, safety and well-being for those families where domestic abuse is an ongoing concern. We will continue to build on this work as a matter of priority.

Taking all this into account, there is a recognition that both workforce (medical and midwifery) and capacity needs to be reviewed now with some urgency, in order to ensure we have a safe and sustainable maternity service for women and babies. The Chief Midwife will lead this work with recommendations being identified within the first year of the strategy.

11.5 Hospital Paediatric Workforce Pressures:

We currently face significant challenges with regards to the number of Paediatric and Neonatal Consultants. Gaps in middle grade registrar rotas caused by maternity leave, less than full time training and out of programme training currently affect all paediatric and neonatal rotas in Lothian (as well as Borders and Fife). This includes the neonatal intensive care unit at the Royal Infirmary Edinburgh (RIE), the paediatric intensive care unit at the Royal Hospital for Sick Children (RHSC), general and speciality paediatric rotas at RHSC and the paediatric and neonatal service at St John’s. From August 2013 there have not been middle grade trainees allocated to the paediatric and neonatal unit at St John’s or Borders for out of hours work.
11.6 Paediatric Workforce Planning: Short, Medium and Long Term

Workforce solutions to the issues across Paediatric services in Lothian will need to be planned for the short, medium and long term. A range of measures have been implemented to build current capacity within Paediatric and Neonatology services across NHS Lothian.

In terms of planning over the medium term, NHS Lothian has reviewed the outcomes of the commissioned independent Tailored Workforce Support Team (TWST) Report, which was set up by the Scottish Government Health and Social Care Directorates, in conjunction with NHS Lothian, to look at the future sustainability of the service. A range of alternative models and workforce options to maintain the service in the medium to long term have been highlighted and are currently being considered in full.

Looking to the longer term it will be important that any workforce planning activity reflects the Scottish Government’s 20:20 vision as well as NHS Lothian’s Strategic Clinical Framework, and in accordance with NHS Lothian’s Vision and Values.

In taking forward this work it will be important to work closely with other NHS Boards given that NHS Lothian provides a number of services across the region.

11.7 Community Child Health

The Community Child Health service is a consultant led service delivering secondary and tertiary paediatric services to the children of Lothian. Acknowledged priorities are children and young people with a disability – encompassing both physical disabilities and learning difficulties – and vulnerable children - including Looked After Children and those requiring protection from harm. Specialist child protection services are delivered by Community Child Health, including interagency referral discussions with partner agencies (Police and Social Work) and medical examinations of children where concerns about neglect, physical or sexual abuse have been raised.

Currently the service is facing significant workforce pressures due to an ageing medical workforce and the associated loss of key personnel, knowledge and skills following retirement and limited responses to recruitment attempts. This is recognised as a national challenge and requires effective workforce planning, working with key stakeholders to ensure that these crucial services remain sustainable over the longer term.

11.8 Child and Adolescent Mental Health

Improving access to specialist services for children and young people with mental health services is a priority for NHS Lothian. The Scottish Government also requires the NHS in Scotland to measure the time children and young people wait for treatment, including for Child and Adolescent Mental Health Services (CAMHS). The Scottish Government has set a target for the NHS in
Scotland to deliver a waiting time target from a child’s referral to treatment for specialist CAMH services to be 18 weeks from December 2014. Work completed to date to agree a tolerance level for CAMH service waiting times has determined that the CAMH services target should be delivered for at least 90% of children.

The single Lothian-wide CAMHS provides a tiered model of care to support and treat children and young people, (and their families and networks of support) aged from 0 to 18 years old, with mental health problems and mental illness. Tier Four provision includes a 12 Bedded inpatient unit serving the population of South East Scotland, an intensive home treatment team and four intensive treatment day services.

Tier Three provision comprises fifteen community / outpatient teams which fall within the remit of the access target. Nine of these teams are geographically defined:

- North Edinburgh: General and ADHD
- South Edinburgh: General and ADHD
- West Lothian : General and ADHD
- Midlothian General and ADHD
- East Lothian General including ADHD

The remaining four teams provide specialist CAMHS to specific populations:

- Children and young people who have experienced sexual trauma and also children presenting with sexualised behaviour problems - the Meadows team
- Children and young people with learning disabilities
- Children and young people with mental health problems and physical health conditions – PPALs Team
- Edinburgh Connect – a team serving looked after and accommodated children in Edinburgh

In April 2011 the upper age range for all referrals to the service was extended to 18 years in line with the requirement of the Mental Health (Scotland) Act and with national policy guidance for specialist CAMHS. No additional resource was allocated to the service to manage the extension of service provision.

The referral rate for Lothian CAMHS continues to increase year on year, inclusive of an increase across the whole spectrum of mental health conditions. For example, children and young people with serious eating disorders including anorexia nervosa have significantly increased in the time period. In comparison with other Scottish Health Boards, NHS Lothian has one of the highest referral rates and rate of accepted referrals.

The expected prevalence of mental health problems in the child population is 10%\(^1\) so although the Lothian referral rate of 0.6%, which is higher than the

\(^1\) 10% prevalence – not all children and young people will be referred to specialist CAMHS. Part of a specialist CAMH service is to build capacity within with Universal Services to enhance their ability to work with children and young people with mental health problems
Scottish mean, this would indicate that in comparison with other Scottish Boards the thresholds are appropriate.

The service also works indirectly to support the work of those working in education, primary and third sector care to improve outcomes for children who do not meet the threshold for referral to specialist CAMHS. If evidence based intervention is offered early in a child’s life and early in the problem cycle then that minimises the impact of the mental health problem on the child’s ordinary development and life. There is evidence that early intervention also leads to reduced health spend across the life cycle.

There has been a concerted effort to improve waiting list management by CAMHS services. The Quest funded A12 team have been working with the clinical services on a number of service improvement strands including:

- Cleansing of data to ensure accurate wait times information
- Introduction of standard operating procedures for ensuring data quality and improved data completeness
- Agreement of standard operating procedures to ensure consistent and efficient management of services’ waiting lists.
- Development of a monthly CAMHS waiting times dashboard
- Planned implementation of the Remind+ telephone and text reminder system to reduce non-attendance

In addition, The Choice and Partnership Approach Model (CAPA) which is designed to improve services’ capacity and patient flow will be implemented across Lothian services.

With the Demand and Capacity activities and further planned improvements planned, the CAMHS Executive Management Team have identified the resource required to sustain current performance and ensure that the target of 90% of children and young people requiring CAMHS are seen within 18 weeks by December 2014. This is currently being considered as part of NHS Lothian’s Financial Plan prioritisation process.

Led by the Strategic Programme Manager for Mental Health and Wellbeing, the CAMHS Executive are working to ensure that there is an increased locality focus to tier three provision.

A CAMHS hub model is being developed which will ensure that there is greater alignment and closer working with key third sector partners within localities. This will offer increased opportunities for co-working, liaison and consultation in line with Getting It Right For Every Child (GIRFEC) principles. This will also take account of the planned re-provisioning of the Sick Children's Hospital which will have reduced out-patient capacity.
11.9 General Practice

In 2013, A Vision for General Practice in the Future NHS was published by the Royal College of General Practitioners. This outlines the changing landscape in which an understanding of high-quality health care is changing. It recognises the move towards a twenty-first-century system of integrated care, where clinicians work closely together in flexible teams, formed around the needs of the patient and not driven by professional convenience or historic location. It is therefore crucial that GPs are involved in the development of plans for the integration of children’s services.

Furthermore, the report states that GPs in 2022 will need expert generalist clinical skills, particularly in the context of managing children with complex medical conditions and that, “They will be able to respond to both urgent and routine needs, providing first-contact services to the majority of children…..”. It is therefore important that GPs generally have opportunities to maintain their knowledge and skills.

NHS Lothian’s Strategic Plan 2014 - 2024 outlines the need to review GP numbers and workforce support in light of the population and demographic changes. In addition, to support GP training in the management of children and young people, GPs are encouraged to access programmes such as the Lothian Fellowship Programme for paediatrics and the National Education for Scotland Paediatric Scholarships, which are particularly aimed at GPs with a special interest or wanting to take a lead in the practice.

11.10 Integration of Children’s Services

The Christie Commission report outlined the importance of integrating services to reduce the complexity and fragmentation of public sector services and have a stronger focus on improving outcomes for people. The integration of adult health and social care services, the creation of the shadow Health and Social Care Partnerships and anticipated future dissolution of the Community Health Partnerships (CH(C)Ps) in April 2015 has a consequential effect for Health Visiting and School Nursing services that are currently managed within CH(C)Ps across Lothian.

There are many opportunities brought by the integration of children’s services, building on the principles of GIRFEC and for improving the outcomes of children and their families. As we work through the practicalities of what this means for staff and the services we offer, NHS Lothian makes a firm commitment to working with staff to:

- fully involve them in decisions that affect them
- identify the opportunities integration brings
- ensure that any identified risks are mitigated
- ensure that patient safety and quality of care will be sustained or enhanced and that there is no inequity across Lothian
- explore more opportunities for interagency training and development that results in improved joint working and in improved outcomes for the children and families staff work with.
12. Finance

Children and young people are crucial to the future well-being and prosperity of Scotland. Healthier adults in the future will reduce the demand placed on NHS services.

The Scottish Government in its report “The Financial Impact of Early Years Interventions in Scotland” has indicated that investing in early years services produces the potential for savings in the short, medium and long term.

Discussions within NHS Lothian during 2012 resulted in a proportion of the additional monies that are received from the Scottish Government to reflect population changes being utilised to support Early Years. Further discussions are required locally and with the Scottish Government to identify resources that are required to implement the requirements of the Children and Young People (Scotland) Bill from 2014.

The financial baseline for this strategy will be 2012-13, recognising that the development of this strategy and NHS Lothian’s commitment to early years has begun a shift in resource, in line with the Early Years Change Fund.

Table 1: NHS spend on healthcare services for children and young people (0-17 years) 2012/13.

<table>
<thead>
<tr>
<th>Spend on Under 18s</th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Lothian Wide</th>
<th>Non-Lothian and other</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatients</td>
<td>£12,564,899</td>
<td>£3,128,096</td>
<td>£2,318,175</td>
<td>£7,009,273</td>
<td>£0</td>
<td>£15,949,753</td>
<td>£40,970,197</td>
</tr>
<tr>
<td>Day Cases</td>
<td>£2,680,065</td>
<td>£643,881</td>
<td>£467,809</td>
<td>£1,342,948</td>
<td>£0</td>
<td>£1,892,494</td>
<td>£7,027,197</td>
</tr>
<tr>
<td>Outpatients</td>
<td>£8,808,712</td>
<td>£1,997,269</td>
<td>£1,838,613</td>
<td>£3,621,171</td>
<td>£0</td>
<td>£1,235,196</td>
<td>£17,500,961</td>
</tr>
<tr>
<td>Community</td>
<td>£9,571,093</td>
<td>£2,182,610</td>
<td>£1,866,719</td>
<td>£4,002,711</td>
<td>£13,797,364</td>
<td>£203,576</td>
<td>£31,624,074</td>
</tr>
<tr>
<td>Payments to Voluntary Organisations</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£603,000</td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>£33,624,770</td>
<td>£7,951,857</td>
<td>£6,491,316</td>
<td>£15,976,103</td>
<td>£14,400,364</td>
<td>£19,281,019</td>
<td>£97,725,429</td>
</tr>
</tbody>
</table>

Table 2: NHS Additional spend on healthcare services for children and young people 2013/14

<table>
<thead>
<tr>
<th>Spend on Under 18s</th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Lothian Wide</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in population - Health Visitors</td>
<td>£135,500</td>
<td>£34,000</td>
<td>£34,000</td>
<td>£67,750</td>
<td>£271,250</td>
<td>£271,250</td>
</tr>
<tr>
<td>Implement 27-30 month review – Health Visitors</td>
<td>£162,000</td>
<td>£40,500</td>
<td>40,500</td>
<td>£81,000</td>
<td>£324,000</td>
<td>£324,000</td>
</tr>
<tr>
<td>Implement 27-30 month review – Speech &amp; Language Therapy</td>
<td>£22,000</td>
<td>£5,500</td>
<td>£5,500</td>
<td>£11,000</td>
<td>£44,000</td>
<td>£44,000</td>
</tr>
<tr>
<td>Increase in population – school nurses</td>
<td>£42,000</td>
<td>£11,500</td>
<td>£11,500</td>
<td>£21,000</td>
<td>£86,000</td>
<td>£86,000</td>
</tr>
<tr>
<td>Enteral Feeding for Children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£86,000</td>
</tr>
<tr>
<td>Implement CEL 16 – review all looked after children</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>£595,907</td>
<td>£595,907</td>
</tr>
<tr>
<td>Totals</td>
<td>£361,500</td>
<td>£91,500</td>
<td>£91,500</td>
<td>£180,570</td>
<td>£681,907</td>
<td>£1,407,157</td>
</tr>
</tbody>
</table>
13. Governance and performance improvement arrangements for overseeing implementation of this strategy

Outcome this section covers:

Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy

The implementation of this strategy will require improvements to the current process of measuring how children and young people’s healthcare services are performing. The production of good quality data and information will be necessary in order to ensure that we know that every child has the best start in life and is growing up healthy, confident and resilient.

While we are good at collating data, we need to ensure that we are collating the right data that evidences that we are achieving positive outcomes or not. We will therefore review the data we collate and ensure that it helps:

- practitioners understand more about the children they work with, either individually or at population level
- contribute to demonstrating progress towards the outcomes of this strategy and the Integrated Children’s Services Plans agreed with partners.

To oversee implementation of this Strategy, the ‘NHS Lothian Children and Young people’s Strategy and Modernisation Group’ will be replaced by the Lothian Children and Young People’s Health and Wellbeing Programme Board.

The remit of this group will be to:

- drive forward and oversee the implementation of this strategy, monitoring progress against identified indicators and outcomes
- identify and progress areas of work where there is a greater chance of improving children and young people’s outcomes by working across Lothian
- share learning across partners and geographical areas in order to improve the quality of service provision at a local and regional level
- clarify the contributions to be made by each agency towards the identified Lothian wide outcomes
- support the integration of children and young people’s services where appropriate in order to improve the pathways of care for children and young people
### Appendix 2: Links to National Data Sources

Appendix 3

Key messages from Fair Society, Healthy Lives
Marmot Review
http://www.marmotreview.org/ - this could go as an appendix?

1. Is a matter of fairness and social justice. In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.

2. There is a social gradient in health – the lower a person’s social position, the worse his or her health. Action should focus on reducing the gradient in health.

3. Health inequalities result from social inequalities. Action on health inequalities requires action across all the social determinants of health.

4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

5. Action taken to reduce health inequalities will benefit society in many ways. It will have economic benefits in reducing losses from illness associated with health inequalities. These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.

6. Economic growth is not the most important measure of our country’s success. The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.

7. Reducing health inequalities will require action on six policy objectives:
   - Give every child the best start in life
   - Enable all children young people and adults to maximise their capabilities and have control over their lives
   - Create fair employment and good work for all
   - Ensure healthy standard of living for all
   - Create and develop healthy and sustainable places and communities
   - Strengthen the role and impact of ill health prevention

8. Delivering these policy objectives will require action by central and local government, the NHS, the third and private sectors and community groups. National policies will not work without effective local delivery systems focused on health equity in all policies.

9. Effective local delivery requires effective participatory decision-making at local level. This can only happen by empowering individuals and local communities.

NHS Lothian Children and Young People’s Strategy
2014 – 2020

Improving the Health and Well-being of Lothian’s
Children and Young People

Draft Implementation Plan

1. Introduction

1.1 Between October 2013 and January 2014, we undertook a public consultation on our draft Children and Young People’s Strategy. Of those that responded to the strategy consultation, 90% agreed with the Strategy’s outcomes and 85% agreed that the actions identified within the Strategy would enable NHS Lothian to achieve our vision - that every child should have the best start in life and grow up being healthy, confident and resilient.

1.2 The outcomes of the Strategy are as follows:

(i) Every child and young person will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity;
(ii) Disabled children and young people will have their additional needs met;
(iii) Children, young people and their families will be involved in decisions that affect their health;
(iv) NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services;
(v) To improve health and resilience in those more vulnerable to poor health NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions;
(vi) The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services, and the development of services at St John’s Hospital;
(vii) NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population;
(viii) Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy.

2. How NHS Lothian will achieve these outcomes:

2.1 There are a range of proposed actions that were identified in the draft strategy to help us achieve these outcomes. Many actions were based on planned activity and we have supporting indicators that will help us...
demonstrate the progress we have to make. This is particularly the case for outcomes (i) and (v) above. Other outcomes have workstreams dedicated to ensuring that they are achieved. Examples of this would be the reprovision of the Royal Hospital for Sick Children (outcome vi) and the developing plans to increase capacity of the Health Visiting workforce (outcome vii).

2.2 We know there are actions that require much more consideration, development and planning to ensure that we get them right and ensure they achieve the desired outcome. An example of this is that local intelligence, supported by evidence of the recent Children’s Services Inspections has informed the outcome (ii) - that disabled children and young people will have their additional needs met. The actions in this plan are therefore developmental and require work to firm up specific actions that will have indicators of success attached to them.

