NHS Lothian Board

Wed 05 February 2025, 09:30 - 12:05

Carrington Room, Inverleith Building, Western General Hospital, EH4 2LF

Agenda

09:30 - 09:33 3 min

1. Welcome

Verbal *John Connaghan*

09:33 - 09:34 1 min

2. Apologies for Absence

Verbal *John Connaghan*

09:34 - 09:35 1 min

3. Declaration of Interests

Verbal *John Connaghan*

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

Please notify changes to loth.corporategovernanceteam@nhs.scot

For further information around declarations of interest please refer to the code of conduct section of the Board Members' Handbook.

Items for Approval or Noting

09:35 - 09:40 5 min

4. Items proposed for Approval or Noting without further discussion

Decision *John Connaghan*

4.1. Minutes of Previous Board Meeting - 04 December 2024

For Approval *John Connaghan*

4.1 NHS Lothian Board Minutes 04-12-24 (Draft to Meeting).pdf (9 pages)

4.2. Finance & Resources Committee Minutes - 23 October 2024

For Noting *Martin Connor*

4.2 Finance and Resources Committee Minutes 23-10-24 (Final).pdf (5 pages)

4.3. Healthcare Governance Committee Minutes - 19 November 2024

For Noting *Andrew Cogan*

4.3 Healthcare Governance Committee Minutes - 19-11-24 (Final).pdf (8 pages)

4.4. Staff Governance Committee Minutes - 30 October 2024

For Noting *Val de Souza*

4.4 Staff Governance Minutes 30-10-24 (Final).pdf (11 pages)

4.5. Midlothian Integration Joint Board Minutes - 19 September and 24 October 2024

For Noting *Val de Souza*

4.5 (a) Midlothian IJB Minutes - 19-09-2024.pdf (4 pages)
4.5 (b) Midlothian IJB Minutes - 24-10-2024.pdf (18 pages)

4.6. Disposal of St Michael's Hospital, Linlithgow

For Approval *Craig Marriott*

4.6 NHSL Board Declaration Surplus St Michaels Hospital (Final).pdf (3 pages)

4.7. Health & Care (Staffing) (Scotland) Act 2019 – Quarter 3 Board Compliance Report

For Noting *Alison Macdonald*

The Board asked to accept **Moderate Assurance** on how NHS Lothian is meeting its legal duties under the 2019 Act, based on the Scottish Government's compliance scoring and its rating of "Reasonable Assurance" for NHS Lothian.

4.7 Health and Care (Staffing) (Scotland) Act 2019 Qtr 3 Compliance Report.pdf (21 pages)

4.8. Pharmacy Practices Committee Outcomes - Quarter 3 Report (October to December 2024)

For Noting *Jenny Long*

4.8 Pharmacy Practices Committee Outcomes - Q3 2024 Report (Final).pdf (4 pages)

4.9. Appointment of Members to Committees & Integration Joint Boards

For Approval *Darren Thompson*

4.9 February 2025 - Board Appointments Report.pdf (3 pages)

Items for Discussion

09:40 - 09:50
10 min

5. Board Chair's Report - February 2025

Verbal *John Connaghan*

09:50 - 10:00
10 min

6. Chief Executive's Report - February 2025

Discussion *Caroline Hiscox*

6. Board Chief Executive's Report 2025-02-05 (Final).pdf (5 pages)

10:00 - 10:05
5 min

7. Opportunity for Committee Chairs or IJB Leads to Highlight Material Items for Awareness

Verbal *John Connaghan*

10:05 - 10:30
25 min

8. Unscheduled Care Improvement Programme at the RIE

Discussion *Jim Crombie*

8. Unscheduled Care Improvement Programme Board Paper Feb 25 (Final).pdf (7 pages)

10:30 - 10:50
20 min

9. Director of Public Health Annual Report 2024

Discussion *Dona Milne*

9. DPH Annual Report 2024 Paper & Appendix 05.02.25 (Final).pdf (42 pages)

10:50 - 11:00
10 min

10. Princess Alexandra Eye Pavilion Update

Verbal Update *Jim Crombie*

11:00 - 11:10
10 min

Break

11:10 - 11:20
10 min

11. Child and Adolescent Mental Health Services (CAMHS) Escalation Update

Discussion *Tracey Mckigen*

11. CAMHS Escalation Update 05.02.25 (Final).pdf (5 pages)

11:20 - 11:30
10 min

12. NHS Lothian Financial Position December 2024

Discussion *Craig Marriott*

12. Board Paper_Finance Update M9_FINAL.pdf (7 pages)

11:30 - 11:40
10 min

13. Corporate Risk Register

Discussion *Tracey Gillies*

13. Board Corporate Risk Register Paper 05.02.25 (Final).pdf (28 pages)

11:40 - 12:00
20 min

14. NHS Lothian Board Performance Paper

Discussion *Jim Crombie*

14. Board Performance Paper & Appendix (Feb2025 Final).pdf (25 pages)

12:00 - 12:02
2 min

15. Any Other Business

Verbal *John Connaghan*

12:02 - 12:04
2 min

16. Reflections on the Meeting

Verbal *John Connaghan*

12:04 - 12:05
1 min

17. 2025 Meeting Dates

For Noting *John Connaghan*

- **23 April 2025**
- **25 June 2025 (10.30am start - Annual Accounts)**
- **13 August 2025**
- **08 October 2025**
- **03 December 2025 (10.30am start)**

LOTHIAN NHS BOARD **4.1**

Minutes of the meeting of Lothian NHS Board held at 09.30am on Wednesday 04 December 2024 in the Carrington Room, Inverleith Building, Western General Hospital, Edinburgh EH4 2LF.

Present:

Non-Executive Board Members: Prof. J. Connaghan (Board Chair); Mr A. Fleming (Vice Chair); Mr P. Allenby (from 11am); Cllr S. Akhtar; Mr E. Balfour; Mr J. Blazeby; Dr P. Cantley; Cllr H. Cartmill; Mr A. Cogan; Mr M. Connor; Ms V. de Souza; Ms E. Gordon; Mr G. Gordon; Prof J. Innes; Mrs K. Kasper; Prof A. Khan; Mr P. Knight; Ms K. Macdonald; Ms T. A. Miller and Cllr D. Milligan.

Executive Board Members: Prof. C. Hiscox (Chief Executive); Miss T. Gillies (Executive Medical Director); Ms A. MacDonald (Executive Nurse Director) and Mr C. Marriott (Director of Finance).

In Attendance: Mr J. Crombie (Deputy Chief Executive); Mr C. Briggs (Director of Strategic Planning); Ms J. Butler (Director of Human Resources & Organisational Development); Ms M. Carr (Chief Officer, Acute Services); Dr J. Long (Director of Primary Care); Ms J. Mackay (Director of Communications & Public Engagement); Ms T. McKigen (Services Director, Royal Edinburgh Hospital & Associated Services); Ms F. Wilson (Chief Officer, East Lothian IJB); Ms M. Barrow (Chief Officer, Midlothian IJB); Ms A. White (Chief Officer, West Lothian IJB); Ms A. Goodfellow (Deputy Director of Public Health and Health Policy); Mr D. Thompson (Board Secretary) and Mr C. Graham (Corporate Governance Team Manager, minutes).

Apologies for Absence: Prof. L. Marson (Non-Executive Board Member); Ms D. Milne (Director of Public Health and Health Policy); Mr P. Togher (Chief Officer, Edinburgh IJB) and Ms M. Campbell (Director of Estates & Facilities).

56. Welcome & Declaration of Interests

56.1 The Chair welcomed members, colleagues, and observers to the Board meeting.

56.2 The Chair asked members to 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. No declarations of interest were made.

56.3 The Chair welcomed Councillor Margaret Graham to her first Board meeting as the new Non-Executive Stakeholder Board Member for Edinburgh Council replacing Councillor Stephen Jenkinson.

ITEMS FOR APPROVAL OR NOTING

57. Items proposed for Approval or Noting without further discussion

57.1 The Chair reminded those present that the Board agenda was made up of two separate sections. The first was the section for approval commonly referred to as “the consent agenda.” The Chair reminded members that they had the opportunity to advise in advance if they wished any matter to be moved out of this section, for discussion. The Board noted that no such requests had been made.

57.2 Minutes of Previous Board Meeting held on 10 October 2024 – Minutes were approved.

57.3 Finance & Resources Committee Minutes – 21 August 2024 – Minutes were noted.

57.4 Healthcare Governance Committee Minutes – 17 September & 22 October 2024 – Minutes were noted.

57.5 Audit & Risk Committee Minutes – 19 August 2024 – Minutes were noted.

57.6 Staff Governance Committee Minutes – 31 July 2024 – Minutes were noted.

57.7 West Lothian Integration Joint Board Minutes – 08 August & 17 September 2024 – Minutes were noted.

57.8 East Lothian Integration Joint Board Minutes – 26 September 2024 – Minutes were noted.

57.9 Edinburgh Integration Joint Board Minutes – 24 September 2024 – Minutes were noted.

57.10 Midlothian Integration Joint Board Minutes – 22 August 2024 – Minutes were noted.

57.11 Health & Care (Staffing) (Scotland) Act 2019 – Quarter 2 Board Compliance Report – Report was noted. The Board agreed to accept **Moderate Assurance** on how NHS Lothian is meeting its legal duties under the 2019 Act, based on the Scottish Government's compliance scoring and its rating of "Reasonable Assurance" for NHS Lothian.

57.12 National Whistleblowing Standards – Quarter 2, 2024/25 Performance Report – Report was noted.

57.13 Drug Related Deaths Annual Report 2023 – Report was noted.

57.14 Appointment of Members to Committees and Integration Joint Boards – The Board approved the recommendations in the paper, as follows:

- The appointment of Ms Elizabeth Gordon, Non-Executive Director, to the Audit and Risk Committee membership, with effect from 4 December 2024.
- The appointment of Mrs Patrica Cantley, Non-Executive Director, to the Audit and Risk Committee membership, with effect from 4 December 2024.
- The appointment of Professor Amjad Khan, Non-Executive Director, to the Healthcare Governance Committee membership, with effect from 4 December 2024.
- The removal of Councillor Harry Cartmill, Non-Executive Director, from the Healthcare Governance Committee membership, with effect from 4 December 2024.
- The appointment of Mr Jonathan Blazeby, Non-Executive Director, to the Remuneration Committee membership, with effect from 4 December 2024.
- The appointment of Wendy Metcalfe, Renal Clinical Director, as, Non-Voting Member of the Midlothian Integration Joint Board, with effect from 04 December 2024.

The Board noted the following appointments:

- The appointment of Councillor Margaret Graham, as a non-executive member of the Lothian NHS Board from 1 November 2024.
- The reappointment of Val De Souza, as a non-executive member of the Lothian NHS Board from 1 April 2025 to 31 March 2029.
- The reappointment of Peter Knight, as a non-executive member of the Lothian NHS Board from 1 April 2025 to 31 March 2029.
- The reappointment of Elizabeth Gordon, as a non-executive member of the Lothian NHS Board from 1 April 2025 to 31 March 2029.
- The reappointment of George Gordon, as a non-executive member of the Lothian NHS Board from 16 May 2025 to 31 December 2026.

57.15 NHS Lothian Board and Committee Dates 2025/26 & 2026/27 – The proposed dates were approved.

ITEMS FOR DISCUSSION

58. Board Chair's Report – December 2024

58.1 The Chair highlighted the following:

- **Mr Pat Togher, Edinburgh HSCP Chief Officer** – The Chair noted that, although absent, this was Mr Togher's final Board meeting before leaving Edinburgh HSCP to take up position as Chief Officer at Glasgow HSCP. The Board recorded its thanks to Mr Togher and wished him all the best in his new role.

- **Scottish Health Awards 2024** – The Chair congratulated two members of NHS Lothian staff who won key awards at this year's Scottish Health Awards:

  - Lindsey Todd, Specialist Radiographer, Department of Clinical Neurosciences
  - Dr Rosamunde Burns, Consultant Anaesthetist

  The Chair also extended congratulations to a further seven NHS Lothian staff who had been nominated for awards and had reached the finalist stage.

- **Audit Scotland Report - NHS in Scotland 2024** – The Chair noted and welcomed the recent publication of this report, which would worthy of further reflection under the finance update, later on the agenda.

59. Chief Executive's Report – December 2024

59.1 The Chief Executive introduced her report, highlighting the key items within this and the following areas were discussed:

- **Fire Safety at the Royal Infirmary of Edinburgh** - The Board noted that the Staff Governance Committee had received an update on Fire Safety on 30 October 2024. The Committee had been content with the thoroughness of the update but had requested additional assurance on the overall impact of the various mitigating actions. This additional assurance briefing session had now been provided and members of the Staff Governance Committee confirmed they had the additional assurance relating to the understanding of the range and effectiveness of mitigating actions.

- **Princess Alexandra Eye Pavilion** - The Board discussed the ongoing engagement with patients and stakeholder organisations about the relocation of PAEP services whilst the closure for essential repair work was in place. Feedback from patients had been generally very positive and any arising issues had been resolved quickly. Such issues related to the complexity of providing alternative transport arrangements and ensuring that patients could adjust the font size on digital correspondence. Staff feedback on the move had also been positive with the provision of transport for staff at start and finish times, proving successful. The Board noted that there was ongoing tracking of any attendance or ongoing provision issues.

- **Health Awards -** The Board reiterated its congratulations to the NHS Lothian nominees and winners at the Scottish Health Awards. There was further discussion about the importance of having an in-person event for NHS Lothian's Celebrating Success event to make staff feel valued. The Director of HR&OD reminded the Board of the tax implications around hosting an in-person event but confirmed that it was hoped there could be an in-person element incorporated into next year's event.

- **Activism against Gender-Based Violence – NHS Lothian Women's Network -** The Director of HR&OD confirmed that this network regularly reported to Staff Governance Committee as one of the five NHS Lothian staff networks. The Board also noted that assurance on equality and diversity activity was provided regularly via the Healthcare Governance Committee.

60. Opportunity for committee chairs or IJB leads to highlight material items for awareness

60.1 Finance & Resources Committee – The Board noted the ongoing good work around sustainability, with the Annual Climate Emergency Sustainability Report being received by the Committee and now published on the website. The Board recognised the work being undertaken by a small team and this was an important area for all Board members to be sighted on.

60.2 Healthcare Governance Committee – The Board noted the lifting of the pause around gender identity services referrals now that the assessment pathways had been reviewed and updated. The Committee was continuing to receive reports as appropriate. The Committee had also had a fuller discussion around the Drug Related Deaths Annual Report 2023.

60.3 Audit & Risk Committee - The Board noted that a tender process was underway, to appoint a new internal audit provider from April 2025. The Board recognised internal audit as a key part of the governance risk assurance programme and noted that there were still several outstanding reports to be received this financial year. The Committee Chair asked responsible executives to ensure that management actions in response to internal audit reports were provided in a timely fashion to ensure the Committee had adequate time to consider these in the current financial year.

61. Annual Ministerial Review 2023/24 – Outcome Letter

61.1 The Chief Executive confirmed that there had been a positive Annual Review held on 7 October 2024 and the Board Secretary had undertaken an exercise with colleagues to capture key learning points which would inform preparations for next year's Annual Review.

61.2 The Board noted the letter from the Minister for Public Health and Women's Health, as a source of **significant assurance** that the Scottish Government had carried out its Annual Review of Lothian NHS Board's performance for 2023/24 and noted that the letter would be published on the Board's website.

62. NHS Lothian Board Assurance Framework Proposal

62.1 The Board Secretary introduced the paper proposing a revised Board Assurance Framework (BAF). He explained that this was intended to meet the specific needs of the Board and its members, and reflect established good practice in NHS corporate governance, demonstrating robust compliance with the principles of the Blueprint for Good Governance.

62.2 The Chief Executive emphasised that the model proposed would be largely familiar to Board members but that reviewing current arrangements was important to provide greater clarity on how key assurances were received and considered by the Board and its committees. She noted the intention to avoid duplication and jargon, and to support better understanding for board members, staff and wider stakeholders

62.3 The Board welcomed and discussed the proposals in more detail. It was agreed that the BAF should be co-produced with board members, by way of a steering group, and that there would be development sessions held in the new year to work through the overall detail. Consideration would also be given to how integration joint boards; primary and social care would align with the BAF. The Chief Executive confirmed that this work would not be done in isolation but would be done in partnership, involving all members of the Corporate Management Team and their teams as part of the reduction of duplication.

62.4 The Board agreed, in principle, to the development of the proposed BAF and its components, as a suitable response to the Board's previously agreed action from its Blueprint Development Session in March 2024.

62.5 It was agreed that there would be an iterative approach taken to developing and delivering the various components of the BAF, which would be influenced by both the prioritisation of assurance needs and available resource capacity. This would permit improvements to be implemented in key areas more quickly. Regular updates would be provided to the Board and its committees as the required programme of work progressed.

62.6 The Board supported the steps forward with the BAF and thanked the Board Secretary for pulling together the proposals.

63. Corporate Objectives and Lothian Strategic Development Framework (LSDF) Mid-Year Review

63.1 The Director of Strategic Planning provided a progress update against the Corporate Objectives for 2024/25, as noted at the end of the first six months of the financial year.

63.2 The Board was reminded of its agreement that the organisation should operate to deliver Corporate Objectives which progress NHS Lothian's strategic direction, and which illustrate the link between this direction and improved organisational (and system) performance. This meant one Corporate Objective for each of the six pillars and five parameters of the LSDF. For each of the six pillars, the Implementation Books provided detailed plans on how these objectives would be delivered.

63.3 Over and above these pillars and parameters, the Board has also adopted Corporate Objectives for four key additional areas: Quality & Safety; Contract Management for the RIE PFU Agreement; Equality & Human Rights; and Protecting People's Health.

63.4 Each Corporate Objective appeared in the personal objectives of at least one member of the Corporate Management Team and therefore linked to individual performance assessment. There would also be consideration of how objectives and performance could be linked to the new Board Assurance Framework in a structured way.

63.5 The Board discussed the highlights and challenges of the Corporate Objectives as outlined at Appendix 1 of the report. There was discussion on public health and prevention related objectives and members wished to ensure that the measurement of outcomes was captured, in addition to process changes. Improvements in the implementation book for the Digital parameter, in particular, were noted. Members discussed workforce related objectives and reflected that, despite financial restrictions, there were opportunities. An increase in rates of sickness absence and the factors driving this were acknowledged. Executives explained that the consistent application of workforce policies and interventions was critical, as well as ensuring shared learning between departments and with other boards. The Chair acknowledged recent investments in staff wellbeing initiatives provided via the NHS Lothian Charity.

63.6 More broadly, the Board discussed the importance of clear performance measures and a healthy organisational culture as key enablers in delivering its agreed objectives. It was acknowledged that new Board Assurance Framework would provide an opportunity to better report against delivery and that processes were underway to appoint a new Director of People and Culture, following the recent announcement of the Director of Human Resources and Organisational Development's planned retirement. It was expected that this would bring greater focus to the development of culture as an enabler

63.7 Following detailed discussion, the Board agreed to accept **moderate** assurance that the Corporate Objectives work was progressing appropriately and that the Corporate Objectives for 2024/25 would be delivered.

64. NHS Lothian October 2024 Financial Position

64.1 The Director of Finance presented an update on NHS Lothian's financial position as at October 2024. He reminded members that the organisation had started the year with a 7% gap, equating to £140M. He noted that next year's gap was currently expected to be of a broadly similar scale , subject to the Scottish Government's imminent budget announcement.

64.2 The current financial position, at Month 7, reflected a £12.4M overspend, in line with expectations. Pressures remained within medical, dental, non-pay, GP prescribing and management of the reduced working week. However, the nurse agency position was improving. In relation to prescribing in general the Director of Finance highlighted that NHS Lothian was a relatively low-cost prescriber with a well-established efficiency programme. The Medical Director added that there was ongoing work with both Primary Care and Acute Services to monitor drugs of low clinical value and reduce or eliminate their prescribing as part of formulary compliance.

64.3 The Q1 forecast was a £32M overspend with improvement expected for Q2, which would be reported and discussed through the Finance and Resources Committee. A number of efficiency workstreams were delivering benefits but a lot of this was based on non-recurring savings. There would be overarching conversations and engagement with business units held in January as part of the push towards breakeven.

64.4 The Board noted that the Scottish Government would announce its Budget for 2025/26 later that day. The Director of Finance reported that the outcomes from the UK budget had been better than anticipated. However, whilst pay uplifts were expected to be fully funded, non-pay budgets were still being modelled on the basis of no uplift. A briefing paper would be provided to Board Members following that afternoon's Scottish Budget announcement.

64.5 A discussion followed on the details of the financial report provided. Members sought to understand the effectiveness of current controls on those areas of expenditure where the pressure was greatest. Further clarity was also sought in relation to the ongoing impacts of the Board's Financial Recovery Plan on patients and services. Members also sought assurance on how changes, reductions or delays in services were communicated to the public and patients.

64.6 The Chief Executive reminded the Board that it had a statutory obligation to deliver financial balance each year but acknowledged the frustration that doing so currently was not possible without consequences for service delivery levels. Efforts to capture and articulate the scale of impact at a collective level were ongoing but represented a significantly challenging task. In the meantime, appropriate due diligence, stakeholder engagement processes and impact assessments continued to be applied to all individual decisions, in line with the agreed governance and decision-making processes. It was considered that demonstrating sound financial management was an important factor for the Board when discussing future initiatives and potential service investments with Scottish Ministers.

64.7 The Director of Finance confirmed that there were national collaborative efforts to address particularly high areas of spend across boards, such as locum spend, with NHS Lothian in a relatively strong position in this area.

64.8 The key findings from the recent Audit Scotland: NHS in Scotland 2024 report were noted by the Board. As in previous years, this report continued to highlight very significant ongoing challenges in relation to the financial sustainability and productivity of the NHS in Scotland. It was considered that addressing these challenges would require a careful balancing of investment and disinvestment decisions, both nationally and within NHS boards. Until a coherent national plan was provided, the onus rested with individual boards to demonstrate leadership in meeting the challenges.

64.9 The Director of Finance offered reassurance to the Board that there was early work underway to anticipate and address the financial challenges for 2025/26. He set out a timeline of planned engagement with departments and leaders within NHS Lothian, commencing in December, with all service plans to be collated and considered by the Corporate Management Team in January.

64.10 The Board noted the financial position to the end of October 2024, including a £12.4m overspend, and accepted that, based on information available at this stage, NHS Lothian was only able to provide **limited assurance** on its ability to deliver a breakeven position in 2024/25.

65. Child Poverty Action Annual Reports

65.1 The Deputy Director of Public Health and Health Policy introduced the paper providing the Board with an annual update of action being taken to tackle child poverty in NHS Lothian.

65.2 The Board noted some key developments highlighted within the report which included: a realignment of reporting and governance processes to the Anchor Institution workstream; embedding data protection impact assessments within the Maternity Trak Care system; the reporting of outcomes from the income maximisation service; details of ongoing work in relation to the child poverty accelerator fund; and work with Public Health Scotland to review key pathways. It was reported that two local authorities were still to publish their reports and that these would be reviewed and approved by the Director of Public Health, under the appropriate delegated authority.

65.3 The Board discussed the details of the reported, noting the changing demographics and welcoming the work being done around income maximisation. Whilst it was noted that income maximisation was not in itself a direct statutory responsibility of the Board, the impacts from this were understood to contribute to addressing the Board's wider population health and prevention duties. The potential for the NHS Lothian Charity to offer support in this area was acknowledged but this was a matter for the Charity's Board of Trustees to consider independently.

65.4 The Board noted the annual update of action being taken by NHS Lothian to tackle child poverty.

66. NHS Lothian Board Performance Report

66.1 The Deputy Chief Executive presented the Board Performance report, noting a number of significant drivers that had been discussed earlier in the meeting, such as finance and workforce, and the impact these had on performance.

66.2 There was discussion on a number of initiatives underway to drive the financial gap down. These included: “Pause and Assess” actions; switching off of Waiting Time Initiatives; the use of external capacity; the use of independent sector capacity and the well-rehearsed plans around capital funding and the implications of these. The Board noted these initiatives and appreciated that whilst these were managing to be maintained this did have an impact on both numbers waiting and waiting times. The migration of PAEP and ophthalmology services to other sites had impacted wider elective capacity and other services.

66.3 The Deputy Chief Executive highlighted that there were also pressures being seen within Diagnostic services such as Endoscopy and Radiology. 31-day cancer performance was in line with the Scottish position, but 62-day performance remained compromised, with the number of referrals increased. It was noted that the Board had benefited from mutual aid in relation to Urology. For the 4hr Emergency Access Standard all adult sites remained constrained. The Board’s October performance was at 60% against the Scottish position of 65%. It was clear that all NHS Scotland front doors and staff were struggling with significant and sustained duress.

66.4 The Deputy Chief Executive outlined the opportunity provided by Scottish Government for the Board to look at unscheduled care and consider a system wide response proposal to approach this differently nationally. A RIE focused response strategy had been developed over the last couple of weeks with input from all Lothian integration joint boards (IJBs). Lothian had been one of three boards asked to submit a proposal and discussions with Scottish Government were ongoing.

66.5 The Chief Officer for Acute Services reported on the pressures within diagnostic testing and due to an increase in urgent cancer referrals. There was a process of consultant led validation of referrals to ensure that referrals were appropriate, and that capacity was be allocated in order of priority. These principles were also used for MRI and Ultrasound referrals. The increase in Endoscopy referrals was being managed as effectively as possible, working with GPs, having previously relied on both waiting list initiatives and external capacity.

66.6 The Chair asked about how Lothian would deal with a system in crisis and what would happen if a critical incident was declared. The Deputy Chief Executive clarified that NHS Lothian’s Corporate Management Team had undertaken a detailed piece of work, building on experiences from last year that outlined triggers for escalation in relation to winter pressures. This dictated the most appropriate response for all acute sites and ensured engagement from health and social care teams, with the options to escalate to the corporate level.

66.7 Based on the recommendations in the paper, the Board noted both the implications of the performance matters described and NHS Lothian’s current levels of compliance against national performance standards and measures.

67. Corporate Risk Register

67.1 The Board received and considered NHS Lothian’s Corporate Risk Register. Members noted the internal audit report on risk management processes, which had been presented to the Audit & Risk Committee in November.

68. Any Other Business

68.1 Non-Executive Recruitment Process & Review of Commitments – The Chair reported that the next round of non-executive recruitment was underway, and the recruitment pack would be shared with members when available. The Chair also intended to review existing non-executive members’ commitments alongside the recruitment of new Board members.

69. Reflections on the Meeting

69.1 The Chair asked members to contact colleagues offline if they wished to discuss any items further.

70. Date of Next Board Meeting

- Wednesday 05 February 2025

Chair's Signature ……
Date ……

Prof. John Connaghan
Chair – Lothian NHS Board

FINANCE AND RESOURCES COMMITTEE

Minutes of the meeting of the Finance and Resources Committee held at 9.30 on Wednesday 23 October 2024 via Microsoft Teams.

Present: Mr M. Connor, Non-Executive Board Member (chair); Cllr S. Akhtar, Non-Executive Board Member; Mr P. Allenby, Non-Executive Board Member; Mr A. Fleming, Non-Executive Board Member; Mr G. Gordon, Non-Executive Board Member.

In attendance: Ms M. Campbell, Director of Estates and Facilities; Mr J. Crombie, Deputy Chief Executive; Professor C. Hiscox, Chief Executive; Dr J. Hopton, Sustainability Programme Director, Facilities; Mr G. Johnson, Non-Executive Board Member, NHS Forth Valley (observing); Mr C. Kerr, Programme Director, Capital Planning; Mr C. Marriott, Director of Finance; Mr A. McCreadie, Deputy Director of Finance; Mr D. Mill, Senior Project Manager, Facilities; Ms B. Pillath, Committee Administrator (minutes); Ms I. Tricker, Finance Manager.

Apologies: Ms T. Gillies, Medical Director.

Chair's Welcome

The Chair welcomed members to the meeting.

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

18. Committee Business

18.1 Minutes and Actions from Previous Meeting (21 August 2024)

18.1.1 Members accepted the minutes from the meeting held on 21 August 2024 as a correct record.

18.1.2 The updated cumulative action note had been previously circulated. Updates discussed would be included in the action plan circulated before the next meeting.

19. Capital

19.1 Property and Asset Management Investment Programme

19.1.1 Mr Kerr presented the previously circulated paper. Concern from the local community about the disposal of the Royal Victoria building was noted. Mr Marriott advised that NHS Lothian was not in a position to invest in land at this time and there was a need to release funds.

19.1.2 The Scottish Government had been approached about the possibility of releasing some capital by extending GP premises leases rather than buying, but this had not been taken forward. This would be raised again.

19.1.3 Mr Marriott agreed to follow up whether there were any lessons learned from the design of the MATS clinic at Astley Ainslie Hospital which was bigger than the service required.

19.1.4 Mr Marriott advised that that the Scottish Government had allocated the estimated capital required for the essential repair works at the Eye Pavilion. Discussions about funding for revenue costs was ongoing. It had been made clear to the Scottish Government that there would be further costs in reopening a building which was due for replacement.

19.1.5 Following problems with fire raising at the closed Edenhall Hospital site, Ms Campbell advised that the first section of the damaged part of the building had now been demolished and the second section would be demolished soon. As the buyer would be seeking planning permission for the site it was likely to be a year before the sale was completed, and so the security of the empty building would remain the responsibility of NHS Lothian.

19.1.6 Mr Marriott advised that Mr Barron would be taking on the role of Head of Capital Planning.

19.1.7 Members accepted the recommendations laid out in the paper.

19.2 Royal Infirmary of Edinburgh Facilities Risk

19.2.1 Ms Campbell presented the previously circulated paper. It was noted that the planned blackstart to check systems had not gone ahead due to the risks involved. Ms Campbell advised that regular generator tests did take place and plans were in place for prioritisation in the case of power loss. Plans would be made to carry out the blackstart after the winter.

19.2.2 It was agreed that timescales should be added to the actions on the risk mitigation plan but noted that some actions were the responsibility of the PFI contractors. Mr Marriott advised that discussions were progressing on the PFI contract negotiations. An update on timescales for actions would be brought to the meeting in February 2025 once this had been agreed. **CM**

19.2.3 Members accepted the recommendations laid out in the paper.

20. Revenue

20.1. Year to Date Financial Position

20.1.1 Mr McCreadie presented the previously circulated paper. It was noted that a paper was expected in the next few weeks on prescribing costs, identifying areas of growth and where efficiency planning should be focused.

20.1.2 It was noted that there had been no uplift in funding for clinical supplies this year and in recent years there had been a less than inflation uplift, so this had been a focus for efficiency savings. Contracts for supplies were often on a three-year cycle which meant that better savings would be achieved as the cycle progressed. A number of

items were already purchased through National Procurement and therefore making savings through bulk buying, but there were opportunities to do more of this.

20.1.3 Mr McCreadie advised that a small reserve of less than 0.5% of the overall revenue was retained each year. More savings could be added to this as appropriate throughout the year and then this would be built back into the following years' planning.

20.1.4 There were service level agreements in place with other boards for both acute and non-acute services. These were cost sharing agreements and NHS Lothian did not profit from them. Agreements had recently been reviewed to make them more efficient. An uplift of £5-6 million was received per year to recover the cost of providing services for other boards.

20.1.5 Mr McCreadie advised that part of the projected overspend for the Board was Integration Joint Board overspend for delegated and non delegated elements. In previous years NHS Lothian had made further allocations to the Integration Joint Boards when financial balance had been achieved, but Integration Joint Boards were also expected to put actions in place to ensure costs were reduced. The system was run as a partnership and there were good links with the chief officers of the Integration Joint Boards through the Corporate Management Team.

20.1.6 Mr Marriott advised that every opportunity had been taken to raise to the Scottish Government the growth in population in Edinburgh and the Lothians, particularly East Lothian, and consequent underfunding compared to other areas.

20.1.7 The proportion of recurrent and non recurrent savings would be similar that year to in previous years, although the total amount of both recurrent and non recurrent had increased.

20.1.8 Members accepted the recommendations laid out in the paper and accepted limited assurance.

20.2 <u>Draft Financial Plan 2025-26</u>

20.2.1 Mr McCreadie presented the previously circulated paper. It was noted that latest population figures showed that the population growth in Edinburgh and the Lothians continued but was slowing. There would be continued lobbying of the Scottish Government to achieve NRAC parity as due to historical lack of funding NHS Lothian was 0.6% below the allocation by population.

20.2.2 As no further money was coming into the health system it was not possible to provide services within budget, and reduction of services would impact performance and waiting times. As a public service, the only levers available to reduce spend was to focus on efficiencies. National decisions needed to be made on structure, buildings, digital innovation and supplies. Currently the investment had been in staff pay, which has not increased productivity in the system.

20.2.3 Members accepted the recommendations laid out in the paper.

21. Scottish Hospitals Inquiry

21.1 Cost of Scottish Hospitals Inquiry to NHS Lothian

21.1.1 A copy of a Freedom of Information response outlining the costs to NHS Lothian had been previously circulated for information. It was noted that in addition to the costs listed, significant time and expertise had been given from former members of staff who were retired and were not funded, including the former Chief Executive and the former Director of Finance. Members noted their thanks to these former members of staff for their contributions.

22. Sustainability

22.1 Climate Emergency and Sustainability

22.1.1 Dr Hopton and Mr Mills presented the previously circulated paper. It was noted that the lack of capital funding for new buildings and to make older buildings more sustainable was challenging for achieving better energy efficiency and carbon reduction. This risk had been highlighted to the Scottish Government. The focus needed to be on other financial and energy models.

22.1.2 Dr Hopton noted proper investment and focus on issues such as sustainable energy and food waste reduction could lead to bigger financial savings.

22.1.3 There were opportunities for NHS Lothian to be an influential partner in discussions with the Council on innovative energy projects.

22.1.4 Sustainable travel for staff and patients should be put in place before new hospital buildings were opened and patterns of transport were established. Mr Mills advised that it was difficult to collect this data from staff and that previous focus for new buildings had been on the carbon footprint but agreed that this was a good aspiration.

22.1.5 Members accepted the recommendations laid out in the paper.

22.2 Public Sector Reform Act Disclosures Annual Report

22.2.1 The paper had been previously circulated for information. Members approved the report for publication.

23. Reflections on the meeting

23.1 The chair agreed to highlight the sustainability report to the Board on the part of the agenda for Committee Chairs' updates.

24. Date of Next Meeting

24.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 18 December 2024**.

25. Further Meeting Dates

25.1 Further meetings would take place on the following dates:
- 12 February 2025
- 26 March 2025

Signed by Chair
18 December 2024

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 13.00 on Tuesday 19 November 2024 by video conference.

Present: Mr A. Cogan, Non-Executive Board Member (chair); Mr E. Balfour, Non-Executive Board Member; Cllr H. Cartmill, Non-Executive Board Member; Mr A. Fleming, Non-Executive Board Member; Mr P. Knight, Non-Executive Board Member.

In attendance: Ms E. Anderson, Associate Quality Improvement Advisor; Ms H. Cameron, Director of Allied Health Professionals; Ms M. Carr, Chief Officer, Acute Services; Ms S. Davidson, Talent Management Programme (observing); Ms F. Ewing, Consultant Radiologist (item 51); Mr S. Garden, Director of Pharmacy; Ms J. Gillies, Associate Director of Quality; Ms T. Gillies, Medical Director; Ms A. Goodfellow, Deputy Director of Public Health; Mr I. Gorman, Service Director, Diagnostics, Anaesthetics, Theatres and Critical Care (item 51); Ms S. Gossner, Chief Nurse, East Lothian Health and Social Care Partnership; Ms L. Guthrie, Associate Director, Infection Prevention and Control; Mr J. Hetherington, General Manager, Diagnostics (item 51); Mr G. Johnston, Non Executive Director, NHS Forth Valley (observing); Dr K. Kallirroi, Associate Medical Director, Anaesthetics, Theatres and Critical Care (item 51); Professor A. Khan, Non Executive Board Member (observing); Mr M. Massaro-Mallinson, Service Director, Edinburgh Health and Social Care Partnership (item 52.1); Ms J. McDonald, General Manager, Anaesthetics, Theatres and Critical Care (item 51); Ms J. McNulty, Associate Nurse Director, Theatres and Anaesthetics (item 51); Mr G. Mills, Talent Management Programme (observing); Ms J. Morrison, Head of Patient Experience; Ms R. Moss, Talent Management Programme (observing); Ms P. Murray, Child Health Commissioner (observing); Ms M. Odam, Talent Management Programme (observing); Dr F. Ogilvie, Consultant in Public Health (item 53.5); Ms C. Palmer, Associate Nurse Director, Western General Hospital (item 53.1); Ms B. Pillath, Committee Administrator (minutes); Dr C. Reid, Consultant in Palliative Care (item 53.1); Mr G. Stark, Talent Management Programme (observing); Ms F. Stratton, Chief Nurse, Midlothian Health and Social Care Partnership; Mr C. Stirling, Site Director, Western General Hospital (item 53.1); Mr D. Thompson, Board Secretary; Ms H. Wallace, Business Manager, Diagnostics, Anaesthetics, Theatres and Critical Care (item 51); Ms S. Walter, Service Manager, Capacity Development, Outpatients and Associated Services and Talent Management Programme (item 53.4 and observing); Ms J. Webster, Talent Management Programme (observing); Dr C. Whitworth, Medical Director, Acute Services; Mr P. Wynne, Director of Community Nursing; Ms L. Yule, Chief Nurse, West Lothian Health and Social Care Partnership.

Apologies: Mr J. Crombie, Deputy Chief Executive; Professor C. Hiscox, Chief Executive; Ms A. MacDonald, Executive Nurse Director; Ms D. Milne, Director of Public Health; Mr P. Togher, Chief Officer, Edinburgh Health and Social Care Partnership; Ms C. Wyllie, Director of Public Protection.

Chair's Welcome and Introductions

Mr Cogan welcomed members to the meeting and members introduced themselves.

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

50. Committee Business

51.1 Minutes from Previous Meeting (22 October 2024)

50.1.1 The minutes from the meeting held on 22 October 2024 were approved as a correct record.

50.1.2 The cumulative action note would be updated following discussion at the meeting and would be circulated with the papers for the next meeting.