2.3 The following section outlines how we will demonstrate that each outcome will be achieved. Where there are gaps, indicators will be developed.
**Outcome (i) Every child will have access to high quality healthcare that is accessible and appropriate to all children and their families, delivered proportionately to need and at the earliest opportunity:**

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Years</td>
<td>Proportion of stillbirths</td>
<td>15% reduction by 2015</td>
<td>See comment</td>
<td>We will continue to improve access to maternity services</td>
<td>Rate was 4.57 per 1,000 in 2011 - currently confirming baseline with SG</td>
</tr>
<tr>
<td></td>
<td>Proportion of infant mortality</td>
<td>15% reduction by 2015</td>
<td>See comment</td>
<td>We will continue the implementation of the Maternity Care Quality Improvement Programme</td>
<td>Rate was 3.98 per 1,000 in 2011- currently confirming baseline with SG</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We will increase public awareness and uptake of Healthy Start Vitamins for Pregnant Women and Infants</td>
<td>Funding has been identified through the Refreshed Maternity Framework to extend PrePare across Lothian</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We will explore with our partners the options for extending specialist services such as PrePare across Lothian</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of new born children exclusively breastfed at 6-8 weeks</td>
<td>TBD</td>
<td>33.9% at 2011/12</td>
<td>We will achieve full UNICEF Baby Friendly accreditation in maternity units at Simpsons and St Johns and across all four CH(C)Ps</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We will develop a Maternal &amp; Infant Nutrition Action Plan to support the national MIN Framework and address issues such as appropriate and timely weaning and maternal healthy weight</td>
<td></td>
</tr>
<tr>
<td>Proportion of children aged &lt;3 registered with a dentist</td>
<td>TBD</td>
<td>40.7% at September 2013</td>
<td>We will improve the dental health of children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of children known to health services with a Named Person</td>
<td>100% by 2015</td>
<td>From April 2014</td>
<td>We will ensure that all children aged 0-5 will have access to a Named Person as required by the Children and Young people (Scotland) Bill</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of uptake for all childhood vaccinations at 24 months</td>
<td>95%</td>
<td>94.8%</td>
<td>We will continue to improve uptake of immunisation for all children</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of children reaching their developmental milestones by 27-30 months</td>
<td>85% by December 2016</td>
<td>67% by October 2013</td>
<td>We will monitor the impact of introducing the 27-30 month assessment and identify interventions that ensure children meet their developmental targets</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Proportion of children offered vision screening</td>
<td>85% uptake by 2014/15</td>
<td>79% uptake during 2013/14</td>
<td>We will improve delivery of preschool orthoptic vision screening across Lothian</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**School age**

| Proportion of Primary 1 children with no obvious dental decay | TBD | 69.8% | We will improve the dental health of children |
| TBD | TBD | TBD | We will support healthy schools work in order to ensure schools are health promoting environments |

**Young People in Transition**

| Indicators outlined in report | TBD | TBD | We will take forward the recommendations of the 'Development for age appropriate cancer services for 16-24 year olds with cancer in Scotland' report (2013) |

**All life stages**

| TBD | TBD | We will implement the recommendations from the Scottish Government Children and Young People’s Palliative Care Network |
| Reduction in number of attendance at A&E | TBD | 41,546 in 2013 | We will implement the HEAT T10 Action Plan, as outlined within the Local Delivery Plan |
| Reduction in proportion of DNAs | TBD | TBD | We will reduce the number of DNAs in Children’s Services | Scoping of DNAs currently being undertaken. In some services, DNAs in excess of 20% |
Outcome (ii) Disabled children and young people will have their additional needs met

Further work is required to develop indicators for achieving these outcomes. A short-life working group will be formed to achieve this task by September 2014.

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Years (Conception – 5)</td>
<td>To be developed</td>
<td>TBD</td>
<td>No current baseline</td>
<td>We will identify ways of improving support for those children whose health needs are not at the most complex end of the spectrum, but whose families require extra support</td>
<td>New development</td>
</tr>
<tr>
<td></td>
<td>TBD</td>
<td>No current baseline</td>
<td>We will explore opportunities for improving pre birth and post birth psychological support for parents of children with exceptional healthcare needs</td>
<td>New development</td>
<td></td>
</tr>
<tr>
<td>School age (5-18 years)</td>
<td>TBD</td>
<td>No current baseline</td>
<td>We will work with our local authority and voluntary sector partners to improve services for children with autism and a learning disability.</td>
<td>Work has commenced with local authority colleagues to review the pathway of care for children with a learning disability and autism. A report on progress will be brought to CMT over the summer 2014.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TBD</td>
<td>No current baseline</td>
<td>We will improve our co-ordination with local authority and voluntary sector partners to support children with various health needs at school – e.g. catheterisation and insulin pump management.</td>
<td>Work has commenced with local authority colleagues to scope the issues and explore solutions. A report on progress will be brought to CMT over the summer 2014.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>TBD</td>
<td>No current baseline</td>
<td>We will identify ways of improving</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Young people in transition (16 – 25) | TBD | No current baseline | support for those children whose health needs are not at the most complex end of the spectrum, but whose families require extra support.

We will work with children, young people and services to develop a set of core principles for managing the transition from children’s to adult services, that services will have to apply.

We will ensure transition planning takes place early and monitor outcomes for all young people. |
Outcome (iii) Children, young people and their families will be involved in decisions that affect their health

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All life stages</td>
<td>Number of children and young people consulted per annum</td>
<td>TBD</td>
<td>315 in 2014 (via Consultation on Strategy)</td>
<td>We will improve the quality of our services through regular engagement with children, young people and their parents through an annual engagement exercise undertaken</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Numbers of staff informed of findings</td>
<td>TBD</td>
<td>0</td>
<td>We will inform staff of findings from Children and Young people Consultation</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Staff trained on UNCRC</td>
<td>TBD</td>
<td>0</td>
<td>We will raise awareness of the UNC Rights of the Child with NHS Lothian staff</td>
<td></td>
</tr>
<tr>
<td></td>
<td>All services for young people will undertake consultation or feedback on service provision with young people using their services at least once per year</td>
<td>TBD</td>
<td>TBD</td>
<td>We will build on learning from Healthy Respect and use innovative ways to engage with young people in order to make our services more accessible and responsive to need</td>
<td></td>
</tr>
</tbody>
</table>
Outcome (iv) NHS Lothian staff will have an increased understanding of the needs of the younger population and will use this understanding to inform the planning and delivery of services

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All life stages</td>
<td>Use of data/local information to inform service development</td>
<td>TBD</td>
<td>None</td>
<td>We will build on examples of good practice where information and data has been used to inform service development</td>
<td>Refer to Children's Partnership Integrated Children's Services Plans</td>
</tr>
<tr>
<td></td>
<td>Refer to Children's Partnership Integrated Children's Services Plans</td>
<td></td>
<td></td>
<td>We will improve our use of information and data to inform service planning across the four Children's Partnerships</td>
<td></td>
</tr>
</tbody>
</table>
Outcome (v) To improve health and resilience in those more vulnerable to poor health NHS Lothian and its partners will work to reduce the impact of social circumstances on health by strengthening universal provision and targeted interventions.

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Years</td>
<td>Proportion of women in each Scottish Index of Multiple Deprivation quintile booked for antenatal care by the 12th week of gestation</td>
<td>90% by March 2015</td>
<td>80.2% in 2011/12</td>
<td>We will undertake targeted interventions to focus on the 10% of women not accessing their midwife within 12 weeks</td>
<td>HEAT Target is 80% - current performance is at 89%</td>
</tr>
<tr>
<td></td>
<td>Proportion of babies small for gestational age</td>
<td>TBD</td>
<td>4.4% in 2011/12</td>
<td>We will work with our partners to help them stop smoking</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of women who are identified as smoking at antenatal booking</td>
<td>TBD</td>
<td>17.7% in 2011/12</td>
<td>We will work with our partners to provide support to pregnant women to help them stop smoking</td>
<td></td>
</tr>
<tr>
<td>School age</td>
<td>Proportion of P1 children in local authority schools that are obese, or above using clinical thresholds</td>
<td>TBD</td>
<td>5.8 in 2011/12</td>
<td>We will work with our partners to improve the healthy weight of children</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Proportion of young people that start smoking at age 13 and 15</td>
<td>TBD</td>
<td>3% at aged 13 and 13% at aged 15 (in 2011)</td>
<td>We will work with our partners in Education and youth work to reduce the number of young people that start smoking at age 13 and 15</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Number of young carers registered with Identification Card</td>
<td>500 young carers registered by September 2015</td>
<td>0</td>
<td>We will pilot the Young Carers Identification Card</td>
<td>Funding application submitted to Scottish Government</td>
</tr>
<tr>
<td>All life Stages</td>
<td>Proportion of Looked After Children and Young People are offered a health assessment within 4 weeks of referral being received by NHS Lothian</td>
<td>100% within 4 weeks June 2014</td>
<td>N/A</td>
<td>We will ensure that every looked after child receives a comprehensive health assessment which includes mental health screening</td>
<td>Previous target based on looked after and accommodated children</td>
</tr>
<tr>
<td>Proportion of children and young people receiving mental health treatment within 18 weeks</td>
<td>18 weeks referral to treatment by December 2014.</td>
<td>90% within 26 weeks at March 2013</td>
<td>We will improve access for those children and young people that need specialist mental health support and treatment.</td>
<td>TBD</td>
<td>TBD</td>
</tr>
</tbody>
</table>
Outcome (vi) The range and quality of healthcare services for children and young people will be improved through the reprovision of the Royal Hospital for Sick Children, the integration of children’s services, and the development of services at St John’s Hospital

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Life stages</td>
<td>Reprovision plans completed</td>
<td>Reprovision complete by 2017</td>
<td>N/A</td>
<td>We will improve healthcare for children and young people through reprovision of the Royal Hospital for Sick Children</td>
<td>Linked to the RHSC reprovision, we will also continue to look for opportunities to develop specialist outpatient services and more day surgery/programmed investigation services at St John’s Hospital</td>
</tr>
<tr>
<td></td>
<td>Increased proportion of clinics will be provided in the community</td>
<td>N/A</td>
<td>N/A</td>
<td>We will improve healthcare for children and young people through the development of services at St John’s Hospital</td>
<td></td>
</tr>
<tr>
<td></td>
<td>To be developed</td>
<td>To be developed</td>
<td>N/A</td>
<td>We will improve healthcare for children and young people through the integration of children’s services</td>
<td>Integration plans to be agreed by December 2014</td>
</tr>
</tbody>
</table>
Outcome (vii) NHS Lothian will have an effective and efficient workforce that is fit to meet the demands of a growing population

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Years</td>
<td>Proportion of children known to health services with a Named Person</td>
<td>100% by 2015</td>
<td>From April 2014</td>
<td>We will ensure that all children aged 0-5 will have access to a Named Person as required by the Children and Young people (Scotland) Bill</td>
<td>Action plan currently in development – needs to be reviewed against the national review of Health Visiting, due to report in April 2014.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>We will increase capacity of the Health Visiting workforce</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Increased numbers of trained Health Visitors</td>
<td>Additional 10 Health Visitors trained during 2014/15</td>
<td></td>
<td>additional 10 nurses to undertake Health Visitor training for 2014/15 with a view to reviewing training needs in response to the national review</td>
<td>As above</td>
</tr>
<tr>
<td>School Age</td>
<td>To be agreed</td>
<td>TBD</td>
<td>TBD</td>
<td>We will consider the findings from the national review of school nursing, due to report in April 2014 and develop a NHS Lothian response</td>
<td></td>
</tr>
<tr>
<td>All life stages</td>
<td>Proportion of children and young people receiving mental health treatment within 18 weeks</td>
<td>90% within 26 weeks</td>
<td></td>
<td>We will increase capacity of CAMHS to improve access for those children and young people that need help.</td>
<td>Business case currently in development</td>
</tr>
</tbody>
</table>
Outcome (viii) Robust governance and performance improvement arrangements will be in place for overseeing implementation of this strategy

<table>
<thead>
<tr>
<th>Life Stage</th>
<th>Indicator</th>
<th>Target</th>
<th>Baseline</th>
<th>What we will do</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>All life stages</td>
<td>Number of meetings per annum</td>
<td>To have first meeting by September 2014</td>
<td>N/A</td>
<td>We will form a Lothian Children and Young People’s Health and Wellbeing Programme Board</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Attendance rate per meeting</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>To be agreed</td>
<td>First report by September 2014</td>
<td>N/A</td>
<td></td>
<td>Strategic Planning will report on progress made against indicators outlined in this Implementation Plan</td>
<td></td>
</tr>
<tr>
<td>Report submitted to Board</td>
<td>First report in June 2015</td>
<td>N/A</td>
<td></td>
<td>An annual report will be submitted to relevant committees of Lothian NHS Board outlining progress towards the vision of the NHS Lothian Strategy</td>
<td></td>
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SUMMARY PAPER - INTEGRATING CHILDREN’S SERVICES IN LOTHIAN

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Full establishment of the Health and Social Care Partnerships has implications for the future management of universal Health Visiting and School Nursing Services, currently managed by CH(C)Ps</td>
<td>3.2</td>
</tr>
<tr>
<td>• Taking into account local needs, existing structures and the developing scope and scale of each Health and Social Care Partnership in Lothian, plans to integrate children’s services are evolving with relevance to each local area.</td>
<td>3.7</td>
</tr>
<tr>
<td>• There is a desire to have greater management alignment across all children’s services and joined up governance in Edinburgh. This has been taken into account when considering the future potential management and governance arrangements for all children’s health services currently being delivered in Edinburgh, including those within the Women and Children’s Directorate and Edinburgh CHP.</td>
<td>3.9</td>
</tr>
<tr>
<td>• Appendix 1 outlines the proposals to develop Integrated Children’s Services within the city of Edinburgh. This proposal will establish systems that further develop effective partnership working at a local level and deliver even better outcomes for children, young people and their families here in Edinburgh</td>
<td>Appendix 1</td>
</tr>
<tr>
<td>• This high level paper will provide the platform for an extensive consultation and engagement programme. This engagement will be taken forward in partnership with staff, the CHP partnership forum and service users as well as recognising Trade Union consultation processes where appropriate and relevant to the changes proposed</td>
<td>3.9.5</td>
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Mike Massaro-Mallinson
Strategic Programme Manager
20 March 2014
mike.massaro-mallinson@nhslothian.scot.nhs.uk
INTEGRATING CHILDREN’S SERVICES IN LOTHIAN

1 Purpose of the Report

The purpose of this report is to invite the Board to:

1.1 Agree the direction of travel for integrating children’s services across Lothian, in line with NHS Lothian’s draft Children and Young People’s Strategy;

1.2 Agree with plans to consult staff on the attached Edinburgh report between May and July 2014.

2 Recommendations

2.1 Acknowledge that full establishment of the Health and Social Care Partnerships has implications for the future management of universal Health Visiting and School Nursing Services, currently managed by CH(C)Ps

2.2 Agree to formal consultation of the Outline Proposal, between May and July 2014.

3 Discussion of Key Issues

3.1 The Christie Commission report outlined the importance of integrating public services if we wished to improve outcomes for the people of Scotland. The four Lothian Local Authorities and NHS Lothian have moved forward promptly with proposals for integration. The programme of work to deliver an integrated children’s service builds on an ethos of integrated children’s service planning in Lothian and follows on from considerable work in establishing the shadow Health and Social Care Partnerships.

3.2 The creation of shadow Health and Social Care Partnerships (Joint Integrated Boards) and anticipated future dissolution of the Community Health Partnerships (CHPs) in or beyond April 2015 has a consequential effect for the future management of universal community child health services.

3.3 An agreement on the future management and governance of these services is required for inclusion in our four Integration Schemes in December this year. The status quo is therefore not an option.

3.4 A number of high level discussions about models which would strengthen and further integrate community child health services have taken place between NHS Lothian and the four local authorities.
3.5 Taking into account local needs, existing structures and the developing scope and scale of each Health and Social Care Partnership in Lothian, plans to integrate children’s services are evolving with relevance to each local area. Plans for West Lothian, Midlothian, East Lothian and Edinburgh are as follows:

3.6 **West Lothian:**

3.6.1 West Lothian CHCP includes all life stages within its portfolio and therefore children’s services are well integrated. NHS Lothian non-Executive members, the Joint Director and West Lothian Council Elected Members agree in principle that current arrangements should continue with the new Health and Social Care Partnership having management responsibility for children’s universal health services in West Lothian. Developing plans for the Health and Social Care Partnership will therefore include proposals to include those services for children currently managed by the CHCP, i.e. health visiting and school nursing.

3.7 **Midlothian:**

3.7.1 Early discussions between NHS Lothian non-Executive members, the Joint Director and Midlothian Council Elected Members have indicated a willingness to include children’s services within the Health and Social Care Partnership. In effect, this would mean that Health Visiting and School Nursing services currently managed through the CHPs and Children and Families Services managed by Midlothian Council could be included within the remit of the Health and Social Care Partnership.

3.7.2 Further consideration still needs to be given to the opportunities to build on what works well at present. This includes the relationship with services that are managed across Midlothian and East Lothian, those with a pan-Lothian remit and transition to adult services – all with a clear focus on improving outcomes for children. Identifying what services are in scope for the Health and Social Care Partnership is a priority action with plans being agreed for October 2014.

3.8 **East Lothian:**

3.8.1 East Lothian Council and NHS Lothian have agreed that all functions currently in Adult Wellbeing and core services in the Community Health Partnership will be delegated to an Integration Joint Board from April 2015. As the legislation progresses through the Scottish Parliament and as guidance from the Scottish Government is being consulted on, it is anticipated that issues will emerge that will require decisions to clarify the content of these functions. These will include criminal justice social work services, housing support services, NHS “hosted” services and NHS acute services. Progress on all matters will be reported to the Partnership, NHS Lothian and the Council as appropriate.