51.2 Membership

51.2.1 This was Mr Cartmill's last meeting of this Committee. Mr Cogan thanked him for his input. Mr Khan would become a member of the Committee from the next meeting.

51. Acute Services Assurance Report – Diagnostics, Anaesthetics, Theatres and Critical Care

51.1 Ms Carr, Mr Gorman, Ms McNulty, Ms Ewing and Dr Kallirroi presented the previously circulated paper. In response to a question about professional and clinical leadership for healthcare scientists and allied health professionals, it was noted that the Chief Radiologist and Lead for Allied Health Professionals reported up through the management structure. There was also a professional lead for Healthcare Science. There was good communication and professional development opportunities for these groups of staff.

51.2 The thrombectomy service operated from 8am to 6pm seven days per week and also covered NHS Boards in the east region using a 'hub and spoke' model and St John's Hospital outwith the 5 day per week service there. The ambition would be to offer a 24/7 service, but this was resource dependent. NHS Lothian provided more hours of service than the other regions in Scotland which were 5 days per week.

51.3 During the temporary closure of the Eye Pavilion, all eye surgery was being provided at St John's hospital where staff had been transferred. Theatre space was being freed up by moving services that did not require anaesthetics. The move had been efficient and there was a focus on catching up on theatre lists to cover those delayed by the move.

51.4 Mr Gorman advised that there were good arrangements for getting diagnostics results to clinical teams in good time. Radiology dealt with 700,000 results per year. There was assurance through the diagnostic teams that there was compliance with the process. Any individual problems in getting results were considered by the Lothian Interface Group with clinicians from primary and secondary care. There was work to do on addressing communications when patients were delayed.

51.5 There were long standing delays in step down from the High Dependency Unit and Intensive Care Unit, readmission and night time discharge from the units. Delay of discharge from the Intensive Care Unit was a capacity issue but also resulted in a poor experience for patients delayed as this was not a good environment for recovery. One bed was always kept available for emergency admissions to the unit.

51.6 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

52. Safe Care

52.1 Edinburgh Health and Social Care Partnership Bed Occupancy / Delayed Discharge Risk Mitigation

52.1.1 The chair welcomed Mr Massaro-Mallinson to the meeting and he presented the previously circulated paper. Additional work ongoing between the four health and social care partnerships aimed at improving the situation. From May, the number of people waiting for a care home had doubled, but improvements had been made on availability of hospital at home places. Redesign work would focus on maximising internal home care services. Work was also being done with Social Work and Housing, but hospital at home was currently the highest impact area.

52.1.2 More work on care home places was needed. More beds had been made available in some areas but more recurring funding was needed to increase this further.

52.1.3 It was noted that it would be useful to see a longer time period in the delayed discharge chart in the paper in order to compare to previous years.

52.1.4 Ms T. Gillies noted that a high level of bed occupancy impacted the care of patients who were delayed as well as those waiting for an acute or mental health bed. Patients not experiencing care in the most appropriate setting was detrimental to the quality of care even if where outcome was not impacted, for example the impact to patients and families when a patient died in an institutional setting rather than a homely setting.

52.1.5 Members accepted the recommendations laid out in the paper and accepted limited assurance. A further update would be given in March 2025. **PT**

52.2 Acute Access to Treatment Risk Mitigation

52.2.1 Ms Carr presented the previously circulated paper. The mitigation had been reported at the Strategic Planning and Performance Committee and some of the mitigations in place discussed. Waiting times were longer in NHS Lothian than in other large health boards. The reasons for this were being assessed, and there was also assessment of the clinical impact of these delays.

52.2.2 Dr Whitworth advised that the consequences of long waits for procedures included deterioration in conditions and delays in determining diagnosis or treatment plan. Processes were in place to identify these cases and to triage again to ensure urgent cases were treated sooner. The delays also lead to a change in behaviour of referrers and those carrying out triage, in referring more patients as urgent due a concern about the effect of delay.

52.2.3 Ms T. Gillies advised that there was no robust data on whether there were increased presentations at the emergency department due to long waits for procedures, but anecdotally unscheduled cancer presentations may be increasing. The number of patients referred as urgent suspicion of cancer increased, but not all

of these were considered urgent after assessment. Primary care referrals for CT scans and x-ray were open as an additional route for treatment referral. A regional piece of work was being considered on routine screening referrals and clinical outcomes. A further report would be brought to the Committee in March 2025 on the different routes for cancer treatment referral. **TG**

52.2.4 Members accepted the recommendations laid out in the paper and accepted limited assurance. A further update would be brought to the Committee in March 2025. **MC**

52.3 Update on national actions related to the Infected Blood Inquiry Oversight and Assurance Group

52.3.1 Ms T. Gillies gave a verbal update. The Scottish Government Oversight and Assurance Group was working on the recommendations from the national Inquiry. An update was being prepared which sent out the specific implications in Scotland. Some of the recommendations would be taken forward following appointment of a Patient Safety Commissioner in Scotland.

52.3.2 Clinical groups had met to consider the clinical recommendations. Some of the wording of the recommendations was not based on current appraised guidance, so work was being done on this. The GMC representatives talked about education in the use of blood. The Scottish Government had set up a group looking at the use of blood and the reduction of unnecessary use. One recommendation was for an end to end tracking system to be in place for blood. This was being considered nationally and the NHS National Services Scotland was preparing a business case to apply to the Scottish Government for funding.

52.3.3 A peer review had taken place at the Scottish Haemophilia Centre on current practice, and the recommendations from this were being worked on.

52.3.4 A paper would be brought to the Committee in March or May 2025 to update on the response to recommendations. **TG**

52.4 Gender Identity Services

52.4.1 Ms T. Gillies presented the previously circulated paper. The short life working group was working on the pathway for patients aged 17 and 18 years, as NHS Lothian had been an outlier in moving 17 year olds into adult services. An update on the outcome of this discussion would be brought to the meeting in January 2025. **TG**

52.5 Maternity Services Update

52.5.1 Ms Carr presented the previously circulated paper. Concerns had been raised regarding rota and safe staffing, as well as the process for escalating safe staffing risks. Maternity Services had now been brought into the process used elsewhere in acute services.

52.5.2 The Staff Governance Committee would oversee the whistleblowing complaint and the upheld complaints in this area. The action required to address the concerns

including managing patient flow and impact on outcomes for mothers and babies would be overseen by the Healthcare Governance Committee.

52.5.3 It was noted that the Healthcare Governance had previously taken a moderate level of assurance on Maternity Services, and this may represent the instability of the evidence on which this was based, but it was confirmed that the data seen was correct.

52.5.4 Work was ongoing with Organisational Development and an interim report would be brought to the Committee in March 2025 before the full Women's Services report in May 2025. **MC**

52.6 Public Protection Annual Report

52.6.1 Members accepted the recommendations laid out in the previous paper, and accepted moderate assurance.

52.7 Significant Adverse Events

52.7.1 Ms T. Gillies presented the previously circulated paper. Data on the proportion of incidents covered by the top three categories of harm was requested for the next report.

52.7.2 The data showed an increase in the number of all incidents. Ms T. Gillies advised that more information had been provided in the previous paper. In terms of maternity cases, because cases were considered together in themed groups the numbers reported as completed could fluctuate. The initial assessment of level of harm by the member of staff reporting the incident on Datix was not always the same as the level of harm agreed as the outcome following investigation and review.

52.7.3 There was a time lag in the reported data of 12 to 18 months from the incident. This was because of the time taking to investigate and to communicate with the families first. There had been no increase in reported avoidable harm outcome 3 and 4 events in maternity services after review.

52.7.4 It was important to encourage all incident reporting from staff even if this initially showed more cases. This ensure that all potential concerns were reviewed. There was less resource for investigation in detail for incidents of poor patient experience rather than incidents of avoidable harm, and different processes were used.

52.7.5 Members accepted the recommendations laid out in the paper.

53. Effective Care

53.1 Safe and Effective Cancer Care

53.1.1 The chair welcomed Mr Stirling to the meeting and he presented the previously circulated paper. It was noted that complaints in the category of 'communication' included complaints about not being able to get thought on the telephone, not receiving a call back when advised, being unable to communicate, or bad news

communicated in such a way that the patient and family did not understand the situation. Complaints about lack of compassion in communication were rare. Work had been done on releasing nurse time for phone calls but data had not been collected to see if this had reduced the number of complaints.

53.1.2 Ms T. Gillies advised that in the next report data would be included on what work was being done to improve performance on Quality Performance Indicators which were not being met.

53.1.3 It was noted that the annual cycle of QPI reporting was based on data, but that Healthcare Improvement Scotland reporting also had an element of peer review.

53.1.4 Mr Garden noted that the Cancer and Therapeutics Advisory Committee considered overall and individual patient therapeutics providing extra scrutiny on access to cost effective cancer medicines.

53.1.5 Incidents had been reported on missed results. Ms Palmer advised that this was a problem across Scotland and had been discussed at the Corporate Management Group meeting. Recent cases had been complex including more than one result, or unexpected results. All scans were considered at the multidisciplinary team meetings. There were a high number of blood results, all of which should be signed off. The CMG would continue to consider improvement measures.

53.1.6 Members accepted the recommendations in the paper and accepted moderate assurance.

53.2 Stroke Care

53.2.1 Ms T. Gillies presented the previously circulated paper and members accepted the recommendations laid out, accepting moderate assurance.

53.3 Organ Donation Annual Report

53.3.1 Ms T. Gillies presented the previously circulated paper. It was noted that work to increase organ donations was done at a national level along with the head of equalities with donations carried out locally.

53.3.2 Members accepted the recommendations laid out in the paper.

53.4 External Providers Annual Report

53.4.1 The chair welcomed Ms Walter to the meeting and she presented the previously circulated paper. External providers were no longer being used in Scotland. It was noted that capacity remained available, but the Scottish Government had not provided funding for this over the past year. The current policy was not to restart external provision.

53.4.2 Members accepted the recommendations laid out in the paper and accepted significant assurance.

53.5 Drug Related Deaths Annual Report

53.5.1 The chair welcomed Dr Ogilvie to the meeting and she presented the previously circulated paper. It was noted that Scotland had a higher drug deaths rate compared to the rest of the UK due to higher social deprivation and a historical drug using population.

53.2 Scoping work was being carried out with the City of Edinburgh Council Alcohol and Drugs Partnership on providing a safe space for drug use but this would not be funded locally unless external funding was available. Ms T. Gillies advised that this had not yet been discussed by the Corporate Management Team and health input would be required due to the need for healthcare staffing.

53.6 Scottish National Audit Programme

53.6.1 Ms T. Gillies presented the previously circulated paper. The nine audit reports were included as papers for exception reporting only. It was agreed that due to the large quantity of information in the audits reports, the important information for members would be included in other assurance reports in the future instead.

54. Exception Reporting Only

Members noted the following previously circulated reports for information:

54.1 Controlled Drug Governance Team Annual Report;
54.2 Pregnancy and Newborn Screening Annual Report;
54.3 Scottish Cardiac Audit Programme;
54.4 Scottish Stroke Care Audit;
54.5 Scottish Multiple Sclerosis Register;
54.6 Scottish Intensive Care Society Annual Report;
54.7 Scottish Hip Fracture Audit;
54.8 Scottish Arthroplasty Project;
54.9 Scottish Renal Registry;
54.10 Scottish ECT Audit Network;
54.11 Scottish Trauma Audit Group.

55. Minutes of Management Meetings and Sub Committees

Members noted the previously circulated minutes from the following meetings:

55.1 Health and Safety Committee, 28 August 2024;
55.2 Organ Donation Sub Group, 15 August 2024.

56. Corporate Risk Register

56.1 Members accepted the recommendations laid out in the previously circulated paper.

57. Reflections on the meeting

57.1 It was agreed that the update on Gender Identity Services would be highlighted at the Committee Chairs' Updates item on the agenda at the next Board meeting.

48. Date of Next Meeting

48.1 The next meeting of the Healthcare Governance Committee would take place at **1.00pm** on **Tuesday 28 January 2025** by video conference.

49. Further Meeting Dates

49.1 Meetings would take place on the following dates:
- 18 March 2025;
- 20 May 2025
- 22 July 2025
- 23 September 2025
- 18 November 2025
- 27 January 2026
- 17 March 2026.

Signed by Chair
28.01.2025

NHS LOTHIAN **4.4**

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 9.30am on Wednesday 30 October 2024 via Microsoft Teams.

Present: Ms V. de Souza, (Non-Executive Board Member - Chair); **Ms E. Gordon** (Non-Executive Board Member); **Mr J. Innes** (Non-Executive Board Member) and **Ms K. Kasper** (Non-Executive Board Member).

In Attendance: Ms C. Hiscox (Chief Executive); **Mrs J. Butler,** Director of Human Resources and Organisational Development; **Ms F. Ireland** (Deputy Director, Corporate Nursing) **Miss T. Gillies** (Executive Medical Director), **Ms H. Fitzgerald** (Partnership Representative) **Mrs R. Kelly** (Deputy HR Director), **Ms M. Campbell** (Director of Facilities); **Mr N. McAlister** (Head of Workforce Planning); **Ms L. Cunningham** (Partnership Representative); **Mr D. Thompson** (Board Secretary); **Mr K. Reeder** (Whistleblowing Liaison Programme Manager); (**Ms S. Augley,** (Operational Science Manager – Blood Science Laboratory – Item 2); **Ms C. McDowall** (Speak Up Ambassador – Item 5.3), **Ms R. Weerakoon –** (Speak Up Ambassador – Item 5.3); **Dr F. Ogundipe,** (Director of Occupational Health & Safety Services – Item 6.1.7) and **Mr G. Ormerod** (Corporate Governance Team -Minute).

Apologies for absence was received from: Ms T. Miller (Employee Director). **Mrs A MacDonald** (Executive Nurse Director), **Mr J Crombie** (Deputy Chief Executive)
Observing: Mr M. Fairbairn (Non-Executive Member of the NHS Forth Valley Board and of the Clackmannanshire and Stirling Integration Joint Board); **Ms K. Cassells** (NHS Forth Valley) and **Mr A. Rennie** (Vice Chair, NHS Forth Valley)

CHAIR'S WELCOME AND INTRODUCTIONS

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.

31. Declaration of Conflicts of Interest

31.1 No interests were declared.

32. Blood Science Laboratory – Presentation

32.1 The Operational Science Manager from the Blood Science Laboratory team presented her team iMatter story. She confirmed that the Blood Science Laboratory is responsible for all of the sites and falls under Diagnostics, Anaesthetics, Theatres, and Critical Care (DATCC). iMatter has played a vital part in the service across four teams to improve communication, allowing the team to function well under pressure.

32.2 The Operational Science Manager acknowledged that she encourages her team to complete the iMatter survey and will work with underachieving teams to promote the importance of participating in the survey, working together with colleagues to reflect feedback across the different service teams, and develop a story board for service actions.

32.3 The Operational Science Manager confirmed that the team discussed feedback from iMatter highlighting the following points:

- Effective team communication was the most desired outcome.
- Four teams created newsletters and notice boards to provide service information and news stories.
- Promotion of staff to new service areas has led to increased involvement with iMatter and the adoption of new ideas.
- Improved communication has led to real transformation and the identification of shared themes among team members.

32.4 The Chair praised the team on their success and stated that it is encouraging to see ideas carried forward when employees change roles.

32.5 Members thanked the service for the presentation and emphasised how small changes can make a big difference.

32.6 A Non-Executive Board Member requested that the team encourage feedback through newsletters. The Operational Science Manager stated that material is sought from staff members for inclusion in newsletters, and input is offered during team inspections. Overall, this has boosted morale, brought employees closer together, and given them a voice.

32.7 The Chair emphasised the importance of feedback loops, dialogue, and team communication.

33. Minutes & Action Note of Previous Meeting held on 31 July 2024

33.1 The minutes of the previous meeting were approved as an accurate record.

34. Matters Arising

34.1 The Director of HR & OD provided an update on Coffee Roulette for Non-Executive Board members, indicating that there had been some team capacity issues but a plan to expand coffee roulette to Non-Executive Directors in 2025 would be brought forward to the December meeting of the Committee.

STAFF EXPERIENCE

35. Advancing Equalities Action Plan 2023/24

35.1 The Deputy HR Director provided an update on the Advancing Equalities Action Plan for 2024/26. She confirmed that a 2-year action plan was approved by the Committee in May.

35.2 The Deputy HR Director provided the following updates since the last committee:

- The organisation achieved the Disability Confident Level 3 Status as a Disability Leader. Level 3 status will be valid for three years, after which the organisation must reapply in 2027.
- As part of the disability confident submission, the board assessor, Microlink PC, hosted a discovery session on 21 October.
- The organisation has signed up for the Equally Safe at Work accreditation. The intention is to progress through the various phases and achieve development status by 2026.
- Gillian McAuley and Rakiya Suleiman have shared a short progress report on career progression for BME nurses and midwives.

- The Trans Staff Experience Project and 2024/26 action plan work has been paused as the member of staff in responsible for this work has now left the organisation and there was no handover. The LGBTQ+ Network is currently discussing and reviewing next steps.
- The Care Experienced staff network will be paused as a staff network due to poor engagement. However, service user information will remain available.
- The Women's Mentoring Programme will be paused until the co-chair returns from maternity leave, then resumed in the summer 2025.

35.3 A Non-Executive Member enquired whether the achievements are summarised and how progress is recorded. The Deputy HR Director confirmed that the last plan was for April 2024, and summary of actions taken is published on HR online.

35.4 Members highlighted the protective characteristics and enquired whether the organisation had learnt anything from the Care Experienced Staff Network.

35.5 The Director of HR & OD responded and highlighted two key issues. She explained that the Corporate Parenting Board had recommended the establishment of the Care Experienced Staff Network and that the Corporate Parenting Board had also been asked for a specific employability programme for those with care experience to be developed. She noted that many people who are care experienced wish to remain anonymous and therefore both programmes of work did not deliver in the way anticipated but there has been valuable learning from both, particularly on how the organisation engage with individuals who are care experienced and for employability programmes the importance of working with third sector organisations.

35.6 The Chief Executive said that she is involved in discussions about this work and strategic content, with an emphasis on discrimination, racism, and sexism, to gain a better understanding of the challenge in Lothian. She encouraged the Staff Governance Committee to monitor this and increase the numbers of conversations around this and culture.

35.7 Members discussed the communication strategy and agreed that communication and engagement information should be brought back to a future meeting to address inequities and a broader culture with management teams.

35.8 The Deputy Director of HR indicated that an initial meeting for the Equality and Diversity conference will be held next week, and some of these issues will be picked up.

35.9 The Chair commended the efforts in achieving the Disability Confident Level 3 status. She requested that the Trans Staff Experience Project and LGBTQ+ Network information should be discussed at a future Committee and any actions from networks should remain on the programme even if they are not currently active.

36. Whistleblowing Report

36.1 The Committee received the Whistleblowing Report, which contained an update on the case that has been with the INWO since August 2022, culminating in a published report in May 2024 and material in Appendix 3 demonstrates progress towards the actions; the INWO has decided on a phased plan due to other parallel processes.

36.2 The Director of HR & OD provided an update on the second investigation with the INWO, which opened in June 2023. This report was published on the INWO website in October, and

the Deputy Chief Executive is currently reviewing the recommendations for patient focussed booking services and DNAs; an update will be provided to the December Committee.

36.3 Members noted that the IWNO has opened two new investigations; the Director of HR & OD confirmed that one case may benefit from a mediated resolution as opposed to an investigation and this will be fedback to the INWO, Ultimately this is a decision for the INWO.

36.4 The Director of HR & OD confirmed that there has been excellent engagement with the Scottish Government, the INWO, workforce colleagues, and the HR team, with all parties agreeing that the whistleblowing standards require review and that in the absence of a formal review process at this stage some focussed work on the interplay between workforce policies and processes and the whistleblowing standards would be useful. The Chief People Officer at Scottish Government is leading on this programme of work.

36.5 Members approved the recommendations outlined in the report.

37. Agenda for Change Reform – update

37.1 The Deputy HR Director provided an update on the Agenda for Change Reforms, which are part of the 2023/24 pay agreement. She indicated that work is progressing in all areas; reducing the working week for the first 30 minutes went into effect on April 1, 2024, with the majority of staff on e-rostering and not rostered completed by end August. She indicated that there were some issues with Hard FM staff, which were resolved by September, as well as service delivery concerns with Soft FM, which were looked into as part of a business case. The target date set by Scottish Government for the 30-minute reduction for all rostered staff, which is the majority of our staff, is 30 November. Work is in progress to review rosters and how to safely implement the 30-minute reduction, for Nursing and Midwifery staff a professionally lead risk assessment process is in place and final rota adjustments are planned for December. Whilst a number of areas can safely absorb the 30-miinute reduction some cannot. In those instances, a risk assessment process is undertaken and where it is deemed additional resources are required to safely reduce the working week, these are considered by the Agenda for Change Programme Board, with final sign off by the Corporate Management Team.

37.2 Members noted that the Band 5 review is progressing, with panels set up and applications progressing. There are c350applications in-progress but not yet at final submission stage. A smaller number of applications have been submitted and are at the matching panel stage.

37.3 The national group set up for protected learning is progressing, meantime the local group are mapping out the various strands of role essential training by profession.

37.4 The Chair enquired whether the Scottish Government funding is non-recurring. The Deputy Director of HR confirmed that the monies are non-recurring and it is unclear what funding would be available in future years. This relates to the cost of the B5 review and the reduced working week.

37.5 A Non-Executive Board Member enquired as to where the data on impact was being reviewed and analysed. The Director of HR confirmed that no decisions have been made on service delivery; where there is a risk to services, a template will be reviewed and considered by the Agenda for the Change Reform Programme Board and then onto the Corporate Management Team (CMT) for final decision. She confirmed if there is a risk and the service is unable to recruit to specialist areas, the organisation will continue to pay the transition allowance, A

final report will be produced at the end of Phase 1 setting out the processes adopted, approach to risk mitigation assessment of impact and costs.

37.6 A Non-Executive Board Member enquired whether there had been communication with the Scottish Government regarding the next steps and further reductions in hours. The Director of HR and OD confirmed that there have been a number of communications and conversations with Scottish Government involving Board Chief Executives, Directors of HR and Directors of Finance, in relation to the need for recurring funding and the plans for the further 60-minute reduction in the working week.

37.7 Members approved the recommendations highlighted within the report.

38. Speak Up Service Report

38.1 The Speak Up Ambassador provided an update on the Speak Up activities and including promote of the service in Q1 and Q2 this financial year. Key highlights included:

- The Speak Up Service has appointed a third ambassador which is a helpful expansion of capacity.
- The service hopes to build and maximise investments and service performance. Complex whistleblowing cases need increased capacity to support contacts in a timely manner, assess earlier interactions, and gather feedback on effective practices for both individuals and organisations.
- Staff turnover has led to opportunities to increase the number of advocates and recruit more diversely.
- Speak Up Week was held in early October. There were opportunities to collaborate and exchange experiences of concerns to assist individuals understand the barriers. The Speak Up service emphasised the value of the service and its related networks for national work.
- Data collation and trend information continues to be recorded with 5 years of data to be available for the next report.
- Speak Up contacts and concerns remain consistent, however there has been a rise in incidents involving administration staff.
- Staff have reported a lack of physical leadership for Speak Up and a lack of confidence in raising concerns. This has already been discussed through lunch and learn sessions, but as an organisation, this will need to be taken forward.

38.2 Members welcomed the Annual Delivery Plan and the excellent work that is being done in this area, such as the Speak Up Week corporate activities and the ability to share stories and promote candid conversations.

Ms Hiscox, Chief Executive left the meeting

ASSURANCE AND SCRUTINY

39. Corporate Risk Register

39.1 3455 – Management of Violence and Aggression

39.1.1 The Deputy Director of Corporate Nursing delivered an update on the Violence and Aggression (V&A) risk, which has been listed on the corporate risk register for some years. She stated that the report updates the training strategy and identifies key areas for staff development.

39.1.2 Members noted that the service continues to train staff banks and REAS employees, with 60% of the training backlog resolved, despite difficulty in finding work-based trainers. Members noticed that the Health and Safety Committee has approved the measurement framework and will continue to report to this Committee.

39.1.3 The Chair thanked the Deputy Director of Corporate Nursing, for the briefing and encouraged the team to monitor their progress.

39.2 3828 – Nurse Workforce – Safe Staffing Levels

39.2.1 The Deputy Director of Corporate Nursing delivered an update on the Corporate Risk Register regarding the risk mitigation plan for managing the nursing and midwifery staffing risk. She stated that the risk remains significant, but she was hopeful that it would decrease with the nursing cohort starting in September and October.

39.2.2 The Deputy Director of Corporate Nursing stated that there is a lower staff turnover and an establishment gap of 5.24%, which will be reduced to 3.12% with staff consideration. She confirmed that the reduction in agency continues, with further controls in place from the Scottish Government, and that services only use agency where there are staffing issues.

39.2.3 The Deputy Director of Corporate Nursing confirmed that the student nurse intake group estimates numbers for midwifery and adult branch services, but the numbers are not increasing to the level needed, resulting in an oversupply in children's and midwifery. She indicated that the service hopes to take part in" earn as you learn" initiatives that offer university students a one-day-a-week B4 role to help support staffing levels, with a risk to the current intake numbers in 2027.

39.2.4 The Director of HR & OD confirmed that the NHS is not seeing the desired intake levels from universities, which was raised during the ministerial review on October 7.

39.2.5 Members accepted moderate assurance and the information detailed in the report.

39.3 5020 – Water Safety

39.3.1 The Director of Facilities provided an update on the water safety risk, stating that it remains at a high-risk level but is in a strong position with 85% compliance for water level safety and dedicated water safety managers in place.

39.3.2 Members noted that the risk had been changed, referring to the previous risk definition during the pandemic. The water safety group has increased monitoring and conducted a thorough review to complete activities, reduce risk, and improve assurance.

39.4 3328 – Traffic Management

39.4.1 The Director of Facilities presented an update on the traffic management risk, stating that it was independently reviewed and that efforts had been taken to mitigate the risk and lower the risk assessment.

39.4.2 Members noted that three of the four red risks have already been allocated funds to address the issues, with work beginning at WGH and Consort submitting cost estimates for two risks at RIE. The Director of Facilities said that with these changes, the risks might be revised, with one remaining at the RIE Emergency Department; however, there are barriers to progressing this risk.

39.4 RIE Fire Safety

39.4.1 The Director of Facilities provided an update on the RIE fire safety risk, confirming that there have been no changes to the grading or controls for the associated risks. She confirmed that the enforcement notices to NHS Lothian, Consort, and the Deputy Chief Executive are still live with an appeal process will take place in December.

39.4.2 The Director of Facilities reported that NHS Lothian is working with the Scottish Fire and Rescue Service (SFRS) to address individual areas and enforcement notices, with significant progress made and work ongoing on walk and talk fire drills, decanting wards, and staff training.

39.4.3 The Director of Facilities indicated that life cycle work is ongoing, with six wards completed and a timetable for fire door upgrades, alarms, and a fire strategy for the site. A dedicated fire risk assessment from each area is being compiled into a single action plan to proceed and complete tasks outlined in the enforcement notice.

39.4.4 Members highlighted a risk and concern with the outstanding areas and legal issues set by the Scottish Fire and Rescue Service (SFRS). The Director of Facilities stated that the service is working on the activities and timeframe, although this is difficult given the amount of work required.

39.4.5 Members agreed that the committee would raise the governance concerns and seek reassurance at the next board meeting on whether the service is doing everything it can to capture the work and the board's position in light of the legal aspect.

VdS & JI

39.4.6 Members approved the recommendations outlined in the report.

40. Health and Safety Assurance Report

40.1 The Executive Medical Director provided an update on the Health and Safety Assurance Report, including local Health and Safety Committee reports, assurances, and meeting minutes.

40.2 The Committee noted the most recent update on the Health and Safety Assurance Report.

41. Occupational Health and Safety Annual Report

41.1 The Director of Occupational Health & Safety Services presented the NHS Lothian Occupational Health and Safety Annual Report 2023/24, which included:

- The Occupational Health Nursing & Medicine Report 2023/24
- The Occupational Health Staff Counselling Service Report 2023/24
- The Occupational Health Physiotherapy Annual Report 2023/24
- The Occupational Health Manual Handling Service Annual Report 2023/24

41.2 A range of activities and service improvements across the Board's Occupational Health Services were highlighted during the presentation of the report, including the implementation of triage calls by the counselling services and implementing the staff joint injection service. In addition, some key challenges were noted, such as recruitment and retention of clinical staff, expanding collaboration with external networks, and challenges at the Royal Infirmary of Edinburgh (RIE) to provide clinical occupational health services.

41.3 The Director of Occupational Health and Safety Services indicated that the service would transition to a new IT system by the end of the year, that new managers will need additional sickness and absence training, and that the manual handling team will have training sessions for day-to-day responsibilities.

41.4 The Chair commended the report's comprehensiveness and level of detail, she suggested that that future reports should provide the highlights on staffing, manual handling, key risks and potential gaps for overall scrutiny and follow the standard template for committee papers.

41.5 The Committee accepted the Report as evidence of assurance that the Board's Occupational Health Service was progressing the objectives agreed in 2023, which were:

- Prevent harm to protect and improve the health of the NHS Lothian workforce
- Improve the quality and safety of LOHSS healthcare
- Secure value and financial sustainability for LOHSS
- Deliver actions to enable change

42. Annual Review of the Staff Governance Terms of Reference

42.1 The Director of HR & OD provided an update on the Staff Governance Terms of Reference (TOR). She confirmed that the Committee had previously committed to revising the Terms of Reference on an annual basis.

42.2 Members agreed to update the advancing workforce equalities to include diversity and inclusion.

42.3 Members agreed that the statement requesting the Committee appoint a Vice Chair could be removed.

42.4 A Non-Executive Board Member discussed the Staff Governance Committee's position as a parent committee to the Remuneration Committee. She indicated that she was unaware of the Remuneration Committee's role. The Director of HR & OD noted that the Annual Remuneration Report is provided to this Committee, and that she would be happy to organise a development session for Non-Executive members of this Committee to aide their understanding on the work of the Remuneration Committee.

JB

42.5 Members agreed to share the TOR with the group before the next Staff Governance Committee meeting in December.

43. Staff Governance Monitoring Assurance – Return to the Scottish Government

43.1 The Deputy Director of HR & OD gave an update on the Staff Governance Monitoring Assurance. She acknowledged that the report details board activity and staff governance standards, and that it will be submitted to the Scottish Government along with other recommendations.

43.2 The Scottish Government template has been updated to align with NHS Lothian's position on supporting networks such as Staff Experience Framework, Work Well Strategy, Retire and Return, Bullying and Harassment, and Whistleblowing.

43.3 Members approved the proposed monitoring assurance report.

44. Health and Care Staffing Act Quarterly Board Compliance Report – 1 July to 30 September 2024

44.1 The Deputy Director of Corporate Nursing provided an update on the Health and Care Staffing Act Quarterly Report. She acknowledged that the report was provided to the Committee as part of the legislation to the board regarding adequate staffing, high-quality care, and staffing responsibilities.

44.2 Members noted that 78% of responses confirmed a reasonable response in place, but scores fell short in three areas that require improvement: 12ID Duty to have a risk-escalation strategy in place (point 4.4); 12IE Duty to have arrangements to address severe and recurring risks (point 4.26) and 2IF Duty: Seek clinical advice on staffing (point 4.43). Further work around policy, communication and education with professional leads is required for these areas.

44.3 Members noted that the report to the Committee does not include agency data, but agency reporting has improved over the last year, with 95% of agencies operating at an acceptable cost.

44.4 The Deputy Director of Corporate Nursing confirmed that the service will reach out to professional leaders in the first quarter of next year to gather information from employees, whether they receive this information from their managers whether this information aligns, and which areas show good practice.

44.5 The Chair emphasised that the information is positive and encouraging to see at the local, regional, and national levels.

44.6 Members accepted moderate assurance and noted that the report would go to the board on 4 December, with agency information included.

SUSTAINABLE WORKFORCE

45. Workforce Report

45.1 The Deputy Director of HR presented the Workforce Report for September 2024, which contained information on short- and long-term absences, recruitment, Speak Up, and mandatory training across the organisation.

45.2 Mandatory training remains at 72% across the organisation, while appraisal compliance has grown by 4% from the previous year to 62%.

46. Year 3 Workforce Plan Actions

46.1 The Director of HR & OD presented the Year 3 Action Plans to support delivery of the Workforce Plan 2022-2025. It was noted that the plans had been developed by service and professional leads and approved by the Corporate Management Team (CMT).

46.2 Members noted that the year two review would be delivered at the December Committee, with plans to begin work on the next three-year Board Workforce Plan 2025-2028 by the end of this financial year; however, at this stage no timetable or guidance have been released by the Scottish Government.

46.3 Members highlighted the importance of beginning the three-year plan early, as in the previous year, rather than waiting for Scottish Government templates.

46.4 The Year 3 Action Plans were endorsed by the Committee.

47. Workforce Efficiencies Programme Board Update

47.1 The Director of HR & OD provided an update on the workforce efficiency programme. She confirmed that there has been marginal progress in relation to workforce reductions, workforce change cannot happen in isolation and goes hand in hand with service change. There has been progress on areas such as reduction in agency spend, scrutiny of sickness absence rates and additional guidance for managers on consistent application of policy, review of salary protection and overtime costs and promotion of good housekeeping in relation to pay and people processes.

47.2 Members noted the information detailed within the report.

48. Leadership Framework update

48.1 The Leadership Framework update was deferred to the December meeting

FOR INFORMATION AND NOTING

49. Staff Governance Statement of Assurance Need

49.1 The Committee noted the Staff Governance Statement of Assurance Need

50. Staff Governance Work Plan

50.1 The Committee noted the Staff Governance Work Plan

51. Any Other Competent Business

51.1 Colleagues from Forth Valley thanked members for inviting them to the Committee, highlighting an interesting meeting with similar challenges for NHS Lothian and NHS Forth Valley.

REFLECTIONS ON THE MEETING

52. Matters to be highlighted at the next Board meeting

52.1 Members agreed to review the RIE Fire Safety with the Chief Executive prior to the next Board meeting.

52.2 A Non-Executive Board Member confirmed that they would highlight positive discussions and detailed reports during today's committee.

53. Matters to be highlighted to another Board Committee

53.1 There were no matters that required to be highlighted to another Board Committee.

54. Date of Next Meeting: Wednesday 11 December 2024

54.1 The next Committee meeting would be held on Wednesday 11 December 2024 at 9.30am.

Signed by Chair
11 December 2024

Midlothian Integration Joint Board

4.5(a)

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday 19 September 2024	2.00pm	Council Chambers, Midlothian House and Virtual Meeting held using Microsoft Teams

Present (voting members):		
Councillor McManus (Chair)	Val De Souza (Vice Chair/virtual)	Councillor McKenzie (Substitute for Councillor Parry)
Dr Amjad Khan (virtual)	Kirsty MacDonald (virtual)	

Present (non-voting members):		
David King, Interim Chief Finance Officer	Morag Barrow, Director of Health & Social Care: Midlothian HSCP, Chief Officer to Midlothian IJB	Nick Clater, Deputy Chief Social Work Officer
Wanda Fairgrieve, Partnership Representative (NHS)		

In attendance:		
Grace Cowan, Head of Primary Care & Older People	Gill Main, Integration Manager	Duncan Stainbank (virtual), Chief Internal Auditor

Claire Gardiner (virtual), External Auditor (Audit Scotland)	Rebecca Green (virtual), Clinical Director	Iina Jaara, Democratic Services Team Leader
Maria Perez, Democratic Services Officer		

Apologies:		
Keith Chapman, Lived Experience member	Claire Ross, Chief AHP	Joan Tranent, Chief Social Work Officer & Chief Officer Children's Services, Partnerships and Communities

1. Welcome and Introductions

The Chair welcomed everyone to this meeting of the Midlothian Integration Joint Board (MIJB). Apologies were received from Keith Chapman, Claire Ross, and Joan Tranent. The Chair noted that Councillor McKenzie is attending the meeting on behalf of Councillor Parry.

2. Order of Business

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

3. Declarations of Interest

None presented.

4. Minute of Previous Meetings

No items for discussion.

5. Public Reports

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
5.1 Chair's Update - Councillor McManus - For Decision The Chair gave a verbal update and highlighted the MIJB's recent meeting and contribution to the National Care Service (Scotland) Bill Consultation. The Chair was unable to attend this session, but was pleased to see that members were generally in agreement. The Integration Manager will circulate the response to members in due course. The Chair also reminded members that there will be a Development Session immediately after this meeting. MIJB noted the Chair's update.	Update was noted.		
5.2 MIJB Annual Accounts 2023/24 (Final Position) - Presented by David King, Interim Chief Financial Officer - For Approval The Interim Chief Financial Officer presented the report of the MIJB Annual Accounts for the financial year of 2023/2024, which have now been audited by the Integration Joint Board's (IJB) Independent Auditors who have reported their view to the IJB's Audit and Risk Committee of 21 September 2024. The Interim Chief Financial Officer asked the External Auditor to also reflect on their report. Board Members are asked to: - • Note the report of the Independent Auditor. • Approve the IJB's annual accounts for 2023/2024. The External Auditor highlighted the report was presented at the normal audit timescales and thanked all IJB members for their help in meeting this deadline. The report includes limited recommendations which have not impacted the view of the External Auditor. The External Auditor highlighted that they are confident in the financial management arrangements in place	The Annual Accounts were approved.		

Report Title/Summary	Decision	Action Owner	Date to be Completed/ Comments
but acknowledged the ongoing challenges in the IJB's financial sustainability. It was reported that MIJB's situation is similar to those of IJBs across Scotland. Good practices were also highlighted. The Vice Chair highlighted a recent MIJB Audit & Risk Committee meeting and expressed that the Committee viewed the audit process and the following report as fair. The Vice Chair thanked the External Auditor for their support in the last year. The Interim Chief Financial Officer asked the IJB to approve the accounts and explained the signing-off process after approval. The IJB members were in agreement and the accounts were approved.			

6. Private Reports

No items for discussion.

7. Any Other Business

The Chair noted that this is Wanda Fairgrieve, the NHS Partnership Representative's last meeting as they are moving onto a role within East Lothian Council and thanked them for their service.