3.8.2 Community Health Partnership core services include local NHS children’s services (Health Visiting and School Nursing) and universal services that include children (e.g. General Practice). Council Children’s Services are managed by the Depute Chief Executive Resources & People Services, together with Education and other corporate council services. It is recognised that there are potential advantages for service users and the Council and NHS Board in bringing Council Children’s Services together with these NHS services into the new partnership.
This has to be balanced against the potential disadvantages of managing these services separately from Education services.

3.8.3 East Lothian Council and NHS Lothian will work together to assess these issues to develop a proposal for Children’s services that will be included in the Integration Scheme with an indicative timeline. In the meantime the Community Health Partnership and the Health and Social Care Partnership will work to ensure that NHS Children’s Services provided in East Lothian are viable and effectively managed and governed.

3.9 Edinburgh:

3.9.1 There is a strong desire to strengthen the integration of children’s services through collaborative working to improve outcomes for, and the wellbeing of, children, young people and families in Edinburgh. Over the last six months discussions have taken place between Chief Executives of NHS Lothian, City of Edinburgh Council, Non-Executive members and CEC Elected Members on how best to build upon the successful partnership.

3.9.2 An effective children’s integrated planning partnership is already in place comprising officers representing the Council services for children, the full range of health services for children, police and the voluntary sector. However there is not a joined up governance arrangement and this is a particular gap and one that the Chief Executives are committed to resolving through effective alignment of service planning, joint commissioning and quality assurance.

3.9.3 There is no intention of City of Edinburgh Council to delegate Children and Families function to the emerging Health and Social Care Partnership nor is there a desire to delegate universal health service provision to the Health and Social Care Partnership. There is, however, a desire to have greater management alignment across all children’s services and a joined up governance mechanism to support these arrangements. This has been taken into account when considering the future potential management and governance arrangements for all children’s health services currently being delivered in Edinburgh, including those within the Women and Children’s Directorate and Edinburgh CHP.

3.9.4 The attached draft report outlines the proposals to develop Integrated Children’s Services within the city of Edinburgh. This proposal will establish systems that further develop effective partnership working at a local level and deliver even better outcomes for children, young people and their families here in Edinburgh.

3.9.5 This high level paper will provide the platform for an extensive consultation and engagement programme across the areas of provision within scope of an Integrated Service in Edinburgh. This engagement will be taken forward in partnership with staff, the CHP partnership forum and service users as well as recognising Trade Union consultation processes where appropriate and relevant to the changes proposed.

3.9.6 The intention is to seek agreement within City of Edinburgh Council and NHS Lothian to take forward this consultation process and to develop a more extensive business proposal (including management structures) for such an Integrated Children’s Service in the city. The final proposal would then be
included with the Edinburgh Health and Social Care Integration Plan to be submitted to Scottish Government in late 2014.

4 **Key Risks**

4.1 There are no key risks identified with the recommendations outlined in this report.

5 **Risk Register**

5.1 There are no new risks noted from this programme for NHS Lothian’s risk register.

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

6.1 As the process develops, a full Equalities Impact Assessment will be undertaken. However, the development of an Integrated Service should help us address areas of inequality more effectively and efficiently throughout Lothian.

7 **Involving People**

7.1 A consultation and engagement programme will be developed to explore the potential in this discussion document and to determine the best structures and approaches to delivering integrated services which improve outcomes.

8 **Resource Implications**

8.1 The development of Integrated Services will be managed within existing budgets. It is anticipated that efficiencies can be achieved through the development of more shared resources and business support functions.

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20 March 2014

**List of Appendices**

Appendix 1: Towards a Model of Integrated Children’s Services for Edinburgh
Vision for children services in Edinburgh

Our vision is for all children to enjoy their childhood and achieve their potential.

The positive Care Inspectorate joint inspection of services for children and young people in the City of Edinburgh in 2013 recognised the work that has been done to implement Getting it right for every child across the authority and to improve outcomes for children and families in line with the aspirations in the city’s Integrated Plan for Children and Young People.

However, we also know we can do more to do to improve the co-ordination and integration of children’s services and our proposals for Integrated Children’s Services are intended to progress this agenda and:

- improve and extend help and support at an early stage for children, young people and families so they get the help they need before difficulties get worse;
- improve planning to meet needs so that children and young people experience long-lasting improvements;
- implement more systematic and joint approaches to quality assurance and self-evaluation to improve outcomes for children and young people;
- continue to reduce outcome gaps for children and young people whose life chances are at risk and place a stronger focus on achieving speedier improvement for the most vulnerable.

This proposal for an Integrated Children’s Service in Edinburgh will establish systems that further develop effective partnership working at a local level and deliver even better outcomes for children, young people and their families here in Edinburgh.

Outcomes

The integrated Plan for Children and Young People (2012-2015) covers the range of services from universal provision to more targeted and intensive interventions and identifies six high level strategic outcomes:

1. Our children have the best start in life.
2. Our children are successful learners, confident individuals, and responsible citizens making a positive contribution to their communities.
3. Our children in need or with a disability have improved life chances.
4. Our children are physically and emotionally healthy.
5. Our children are safe from harm.
6. Our children outcomes are not undermined by poverty or inequality.

**Key Principles** We are determined to “do whatever it takes” (in terms of support, service development and service delivery) to achieve these outcomes. This means:

- Maintaining a focus on prevention and early intervention in our service planning and delivery
- Working with people to help them make the most of their own strengths and resources
- Developing services in partnership with children, families and communities so that we build on assets to develop solutions and judge their effectiveness together.
- Providing services and early interventions as soon as they are needed and for as long as they are needed with regular reviews of the effectiveness of those interventions.
- Making it easy for people to access our services as locally as possible.
- Making sure our services are joined up and working together effectively.
- Ensuring that children and families have one person that they can get, wherever possible to know over time and who will work with them to help them get the help they need.

**Proposals for the development of integrated children’s services in Edinburgh**

1. To establish a Joint Integrated Children’s Services Board within the Edinburgh Community Planning Partnership.

**Governance Arrangements – Children’s Services in Edinburgh**

This Children’s Partnership Board would include equal membership from Council and NHS alongside Police Scotland and Voluntary Sector representation and would oversee the work of the existing officer-led Children’s Partnership as well as the delivery of the following services for children in Edinburgh: Education, Social Work and NHS Lothian Community Children’s Services.
It is envisaged that the Board would initially operate on a consensual basis, similar to the former Joint Board of Governance for adult services in Edinburgh. Whilst recognising the need to develop appropriate management structures, this would ensure a holistic view of all of children’s services in Edinburgh from universal to specialist and acute services and build on the successful work of the Children’s Partnership. We would expect that the development of such a Board will also improve transition arrangements for young people moving into adult services and build on the important interface with existing adult treatment and care services in terms of better supporting families as a whole unit.

2. To strengthen management arrangements of children’s health services in Edinburgh through a Single Director of Health for Children and Young People.

The creation of the shadow Health and Social Care Partnership and anticipated future dissolution of the Community Health Partnership (CHP) in April 2015 has a consequential effect for Health Visiting and School Nursing services that are currently managed within Edinburgh CHP. It has been proposed that these services will not be managed or governed within the Edinburgh Health and Social Care Partnership. An agreement on the future management and governance of these services is therefore required for inclusion in our Health and Social Care Integration Plan. The status quo is therefore not an option. A number of high level discussions about models which would strengthen and further integrate community health services a preferred management arrangement has been proposed.

This proposal is to incorporate the CHP managed Children’s Services within the existing portfolio of the Director of Operations for the Women and Children’s Directorate, who currently manages a wide range of NHS Lothian wide and Edinburgh Community Child Health Services including Community Medical Staff, the Community Children’s Nursing Team, Children’s Outreach Service & Community Respite, Complex Care / Packages of Care and supply of NHS Community Children’s Equipment. This would bring together the management of Edinburgh’s children’s community health services under one NHS Director of Children’s Health Services. Under this arrangement all universal and specialist children’s community health services currently managed within Women and Children’s Directorate and the universal services within the CHP will be managed as a single operational unit. This structure will ensure that all elements of professional accountability, support and supervision are appropriately developed, managed and delivered.

There is the potential to include the management of Child and Adolescent Mental Health Services, Family Nurse Partnership and Allied Health Professionals. Given the significant contribution these services make to the health and wellbeing of children and young people it will be important to consider this as part of the consultation process. Should all these services be included within a single management arrangement it is envisaged that a ‘Head of Children’s Community Health Services’ will be required with clear lines of professional leadership and accountability.

The Director of Health for Children will work in partnership with the Director of Children and Families in the Council and together they will have responsibility for the delivery of children’s services in Edinburgh. This will strengthen the work of the existing Children’s Services Chief
Officers’ Group which comprises the Director of Children and Families in the Council, the NHSL Child Health Commissioner, the Police Commander and the Voluntary Sector lead from the Children and Families Network.

3. To ensure the consistent implementation of Getting it Right for Every Child for all children and families

Edinburgh already has effective arrangements in place for Getting it Right for Every Child in Edinburgh. These arrangements were commended in the recent inspection of children’s services in Edinburgh and include:

- A named midwife responsible for maternal health and continuity of care during pregnancy and until handover to the named Health Visitor around 10-14 days of a baby’s life.
- A named Health Visitor until the child enters Primary School
- A named Head Teacher for school age children.
- The development of a single assessment and single plan for a child or a family.
- That every child or family should have one person that they can get to know over time and who will work with them to help them get any extra help they need. For most children this will be a health visitor or head teacher but for some children with complex needs this will be another professional.

The integration of services will support the further embedding of these arrangements and ensure that the core elements are consistently applied in practice across the city in line with the requirements of the Children and Young People’s Bill

4. To establish neighbourhood multidisciplinary children’s services management teams across Edinburgh to ensure the oversight and delivery of integrated children services.

Multi-agency Children’s Services Management Groups (CSMGs) are already operating in 5 areas across the city. Their remit is to develop Getting it Right practice, support the development of the ‘Team around the Cluster’ model and improve interagency collaboration and the effectiveness of services at local level. Each is supported by an Area Co-ordinator. The CSMGs should comprise operational managers who have responsibility for a range of children’s services within a defined geographical area: to progress the integration agenda it will be important that the membership and remit of the CSMGs are revised and formalised and that they comprise Service Managers from the key services for children in Edinburgh e.g. education, social work, NHS Lothian Community Children’s Services, police and voluntary sector.

Their role will be to provide the necessary leadership to ensure the delivery of the vision and outcomes for children within their local area. They will ensure that the services they manage work together effectively to “do whatever it takes” to improve the outcomes and life chances of children in their area. They will have a key role in translating the principles for integrated services into reality for the children and families in their area and for maximising the opportunities for collocation and shared business services. The boundaries of each CSMG should be determined during the period of consultation in order to maximise the potential for synergy between adult and children’s service integration.
5. To extend the Total Place approach to the other school clusters across the city.

The work to date in Total Neighbourhood in East Edinburgh and the first year evaluation of Total Craigroyston both demonstrate good progress towards improving coordination with positive feedback from local people about the work which is being undertaken to “join things up”. Whilst there is much more to do to realise the potential of fully integrated local services for children and families, outcomes for children and young people have already improved markedly in a number of areas in Craigroyston:

- The number of school leavers into positive destinations is the highest level recorded.
- Educational attainment and staying on rates at Craigroyston high school have improved significantly with 100% pupils attaining 5 standard grades at level 3.
- Feedback from secondary school staff is that the attainment of S1 pupils on transfer is the best it has been for a number of years.
- Joint work between health visitors and social work is resulting in support being offered much earlier to families who need it.

Some outcomes have not yet improved, (for example school attendance levels remain a cause for concern) and there are still concerns about a number of young people involved in antisocial behaviour in the community as well as about the increased impact of substance misuse on families. Issues such as this will remain a focus for the integration agenda as we go forward. Feedback from staff and parents is largely positive with a number of important strengths identified (see annex 1 for details of feedback from Craigroyston). Parents recognised that services were prioritising their area and working more closely with the community and across different services to meet local needs. Staff across the agencies highlighted that there was a real sense of partnership and listening to feedback from local people and of working jointly to address problems. No one was under any illusion that Total Craigroyston was a panacea or that there were any easy solutions to longstanding problems. Rather there was a sense of local services working more closely together and in partnership with the community they serve to tackle problems together and learn from what was working and what was not. This in turn was having a positive impact on outcomes for children and families. This “can do”, solution focused, learning culture is key.

As part of the integration agenda it is proposed to extend the Total Place approach to the other school clusters throughout the city on a phased basis. This will involve identifying the multi-agency team (including education, community learning and development, social work, health, housing, community safety, police and voluntary sector staff) linked to each school cluster throughout Edinburgh. The role of the team will be to provide the necessary support to ensure the delivery of the vision and outcomes for children within their local area. Staff will ensure they work together effectively to “do whatever it takes” to improve the outcomes and life chances of children in their area and translate the principles for integrated services into reality for the children and families in their area. For each cluster the focus will be on:

- strengthening support for children and families from universal services;
- strengthening support for families;
- strengthening support for the community.
Highly skilled leadership is seen to be key to the success of the Total Place approach with clear responsibility delegated to an identified individual to coordinate the work of local services, ensure that services are working together effectively and in partnership with the community for the benefit of children and families.

It is therefore proposed to identify a Coordinator for each cluster team. This will be from within existing resources on the basis that these arrangements will make more effective use of the wide range of multi-agency resources already in place within each local area. Coordinators will be appointed on a phased basis informed by an assessment of need and local circumstances by the neighbourhood CSMG.

Staff and parents had feedback about how they would like to see services improve. This feedback is included at annex 1. An improvement plan is being developed to respond to this feedback and will be taken forward as part of the wider plans for developing integrated services.

6. To develop integrated city wide services for children with additional support needs /disabilities.

There are some groups of children, for example with additional support needs or a disability who require more specialist services than are routinely available at a locality level. Examples include children with complex and exceptional healthcare / additional support for learning needs, autism or mental health problems or with disabilities and severe and challenging behaviour. Work is required to ensure a coordinated multi-agency getting it right approach and to improve the consistency in the quality and availability of provision for children with a disability across Edinburgh. It is proposed to build on the successful model of case management referral groups to ensure that these children’s needs are identified and that they access support in the best way possible and to look specifically at the “team support” that would be most appropriate in a special school or home setting. Opportunities should also be explored for improving joint commissioning approaches to ensure that the planning and delivery of services is as integrated as possible, meeting the needs of children as close to home, wherever possible.

Consultation and engagement

It is proposed to engage, consult and inform staff, children and families, NHS staff partnership and Trade Unions from the respective organisations on these proposals to shape their further development in readiness for submission to the Government as part of the Edinburgh Health and Social Care Integrated Plan by December 2014.

S Egan, Associate Director and Child Health Commissioner, NHS Lothian
F Mitchell, Director of Operations, NHS Lothian
G Tee, Director, Children and Families, City of Edinburgh Council
Overall there is strong support from parents and staff about the Total Craigroyston approach.

The following strengths were identified:

- Parents recognised that services were prioritising their area and working more closely with the community and across different services to meet local needs. There was a sense of partnership and listening to feedback from local people and working jointly to address problems. Parents reported that a wide range of statutory and voluntary services were available locally.
- They highlighted the importance of being able to get support from universal services, having open access services and services which supported the whole child and the whole family. They appreciated services which worked in partnership with parents and involved them in the development of solutions. They valued having a relationship with a key individual who get to know them over time.
- They valued “Trim” the residents/ tenants group and felt this could be used more e.g. to advertise services available locally. They valued having the community shop, food coop, open cafe and activities run by local people for local people.
- They highlighted the importance of schools as providing highly valued, non stigmatising support. They valued schools which welcomed parents (fathers as well as mothers), ran breakfast clubs, after school clubs and holiday provision, led work on Rights Respecting Schools addressed issues of bullying, provided advice and support for parents including parenting programmes. They highlighted the excellent work of the home school link worker at Forthview primary school.
- They valued the range of services provided through the early years centres and would like more of these e.g. longer session times. They valued the Pilton Community Heath project.
- They appreciated services which worked in partnership with parents, took a whole family focus and were willing to “do whatever it takes” to meet the family’s needs.
- They valued the “My Child” year long course run by adult education and which was on offer for all parents and also the Health and Literacy project at Pennywell.
- They valued voluntary sector services e.g. the pregnancy cafe and Bump Start at the Haven, Circle family support service. They valued the Pilton Community Heath project.
- They valued the expertise of staff from Rowanfield Special School and its multi-agency approach.
- Staff also valued Total Craigroyston and even staff who had worked in the area for a long time said they had a better idea of the full range of services available locally. They appreciated the Support in Time meetings to coordinate support for particular children and families.

Parents and staff also had a number of suggestions for improving services
• They felt services needed to be available earlier and not just when problems had developed and the staff should listen more to parents and children when they said they had concerns about their child. They did not like having to tell their story to so many different people.
• They felt that it was difficult to get a clear picture of the range of services available in the area and that some parents may not know where to go to for help.
• They had concerns about lack of early diagnosis and help for children with Additional Support Needs and about long waiting times for some services e.g. occupational therapy, speech therapy, counselling and mental health services. Parents of children with complex needs often had lots of appointments and sometimes had difficulty accessing them e.g. children in special schools could have lots of appointment in different places.
• They thought there needed to be better support for domestic abuse and for families with parents in prison.
• They thought there should be more for young people to do in the local area (or more information about what is available for them). There is a particular problem with young people taking and driving cars causing a risk to themselves and others.
• They thought transition from primary to secondary school could be improved.
• There were difficulties with thresholds for services e.g. could the pregnancy cafe keep some families for longer if they needed it, could a midwife continue beyond 10 days?
• There is a lack of space for some activities e.g. for community groups to meet, lack of a parents room in the early years centre.
• There isn’t a good multiagency system for identifying the families which need help early on. There aren’t enough services offering direct, practical help to parents e.g. family support workers. Parents and staff felt that better use could be made of resources in the local community e.g. older people in the community who could act as “grandparents” for young families experiencing hardship.