8. Date of Next Meeting

The next meeting of the Midlothian Integration Joint Board will be on Thursday the 17th of October 2024, 14:00-16:00.

The meeting terminated at 14:10.

Midlothian Integration Joint Board

4.5(b)

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday, 24 October 2024	2.00pm	Council Chambers, Midlothian House and Virtual Meeting held using Microsoft Teams.

Present (voting members):		
Connor McManus (Chair)	Val de Souza (Vice Chair NHS) (attended virtually)	Dr Amjad Khan (NHS Lothian)
Councillor Milligan	Andrew Fleming (NHS Lothian)	Kirsty MacDonald (NHS Lothian attended virtually)

Present (non-voting members):		
Morag Barrow (Chief Officer)	David King (Interim Chief Finance Officer)	Nick Clater (Head of Adult Services and Chief Social Work Officer)
Grace Chalmers (Partnership Representative)	Claire Ross (Chief AHP)	Dr Rebecca Green (Clinical Director)

In attendance:		
Councillor McKenzie	Gill Main (Integration Manager)	Fiona Kennedy (Group Service Manager)
Grace Cowan (Head of Primary Care and Older Peoples Services)		Jim Sherval (Consultant in Public Health) (attended virtually)

Midlothian Integration Joint Board

Thursday 24 October 2024

Elouise Johnstone (Performance Manager) (attended virtually)	Martin Bonnar (attended virtually)	Ruth Flynn Public Health Practitioner
	Councillor Virgo (attended virtually)	Iina Jaara (Democratic Services Team Leader)
Hannah Forbes (Democratic Services Officer)	Maria Perez (Democratic Services Officer)	Nicola Thorburn (Democratic Services Officer)

Apologies:		
Councillor Parry	Christine Gardiner (External Auditor, Audit Scotland)	Fiona Stratton (Chief Nurse)

1. Welcome and Introductions

The Chair welcomed everyone to this Meeting of the Midlothian Integration Joint Board (MIJB).

Apologies were received from Councillor Parry, Christine Gardiner (Audit Scotland) and Fiona Stratton (Chief Nurse).

2. Order of Business

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

3. Declarations of Interest

No declarations of interest were received.

Keith Chapman disclosed that he is a trustee of Alzheimer Scotland.

4. Minute of Previous Meetings

4.1 The Minute of previous Midlothian IJB Board Meeting held on 22nd August 2024 was approved as an accurate record.

4.2 The Minute of the meeting of the MIJB – Strategic Planning Group held on 29 August 2024 was approved as an accurate record.

4.3 The Minute of the meeting of the MIJB - Audit and Risk Committee held on 6 June 2024 was approved as an accurate record.

5. Public Reports

	Decision	Action Owner	Date to be Completed/Comments
5.1 Chair's Update, presented by Councillor McManus The Chair provided a brief update, highlighting the upcoming finance workshop provided by David King in November. At the next meeting of MIJB the chair will not be able to make this meeting, Val de Souza will be chairing the meeting in the absence. The Chair reminded members of the MIJB that there are two town hall briefings coming up.			
5.2 Chief Officer's Report – Presented by Morag Barrow, Chief Officer Morag Barrow, Chief Officer, presented the report and advised the paper sets out the key strategic updates for the Board. This report is for noting. The Chief Officer highlighted items for the attention of the Board. • The position we are in with the Chief Finance officer, it was explained that we have failed to recruit to the deadline, there needs to be an agreed decision on the next steps. • The first Partner meeting since Covid has taken place and noted that they will be meeting regularly to discuss any issues. Another meeting is planned for mid-November. • The Pharmacy team won the NHS Lothian awards for negotiation costing and prescribing. Congratulations was passed to the team. • In terms of where we are regarding transformation, Dr Rebecca Green is leading some work with Fiona Stratton and Claire Ross regarding the transformation approach. The full report will be available after Christmas.			

Midlothian Integration Joint Board

Thursday 24 October 2024

	Decision	Action Owner	Date to be Completed/Comments
Staff were commended on the great work. A question arose regarding whether the legal opinion from the King's Council was going to be shared. Nick Clater advised that there is an 18-page opinion that and a summary from Midlothian Council's Legal Section. He will ascertain whether this can be shared. Delayed discharge status was highlighted. Grace Chalmers gave an update, and advised that there been no intervention from the Scottish Government in Midlothian			
5.3 Strategic Planning Group Update – Report presented by Andrew Fleming, SPG Chair Officer Andrew Fleming, Strategic Planning Group (SPG) Chair, presented the report and advised the paper sets out the key strategic updates for the Board. This report is for noting. SPG Chair reported that due to lower than anticipated engagement, planned in-person townhall sessions had been cancelled as part of the consultation on the draft Strategic Plan. Discussion took place as to engagement with the community and other options to explore, noting that other regular community events would not be happening due to resource limitations. The Chief Officer advised the Board, that if they haven't responded to any invitations to please respond for the upcoming virtual sessions.			
5.4 Audit and Risk Committee Update – Report presented by Val de Souza, Audit and Risk Chair Val de Souza, Vice Chair NHS presented the report. This report provides an update on Audit and Risk committee and is for noting.			

Midlothian Integration Joint Board

Thursday 24 October 2024

	Decision	Action Owner	Date to be Completed/Comments
The Vice Chair highlighted the key points discussed at the meeting on 19th September Audit and Risk Committee, 1) the need for a fair and transparent process whilst recruiting for an independent member. 2) the need for a Vice Chair for the Audit and risk committee to be appointed 3) The risk register was discussed, highlighting the financial risks and the details around the risk level being increased. 4)The main body of the meeting was with Audit Scotland. Audit Scotland presented their report that scrutinised the IJB governance, they were satisfised while highlighting some low-level issues. The low-level issues have now been investigated, and the auditors are satisfied. The Audit Commission report was noted, and it was expressed that the report should be circulated to members for information. The Chair thanked the Vice Chair NHS for the update on the Audit and Risk committee.			
For Decision **5.5 MIJB Membership Recommendations - Paper presented by Democratic Services** Iina Jaara, Democratic Services Team Leader presented the paper. This report provides information about changes to non-voting membership of the Midlothian Integration Joint Board (IJB) and seeks the Board's formal endorsement of them. **Members are asked to:** • Endorse the nomination of Nick Clater as a non-voting member of the Midlothian Integration Joint Board • Note the formal resignation of Johanne Simpson from the role as Medical Practitioner to the Midlothian Integration Joint Board The report was approved by the Board.			

Midlothian Integration Joint Board

Thursday 24 October 2024

	Decision	Action Owner	Date to be Completed/Comments
For Decision **5.6 Annual Performance Report Review for Publication - Paper presented by Elouise Johnstone, Performance Manager** The Performance Manager presented the report, advising it was for decision. The purpose of the report is to update Midlothian Integration Joint Board (IJB) on the Annual Performance Report (appendix 1), providing information on the health and wellbeing of the people of Midlothian and an assessment of our performance towards achieving the 9 National Health and Wellbeing Outcomes. It also describes the financial performance of the IJB, and the quality of health and care services delivered during 2023/24. The Chair thanked the Performance Manager for the report and opened to any questions. Comments were noted on the report structure and content, with the Performance Manager and team being commended for all their hard work. The carers strategy timeline and vacancy of Board representation from carers was raised. The Integration Manager stated that the need for care has changed since the last careers strategy review. Advising this will be due for review at the publication of the next plan. The Head of Adult Services expressed the need for carers and the efforts that have been taken to fulfil the Board post. Discussions turned to the Weight Management service. The Chair asked the Chief AHP if traditional methods were still employed or if are we adapting to new methods due to the fluctuation in the area. The Chief AHP advised that the Weight Management Service is divided into 3 tiers, outlining each. Challenges around the associated costs in the current climate was stressed, restricting the adaptability we would like to have. The Chair thanked The Performance Manager again for the report.			

Midlothian Integration Joint Board

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	Decision	Action Owner	Date to be Completed/Comments
For Decision **5.7 Report on Commissioned Scoping Exercise on Employability & Opportunities for Better Partnership Workforce Planning – Paper presented by Jim Sherval, Public Health Consultant** Jim Sherval, Public Health Consultant, presented the report and advised it is for decision. The report sets out the result of the IJB commissioned scoping exercise, and presents the actions recommended by the Workforce Governance Board. **Members are asked to:** • Note the outcome of the commission and the actions being taken forward by the Workforce Governance Board • identify capacity from existing resources to take actions identified as priority and operational forward. • present these for discussion and agreement at the Workforce Governance Board The Chair thanked the Public Health Consultant for the report and welcomed questions. There was a question raised in relation to the benefits and when will we expect to see the outcomes of that. The Public Heath Consultant advised these are currently in development with the Partnership.			

	Decision	Action Owner	Date to be Completed/Comments
For Discussion **5.8 IJB Performance Report - Paper presented by Elouise Johnstone, Performance Manager** Elouise Johnstone, Performance Manager, presented the report. The purpose of the report is to update the IJB on progress towards the IJB performance goals set for the financial year 2023/24. It was noted that the Performance Assurance and Governance Group has now been dissolved and going forward data scrutiny responsibility has been transferred to the Strategic Planning Group. The newly agreed strategic governance map was included as appendix 2 of the report. Appendix 1 contains published data. A slight improved is reported in relation to the A&E attendance indicator. While unplanned admissions and days in acute beds failed to meet target, the link between unplanned admissions and unplanned days in acute beds is clear and that is a systemic challenge. It was noted that the end of life and balance of care figures are not available locally so there is no management data to discuss. Appendix 2 details the strategic governance map, with emphasis drawn to column 6, 'What difference does this make'. This column is aligned to the 9 National Health and Wellbeing Outcomes, making it easy to support information with data for annual reporting to the Scottish Government. Colour coding on the map indicates both progress towards our goals, and confidence in the evidence provided. The Chair thanked the Performance Manager for the report and opened it up for discussion. The Board commented on the clearly laid out report and asked whether Management Steering Group (MSG) indicators are still relevant as other metrics appear more relevant now. The Performance Manager confirmed that the MSG framework was designed to assess acute and secondary care			

Midlothian Integration Joint Board

Thursday 24 October 2024

	Decision	Action Owner	Date to be Completed/Comments
progress rather than the Integration Joint Board progress, but until legislation is revised it is a requirement to continue to report MSG. The report presented includes complementary and supplementary data, which is more relevant in telling of what the Health and Social Care Partnership and the Integration Joint Board does. Discussion ensued regarding whether this data was ever relevant given how all parts of the system interact has changed over the last ten years. It was noted it is necessary to use rationale to make sense of data and have the data that is necessary to make decisions. It was agreed that the lag in data makes it less informative with a view to strategic planning. Efforts are being made to make data less prominent in this work. The Board was advised outcomes are helpful to inform the IJB how well it is doing, and the Strategic Planning Group will review the strategic governance map columns in future meetings and issue new directions as they have a place in governance framework. The Performance Manager advised that her criticism of MSG is due to them maybe not being as timely or relevant to the MIJB but remain relevant to other parts of the system to make good decisions. Referring to a recent study where admissions data and emergency admissions data were used to create a reliable predictive tool for use in primary care, it was suggested this may be interesting as another point of view. The Board noted the improvement goals set in the report and the inclusion of the new Strategic Governance Map.			

Midlothian Integration Joint Board

Thursday 24 October 2024

	Decision	Action Owner	Date to be Completed/Comments
For Discussion **5.9 Midlothian Drug Misuse and Alcohol Specific Deaths 2023 - Paper presented by Nick Clater, Head of Adult Services and Chief Social Work Officer and Martin Bonnar, lead officer alcohol and drug partnership (MELDAP)** *Note there were slides to be shown but due to admin issues these were not available and will be presented at the next meeting.* Nick Clater, Head of Adult Services and Chief Social Work Officer presented the report. This report highlights pertinent areas relating to Drug Misuse and Alcohol Specific Deaths in Midlothian. It was noted Midlothian operates as a joint Alcohol and Drug Misuse Partnership with East Lothian to support drug and alcohol users (MELDAP) which is unique in Scotland. While drug and alcohol specific death numbers are published every year, the report outlines the 5-year average to illustrate a clearer picture of the extent of the issue in Midlothian. Published figures for 2022 showing 4 drug misuse deaths, which is uncharacteristically low. The figure increased to 20 in 2023, making the 5-year average 17. In terms of statistical predictions, the report indicates people living in deprived areas are 15 times more likely to die from a drug related issue than those in more affluent areas. Likewise, there is a pattern of higher risk linked to polydrug use mixed with alcohol. The increased toxicity of the different drugs combined is also compounded by the existence of mental and physical health issues in the cohort the data comes from. It was noted there is a stark difference in terms of drug misuse figures between England and Scotland, or when Scottish figures are compared with the rest of Europe. The Head of Adult Services and Chief Social Work Officer clarified that there is a higher prevalence of drug use in Scotland (1.62%) compared	Report to be updated to include suggestions for amendment requested at today's meeting and presented at another forum.	NC / MB	December 2024

	Decision	Action Owner	Date to be Completed/Comments
to EU countries (0.74%), the figure of drug users in Scotland is roughly double the rate of other countries. Highlighting the effects of increased substances in circulation, new drugs entering the scene. There are also theorised links to adverse childhood experiences to account for the figures. In terms of alcohol specific deaths, the report authors advised caution on how these are counted and managed. The 3-year average is 15-18%, in line with the rest of the country. As it is the case with drug specific deaths, there are often patterns like poverty indexes and physical conditions often observed in connection with these figures. The range of services available through MELDAP has extended over the past years to include a contact service. There is also wider coverage around Naloxone, a drug that reverses the effects of opioids, but this is not always effective as opioids are not necessarily the reason behind an overdose. Naloxone becomes less effective in the case of polydrug use. There are also situations where users may need more than one dose in order to receive the appropriate strength, and as such Naloxone doesn't always manage to save users in the event of an overdose. A change in the substances available in Midlothian, and an increase on the number of synthetic opioids in circulation is another concerning pattern. Last July there were 5 people who died in matter of days due to substances coming from other part of the Lothians. Finally, the role of Number 11 as a multi-service hub working together under the same roof was highlighted as a strength, offering support to clients of the substance misuse service but also criminal justice and mental health. This was seen as a success story in terms of services working together that should be replicated in other areas of the country and is in line with the Scottish Government's recommendation to streamline services. The Board asked for clarification on how many of those in these figures had been involvement with Midlothian services. Recognising that the process to acquire these figures can make answering this question tricky, it was noted generally 40 to 50% of individuals in the death statistics are already known			

	Decision	Action Owner	Date to be Completed/Comments
to services. This figure can fluctuate year on year. It was stressed that professionals strive to use every opportunity services interact with clients, to draw as many individuals at risk as possible into the service. This is due to the protective factor being known to substance misuse services has. For example, Substance Misuse Service has active referrals for an average of 300 people who are known drug and alcohol users and are less likely to suffer harm as a result of this referral. The Head of Adult Services clarified that a fraction of the death numbers are users who were not known to substance misuse services but may have been known to other areas like criminal justice or mental health, either at the time of their death or in the past. Highlighting the need to get as many people at risk into services to maximise the chances of working constructively with them. Reducing mortality rates related to substance use presents significant challenges, primarily due to the harmful nature of drugs circulating in the community. Additionally, the impact of each death is felt acutely by staff, as often they have known the individual through the service. It was noted that mental health issues tend to increase as financial situations worsen for people. It was queried whether this is reflected on the year-on-year alcohol and drug death statistics. It was noted, drug and alcohol specific deaths have largely stayed the same. The service is worried about the impact of cost-of-living issues. Figures have not been impacted by policies like minimum unit alcohol pricing. The service recognised they could be doing more given the harm alcohol does. The Board congratulated MELDAP for achieving so much, offering approaches not being replicated elsewhere in the country and for their good engagement with service users. In terms of user experience, the Board recommended to build the feedback of users into the report as it is such a dynamic field. The Board acknowledged the significance of this discussion in order to evaluate the current approach and assess the impact of risk reduction on A&E figures, which should be addressed in the next version of the report.			

Midlothian Integration Joint Board

Thursday 24 October 2024

	Decision	Action Owner	Date to be Completed/Comments
The Chair agreed on the need to move conversation to another forum and thanked everyone involved in the report.			
For Discussion **5.10 Public Health Update - Homeless Prevention Duty Paper by Jim Sherval, Public Health Consultant, and Ruth Flynn, Public Health Practitioner** This agenda item was deferred until 19 December 2024 due to time constraints.	Item deferred until 19 December 2024		
For Discussion **5.11 Integrated Assurance Report Paper presented by Claire Ross, Chief AHP** This agenda item was deferred until 19 December 2024 due to time constraints.	Item deferred until 19 December 2024.		
For Discussion **5.12 Darzi Report Discussion - Paper prepared by Gill Main, Integration Manager** This agenda item was deferred until 19 December 2024 due to time constraints.	Item deferred until 19 December 2024.		

Midlothian Integration Joint Board

Thursday 24 October 2024

	Decision	Action Owner	Date to be Completed/Comments
For Discussion **5.13 MIJB Finance Update - Paper prepared by David King, Interim Chief Financial Officer** David King, Interim Chief Financial Officer presented the report, detailing the current financial situation. The Chief Financial Officer expressed his concern over the current situation and its challenges. An overspend identified in January/February 2024 was noted where reserves were still available, but this is no longer the case. The report stressed the need to keep the momentum of work done to create funding. An updated position was available since NHS has provided a financial forecast, and the Council has provided a Quarter 2 review, identifying an overspend of £8.4 million. The Chief Financial Officer pointed out two items of interest, 1) the health position has deteriorated, due to the challenges around the prescribing budget which continues to have an ever deteriorating overspend. It is a complicated model, with little scope for action in terms of practice as there are known issues with price and volumes. 2) the Social Care position, which had a forecasted overspend of £8.6. million, larger than the spillage in recovery plans. The updated forecast shows a £5.2 million overspend, which while still considerable it is an improvement over the quarter 1 forecast. The Chief Financial Officer stressed that the IJB is a strategic planning group and to deliver a strategic plan it has a budget. The Integration scheme that governs the IJB stipulates that it must refer to its Partners in case of an overspend to provide recovery actions. Health and Social Care was identified as the biggest of these partners, where most of the financial pressures lie. To identify recovery actions, there have been finance workshops and this report also considers the impact in people the IJB serves, what are the risks and mitigating actions. The Chief Financial Officer stressed that Midlothian Council, the Health and Social Care Partnership and the NHS have a great working relationship that is key to its success as an IJB. At present, it is clear that action must be taken to find £5.2 million due to the sizeable financial risk to the Council, and	Further workshop to be arranged in November to find further savings in order to bring a balanced budget by December IJB Chair to write to government in order to lobby for additional funding and raise awareness about the	DK	December 2024 November 2024 19 December 2024

	Decision	Action Owner	Date to be Completed/Comments
warned that the Board must be ready to consider further actions, giving consideration to what benefit they will deliver and what impact they will have in the population of Midlothian. After the workshop, next steps would be explored, looking for savings and recognising the existing budget is the only resource to deliver the strategic plan. Additional factors to consider, such as the UK budget on 30 October, and the Scottish Budget in December. Local governments have also agreed to honour pay awards which they plan to fund but that may put local authorities in a difficult position finance wise. It was also noted that several health boards across Scotland are also not breaking. After these pay awards there will be little change to fund the IJB and will not cover the pressures the system is experiencing. The Chief Financial Officer stressed the need to consider figures and the situation by December and determine what recovery actions will be needed so that the Board does not find themselves in crisis point. The Board was reminded of the duty to break even and have a balanced budget. Councillor Milligan echoed the concerns and noted that as part of the Council budget consultation the public was made aware of the very difficult decisions the Council and the Midlothian IJB is faced with. As further tranches of savings are planned, this needs to be used as an opportunity to make clear to residents. Councillor Milligan warned that the £9.4 million gap assumes that the council tax will have a 5%increase, that the pay rise will be 2% and that there will be a cash flat settlement from the Scottish Government. It was stressed that if no action is taken the gap will grow exponentially unless more funding is given, so there is the need for joint working and serious conversations to determine what it is possible to achieve. The Chair advised the consultation was simplified and the wording regarding Health and Social Care is aimed at seeking the public's priorities on matter. In terms of more holistic approach, the Council Leader has also written to the UK and Scottish Governments. It was suggested whether the IJB may want to	consequences of cuts Partners in the IJB to look at their services to the Board and determine red button actions in order to agree to a route map		

Midlothian Integration Joint Board

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	Decision	Action Owner	Date to be Completed/Comments
explain the choices that may need to be made. Committee members agreed the average resident may not be aware of what the cuts may mean for them and supported letters to the Government. Councillor Milligan noted that although the Health and Social Care consultations concern important decisions, past experiences have shown take up to be poor and that as it is an invisible cost for most people. Increased awareness amongst Elected Members was noted relating to Board funding issues thanks to briefings. It recognised that further cuts may be necessary, with the implications of these to be made clear in briefings such as closing care homes, wards, daycare or non-statutory services. It was agreed partners would meet and consider savings and come back to the Board with proposals by November. A roadmap would be created over the next two months to give purpose to the conversation. While this may not be enough to find the gap, it was recognised the budget position had improved. Demand is ever changing as the Midlothian population changes, so it is expected next year would be as challenging if not more as due to cost pressures. The Chief Financial Officer reminded of the importance of sharing burdens, but the statutory delivery of Social Care belongs to Midlothian Council. While there is responsibility of breaking even, it is possible that removing the gap entirely could be detrimental. The Board agreed, noting transformational actions may be cost cutting, but will require time to plan and deliver accordingly. It was also pointed out that these actions may result in protest that will become a contentious issue between the IJB and the Council. While it is the Board's responsibility to break even and have a balanced budget, it is also their responsibility to keep people safe. The Chair thanked all members for their contributions and advised that the matter will come for discussion in the December IJB meeting where all services were asked to have their red button issues noted so a roadmap could be agreed.			

	Decision	Action Owner	Date to be Completed/Comments
Report For Noting **5.14 Community Payback Orders Justice Report - Paper presented by Fiona Kennedy, Group Service Manager** The Board noted the contents of the report.	Report noted		
Report For Noting **5.15 Review of Risk Register Policy - Paper presented by David King, Interim Chief Financial Officer.** The Board noted the contents of the report.	Report noted		

5 Private Reports

No items for discussion.

6 Any Other Business

No items for discussion.

7 Date of Next Meeting

A Development Session for board members only will be held on Thursday 21st November 2024, 14:00 – 16:00, development session for board members only.

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The next full board meeting of the Midlothian Integration Joint Board will be held on Thursday 19th December 2024, 14:00 – 16:00. This will be chaired by Val de Souza as Councillor McManus noted he is unable to attend this meeting due to a prior engagement.

Members were also reminded there are three upcoming briefings, one on 31 October 2024 and two town hall events on 6 November 2024.

The meeting terminated at 16.08pm.

NHS Lothian

4.6

Meeting: Lothian NHS Board

Meeting date: 5 February 2025

Title: Disposal of St Michael's Hospital, Linlithgow

Responsible Director: Craig Marriott, Director of Finance

Report Author: Campbell Kerr,
Programme Director, Capital Planning

1 Purpose

This report is presented for:

Assurance	☐	Decision	☒
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☒	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to invite the Board to formally declare St Michael's Hospital surplus to requirements following recent consideration by the Finance and Resources Committee.

2.2 Background

A decision to close the hospital and relocate all services was taken by West Lothian Integrated Joint Board in August 2023.

All consultation activity and impact assessments in advance of this decision were undertaken by the IJB, as the relevant planning body.

All services have now vacated the hospital and the site is now entirely vacant.

Neither NHS Lothian nor the West Lothian Integrated Joint Board has any future plans or use for the site, leading to the property being considered a non-essential asset and thereby triggering the mandatory requirements of the NHSScotland Property Transactions Handbook.

The Scottish Government Property Transaction Guidance states that any surplus property must:

- be disposed as soon as possible after being declared surplus and consistent with achieving the best return.
- be disposed with regard to the current market conditions and good market practice
- only be disposed on receipt of professional advice

On receipt of the approval to declare surplus, the property will be offered to other public sector interests through the Scottish Government's "trawl process". If no interest is forthcoming, the property will proceed to be marketed in accordance with the Scottish Government's Property Transaction Guidance.

In accordance with the Community Empowerment (Scotland) Act 2015 / Right to Buy legislation, community groups and other appropriately constituted parties can express an interest in all or parts of these properties.

NHS Lothian's marketing agent has been appointed and is advising on this disposal. Legal advice will be obtained through the Central Legal Office.

2.3 Assessment

2.3.1 Quality/ Patient Care

As all services have already relocated from the hospital site there is no impact on the quality of care and services arising from declaring the site surplus.

2.3.2 Workforce

As all services have already relocated from the hospital site there is no impact on staff arising from declaring the site surplus.

2.3.3 Financial

Any costs associated with the disposal, including fees, security costs etc will be offset against the sale receipt.

2.3.4 Risk Assessment/Management

The key risks associated with the disposal of the property are:

- Community Asset Transfer request delaying site disposal
- Failure to secure a timely receipt due to market conditions
- Risk to reputation and the costs associated due to any inability to dispose of the property

2.3.5 Equality and Diversity, including health inequalities

The HSCP has undertaken consultation on the relocation of services and the closure of the hospital site.

Consultation is ongoing regarding the plans to dispose of the site.

2.3.6 Other impacts

N/A.

2.3.7 Communication, involvement, engagement and consultation

A group, including community representatives and elected members, has been established to allow the views of the community for the future of the site to be communicated and considered

2.3.8 Route to the Meeting

The hospital site closure has been approved by the West Lothian Integrated Joint Board.

Declaring the site surplus has also been discussed and approved at the Lothian Capital Investment Group and the Finance and Resources Committee.

2.4 Recommendation

The Board is asked to confirm, based on the recommendations of the Finance and Resources Committee, that:

- The St Michael's Hospital site is formally declared surplus to requirements.

3 List of appendices

- None

NHS Lothian

4.7

Meeting:	**NHS Lothian Board**
Meeting date:	**05 February 2025**
Title	**Health and Care (Staffing) (Scotland) Act 2019, Quarterly Board Compliance Report Quarter 3, 01 October – 31 December 2024**
Responsible Executive:	**Alison Macdonald, Executive Nurse Director**
Report Author:	**Fiona Tynan, Associate Nurse Director, Corporate Nursing**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☒	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	**Workforce (supply or wellbeing)**	☒
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	**Effective**	☒
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

2.1.1 The Health and Care (Staffing) (Scotland) Act 2019 (hereafter referred to as the "Act") stipulates that the Executive-level clinician on the Board responsible for the legislation, in this case the Executive Nurse Director, must submit quarterly reports to the Board, outlining compliance with the duties across all staff groups and settings covered by the Act. The views of staff on compliance must be included in these reports.

2.1.2 The Board are provided this report (appendix 1) as part of the legislative requirement under the Act and are recommended to accept this report as meeting that obligation under the Act.

2.1.3 Utilising the Corporate Governance and Assurance system the Board are asked to accept **Moderate Assurance** on how effectively NHS Lothian is meeting its legal duties in this area. This assurance level is based on an overall "Reasonable Assurance" rating generated by the Scottish Government's compliance scoring.

2.2 Background

2.2.1 The Act aims to ensure appropriate staffing is in place, to enable high quality care and outcomes by setting out a number of duties around staffing. These apply to all clinical staff and leaders/managers of clinical teams and requires clearly defined systems and processes to be in place, and used, to enable transparent staffing decisions to be made and recorded.

2.3 Assessment

2.3.1 Quality/ Patient Care

The duties under the provisions of the Act set in statute the section 12IA Duty to ensure appropriate staffing; "that at all times suitably qualified and competent individuals from such a range of professional disciplines as necessary are working in such numbers as are appropriate for the health, wellbeing and safety of patients or service users and the provision of high-quality health care."

Detail of assessment of compliance with the duties to achieve this aim is within the Board Report (appendix 1).

2.3.2 Workforce

The report includes an overall level of assurance by duty and across duties (point 4.1 and 4.3) and includes updates on progress against Board approved recommendations from previous Board Quarterly Compliance Reports.

2.3.3 Financial

There are no specific financial implications associated with this paper, however, the paper reports on compliance with the 12IB Duty to ensure appropriate staffing: agency worker (point 4.4 to 4.10)

2.3.4 Risk Assessment/Management

The report includes an overall level of assurance by duty and across duties (point 4.1 and 4.3) and provides updates on progress against Board approved recommendations from previous Board Quarterly Compliance Reports.

It is not anticipated that there needs to be an entry on a risk register relating to any aspect of this report.

2.3.5 Equality and Diversity, including health inequalities

The report and its recommendations will not have an impact on equality, socio-economic disadvantage or children's rights therefore no impact assessment is required.

2.3.6 Other impacts

None

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to gather and consider the views of staff from across professions and settings on their views as to NHS Lothian's compliance with the duty to ensure appropriate staffing and on how clinical advice is sought and regarded to in decision making. Detail of how this was carried out can be seen in point 2.3, 3.9, 5.0 of the report.

2.3.8 Route to the Meeting

The Health and Care Staffing Programme Board has reviewed and approved the content of this report on 6 January 2025. Previously, the governance and assurance route for the report included to the Staff Governance Committee for approval and to the Lothian Partnership Forum for awareness. However, for the Quarter 3 report this was not possible, due to the absence of submission dates for these meetings since the 4 December 2024 Board Meeting and Quarter 2 report submission and before this Board meeting.

2.4 Recommendation

The Board are:

- Provided with this quarterly report as part of the legislative requirement under the Act and are recommended to accept this report as meeting that obligation under the Act.
- Note that the report attached is constructed using the Scottish Government rating criteria.
- Note that the report attached provides updates on progress against Board approved recommendations from previous Board Quarterly Compliance Reports.
- Accept **Moderate Assurance** on how NHS Lothian is meeting its legal duties under the 2019 Act, based on the Scottish Government's compliance scoring and its rating of "Reasonable Assurance" for NHS Lothian.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1:** Health and Care (Staffing) (Scotland) Act 2019, Quarterly Board Compliance Report Quarter 3, 01 October – 31 December 2024

Appendix 1

Health and Care (Staffing) (Scotland) Act 2019
Quarterly Board Compliance Report

Quarter 3
01 October – 31 December 2024

Date:

Report Authors:
Fiona Tynan, Associate Nurse Director, Corporate Nursing
Kevin Dickson, Health and Care Staffing Lead

Executive Lead: Alison Macdonald, Executive Nurse Director

Situation

2.0 The provisions in the Health & Care (Staffing) (Scotland) Act 2019 (hereafter referred to as the Act) came into force on 1 April 2024.

2.1 The Act aims to enable high quality care and improved outcomes for people using services in both health and care by helping to ensure appropriate staffing. The Act places duties on health boards, care service providers, Healthcare Improvement Scotland, the Care Inspectorate and Scottish Ministers.

2.2 All clinical staff, including staff who provide clinical advice, are subject to the duties within the Act. Leaders/ Managers of clinical teams also have specific duties under the Act to comply with. The Act does not apply to non-clinical staff e.g. administrative and maintenance staff etc.

2.3 Section 12IF of the Act sets out that quarterly reports, as a minimum, on compliance with the Act, are to be provided to the Board of the relevant organisation(s) by the Executive-level clinician on the board with responsibility for the legislation, in this case, the Executive Nurse Director. These reports must include staff's views on compliance. A Board wide Compliance and Assurance Audit (hereafter referred to as the Audit) was distributed to managers during Quarter 1 (Q1) and Quarter 2 (Q2) to gather staff views.

2.4 This quarterly report serves two purposes:

- to provide NHS Lothian's Board with a summary of compliance levels across all the duties and requirements of the Act.

- to provide NHS Lothian's Board with an update on progress against approved recommendations from the Q2 Health and Care (Staffing) (Scotland) Act 2019 Quarterly Board Compliance Report.

2.5 The report details compliance with the duties through the systems and processes that are in place to meet the requirements of the Act and ensure appropriate staffing. It does not include reporting on any workforce data as this is not a requirement of the Act.

2.6 Applying the Scottish Government rating system, the overall level of assurance is "Reasonable". That is, systems and processes that are aligned with the duties in the Health & Care (Staffing) (Scotland) Act 2019 are in place for, and used by, 50% or above of all services/ professional groups managed by respondents to the Q1 and Q2 Compliance and Assurance Audit. Utilising the Corporate Governance and Assurance system employed within NHS Lothian's Board, the assurance level for Quarter 3 (Q3) remains **Moderate** on how effectively NHS Lothian is meeting its legal duties within the Health & Care (Staffing) (Scotland) Act 2019.

Background

3.0 The duties under the provisions of the Act set in statute the 12IA Duty to ensure appropriate staffing; “that at all times suitably qualified and competent individuals from such a range of professional disciplines as necessary are working in such numbers as are appropriate for the health, wellbeing and safety of patients or service users and the provision of high-quality health care.”

3.1 There are further duties within the Act:

- **12IB Duty to ensure appropriate staffing: agency worker** (reporting instances of high-cost agency staff, when agency costs have been higher than 150% of the equivalent NHS staff cost for the equivalent post for the same period).

- **12IC Duty to have real time staffing assessment in place and 12ID; Duty to have a risk escalation processes in place** (having procedures in place for identifying risks relating to staffing and then mitigating these or escalating as required).

- **12IE Duty to have arrangements to address severe and recurrent risks** (Having arrangements set out on how information on staffing risks will be collated, analysed and recorded, including reporting to The Board when required). The Act does not define what a severe or recurrent risk is – organisations are expected to determine a locally accepted definition.

- **12IF Duty to seek clinical advice on staffing** (to have in place arrangements for seeking and having regard to appropriate clinical advice in making staffing decisions and having arrangements for recording and explaining decisions that conflict with that clinical advice).

- **12IH Duty to ensure adequate time given to clinical leaders** (giving sufficient time and resources to clinical leaders to carry out their leadership role).

- **12Il Duty to ensure appropriate staffing: training of staff** (to ensure that staff are provided with information and training to implement the duties in The Act effectively **and** ensure that staff are suitably qualified and able to maintain competence in their role).

- **12IJ Duty to follow common staffing method, including 12IL training and consultation of staff.** The Common Staffing Method is a consistent triangulated assessment with nine components including reviewing the results of staffing level tools which should be run once per year. This Duty requires organisations to use the Common Staffing Method as a framework for gathering and analysing relevant staffing and quality data.

This helps clinical leaders understand and evidence staffing requirements and quality of care for their clinical areas.

3.2 The Act also lists '**guiding principles'** to be met when organisations are arranging staffing:

(a) that the main purposes of staffing for health care are:

(i) to provide safe and high-quality services, and

(ii) to ensure the best health care or care outcomes for service users

(b) in so far as consistent with these main purposes, staffing is to be arranged while:

(i) improving standards and outcomes for service users;

(ii) taking account of the particular needs, abilities, characteristics and circumstances of different service users;

(iii) respecting the dignity and rights of service users;

(iv) taking account of the views of staff and service users;

(v) ensuring the wellbeing of staff;

(vi) being open with staff and service users about decisions on staffing;

(vii) allocating staff efficiently and effectively, and

(viii) promoting multi-disciplinary services as appropriate.

3.3 All these principles must be considered together when determining staffing levels, and organisations are also expected to provide information on the steps they have taken to have regard to the guiding principles in the Board's annual report to Scottish Ministers.

3.4 Section 2 of the Act "Guiding principles etc. in health care staffing and planning" stipulates that Boards must also have regard to the guiding principles when planning or securing the provision of health care from a third party.

3.5 NHS Lothian's Health and Care Staffing Programme Board, chaired by the Executive Nurse Director sets direction and provides oversight on multi-professional work pan Lothian to ensure compliance with the duties within the Act.

3.6 NHS Lothian has established a core team to support the implementation of the Act and a network of lead professionals.

3.7 A Reporting Subgroup was commissioned to consider all legislative requirements regarding reporting and to develop a reporting plan to ensure

NHS Lothian's compliance with the duties within the Act. This plan was supported by the Corporate Management Team (CMT) in January and April 2024, including development of a board wide Compliance and Assurance Audit to help gather accurate data on compliance with the duties.

3.8 The Quarter 1 (Q1) and Quarter 2 (Q2) Board Compliance Reports were approved by NHS Lothian's Board on 12 August and 4 December 2024 respectively. Both reports utilised the Corporate Governance and Assurance system employed within NHS Lothian's Board. The level of Moderate Assurance of how effectively the organisation had carried out its duties was provided and accepted for both reports. This Moderate Assurance was based on an overall "Reasonable Assurance" rating generated by the Scottish Government's compliance scoring.

Assurance Level Rating

3.9 Responses from the Q1 and Q2 Audit were used to rate compliance at NHS Lothian level and by profession. A Red, Amber, Yellow and Green (RAYG) system (Table 2) of categorising the assurance level is employed throughout this report. This aligns with the rating system employed within the Health and Care (Staffing) (Scotland) Act 2019 Annual Reporting Template on compliance, provided by the Scottish Government (SG). Aligning the rating system in the Board's quarterly reports will enable the accurate formulation of the annual report submitted to the Scottish Government. Boards are free to develop their own format/ template for quarterly reporting as none has been provided by the Scottish Government.

3.10 **Table 2.** Red, Amber, Yellow and Green (RAYG) Compliance Ratings

Green (substantial assurance)	Systems and processes are in place for and used by all services and professional groups managed by respondents.
Yellow (reasonable assurance)	Systems and processes are in place for, and used by, 50% or above of all services/ professional groups managed by respondents.
Amber (limited assurance)	Systems and processes are in place for, and used by, under 50% of all services and professional groups managed by respondents.
Red (No assurance)	No systems are in place.

3.11 Please note, the RAYG ratings are based on question responses to the Compliance and Assurance Audit questions per Duty and draw on data from both the Q1 and/or the Q2 Audit.

3.12 The Scottish Government have indicated that Boards will be expected to demonstrate robust processes are in place to meet legislative requirements. A common thread throughout the Statutory Guidance is that the legislation is not

prescriptive in nature, therefore with the exception of the staffing level tools, the processes, practices and procedures Boards choose to use is often at their discretion.

3.13 Since enactment on 1 April 2024, Healthcare Improvement Scotland's (HIS) role and function has changed to monitoring health boards compliance with the duties as cited within the legislation.

3.14 HIS will write each quarter to request a copy of the Board's Internal Quarterly Report and Use of High-Cost Agency Staff Report and at the end of the financial year will write to request a copy of the Board's Annual Report to Scottish Government and Workforce Plan. To support this function, HIS has written to the Board's Executive Leads for the Act inviting them to attend Quarterly Board Engagement calls, providing an opportunity to discuss the content and progress as identified within the Board Quarterly reports.

3.15 The Q2 Board Compliance report was approved on 4 December 2024 and was based on data from the Q2 Compliance and Assurance Audit.

Assessment

Overall level of assurance

4.0 The overall level of assurance per Duty in Q3 did not change when compared with Q2. 12IE Duty to have arrangements to address severe & recurrent risks changed from Reasonable Assurance in Q1 to Limited Assurance in Q2. This change is attributed to the application of focused questions in Q2, which reduced uncertainty and provided a deeper understanding of the compliance level for the 12IE Duty compared to Q1.

4.1 **Table 3.** Overall level of assurance by Duty
Q1, Q2 and Q3, 2024 Compliance & Assurance Audit

Duty	12IA	12IC	12ID	12IE	12IF	12IH	12II	12J&L
	Appropriate staffing	Real-time staffing assessment	Risk escalation process	Address severe & recurrent risk	Seek clinical advice on staffing	Adequate time for clinical leaders	Training of staff	Follow the common staffing method
Quarter 1	Limited	Reasonable	Reasonable	Reasonable	Reasonable	Reasonable	Reasonable	Reasonable
Quarter 2	Limited	Reasonable	Reasonable	Limited	Reasonable	Reasonable	Reasonable	Reasonable
Quarter3	Limited	Reasonable	Reasonable	Limited	Reasonable	Reasonable	Reasonable	Reasonable

4.2 The overall level of assurance across all duties remains unchanged at Reasonably Assured:

4.3 **Overall Level of Assurance, of how the organisation has carried out its duties under section 2 of the 2019 Act, and sections 12IA, 12IC, 12ID, 12IE, 12IF, 12IH, 12II, 12IJ and 12IL, as of December 2024:**

Reasonably Assured

12IB Duty to ensure appropriate staffing: agency workers

4.4 The Act stipulates that, the board must report on the number of occasions that it has paid an agency worker more than 150% of the amount that would be paid to a full-time equivalent employee to fill the equivalent post for the same period. The report must include the number of occasions on which it is paid more than 150%, the amount paid on each occasion and the circumstances that have required the higher amount to be paid. The Scottish Government provide a template for this report which includes the figures to be used for a full-time equivalent employee for each band / grade so that all Boards are reporting consistently.

4.5 The Duty does not prohibit the use of workers above the 150% figure, rather it states that the amount to be paid to secure the services of an agency worker should not exceed 150%, but if it does then all instances of this have to be reported quarterly to the Scottish Ministers.

4.6 Compliance with the Duty to ensure appropriate staffing: agency workers is not surveyed within the Compliance & Assurance Audit. The reporting obligations are managed through the Staff Bank (the service securing all supplementary staffing) rather than via the wider workforce.

4.7 It should be noted that agency spend will be managed through numerous operational and professional groups. Parallel work in NHS Lothian to manage agency utilisation is in place and reports to the Workforce Thematic Efficiency Programme Board.

4.8 The agency reports should cover the following periods and are required to be submitted according to the timelines set out in table 7.

4.9 **Table 7.** NHS Lothian: Agency Reporting Timeline and Update

Period	Deadline	Status
01 March to 30 June	31 July 2024	Submitted
01 July to 30 September	31 October 2024	Submitted
01 October to 31 December	31 January 2025	On track for submission
01 January to 31 March	30 March 2025	Not Yet Started

4.10 Narrative for the period 01 July to 30 September agency data was provided within the Quarter 2 Health and Care (Staffing) (Scotland) Act 2019, Quarterly Board Compliance Report and narrative for the period 01 October to 31 December will be provided in the Quarter 4 report.

Update on Recommended Actions to Address Gaps in Compliance

5.0 The following updates on progress with recommendations from the 2024/25 Quarter 2 Board Compliance and Assurance Report are based on the views of NHS Lothian's Professional Leads for the Health and Care (Staffing) (Scotland) Act 2019.

The Health and Care Staffing Programme Board have commissioned:

5.1 Board wide policy and guidance to be produced, laying out definitions and requirements to comply with the Act, which will ensure all staff understand their roles and responsibilities with regards to the Act. The Statutory Guidance will help inform this. This includes, but is not limited to increasing clarity:

- around the roles and responsibilities when seeking and having regard to clinical advice.
- with defining severe and recurrent risks.

Areas of success, achievement or learning and resultant actions

5.2 Clinical advice should be sought and had regard to when complying with all health duties within the Act including when defining severe and recurrent risks. The Allied Health Professions (AHP) Health and Care Staffing Working Group have agreed to collaborate, share and further develop agreed definitions for severe and recurrent risks. This work will commence in Q3. Over 70% of AHP professional leads report full compliance with structures and support for staff to give clinical advice and views regarding staffing levels. Structure and support mechanisms includes regular staff meetings and huddles that contain formal agenda items to discuss staffing level and risks.

5.3 Pharmacy teams all have resilience plans which help define staffing level risks and a process has been drafted for staff to record their disagreement with staffing decisions and request a review. Further work is ongoing within Pharmacy on how severe and recurrent risks are defined and managed. The Pharmacy profession is involved in a SafeCare (real-time staffing assessment) pilot, and SafeCare can enable the Pharmacy service to identify recurrent risks using novel methods, through the aggregation and reporting of staffing level risks that are not currently captured within Pharmacy.

5.4 Within Nursing & Midwifery, a Standard Operating Procedure (SOP) and Guidance for applying the Common Staffing Method (see section 3.1) in Nursing and Midwifery workforce reviews is being tested. This includes governance via the Nursing and Midwifery Workforce Programme Board, and testing is ongoing within Community Nursing. Once this Common Staffing Method Guide and SOP has been tested, implementation will proceed in all Nursing and Midwifery areas, ensuring Senior Nurses and Midwives have oversight of all workforce reviews to ensure they are compliant with the legislation and that the professional voice/ appropriate clinical advice has been sought.

5.5 In addition, a SOP around the real-time staffing assessment requirements of the Act, using the SafeCare System, was implemented in Nursing and Midwifery and is being developed and tested in non-inpatient areas.

5.6 Understanding how to define and identify severe and recurrent risks will involve analysing staffing level risks over time that were identified and collated as part of a real-time staffing assessment. Professional Leads and Administrative staff within the Psychology service are working collaboratively around the completion of a Psychology specific real-time staffing tool and the mechanisms for escalation. The Psychology specific real-time staffing tool integrates with clear line management structures that allow queries on staffing to be raised (to comply with the Duty to have a risk escalation process in place). Whilst a risk register is used to flag longer term challenges with staffing issues in particular services (to comply with the Duty to address severe and recurrent risks). An audit tool to monitor compliance has been also developed. However, due to the limited number of escalations within the Psychology service, due to how the service operates, work is in progress to understand whether the right mechanisms to identify severe and recurrent risks are in place.

5.7 The afore mentioned board wide policies and guidance being developed are profession specific. However, overarching policies and guidance for certain duties will be developed which will include templates for managers to use to lay out procedures to their staff. This work will be driven through the establishment of a Health & Care Staffing Professional Leads Group, with individual subgroups that will report into NHS Lothian's Health and Care Staffing Programme Board.

Areas of escalation, challenges or risks

5.8 Defining severe and recurrent risks has been challenging when definitions of risk levels are subject to wider consensus and benchmarking across NHS Scotland Boards, as is the case within the Allied Health Professions. There are no national programmes to support this work. In mitigation, the AHP Workforce Planning Lead for NHS Lothian collaborates with colleagues nationally to share learning; however, the role of AHP Workforce Planning Lead within NHS Lothian is not recurringly funded.

5.9 Producing Board wide policy and guidance or laying out definitions and requirements to comply with the Act can be challenging when there are time constraints, with work required to be produced between quarterly Board compliance reports. However, a Lead for the development of Health & Care Staffing policies and guidance has been appointed and will link in with the Professional Leads Group for support with development and testing.

5.10 To increase clarity around the roles and responsibilities when seeking and having regard to clinical advice, work is required to clearly articulate which parts of staffing decisions fall into clinical advice over and above existing processes such as recruitment and Workforce Organisational Change. The Psychology Senior Management Team plans to review practice and legislation to consider this issue further.

5.11 Language employed within the Act can be a barrier to increasing clarity around seeking and having regard to clinical advice. Staff groups might not consider terms used as applicable. For example, staff within the Pharmacy service use terms such as “clinical staff” differently from how it is applied within the Act. The Pharmacy profession will review and contribute to any policy/ guidance produced to ensure it reflects their service whist continuing to educate staff about key differences between profession specific and legislative language.

The Health and Care Staffing Programme Board have commissioned:

5.12 The Board wide communication and education planning group to continue work to raise awareness among all levels of staff utilising national educational resources. For example, communication and education on:

- How to mitigate staffing level risks.
- Roles and responsibilities when addressing severe and recurrent risks.
- Who to seek clinical advice on staffing from.

Areas of success, achievement or learning

5.13 The Health & Care Staffing Communication and Education Group which consists of professional leads from across NHS Lothian has created a centrally available resource on the staff intranet, which includes links to all national Health & Care Staffing resources, as well as local information per professional group. A quarterly review process has been set up to ensure these resources remain remains relevant and update.

5.14 NHS Lothian’s Health and Care Staffing Professional Leads attend shared learning events run by Healthcare Improvement Scotland (HIS). HIS provide a monitoring role within the legislation and organise learning events that are a good opportunity to learn and share. Such events decrease uncertainty by providing information and guidance on the legislation, which is dispersed across NHS Lothian, raising awareness among all levels of staff. Dissemination has taken place within various professional groups and through Health and Care Staffing learning events provided by the Health and Care Staffing Team.

5.15 Such learning events include the Corporate Induction for new starts within NHS Lothian. The Health and Care Staffing Team now has a recurring agenda item to present within the induction week schedule. This proactive approach to communication and education on various aspects on the Act provides an opportunity to raise awareness among all levels of staff at a formative juncture.

5.16 Users of the Health and Care Staffing Compliance and Assurance Audit explained that the survey also served as an educational tool. Respondents gained knowledge of the Act though viewing the legislation broken down into separate Duties with descriptions of legislative obligations. The reflections that are required to compete the Audit for a service, helped areas to consider what the legislation means for their area(s) and actions to increase compliance. NHS Lothian’s Health and Care Staffing Professional Leads have supported key stakeholders through making the Audit available as part of an initial scooping exercise, understand compliance for their area and or profession.

5.17 Similarly, the Health and Care Staffing Team have contributed to profession specific staff training days within Nursing and Healthcare Science to raise awareness of the legislation and encourage the use of national resources such as the TURAS Skilled level learning resource. Widening the use of national resources will form part of future professional lead group efforts going forward. TURAS Skilled level learning resource uptake is monitored through monthly reports compiled by Healthcare Improvement Scotland. These reports, which are pre-filtered at NHS board level, are then analysed by the Health and Care Staffing Team and sent to professional leads to encourage uptake of the resources within their professions. The learning resources contain information at different levels on the Act, from foundation to practitioner. During 2024 (to-date) 370 staff completed the HIS Skilled Health and Care Staffing learning resource on TURAS. This is a 234% increase from 107 completions in 2023 (data available from May 2023).

Areas of escalation, challenges or risks

5.18 The number of staff completing the HIS Informed Health and Care Staffing learning resource on TURAS peaked in April 2024 around enactment and has decreased month on month throughout the rest of 2024. This actuality is reflected in the Q2 recommendation to “raise awareness among all levels of staff using national resources”.

5.19 As suggested by the TURAS education uptake results for 2024 (to-date), activity to promote learning resource completion has declined post enactment. The Health and Care Staffing Leads Group for NHS Lothian will create new objectives to increase compliance with national resources and meet the recommendations of the Board. As mentioned previously, this Group is to be re-formed with a new Chair to proceed recommendations through 2025/26. One challenge for professional leads in this area is that data provided by HIS on resource completions cannot be broken down by board then profession to produce targeted actions for improvements.

5.20 The Pharmacy profession has identified further educational needs around specific duties and within specific services. For example, some service leads answered 'No' to certain questions around compliance within the Audit, despite robust process being in place. Thus, the Audit identified opportunities to raise awareness among staff about existing compliance and robust processes. This includes educating areas on recognising and capturing current practices or communicating the availability of underutilised processes.

5.21 Within the Psychology service there is limited or no flexibility to move staff quickly as a response to short term or unexpected absence. This creates a challenge for the Psychology profession, as redeploying staff is integral to pre-available real-time staffing assessment tools such as SafeCare. Therefore, a profession specific real-time staffing tool was designed for use within Psychology. The flexibility to redesign and innovate is purposively built into the Act, supporting profession specific approaches to complying with the legislation.

5.22 Within the Psychology service, an audit process is being refined to ensure that escalations and safe staffing patterns are being identified and worked through onto risk registers by the Senior Management Team. Board recommendation of raising awareness among all levels of staff is an additional task for administration and lead staffing groups within Psychology. For example, training on staff has used staff capacity and a real-time staffing tool has added additional recording practices into any absence. The Psychology Service is undergoing an administration review as well as a review of staffing in light of reduced Scottish Government funding for Psychology posts and this additional administrative ask is being factored into decision-making.

The Health and Care Staffing Programme Board have commissioned:

5.23 The Health and Care Staffing Professional Leads to further analyse on the results per profession and per area and report locally through governance groups on key findings, identifying any profession specific gaps and actions required to mitigate.

Areas of success, achievement or learning

5.24 The Audit results have decreased uncertainty by enabling the identification of gaps in compliance by profession and location. These insights allowed Professional Leads to raise awareness among all levels of staff, identifying development needs and resultant actions.

5.25 Within the Allied Health Professions, reports on the Health and Care Staffing reporting position, progress and next steps are formally received and discussed through NHS Lothian's AHP Health and Care Staffing Working Group and through the AHP Workforce Planning Group. Profession specific escalations of staffing risk are formally raised through the AHP Workforce Planning Group, and in profession-specific fora. The Board wide communication and education around defining severe and recurrent risks will further enhance these business processes.

5.26 The Q1 Health & Care Staffing Board Compliance Report (Q1 Report) was discussed at the Nursing and Midwifery Workforce Programme Board, with Nursing and Midwifery specific areas of success and challenge highlighted. Areas identified in the Q1 Report are also flagged on risk registers in Psychology and results from the Audit and the Board Compliance Report are discussed at senior leadership meetings and with service leaders within Pharmacy.

5.27 The Audit results are also used to raise awareness among all levels of staff by helping to identify relevant educational resources. Within the Pharmacy profession, there is an appetite for a board wide approach to education and the Pharmacy profession is exploring the inclusion of Health and Care Staffing modules as part of staff personal development plans.

5.28 Building on successes going forward will involve further reports to professional groups to share key findings and use the narrative from the raw data to inform and drive improvement work. Healthcare Science improvement work will be framed utilising national resources. For example, a checklist shared at The Health and Care Staffing Act: Sharing the Learning Event will support monitoring, recording and progression with the legislation. Analysing Audit results and reporting locally will also involve making Health and Care Staffing a standing item, with an expectation for regular updates, like the practice within Pharmacy professional groups.

5.29 The Medical profession note progress across all rotas with national e-Rostering implementation. Once Medical staff and their rotas have migrated to the national HealthRoster system, they will automatically have access to SafeCare. This system can be used to meet requirements of the Duty to have a real-time staffing assessment, risk escalation process in place and the Duty to address severe and recurrent risks. SafeCare pulls data on available staffing from HealthRoster to enable staffing level risk assessments and will provide the medical profession with novel data to analyse and report locally through governance groups on key findings, identifying any gaps and actions required to mitigate.

Areas of escalation, challenges, or risks

5.30 The work of Professional Leads to further analyse results and report locally through governance groups on key findings, identifying any profession specific gaps and actions required to mitigate is currently maintained within some professions without a dedicated Health & Care Staffing Professional Lead. For example, there is no dedicated lead for the Healthcare Science Profession. A workforce paper is being progressed via the Diagnostic Anaesthetics Theatres and Critical care (DATCC) management team on the Healthcare Science profession to address this gap within Healthcare Science.

5.31 In addition, there is no recurrent funding in place for the professional AHP Workforce Planning lead who undertakes analysis and Health and Care Staffing programme leadership across all 13 AHP professions, in all NHS Lothian operational areas. Without dedicated professional Health and Care Staffing leads there is a risk of duplication and reduced coordination. Lothian Chief Officers have been approached to consider proportionately funding the AHP Workforce Planning Lead on a recurring basis and should this not be agreed have been asked to detail how they propose to meet the requirements for AHPs.

5.32 The Q1 and Q2 Compliance and Assurance Audit produced a vast array of quantitative and qualitative information. An analysis of results was provided in the Q1 and Q2 Health and Care Staffing Board Compliance Reports. The Audit results are also analysed by professional leads to develop targeted actions. However, the short time periods between quarterly reports restricts the amount analysis and local reporting that can be progressed quarter on quarter. The decision to provide an update in Q3 and not run a Q3 Audit was positively

received by professional leads and this will allow time to report locally as well as develop and implement action plans.

The Health and Care Staffing Programme Board have commissioned:

5.33 The Health and Care Staffing Professional Leads to continue to work together to share areas of success, good practice, and areas of challenge to work towards consistency across the Board and overall improved compliance including work to:

- assure consistency and benchmarking within each duty e.g. variations in professional judgement.
- develop and onboard systems to support duties e.g. HealthRoster, SafeCare, eJobPlan.
- integrate the data into service planning, workforce planning and improvement cycles.
- Enhance the availability of out-of-hours clinical advice on staffing, risk escalation and mitigation, particularly from central departments.

Areas of success, achievement or learning

5.34 Across NHS Lothian, professional leads for Health & Care Staffing are working to share areas of success, good practice, and areas of challenge. This collaboration can be inter-professional in nature. For example, most Healthcare Science services do not use SafeCare for real-time staffing assessment as it is not available to them yet. Pharmacy colleagues are trialling configuration changes to SafeCare, and the findings will be shared across all professions who do not use SafeCare.

5.35 The Health and Care Staffing Team has also worked closely with Pharmacy to share best practice and develop and onboard systems to support meeting obligations in the legislation. This includes the SafeCare Clinical Lead for NHS Lothian delivering training for the Pharmacy profession. The eRostering Team also supported Pharmacy with getting ready to pilot the system.

5.36 One AHP profession, Speech and Language Therapy, is live on HealthRoster and is piloting HealthRoster features. HealthRoster is the national electronic rostering system that is being rolled out across NHS Scotland. The AHP feature pilot will commence early 2025 and will report widely through Non-medical Job Planning Group, throughout AHP professions in NHS Lothian, and there is considerable interest across NHS Scotland AHPs.

5.37 Support from key stakeholders across Corporate Nursing is key to effectively piloting HealthRoster or SafeCare features that meet legislative obligations.

5.38 The Act can be viewed as operationalising workforce planning. A key component of the legislation involves considering how identified compliance risks are used to inform workforce plans and this is measured in the Health and Care Staffing Annual Report on compliance that is submitted to The Scottish

Government. This will involve integrating Audit data into Board and service workforce planning cycles, especially when planning the required workforce as part of the 6 steps to Integrated Workforce Planning that is recommended for use by the Scottish Government. Board workforce plans have 3-year actions with an annual review. The Healthcare Science actions from NHS Lothian's 3 Year Workforce Plan includes Lothian's Healthcare Science Professional Lead conducting an options appraisal of where Healthcare Science services are located within the management structure. This activity will look for opportunities to improve service planning, workforce planning and quality improvement cycles and can draw on compliance data from the Audit.

5.39 It is recognised that once board wide guidance is embedded, it will be possible to better monitor these individual workstreams.

Areas of escalation, challenges, or risks

5.40 The rollout of SafeCare within Nursing & Midwifery adult inpatient areas began in May 2015 and has been mandated for use in all adult inpatient areas since February 2022. Pharmacy is the only non-Nursing & Midwifery profession currently trialling SafeCare. The Pharmacy lead noted that this isolation can be challenging since SafeCare was designed for inpatient Nursing areas, and Pharmacy will use it differently, without patient numbers and acuity data. The rollout of the reduced working week has further complicated this, as the HealthRoster Team has reduced capacity due to the transition to the reduced working week, which also affects SafeCare. This has limited real-time staffing assessments and paused AHP onboarding to HealthRoster, a prerequisite for SafeCare. The HealthRoster Team's support is essential for SafeCare's success, and capacity challenges may intensify as more professions adopt it. The Pharmacy lead also highlighted additional training needs for HealthRoster, requiring extra resources.

5.41 e-JobPlan is a software application that sits within HealthRoster and can help professions covered by the Act comply with legislative obligations. The further use of e-JobPlan for AHPs would require financial resource to purchase sufficient licences. An AHP pilot of this system will inform the position for non-medical professions wider than the Allied Health Profession. e-JobPlan will support the oversight and optimisation of NHS Lothian AHP staffing positions and this work is paused until HealthRoster, with SafeCare are live in all AHP services.

5.42 Within Psychology, meeting the Duty to have a real-time staffing assessment in place has involved an additional system rather than using existing systems such as SafeCare, which is time consuming. Psychology will move to HealthRoster at some point; however, the timescales are currently unclear. Integrating findings from real-time staffing and safe staffing into workforce planning will take some time as there are no existing benchmarks for Psychology nationally, but this is under consideration as Psychology progresses compliance with the Act. Actions taken to address this situation include linking in with Heads of Psychology Scotland around national

Psychology directives and attending Health & Care Staffing Programme Board meetings with other Health & Care Safe Staffing Leads.

Other work ongoing/ planned/ completed

5.43 The Healthcare Science profession have made progress with the 12IA Duty to ensure appropriate staffing, as the majority of services have been able to absorb the 30-minute reduction in the working week by re-organising methods of delivering services. However, the Professional Lead for Healthcare Science explained that there is likely to be a service impact for most Healthcare Science services for any further reduction to the working week and services are currently working on risk assessments.

5.44 The Psychology Service plan to implement senior management team logs for legislative obligations around seeking and having regard to clinical advice, risk escalation, risk mitigation and time to lead. Issues have been identified with some of these requirements and plans are being considered that can mitigate these. This includes further work regarding seeking and having regard to clinical advice as described within the Act and ensuring the staff group understands this Duty, such as having robust processes in place to record views and decisions on staffing made that go against clinical advice. Risk registers are used currently, and steps have been taken to mitigate short-term situations where possible. Within the Psychology service, the compliance issues being identified are not acute and therefore immediate action is not taken, as it is not possible to find an immediate mitigation. However, existing processes such as a risk register and workforce organisational change are options. Due to wider issues in Psychology, some steps for progressing issues like the broader staffing structure are on hold at present.

5.45 The Duty to follow common staffing method is a triangulation approach within the Act to making decisions around staffing and includes the use of staffing level tools in Nursing and Midwifery. An internal audit assessing the internal controls on this Duty is underway in Q3. The audit also considers workforce planning in Nursing and the adherence to the statutory guiding principles. Audit sample areas are the Royal Infirmary Edinburgh and Royal Edinburgh and Associated Services (REAS).
Collaborative work is ongoing with Healthcare Improvement Scotland on the development and testing of Nursing Children and Young People and Mental Health & Learning Disabilities staffing level tools on SafeCare. Staffing level tools allow areas to capture patient acuity typically over a two-week period and for comparison with funded establishments. This approach is outlined in the Duty to follow common staffing method. The staffing level tools are currently hosted on the SSTS system and Healthcare Improvement Scotland plan to transfer tools onto the SafeCare system incrementally going forward.

5.46 Development and testing are also ongoing with Community Nursing and Maternity Assurance Frameworks. Using a quality management approach, the frameworks will ensure consistent, robust processes and systems for measuring, assuring, and reporting on the quality of care and practice. The data will be used in applying the Common Staffing Method in workforce reviews.

Further updates on these actions will be provided in future quarterly reports.

NHS Lothian

4.8

Meeting: NHS Lothian Board

Meeting date: 5 February 2025

Title: Pharmacy Practices Committee Outcomes – Quarter 3 2024/25

Responsible Director: Jenny Long, Director of Primary Care

Report Author: Aleisha Hunter, Primary Care Contracts Manager

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☒	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☒	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☐	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Director (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to advise the Board on outcomes of Pharmacy Practices Committee hearings held in Q3 2024/25.

2.2 Background

This information is for noting and will be provided to the Board on a quarterly basis with an annual report provided following the end of the financial year. The full minutes from all Pharmacy Practices Committee hearings can be found on the NHS Lothian website via the following link:

Previous Decisions – Pharmacy Application Process

2.3 Assessment

PPC Hearing Outcomes

No new applications have been considered by the PPC since August 2024. This is due to several applicants not proceeding beyond the pre application stage; either withdrawing their interest or failing to meet the required procedural timescales.

Appeal Outcomes

We have been notified of the following appeal outcomes from 1st October 2024:

- Pumpherston, West Lothian - application not granted. The applicant lodged an appeal. NAP concluded that the appeal was unsuccessful; the process is now at an end.

- Granton, Edinburgh – application not granted. Appeal upheld. PPC reconvened on 6th May 2024. Further appeal upheld. PPC reconvened on 20th August 2024. The applicant then lodged a further appeal. NAP refused the appeal on 9th October 2024; the process is now at an end.

- Calderwood, West Lothian - application not granted. Appeal upheld. PPC reconvened on 16th December 2024. The applicant has a right of appeal against the decision, we are still within the appeal period.

Additional Information

On 26th September 2023 the PPC granted an application in Linlithgow, West Lothian. Appeals against this decision were lodged by interested parties, with NAP concluding on 25th September 2024 that the latest appeal was unsuccessful in its entirety, bringing the process to an end. We have since been informed that one of the interested parties has now lodged a Judicial Review against the NAP. The Board may be called to be a participant in proceedings, we await an update from CLO colleagues.

Upcoming hearings

- Securing quorate panels for 2025/26 is proving challenging. We will continue to work with colleagues to try and secure dates, ideally at the rate of one per month, up to the end of Q4 2025/26. These dates will be utilised for new applications as required.

2.3.1 Quality/ Patient Care

Many pharmacy applications are not granted by the PPC. This aligns with our extant Pharmaceutical Care Services Plan which outlines we have good core provision of pharmaceutical services for our population. Therefore, while the few granted applications should improve access to pharmaceutical services for that neighbourhood, the process itself of managing unsolicited applications is not effective, efficient, or person-centred (we cannot commission services based on population need). However we are required to work within the current framework as set out in the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009.

2.3.2 Workforce

Management of the pharmacy application process is labour intensive and requires PPC members' time and the time of the primary care contracts team to administer the process, which are managed within existing resources.

2.3.3 Financial

The key resources are workforce as described above which are managed within core budgets.

2.3.4 Risk Assessment/Management

There is a risk that PPC hearings are delayed due to the challenges in providing quorate panels, leading to delay in processing pharmacy applications.

There is a risk that the reform of the current regulations (National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 as amended) is further delayed and the challenges with the current procedures continue, leading to an unsatisfactory process for both applicants and health boards.

Risks relating to the pharmacy application process are held on local risk registers.

2.3.5 Equality and Diversity, including health inequalities

Each PPC hearing considers the impact on inequality as part of their discussion and decision-making.

2.3.6 Other impacts

No other known impacts.

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders, including patients and members of the public, where appropriate:

- as part of every pharmacy application there is a consultation exercise with the public.

2.3.8 Route to the Meeting

This information is for noting and will be provided to the Board on a quarterly basis.

2.4 Recommendation

- **Awareness** – For Members' information only.

3 List of appendices

No appendices are included with this report.

NHS Lothian

4.9

Meeting:	**NHS Lothian Board**
Meeting date:	**5 February 2025**
Title:	**Appointment of Members to Committees & Integration Joint Boards**
Responsible Executive:	**Board Chair**
Report Author:	**Darren Thompson, Board Secretary**

1 Purpose

This report is presented for:

Assurance	☐	**Decision**	☒
Discussion	☐	**Awareness**	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other – **Committees / IJB Membership**	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☐	**Effective**	☒
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

Lothian NHS Board's Standing Orders reserve certain matters to the Board, including decisions on the appointment of members to its committees.

This Report has been prepared so that the Board may ***approve*** the following:

Pharmacy Practices Committee

- The reappointment of Martin Connor, as Co-Chair of the Pharmacy Practices Committee, for a further term, from 09 February 2025 until 31 August 2025.

2.2 Background

Appointments to the Board's Committees are recommended by the Board Chair, following discussions with the relevant Committee Chairs and the recommended appointees. Considerations include the collective skills and experience required by each Committee, as well as the resource capacity and time commitments of individual non-executives.

Pharmacy Practices Committee

Specific Regulations prescribe the membership and operation of the Pharmacy Practices Committee (PPC). It has seven members, being one NHS Non-Executive Board member (Chair), three pharmacists, and three lay members. A Non-Executive Board member convenes the PPC each time it meets. For practical reasons the NHS Board has appointed several individuals to fill the required positions, as this facilitates convening the PPC each time a hearing is required and allows a fresh panel to consider any appeals.

The volume and frequency of scheduled Pharmacy Practices Committee (PPC) hearings means there is a need to maintain a pool of several non-executive board members who may be called upon to chair a hearing.

2.3 Assessment

2.3.1 Quality/ Patient Care

- Not Applicable.

2.3.2 Workforce

- Not Applicable.

2.3.3 Financial

- Not Applicable.

2.3.4 Risk Assessment/Management

This report and its recommendations attend to actual or anticipated gaps in the membership of committees, and it is not considered that there needs to be an entry on a risk register.

Key Risks

- A committee or IJB does not meet due to not achieving quorum, leading to a disruption and delay in the conduct of the Board's governance activities.
- The Board does not make the most effective use of the knowledge, skills and experience of its membership, leading to the system of governance not being as efficient and effective as it could be.

2.3.5 Equality and Diversity, including health inequalities

- The statutory duties **do not apply** to the recommended decision, this report does not relate to a specific proposal which has an impact on an identifiable group of people.

2.3.6 Other impacts

- Resource Implications - This report contains proposals on the membership of committees. Where members are new to committees, it is probable that they may require further training and development to support them in their roles. This will be addressed as part of normal business within existing resources.

2.3.7 Communication, involvement, engagement and consultation

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

2.3.8 Route to the Meeting

- There are no prior committee approvals required.

2.4 Recommendation

- ***Decision*** – The Board is asked to approve the reappointment of Martin Connor, as Co-Chair of the Pharmacy Practices Committee, for a further term, from 09 February 2025 until 31 August 2025.

3 List of appendices

- None.

NHS Lothian

6.

Meeting: **NHS Lothian Board**

Meeting date: **5 February 2025**

Title: **Chief Executive's Report**

Responsible Executive: **Professor Caroline Hiscox, Chief Executive**

Report Author: ***As above.***

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other [Priority Issues]	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☒
Primary Care	☒	Digital	☒
Unscheduled Care	☒	Environmental Sustainability	☒

This aligns to the following NHSScotland quality ambition(s):

Safe	☐	Effective	☒
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The Chief Executive's Report is a standing item on the Board's agenda. Its purpose is to:

- Highlight key areas of progress or challenge since the last meeting, which are of relevance to the Board and not already covered on its agenda.
- Ensure that Board members are informed of and alert to any emerging developments that may impact significantly upon the Board's business and operating environment.
- Provide appropriate context and scene-setting for the Board's meeting agenda.

The Chief Executive's Report is primarily for the Board to note but members will have the opportunity to ask any questions arising from its contents.

2.2 Background

It is an important principle that, wherever possible, there are "no surprises" for the Board in terms of significant developments. The Chief Executive's Report represents one of the mechanisms that is in place to support this principle, alongside standalone briefings and other governance meetings.

2.3 Assessment

The Chief Executive's Report is provided for information only. Any items requiring a later decision by the Board, or one of its committees, will be addressed as standalone items, with appropriate papers, and therefore individually impact and risk assessed.

2.4 Recommendation

- **Awareness** – The Board is asked to note the Report.
- **Discussion** – Board members are invited to ask questions arising from the Report.

3 List of appendices

The following appendices are included with this report:

- **Appendix 1, Chief Executive's Report – February 2025**

Appendix 1

Chief Executive's Report
NHS Lothian Board Meeting, 5 February 2025
Professor Caroline Hiscox

1. NHS Scotland Board Chief Executives / Executive Group

I have continued to engage with and contribute to this new leadership forum, established within NHS Scotland and providing a focus for collaborative discussion and action on national challenges. Further meetings were held in December and January, and I will be sure to reflect any relevant highlights from these during the Board's discussions.

2. Princess Alexandra Eye Pavilion

I want to acknowledge the ongoing and significant efforts of all staff in managing the unavoidable temporary closure of the Princess Alexandra Eye Pavilion (PAEP) in October 2024. The Deputy Chief Executive will provide a more detailed progress update on this, elsewhere on the Board's agenda.

3. Financial Planning for 2025/26

The Corporate Management Team came together in a development session in January, along with a number of members of the wider leadership team, to collectively review and discuss the first stage proposals from each service intended to achieve the required level of financial savings in 2025/26. This will inform the development of the Board's Financial Plan and the Annual Delivery Plan for the next year, for both of which we were required to provide early drafts back to the Scottish Government before the end of January. We are challenging ourselves robustly on the required balance between recurring and non-recurring savings but also on the need to bring the same level of energy and commitment to system transformation and improvement as we do in the area of financial efficiency.

4. Developing our approach to transformation and innovation

I welcomed the First Minister's statement on 27 January relating to NHS renewal. Whilst national vision and leadership on innovation and transformation is critical, we are mindful that NHS Lothian and other boards have their parts to play. There are opportunities to demonstrate leadership on reform within our local health and care system, in response to increasing demands, evolving demographics and financial constraints. I have initiated some further strategic thinking within the Corporate Management Team about how we can position NHS Lothian as a leader in this space by considering the principles of a Values Based Healthcare (VBHC) approach. I plan to share details with Board members and wider staff very soon on a refreshed approach to innovation, redesign and transformation within NHS Lothian. Thereafter, I will convene a small working group to develop key concepts and proposals.

5. Maternity Services

Board members are aware from recent briefings and discussions at the Strategy, Planning & Performance Committee that a number of issues and concerns have been brought to light within NHS Lothian's Maternity Services. Routes of escalation included our established Whistleblowing processes, feedback from staff engagement events and via concerns raised to Healthcare Improvement Scotland (HIS). Significant management oversight processes, structures and resources have been put in place and a responsive action plan has been developed and is being implemented. I wish to reassure the Board and the public that a significant level of activity is underway to ensure that the issues identified, primarily relating to workforce and culture, are fully addressed. We are liaising closely with HIS, with our staff and with patients on this work. In addition, as part of an organisation-wide review of staffing levels in line with the new Health and Care Staffing legislation CMT agreed on 28 January to an additional 32 substantive posts in Maternity Services. A detailed discussion also took place at the Healthcare Governance Committee on 28 January, ensuring that members have full awareness of the issues and assurance on the response.

6. Veterans First Point Lothian

Board members are aware of the decision taken by CMT in late 2024, as part of the Board's approved 2024/25 Financial Recovery Plan, to remove NHS Lothian's matched funding contribution for the Veterans First Point Lothian Service. This is an additional, bespoke mental health service provided for armed forces veterans, funded in recent years by a non-recurring Scottish Government grant, to which NHS Lothian made a matched contribution. I recognise that this difficult decision has understandably generated an emotive response, and also that our approach to engagement with service users was initially less than ideal. However, I am pleased to say that staff within the service and service users themselves have responded very constructively to the challenge of how we ensure continued delivery of dedicated mental health support for veterans, within a reduced funding envelope. Work to review the service is therefore well underway, informed by this staff and service user engagement, and we expect to see redesign options for discussion at the Corporate Management Team before the end of February 2025. This will ensure we have a redesigned service in place for the new financial year. During this process of review and decision-making, we are ensuring that we have due regard to the Board's duties under the Armed Forces Covenant.

7. Resilience Response – Storm Eowyn

The Red Weather Warning associated with Storm Eowyn on Friday, 24 January saw us standing up our local resilience response and liaising closely with partners in HSCPs, SAS, other territorial boards, as well as other bodies involved in Local Resilience Partnerships (LRPs). Managing the continuation of services whilst ensuring the safety and wellbeing of staff and patients was challenging, at a time when there are pressures already in the system. I am grateful to all for the strong teamwork demonstrated in managing our response and ensuring the continued provision of urgent care for our patients who needed it most, both in hospitals and in the community. My particular thanks go to staff members who made an extra effort to travel to work to support our critical activity.

8. 2025 New Year Honours for NHS Lothian Staff

I was delighted to see recognition in the 2025 New Year Honours List for Rakiya Sulieman, our Equality & Diversity Adviser and for the former NHS Lothian Chief Executive, Calum Campbell.

Rakiya was appointed an MBE for services to eliminating discrimination and advancing equality and good relations. Calum was appointed an OBE for services to healthcare in Scotland. I invite the Board to acknowledge these awards and congratulate both Rakiya and Calum on this well-deserved recognition for their respective commitments and efforts.

9. Corporate Office Accommodation

The implementation of the planned move of our corporate headquarters location and associated staff teams from Waverley Gate to West Port has continued. Following an earlier move for executive and corporate directors in late 2024, January saw us beginning to move staff from across wider departments, including Finance, Strategic Planning, Corporate Nursing, Communications, Human Resources, Primary Care, Analytical Services, Pharmacy, Public Health, etc. Any disruption to the delivery of key corporate services has been minimised due to the hard work and flexibility of staff, both in managing the move directly but also thanks to the willingness of staff to accommodate change and adapt to a different working environment. I look forward to welcoming to West Port those Board members who have not yet had a chance to visit and make use of our new offices.

NHS Lothian

8.