Recommendations

1. Strengthen work in schools in relation to home school links, parent support, parenting, out of school care.
2. Increase the availability of the “My Child” programme run by adult education.
3. Provide better information for parents on the range of support available for them.
4. Look at the services available on an area basis to make it easier for parents to access support and for services to work together effectively e.g. early years centres as a point of support for under 5s, schools (with home school link workers) as a point of support for school age children, community centres providing multiagency support services e.g. health clinics, more co location of services so services work together more closely and parents know where to go to for help. The new Muirhouse centre provides an opportunity for this.
5. Improve coordination of support for individual children and families e.g. developing a child or family plan overseen by someone who has a relationship with the family over time, is able to do “whatever it takes” to support the family with services which are needs led rather than service led e.g. being able to keep with a family if they need it.
6. Increase the number of open access services which parents can go to without the need for a referral or a waiting list.
7. Increase availability of early intervention services for all children e.g. health visitors, school nurses, home school link workers.

8. Increase support for children with additional support needs and make it easier and faster to access services. In particular, increase availability of occupational therapy, speech and language therapy and mental health services. Make it easier for children to access services e.g. local clinics, school based services, text message reminders about appointments.

9. Increase availability of support for parents e.g. parenting, family support services.
Management Structure for NHS Lothian Children’s Services in Edinburgh

Annex 2

- Corporate Management Team
  - Women and Children’s Directorate Management Team
    - Community Child Health Medical Staff
    - Community Children’s Nursing Team
    - Health Visiting and School Nurse Service
    - Children’s Outreach Service & Community Respite
    - Community Midwifery
    - Royal Sick Children’s Hospital
    - Complex Care / Packages of Care
    - Supply of NHS Community Children’s Equipment
    - Child and Adolescent Mental Health Services*
  - Mix of Management arrangements*
    - Allied Health Professionals (AHPs)
    - Looked After Children’s Nurses
    - Child Protection Advisors
    - *Family Nurse Partnership Teams (FNP)
  - Corporate Nursing

*Structure reflects discussions taking place regarding the inclusion of CAMHS within the Children and Women’s Directorate

Note FNP currently line managed in Edinburgh CHP by Chief Nurse but accountability to Corporate Nursing

Children’s AHP’s are managed in three parts of the organisation with Professional Structure to the AHP Director.
1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve a new version of the Local Access Policy.

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 approve a new version of the Local Access Policy with an effective date of 1st May 2014.

3 Discussion of Key Issues

3.1 The Scottish Government expects that Boards articulate their approach regarding the management of waiting list in a local access policy. This document is attached as appendix 1 for approval.

3.2 The policy outlines the Board’s approach to waiting list management and follows guidance from Government. The previous version of the document was approved by the Board in May 2013.

3.3 If approved, the principles outlined in the document will be incorporated into the standard operating procedures (SOPs) used by staff and implemented from the beginning of May.

3.4 If this policy was to be adopted, the most significant impact upon practice would be the change in the duration required for a reasonable offer. It is proposed to move from 14 days to 7.

3.5 This move is necessary as a change is being made to national reporting. ISD, in discussion with the Scottish Government’s Health Department, is revising the manner in which management information reports on waiting time performance are compiled. To date, the monthly management information (MMI) returns have been put together by each health board, providing an overall position. This is to move to a position where ISD produces a report for the Government based on information about individual patients’ journeys held in the National Data Warehouse.

3.6 When calculating how long a patient was waited, the national data warehouse is set to 7 days as the timeframe for a reasonable offer and does not take account of any local variation that there may be. NHS Lothian asked previously that the warehouse accommodate the local decision on use of 14 days. This was unsuccessful.
3.7 As indicated in 2012 by PricewaterhouseCoopers it is necessary that figures on performance are consistently reported at all levels. Reporting differing figures to the Government and the Board would not be acceptable. This will occur unless timescales for a reasonable offer are consistent locally with those used in the National Data Warehouse. Therefore moving to use 7 days locally addresses this governance issue.

3.8 NHS Lothian is the only board not to use 7 days currently.

3.9 The 7 day rule determines the amount of advance notice that routine patients must receive advance of an appointment. In practice it also determines the amount of time a patient has to indicate that an offer made is not suitable.

3.10 If a patient responds to the first offer of a date within 7 days, then a second date would be proposed without any adjustment. If a patient takes longer than 7 days to indicate that the date offered was not appropriate then the patient’s waiting time clock would be reset.

3.11 In light of the discussions last year, board members will be familiar with the arguments for and against the use of 7 days. Contact with members of patient groups, MSPs and the local GP subcommittee over the move to 7 days have reiterated these points. Themes are consistent with those identified in the equality impact assessment undertaken locally.

3.12 Points highlighted included that the shorter timescale can be challenge for those with additional needs. It was suggested that those patients who are also carers may require longer to make arrangements and it may take longer for those who have difficulty with English or of low literacy to seek help to understand a letter. It was felt that there may be delays with the post or patients may have difficulty getting in touch with departments to indicate a date is not suitable.

3.13 Many of the actions to address these points are already underway. However additional steps have also been identified.

3.14 Board members will be aware that in December 2013 Audit Scotland highlighted the work currently underway locally to improve communication with those with additional needs. This will enable correspondence to be tailored to patients’ requirements – for example letters in large print or a language other than English. The support to progress this work is currently being reassessed to ensure that it is sufficient so that it can be put in place shortly.

3.15 Communication on waiting times is also a theme being considered by a Short Life Working Group established by the Scottish Government. The output from this work, as well as an introduction of further letter functionality on Trak, will be taken into account in a review of patient communications on waiting times. The Director of Communications and Public Affairs has agreed to assist in this work, with advice sought from patient groups.

3.16 While a move to seven days reduces the timeframe for a response, providing more notice is preferable to both patients and services. Significant booking of capacity used for routine patients starts from as far as a month in advance. Reports are being introduced so that these timescales can monitored and steps taken to improve the notice given to patients. It is recognised that although patients will already be aware that they are waiting for an appointment and may made arrangements in anticipation, the further in advance these arrangements are confirmed, the better.
3.17 Reporting is established to monitor response times and levels of demand on particular telephone numbers. This can highlight where patients may face difficulty getting in touch. The potential for these reports to cover all appropriate numbers is being pursued.

4 Key Risks

4.1 Not addressing the inconsistency between the local timescale for a reasonable offer and that specified in national guidance and used in National Data Warehouse will create a governance issue, with differing levels of performance reported to the Board and to the Government. The proposals included in the Local Access Policy address this.

4.2 To mitigate the potential adverse impact from moving to 7 days, impacting particularly on communication, a number of steps are proposed above.

5 Risk Register

5.1 The risks to achievement of waiting times standards is already included in the corporate risk register.

5.2 The actions highlighted above are to be incorporated into that entry.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment was carried out in March.

6.2 The main findings and actions taken to mitigate them are outlined in the main body of this paper.

7 Involving People

7.1 Opinions, particularly focusing on the move from 14 to 7 days, were sought from members of staff, members of patients groups and the GP subcommittee.

7.2 This issue was also discussed with local MSPs on the 7th March.

8 Resource Implications

8.1 There are no additional resource implications from approval of this policy.

Andrew Jackson
Strategic Planning
21 March 2014
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List of Appendices

Appendix 1: Local Access Policy
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1. Introduction

NHS Lothian is committed to delivering high quality, effective, patient-centred care for all its patients in line with national guidance and standards.

The NHS Scotland National Access Policy was developed to provide a common vision, direction and understanding of how Boards should ensure equitable, safe, clinically effective and efficient access to services for their patients.

This NHS Lothian Local Access Policy details how the principles set out in the National Access Policy apply to NHS Lothian services.

The principles and responsibilities in this policy will help ensure that systems are in place to optimise the use of facilities and available capacity in order to deliver high quality, safe patient care in a timely manner.

2. Background

NHS Scotland’s Efficiency and Productivity Programme Delivery Framework (June 2009) set out a commitment to achieve evidence based clinical practice by improving consistency of care, reducing variation and creating the right culture and organisational conditions required to support transformational change.

It is essential that NHS Scotland uses resources in a cost effective way. It is recognised that a culture of continual service redesign and improvement is necessary to achieve transformational change. The need to improve consistency of care and reduce variation across NHS Scotland is part of an explicit ongoing commitment to evidence based clinical practice.

NHS Lothian’s Local Access Policy aims to ensure consistency of approach in providing access to services and, as such, it supports the following publications:

- The Patient Rights’ (Scotland) Act 2011
- The Patient Rights’ (Treatment Time Guarantee) (Scotland) Regulations 2012
- The Patient Rights’ (Treatment Time Guarantee) (Scotland) Directions 2012
- Patient Rights’ (Scotland) Act 2011 Treatment Time Guarantee Guidance
- NHS Scotland Waiting Time Guidance
- Effective Patient Booking for NHS Scotland
- Armed Forces CEL 8 (2008); Armed Forces CEL 3 (2009); Armed Forces CEL 39 (2010)
- Adult Exceptional Aesthetic Referral Protocol CEL 27 (2011)
- The Mental Health (Care and Treatment) (Scotland) Act 2003

This policy is supported by a set of Waiting List Management Standard Operating Procedures (SOPs) that ensure a consistent approach to the management of referrals and waiting lists.
3. **Waiting Times Standards**

NHS Lothian is required to ensure that there is equitable and sustainable delivery of waiting time standards, with systems in place to ensure sufficient capacity is available and there is optimal use of this capacity to deliver waiting times targets. This will involve working collaboratively with other healthcare providers and will ensure patients receive the most appropriate treatment with the shortest wait.

4. **Key Principles of the NHS Lothian Local Access Policy**

4.1 **Key Principles**

There are a number of key principles that underpin the achievement of the aims of the NHS Lothian Local Access Policy and delivery of waiting time standards.

- The patients’ interests and their responsibility to participate in an effective and efficient access process are paramount.
- Patients are offered care according to clinical priority and within agreed waiting time standards.
- Sufficient capacity should be available and optimally utilised to deliver waiting times.
- Referrals are managed effectively through electronic triage where available
- Variations in referral patterns are identified, discussed and reduced where appropriate.
- Waiting lists are managed effectively using electronic systems
- Patients will be referred to a clinical team and will be seen by an appropriate member of that team rather than a named consultant.
- Patients should not be referred or added to a waiting list if they are not available for treatment due to medical reasons.
- Staff have been appropriately trained in the application of the Waiting List Management SOPs and the Patient Administration Systems in place.

NHS Lothian aims to:
- Maximise the use of resources, including staff time
- Reduce non-attendance
- Ensure the provision of short-stay surgery is maximised
- Reduce avoidable follow up appointments
- Use information to facilitate improvement in service provision
- Ensure partnership working with stakeholders in primary, secondary and social care.
- Achieve inclusive and equal access for all service users
- Ensure patients are not disadvantaged if there is a reasonable explanation why they were unable to respond to an offer within 7 days
4.2 The Treatment Time Guarantee (TTG):

- Once a patient has been diagnosed as requiring inpatient or day case treatment and has agreed to that treatment, that patient's treatment must start within 12 weeks of the treatment having been agreed (12 Week Treatment Time Guarantee).

- In most cases a diagnostic test will not fall under the definition of a ‘treatment’ in the Act, and as such the treatment time guarantee will not apply to such a test.

- However, in a small number of cases it may be clinically appropriate to undertake the diagnostic procedure and the treatment at the same time. In such a case this would be covered by the treatment time guarantee, although in fact this would record a zero days wait as agreement to treat would be the same day as the treatment was undertaken.

- Treatments in an outpatient setting are not covered by the treatment time guarantee.

- The exceptions to the TTG are listed below:
  - assisted reproduction
  - obstetrics services
  - organ, tissue or cell transplantation whether from living or deceased donor
  - designated national specialist services for surgical intervention of spinal scoliosis
  - the treatment of injuries, deformities or disease of the spine by an injection or surgical intervention (exclusion until 1st April 2014)

4.3 Reasonable Offers of Appointment

- Patients will receive an offer of appointment at least 7 days before the date of the appointment or admission.

- Routinely a reasonable offer of appointment is the offer of two or more different dates of appointment for each stage of the patient's treatment pathway, with a minimum of seven days notice from the date the appointment offer is made to the date of the appointment.

- If a patient refuses the opportunity to be seen by an external provider and they cannot be seen in NHS Lothian within their guarantee date then ‘choice of location/consultant’ unavailability will be applied.

- Offers of appointment will be made either by telephone, by letter or in person depending on the clinical service. Clear guidelines for booking processes are included in the SOPs.

- A reasonable offer will constitute an offer of treatment in any NHS Lothian hospital or any location within 97 minutes travel time of its headquarters, Waverley Gate in central Edinburgh. This will be considered reasonable for non-paediatric care as long as a patient’s additional needs are taken into account. This travel boundary is shown in the map detailed below.

- In light of the limited number of other locations, offers at any location in the UK will be considered reasonable for paediatric care.
- Where a patient is treated outside of the NHS Lothian Board area, NHS Lothian will be responsible for any transport and accommodation ‘costs reasonably incurred’ by the patient and their carer (if necessary).

- If a patient refuses two or more reasonable offers the patient’s waiting time clock will be reset and they may be returned to their referrer (normally their GP) if clinically appropriate to do so. This will be balanced against any issues relating to child protection or vulnerable adults.

Map showing NHS and Private Hospitals
Within a 97 Minute* Drive Time of Waverley Gate
4.4 Unavailability

- Unavailability can be applied under two categories; medical unavailability and patient advised unavailability:
  - Medical unavailability indicates that a patient has another medical condition that prevents them continuing with treatment for a period of time.
  - Patient advised unavailability indicates that the patient has advised they are unavailable for a period of time.
- Patient advised unavailability may also be applied if the patient has requested a specific location or consultant and it is not possible to accommodate this choice within the current relevant waiting time standard.
- All instances of unavailability will be clearly documented on the appropriate electronic hospital system.
- Each period of unavailability should be no longer than 12 weeks without review.

4.5 Cancellation & Did Not Attend

- If the patient has accepted a reasonable offer of appointment but then informs NHS Lothian that they can not attend (CNA) an appointment, the waiting time clock will be reset to zero, where it is reasonable and clinically appropriate to do so and a further reasonable offer will be made within their waiting time guarantee.
- If a patient cancels an accepted offer for a third time then clinical advice will be sought to decide if a further offer should be made. If not, the patient will be removed from the waiting list and returned to their referrer.
- If a patient does not attend (DNA) an agreed appointment and has not informed NHS Lothian of this in advance, then the patient’s waiting time clock will be reset to zero, if clinically and reasonable appropriate to do so. Clinical advice will then be sought to decide if a further appointment should be offered to the patient. If not, the patient will be removed from the waiting list and returned to their referrer.
- If a patient contacts NHS Lothian within 7 days of this missed appointment they may be reinstated on the waiting list. If more than 7 days has passed then the patient should be referred again by their GP.
- If a clinic is running late and patient is unable to wait to be seen then their waiting time clock may be reset depending on the length of the delay and individual circumstances.

4.6 Patient Waiting Time Correspondence

- All patient correspondence will clearly highlight how patients can contact NHS Lothian if they are unable to keep an appointment or require any further information.
- Appointment letters will include details of the consequences of non-attendance and that the patient has a responsibility to attend a previously agreed appointment.
• Patient information will also provide details of the NHS Lothian Customer Relations and Feedback Team in case the clinical department is unable to resolve any issues that may arise.

• Patients will be made aware of how long they are likely to be in the department for their appointment/admission.

• The Patient Rights’ Act requires NHS Lothian to ensure that patients receive appropriate written correspondence on the following:
  - How their waiting time is calculated
  - What constitutes a reasonable offer
  - Implications of not attending an agreed appointment (DNA)
  - Implications of cancelling an agreed appointment (CNA)
  - Implications of refusing two or more different dates of appointment (a reasonable offer)
  - Implications of being unavailable
  - How to give feedback
  - How to complain

Patients will also be advised in writing if:
  - They are eligible for TTG
  - They have periods of unavailability applied
  - They are returned to GP (GP letter also to be issued)
  - NHS Lothian is unable to meet the TTG

5. Responsibilities under the NHS Lothian Local Access Policy

This policy details the responsibilities that will ensure equity and a consistency in approach to access to services within NHS Lothian.

The four key responsibilities under the NHS Lothian’s Local Access Policy are:

1. To communicate effectively with patients.
2. To manage referrals effectively.
3. To manage waiting lists effectively.
4. To use information to support improvements in service provision.

5.1 To communicate effectively with patients

There is a need to ensure that patients are appropriately informed at all stages of the patient journey. Communicating effectively with patients will help to inform them of when, where and how they are to receive care and their responsibilities in helping to ensure that this happens.

NHS Lothian will ensure that:

• Patients are provided with clear, accurate and timely information about how processes will operate for arranging for them to be seen or to be admitted to hospital.
- Patients are given clear instructions on how and when to contact the hospital to either accept or decline an appointment and admission date, and the timeframe in which to do this.

- Patients are given clear information on the consequences of not responding quickly to hospital communications, and the impact this could have on their waiting time.

- Communications with patients should be in a format appropriate to their additional support needs e.g. large print, community language.

- Clear processes and procedures are in place so that patients can inform the Board of any changes in their details and/or their ability to attend their appointment.

- If treatment occurs outside of the NHS Lothian area, or if clinics are held infrequently, patients are made aware of any reasons for this and that this is made clear as early in the process as possible.

- Patients are made aware that they must inform the hospital of any changes to their details, e.g. name, address, postcode, telephone number or GP as soon as possible.

- GPs are aware of their obligation to advise patients of their own responsibilities in the waiting times pathway. To this end, patients will be made aware that they are required to attend their agreed appointment and where the appointment is not required, or they are unable to attend, they should inform the hospital at the earliest available opportunity.

- Patients are made aware of their responsibility to inform their GP and the hospital if their medical condition improves and no longer requires an appointment or deteriorates in a way which may affect their attendance.

- Patients are made aware that they need to advise when they will not be available to attend or be admitted to hospital for any periods of time (e.g. holiday or work commitments). If circumstances change after the referral is made they must inform the hospital at the first opportunity.

- Patients/Carers are made aware of their responsibility to inform NHS Lothian of any additional needs they may have so these can be taken into account when making offers of appointments and the forms of communication used.

- Where patients do not attend for appointments the primary care team will have arrangements in place to check with the patient if referral is still needed prior to re-referral.
5.2 To manage referrals effectively

Improvements in waiting times should be delivered through an effective partnership between Primary and Secondary Care, with appropriate protocols and documentation in place.

5.2.1 Referrer

- Prior to referral, the clinician should explain to the patient the range of options to be considered. It should be explained that patients may not need to access specialist or consultant-led services.

- The referring clinician should advise patients of why they are being referred, the expected waiting time and outline to patients their responsibilities for keeping appointments and the consequences of not attending.

- The referring clinician should advise patients that they may be offered an appointment/treatment in any of NHS Lothian’s hospitals or any of the locations previously detailed in section 4.3. If a patient does not accept a reasonable offer of appointment or admission, this may have implications for the time they have to wait and may result in patients being returned to their GP’s care.

- Where treatment cannot be provided locally and the patient needs to travel elsewhere, the patient should be made aware of that as early as possible.

- The referring clinician should ensure that the Patient Rights Act is highlighted to the patient. The referring clinician should also ensure that the patient is aware of the 12 week Referral to Treatment Guarantee, should Inpatient or Day case treatment be required.

- The referring clinician should ensure that the patient is available to commence treatment. When the referrer is aware that the patient will be unavailable for a period of time, the referrer should either delay sending the referral until they know the patient is available or clearly note the patient’s unavailability period on the referral form/letter.

- Referrals should be made electronically and as per local protocols.

- GPs should make referrals to a clinical service and not a named consultant.

- Wherever possible patients should be referred directly for Diagnostics tests if applicable and available.

- Referrers must check that they are providing accurate, timely and complete information within their referral including:
  - CHI identifier (unless they don’t have one)
  - Full demographic details including:
    - Name
    - Address
    - Ethnicity
- Postcode
- Up to date mobile and home telephone numbers
- E-mail address
- Preferred method of contacting patient i.e. letter, phone or e-mail
- Patient's unavailability period if applicable
- Patient's ability to attend an appointment at short notice
- Armed forces/veteran status if applicable
- Additional Support Needs e.g. visual impairment, hearing impairment etc
- An indicator of 'vulnerability' if applicable
- Category e.g. routine, urgent, suspicion of cancer, veterans or other priority groups
- Patients referred with suspected cancer must be marked as ‘URGENT-SUSPICION OF CANCER’.

5.2.2 Receiving Clinical Site

The Acute Division will ensure that:

- There is a structured and transparent approach to the management of referrals, scheduling and booking for all patients detailed within the Waiting List Management SOPs.
- Referrals are triaged electronically where possible.
- The date of receipt of all referrals is recorded.
- Systems and procedures are in place to triage and prioritise referrals in accordance with referral category (e.g. URGENT).
- All urgent cancer patients are seen as soon as possible within cancer waiting time standards.
- Armed Forces personnel, veterans and their families who move between areas retain their relative point on the pathway of care within the national waiting time targets. Refer to Access to NHS Care for Armed Forces Personnel CEL 8 (2008) and CEL 3 (2009).
- Special exemptions that exist for Armed Forces veterans enable them to receive priority treatment if the condition is directly attributable to injuries sustained during the war periods are followed. Refer to HDL 2006 16 – Priority Treatment for War Pensioners and to Access to Health Services for Armed Forces Veterans – Extension to Priority Treatment CEL 8 (2008).
- Patients are booked as close to the date of receipt of referral as reasonably possible and within the national stage of treatment targets.

5.2.3 Receiving Clinician

- It is the receiving clinician’s responsibility to communicate with the referrer to offer advice on whether a referral is suitable.
- Any referrals received for a service that is not delivered in the NHS Lothian Board area will be returned to the original referrer with advice. Where it is judged that the referral would be more appropriately managed by another service provided by NHS Lothian, the referral will be passed to that service and the referrer informed.

- Receiving clinicians and managers must ensure that waiting lists properly reflect their clinical priorities and are managed effectively.

5.2.4 Patient Transfer

- The transfer of any part of a patient’s health care to other Health Board areas or to the independent sector must always be with the consent of the patient. The transferring consultant will be involved in this decision.

- If the receiving Health Board or Independent Sector provider is included in the list of ‘reasonable’ locations identified in section 4.3 and the patient does not wish to be transferred, a period of unavailability may be applied to reflect the patient choice of location/consultant as detailed in section 4.4.

- Appropriate documentation and information will be provided to the receiving Health Board (or Independent Sector provider where appropriate).

- Patients from the Independent Sector opting to transfer to NHS treatment must be referred back to their GP to discuss their options and, if appropriate, referred to NHS Lothian. The 18 Week RTT will then commence on receipt of the referral by NHS Lothian.

5.3 To manage waiting lists effectively

To support delivery of waiting times standards NHS Lothian is required to manage waiting lists effectively. This includes triaging of referrals, management of both new and return patients and accurate recording of clinic outcomes.

NHS Lothian will ensure that:

- Systems, processes and resources are in place to make sure that all staff are adequately trained to use local systems to help manage access to services.

- All new referrals are triaged electronically, where possible, with all new appointments having a corresponding waiting list entry.

- Patients are seen within maximum standard waiting times and booked in turn, according to clinical priority.

- Details of patients on the waiting list who are admitted as emergency admissions are communicated to waiting list management.

- Patients are only added to a waiting list if they are available to commence treatment.
Systems and procedures are in place to make sure waiting list managers are aware of any patient cancelled on the day of, or after, admission, the reason for cancellation and any period of unavailability that may need to be applied.

Systems and procedures are developed to review and validate waiting lists to ensure accuracy and that national and local access times are achieved.

A Directory of Services is maintained.

Patients will only receive a return appointment if there is a clinical need.

Systems and procedures are in place to monitor and manage the number of return appointments.

All patients, or as appropriate their parent/guardian or carer, undergoing a procedure have indicated in writing that they consent to treatment.

Effective communication is in place to notify the referring clinician on the decisions made for their patients e.g. treatment to be provided, treatment delayed because medically unavailable, treatment not required.

Systems and procedures are in place to communicate, manage and record all outcomes at clinics, additions or alterations to the waiting list electronically.

Arrangements in place to identify which condition should take precedence if a patient requires treatment for different conditions and is on two or more separate pathways.

Clinic templates are regularly reviewed to ensure they reflect changing needs.

Onward referrals are completed to make sure the receiving healthcare provider has the necessary information to manage the patient treatment pathway. Any transfer of data will comply with NHS standards in relation to data security and confidentiality.

5.4 To use information to support improvements in service provision

The ability to effectively monitor and manage services requires good quality data. This helps to inform performance and identify areas for future improvement.

The factors which influence waiting times, such as changes in referral patterns, will be regularly monitored and management action will be taken in sufficient time to ensure waiting time standards are maintained.

New to return and DNA ratios will be regularly reviewed and steps will be taken to address any issues as necessary.

Efficiency and productivity will be effectively monitored and any necessary change will be supported where required.

Benchmarking information will be used wherever possible in reviewing clinic templates and efficiency.
6 Conclusion

By following the key principles set out in this Local Access Policy and defining responsibilities under those principles, NHS Lothian will ensure equity of service and reduce variation.

NHS Lothian will use the Local Access Policy in conjunction with other relevant National and Board Guidance and best practice documentation. NHS Lothian will ensure that their local procedures reflect the principles laid out in this Local Access Policy.
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.

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<th>Summary</th>
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<td>3.1.1 &amp; Graph 4</td>
<td>Patients continue to wait longer than the 4 week and 2 week target for delayed discharges. Actions to address this situation are set out in the Unscheduled Care report of January 2014.</td>
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<td>3.1.2 &amp; Graphs 6-8</td>
<td>The latest release of HSMR shows that for all three acute sites are below the Scottish average although only the Royal Infirmary of Edinburgh is statistically significant</td>
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<td>3.1.3 &amp; Graphs 10-11</td>
<td>The HEAT target for reduction in C.Difficile and Staph. aureus bacteraemias (SAB) has not been achieved. Actions to address this are set out in the HAI paper on the Board agenda.</td>
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<td>3.1.4 &amp; Graph 12</td>
<td>The Cardiac Arrest numbers have increased in recent months. This is due to an increase in numbers of arrests at the RIE and WGH sites. St. John’s is sustaining a significant drop in arrest calls with a 59% reduction by implementing a change package based on work undertaken by Salford NHS Foundation Trust which focuses on reliable identification, response and escalation of deteriorating patients at a ward level. A collaborative approach using the same change package will be initiated in May at the WGH and RIE sites focusing on acute receiving units and downstream medical wards where there is a greater incidence of arrest.</td>
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<td>3.1.6 &amp; Graph 14</td>
<td>The local target set to reduce pressure ulcers to zero by March 2014 was aspirational in nature and work being undertaken has increased awareness and reporting. The actions to reduce pressure ulcers and improve management were supported by Healthcare Governance in January 2014.</td>
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<td>3.1.7 &amp; Graphs 17-19</td>
<td>Compliance with stroke targets for timely admission to stroke unit and swallow screen remain challenging. Actions to address this current situation are set out in the Unscheduled Care report of January 2014.</td>
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<tr>
<td>3.1.8</td>
<td>Patient Experience and the management of Deteriorating Patients are areas identified by the Board as requiring a self assessment against the Lanarkshire Recommendations which is due to report in June 2014.</td>
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Simon Mackenzie
Medical Director Quality Improvement
19 March 2014
Simon.Mackenzie@nhslothian.scot.nhs.uk
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for March 2014, 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

3.1.1 Patients who are ready for discharge continue to wait longer than 2 weeks (target to be achieved by April 2015) with a number of patients waiting over 4 weeks (Graph 4). NHS Lothian is not meeting the A&E 4 Hour Waiting Times target (Graph 15). Actions to address this current situation will be set out in the Unscheduled Care Report for the April Board.

3.1.2 The Dashboard includes the latest release of HSMR which are calculated quarterly and this ISD release includes information up to the quarter July-September 2013. The ISD publication in addition to the graphs 6-8, includes the percentage reduction in HSMR since October to December 2007. An aim of the Scottish Patient Safety Programme is to achieve a 20% reduction by December 2015 from the baseline of 2007.

The summary position is shown in Table 1 below:

<table>
<thead>
<tr>
<th></th>
<th>Observed deaths: July-Sept 2013</th>
<th>Predicted deaths: July-Sept 2013</th>
<th>HSMR</th>
<th>Reduction in HSMR from 2007</th>
<th>Crude mortality rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scotland</td>
<td>5819</td>
<td>6795</td>
<td>0.86</td>
<td>12.5%</td>
<td>2.6%</td>
</tr>
<tr>
<td>RIE</td>
<td>331</td>
<td>485</td>
<td>0.68</td>
<td>14.8%</td>
<td>2.8%</td>
</tr>
<tr>
<td>WGH</td>
<td>215</td>
<td>300</td>
<td>0.72</td>
<td>12.2%</td>
<td>3.1%</td>
</tr>
<tr>
<td>SJH</td>
<td>133</td>
<td>176</td>
<td>0.76</td>
<td>3.6%</td>
<td>1.9%</td>
</tr>
</tbody>
</table>

All are below the Scottish average although only RIE is statistically significant. See below for commentary on trends.
Royal Infirmary of Edinburgh

The HSMR is statistically lower than the Scottish average for this quarter. The reduction in HSMR since 2007 is predominantly due to a rise in the predicted number of deaths rather than to a change in the actual number of deaths.

Western General Hospital

The HSMR for this quarter is not statistically different to the Scottish average. A contributory factor to the headline reduction in HSMR may be that the baseline is taken as Oct-Dec 2007: that was the highest quarterly HSMR ever at WGH and may have been an outlier (as the very low value for January-March 2013 was an outlier). At the Western, both observed and predicted mortality reduced 4 years ago and since then the HSMR has shown no significant change.

St. John’s Hospital

The HSMR for this quarter is not statistically different to the Scottish average. There has been no statistically significant change in HSMR since 2007. This lack of reduction is unusual across Scotland. At St. John’s both observed and predicted mortality have increased. There is an apparent reduction in the last two quarters but this is not statistically significant and may be seasonal, may be random, or may be the start of a trend.

3.1.3 The HEAT target for reduction in C. Difficile and Staph. aureus bacteraemias (SAB) has not been achieved (see Graphs 10 & 11). Actions to address this are set out in the HAI paper on the Board agenda.

3.1.4 The Cardiac Arrest numbers have increased in recent months (see Graph 12). This is due to an increase in numbers of arrests at the RIE and WGH sites. The aim is to reduce cardiac arrests by 50%: St. John’s is sustaining a significant drop in arrest calls with a 59% reduction compared to the baselines by implementing a change package based on work undertaken by Salford NHS Foundation Trust which focuses on reliable identification, response and escalation of deteriorating patients at a ward level. A collaborative approach using the same change package will be initiated in May at the WGH and RIE sites focusing on acute receiving units and downstream medical wards where there is a high incidence of arrest. This will examine safety culture, reliable escalation at ward level and end of life care.

The Scottish Patient Safety Programme Deteriorating Patient workstream is an area that the Board agreed should be included in the self assessments against the Lanarkshire Report. This is due to report to the Board in June 2014.

3.1.5 Falls Reduction - Achieving a 20% reduction in-patient falls has been difficult (Graph 13). Care rounding which seeks change the system from one where patients request care and waits to a system where care needs are anticipated based on individual need has resulted in some improvement. However additional improvement interventions require testing and these will form part of the SPSP falls reduction workstream. The refreshed Acute Patient Safety Programme published in late 2013 includes both falls reduction and pressure ulcer reduction and has new measures associated with these workstreams. The new measures will be reported in the June Quality Report.
3.1.6 Pressure Ulcer Management – NHS Lothian started to report grade 2 and above pressure ulcers in August 2011 (Graph 14) and initial figures suggested 30-37 acquired pressure ulcers per month. A local target to reduce this to zero (‘from one a day to none a day’) by March 2014 was set. This may have been premature as there was inconsistency in reporting (definition of a pressure ulcer, duplicate reporting and underreporting) that required addressing. The Healthcare Governance Committee received a detailed report on the work to reduce pressure ulcers in January 2014 and supported the following actions to be taken to reduce pressure ulcers and improve management which includes:-

- Identification and education of Tissue Viability (TV) link nurses helping to increase awareness, improve management and provide more accurate assessment and subsequent recording
- Identification and development of TV Champions to roll out local education
- Care Rounding implemented for all appropriate patients in inpatient areas
- Risk assessment bundle being piloted and rolled out for all patients admitted to hospitals
- Promotion of safety cross to record days between pressure ulcers locally to support improvement work
- Improving the information on Datix reporting to improve reliability and consistency of reporting to inform improvement
- Improving information for staff on adverse events investigation and process to identify avoidable versus unavoidable pressure ulcers
- Sharing learning from these investigations.

3.1.6.1 In summary, whilst there is still need for improvement, there has been more progress than may be apparent from graph 14. The new SPSP measurement plan advises concentrating on days between pressure ulcers and monitoring of this will commence in April 2014.

3.1.7 Stroke targets compliance – Although there has been an improvement as a result of actions taken to address compliance, the standards for admissions into the stroke unit (Graph 17) and swallow screens (Graph 18) are not being met. Actions to address this current situation were set out in the Stroke Performance Report under item 2.6 of the November 2013 Board and Unscheduled Care report in January 2014. Stroke care was also on the January 2014 agenda of the Healthcare Governance Committee and included a presentation from the lead clinician and manager on current compliance with standards and actions being taken to improve this.

3.1.8 Patient Experience - The February 2014 Board Quality Report set out pilot results from work undertaken with 11 test teams across the organisation. The next stage was to feedback these results to the teams which is taking place in the form of ‘Improvement Conversations’ based on both quantitative and qualitative data. The Person Centred Healthcare Team (PCHC) are asking teams to consider what tests of change they might use to achieve improvement.

- Examples of action/improvements include reviewing visiting times in the ward but asking what the patients and families would like before any changes are made, reviewing specific ward-based patient information, implementing “patient
at a glance” white boards to aid communication between therapists, staff and patients. The PCHC Team have agreed with the test teams that they will be visited again during the month of March to gain further patient feedback and hopefully hear from the patients if the local actions / improvements are making a difference.