Meeting: NHS Lothian Board

Meeting date: 05 February 2025

Title: Unscheduled Care (USC) Improvement Programme

Responsible Executive: Jim Crombie, Deputy Chief Executive

Report Author: Oli Campbell, Programme Director – USC

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☒	Local policy	☒
Emerging issue	☐	NHS / IJB Strategy or Direction	☒
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

This report informs the Board of plans by NHS Lothian to improve unscheduled care (USC) performance (initially focused on the RIE) in partnership with Lothian IJBs, HSCPs and Local Authorities, after being successful in bidding for financial support from Scottish Government to support these initiatives.

The planned unscheduled care improvement work is designed to address the pressures on the RIE Emergency Department, which is the busiest in Scotland, serving 40% more patients than its designed capacity and covering Edinburgh, Midlothian and East Lothian, while functioning as a Major Trauma Centre for the South-East of Scotland.

2.2 Background

The Unscheduled Care (USC) Framework is an integral part of the NHS Lothian led Lothian Strategic Development Framework (LSDF). Performance is overseen by the 'whole system' USC Programme Board, chaired by the East Lothian HSCP Chief Officer, Fiona Wilson, with support from the USC Tactical Committee. Both groups include senior service-wide representation from Acute, HSCPs and other key areas.

Ahead of the Scottish Government (SG) budget in December 2024, NHS Lothian was approached by representatives of SG and asked for a set of proposals to be rapidly developed with the primary aim of improving performance against the 4 Hour Emergency Access Standard (EAS) particularly within the Royal Infirmary of Edinburgh site. SG specifically requested that all proposals must represent additional capacity with no additional monies provided to be used maintaining the status quo of the site.

Proposal Submission

The scope and focus of this work are on RIE and its Health & Social Care infrastructure. Local discussions via a short life working group (SLWG) on how best to deliver improvements has involved leaders from NHS Lothian, the Health and Social Care Partnerships (HSCPs) and Local Authorities (LAs). From these discussions a comprehensive list of the options available to decompress the system and the RIE was developed, primarily through reducing occupancy with immediate effect thus enabling flow as well as safe patient care. This intended result of whole system prioritisation is aimed at delivering an immediate step change over the winter months that will decompress the system, improve patient safety and system performance, whilst enabling transformational redesign that reduces reliance (where appropriate) on institutional beds.

The SLWG also reviewed the existing USC strategic programme structure (LSDF) and ensured that actions aligned where possible to the existing workstreams and approach. The existing LSDF is driven through a whole system USC Programme Board and is supported by a USC Tactical Committee. Both of these groups are led by leaders within HSCPs in Lothian and have wide whole system representation.

Partners agreed to the following outputs which would be measured through the associated proposals:

1. Accelerate *"…existing LSDF plans to improve USC performance, with a particular focus on actions that will deliver improved performance along with patient safety over the winter months."*
    - *Expediting roll out of Discharge without Delay (DwD) including rapid adoption of Planned date of Discharge (PDD) with a focus on reducing length of stay.*
    - *Improving the experience for those presenting to the Emergency Department with mental health conditions.*
    - *Transforming the services available through the Rapid Assessment Care Unit.*
    - *Transforming models of care across the Lothian Health and Care System (LHCS) for frail citizens who require medical and social care support.*
    - *Strengthening the offer of the Flow Navigation Centre and those services it interfaces with.*
2. Develop *"…a comprehensive proposal that seeks to address the deficits in demand and capacity borne out over the Lothian Health & Care System whilst simultaneously enabling radical transformation of models of care to ensure long term sustainability and improved patient safety and experience."*
    - *Enabling a shift in the balance of care, particularly around assessment and provision of rehabilitation support, from the acute hospital setting to the patient's home.*
    - *Strengthening the HSCPs' capacity to provide patients with care at home to meet current demand.*
    - *Strengthening Primary Care's capacity to provide enhanced care for frail citizens, reducing reliance on hospital bed-based care*
    - *Reducing the reliance on the RIE Emergency Department as the "place of safety" for those with acute mental health requirements.*

Timelines and Anticipated Performance

The proposals were modelled with input from the national Centre for Sustainable Delivery (CfSD) and assumed recurring investment of £14.5 million to deliver the desired impacts in the RIE (as shown in table 1 below).

Table 1 – Impact of Proposed USC Actions

	End of Month Estimated Impact Timeline						
	Jan-25	**Feb-25**	**Mar-25**	**Apr-25**	**End Q1 25/26**	**End Q2 25/26**	**End Q3 25/26**
Anticipated Beds released	**27**	**73**	**113**	**112**	**135**	**135**	**158**
Long Waits (>8hrs) percentage reduction	34%	91%	In theory majority of long waits should be eradicated. (There will always be exceptions)				
Performance	53%	67%	79%	79%	86%	86%	93%
RIE Bed Occupancy	98%	92%	87%	85%	<85%	<85%	<85%

The agreed proposals for performance improvement are as follows:

- *Component 1: Aimed at the immediate decompression of the system with impact delivered by end January 2025.*
- *Component 2: Aimed at the acceleration of strategic actions that will deliver impact by end April 2025.*
- *Component 3: Aimed at further acceleration of larger strategic actions that will be commenced in 2024/25 deliver impact by Q2 2025/26 and ensure sustainability of delivery.*

2.3 Assessment

Context: Financial and Existing Capacity Constraints

As service demand increases, arising from both population growth and population ageing, the NHS and its Local Authority partners are experiencing severe budget pressures, requiring action to deliver efficiencies, including making changes to services. NHS Lothian faces a £120m financial gap in 2025/26 and similar substantial financial challenges are faced by Local Authorities within the region. It must be noted that any improvement actions associated with improving USC and the corresponding investment, risk being offset by other significant cuts which will be made to Health and Social Care services across Lothian.

NHS Lothian's own whole system bed modelling (conducted by an external consulting firm in 2024) describes "…significant gaps in capacity to meet current and projected demand…". This suggests that across the NHS Lothian area the health and care system requires:

- Projected need for 720 additional acute beds by 2033.
    - If NHS Lothian is successful in delivering significant mitigations this figure would reduce to requiring an additional 80 beds (these modelled mitigations are extremely ambitious and assume the removal of all delayed discharges from acute hospitals).
- Projected need for 300 additional acute beds by 2043 (even if all mitigations are implemented).
- An additional 288 community beds and an additional 1,900 care home beds across the Lothian region by 2043.

This capacity issue was compounded in November 2024 when facilitating the closure of a clinical area on the Western General Hospital (WGH) campus, resulting in alternative arrangements for the provision of inpatient services being moved from a bed-based model to focus on admission prevention and community provision. However, due to the challenging financial landscape not all measures were able to be realised. Therefore, there remains a risk that the reduced bed capacity will not be immediately mitigated against during the winter months.

Programme Implementation Structure

An Executive Oversight Group has replaced the initial SLWG tasked with developing and submitted the proposal for performance improvement to SG:

- Chaired by the NHS Lothian Deputy Chief Executive and meets twice weekly.
- Comprised of both stakeholders and leaders from across unscheduled care planning and operational services.
- Is driving action-focused, system-wide improvement, whilst regularly communicating with IJB Chief Officers and the wider Health and Social Care system.

The key objectives for this improvement work through the Oversight Group have been defined as:

- *Reduce overall Hospital Occupancy*
- *Reduce overall Length of Stay (LoS)*
- *Reduce Number of A&E admissions*
- *Reduce Number of A&E attendances*
- *Improve 4 Hr Emergency Access Standard*

This Oversight Group will provide strategic focus and has been established to ensure momentum towards delivering this priority set of improvement plans. In the short term this group will support progress of the implementation plan and provide oversight and monitoring. This group will also seek evidence that appropriate assurance processes are in place across directorates/divisions to monitor, deliver and sustain improvement.

Membership of the Oversight Group was developed ensuring attendance from not only NHS Lothian and the four HSCPs but with experience from a range of areas including Finance, Acute, Community Care, AHPs and Primary Care. Ensuring this whole system approach is essential in developing a multi-disciplinary, fully integrated methodology which will drive forward significant culture changes within NHS Lothian. Communication remains at the forefront of these ambitions with each member of the group accountable for consistent cascading of information through peer groups, professional networks, organisational leadership groups/boards whilst supporting the evolution of robust plans and implementation programmes.

The Oversight group has used data extensively to frame discussions, with new dashboards and daily reports having been commissioned ensuring managers and group members have access to data points that provide early signals that improvement efforts are delivering as expected.

The remit of this group will be guided by any key Scottish Government strategies and performance measures, the existing Lothian Strategic and Development Framework (LSDF) Unscheduled Care (USC) programme, structure and aims and the USC Measurement Framework which encapsulates the majority of key data points for discussion.

The NHS Lothian Chief Executive Officer (CEO) has also led discussions with the four Lothian Local Authority CEOs to reach consensus on joint action. A new whole-system monthly meeting has been established to bring together leaders of the Lothian Health and Care System and Local Authorities.

Links to Annual Delivery Plan and the LSDF

The Scottish Government recently released 2025/26 planning guidance which set out priority areas for Boards, including key areas on focus for USC. The following table sets out an initial self-assessment of our extant (LSDF) plans against these key areas of governmental focus.

Table 2 – Self-Assessment against Scottish Government Priority Areas

Scottish Government Priority Areas	**New SG USC Plan***	**Extant LSDF**
Reduce Delayed Discharges	✓	✓
Optimising Flow Navigation Centres	✓	✓
Scheduling of Appointments	✓	✓
Professional-to-professional advice with a focus on care home support.	✓	✓
Reduce hospital admissions for patients with low clinical value such as those aged over 85 and end of life care	✓	✓
Improving urgent care in the community	✓	
increasing Hospital at Home pathways	✓	✓
Improving access to 'same day' services		✓
Early and effective triage, rapid decision-making and streaming to assessment areas.		✓
Ensure people are discharged as soon as they are medically safe, by promoting robust and responsive operational management	✓	✓
Rehabilitation and reablement in line with the 6 principles of good rehabilitation	✓	
Implement Frailty Units or designated bed base at the front door	✓	
Discharge to assess support that will facilitate new services within 24-36 hours of request, 7 day per week to provide recovery in the community	✓	✓

*Refers to initiatives funded within the £14.5m

Key objectives for 2025/26 USC Programme are set out below.

(1) Implement the recently approved plan to improve USC performance, initially focused at the RIE. This includes;
   A. Expanding HSCP capacity to improve flow from acute sites into the community as well as increasing admission avoidance capability.
   B. Developing frailty teams within each of the emergency departments.
   C. Strengthening the Flow Navigation Centre through the addition of medical staff to assist with professional to professional calls with referrers.
   D. Explore and develop a chair assessment area adjacent to the emergency department within the RIE for mental health presentations.
   E. Deploy the "Discharge Risk Indicator Tool" to be used by Multi-Disciplinary Teams (MDT) to consistently stratify risk and pathways for patients at discharge.
   F. Ensure all areas use Planned Date of Discharge (PDD) effectively.
   G. Deploy the Primary Care Frailty Local Enhance Service.

(2) Ensure DwD is embedded in practice across the Lothian system and continue the site based LoS programmes, including the use of "criteria to reside"

(3) Review "interface" models of care (RACU/H@H/OPAT/CRT/Heart Failure) to maximise, where appropriate expand, and standardise models of care and routes into these services.

(4) Develop a case for Frailty Unit(s) or bespoke bed-based models for frail patients.

(5) Develop bespoke plans to improve performance at St John's Hospital (SJH) based on the principles and initiatives found in the RIE improvement plan.
(6) Review USC portfolio spend (spend incurred across MTFF) across "frailty" and "interface" strands (via associated programme boards) with a view to maximising performance by shifting spend where appropriate from inpatient bed-based care to prevention, community or front door models of care.

Financial

As service demand increases, arising from both population growth and population ageing, the NHS and its Local Authority partners are experiencing severe budget pressures, requiring action to deliver efficiencies, including making changes to services. NHS Lothian faces a £120m financial gap in 25/26 and similar substantial financial challenges are faced by Local Authorities within the region.

As 25/26 will demand similar significant savings to be achieved as the previous year, the impact of the actions (and additional investment) may be eroded by the recovery actions required. Further reductions in service provision will challenge the ambition of whole system performance improvement. Continued close engagement across the system, as well as a joint communications plan, will be required to mitigate this risk. This will be monitored closely as the financial year develops.

Equality and Diversity, including health inequalities

ECRIA's will be conducted as appropriate on any applicable proposals.

Route to the Meeting

The proposal was presented and approved at the 3x associated IJBs during the week commencing 16/12/24, therefore giving a green light to press on with the implementation of the proposals. Approved IJB Papers:

- Midlothian IJB Paper
- Edinburgh IJB Paper
- East Lothian IJB Paper

There are further internal NHSL background documents available to Board members with the meeting Admincontrol folder.

2.4 Recommendation

The Board are recommended to;

- **Note** the successful bid for investment into the Lothian USC system.
- **Note** the action plan developed in line with this investment and associated expected performance trajectories.

NHS Lothian

9.

Meeting: NHS Lothian Board

Meeting date: 5 February 2025

Title: Director of Public Health Annual Report 2024

Responsible Executive: Dona Milne
Director of Public Health and Health Policy

Report Author: Dona Milne
Director of Public Health and Health Policy

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☒	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☒
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☐	Effective	☒
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The Director of Public Health has a responsibility to ensure that the needs of the population are considered regularly as part of local and national policy developments. The annual report informs this work by describing who our population are, what affects their health and what the evidence tells us that we should do to improve health outcomes and reduce health inequalities.

2.2 Background

Each year the Director of Public Health report has drawn attention to a key priority within public health. The report for 2024 has a focus on the need for increasing our prevention efforts within the health and care system and working alongside our partners. It complements the previous report on prevention that was approved by the Board in April 2024.

2.3 Assessment

In this report we outline some of our recent work on making the case for prevention, both in terms of its cost effectiveness and its impact on health outcomes. We talk about the different forms of prevention and the importance of strengthening our focus on the building blocks of health (where we expect to see the greatest gains) - much of which is undertaken through local place-based approaches with our partners.

2.3.1 Quality/ Patient Care

The final section of this report talks about prevention within health and care.

Preventative healthcare services, such as immunisation or support to stop smoking are already embedded across a range of primary care services within local communities. These can provide opportunities to engage our populations and contribute to improving outcomes. Maintaining a health equity focus to increase engagement with hardly reached populations is a key objective for the public health healthcare team.

2.3.2 Workforce

The Public Health workforce is multi-disciplinary in nature drawing upon a range of clinical and non-clinical specialists. The work of the specialist public health workforce in Lothian has been restructured to enable a greater focus on addressing the building blocks of health alongside delivering on our clinical areas of work.

2.3.3 Financial

This report does not identify specific resource implications. However, resources are required to ensure that this work continues to be delivered. We do recognise that this will be a considerable challenge during a period of reduction in funding to public, community and voluntary sector services, but is an important investment for the longer term.

2.3.4 Risk Assessment/Management

Declining population health leads to more demand for health and care services. There is a risk that current financial challenges result in limited ability to invest in prevention which we know can improve population health and reduce inequalities. There are no corporate risks related to this area.

2.3.5 Equality and Diversity, including health inequalities

This report identifies areas of work that will improve outcomes for people and reduce health inequalities, it is particularly relevant to the Fairer Scotland Duty.

An Equality and Children Rights Impact Assessment is not required for this report. However, an impact assessment has been undertaken on strengthening our approach to prevention and is available on our public-facing website.

2.3.6 Other impacts

This report can be used across the health and care system in Lothian and with our community planning partners to ensure that plans and policies are underpinned by a good understanding of the needs of our local population and that interventions are evidence based.

2.3.7 Communication, involvement, engagement and consultation

This report is a statement of the health of the population and does not require public engagement or consultation.

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Public Health Senior Management Team

2.4 Recommendation

- **Discussion** - Board members are asked to note that the evidence relating to improving health outcomes and reducing inequalities requires a focus on prevention within the Lothian Health and Care System.

3 List of appendices

The following appendices are included with this report:

Appendix 1, Director of Public Health Annual Report 2024

Appendix 1

NHS Lothian

NHS Lothian
Director of Public Health Annual Report 2024

Public Health and Health Policy

Contents

Annual Report Contributors:

Kristen Bowles	Kat Davidson	Rachel Gill
Ashley Goodfellow	Martin Higgins	Avril Mackay
Dona Milne	Nora Murray Cavanagh	Flora Ogilvie
Judith Stonebridge	Ross Whitehead	Jamie Zike

Table of Figures

Introduction

In the introduction to the 2023 Director of Public Health Annual report we highlighted the importance of our commitment to creating a society where everybody can thrive, be given the best possible start in life and improved life chances throughout the life course. The report recognised the importance of what many have called the building blocks for a healthy life, such as good education, a stable job, good pay and a safe, affordable place to live. These building blocks are essential if we are to improve longer term health outcomes and see an increase in life expectancy, particularly healthy life expectancy.

In this report we provide you with some up-to-date-information about the Lothian population and their health. We use recently updated census data, alongside routine health data and the results of our recent public health survey to give you a rounded picture of the health issues facing our population. We have seen demographic changes in recent years – notably an ageing population, declining birth rate and smaller households - and these are likely to continue. We have seen an increase in poor mental health, particularly amongst young adults and we continue to see the poorest people in our communities living longer in ill-health.

Population health has always benefitted from effective primary prevention: clean water, sewage systems, universal education, universal vaccination programmes, mandatory seatbelts in cars, the back-to-sleep campaign, and legislation on smoking in public places. Crucially, these whole population interventions do not increase inequalities as there are no barriers to entry in terms of money, time and effort. Good public health is always about prevention and has the added benefit of being one of the most cost-effective interventions the NHS and wider health and care system can make to improve population health and reduce health inequalities.

In this report we outline some of our recent work on making the case for prevention, both in terms of its cost effectiveness and its impact on health outcomes. We talk about the different forms of prevention and the importance of strengthening our focus on the building blocks of health (where we expect to see the greatest gains) - much of this work undertaken through local place-based approaches with our partners. The importance of place cannot be emphasised enough; our partners in the local authorities understand this well and we all recognise the importance of creating policies that support the creation of healthy places where people can live and work well together.

The final section of this report talks about prevention within health and care. Our primary care colleagues are embedded in local communities and are often the first point of contact with the health and care system. Their understanding of local health needs and how to intervene early, along with our partners in the community and

voluntary sector, to improve health are essential components of a system wide prevention approach.

I hope that you find this report useful, that it increases your knowledge of our local population and their health needs and is able to convince you of the need for an increased focus on prevention. Many people have said that our current fiscal pressures do not support an increased focus on prevention. This feels short-sighted. We need to focus on prevention more than ever before if we expect to see any degree of health gain within our population, particularly for those experiencing the most disadvantage. A focus on prevention will improve individual and population health outcomes and will also decrease the demand for care and treatment in the future.

Dona Milne

Director of Public Health and Health Policy

NHS Lothian

Lothian's Demographics

Population size

Understanding the demographic characteristics of our population such as their age, sex, ethnicity and deprivation is a crucial first step in shaping policy and practice to support health and wellbeing. As of mid-2023 the total population of Lothian was estimated to be 919,060 people (51% female, 49% male). Figure 1 shows the distribution of Lothian's population by age group, and highlights that the largest five-year age group is 20-24 year-olds, comprising 8% of Lothian's total population. The concentration of young working-age people in Lothian reflects the status of the City of Edinburgh as an education and employment hub driving migration to the area for study and work. Lothian's other local authority areas typically have a greater proportion of older people (Figure 2). In East Lothian and West Lothian, the largest age group is 55-59 (both 7.7%), with 35-39 being the largest group in Midlothian (7.4%).

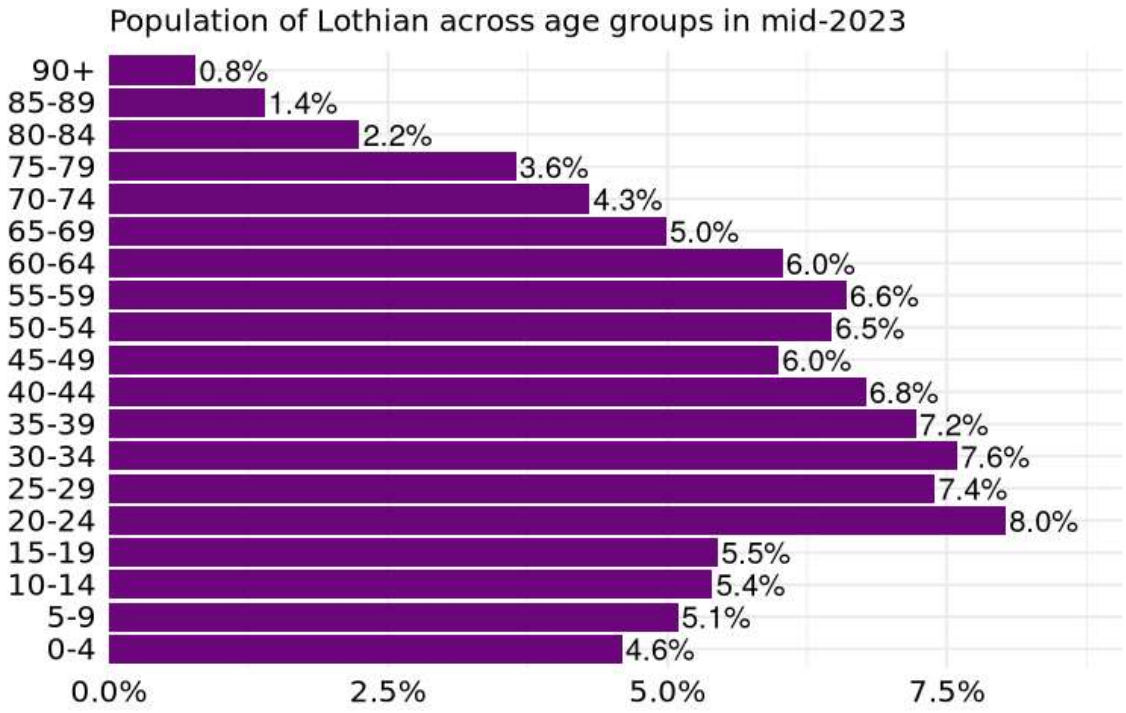

Figure 1 - age and sex distribution of Lothian's population, data source: Mid-2023, Population Estimates Scotland, National Records of Scotland

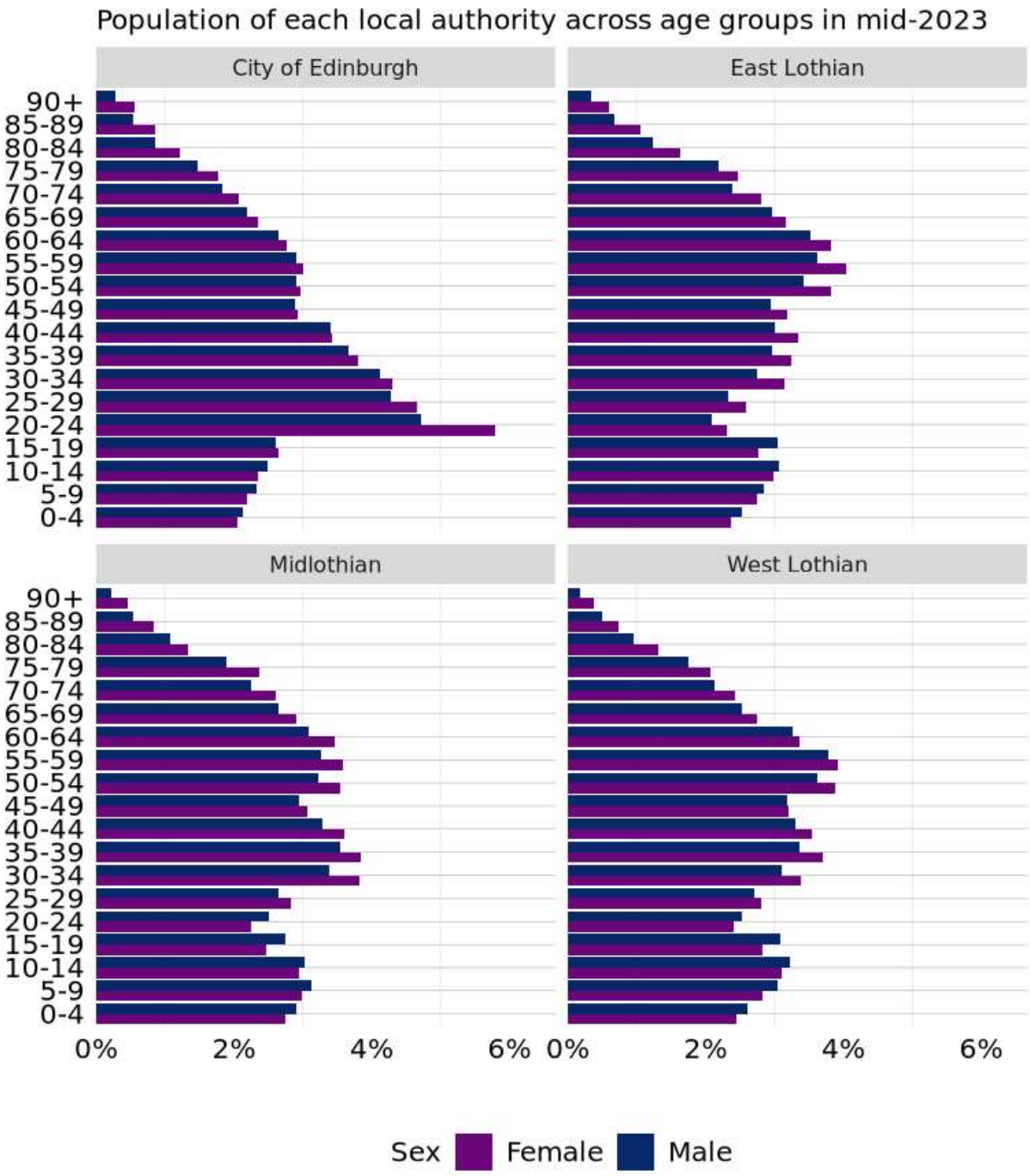

Figure 2 - age and sex distribution of Lothian's local authority areas, data source: Mid-2023 Population Estimates Scotland, National Records of Scotland

Population change

Scottish Census data from 2011 and 2022 can be used to examine change over time in Lothian's population. Over this period, Lothian's population increased by nearly 70,000, but changes were not seen uniformly across the life course. Figure 3 shows the percentage change between 2011 and 2022 by age group, which highlights particular growth in Lothian's population of people aged 55 and over (in absolute

terms 51,043 more people), with the population of 70-74 year olds growing by 26% between 2011 and 2022 (10,560 more people). Conversely, there has been relatively little change in the size of the population aged 15-29 and the number of people aged 0-4 years has decreased by 15% over this period (in absolute terms, 6,317 fewer people).

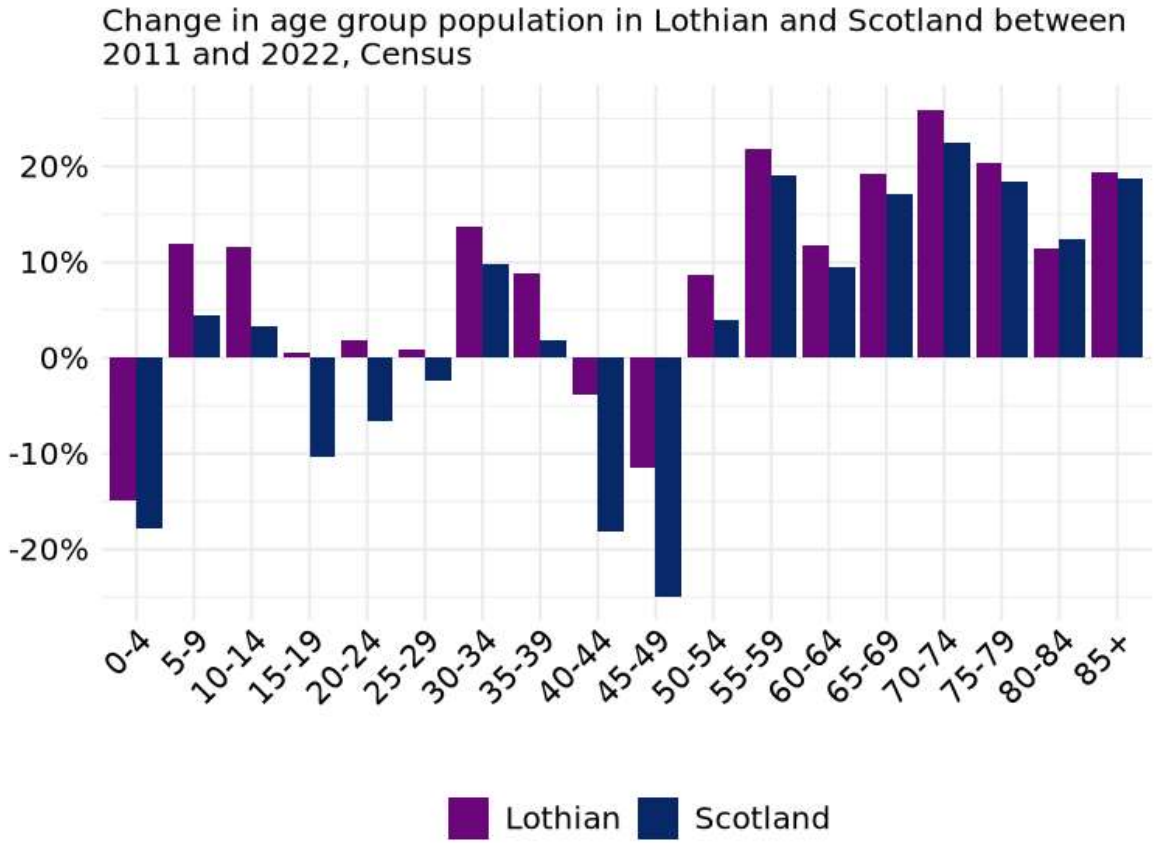

Figure 3 - the percentage change in population between 2011 and 2022 by age group, data source: Scotland's census

Distribution of deprivation

Whilst most of Lothian's residents live in areas of low deprivation (22.1% of Lothian's population live in Scotland's 10% least deprived areas), 34,620 people in Lothian live in Scotland's 10% most deprived areas. The distribution of deprivation is not equal across Lothian's local authority areas, with 25.7% of Edinburgh's and 33.3% of East Lothian's populations living in Scotland's 40% most deprived areas, compared to Midlothian and West Lothian which are closer to Scotland's distribution of deprivation in this respect (40.2% and 41.5%, respectively).

Ethnicity

According to the 2022 Scottish Census, the largest ethnic group in Lothian is those who identify as white, who comprise approximately 89% of the total population. Figure 4 presents the distribution of ethnicity by age across Lothian. The most ethnically diverse age group (as a proportion of its total population) is those aged 16-

24, of whom approximately 82.8% are white, 3.0% (3,314 individuals) are from mixed or multiple ethnic backgrounds, 11.2% (12,533) are Asian, Scottish Asian or British Asian, 1.2% (1,339) are African, 0.2% (271) are Caribbean or black, and 1.6% (1,815) identify as other ethnic groups. The least ethnically diverse age group is those aged 65 and over, of whom approximately 97.8% are white.

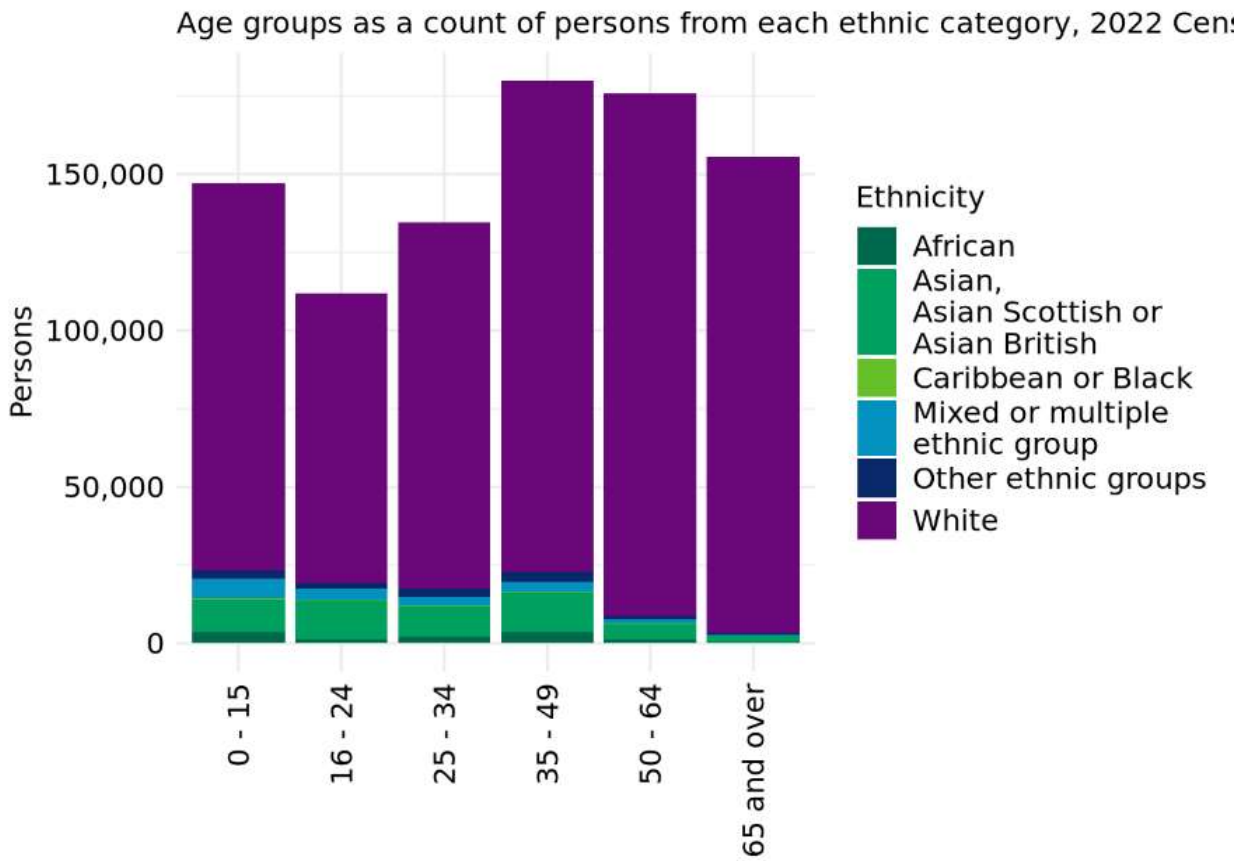

Figure 4 - distribution of ethnicity by age across Lothian, data source: Scotland's census

Mortality

8,852 people died in Lothian in 2023 with the leading causes being: cancers (27.7% of total deaths), circulatory diseases (24.4%), respiratory diseases (10.4%), diseases of the nervous system and sense organs (8.9%), and external causes such as injury and poisoning (6.2%). All-cause mortality is an important summary statistic which can be used to highlight possible changes over time in population-level health status and its determinants. Figure 5 shows trends in age-standardised all-cause mortality rates for Lothian and Scotland between 2006 and 2023 (age-standardisation accounts for differences in age distribution over time and between geographic regions so these changes cannot be attributed to ageing). While Lothian's mortality rate as of 2023 (1,101.1 persons per 100,000) continues to be lower than that seen across Scotland as a whole (1,165.5 persons per 100,000), both areas show little

evidence of returning to pre-pandemic levels, with Lothian's rate growing by 5.7 persons per 100,000 since 2022 and Scotland's increasing by 9.8 persons per 100,000.

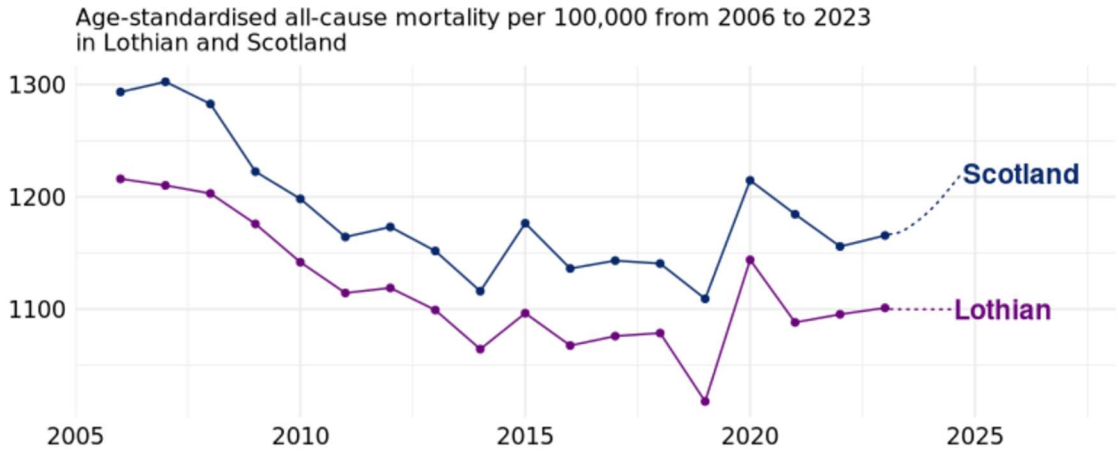

Figure 5 - trends in age-standardised all-cause mortality, data source: Vital Events Reference Tables 2023 - National Records of Scotland (NRS)

Early all-cause mortality

In addition to overall mortality, early all-cause mortality (deaths occurring before the age of 75) is important to monitor at a population level as it represents an opportunity to highlight and act on causes of unfulfilled life expectancy. Many of the 3,174 deaths that occurred in Lothian's under 75s in 2023 are avoidable with early preventative action on the social, economic and commercial determinants of health, such as those caused by suicide, alcohol or drugs.

Figure 6 shows trends in early all-cause mortality for Lothian and Scotland between 2006 and 2023. Similarly to overall mortality, Lothian's age-standardised rate has been lower than the Scottish average every year since 2006. The rate of premature mortality saw a sharp increase in both Lothian and Scotland after 2019, before beginning to fall in 2022; neither rate has returned to a pre-pandemic level, with Lothian currently seeing an age standardised rate of 408.8 persons per 100,000 in 2023, compared to 441.5 persons per 100,000 in Scotland.