3.1.8.1 Following a recent discussion with colleagues from NHS Lothian and Healthcare Improvement Scotland further work will be undertaken to agree the question set and develop a more co-ordinated approach to ensure that information and data is available at a variety of different levels across NHS Lothian.

3.1.8.2 Patient Experience has been identified by the Board as an area that requires self-assessment against the Lanarkshire recommendations and this self-assessment is due to report in June 2014.
Quality Dashboard – March 2014 (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 focusing 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 *
- 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 *
- Inpatient Falls with Harm *
- Inpatient Pressure Ulcers Grade 2 or above *

**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 2012 – June 2013**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian Rate (Per 1000 admissions)</th>
<th>Scottish Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>23.3</td>
<td>21.1</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>45.3</td>
<td>40.6</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>49.7</td>
<td>47.4</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>115.6</td>
<td>109.4</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>1.07</td>
<td>1.00</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>0.90</td>
<td>1.00</td>
</tr>
</tbody>
</table>
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, Monthly (Jan 2013 -Dec 2013)

Data Source: Datix   Exe 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, Monthly (Jan 2013 -Dec 2013)

Data Source: Datix   Exe Lead: Alan Boyter

**Title:** Number of Complaints (Graph 3)
**Numerator:** Total number of complaints
**Goal:** Reduction in number of formal complaints

**Outcome Measure**
Formal Complaints monthly across NHS Lothian (Oct 2012-Dec 2013)

Data Source: Datix   Exe Lead: Alan Boyter

**Title:** Delayed Discharges & Average Length of Stay (Graph 4)
**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   Exe Lead: Melanie Johnson

**Title:** Staff Absence Levels (Graph 5)
**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)   Exe Lead: Alan Boyter

6
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.

**Goal:**

- **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

### Outcome Measure

**Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – Sept 2013**

Data Source: ISD (Quarterly)  
Exec Lead: David Farquharson

**Outcome Measure**

**Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – Sept 2013**

Data Source: ISD (Quarterly)  
Exec Lead: David Farquharson

**Outcome Measure**

**Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – Sept 2013**

Data Source: ISD (Quarterly)  
Exec Lead: David Farquharson

### Outcome Measure

**Incidents with harm (Graph 9)**

**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

### Outcome Measure

**C. difficile associated disease against HEAT Target 2012-13 (Graph 10)**

**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
### Safe (cont’d)

**Title:** Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Graph 11)

**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.

**Outcome Measure**
Progress against HEAT Target for S.aureus Bacteraemia

![Graph of S.aureus Bacteraemia](image)

**Data Source:** Infection Control Team  
**Exec Lead:** Melanie Johnson

**Title:** Number of Cardiac Arrests (Acute Wards) (Graph 12)

**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

**Outcome Measure**

**Source Data:** Local Audits (Resuscitation Officer Database)  
**Exec Lead:** David Farquharson

**Title:** Patient Falls with Harm (Graph 13)

**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 March 2013

**Outcome Measure**
Count of reported patients’ falls with harm

![Graph of Patient Falls with Harm](image)

**Data Source:** Datix  
**Exec Lead:** Melanie Johnson

**Title:** Number of Pressure Ulcers per month across NHS Lothian (Graph 14)

**Numerator:** Number of Grade 2 or above pressure ulcers

**Goal:** To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2014 (from one a day to none a day)

**Outcome Measure**
Count of all pressure ulcers (Grade 2 and above) developed in NHS Lothian hospitals reported on Datix

![Graph of Pressure Ulcers](image)

**Data Source:** Datix  
**Exec Lead:** Melanie Johnson
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.

<table>
<thead>
<tr>
<th>Title: A&amp;E 4 Hour Wait (Graph 15)</th>
<th>Title: Cancer Waits 62 Days from Diagnosis to Treatment (Graph 16)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Number of patients waiting less than 4 hours from arrival to admission or discharge</td>
<td>Numerator: Number of patients waiting 62 days to treatment</td>
</tr>
<tr>
<td>Denominator: Number of patients attending</td>
<td>Denominator: Number of cancer patients</td>
</tr>
<tr>
<td>Goal: 98% of patients waiting less than 4 hours from arrival to admission by March 2014</td>
<td>Goal: 95% of patients from diagnosis to treatment wait no longer than 62 days</td>
</tr>
</tbody>
</table>

Data Source: Patient Administration System (TRAK)  
Exec Lead: Melanie Johnson

Data Source: SGHD Management Information  
Exec Lead: Jim Crombie

Title: Admission to Stroke Unit within 1 day of admission (Graph 17)  
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  
Note: 2013 data is not validated and should be treated as provisional

Data Source: ISD  
Exec Lead: Melanie Johnson

Title: Stroke Treatment Measures (Graph 18)  
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  
Note: 2013 data is not validated and should be treated as provisional

Data Source: ISD  
Exec Lead: Melanie Johnson
**Effective (cont'd)**

<table>
<thead>
<tr>
<th>Title:</th>
<th>Stroke Treatment Measures (Graph 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of patients admitted with initial diagnosis of stroke</td>
</tr>
<tr>
<td>Goal:</td>
<td>90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission</td>
</tr>
</tbody>
</table>

**Process Measure**  
Note: 2013 data is not validated and should be treated as provisional

![Graph showing scanning within 24 hours](graph)

Data Source: ISD  Exec Lead: Melanie Johnson
4 **Key Risks**

4.1 Achieving the C.Difficile HEAT target, stroke targets, delayed discharge target, cardiac arrest target SPSP goal.

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. Patient Experience 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 Not applicable.

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.
List of Appendices

Appendix 1: Supporting 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 readmissions 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. [http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs](http://www.ic.nhs.uk/services/the-casemix-service/new-to-this-service/what-are-healthcare-resource-groups-hrgs)
SUMMARY PAPER - FINANCIAL PLAN 2014/15 - 2018/19

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Paragraph</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Approval is sought for the Financial Plan which sets out the proposed investments for 2014/15 and beyond, based on known and anticipated additional funding. These proposed investments require a cash releasing efficiency target of £37.3m, to ensure financial balance is achieved</td>
<td>2.1</td>
</tr>
<tr>
<td>• In addition to the £37.3m recurring saving approval is sought for a £13m target of non-recurring savings. The non-recurring target will be held corporately to be delivered through identification of non-recurring benefits.</td>
<td>2.1</td>
</tr>
<tr>
<td>• The 5 Year Financial Plan includes investments beyond 2014/15. There are significant pay issues over the next few years and indications are that the system needs to plan to deliver annual efficiencies of circa £40m moving forward.</td>
<td>3.17 to 3.19</td>
</tr>
<tr>
<td>• The 14/15 LRP target of £37.3m will be allocated over the business units; 5% target for Corporate Departments and the balance spread equally across all business units. All undelivered LRP in 2013/14 will be carried forward at business unit level.</td>
<td>3.23</td>
</tr>
<tr>
<td>• When completing the financial plan, and setting the efficiency target, there are a number of potential cost pressures which have been assumed as being ‘manageable’ at an operational budget level. In addition there are a number of key risks that will need to monitored and managed during the year.</td>
<td>4.2 to 4.3</td>
</tr>
</tbody>
</table>
1 Purpose of the Report

1.1 The purpose of this report is to seek approval of the Financial Plan 2014/15 – 2018/19. This paper has previously been discussed at the Joint Management Team and the Finance & Resources Committee.

1.2 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendation

2.1 Approve the Financial Plan which sets out the proposed investments for 2014/15 and beyond, based on known and anticipated additional funding;

2.2 Note these proposed investments require a cash releasing efficiency target of £37.3m, to ensure financial balance is achieved;

2.3 Approve a recurring Local Reinvestment Target (LRP) of £37m; split across individual business units;

2.4 Approve a £13m target of non-recurring savings. The non-recurring target will be held corporately to be delivered through identification of non-recurring benefits.

3 Discussion of Key Issues

Background

3.1 The Financial Plan 2014/15 – 2018/19 has been developed over a period of months, with an initial overview of proposals being presented to the Joint Management Team (JMT) and Finance & Resources Committee (FRC) in December 2013. That report provided the context for financial planning for 2014/15 and beyond, encompassing commentary on the Scottish Government’s draft budget for 2014/15 as well as the overall health budget, as set out in the letter from the Chief Executive of the NHS Scotland to NHS Board Chief Executives on 11 September 2013. Further updates were presented to the February Board Meeting and the Finance & Resources Committee in March.

3.2 Development of the financial plan is an iterative process, taking cognisance of:

- planning assumptions in relation to pay, prices and drugs uplifts as shown in Table 1
- known or anticipated cost increases which are deemed “unavoidable”;
- planned investments which have already been approved through the Board’s governance processes; and
- any recurring impact of issues emerging in the current financial year, including delivery of savings targets.
Table 1: Planning assumptions for uplifts

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Base Uplift</td>
<td>2.69%</td>
<td>1.80%</td>
<td>1.80%</td>
<td>1.80%</td>
<td>1.80%</td>
</tr>
<tr>
<td>Pay</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
<td>1.00%</td>
</tr>
<tr>
<td>Prices</td>
<td>2.1% - 3.1%</td>
<td>2.1% - 3.1%</td>
<td>2.1% - 3.1%</td>
<td>2.1% - 3.1%</td>
<td>2.1% - 3.1%</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>3.50%</td>
<td>3.50%</td>
<td>3.50%</td>
<td>3.50%</td>
<td>3.50%</td>
</tr>
<tr>
<td>Hospital Drugs</td>
<td>6.49%</td>
<td>7.79%</td>
<td>7.79%</td>
<td>7.79%</td>
<td>7.79%</td>
</tr>
</tbody>
</table>

3.3 Over the past 3 months our financial planning assumptions have been reviewed, both in light of any further information locally, and to take cognisance of guidance issued by the Scottish Government Health & Social Care Directorates.

3.4 Table 2 sets out the current draft of the financial plan for next year, confirming the anticipated gap between income and expenditure of £37m, further detail is provided in Appendix 1.

Table 2: NHS Lothian draft financial plan 2014/15

<table>
<thead>
<tr>
<th></th>
<th>Rec £m</th>
<th>Non rec £m</th>
<th>Total £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRP brought forward - deficit</td>
<td>(6.6)</td>
<td>0.0</td>
<td>(6.6)</td>
</tr>
<tr>
<td>Capacity &amp; Unscheduled Care</td>
<td>(9.3)</td>
<td>0.0</td>
<td>(9.3)</td>
</tr>
<tr>
<td>Nursing</td>
<td>(4.0)</td>
<td>0.0</td>
<td>(4.0)</td>
</tr>
<tr>
<td><strong>2014/15 recurring commitments bfwd</strong></td>
<td>(19.9)</td>
<td>0.0</td>
<td>(19.9)</td>
</tr>
<tr>
<td>Uplifts (as noted above)</td>
<td>29.3</td>
<td>0.0</td>
<td>29.3</td>
</tr>
<tr>
<td>NRAC uplift</td>
<td>17.5</td>
<td>0.0</td>
<td>17.5</td>
</tr>
<tr>
<td>Non Lothian Income/other</td>
<td>2.0</td>
<td>2.7</td>
<td>4.7</td>
</tr>
<tr>
<td><strong>Net position before investments</strong></td>
<td>28.9</td>
<td>2.7</td>
<td>31.6</td>
</tr>
</tbody>
</table>

**Proposed investments**

- Pay & Workforce 16.0
- Medicines & Supplies 17.7
- Capacity 8.6
- Service Developments 1.4
- Infrastructure 6.8
- Repayment of Brokerage 0.0
- Other 2.8

**Total proposed investments** 53.3

**Net shortfall (LRP)** (24.4) (12.9) (37.3)
3.5 Recurring commitments brought forward from 2013/14 total £19.9m. These individual components combine to form the starting point for the 14/15 plan:

- As previously reported, it is anticipated that elements of the 2013/14 recurring savings target will be delivered on a non recurring basis only, while work on recurring plans are implemented. The recurring carry forward to 2014/15 has been estimated at Mid Year at £6.6m, and this represents the extent to which the organisation has an over commitment against available recurring funding. A further LRP forecast has been undertaken at the end of February which indicates an increase of £2.4m LRP recurring carry forward. Work is underway to mitigate this increase however ultimately LRP targets for 14/15 will be required to be adjusted to reflect actual to levels of non delivery.
- Investments in capacity/unscheduled care (£9.3m) and nursing (£4.0m) made in 2013/14 but funded non recurringly in year, recognising the further NRAC uplift in 2014/15.

3.6 Pay & Workforce – there are a number of components addressed within the additional investment in our workforce:

- Pay uplift – the additional pay uplift has been modelled on the basis of 1% increase for staff, including a minimum of £300 for all staff earning less than £21k.
- Changes both in the way we reimburse sessional medical staff within the Emergency Medical and Lothian Unscheduled Care (LUCs) services and an increase in their rate of pay.
- Medical staffing (terms & conditions) – this investment reflects the impact of contractual arrangements for Consultant staff in relation to seniority payments, as well as discretionary points. This has been modelled on an individual consultant basis.
- Workforce plan – there are a number of investments in clinical staff already approved through the JMT, including Emergency Department workforce redesign; obstetrics & gynaecology; and St Johns paediatric services.
- Patient Safety in Maternity Services – This recognises the current issues in nursing staffing levels within maternity services and is the initial phase of the establishment review currently being undertaken across the organisation
- AHP and PTB Incremental Drift – Further work is required to fully understand the underlying issues and financial consequences across the system, as well as at an individual budget level. The investment proposed for 2014/15 is an estimate of the current financial pressure.

3.7 Medicines & Supplies – there are a number of components addressed within the additional investment in non pay areas:

- Secondary care prescribing – A detailed review of existing pressures, expected growth in long term conditions (cancer, HIV, Lucentis and Biological Therapies) as well as the expected impact of new SMC Medicine Approvals during 2014/15 has concluded that a minimal investment of £5m will be required in Acute Medicines in 14/15. This reduced investment from prior years comes with associated risks. There is no investment for additional costs which may arise from changes to the Individual Patient Treatment Requests (IPTR) process, it is assumed that any
increases in costs will be offset by SGHD benefits derived from the national change in drug tariffs.

- **GP prescribing** – The GP Prescribing budget supports the costs of drugs for scripts written out by Lothian’s GP practices. This expenditure is reviewed annually by the Medicines Management Team who prepares, with finance, an estimate of likely growth for the following year based on the particular trends in each therapeutic area. They also consider information on new drugs which will be introduced into Primary care. The forecast for 2014/15 suggests an increase in costs of c. £4.5m which includes increase in volumes along with new drugs entering into the system.

- **Supplies inflation** – a general uplift of 2.1% on non pay costs has been assumed. Some specific costs that are linked to the Retail Price Index (RPI) have had an uplift of 3.1% applied. For resource transfer, the increase is 2%, as agreed in principle with Chief Executives across NHS Scotland. In relation to the PPP contracts, the inflationary uplift reflects our contractual obligations under the terms of each Project Agreement.

### 3.8 Capacity & service developments

- The level of investment required to support both elective and unscheduled care is one of the key determinants of the financial plan, the details of which are being finalised. Taking cognisance of the £9.3m brought forward, the draft plan includes £17.9m recurring investment in scheduled and unscheduled care. In addition a further £9.0m is set non-recurringly aside to support independent sector activity. It is clear that this level of investment is unsustainable in an environment where uplift is reducing, costs are increasing and the system is challenged in delivering recurring efficiency savings.

- Service developments of £1.6m are included in the draft Financial Plan, encompassing a range of proposals across the organisation. These are detailed in Appendix 1, and reflect investments which have already been approved via prior year financial plans or formal governance processes during this year; or relate to regional and national policy issues.

### 3.9 Infrastructure – there is investment required to meet the revenue consequences of the capital investment programme, as well as other costs associated with the asset and property base

- **Rates** – this is the increase in the poundage rate for 2014/2015 on the NHS Lothian estate.

- **Energy** – during the current year, there has been a significant cost pressure due to increased energy tariffs. Despite concerted efforts to improve energy usage, the impact of the price increases cannot be mitigated and requires a considerable investment.

- **Capital developments** - the planned investments reflect the revenue impact of approved business cases including fees and project team costs for the Royal Hospital for Sick Children / Department of Clinical Neurosciences and Royal Edinburgh Hospital Campus projects. In addition, the impact of business cases which are nearing formal approval have also been included, such as the St John’s maternity unit and burns ward project.
3.10 The other proposed investments include funding to support invest to save projects along with current financial pressures and new recognised priorities for 14/15.

3.11 The net shortfall of £37m is a combination of a recurring pressure of £24m and a non recurring pressure of £13m. It is proposed that the associated LRP target of £37m is delivered fully on a recurring basis, to recognise the future year reduction in uplifts and NRAC growth. If the £37m is fully delivered this will provide some headroom for 2015/16.

3.12 There are a number of potential issues which have not been included in the financial plan. If further pressures/developments are agreed to be funded then this will result in a consequential increase in the LRP target for the organisation.

3.13 It is recognised that delivering £37m of recurring in year savings will be a significant task. To maximise the ability to support any emerging issues, an additional £13m non recurring target will be introduced. This will be delivered through the management of new allocations, provisions and other one off in year benefits. Therefore in 2014/15 the Board will have a combined LRP target of £50m, £37m recurring and £13m non recurring.

**Beyond 2014/15**

3.14 The current draft Financial Plan incorporates assumptions on additional income and planned investment for the 4 years beyond 2014/15. The SGHSCD guidance mentioned in section 3.4 sets out indicative uplifts to baseline allocations for 2015/16 to 2018/19. These show 1.8% in 2015/16 – 2018/19; although this will be clarified during the Spending Review process in 2014/15.