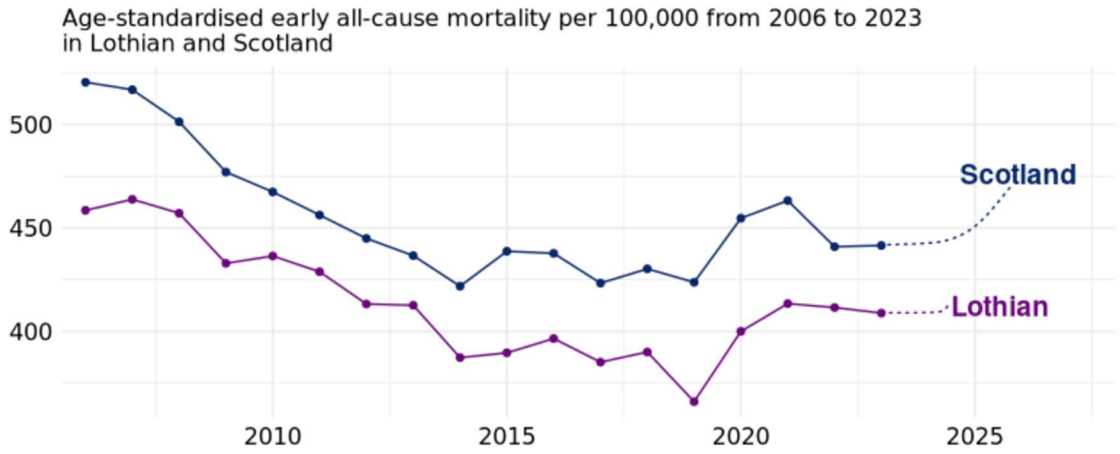

Figure 6 - trends in early all-cause mortality, data source Vital Events Reference Tables 2023 - National Records of Scotland (NRS)

Life expectancy

Life expectancy is a further vital summary statistic in understanding overall population health. Following decades of increasing life expectancy and healthy life expectancy (the number of years that a person is expected to live in good health), the number of people dying early has been increasing since 2019 (Figures 6 and 7). Our 2023 Director of Public Health Report highlighted that national patterns in stalling life expectancy from 2013 onwards were reflected within Lothian up until 2020. Scotland's public health challenges mean that the poorest in our society are more likely to die early and live more years in ill health, compared to the wealthiest, and this gap is widening. Continuous monitoring of data on life expectancy is important to alert us to the possibility of changes in factors (such as the building blocks of health) that are known to influence the health and longevity of the population at large.

Figure 7 shows trends in life expectancy for Lothian and Scotland between 1993 and 2023. Life expectancy for both males and females in Lothian has consistently been greater than the Scottish average since 1993. Although life expectancy fell slightly in both Lothian and Scotland after 2019, both geographies have seen a slight uptick in life expectancy since 2022. In 2023, life expectancy in Lothian was 81.7 years for women (an increase of 0.02 years since 2022) and 77.8 years for men (an increase of 0.12 years since 2022). By comparison, the average life expectancy in Scotland was 80.8 years for women (an increase of 0.11 years since 2022) and 76.8 years for men (an increase of 0.26 years since 2022).

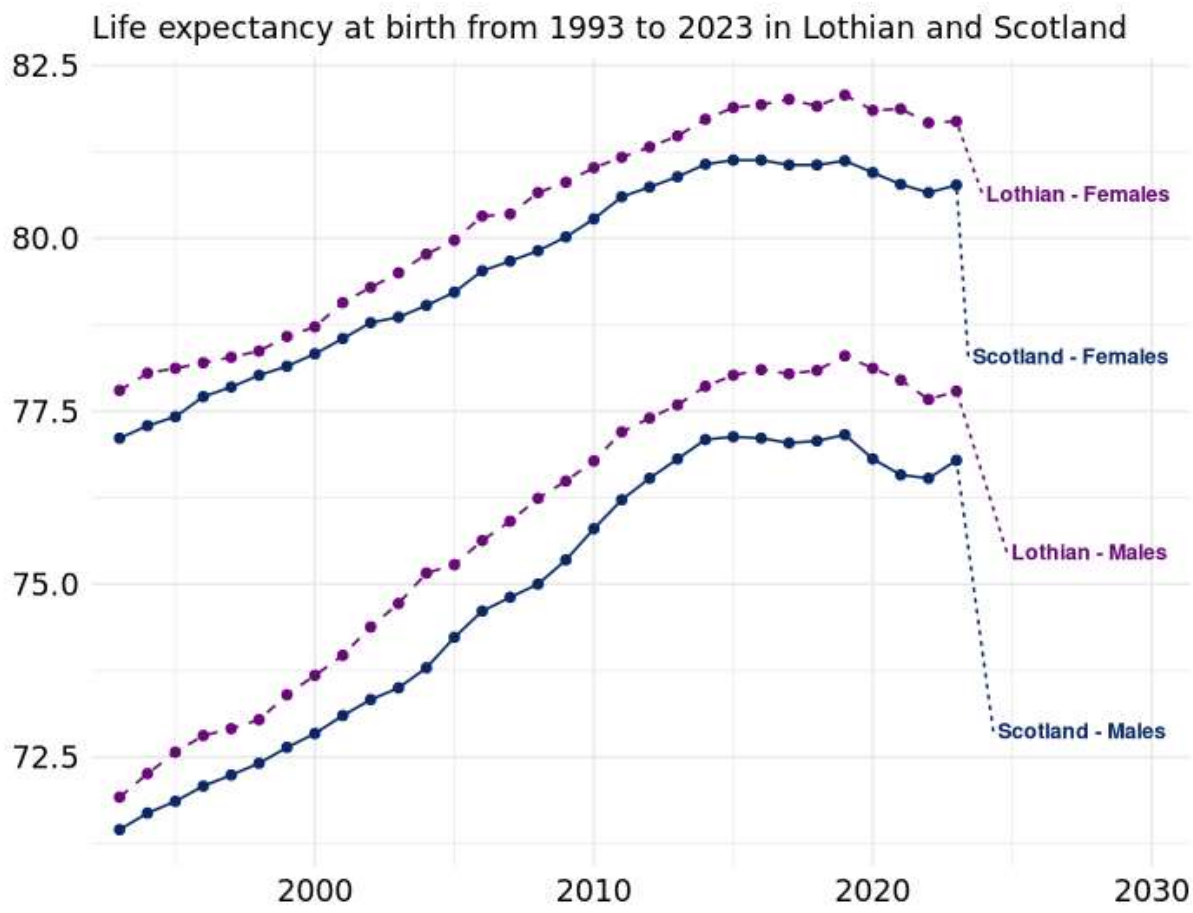

Figure 7 - trends in life expectancy, data source: Vital Events Reference Tables 2023 - National Records of Scotland (NRS)

Self-reported health status

Self-reported health is another important metric in understanding the level of need in a population which is particularly valuable in the identification of opportunities for prevention and early intervention.

The Scottish census records the proportion of the population reporting a range of specific health conditions. Figure 8 shows the proportion of Lothian's population reporting each of a series of health conditions in 2011 and 2022, with nearly 1 in 5 (19.4%) of Lothian's population currently reporting that they have a long-term illness (compared to 21.4% in Scotland). A particularly large increase was seen between 2011 and 2022 in the proportion of people reporting a mental health condition, rising from 4.2% to 11.6% for Lothian (mirroring changes observed nationally). It is important to note that changes in reporting of mental health conditions may in part reflect changes in awareness and stigma around mental wellbeing. However, increases in specific mental health conditions have been reported elsewhere and

decreases in mental wellbeing as a result of the COVID19 pandemic have also been reported.

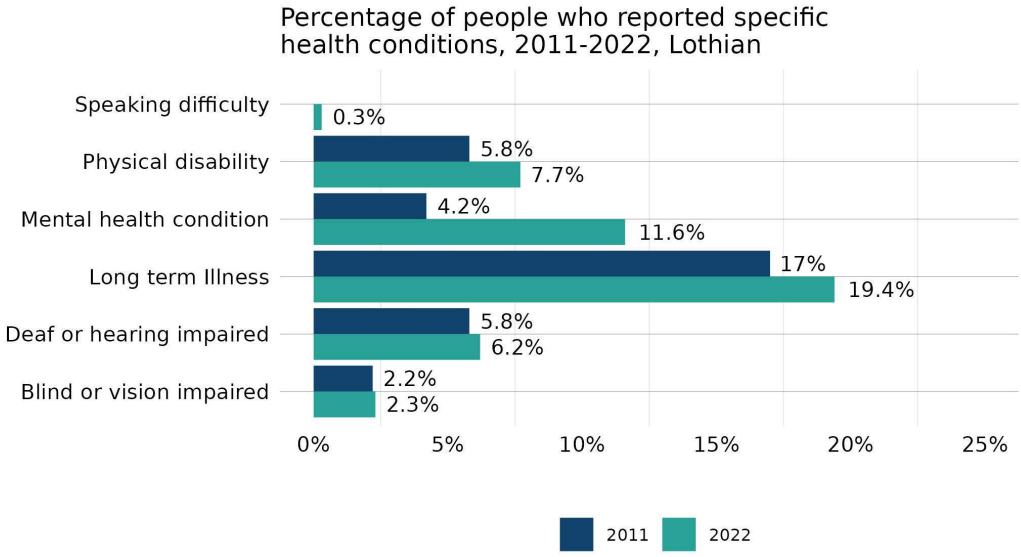

Figure 8 - proportion of Lothian's population reporting health conditions, data source: Scotland's census (Note: Speaking difficulty was not measured as a long-term condition in the 2011 census)

While the rate of people reporting mental health conditions increased across all age groups from 2011 to 2022, the largest increase was in the 16-24 age group which rose from 2.5% to 15.4% for all-Scotland and from 2.5% to 16.9% for Lothian (Fig. 9).

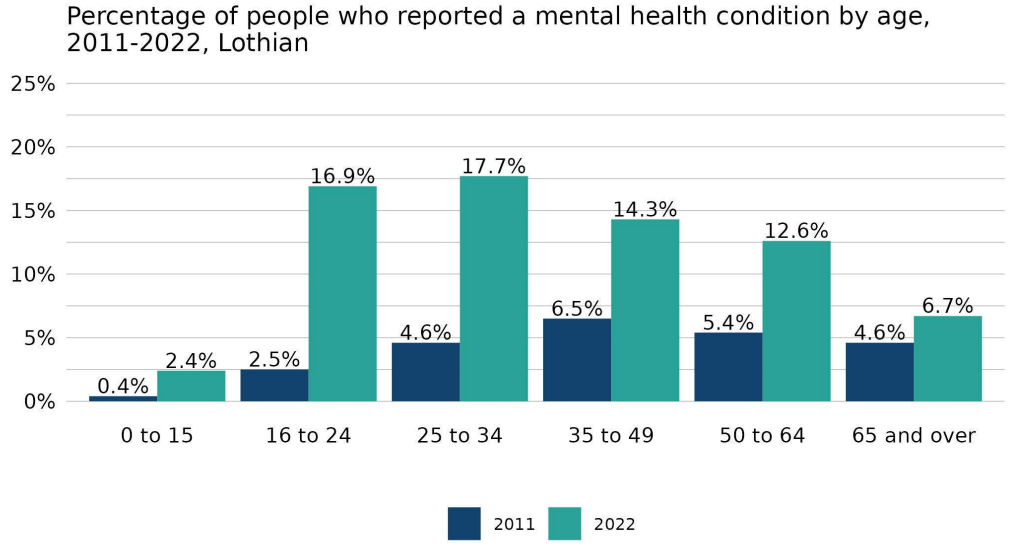

Figure 9 - rate of reporting of mental health conditions, data source: Scotland's census

Mirroring national patterns, females are more likely than males to report mental health conditions. These trends are, however, strongly patterned by age (Figure 10), with around double the prevalence of self-reported mental health conditions among females aged 16-24 (22.2%) compared to males this age (11.2%)

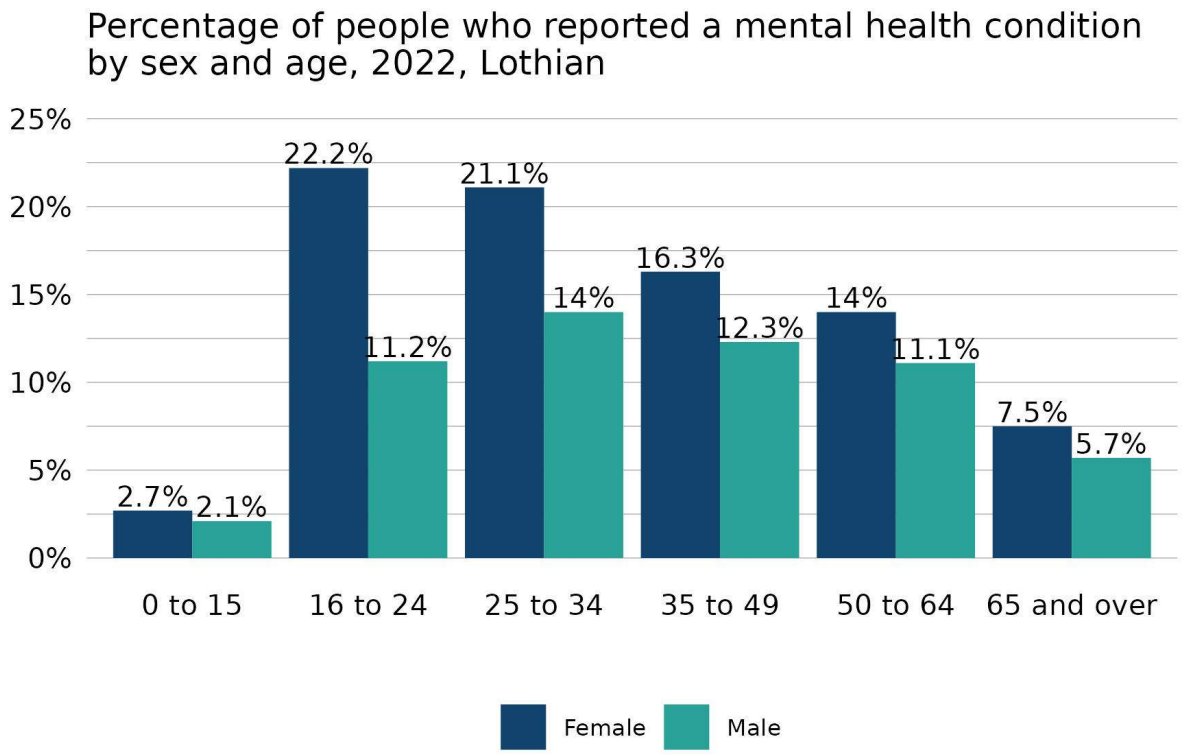

Figure 10 - rate of reporting of mental health conditions by sex and age, data source: Scotland's census

The changing demographics of Lothian's population and its health presents unique challenges and opportunities for improvement. The region attracts young and working-age people for education and work, and while outcomes relating to physical health and longevity are typically slightly better than those seen nationally, the changing context of an ageing population needs to be anticipated in the design of policy and practice.

Data from the 2022 census highlight particular challenges for the current generation of younger people (especially females) in terms of mental health outcomes. Given the apparent trend of this situation worsening over time, it is vital we understand and act on the determinants of mental health. This is especially the case in the context of inequalities in population health in the region. To facilitate better understanding and measurement of the building blocks of mental health, Public Health Scotland have developed sets of mental health indicators for adults and children, which can be used as a basis for identifying opportunities to prevent poor mental health outcomes before they emerge.

The case for prevention

The burden of disease

The Scottish Burden of Disease study is a population health surveillance programme which monitors the diseases, injuries and risk factors which prevent people living longer lives in better health.[1] This study forecasts that the burden of disease will increase in Scotland by 21% over the next 20 years, even though the number of people in Scotland is expected to decline (although, in Lothian, the population is expected to continue increasing due to net migration). The overall burden of disease will be largest for cardiovascular diseases, cancers and neurological conditions, which are expected to account for over two thirds of the increase.[2] These estimates only account for projected demographic changes and do not factor in changes in disease prevalence and mortality that could occur due to changing risk factor profiles, reduced access to services, or advances in prevention and treatment.

To reduce the forecast burden of disease, it is essential that we prevent the underlying causes of these diseases. Prevention activity will help to improve population health outcomes, reduce inequalities in health and support the sustainability of health and social care services.

What is prevention?

Prevention in public health terms is about keeping people healthy and reducing the risk of ill health, injury or early death. We noted in the introduction the productive history between population health and primary prevention and particularly its effectiveness in reducing inequalities. But primary prevention can be supported by complementary prevention work within the NHS and wider health and care system, which focuses on early interventions and better mitigation of illness and disease.

Public Health Scotland outlines how three types of prevention can address poor outcomes:

1. **Primary** prevention stops the problem occurring in the first place. Activity includes acting on the building blocks of health, such as income, employment, housing and education, or interventions such as vaccination.
2. **Secondary** prevention (or **early intervention**) focuses on identification of problems to support early intervention and treatment. This includes screening for breast, bowel or cervical cancer, and early years health visitor checks.

[1] Scottish Public Health Observatory. Burden of Disease Study. Overview - ScotPHO (accessed 17 October 2024).
[2] McAdams R. Public health approach to prevention and NHS Scotland. Public Health Scotland: Edinburgh; 2023.

3. **Tertiary prevention (or mitigation) aims to make sure an ongoing health** problem is well managed to avoid crises and reduce the harmful consequences, such as foot care for people with diabetes.

Primary prevention is incredibly cost effective -- up to three or four times more cost effective than investing in treatment. Primary prevention provides an average of £14 return for every £1 invested. The return is higher for interventions such as vaccinations (£34 return for every £1 invested) and legislative measures (£46 return for every £1 invested). Secondary and tertiary prevention returns £5 for every £1 invested.

Improving population health and reducing health inequalities

Our health is shaped by a combination of social, economic and environmental factors. Where we live, our work conditions, our housing and education are fundamental building blocks and the primary drivers of our health and wellbeing. The health and care system, as public health leaders, should prioritise work on addressing the building blocks of health alongside the direct delivery of healthcare. More detail can be found on these actions in the next section Importance of Place in Prevention.

Interventions in the early years have been shown to be particularly cost effective and yield significant return on investment. The Royal College of Paediatrics and Child Health states that a focus on improving children and young people's health is one of the best investments we can make to maximise future population health. Access to effective contraception, supporting the physical and mental health of women before, during and after pregnancy, supporting infant feeding and child development, will all help children have the best start in life.

The health and care system should continue supporting interventions that tackle modifiable disease risk factors, including obesity and tobacco and alcohol use. Services that tackle respiratory and cardiovascular conditions and diabetes can benefit significantly from an enhanced focus on primary and secondary prevention. These interventions should be delivered alongside screening and immunisation programmes as part of an effective whole population prevention plan. We also know that there is most health gain from focusing our prevention activity on the population groups at greatest risk of poorer health, such as those living in areas of deprivation. The section on 'Accessing Local Preventative Healthcare' sets out some of the work underway to improve population health outcomes through delivery of local healthcare services.

Embedding prevention

There are some important steps to embedding prevention across the health and care system to ensure this becomes a standard part of what the health and care system does.

1. We need to **make prevention a system wide priority**, embedding prevention across services and plans
2. We need to use our role as an Anchor Institution to promote good health and highlight our commitment to **primary prevention**
3. We need to **spend more of our money on prevention activity**, shifting the balance of care from acute or crisis provision to prevention and primary care focused activity. This will require a longer-term commitment to a preventative approach to improving population health, and the need to make difficult decisions about where we spend our finite resource
4. We need to use data and evidence to understand and shape our prevention work, and ensure we **measure the impact of implementing prevention activity** (in the short and longer term) so that we know it is working, allowing things to change if they are not.

We need to support local services and partners to **embed prevention** in all the work that they do.

Importance of place in prevention

The places in which we live - our communities, homes, workplaces, greenspaces and streets - play a crucial role in shaping our health and wellbeing. When we talk about “place” we mean more than geography; place encompasses the social, economic and physical structures that influence health outcomes. A place-based approach acknowledges the interaction between the physical and economic environment around us and its impact on the people who live, work and learn within that environment (the social environment). Public health efforts increasingly recognise that addressing the building blocks of health through place-based approaches can prevent disease and improve quality of life across communities. This requires collaboration across public, voluntary, business sectors and communities. This approach is especially critical as we face society’s toughest challenges, from the climate emergency to issues of health equity and commercial influences that have a negative impact on health.

Partnerships for place-based prevention

Tackling inequalities and population health improvement is a task extending beyond the NHS. Adopting a health in all policies approach means that population health improvement is a shared objective for the whole public, private, community and voluntary sector. As defined by The Health Foundation, ‘Health in all policies is an established approach to improving health and health equity through cross-sector action on the wider determinants of health: the social, environmental, economic and commercial conditions in which people live’. It is vital to prioritise action on social causes of ill health such as low income, homelessness, poor housing and unemployment or underemployment. Improvements in these social factors will have benefits for individual-level risk factors associated with poor health such as smoking, high blood pressure, obesity, poor diet, low physical activity and excessive alcohol consumption. Despite the compelling evidence that most activity tackling inequalities in health must be focused on the building blocks of health, there has been a tendency for population health policy and practice to prioritise or revert to behavioural and lifestyle interventions which focus on individuals rather than systems and structures. An effective public health approach needs to maintain focus on the fundamental determinants of health and inequalities.

Public health action needs to balance carefully the need for overall health improvement with targeted support for those with greatest need. This need to balance universal and targeted approaches is why the principle of proportionate universalism underpins much public health work and equitable health and care service provision.

> *'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.'* [3]

Partnership and Place work is about action – mostly in partnership – that seeks to reduce inequalities and improve population health. There are global, international or national factors such as economic cycles, global pandemics and wars or government policies such as austerity, that influence employment, income, housing, education and other building blocks in a more profound way than most actions within the gift of public health professionals. Public health priorities can be advanced by activity that focuses on legislation (bans on smoking in public places or minimum unit pricing for alcohol) and strategic influence on policymaking. Our Public Health Partnership and Place teams, set up to work locally with partners on the building blocks of health, seek to influence policy and decision-making at a local level with a particular focus on work with community planning partners. Our work in community planning provides opportunities to join with other public bodies such as local authorities, Police Scotland, colleges and universities alongside our community, voluntary and private sector allies to focus on joint action tackling complex problems that contribute to poverty and inequalities.

Healthy places

Spatial planning and the thoughtful use of land and resources can profoundly influence population health by creating spaces that promote physical activity, reduce pollution and offer access to essential services. Effective spatial planning involves coordinating local policies to foster environments that prioritise health.

By improving access to greenspaces and designing safer streets, spatial planning enables communities to benefit from physical activity and mental relaxation. Additionally, well-planned spaces can reduce social isolation by enhancing walkability and providing safe, accessible options for active travel. An example of this is our Public Health input into the Midlothian Local Development Plan 2.

A Local Development Plan (LDP) forms the policy basis for decisions on planning applications over a 10-year period. The first stage in the preparation of a new plan is the compilation of an Evidence Report. The Midlothian Partnership and Place team collaborated with Midlothian Council, Midlothian Health and Social Care Partnership

[3] Marmot M *et al* , 2010; Fair Society: Healthy Lives (The Marmot Review)

and Public Health Scotland to develop the health chapter of this report, supporting a "health in all policies" approach. This included providing evidence on the:

- health of Midlothian communities;
- relationship between health and place;
- capacity of the health and social care infrastructure;
- impact of rapid population growth; and
- creation of healthier places.

The evidence report also relied upon the Place and Wellbeing Outcomes and the Place Standard Tool. This collaborative approach aims to influence local planning policies that promotes a healthy built environment, as demonstrated by Figure 11 below.

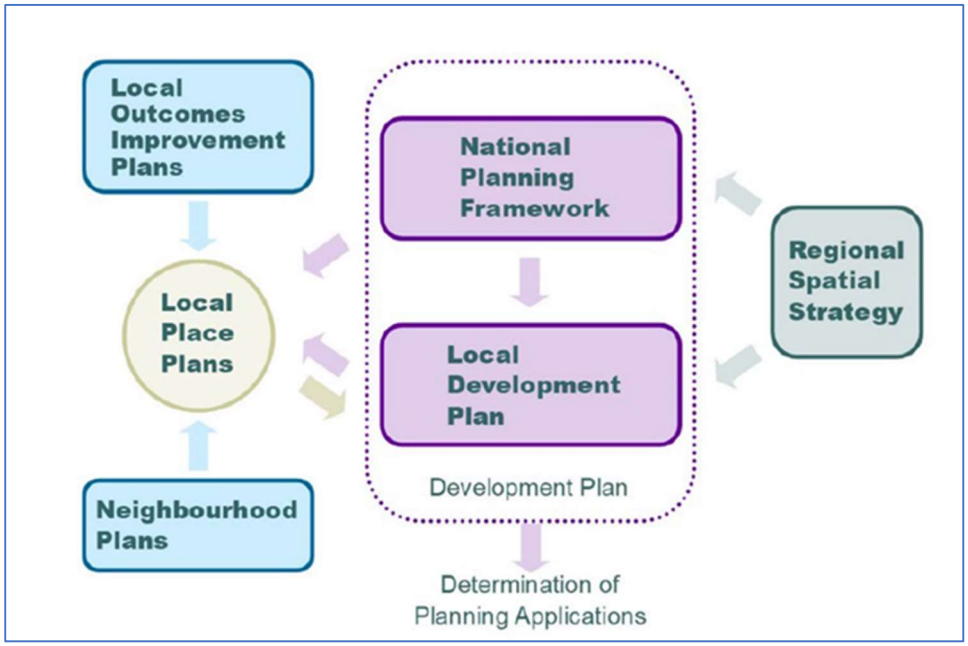

Figure 11 - Links Between LDP and Local Planning

To further promote healthy places, we need to consider the commercial determinants of health, which make harmful products like alcohol, tobacco and unhealthy foods, as well as gambling and sexual entertainment, readily available and accessible in our communities. These determinants often disproportionately affect vulnerable populations and can exacerbate health inequalities. Addressing these is essential to promoting healthier communities and environments.

"Working to address the commercial determinants of health can reduce the availability, accessibility, and affordability of health-harming products such as alcohol, tobacco and food and drinks high in fat, sugar and salt."[4]

Looking specifically at alcohol as a commercial determinant of health, there has been good evidence for over a decade that increased alcohol availability (outlet density) is associated with harms to health.[5] High alcohol availability creates harm by directly increasing opportunities for purchases, and influences the perceived normality of alcohol consumption, including the exposure to children and young people. It also makes it more difficult for people to recover from alcohol dependence.[6] Alcohol related mortality and morbidity are significantly higher in neighbourhoods with a greater density of alcohol outlets, especially alcohol off sales.[7]

The Centre for Research on Environment Society and Health (CRESH) explored how physical and social environments can influence population health, for better and for worse. The CRESH data shows the density of alcohol, tobacco, food (takeaways and supermarkets) and gambling retailers in our communities. We analysed the alcohol density data and our NHS Lothian Public Health Survey data across Lothian which shows that when looking at all alcohol outlets (on-sales and off-sales) people living in the 25% of areas with highest alcohol outlet density had 42% higher odds of risky drinking than those living in areas having no alcohol outlets. This relationship holds when controlling for factors that might otherwise explain this relationship, such as age, sex, deprivation and local authority.

Our Partnership and Place teams continue to advocate to local authority alcohol licensing boards on the harmful effects of increasing alcohol availability in our communities.

[4] NHS Lothian Public Health and Health Policy - A strengthened approach to prevention across the Lothian health and care system

[5] Campbell C, Hahn R, Elder R et al. The effectiveness of limiting alcohol outlet density as a means of reducing excessive alcohol consumption and alcohol-related harms. American Journal of Preventive Medicine 2009; 37(6):556–569.

[6] https://pubmed.ncbi.nlm.nih.gov/28886441/

[7] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4415114/#:~:text=An%20IQR%20increase%20in%20off,%2C%2015%25%20higher%20mortality).

Local Place - priorities for action

- **Influence Local Development Plans**: Collaborate with local authorities to influence planning policies that promote healthy built environments, including walkable green spaces.
- **Policy Advocacy**: Support policy changes at national and local levels to regulate alcohol, tobacco, gambling and food products high in sugar, salt and fat.
- **Reducing Exposure to Health-Harming Commodities**: Influence local policies around licensing, advertising and other controls on harmful products.

Anchor organisations focus on prevention

NHS Lothian also recognises that its responsibilities extend beyond the delivery of high-quality health and social care. We employ more than 25,000 people in the region, we have influence in spending substantial amounts of money on goods and services, and own, lease and operate numerous buildings. With staff and services in almost every community across the region, NHS Lothian is a key anchor organisation. Our Anchor Institution commitment means we need to use our influence in spending decisions, capital investment and disposals, and our status as the biggest employer in the region to impact positively the health of the local population. NHS Lothian's approach to its Anchors work is on our website. And, crucially, in keeping with a focus on partnership and place, our Anchors Institution work so far has relied on alliances and joint work with organisations such as NHS Lothian Charity, the four Local Employability Partnerships (LEPs) and the Third Sector Interfaces across Lothian.

Funding provided by NHS Lothian Charity for five years is the basis for a more sustainable Anchors-inspired approach to our hospital income maximisation services. Community Health Advice and Information, Citizens Advice Edinburgh, Citizens Advice West Lothian, Penicuik Citizens Advice and Musselburgh Citizens Advice have been commissioned to deliver hospital income maximisation services at six sites in Lothian. These services are available to any patient, carer/family member or Lothian staff on these sites who require financial information or advice. Income problems can impact the health and care system by resulting in delayed discharges, inappropriate use of clinical staff time, increased recovery period and risk of readmission. In two years, £2,400,000 has been gained for people using these services – this means money in the pockets of people experiencing low incomes and poverty. Taking action to reduce poverty and maximise incomes reduces financial stress and provides people with a standard of living that protects and promotes their health.

The Lothian Community Benefits Gateway is a service facilitated by public health teams and Third Sector Interfaces in each local authority which aims to link NHS suppliers with local community need. NHS Lothian has delivered the most benefits via the Benefits Gateway across all of NHS Scotland. Partnership work continues with Third Sector Interfaces to identify social enterprise partners to develop sustainable catering facilities within NHS Lothian, whilst supporting employability opportunities for local communities.

Work with the four LEPs has established an innovative work placement programme within NHS Lothian. Twelve, six-month placements have been established across the Lothian health and care system. Crucially, our placements are supported by NHS Lothian Workforce Development and LEP link workers with expertise in employability. This represents a new approach to supporting people who have been furthest from employment into work. Working alongside Workforce Planning colleagues, we hope to expand our understanding of future opportunities for this type of work.

Anchors - priorities for action

- **Workforce**: continue to support the delivery of the NHS Lothian Employability Plan and to scale up the Lothian LEP-NHS Gateway placement programme; expand innovative and inclusive recruitment practice such as the co-ordinated recruitment approach in Estates and Facilities to other parts of NHS Lothian. This includes recruiting for multiple vacancies across similar jobs in one campaign with centralised support, resulting in a more efficient recruitment process.
- **Expenditure**: work with NHS Lothian Charity and colleagues across the NHS and Health and Social Care to expand our income maximisation service model so that all pregnant women and families with young children have easy access to income maximisation services
- **Land and Assets**: establish a sustainable model for health facilities catering with social enterprises so that patients, staff and visitors can get food and drink while people develop skills and experience that support them into the labour market.

Climate emergency and environmental sustainability

Increasing community resilience to climate change can protect people from the effects of severe weather, infectious disease and other health impacts of climate changes. The wide range of preventative and adaptive actions that should be taken, are set out in the NHS Scotland Climate Emergency and Sustainability Strategy 2022-26 and echoed in the NHS Lothian Sustainable Development Framework 2023.

Our focus is on areas where changes will result both in reduced greenhouse gas emissions, and health benefits, with transport and housing being two key examples.

Sustainable travel supports people to be physically active as well as reducing population exposure to road danger, air and noise pollution, and creating public spaces that are better for communities and businesses. In parallel, work to identify and remedy properties with poor quality insulation can support health directly by reducing exposure to cold and damp, which can exacerbate cardiovascular and respiratory disease, as well as reducing the amount of home energy used, and greenhouse gases emitted. As domestic transport and fuel for heating buildings are two of the largest contributors to Scotland's greenhouse gas emissions, as shown in Figure 12, these are important areas to address.

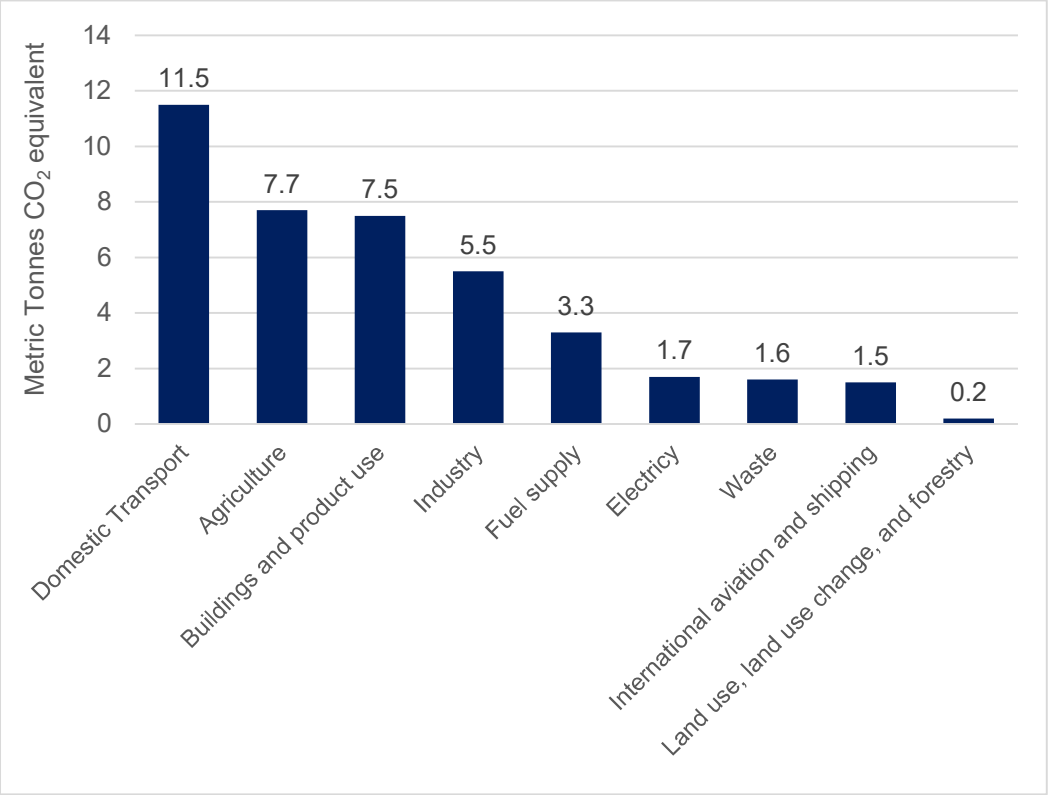

Figure 12 - Scottish Greenhouse Gas Emissions by Territorial Emissions Statistics Sector 2022[8], data source: Scottish Greenhouse Gas Statistics 2022 - gov.scot

In relation to transport, those on the lowest incomes, as well as young and older people, are less likely to have access to private cars, as shown in Figure 13, therefore supporting access to safe, sustainable and affordable transport is important to reduce inequalities.

[8] Section B. Results - Scottish Greenhouse Gas Statistics 2022 - gov.scot

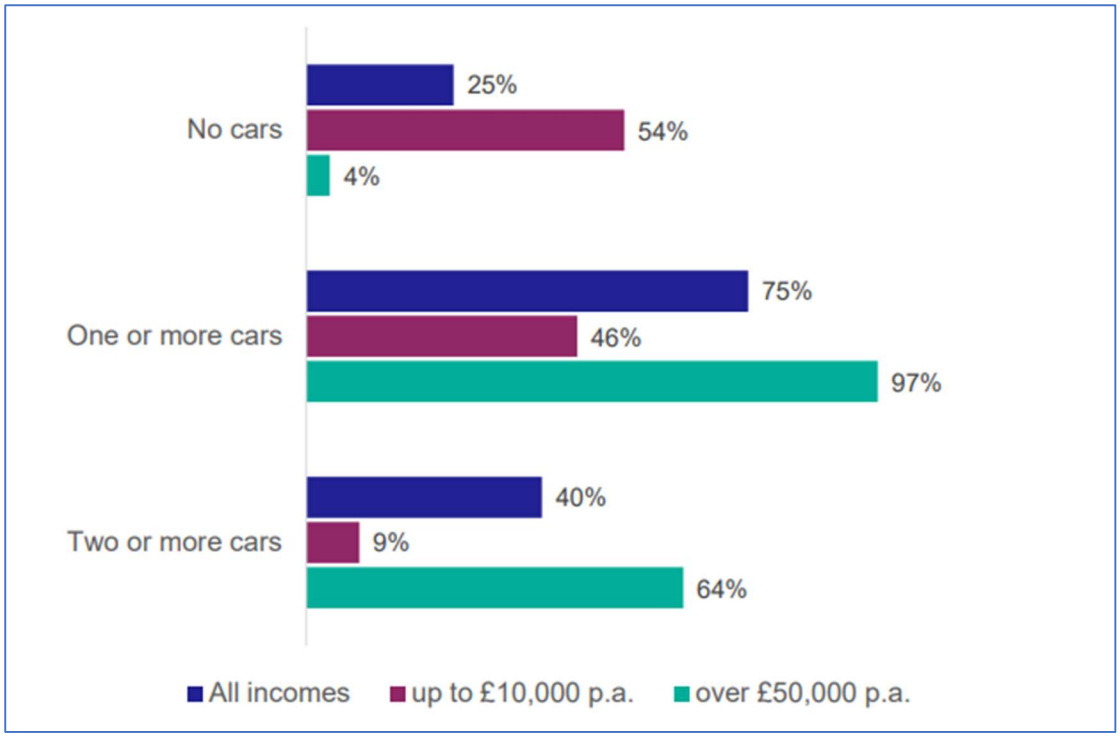

Figure 13 - Household Access to Cars or Vans by Household Income Band 2022, data source: Transport and Travel in Scotland[9]

In 2024 NHS Lothian provided public support for the City of Edinburgh Council's implementation of key aspects of the City Mobility Plan - the enforcement of the Pavement Parking Ban and the Low Emission Zone – while also ensuring NHS Lothian's fleet is compliant. We have also worked with primary care staff to better understand their concerns in relation to Controlled Parking Zones and to emphasise the overall importance to population health of reduced levels of private vehicle use.

Within housing, a range of welfare rights and debt advice providers, including those commissioned within our NHS hospitals, routinely signpost people to Home Energy Scotland's advice on ways to make homes warmer and reduce energy bills. In Edinburgh, work is also taking place to inform the best deployment of a limited number of 'damp sensors' within social housing properties, to alert the local authority when poor quality home insulation or property maintenance is causing levels of damp which could harm health.

Our recent NHS Lothian Public Health Survey 2023 identified that younger people are more likely to be living in poor quality housing and more likely to experience fuel poverty, in contrast to a historic view that these issues may predominantly affect older people, emphasising the importance of routinely asking about money and housing worries in conversations with a wide range of service users.

[9] Transport and Travel in Scotland

Climate emergency and environmental sustainability - priorities for action

- Continue to take action to **reduce the greenhouse gas emissions** associated with the provision of healthcare services and support the resilience of our communities against the impacts of climate change.
- Continue to **design services located close to where people live**, or be digitally inclusive, to reduce the need for people to travel, ensuring sustainable transport options are provided, including reducing the proportion of staff who travel by unsustainable modes and the transport impact of the goods and services we procure.
- Continue to **advocate for the importance of stable, affordable, good quality homes** that are appropriately insulated to enable people to stay warm without excessive spending on fuel, ensuring that support is targeted at groups who are more likely to be suffering from fuel poverty.

Accessing local preventative healthcare

Missingness in healthcare

The emerging body of research around the concept of 'missingness' in health care systems and hardly reached populations has led to this priority to address the gaps in care and reduce the impact of health inequalities on health outcomes. Missingness can be defined as the repeated tendency not to take up offers of care such that it has a negative impact on the person and their life chances.

Public Health staff supported the NHS Lothian outpatient redesign to ensure that services meet the needs of our populations. The Public Health Intelligence Team are researching populations who do not attend outpatient appointments, commonly referred to as DNAs (Did Not Attends). Understanding the factors that contribute to non-attendance helps to make a systematic shift from punitive to supportive service design and delivery. It is increasingly clear that language and terminology play a significant role and understanding missingness as a concept allows our structures to be proactive and promote a compassionate patient-centred approach. When we better engage and help patients to access healthcare, the whole system benefits.

Preventative healthcare services, such as immunisation or support to quit smoking, are already embedded across a range of primary care services within local communities. These can provide opportunities to engage our populations and contribute to improving outcomes. Maintaining a health equity focus to increase engagement with hardly reached populations is a key objective for the public health healthcare team.

NHS Lothian services provided 2,766,441 outpatient appointments in 2023/2024 over a wide range of clinical specialties and at numerous locations, including hospital sites. Around 8% of outpatient appointments are not attended and this rate has remained similar over time. Missed appointments can prevent or delay people from accessing healthcare at the right time, which can lead to declining health and quality of life and a higher risk of all-cause mortality. Missed appointments also have the knock-on effect of reducing the number of available appointments and increasing waiting times for other service users. Further exploration of the causes and factors for these missed appointments can help us to identify the needs of our population to support them to receive care at the right time and in the right place.

There are strong relationships between a person's characteristics and their likelihood of missing their scheduled outpatient appointment. Exploration of data by the Public Health Intelligence Team has revealed several factors outside of individual patients' control which are associated with the likelihood of missing scheduled outpatient appointments. The data seen in the figure below shows that men were more likely to miss their appointment than women. Looking across all age groups, the age-standardised DNA rate in 2023 was 11.7% for male patients and 9.3% for female patients. In 2024, the age-standardised DNA rate was 11% for male patients and 8.7% for female patients. Some research suggests that men may be more reluctant to seek help, and this may make them more likely to miss appointments. Men are

also more likely to work in jobs that have no fixed place of work than women, which could contribute to a more unpredictable lifestyle and increased difficulty accessing services. Young people were also more likely to miss their appointments than older people, possibly due to work and study commitments and experiencing better overall health.

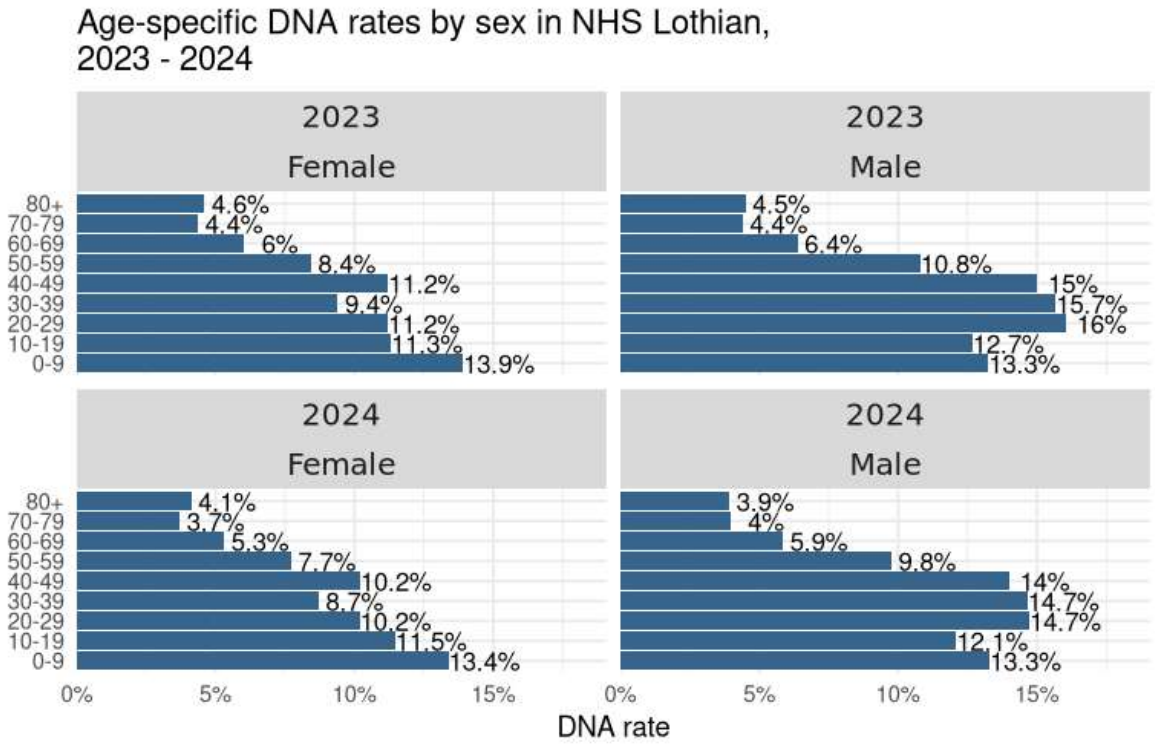

Figure 14 – Age specific DNA rates by sex, data source: NHS Lothian

People from Black and Asian ethnic groups were more likely to miss their appointments compared to white patients, which could be due to language or cultural barriers. Additionally, people living in the most deprived areas were more likely to miss an appointment than people living in the least deprived areas. Research suggests that people from more deprived backgrounds face barriers to accessing healthcare that less deprived people do not experience, possibly due to less predictable or more demanding daily routines, ineffectiveness of established types of reminders and communication issues with their providers. There are already clear inequalities in health outcomes between many of these population groups and delays in getting help for health problems by missing appointments could contribute to a widening gap in health outcomes.

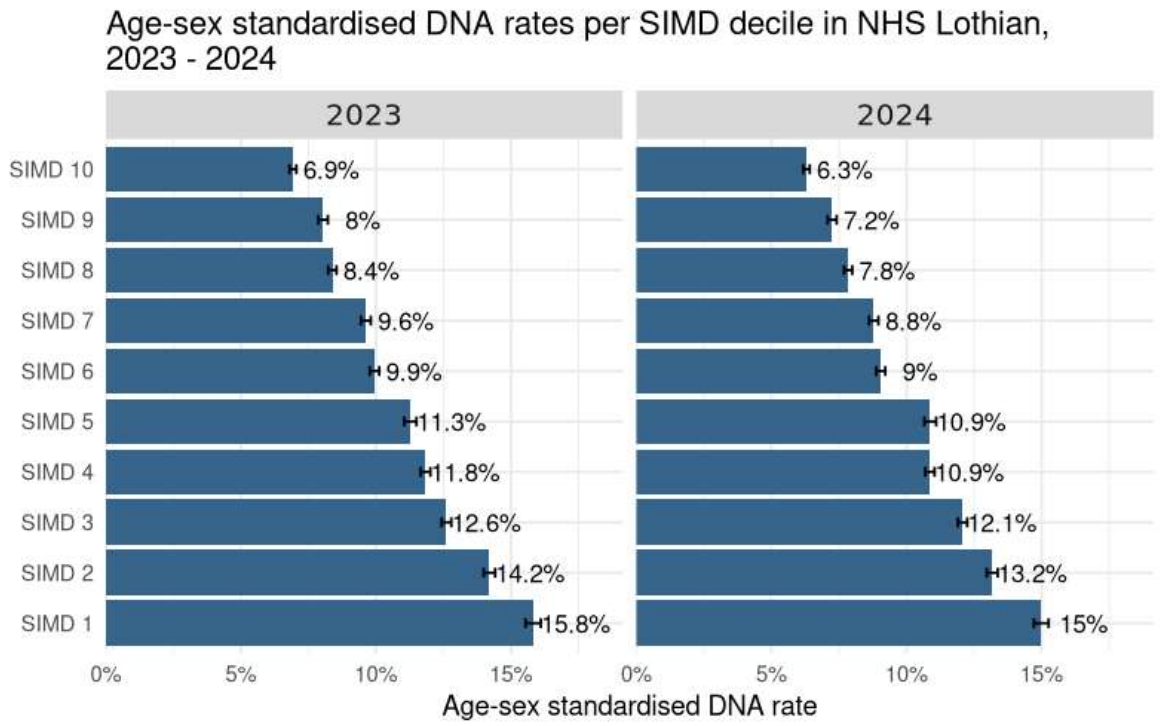

Figure 15 - Age - sex standardised DNA rates, date source: NHS Lothian

Our data also show that people who waited longer to access outpatient care were more likely to miss their appointments. Other research suggests that as patients wait longer for their appointments, they are more likely to forget, experience symptom improvement or seek care somewhere else (e.g. private care).

People who have many appointments or who have previously missed appointments were also more likely to miss an appointment. These patients could have multiple health conditions and having to keep track of many appointments, may make them more prone to forgetfulness. Return patients were also more likely to miss an appointment compared to patients having their first appointment with a service. Follow-up appointments are generally scheduled based on specific time intervals (e.g. 6, 9 and 12 months) rather than clinical need. This could mean that the patient weighs the costs and benefits of travelling to their appointment and decides that it is not worth going, especially when they have other family and work commitments.

Improved attendance at primary and secondary care appointments improves health outcomes and leads to improved professional experience for our healthcare workers, which in turn will aid retention and reduce staff burnout. NHS Lothian Public Health is working to embed a patient centred approach to understanding what drives gaps in access to health care.

Waiting Well

NHS Lothian is committed to supporting people who are waiting for treatment through the NHS Scotland '[Waiting Well]' programme. These efforts should also help to reduce missed appointments.

The aim of Waiting Well is to take a preventative and proactive approach to ensure that a person's health and wellbeing does not deteriorate in the waiting period, together with identifying opportunities to stabilise or enhance health and wellbeing.

Supporting people on waiting lists is important for the individual themselves but also to maximise the sustainability, efficiency, and effectiveness of our services. There is good evidence that people who have been waiting long periods of time for their appointments are at risk of deconditioning or experiencing deteriorating mental and physical health. This leads to longer recovery times, worse health outcomes and in some cases cancellation of appointments due to modifiable risk factors having not been adequately addressed, for example before surgery. Indeed, the focus on Waiting Well is to switch from a passive period of waiting to a time where proactive action can take place, both by the person and the system. For some people, this may simply keep them in a stable position of health (avoiding preventable deterioration and thus higher unscheduled demand for services in the interim). For others, they may even optimise their health to a point which leads them to delay/even negate the need to join or stay on a waiting list, or for surgery, allowing them to have enhanced recovery.

Therefore, using a Waiting Well approach can be vital to support people in their health and wellbeing during this waiting period. Optimising access to good information as well as support in a setting close to home and across a range of health and social care pathways can also strengthen this approach. A toolkit has recently been developed which will allow NHS Lothian to undertake self-assessment and identify areas of focus for implementation of this programme. Collaboration across primary and secondary care together with inclusion of all multidisciplinary teams will be key to successful implementation.

Primary and community services

Primary care services provide opportunities for preventative interventions for people within their own local community and often utilising local resources. An example of this is community pharmacy which, due to its accessibility and local presence, can be a key asset in improving the health of the local population. Community pharmacy has some unique aspects including walk-in access to a team of highly skilled health care professionals. Community pharmacies are situated within all of our communities and are often the first point of contact for people who otherwise may face social and economic barriers to care. Pharmacy teams, as experts in medicines, can provide free advice, treatment and onward referral for a range of conditions, and support people to access the right care in the right place without having to go to their GP or local Emergency Department for non-urgent treatment. For example, the NHS Pharmacy First Scotland service enables symptomatic patients convenient access to care at community pharmacies for clinical conditions such as earache or urinary tract infections. Community pharmacy can also ensure access to key preventative interventions such as the structured support programme to stop smoking. Medicines have a significant role to play in both treating and relieving the symptoms of disease as well as preventing ill health. Pharmacy teams are ideally situated to ensure equitable expertise and access to medicines and healthcare, optimising benefit and preventing harms. A key approach to optimise the role of community pharmacy is continued collaboration by NHS Lothian and the four local health and social care

partnerships with other stakeholders in the development and implementation of the local Pharmaceutical Care Services Plan.

A further example of services sited within primary care with a health equity focus is the growth of the Deep End GP movement. Deep End GP practices serve the most deprived communities with a high proportion of patients in the 15% most deprived data-zones. This highly local hub and spoke work within primary care and GPs in particular, provides a high impact public health benefit. The GP Lead for Health Inequalities within Public Health and Health Policy has had a key role in leading in strategic, education and advocacy spheres across Public Health and GP colleagues contributing to improved outcomes for our vulnerable people within our populations.

Accessing local preventative healthcare - priorities for action

- Continue work on reducing inequalities in access to healthcare through developing our understanding of did not attend data and ‘missingness’, and developing actions to support engagement with healthcare services.
- Work across services to develop and deliver a person-centred approach to Waiting Well, and our prehabilitation services.
- Harness role of community pharmacy in provision of preventative healthcare through development and implementation of the Pharmaceutical Care Services Plan

Conclusion

We hope that this report has made a clear case for continued and increased investment in prevention. The evidence is strong enough to justify increased use of resources but where those resources come from will be our biggest challenge. The public and community and voluntary sectors that drive much of this effort are under increasing pressure to deliver more with less. In these circumstances it would be easy for all of us to retrench to our individual statutory duties not what our populations need.

This would be a short-sighted approach, one that would increase poor health in our most deprived communities and increase the demand for health and social care in the future – at an even greater cost to the public purse. We have strong public and community and voluntary sector networks to build on in Scotland and at times like these we need to increase our partnership efforts towards delivering common goals more than ever.

Scottish Government's public service reform programme recognises a pressing requirement for reform to ensure fiscal sustainability. However, the route to achieving that fiscal sustainability is not about a focus on reduction in service, it is about reducing the demand for public services ('prevention') and changing the model of service delivery for better results. In short this is about focussing on improving outcomes, and ultimately improving people's lives is committed to a public sector reform programme.[10]

As part of the prevention focused reform agenda; we expect the Scottish Government to publish a ten-year Population Health Framework for Scotland in the Spring. This will be the first time we have had a national framework of this kind. We need to imagine what that could achieve for Scotland with prevention at the core of our work. This is not a job for public health teams alone (whether local or national) but it is for the whole system to identify where we put our collective effort for the benefit of our populations. From a public health perspective, we will continue to prioritise partnership working in Lothian and Scotland with a focus on prevention and reducing inequalities. We hope that we can convince many of our partners to join us in that effort.

[10] Letter from the Minister for Public Finance to the Convener of 23 September 2024

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Improving and protecting the health of the people of Lothian

The Role of the Public Health Department in Lothian
Approximately 175 people are employed in the department. We operate four divisions as illustrated below. We provide specialist advice and leadership to NHS Lothian, the four Lothian local authorities and the voluntary and community sector to shape services and create healthy communities for everyone.

- **Health Care Public Health**

The Health Care Public Health team provide:
> Leadership and oversight across the pathways of the six National Screening Programmes (breast cancer, bowel cancer, cervical cancer, diabetic eye screening, abdominal aortic aneurysm, pregnancy and new-born)
> Dental Public Health expertise to assess and improve the oral health needs of the population
> Strategic leadership and assurance for Immunisation Programmes
> Professional expertise on pharmaceutical public health

- **Business and Administration**

The Business and Administration team provide flexible administrative and clerical support across the Department. They play a critical governance role ensuring that the Department has robust processes and business procedures to meet strategic and operational objectives and priorities. The team also monitor and track workforce performance.

- **Health Protection**

The Health Protection team work to protect the health of the local population from communicable and infectious diseases and environmental hazards. The team provides specialist public health advice, direction and operational support to NHS Lothian, local authorities and other agencies.

- **Population Health**

The Population Health division includes:
> Partnership and Place teams for each of Lothian's four local authority areas focusing on tackling inequalities and improving population health.

Other population health functions cover the whole of Lothian:
> a Public Health Intelligence Team providing high-quality, rigorous evidence and data for public health strategy and policy
> Maternal and Children's Public Health, including the Maternal and Infant Nutrition team

> a Sexual Health Improvement team (Healthy Respect) and
> a Tobacco Control team which includes NHS Lothian's Quit Your Way smoking cessation service.

- **Board wide hosted programmes**

Public Health and Health Policy hosts four services that deliver Board-wide remits: (i) Resilience (ii) Equalities and Human Rights (iii) Safe Haven, and (iv) Child Health Commissioner.

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NHS Lothian

NHS Lothian

11.

Meeting: NHS Lothian Board

Meeting date: 5 February 2025

Title: Child and Adolescent Mental Health Services (CAMHS) Escalation Update

Responsible Director: Tracey Mckigen, Service Director, REAS

Report Author: Lisa Canale, Clinical Services Manager REAS (CAMHS)

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☒	Awareness	☒

This report relates to:

Annual Delivery Plan	☒	Local policy	☐
Emerging issue	☒	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☒
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHS Scotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Director (named above) in advance of the meeting.

2 Report summary

2.1 Situation

NHS Lothian was informed in December 2024 that the Mental Health Director in Scottish Government had recommended that it should be escalated for CAMHS performance to Stage 3 of the NHSScotland: support and intervention framework. It was confirmed verbally on 28 January 2025 that this recommendation had been accepted by the National Planning and Performance Oversight Group, a sub-group of the Government's Health and Social Care Management Board. However, we await formal written confirmation of this decision. We understand the escalation decision is based on NHS Lothian not meeting the national standard for CAMHS, which says that 90% of children & young people (CYP) should start treatment for their mental health within 18 weeks of referral.

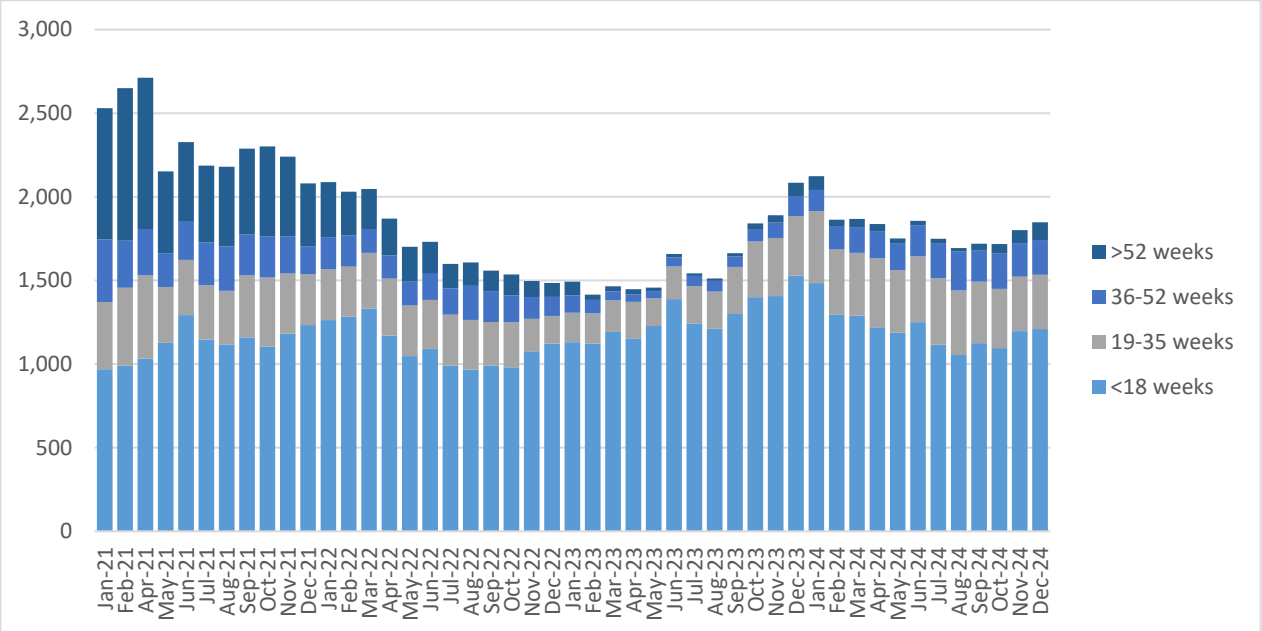
This report serves to make the Board aware of the anticipated formal decision to escalate NHS Lothian, on the basis described above, and provides;

- An update on CAMHS progress towards meeting the national standard
- Details on recent changes in the CAMHS workforce and financial resource
- National benchmarking data on CAMHS performance
- Immediate next steps agreed with Scottish Government officials on 28 January 2025.

This report details the recorded position at month end December 2024.

2.2 Background

The graph below shows the number of patients waiting from January 2021 to December 2024 for all reportable waits across CAMHS (assessment and treatment).In Jan 2021, the total number of patients waiting was 2,530 with 1,561 patients waiting >18 weeks. This compares to 1,848 waiting and 639 patients waiting > 18 weeks at end December 2024.



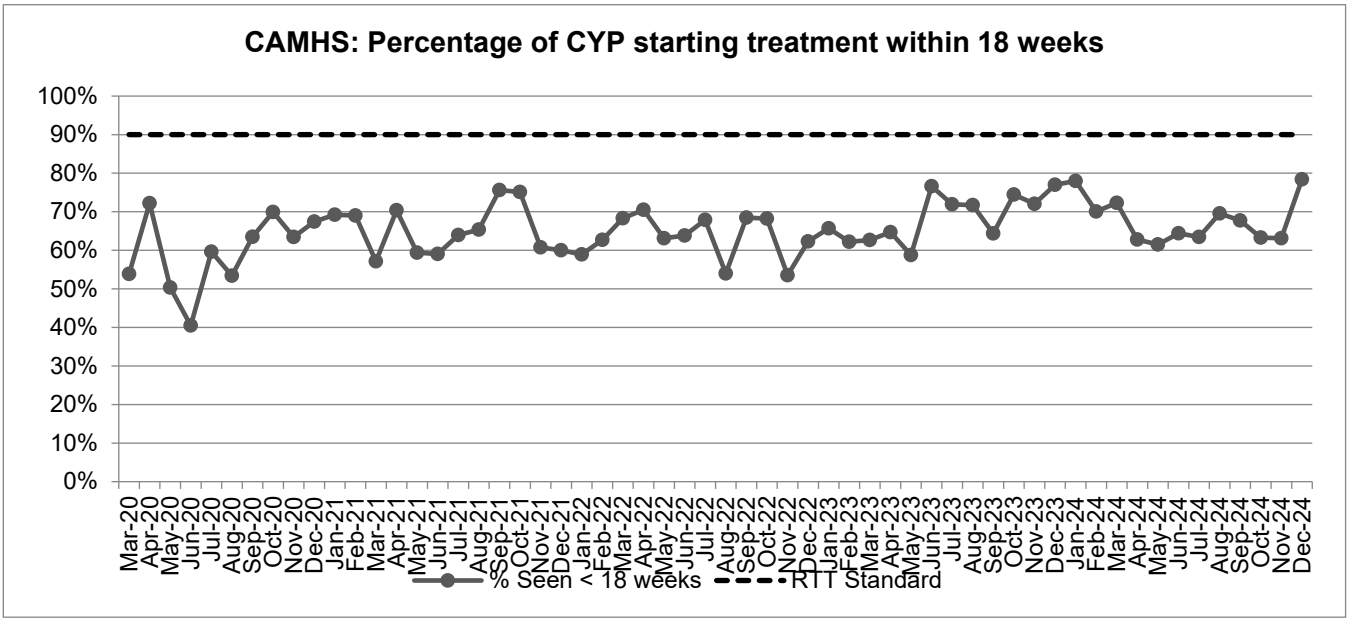
Note: *Neurodevelopmental Assessment waits have been excluded from the Waiting Times submission from December 2021 onwards (as advised by Scottish Government). ND data is not including in the graph above.*

2.3 Assessment

2.3.1 Performance

Referral to Treatment %

In December 2024, 78.4% Children and Young People started treatment within 18 weeks from referral.



Treatment Demand

Mental Health treatment demand average over a 12-month period was 76 in 2021; 75 in 2022; 102 in 2023; 121 in 2024. This represents a 62% increase in demand for treatment since 2021. Job plans are monitored on a weekly, monthly and quarterly basis to ensure that capacity within teams is being maximised to respond to this demand.

Child, Adolescent and Psychological Therapies National Dataset (CAPTND)
Report published 3 September 2024.

CAMHS in CAPTND 3 September 2024 - Child, adolescent, and psychological therapies national dataset (CAPTND) - Publications - Public Health Scotland

The CAPTND reports that the submitted referral count in the quarter April - June 2024 in CAMHS Lothian was 2,114. This is significantly higher than all other boards across Scotland. There is ongoing work to understand the reasons for this and any mitigations that can be put in place. The % acceptance rate in CAMHS Lothian is also higher than other boards and again there is work ongoing to better understand this.

However, in the quarter ending June 2024, NHS Lothian CAMHS delivered a total of 10,750 appointments this is around 23% of all appointments delivered across Scotland.

2.3.2 Workforce

The table below shows the change of staff numbers (WTE) in post across our CAMHS services since initial recovery plan.

	2021	**2022**	**2023**	**2024 – M9**
Total In Post (WTE)	262.25	305.73	306.8	300.64

In addition to this internal workforce, independent capacity was used to support recovery. Reductions in the Mental Health Outcome Framework (MHOF) funding provided by Scottish Government has brought significant challenges in terms of reduction in capacity, re-evaluating initial plans and the need for service review to create new plans in line with current funding.

Mental Health Outcome Framework changes

	2021/22 allocations
Mental health recovery and renewal fund (CAMHS and PT)	4,907,458
Psychological therapies	579,723
Mental Health Outcomes Framework	2,705,300
CAMHS improvement (Phase 2)	1,546,543
Total	**9,739,114**

	2022/23 allocations
Mental Health Outcomes Framework 2022/23	9,154,510*
CAMHS improvement (Phase 2)	-
Total	**9,154,510**

*2022/23 allocation was collated including CAMHS, PT and Eating Disorders. The amount allocated to eating disorders was £408,490 so total CAMHS and PT allocation was £8,747,320. This was against an expected allocation of £11.4m.

2.3.3 Next Steps

The Scottish Government has requested revised trajectories by mid-February which detail how CAMHS in NHS Lothian can meet the 18-week standard by the end of December 2025. Ongoing support has been offered to ensure we continue to fully implement the CAPA model in each partnership.

A review is underway with colleagues in Waiting Times Governance and Data Analytics teams to review the application of the data definition of starting treatment within CAMHS to ensure this is being applied correctly within NHS Lothian CAMHS. We are aware of variation in interpretation of the specification across Scotland.

Initial modelling suggests that, to recover the waiting list by December 2025, starting February 2025 an additional 127 new patient appointments are required each month.

Delivery of this level of increase is likely to require a combination of additional clinical and administrative workforce capacity and potentially utilising independent sector resources and solutions.

2.3.4 Equality and Diversity, including health inequalities

No specific decision(s) are being sought from this paper.

2.3.5 Other impacts

N/A.

2.3.6 Communication, involvement, engagement and consultation

There will be ongoing communication as the recovery plan is developed.

2.4 Recommendation

- **Discussion** – Examine and consider the implications of the escalation of CAMHS to Stage 3 of the NHSScotland support and intervention framework
- **Awareness** – To note the pending formal notification of this escalation decision and the background to current levels of CAMHS performance.
- **Awareness** – To note that relevant senior staff will continue to engage with Scottish Government officials on this matter to consider what levels of support may be offered to reduce waiting lists and to agree an appropriate recovery plan to be reflected within the Board's 2025/26 Annual Delivery Plan (ADP).

3 List of appendices

None.

NHS Lothian

12.

Meeting: NHS Lothian Board

Meeting date: 5th February 2025

Title: December 2024 Financial Position

Responsible Executive: Craig Marriott, Director of Finance

Report Author: Andrew McCreadie, Deputy Director of Finance

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other - Financial Reporting	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHS Scotland quality ambition(s):

Safe	☐	Effective	☐
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to provide the Board with an update on the financial position as at December 2024 for NHS Lothian.

2.2 Background

This report forms part of the reporting cycle to the Board on the financial performance of NHS Lothian, in support of delivering year end financial targets. This paper updates on the year to date position for the first nine months.

2.3 Assessment

After 9 months, the reported financial position for NHS Lothian is a year to date overspend of £10m. The financial position is comprised of an operational overspend of £26.1m, offset by the release of corporate reserves flexibility of £16.1m. Table 1 below shows this breakdown in summary with further information in the body of this paper.

Table 1 – Month 9 Summary Financial Performance

	Month 9 Variance from Budget £'000
Pay	13,255
Non Pays	(49,433)
Income	10,044
Operational Position	**(26,134)**
Corporate Reserves Flexibility	16,084
Total Variance	**(10,050)**

2.3.1 Quality/ Patient Care

There are no new quality or patient care implications from this report.

2.3.2 Workforce

There are no new workforce implications from this report.

2.3.3 Financial

Financial Position as at 31st December 2024

Medical and Dental pay budgets continue to be the main areas of overspend and are now reporting an overspend of £9.4m for 9 months of the year. There is a slowing down in the levels of the monthly overspend position due to an improvement in the number of non compliant rotas, a decrease in the use of locums/agency and a reduction in unfunded vacancies. The 2024/25 pay award for many Medical and Dental staff has now been paid with the increase made in December and arrears due in February. Funding from the Scottish Government has only been received for consultant grades to date. An assumption of funding

has therefore been included within the month 9 position while we confirm and agree the overall allocation from the Scottish Government to cover the full cost of the medical and dental pay award.

Non-pay budgets report a £49.4m overspend with Drug costs exceeding budgets and being £11.5m overspent, and Medical Supplies £20.3m overspent. The non-pay budget pressures continue to be impacted by contractual price increases and the 0% funding uplift for 2024/25. GP Prescribing is reporting a £12.2m overspend, which continues to see price per item fluctuate and higher than expected growth in the number of items. Overall Table 2 shows the breakdown across the main expenditure headings with further details on Appendix 1 and 2.

Table 2 – Breakdown of Variance

Description	Month 9 Variance from Budget £000's
Medical & Dental	(9,440)
Nursing	13,628
Administrative Services	2,644
Support Services	(1,469)
Other Therapeutic	4,203
Other Pay	3,689
Total Pay	**13,255**
Drugs	(11,456)
Medical Supplies	(20,265)
Property Costs	(7,281)
Administration Costs	(2,821)
Other Non-Pay	4,589
Pharmaceuticals	(12,158)
Other FHS	(236)
Total Non-pay	**(49,628)**
Income	**10,044**
Other	**(910)**
Profit/loss On Disposal	**1,104**
Operational Position	**(26,134)**
Corporate Reserves Flexibility	16,084
Total Variance	**(10,050)**

Transitional allowance overtime or excess hours payments continue to be paid as part of the Agenda for Change (AfC) non pay reform for the reduced working week (RWW). December payments relate to November transitional allowances, totalling £0.7m in month and £8.4m year to date and are included within the position. Work continues through the AfC Reform Programme Board to support the process of managing the RWW. Transitional Allowance overtime payments should now drop off with arrangements in place for managing the RWW within staffing rosters. Funding of £30.2m has been received non recurrently from the Scottish Government for the year to meet additional costs across all the AfC Reforms this year, and from this allocation, £8.4m of funding has been included in the position to match the costs to date.

Year End Forecast

The Finance and Resources (F&R) Committee received an update on the year end forecast at its December meeting based on Month 7 data, which showed a projected overspend at the year-end of c£23m. The Committee acknowledged this position and were content to receive limited assurance on delivering financial balance at that time.

Since then, further work is being progressed on the year end position following the Month 9 outturn and additional information subsequently received on in-year costs and allocations from the Scottish Government. A further update on the year end forecast will be provided to the F&R Committee later in February.

Financial Recovery Plans (FRPs)

Up to November, at a summary level and against £35m of planned Business Unit FRP savings, £36.5m has been recorded as delivered, representing a small over-achievement of £1.4m. Table 4 shows the delivery against Business Units.

Table 3 – Financial Recovery Plans (FRPs)

	Schemes Identified	Planned April - November	Achieved April - November	Over/Under Delivery April - November	CY Forecast @ M08	CY Projected Shortfall
	£'000	£'000	£'000	£'000	£'000	£'000
Acute Services Division	25,038	15,270	15,815	544	24,975	(63)
Corporate Services	6,137	3,996	4,431	435	6,156	19
East Lothian HSCP	4,294	2,792	2,508	(284)	3,511	(783)
Edinburgh HSCP	4,854	2,978	3,664	686	5,379	525
Midlothian HSCP	3,453	2,217	2,102	(115)	2,857	(596)
West Lothian HSCP	4,141	2,654	3,000	346	4,123	(18)
Facilities	4,418	2,308	2,424	116	4,167	(252)
REAS	3,311	2,207	1,867	(340)	2,642	(669)
Directorate Of Primary Care	953	635	647	12	953	0
Income/Healthcare Purchases	388	0	0	0	388	0
Total	**56,987**	**35,057**	**36,458**	**1,401**	**55,150**	**(1,837)**

Based on the latest estimates, a shortfall of £2m is currently forecast as noted above against the planned Business Unit Schemes identified.

The detailed breakdown of FRP savings or workstreams' cost reduction initiatives is reported routinely to the relevant workstream programme group and to the Financial Oversight Board (FOB) for governance and support in relation to those schemes at variance with planned delivery. The requirement for the achievement of the 3% FRP target at a Business Unit level is a key vehicle for achieving financial balance with FOB escalation criteria for breaching set thresholds in place.

2.3.4 Risk Assessment/Management

The corporate risk register includes the following risk:

- Risk 3600 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. (Finance & Resources Committee)

The contents of this report are aligned to the above risk. At this stage there is no further requirement to add to this risk.

2.3.5 Equality and Diversity, including health inequalities

The Public Sector Equality Duty and / or Fairer Scotland Duty does not apply to this report.

The report shares the financial position for awareness and does not relate to the planning and development of specific health services. Any future service changes or decisions that are made as a result of the issues raised in this report will be required to adhere to the Board's legal duty.

2.3.6 Other impacts

There are no other impacts from this report.

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders, including patients and members of the public, where appropriate. The implementation of the Financial Plan and the delivery of a breakeven outturn may require service changes. Any future service changes that are made as a result of the issues raised in this report will be required to adhere to the Board's legal duty to encourage public involvement.

2.3.8 Route to the Meeting

Monthly reporting is provided to the Corporate Management Team (CMT). The month 9 financial position was reported in January.