3.15 In addition to the baseline uplift, SGHSCD have funding set aside to support the ongoing implementation of the NRAC formula. We have received confirmation from SGHSCD that NHS Lothian should plan on the basis of £7m in 2015/16, which is a £10m reduction to that allocated for 2014/15.

3.16 Table 3 provides a summary of income assumptions from 2015/16 onwards:

<table>
<thead>
<tr>
<th>Table 3 – Income Assumptions 2015/16 – 2018/19</th>
</tr>
</thead>
<tbody>
<tr>
<td>2015/16</td>
</tr>
<tr>
<td>£m</td>
</tr>
<tr>
<td>Baseline Uplift</td>
</tr>
<tr>
<td>NRAC</td>
</tr>
<tr>
<td>Total</td>
</tr>
</tbody>
</table>

3.17 The detail of the 5 Year Financial Plan is presented in Appendix 2. In relation to planned investments beyond 2014/15, these are largely reflective of assumptions for pay and supplies uplifts (including medicines); the revenue implications of approved capital developments; and the balance of the brokerage funding to be repaid to SGHSCD. An assumption with regard to the level of annual pressures and the impact of demographic change costs has been included from 2017/18 to present a realistic indication of the annual LRP target of circa £40m.
3.18 There are significant pay issues that will impact over the next few years. In 2015/16 there is a proposed 2% increase in the employers pension contribution and this has been estimated at £11.8m for the Board. In 2016/17 changes to the employers national insurance contributions will mean a further £13.7m of pay costs. These changes combined with a lower level of uplift will result in minimal flexibility to fund further developments/pressures during 2015/2017.

3.19 The indications are that the system needs to plan to deliver annual efficiencies of 3%-5% and this will be a key issue for the Board moving forward. Work will continue to refine the 5 year revenue plan including sensitivity analysis around uplifts and revenue consequences of the 5 year capital plan.

**Efficiency & Productivity 2014**

3.20 For 2014/15 an overall recurring LRP target of £37.3m requires to be set, this equates broadly to 3% of NHS Lothian’s Annual Recurring Budget. Table 4 below sets out the overall estimated recurring LRP target for 2014/15. Appendix 3 provides a more detailed breakdown over the business units.

3.21 The target includes the forecast level of LRP to be carried forward from 2013/14. The actual level of LRP undelivered or met on a non-recurring basis and therefore carried forward from 2013/14 will be confirmed as part of the year-end annual accounts process.

**Table 4: Overall NHS Lothian 2014/15 LRP Position**

<table>
<thead>
<tr>
<th></th>
<th>£’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Carry Forward from 2013/14</td>
<td>6,550</td>
</tr>
<tr>
<td>2014/15 Savings Target</td>
<td>30,744</td>
</tr>
<tr>
<td><strong>2014/15 LRP Total Target</strong></td>
<td><strong>37,295</strong></td>
</tr>
</tbody>
</table>

3.22 The £6.5m estimated carry forward represents 24% of the total £27.8m 2013/14 target. This is based on the mid year review forecast. The further forecast undertaken at the end of February indicates an increase of £2.4m recurring carry forward arising from an anticipated further increase in undelivered Local LRP across Acute Services. Work is underway to mitigate this increase however ultimately LRP targets for 14/15 will be required to be adjusted to reflect any increase to levels of non delivery. The recurring shortfall will not be confirmed until the Year End Annual Accounts process is concluded.

3.23 Discussions at the NHS Lothian Efficiency & Productivity Group in December confirmed that the 14/15 LRP target would be allocated as follows:-

- 5% target for all Corporate Departments (as the first step of a 2 year 10% target)
- Balance of LRP (equating to 3.3%) spread equally across all business units.
- All undelivered LRP in 2013/14 will be carried forward at business unit level to be consolidated with new allocation to form the overall 14/15 target.

3.24 It was also agreed that delivery of all business unit targets would be supported by work stream opportunities including such areas as Procurement, Acute Prescribing, Outpatients, Effective Interventions and Innovation. For each work stream, nominated
Executive Directors would be tasked with leading the development of plans to support LRP delivery across the organisation. Responsibility for delivery of targets would remain with budget holders at business unit level with work streams setting out the scope of opportunity and supporting budget holders to deliver thereon.

3.25 Programme Management support will continue to be provided to all workstreams and where required project management support will also be resourced. A full plan setting out how programme management support from the Efficiency & Productivity Team will be spread across all business units/work streams will be approved through the NHS Lothian Efficiency & Productivity Group in April 2014. Full partnership involvement will continue to be a key element of both workstream and local scheme development. Partnership working arrangements will also be finalised through the NHS Lothian Efficiency & Productivity Group in April 2014.

3.26 The NHS Lothian Efficiency & Productivity Group set aside its meetings in February and March to undertake a detailed review of the 14/15 LRP Plans for each Business Unit. As at 21st February 2014 recurring plans of £8.1m have been submitted against the £37.3m target as set out at Table 5 below. Agreement was made at the February E & P Group meeting that specific review will be given of all proposals impacting on bed numbers and on Nursing staff by the Director of Unscheduled Care.

Table 5: Plans submitted against 2014/15 Targets

<table>
<thead>
<tr>
<th></th>
<th>2014/15 Recurring Target</th>
<th>Identified @ 21 February 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Corporate Departments</td>
<td>3,652</td>
<td>1,032</td>
</tr>
<tr>
<td>Scheduled Care</td>
<td>12,288</td>
<td></td>
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<tr>
<td>Unscheduled Care</td>
<td>6,602</td>
<td></td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>4,977</td>
<td></td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>1,346</td>
<td>1,170</td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td>570</td>
<td>442</td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>1,609</td>
<td>888</td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>4,303</td>
<td>2,450</td>
</tr>
<tr>
<td>Facilities</td>
<td>2,314</td>
<td>2,100</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>635</td>
<td></td>
</tr>
<tr>
<td>Unallocated</td>
<td>(1,002)</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>37,295</strong></td>
<td><strong>8,082</strong></td>
</tr>
</tbody>
</table>

3.27 The March meeting of the NHS Lothian Efficiency & Productivity Group will consider detailed plans for all other areas, in particular Scheduled Care, Unscheduled Care and Edinburgh CHP. These three areas together make up £24m of the overall £37m LRP target for 14/15 and it is essential that significant progress has been made by mid March to set out robust achievable proposals.
3.28 As previously mentioned an additional £13m non recurring LRP savings target has been set. To date £7.2m has been identified as follows:

<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td>Property Sales</td>
<td>4.0</td>
</tr>
<tr>
<td>Rates rebate on Primary Care Premises</td>
<td>1.2</td>
</tr>
<tr>
<td>VAT Recovery</td>
<td>0.8</td>
</tr>
<tr>
<td>Allocation Review</td>
<td>1.2</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>7.2</strong></td>
</tr>
</tbody>
</table>

Work is ongoing to identify further sources which will become available in year including the introduction of a robust review of all Scottish Government allocations together with a top slice approach for all new allocations.

4 **Key Risks**

4.1 Whilst every effort has been made to ensure all likely additional costs and national, regional and local priorities for investment have been incorporated into the financial plan at this time, there remain a number of inherent uncertainties and associated risks. The financial planning process is an ongoing and iterative cycle, and it is not possible to fully eradicate all financial risks facing individual service areas, nor the wider organisation.

4.2 It is important to note that in completing the financial plan, and thus the efficiency target, there are a number of potential cost pressures which have been assumed as being ‘manageable’ at an operational budget level. This is largely based on the current in year performance. Examples include: incremental drift (£3.0m across a number of disciplines); and nursing enhancements (£1.5m). As pressures on the delivery of LRP continue, the sustainability of this approach will need to be reviewed.

4.3 Other risks to be highlighted include:

- The potential cost of changes to pay terms & conditions, specifically the review of the implementation of transitional points under Agenda for Change and the ongoing discussions with Consort;
- Availability of SGHSCD funding for nationally funded programmes & initiatives;
- Revenue impact of the capital investment programme including transitional or double running costs not yet identified, and development costs required to support all projects;
- New or changed policy initiatives emerging during the financial year, including national arrangements for procurement; and
- Continued management of the financial exposure on both elective and unscheduled care capacity pressures
- The potential cost of changes to the Individual Patient Treatment Reviews (IPTR) and additional SMC and Formulary drugs approvals
- Deliverability of recurring £37m and non recurring £13m LRP targets.
5 Risk Register

5.1 At this time, there is nothing to add to the Risk Register.

6 Health and Other Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 Involving People

7.1 A workshop was held in November 2013 with key managerial and clinical representatives from across the organisation, to consider both the financial plan and efficiency & productivity issues.

8 Resource Implications

8.1 The resource implications are set out above.

Craig Marriott
Deputy Director of Finance
11 March 2014
craig.marriott@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian draft financial plan 2014/15
Appendix 3: 2014/15 LRP Targets
### 2014/15 recurring commitments bfwd

<table>
<thead>
<tr>
<th>Category</th>
<th>Recurring £k</th>
<th>Non recurring £k</th>
<th>Total £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>LRP brought forward</td>
<td>(6,550)</td>
<td>0</td>
<td>(6,550)</td>
</tr>
<tr>
<td>Capacity &amp; Unscheduled Care</td>
<td>(9,350)</td>
<td>0</td>
<td>(9,350)</td>
</tr>
<tr>
<td>Nursing</td>
<td>(4,032)</td>
<td>0</td>
<td>(4,032)</td>
</tr>
<tr>
<td><strong>Total 2014/15 recurring commitments bfwd</strong></td>
<td><strong>(19,932)</strong></td>
<td>0</td>
<td><strong>(19,932)</strong></td>
</tr>
</tbody>
</table>

### Income

- Anticipated uplift: 30,666 £k
- Anticipated uplift - NRAC: 17,521 £k
- Change Fund (OP): (1,392) £k
- Non Lothian Income - Base uplift 2.7%: 2,000 £k
- Other Sources: 0 £k

**Total Income:** 48,795 £k

### Proposed Investments

#### Pay Uplift
- Pay Uplift (1%): 7,722 £k
- Pay Uplift (£300 for < £21k): 1,241 £k

**Total Pay Uplift:** 8,963 £k

#### Pay Terms & Conditions
- Consultant Contract - Seniority Payments: 1,120 £k
- Discretionary Points (Medical Staff): 764 £k
- Senior Manager/ Executive Level Pay - 13/14: 290 £k
- Community Dental Service - New Pay Scales: 171 £k
- Auto enrolment overprovision: (1,025) £k
- Clinical Support Workers Commitment Allowance: 65 £k
- LUCs Service & Emergency Medicine Rates of Pay: 1,227 £k

**Total Pay Terms & Conditions:** 2,582 £k

#### Workforce
- Emergency Department Workforce Plan: 512 £k
- Apprenticeships: 0 £k
- ST Johns Paediatric Medical staffing Workforec Plan: 127 £k
- Obstetrics & Gynaecology Workforce Plan: 476 £k
- Patient Safety in Maternity Services: 1,047 £k
- Consultant Job Planning - HR Resource: 70 £k
- Additional Foundation Posts SE Deannery: 216 £k
- Public Records Compliance Manager: 44 £k
- HR Recruitment Resource: 201 £k
- Occ Health Staff Physio Post: 36 £k
- AHP/FTB Incremental Drift: 1,398 £k
- Clinical Lead Funding: 0 £k
- Speciality Trainee Growth: 309 £k

**Total Workforce:** 4,436 £k

#### Prescribing
- Secondary Care Prescribing: 5,000 £k
- GP Prescribing: 4,500 £k
- Immunisation: 687 £k
- Orphan Drugs: 287 £k
- Flu vaccination: 400 £k

**Total Prescribing:** 10,874 £k

#### Prices Uplift
- Supplies: 5,349 £k
- Facilities Supplies Pressures: 722 £k
- Consort Indexation: 500 £k
- Primary Care PFI Uplift: 212 £k

**Total Prices Uplift:** 6,783 £k

#### Capacity & Unscheduled Care
- Sustainable Delivery of TTG/WT Standards: 7,142 £k
- Endoscopy SEAT Regional Unit: 697 £k
- Orthopaedics - NHS Borders SLA: 713 £k
- Independent Sector & Other Contractors: 0 £k

**Total Capacity & Unscheduled Care:** 8,552 £k

#### Brokerage
- Waiting Times Brokerage: 0 £k

**Total Brokerage:** 0 £k
<table>
<thead>
<tr>
<th>Service Developments</th>
<th>Recurring £k</th>
<th>Non recurring £k</th>
<th>Total £k</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult Insulin Pumps</td>
<td>273</td>
<td>0</td>
<td>273</td>
</tr>
<tr>
<td>Family Nurse Partnership</td>
<td>52</td>
<td>0</td>
<td>52</td>
</tr>
<tr>
<td>Home Oxygen</td>
<td>75</td>
<td>0</td>
<td>75</td>
</tr>
<tr>
<td>Hub South East Territory</td>
<td>100</td>
<td>0</td>
<td>100</td>
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<tr>
<td>Future National Services</td>
<td>771</td>
<td>0</td>
<td>771</td>
</tr>
<tr>
<td>Scotstar - national service</td>
<td>256</td>
<td>0</td>
<td>256</td>
</tr>
<tr>
<td>Transport HUB</td>
<td>500</td>
<td>0</td>
<td>500</td>
</tr>
<tr>
<td>Paediatric Insulin Pumps</td>
<td>182</td>
<td>0</td>
<td>182</td>
</tr>
<tr>
<td>Change Fund agreed service reductions</td>
<td>(1,392)</td>
<td>0</td>
<td>(1,392)</td>
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<tr>
<td>ARIA Software Funding</td>
<td>177</td>
<td>0</td>
<td>177</td>
</tr>
<tr>
<td>Police custody and forensic service</td>
<td>400</td>
<td>0</td>
<td>400</td>
</tr>
<tr>
<td>Gender Reassignment</td>
<td>0</td>
<td>125</td>
<td>125</td>
</tr>
<tr>
<td>West Lothian Phlebotomy</td>
<td>70</td>
<td>0</td>
<td>70</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>1,464</strong></td>
<td><strong>125</strong></td>
<td><strong>1,589</strong></td>
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<table>
<thead>
<tr>
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<th>Recurring £k</th>
<th>Non recurring £k</th>
<th>Total £k</th>
</tr>
</thead>
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<tr>
<td>Rates</td>
<td>489</td>
<td>0</td>
<td>489</td>
</tr>
<tr>
<td>Energy</td>
<td>2,090</td>
<td>0</td>
<td>2,090</td>
</tr>
<tr>
<td>CRC Scheme - cost of Climate Change</td>
<td>91</td>
<td>0</td>
<td>91</td>
</tr>
<tr>
<td>Premises Rental Uplift</td>
<td>220</td>
<td>0</td>
<td>220</td>
</tr>
<tr>
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<td>227</td>
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<table>
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<td>65</td>
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| Total Expenditure       | £53,300      | £15,559          | £68,858 |

| Net position before LRP | (24,437)   | (12,859)          | (37,295) |
|---------------------|---------|---------|---------|---------|---------|
| **LRP brought forward** | (6,550) | 0       | 0       | 0       | 0       |
| **Capacity & Unscheduled Care** | (9,350) | 0       | 0       | 0       | 0       |
| **Nursing** | (4,032) | 0       | 0       | 0       | 0       |
| **Recurring Commitments b/ fwd** | (19,932) | 0       | 0       | 0       | 0       |
| **Uplift** | 29,274 | 0       | 21,384 | 0       | 21,384 |
| **NRAC** | 17,521 | 7,000   | 0       | 0       | 0       |
| **Non Lothian Income / Other** | 2,000 | 4,700   | 1,333  | 0       | 1,333 |
| **Net Position before Investments** | 28,863 | 2,700   | 29,717 | 2,200   | 31,917 |
| **Proposed Investments** |         |         |         |         |         |
| **Pay & Workforce** | 15,981  | 717     | 16,698  | 0       | 15,255 |
| - Employers Increased Pension Contributions | 0       | 0       | 11,780  | 0       | 11,780 |
| - Employers National Insurance Changes | 0       | 0       | 0       | 0       | 0       |
| **Medicines & Supplies** | 17,657  | 0       | 17,777  | 0       | 17,588 |
| **Capacity & Unscheduled Care** | 8,552   | 9,000   | 7,000   | 17,843  | 13,245 |
| **Service Developments** | 1,464   | 125     | 1,589   | 1,452   | 1,445  |
| **Infrastructure** | 6,800   | 1,026   | 7,826   | 11,775  | 805    |
| **Repayment of Brokerage** | 2,846   | 691     | 3,537   | 151     | 1,057 |
| **Total Proposed Investment** | 53,300  | 15,559  | 68,858  | 69,032  | 8,987 |
| **Net Shortfall LRP** | (24,437)| (12,859)| (37,295)| (39,314)| (6,787) |

NHS Lothian Draft 5 Year Financial Plan
<table>
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<tr>
<th>Area</th>
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<td>(6,803)</td>
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<td>(1,346)</td>
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<td>(4,977)</td>
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<tr>
<td>Mid Lothian CHP</td>
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<td>(570)</td>
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<td>(1,609)</td>
<td>(1,609)</td>
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<td>(505)</td>
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<td>(673)</td>
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<td>(104)</td>
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<td>(349)</td>
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<tr>
<td>Pharmacy</td>
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<td>(350)</td>
<td>(635)</td>
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<td>(292)</td>
<td>(401)</td>
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<td>(596)</td>
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<td>Strategic Other</td>
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<td></td>
<td><strong>(6,550)</strong></td>
<td><strong>(30,725)</strong></td>
<td><strong>(37,275)</strong></td>
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NHS LOTHIAN

Board Meeting
2 April 2014

Director of Finance

PROPERTY AND ASSET MANAGEMENT INVESTMENT PROGRAMME 2014/15 - 2018/19

1 Purpose of the Report

The purpose of this report is to ask the Board to approve the draft 5 year property and asset management investment programme for 2014/15 to 2018/19.

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

2 Recommendations

2.1 Approve the draft Property and Asset Management Investment Programme for 2014/15 to 2018/19;

2.2 Note that the plan has been submitted as part of the draft 5 year Local Delivery Plan (LDP) with a balanced position. The timing of capital projects not yet fully approved will require to be managed to ensure delivery of this in 2014/15 and beyond.

3 Discussion of Key Issues

3.1 Overview of the Property And Asset Management Investment Programme

To aid the development of a programme which aligns with and supports the clinical strategy, master plans have been commissioned for all major sites. Each of these masterplans is at a different stage of development and the draft 5 year programme captures the agreed and emerging priorities. It will form part of the Property and Asset Management Strategy, under the “where we are going” section, to be submitted to the Scottish Government Health and Social Care Division (SGHSCD) following governance approvals.

The draft programme for 2014/15 onwards is summarised in table 1 below. This shows a potential over commitment for next financial year and a significant over commitment thereafter. Ensuring a balance position is achieved will require a combination of: prioritisation of unapproved projects via the masterplanning process; reviewing the timing of unapproved projects; exploration of potential funding routes with SGHSCD, Scottish Futures Trust (SFT) and council partners; and detailed consideration of the revenue consequences of capital build aspirations that support the clinical strategy.
<table>
<thead>
<tr>
<th></th>
<th>2014/15 £m</th>
<th>2015/16 £m</th>
<th>2016/17 £m</th>
<th>2017/18 £m</th>
<th>2018/19 £m</th>
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<td><strong>Specifically funded schemes</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Investments (agreed &amp; proposed)</td>
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<td>16.403</td>
<td>65.830</td>
<td>115.882</td>
<td>130.358</td>
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<td>-14.503</td>
<td>-24.537</td>
<td>-25.140</td>
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<td><strong>Specific funding gap</strong></td>
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<td>1.900</td>
<td>41.293</td>
<td>90.742</td>
<td>123.509</td>
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<td><strong>Schemes funded via formula</strong></td>
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<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Proposed investments</td>
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<td>36.429</td>
<td>38.524</td>
<td>23.714</td>
<td>23.377</td>
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<td>Retained Receipts</td>
<td>-2.750</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
<td>0.000</td>
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<tr>
<td><strong>Formula over commitment to be managed</strong></td>
<td>9.238</td>
<td>10.741</td>
<td>7.465</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>Total planned capital expenditure</td>
<td>67.109</td>
<td>52.832</td>
<td>104.354</td>
<td>139.596</td>
<td>153.735</td>
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<tr>
<td>Total assumed funding</td>
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<td>-40.191</td>
<td>-55.596</td>
<td>-50.828</td>
<td>-32.537</td>
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<td>12.641</td>
<td>48.758</td>
<td>88.768</td>
<td>121.198</td>
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Table 1 includes an over commitment against formula funding for the next three years. This is considered to be manageable. The large funding gap in the years 2016 – 2019 is due to large capital schemes that have not yet received approval from the SGHSCD, and which therefore do not have specific funding agreed.

This 5 year plan has been submitted to the SGHSCD as part of the draft LDP for 2014/15 – 2018/19. There is therefore a requirement to prioritise formula funded schemes in order to achieve a balanced position in the first three years.

### 3.2 Forecast Resources

Indicative allocations for 2014/15 and 2015/16 were initially notified by Scottish Government Health and Social Care Directorate (SGHSCD) in February 2012 and reconfirmed in September that year. The funding for 2014/15 has now been confirmed, having been amended to reflect the rephasing of schemes which are specifically funded (i.e. those over £5m and a small number of nationally financed schemes). Projects in this category include: the enabling works for the Royal Hospital for Sick Children and the Department of Clinical Neurosciences; support for the first phase of the Royal Edinburgh reprovision; enabling funds for revenue funded hub projects; and current phases of the national radiotherapy replacement programme.

Funding received for these major schemes is supplemented by:

- The *formula allocation*, which is used to fund projects under the £5m delegated limit;
- Anticipated *capital receipts*, representing the net book value of properties scheduled for sale. Major disposals include the second part of the Eastern General site and Roslynlee Hospital, both of which are planned for 2014/15. The level of receipts will be revised as the Property and Asset Management Strategy develops; and
Although there are currently no major donations in the programme, these will be incorporated as and when they arise.

Beyond the current spending review, the level of capital funding available nationally and for the NHS specifically has not been confirmed. This is clearly a major risk for the investment programme set out and we are working closely with SGHSCD and other partners to explore funding opportunities.

3.3 Projected Investments

The detailed investment programme for the next 5 years is included in Appendix 1 and summarised in table 3 below. Costs are based on a combination of:

- Figures from the latest initial agreements (IAs), standard business cases (SBCs) and final business cases (FBCs);
- The quarter 3 (2013/14) review of the capital programme; and
- Other estimates where these are available.

Table 3: Projected 5 year property and asset management programme

<table>
<thead>
<tr>
<th></th>
<th>14/15</th>
<th>15/16</th>
<th>16/17</th>
<th>17/18</th>
<th>18/19</th>
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<td>6.652</td>
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<td>5.000</td>
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<tr>
<td>Integration</td>
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<td>3.300</td>
<td>14.500</td>
<td>35.100</td>
<td>30.000</td>
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<td>Edinburgh Bioquarter Campus &amp; Liberton Hospital</td>
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<td>15.772</td>
<td>24.071</td>
<td>25.595</td>
<td>17.548</td>
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<td>Western General Campus</td>
<td>9.009</td>
<td>2.695</td>
<td>7.282</td>
<td>13.045</td>
<td>23.301</td>
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<tr>
<td>St John's Campus</td>
<td>5.048</td>
<td>1.430</td>
<td>11.000</td>
<td>6.900</td>
<td>0.000</td>
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<td>Royal Edinburgh Campus</td>
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<td>0.575</td>
<td>16.948</td>
<td>32.742</td>
<td>53.009</td>
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<td>Lauriston Campus</td>
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<td>0.300</td>
<td>0.500</td>
<td>4.500</td>
<td>4.500</td>
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<tr>
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<td>2.500</td>
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<td>0.000</td>
<td>0.000</td>
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<tr>
<td><strong>Planned Net Capital Expenditure</strong></td>
<td><strong>64.359</strong></td>
<td><strong>52.832</strong></td>
<td><strong>104.354</strong></td>
<td><strong>139.596</strong></td>
<td><strong>153.735</strong></td>
</tr>
</tbody>
</table>

To reflect the move to a master planning approach, the 5 year plan is structured by campus, irrespective of funding source. Schemes funded from both specific and formula allocations are shown within the same campus, encouraging a coherent approach to planning.

The plan will vary throughout the year, as required, to reflect changes in phasing of expenditure and the agreement of business cases as they are progressed through the governance process.

An update on the major components of the programme is given in sections 3.4 to 3.13 below.
3.4 **Rolling Programmes**

This section of the plan reflects an annual level of investment in agreed programmes, with individual schemes prioritised through appropriate recognised governance.

- An allowance of £5m p.a. has been built into the plan to address the *backlog maintenance* priorities, reducing to £2.5m p.a. from 2016/17 reflecting the anticipated decline in reliance on this programme as the major backlog is addressed.

- The budget for *medical equipment* over the 5 year period has been increased in line with the planned replacement programme. This is significantly in excess of the £5m p.a. previously provided and a detailed exercise is being undertaken to establish anticipated risks within the medical equipment programme, and prioritise accordingly.

- £2m annually to address strategic priorities relating to *e-health*.

- Provision of £1.5m has been made to fund all *service redesign projects* under £0.25m.

3.5 **Primary Care Sites**

New programmes are proposed to support *modernisation of GP premises*. Funds of up to £5m have been set aside in each year to fund priorities, with the potential to incorporate developments arising from integration.

Active projects include:

- **GP Surgery Ratho** – The owner of the preferred site has written to NHS Lothian indicating that he is withdrawing from the land transaction. Discussions are ongoing with the site owner and, in parallel, a request has been made to the City of Edinburgh Council to determine if they have any potential sites in the area.

- **Tranent Health Centre** – an extension of the existing premises, currently on site with a planned completion date of August 2014.

- The 3 *partnership centres* (*Blackburn, North West Edinburgh and Firhill*) which, due to their value, are being “bundled” and progressed jointly as one revenue funded project. Following agreement on the configuration of the North West Edinburgh project, a single outline business case will be completed by March 2014, with financial close scheduled for the end of 2014.

3.6 **Integration**

Over time, Health and Social Care integration will have a major influence on property strategy as joint integration boards develop their strategic plans. The draft programme recognises this although it is not yet fully clear what impact this will have in practice. In the short term a number of projects are being progressed which support joint service planning, including:
• *East Lothian Community Campus* - hub SE has been engaged to provide strategic support and models based on re-provision of existing facilities and elements of repatriation of services to East Lothian are being explored. An initial programme has been prepared in support of an operational date in late 2017, although it is accepted that this is a challenging timescale and a funding source has not yet been agreed;

• *Unscheduled Care Capacity* – in line with the unscheduled care (USC) plan, provision has been made to upgrade 2 further wards at the Royal Victoria Hospital and to make improvements at Liberton Hospital, Astley Ainslie and Corstorphine;

• *Royal Victoria Hospital Redevelopment* – NHS Lothian and City of Edinburgh Council (CEC) are working with hub SE to develop proposals for the redevelopment of the Royal Victoria Hospital in line with the USC plan. Whilst this work is at an early stage an allowance has been reflected in the draft programme; and

### 3.7 Edinburgh Bioquarter Campus

The *RHSC/DCN* project is the major development for this campus over the 5 year planning period. As we progress through the procurement process, enabling works have begun on site in 2013/14 and services decanted to other facilities accordingly. A preferred bidder will has been appointed and financial close is due on October 1st 2014.

Other investments include:

• *Rehousing of existing services* – linked to RHSC/DCN, this scheme involves the reintegration of non clinical areas on the 2nd floor to accommodate expanded renal and transplant critical care beds. The 1st floor space will allow for increased critical care capacity to accommodate DCN activity;

• *Endoscopy Decontamination* – the draft plan contains proposals to provide fully compliant facilities on the Western and Royal sites. The availability of capital funding has constrained both units being progressed simultaneously and the service was asked to review the phasing. As a result, the project at the Royal is scheduled with the earlier start date of July 2014;

• *LEPP* – a key part of the implementation of the managed service for NHS Lothian laboratories, this will allow the laboratories at the Royal Infirmary to be prepared for the installation of the standard analyser platform; and

• *RIE lifecycle* – this represents the proportion of the lifecycle costs for the RIE accounted for as a capital grant.

### 3.8 Western General Campus

Development of the *Edinburgh Cancer Centre* is the major element of the masterplan for the campus and a key priority for NHS Lothian. Construction is
planned to begin in 2017 but is dependant on completion of a c£9m infrastructure programme.

Plans for the site include:

- **Radiotherapy Linear Accelerator Replacement** – the nationally funded replacement programme will continue throughout the period of this 5 year plan. Budget for phase 9 has been agreed at £5.0m, with a further £5.0m anticipated in the period to 2018/19;

- **Pharmacy Modernisation** - upgrading of the aseptic suite, to provide specialist clean room facilities and equipment for the preparation of ready to inject medicines. The SBC is being progressed and work is anticipated in July 2014;

- **Colorectal Capacity** – the proposed expansion of ward 58 will increase capacity and support achievement of waiting time targets. Agreement to proceed to IA has been given, estimated costs are £1m and the planned completion date is towards the end of 2014/15; and

- **Endoscopy Decontamination** – build of a fully compliant unit on the Western General campus. The IA has been approved; however the unit at the Royal Infirmary has been prioritised and the anticipated completion date has slipped to 2016.

### 3.9 St John’s Campus

Development of additional capacity and the conversion of non clinical space are the main challenges for the emerging St John’s masterplan, along with a significant programme of backlog maintenance. Active projects include:

- **Maternity & Special Care Baby Units** – work has now re-started on the main project and the unit is expected to be operational in June 2014. Following the decant of the Special Care Baby Unit (SCBU), the opportunity has arisen to address a number of issues related to new standards of care and the required modernisation the unit in order to comply with HEI guidance. Given the limited window to complete these works in advance of the labour suite becoming operational, design work has been commissioned. This project is anticipated to cost £1.2m-£1.4m and the governance will run concurrently with early enabling works with a business case being presented to F&R in May 2014;

- The **MRI Scanner** has been approved and the first valuation has been received from the main contractor. This is scheduled to be operational by September 2014; and

- **Community Dentistry Decontamination** - there were 2 elements to the programme for the provision of appropriate decontamination of instrumentation used by the community dental service, new units at the Western General and St John’s Hospitals. Whilst the Western unit is now operational, a number of issues have arisen with the proposed site at St John’s. With the exception of a significant increase in costs, these have now all been resolved.
3.10 Royal Edinburgh Campus

Approval for the OBC for Phase 1 of the redevelopment of the REH Site was received from SGHSCD this month. The planning submissions for the outline masterplan and detailed phase 1 schemes have been submitted. Objections from the incumbent bowling club have been one of the key areas of risk and the club vacated the site on 3rd February.

Agreement has been reached with SGHSCD to reinvest RHSC/DCN slippage in early enabling and infrastructure works. This will be particularly beneficial in terms of utilities and site preparation, and HUB SE have now contracted for this work.

The funding route has not been confirmed for future phases.

3.11 Lauriston Campus

Proposals for the reprovision of services and the Edinburgh Eye Pavillion, as well as schemes at the Edinburgh Dental Institute and other capacity developments on the campus will be considered as part of master planning.

3.12 Other Schemes

There are several other proposed schemes that are across several campuses. These include microbiology automation, Regional Learning Disabilities and Autism Unit and the separate strategies for Labs and Catering.

3.13 Revenue Funded Schemes

It is unclear the extent to which SGHSCD revenue support will be available for projects beyond the current pipeline (RHSC/DCN, Royal Edinburgh Phase 1 and the partnership “bundle”).

A summary of NHS Lothian revenue funded infrastructure investments is provided in Appendix 2 with any elements of funding from traditional capital included separately in Appendix 1.

Scottish Futures Trust (SFT) and the 5 Hub companies have appointed 2 funders to provide long term senior debt finance across all 18 “pipeline” Scottish DBFM projects. These are health and school schemes with Scottish Government revenue support with a capital value totalling c£450m. For NHS Lothian this arrangement will cover Phase I of the Royal Edinburgh Hospital and the Partnership Centre Bundle. Alternative arrangements will be required for future phases of the Royal Edinburgh and East Lothian Community Hospital if these projects are to be revenue funded. The funder selected for the South East is Nord Landesbank, with Aviva as a substitute. Whilst this is seen as a positive strategic initiative; we are discussing the implementation practicalities and associated costs with Hub South East and SFT.

4 Key Risks

4.1 The key risks inherent in the capital programme are: the imbalance in the plan for 2014/15; the lack of clarity over funding beyond the current spending review; and the revenue consequences of capital build decisions. This will be mitigated by:
prioritisation of schemes through the master planning approach; managing the phasing of schemes; and working with partners to identify alternative funding solutions.

5 Risk Register

5.1 There is nothing to be added to the corporate risk register at this stage. Individual risk registers for the major service redesign projects/developments are considered by project boards, and regular updates will be provided to the Finance & Resources Committee under a separate agenda item.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 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. These documents incorporate capital expenditure.

At an individual project level, there are specific arrangements in place to allow full engagement with stakeholders.

8 Resource Implications

8.1 The resource implications are outlined above.

Susan Goldsmith
Director of Finance
18 March 2013
Susan.goldsmith@nhslothian.scot.nhs

List of Appendices

Appendix 1: NHS Lothian Property and Asset Management Investment Programme 2014/15 – 2018/19
Appendix 2: NHS Lothian Revenue Funded Infrastructure Investment
## NHS Lothian Property and Asset Management Investment Programme
### 2014/15 - 2018/19

### 5 Year Property & Asset Investment Programme

<table>
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<th>Rolling Programmes</th>
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### Integration

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### Royal Edinburgh Campus

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**Western General Campus**

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**Lauriston Campus**

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**Other Schemes**

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</tbody>
</table>

Planned Capital Expenditure: 67.109 £m
Planned Retained Receipts: (2.750) £m
Planned Net Capital Expenditure: 64.359 £m

Key: A = approved; IG = In Governance; NG = Not in Governance
### NHS Lothian Revenue Funded Infrastructure Investment

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Estimated Capital Value £m</th>
<th>Estimated Unitary Charge £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Firhill Partnership Centre</td>
<td>7.0</td>
<td>0.71</td>
</tr>
<tr>
<td>Blackburn Partnership Centre</td>
<td>3.92</td>
<td>0.78</td>
</tr>
<tr>
<td>North West Edinburgh Partnership Centre</td>
<td>10.15</td>
<td>1.23</td>
</tr>
<tr>
<td>Royal Edinburgh Redevelopment - phase 1</td>
<td>45.17</td>
<td>5.43</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>66.24</strong></td>
<td><strong>8.15</strong></td>
</tr>
</tbody>
</table>