- Corporate Management Team, 28th January 2025

2.4 Recommendation

The report asks the Board for:

- **Awareness** – For Members to note the financial position to the end of December 2024 reporting a £10m overspend with NHS Lothian.
- **Awareness** – For Members to note the latest financial forecast will be reported to Finance & Resources Committee on 12th February 2025.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Lothian Income & Expenditure Summary to 31st December 2024
- Appendix 2, NHS Lothian Summary by Operational Unit to 31st December 2024

Appendix 1 - NHS Lothian Income & Expenditure Summary to 31st December 2024

Description	Annual Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Medical & Dental	373,296	279,455	288,895	(9,440)
Nursing	673,622	506,322	492,694	13,628
Administrative Services	200,214	140,033	137,389	2,644
Allied Health Professionals	123,105	92,415	89,483	2,932
Health Science Services	57,864	43,374	42,743	631
Management	7,996	5,570	4,995	575
Support Services	104,908	78,024	79,493	(1,469)
Medical & Dental Support	20,039	14,903	14,499	404
Other Therapeutic	73,015	54,523	50,320	4,203
Personal & Social Care	3,525	2,462	1,972	490
Other Pay	(3,486)	(3,667)	(3,840)	173
Emergency Services	0	0	27	(27)
Vacancy Factor	(2,134)	(1,501)	(10)	(1,491)
Pay	**1,631,965**	**1,211,916**	**1,198,660**	**13,255**
Drugs	155,480	124,341	135,798	(11,456)
Medical Supplies	104,047	80,005	100,270	(20,265)
Maintenance Costs	6,854	5,298	6,997	(1,699)
Property Costs	58,057	41,837	49,118	(7,281)
Equipment Costs	36,455	24,203	27,048	(2,845)
Transport Costs	8,710	6,884	8,706	(1,822)
Administration Costs	250,720	81,556	84,376	(2,821)
Ancillary Costs	11,898	8,780	13,526	(4,747)
Other	(3,105)	(8,876)	(15,442)	6,566
Service Agreement Patient Service	45,404	32,837	32,465	371
Savings Target Non-pay	11,772	9,058	0	9,058
Resource Transfer/LA Payments	124,176	89,455	89,748	(293)
Non-pay	**810,469**	**495,377**	**532,611**	**(37,234)**
Premises	0	0	1	(1)
Additional Services	0	0	1	(1)
Gms2 Expenditure	163,883	129,494	129,643	(149)
NCL Expenditure	813	609	699	(89)
Other Primary Care Expenditure	87	65	61	4
Pharmaceuticals	165,891	123,546	135,704	(12,158)
Primary Care	**330,673**	**253,714**	**266,108**	**(12,394)**
Other	**(15)**	**(10)**	**899**	**(910)**
Income	**(404,341)**	**(312,705)**	**(322,749)**	**10,044**
Extraordinary Items	**0**	**0**	**(1,104)**	**1,104**
Operational Position	**2,368,751**	**1,648,292**	**1,674,426**	**(26,134)**
Corporate Reserves Flexibility	16,084	16,084	0	16,084
Total Variance	**2,384,835**	**1,664,376**	**1,674,426**	**(10,050)**

Appendix 2 - NHS Lothian Summary by Operational Unit to 31st December 2024

Month 9 Variance from Budget	Acute Services Division	East Lothian Partnership	Edinburgh Partnership	Midlothian Partnership	West Lothian Partnership	Directorate Primary Care	REAS	Corporate Services	Facilities	Strategic Services	Research & Teaching	Income & Healthcare Purchases	Operational Variance	Corporate Reserves Flexibility	Total
	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000	£'000
Medical & Dental	(9,288)	143	40	88	(13)	761	(675)	370	(63)	0	(805)	0	(9,440)	0	**(9,440)**
Nursing	2,881	3,091	4,727	637	2,431	194	(0)	(135)	(53)	(1)	(144)	0	13,628	0	**13,628**
Administrative Services	1,975	491	890	(99)	425	(684)	(8)	(187)	274	1	(433)	(1)	2,644	0	**2,644**
Allied Health Professionals	93	522	976	122	477	646	85	(6)	50	(0)	(32)	0	2,932	0	**2,932**
Health Science Services	571	(6)	315	0	(18)	(45)	(14)	(129)	(15)	(0)	(27)	0	631	0	**631**
Management	(144)	83	95	(7)	1	83	7	276	169	0	12	0	575	0	**575**
Support Services	73	(3)	157	136	5	(35)	221	333	(2,355)	0	0	0	(1,469)	0	**(1,469)**
Medical & Dental Support	(424)	25	10	0	0	728	33	31	0	(0)	0	0	404	0	**404**
Other Therapeutic	77	419	670	5	452	(69)	802	1,746	(17)	(0)	119	0	4,203	0	**4,203**
Personal & Social Care	36	65	59	0	0	39	(14)	309	0	0	(5)	0	490	0	**490**
Other Pay	(13)	0	16	20	1	35	6	8	0	0	100	0	173	0	**173**
Emergency Services	0	0	0	0	0	0	0	0	(27)	(0)	0	0	(27)	0	**(27)**
Vacancy Factor	(0)	0	(1,490)	0	0	0	0	0	0	0	0	0	(1,491)	0	**(1,491)**
Pay	**(4,163)**	**4,829**	**6,464**	**902**	**3,760**	**1,654**	**445**	**2,617**	**(2,036)**	**(0)**	**(1,215)**	**(1)**	**13,255**	**0**	**13,255**
Drugs	(8,852)	(435)	(535)	(188)	(140)	(364)	(553)	114	(3)	(500)	0	0	(11,456)	0	**(11,456)**
Medical Supplies	(16,812)	(497)	(1,454)	(297)	(484)	(71)	(72)	(32)	(545)	(0)	(0)	0	(20,265)	0	**(20,265)**
Maintenance Costs	(617)	(49)	(48)	(33)	(97)	178	(81)	(198)	(754)	0	0	0	(1,699)	0	**(1,699)**
Property Costs	(53)	(16)	(9)	200	(71)	(5)	(25)	(27)	(7,274)	0	0	0	(7,281)	0	**(7,281)**
Equipment Costs	(2,139)	(438)	(385)	(11)	(212)	151	(83)	123	170	(4)	(17)	0	(2,845)	0	**(2,845)**
Transport Costs	(803)	(344)	(227)	(119)	(14)	(23)	(114)	15	(183)	16	(4)	(23)	(1,822)	0	**(1,822)**
Administration Costs	(707)	150	(188)	92	282	61	(390)	(1,861)	735	(2,006)	990	22	(2,821)	0	**(2,821)**
Ancillary Costs	(459)	(37)	(3)	(1)	(15)	(12)	(55)	(1,407)	(2,758)	0	(0)	0	(4,747)	0	**(4,747)**
Other	6,430	(1)	(6)	0	1	(3)	2	(164)	306	0	0	0	6,566	0	**6,566**
Service Agreement Patient Serv	(24)	(45)	3	2	(179)	(13)	1,066	66	(11)	0	(251)	(242)	371	0	**371**
Savings Target Non-pay	(71)	0	0	0	0	0	0	1,340	0	7,789	0	0	9,058	0	**9,058**
Resource Trf + L/a Payments	(41)	(109)	9	(53)	5	0	(75)	(0)	(29)	0	0	0	(293)	0	**(293)**
Non-pay	**(24,148)**	**(1,822)**	**(2,845)**	**(407)**	**(924)**	**(101)**	**(381)**	**(2,031)**	**(10,346)**	**5,295**	**718**	**(243)**	**(37,234)**	**0**	**(37,234)**
Premises	(1)	0	0	0	0	0	0	0	0	0	0	0	(1)	0	**(1)**
Additional Services	0	0	0	0	0	0	0	0	(1)	0	0	0	(1)	0	**(1)**
Gms2 Expenditure	(6)	(90)	(241)	(100)	291	43	(7)	(9)	(31)	0	0	0	(149)	0	**(149)**
Ncl Expenditure	0	0	0	0	0	(89)	0	(0)	0	0	0	0	(89)	0	**(89)**
Other Primary Care Expenditure	4	0	0	0	0	0	0	0	0	0	0	0	4	0	**4**
Pharmaceuticals	0	(1,809)	(4,932)	(1,263)	(2,868)	(1,306)	0	0	21	0	0	0	(12,158)	0	**(12,158)**
Primary Care	**(2)**	**(1,899)**	**(5,174)**	**(1,364)**	**(2,577)**	**(1,352)**	**(7)**	**(9)**	**(11)**	**0**	**0**	**0**	**(12,394)**	**0**	**(12,394)**
Other	**(3)**	**0**	**(14)**	**0**	**0**	**(0)**	**0**	**(0)**	**(642)**	**0**	**0**	**(251)**	**(910)**	**0**	**(910)**
Income	**2,935**	**30**	**(269)**	**21**	**15**	**9**	**6**	**1,346**	**2,008**	**(15)**	**496**	**3,462**	**10,044**	**0**	**10,044**
Extraordinary Items	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,104**	**0**	**0**	**1,104**	**0**	**1,104**
Operational Position	**(25,381)**	**1,138**	**(1,838)**	**(847)**	**274**	**210**	**62**	**1,923**	**(11,027)**	**6,383**	**0**	**2,968**	**(26,134)**	**0**	**(26,134)**
Corporate Reserves Flexibility	0	0	0	0	0	0	0	0	0	0	0	0	0	16,084	**16,084**
Total Variance	**(25,381)**	**1,138**	**(1,838)**	**(847)**	**274**	**210**	**62**	**1,923**	**(11,027)**	**6,383**	**0**	**2,968**	**(26,134)**	**16,084**	**(10,050)**

NHS Lothian

13.

Meeting: NHS Lothian Board

Meeting date: 5 February 2025

Title: Corporate Risk Register

Responsible Executive: Tracey Gillies, Medical Director

Report Author: Jill Gillies, Associate Director of Quality

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☒	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other – corporate risk	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☒
Primary Care	☒	Digital	☒
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHS Scotland quality ambition(s):

Safe	☒	Effective	☐
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to review NHS Lothian's Corporate Risk Register (CRR) and associated processes to ensure it remains fit for purpose.

Board members are asked to:

2.1.1 Review the November/December 2024 updates provided by the executive leads concerning risk mitigation, as set out in the assurance table in appendix 1.

2.1.2 Note that CMT have approved the process for setting target risk scores.

2.1.3 Note minor changes to risk descriptions **5186 4-hour emergency access target** and **5185 Access to treatment** to remove references to covid.

2.1.4 Note that CMT has reviewed the divisional high and very high risks in December 2024.

2.1.5 Note the overview of the changes in the CRR over the past 2 calendar years in table 1.

2.1.6 Note that management actions agreed in the internal audit report of the corporate risk register process have been implemented.

2.2 Background

2.2.1 Role of the Corporate Management Team (CMT)

It was agreed at the February 2021 CMT that the CRR would be managed through the CMT and subject to review every two months, with the risk manager in attendance to ensure proactive management, including timely feedback from assurance committees and alignment of assurance levels and risk grading. A process has been established to meet executive leads prior to each CMT to inform the CMT risk paper.

The CMT then make recommendations to the Board with respect to new and/or amended risks, with a clear articulation of the risk that cannot be managed at an operational level, explicit plans to mitigate the risk along with associated measures to assess the impact of these plans. This collective oversight strengthens the NHS Lothian risk management system including our assurance system.

2.2.2 Understanding the very high and high risks at divisional and corporate level is a key component of Lothian's risk management system. The current very high and high risks at Acute, REAS, HSCP level as well as corporate single system risks registers such as Public Health, Nursing and Pharmacy were reviewed by the CMT in December 2024.

There is a requirement that all very high and high divisional and corporate risks have plans in place to mitigate the risk which are monitored proactively. If the risk cannot be managed by a director, it will be escalated to CMT for discussion.

2.2.3 All risks on the CRR relate to the delivery of NHS Lothian objectives as agreed by the Board in April 2024.

2.2.4 Any new or materially worsening risks will be presented to the Strategic Planning and Performance Committee (SPPC) prior to submission to the Board.

2.2.5 The risk management process is set out in the Risk Management Policy as approved by the Board in April 2023.

2.3 Assessment

2.3.1 Process for setting target risk scores.

CMT members agreed a standard approach at the December meeting to set target gradings for all corporate risks to ensure that consistency is taken. This is recognised as good practice and recommended by internal audit as part of risk management but has not been applied to all risks on the corporate risk register.

2.3.2 Consistent with current policy/procedure, risk owners and handlers should collaborate to propose a target risk grading for each of their risks using the standard approach. That is:

- the anticipated risk score once all possible controls and mitigations have been implemented
- the risk level which the organisation is prepared to tolerate once all possible controls and mitigations are deployed

It is recognised that full mitigation of several corporate risks will not be within control of NHS Lothian. It was therefore agreed that performance targets for our corporate risks are cognisant and aligned with our LSDF and ADP aims.
Quality department staff will support this process over the coming months and once agreed by CMT, recommended target risk scores will be included in recommendations to the Board.

2.3.3 Further work will be undertaken in the coming months alongside the development of the Board assurance framework which will help to strengthen our risk management processes and address recommendations from internal audit. This will include further consideration and review of risk scoring as defined below:

- **Untreated Score:** the inherent risk score, with no controls applied, representing the "reasonable worst-case scenario" for the risk. If there were no controls, mitigation or contingency plans in place, how likely is it the risk would materialise and what would the impact be?
- **Current Score:** the score considering any controls that are currently in place to manage the risk.
- **Target Score:** as noted above, the optimum risk score when all possible controls and mitigations have been adequately implemented and are operating effectively.

2.3.4 Board members are asked to note minor revisions to the descriptors for two risks, as set out below:

Risk 5186 – 4-hour emergency access target
There is a risk that NHS Lothian will fail to deliver safe and timely unscheduled care to patients presenting to EDs due to the volume and complexity of patients, challenges in managing flow through the department, and availability of beds, leading to a delay in first assessment, diagnosis and subsequent treatment for patients and therefore increased likelihood of patient harm and poor experience of care.

Risk 5185 – Access to treatment
There is a significant risk that NHS Lothian will fail to achieve waiting time standards and that waits further increase for inpatient, day case procedures, Out-patients, diagnostic and cancer patients with demand exceeding capacity. This will lead to delay in diagnosis and potential progression of disease and hence poorer experience and outcomes for patients.

2.3.5 Divisional High and Very High Risks

CMT have reviewed the high and very high risks on the acute services, HSCPs, REAS and corporate services risk registers at the December meeting. There are common themes, closely related to risks contained in the CRR including:

- Finance
- Waiting times
- Capacity
- Workforce
- Violence and aggression
- Estates

2.3.6 Agreed management actions following the internal audit of the CRR have been implemented including some changes to the risk assurance table to accommodate. This includes a numerical breakdown of risk gradings, the risk response (all are treated) and space to add target risk grading once agreed by risk owners and CMT members. Progress will be reported to the Audit and Risk Committee at their February meeting.

2.3.7 Summary of risk profile

An overview of changes to the CRR over the last 2 calendar years is provided in Table 1 below.

Table 1

Risk Title	CMT Meetings 2023-2025												
	Jan-23	Feb-23	Apr-23	Jul-23	Aug-23	Oct-23	Dec-23	Feb-24	Apr-24	Jun-24	Sep-24	Nov-24	Dec-24
3600 - Finance	25	25	25	25	25	25	25	25	25	25	25	25	25
5186 - 4 Hours Emergency Access Target	20	25	25	25	25	25	25	25	25	25	25	25	25
3726 - Hospital Bed Occupancy	20	25	25	25	25	25	25	25	25	25	25	25	25
5185 - Access to Treatment	20	25	25	25	25	25	25	25	25	25	25	25	25
5510 - REH Bed Occupancy	25	25	25	25	25	25	25	25	25	25	25	25	25
5784 - Low Secure Accommodation	Split of risk 5687, approved by Board April 2024							20	15	15	15	15	15
5785 - High Secure Female Accommodation	Split of risk 5687, approved by Board April 2024							12	12	12	12	12	12
5388 - HSDU Capacity	20	20	20	20	20	20	20	20	20	20	20	20	20
3828 - Nursing Workforce	20	20	20	20	20	20	20	20	12	12	12	12	12
5737 - Royal Infirmary of Edinburgh Fire Safety	New risk approved by Board Dece					20	20	25	25	25	25	25	25
1076 - Healthcare Acquired Infection	16	16	16	16	16	16	16	16	16	16	16	16	16
5189 - RIE Facilities	15	15	15	15	15	15	15	15	15	15	15	15	15
3455 - Violence & Aggression	15	15	15	15	15	15	15	15	15	15	15	15	15
3328 - Roadways/Traffic Management	12	12	12	12	12	12	12	12	12	12	12	12	12
5020 - Water Safety and Quality	12	12	12	12	12	12	12	12	12	12	12	12	12
5322 - Cyber Security	12	12	12	12	12	12	12	12	12	12	12	12	12

2.3.8 Quality/ Patient Care

The CRR includes risks to quality and patient care and risk mitigation plans will positively impact on quality of care.

2.3.9 Workforce

The resource implications are directly related to the actions required to mitigate against each risk. The mitigation of risks relating to staff health and safety will positively impact on health and well-being.

2.3.10 Financial

The resource implications are directly related to the actions required to mitigate each risk. This is managed through relevant governance and operational management structures which are set out against each risk.

2.3.11 Risk Assessment/Management

In line with the CRR process, risks are identified and/or escalated for assessment and consideration by the CMT who will in turn make recommendations to the Board. Risk mitigation plans are in place for all risks on the CRR and are monitored through reporting to relevant governance committees for assurance.

2.3.12 Equality and Diversity, including health inequalities

This paper does not consider developing, planning, designing services and/or policies and strategies therefore the statutory duties do not apply.

2.3.13 Communication, involvement, engagement, and consultation

This paper does not consider developing, planning, designing services and/or policies and strategies therefore the statutory duties do not apply.

2.3.14 Route to the Meeting

In line with agreed process, discussions are held with executive leads to provide updates on risks which are then considered by the CMT who make recommendations to the Board. Following Board review, the updated CRR is shared with Audit and Risk and Healthcare Governance Committees to provide context for discussions at their meetings.

2.4 Recommendation

Discussion – Board members are asked to:

- Review the November/December2024 updates provided by the executive leads concerning risk mitigation, as set out in the assurance table in Appendix 1.
- Note that CMT have approved the process for setting target risk scores.
- Note minor changes to risk descriptions **5186** 4-hour emergency access target and **5185** Access to treatment to remove references to covid.
- Note that CMT have reviewed the divisional high and very high risks at their December meeting.
- Note the overview of the changes in the CRR over the past 2 calendar years in table 1.
- Note that management actions agreed in the internal audit report of the corporate risk register process have been implemented.

3. List of appendices

The following appendices are included with this report:

- Appendix 1: Risk assurance table

Appendix 1

Risk Assurance Table – Executive/Director Updates

Datix ID	Risk Title & Description	Committee Assurance Review Date
3600	**Finance** There is a significant risk that the Board is unable to respond to core existing service requirements as well as those arising from the population growth in all age groups across NHS Lothian, whilst maintaining its aging estate. This is because of a combination of the greatly restricted level of capital and revenue resource available for 2024/25, together with the uncertainty around future resources. This will result in an inability to plan for and deliver not only core services, on a financially prioritised and risk/ needs assessed basis, but also the additional capacity and infrastructure required. Resource limitation also impacts recovery from this situation and the ability to plan in the medium to long term, against a trajectory of increasing demand and ageing capital assets. Executive Lead: Craig Marriott Corporate objective: Revenue **Risk Response: Treat**	**Finance & Resources Committee** **March 2024** • **Limited assurance accepted.** ***Next to be presented March 2025***
		Outcome of Executive Lead Discussions **September/October 2024** • Pay awards have now been confirmed although recurrent funding has still to be identified at a national level. • The limited capital flexibility is now having an impact on fragile services. The Eye Pavilion and RIDU have both got significant and urgent capital investment requirements. This will also have a detrimental impact on the revenue position. • We are now progressing with the financial plan for 2025/26 - it is clear that the size of the recurrent gap will increase due to the limited recurrent uplift and pressure on services. In mitigation, we are running a series of sessions to review potential choices to improve our fiscal sustainability. These will potentially impact on the service performance. **November / December 2024** • **Improving financial position in month 7 has reduced year end forecast to circa £20m overspend. The improvement has been achieved from the delivery of additional non-recurring 4% actions identified within the financial plan.** • **The 25/26 Scot Gov budget will be announced on 4 Dec, at present it is estimated that the opening financial gap will be consistent with the 2024/25 gap circa £120m deficit.** • **Management action has been taken to identify efficiency/savings opportunities for 2025/26 by delivering a combination of 3% efficiency savings and an estimated requirement of 3% cost savings. This work will require to be assessed for its compliance with equalities impact assessment. There will**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		also be a requirement to work with SG to test the authorising environment cascade. • **The capital position in year has been managed robustly to mitigate unknown capital deficiencies. For 2025/26 the expectation is that the capital challenge will continue – this will mean that the Board will continue to rely on its risk-based investment framework.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading		
5186	**4 Hours Emergency Access Target** There is a risk that NHS Lothian will fail to deliver safe and timely unscheduled care to patients presenting to EDs due to the volume and complexity of patients, challenges in managing flow through the department, and availability of beds, leading to a delay in first assessment, diagnosis and subsequent treatment for patients and therefore increased likelihood of patient harm and poor experience of care. New risk created from previous risks 3203 & 4688. Approved by June 2021 Board. Executive Lead: Jim Crombie Corporate objective: Unscheduled care **Risk Response: Treat**	**Healthcare Governance Committee** – person-centred, safe, and effective care. **July 2024** • **Limited assurance accepted.** ***Next to be presented January 2025*** **Strategic Planning and Performance Committee** – Performance **November 2023** • **Limited assurance:** ***Next to be presented January 2025***	
		Outcome of Executive Lead Discussions **September/October 2024** • The average 4-hr performance for NHS Lothian in August was 61% against the national average of 65.8%. This was below the trajectory of 65.7%. • As part of the RIE improvement work, a Breach Process Review has been drafted to complement the NHS Lothian 4- hour Emergency Care Standard & Breach Reporting Standard Operating Procedure. • There is a risk that changes to the bed base in Edinburgh City will have an impact on RIE capacity, increasing delays and adding further pressure to acute flow.	

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td></td><td></td><td colspan="2">

Work is ongoing with Edinburgh HSCP to develop proposals to mitigate impact including the expansion of the RIE ED frailty model, introduction of the model WGH and securing additional community capacity.
There is a risk that RIE services will not be able to offset winter pressures through service led initiatives because there will not be a winter funding provision nationally unlike previous years, leading to high levels of overcrowding in ED and poor patient flow.

November / December 2024

Performance against the Emergency Access Standard remains challenging.
Compliance for Lothian was at 61.28% in September & 60% in October.
Compliance for the RIE was at 48% for September (Admitted: 26.1% / Non-Admitted: 58.2%) & 47% for October.

<table>
<tr><th>Site</th><th>Performance (September-2024)</th><th>Trajectory (September 24)</th><th>Latest performance (October 24)</th><th>Trajectory (October 24)</th></tr>
<tr><td>Lothian</td><td>62%</td><td>65.7 %</td><td>60%</td><td>71%</td></tr>
<tr><td>RHCYP</td><td>91%</td><td>94%</td><td>90%</td><td>94%</td></tr>
<tr><td>RIE</td><td>48%</td><td>60%</td><td>47%</td><td>65%</td></tr>
<tr><td>SJH</td><td>61%</td><td>65%</td><td>55%</td><td>65%</td></tr>
<tr><td>WGH</td><td>62%</td><td>64%</td><td>63%</td><td>65%</td></tr>
</table>

In response to current performance and concerns regarding winter pressures a SLWG has been established to drive focused improvement work on priority areas below:

Reduce Hospital Occupancy
Reduce Length of Stay (LOS)
Reduce A&E Attendances
Reduce A&E Admissions

The final plan was submitted to Scottish Government in November 2024

</td></tr>
<tr><td></td><td>Risk Grading:</td><td>CMT November 2024
Very High 25
(Likelihood: Almost Certain (5), Impact: Extreme (5))</td><td>CMT December 2024
Very High 25
(Likelihood: Almost Certain (5), Impact: Extreme (5))</td></tr>
<tr><td></td><td>Target Risk Grading</td><td></td><td></td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date

3726	**Hospital Bed Occupancy**
	
	There is a risk that patients do not receive safe and effective care due to high level of bed occupancy, leading to increased risk of harm, poor patients and staff experience and impacting on flow resulting in crowding in front door areas and long waits for admission, cancellation of elective procedures and NHS Lothian's capacity to achieve national standards.
	
	Executive Lead: Jim Crombie
	
	Corporate objective: Unscheduled care
	
	Risk Response: Treat
		<u>Healthcare Governance Committee</u> – person-centred, safe, and effective care.
		
		July 2024
		• **Limited assurance accepted.**
		
		Next to be presented January 2025
		
		<u>Strategic Planning and Performance Committee</u> – Performance
		
		May 2023
		• **Limited assurance accepted.**
		
		Next to be presented January 2025
		
		<u>Outcome of Executive Lead Discussions</u>
		
		September/October 2024
		• Bed occupancy rates continue to exceed 85% in all sites.
		• The three adult acute sites continue Length of Stay (LoS) improvement programmes with the aim of reducing downstream bed occupancy levels and improving system flow.
		  • RIE
		  ○ Weekly discharges have remained steady with mean LoS across the site starting to recover compared with earlier in 2024. A decrease in Total Occupied Bed Days (TOBD) has been observed across the site by circa 400 days in one month.
		  • WGH
		  ○ Discharge without Delay (DwD) funding is only secured on a non-recurring basis for 2024/2025, which has resulted in reductions to both Home First and Social work resources from March 2024 due to the funding model being non-recurring limiting recruitment opportunities.
		  • SJH
		  ○ Data still suggests that Planned Date of Discharge (PDD) implemented on wards is having a positive impact on the average LoS.
		  ○ The average LoS on wards with PDD implemented remains at an average of 5.9 days, reflecting a sustained improvement compared to pre-PDD levels.

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		○ Occupied Bed Days for delayed discharges remains challenging across Lothian - 321 bed days were lost to delays in Jan to July 2024 against the 221 recorded for the same period in 2023. There is ongoing work from West Lothian HSCP in particular to address the increase in delays. **November / December 2024** • **Bed occupancy rates continue to exceed 85% in all sites.** • **The Length of Stay programmes (Led by Site Directors) on the adult acute sites has been received positively by specialty teams and sites are developing LoS action plans with each of the specialties that will be supported by the site leadership teams. Total occupied bed days for patients stays that are "not-in-delay" has dropped by around 5%.** • **Initiatives aimed at reducing admissions, such as the Rapid Assessment Care Unit (RACU) and Hospital at Home, are performing well. Direct GP referrals to these services are increasing.** • **Whilst the total occupied bed days for patient stays "not-in-delay" has dropped by 5% the total occupied bed days for patient stays in delay (PHS definition), albeit a much smaller number, has increased by 26%. This diminishes the positive impact from the reduction in bed days for the stays that are "not-in-delay".** • **All 4 HSCPs reporting challenges due to lack of care home places and closure of in-patient beds.** • **Closure of Ward 74 (WGH) at the end of October to accommodate RIDU will further challenge bed availability.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading		

5185	**Access to Treatment** There is a significant risk that NHS Lothian will fail to achieve waiting time standards and that waits further increase for inpatient, day case procedures, Out-patients, diagnostic and cancer patients with demand exceeding capacity. This will lead to delay in diagnosis and potential progression of disease and hence poorer experience and outcomes for patients. New risk created from previous risks 3211 & 4191. Approved by June 2021 Board. Executive Lead: Jim Crombie Corporate objective: Scheduled care **Risk Response: Treat**	**<u>Healthcare Governance Committee</u>** – person-centred, safe, and effective care. **November 2024** • **Limited assurance accepted.** **<u>Strategic Planning and Performance Committee</u>** – Performance **May 2024** • **Limited assurance accepted.** ***Next to be presented January 2025*** **<u>Outcome of Executive Lead Discussions</u>** **September/October 2024** • Reporting of performance against waiting time standards is included in the Public Board Performance paper at every meeting for further information. • Performance will be impacted by financial constraints, both capital and revenue, with impact and mitigations included in the Annual Delivery Plan 2024/25 (ADP). This plan was approved by the Scottish Government in Quarter 1 of 2024. • Scheduled Care Trajectories were resubmitted to Scottish Government in August 2024 to reflect the additional activity predicted due to funding received (see July/August update). Scottish Government have indicated that they plan to write to NHS Lothian acknowledging the resubmitted trajectories in the next few weeks. • £2m of Detect Cancer Earlier (DCE) non-recurring revenue funding is available nationally to support local implementation of the National lung cancer and head and neck cancer optimal diagnostic pathways in 2024/25. Following submission of NHS Lothian bids on 26 July 2024, Scottish Government have asked for a prioritisation of requests due to the volume received and insufficient funding available. NHS Lothian confirmed prioritisation of original requests on 2 August 2024 and await confirmation of funding available/ bids to be supported. Further information will be provided to the Board via the Performance Paper presented to the Board meetings.

November / December 2024

		Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24
Outpatient	Over 52 weeks	8,729	9,918	11,366	12,566	13,787	13,882
	Trajectory			12,550			18,604
	Variance			-1,184			-4,722
	Over 78 weeks	1,636	2,141	2,539	2,659	3,188	3,268
	Trajectory			4,072			7,158
	Variance			-1,533			-3,890
	Over 104 weeks	52	77	128	245	343	498
	Trajectory			283			1,073
	Variance			-155			-575
Inpatient Daycase	Over 52 weeks	6,519	6,638	6,738	6,695	6,704	6,731
	Trajectory			7,901			7,872
	Variance			-1,163			-1,141
	Over 78 weeks	2,420	2,408	2,340	2,349	2,386	2,424
	Trajectory			3,240			3,258
	Variance			-900			-834
	Over 104 weeks	445	454	461	448	453	447
	Trajectory			631			662
	Variance			-170			-215

- **Further information performance against waiting time standards and ADP trajectories are included in the Public Board Performance paper at every meeting.**
- **The full impact of the temporary closure of PAEP on waiting times is still being worked through. Routine Ophthalmology activity will be significantly reduced during the initial 2-week period to enable transfer of equipment and staffing. However, urgent activity will be maintained. Impact will also be seen in Orthopaedics and ENT particularly given theatre matrix changes necessary to accommodate Ophthalmology.**
- **The temporary closure of theatres requiring repair at St John's Hospital in September resulted in the loss of 16.5 sessions per week, equating to 33-40 procedures but the full theatre matrix is currently under review due to move of Ophthalmology activity.**

	Risk Grading:	**CMT November 2024** **Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))	**CMT December 2024** **Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading		
5388	**HSDU Capacity** There is a risk that HSDU is unable to meet current or future capacity demands for theatre equipment due to physical space limitations of the current department and lack of staff with appropriate competence to maintain and repair key equipment leading to closure of operating theatres and subsequent cancellation of patient operations impacting on quality of patient experience. New risk approved by Board June 2022. Executive Lead: Jim Crombie Corporate objective: Capital **Risk Response: Treat**	**<u>Finance and Resources Committee</u>** **August 2024** • **Limited assurance accepted.** ***Update provided to every meeting alternating paper and verbal – next paper December 2024***	
		<u>Outcome of Executive Lead Discussions</u> **September/October 2024** • Re-provision project remains on hold. • Paper regarding the critical infrastructure has not reached completion. It is anticipated the paper will be completed by end September 2024. • Additional issues with steam pipework and supply are noted since the last update, however these have not caused major disruption to productivity. • The unit continues to support NHS Grampian with approximately 50 trays being processed per week. • Risk mitigation plan has been updated as part of the most recent formal corporate risk paper and was accepted by Finance & Resource Committee. **November / December 2024** • **Continued restrictions to Capital Budget is the longer term risk to the overall solution related to this risk (i.e. full reprovision of the HSDU).** • **Full detail surrounding the risk mitigations are contained within previous update papers. As above, funding is the primary risk along with complexities in PFI arrangements, particularly relating to asset upgrade works and futureproofing of the HSDU.**	
	Risk Grading:	**CMT November 2024** **Very High 20** (Likelihood: Certain (5) Impact: Major (4))	**CMT December 2024** **Very High 20** (Likelihood: Certain (5) Impact: Major (4))
	Target Risk Grading		

3828	**Nursing Workforce** There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and/or inability to recruit to specific posts. The subsequent high use of supplementary staffing to counteract shortfalls potentially leading to compromise of safe patient care impacting on length of stay and patient experience. Executive Lead: Alison MacDonald Corporate objective: Workforce **Risk Response: Treat**	**<u>Staff Governance Committee</u>** **October 2024** • **Moderate assurance accepted.** ***Next to be presented March 2025***	
		<u>Outcome of Executive Lead Discussions</u> **September/October 2024** • Still on track with expected new starts in coming months. • Vacancy gap in August was 6.71% which is expected as new starts come in towards the end of August. • Establishment gap of less than 5% is anticipated by the end of 2024. • There are recognised pockets of shortfall e.g. neonates, Melville unit, St Johns. • Continuing to host open days and engagement sessions with potential recruits. **November / December 2024** • **Vacancy gap now reduced to 5.6% with around 300 nurses and midwives still to start between November and January.** • **Continuing shortfall in Melville unit requiring supplementary staffing.** • **Health check reviews of establishments for inpatient areas will all be reported by December to enable improved control of deployment of staff.** • **Methodology being developed for community health check reviews.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		High 12 (Likelihood: Possible (3) Impact: Major (4))	**High 12** (Likelihood: Possible (3) Impact: Major (4))
	Target Risk Grading		

<table>
<tr><td>5020</td><td>Water Safety and Quality

There is a risk that Legionella may be present in water supplies to healthcare premises due to reduced or no usage of water in some areas during Covid pandemic, seasonal increase in water temperature and incomplete implementation of existing plans to improve systems of control around water safety and provide assurance through documented evidence.

This may lead to harm to patients, staff and the general public, potential prosecution under H&S law. In addition, the ability to remobilise services following Covid-19 will be affected where we are not able to demonstrate safety of water systems.

New risk approved by Board 12 August 2020.

Executive Lead: Jim Crombie

Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian

Risk Response: Treat</td><td colspan="2"><u>Staff Governance Committee</u>

December 2024
• Limited assurance accepted.

Next to be presented March 2025

<u>Outcome of Executive Lead Discussions</u>

September/October 2024
• Paper currently being drafted following proposed changes agreed by the Water Safety Group. This paper will review the risk description and mitigation plan to ensure alignment with the current risk profile.
• A paper instructing Consort to comply with Scottish Health Technical Memorandum (SHTM 04) is to be taken to the Water Safety Group for consideration.

November / December 2024
• Following discussions at the Water Safety Group and the NHS Lothian Health and Safety Committee it is now recommended that this risk can be re assessed and the grading reduced to medium with moderate assurance proposed.
• Controls around Water Safety have improved significantly, and this can be demonstrated via procedures and processes now in place.
• This will be considered at the Estates & Facilities Head of service meeting prior to presentation to January 2025 CMT for agreement to remove from the CRR and managing locally through Estates & Facilities Risk Register.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>CMT November 2024</td><td>CMT December 2024</td></tr>
<tr><td></td><td></td><td>High 12
(Likelihood: Possible (3) Impact: Major (4))</td><td>High 12
(Likelihood: Possible (3) Impact: Major (4))</td></tr>
<tr><td></td><td>Target Risk Grading</td><td></td><td></td></tr>
<tr><td colspan="4"></td></tr>
</table>

5189	**RIE Facilities** There is a risk that facilities in the RIE are not fit for purpose because of a failure to carry out required Life cycle Works and maintenance of the estate including: • Infrastructure (lifts, electrical systems, heating, ventilation, water, medical gases) • Water quality and management of water systems (flushing, temperature control, periodic testing) • Window safety and maintenance • Fire Safety Leading to interruption to services, potential harm to patients and staff and significant remedial costs. New risk approved by Board June 2021. Executive Lead: Jim Crombie Corporate objective: RIE **Risk Response: Treat**	**Finance & Resources Committee** **October 2024** • **Limited assurance accepted.** ***Update provided to every meeting alternating paper and verbal – next paper February 2025*** **Outcome of Executive Lead Discussions** **September/October 2024** • A wider review of this risk is yet to be established. This, however, is required to ensure this risk is fully updated and in line with the current risk profile. • A formal update paper will be required for the F&R Committee meeting of October 2024. **November / December 2024** • **This risk will be subject to further formal review with proposals for change to the risk description and mitigation plan elements. It is not perceived that this will necessarily lead to the suggestion of a change to risk grading or assurance level.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		High 15 (Likelihood: Possible (3) Impact: Extreme (5))	**High 15** (Likelihood: Possible (3) Impact: Extreme (5))
	Target Risk Grading		

<table>
<tr><td>3455</td><td>Violence & Aggression

The nature of services provided by NHS Lothian means there is a potential risk of violent and/or aggressive behaviour across all the organisation but in particular mental health, learning disability services and emergency departments resulting in harm to person and poor patient and staff experience, with potential prosecutions, and fines for health and safety breaches.

Executive Lead: Alison MacDonald

Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian

Risk Response: Treat</td><td colspan="2"><u>Staff Governance Committee</u>

October 2024
• Moderate assurance accepted.

Next to be presented March 2025

<u>Outcome of Executive Lead Discussions</u>

September/October
• Staff bank and REAS have successfully recruited and trained trainers and are making a significant impact with around 360 bank staff trained and in REAS around 280.
• Challenges remain in recruiting trainers in acute services and amongst medical staff, with the bulk being covered by nursing staff.
• A measurement evaluation framework has been developed and agreed by the H&S committee.
• Further work is underway to improve accuracy of purple pack completion, incorporating training needs analysis. Digital support is being explored to assist with this.

November / December 2024
• Continue to make good progress with training for staff bank and REAS.
• Challenges remain in recruiting work-based trainers therefore alternative solution are being explored.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>CMT November 2024
High 15
(Likelihood: Almost Certain (5) Impact: Moderate (3))</td><td>CMT December 2024
High 15
(Likelihood: Almost Certain (5) Impact: Moderate (3))</td></tr>
<tr><td></td><td>Target Risk Grading</td><td></td><td></td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>3328</td><td>Roadways/Traffic Management

There is a risk that the road traffic infrastructure on the 4 acute sites (RIE, St John’s, WGH, REH) is inadequate, due to the volume of traffic as a result of increased demand for parking plus</td><td colspan="2"><u>Staff Governance Committee</u>

December 2024
• Limited assurance accepted.

Next to be presented March 2025</td></tr>
</table>

	construction projects causing interruption to traffic flow. This impacts on access to services, increasing levels of staff abuse and the potential physical harm to staff, patients, and the public. Executive Lead: Jim Crombie Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian **Risk Response: Treat**	**<u>Outcome of Executive Lead Discussions</u>** **September/October 2024** • The afore noted review, carried out by Corporate Health & Safety (H&S) colleagues, has now concluded, and was discussed at CMT. This review contains a series of recommendations which will alter the detail of this Corporate Risk. • A paper will be drafted by Estates & Facilities for the Staff Governance Committee in October 2024 and CMT which will incorporate the recommendations from the H&S Team review. **November / December 2024** • **Adverse events are stable with no significant events recorded (verbal abuse to car parking staff and damage to NHS Lothian vehicles are the predominant categories reported). There is practical and visible evidence that the absence of significant adverse events and harm in these areas is attributed to the on-site Car Parking and Logistics teams.** • **Pan Lothian Car Parking Group maintains oversight of risks and actions – meets monthly.** • **Local Traffic Management Groups maintain oversight of local/site specific risks and actions.** • **The Corporate Health & Safety Team conducted a specific review of this risk (report available upon request). The review recommended downgrading 3 of the 4 components of the risk and setting up a specific SLWG to review and mitigate the remaining risk in relation to the RIE ED** • **CMT agreed to retain the risk on the corporate risk register.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		High 12 (Likelihood: Possible (3) Impact: Major (4))	**High 12** (Likelihood: Possible (3) Impact: Major (4))
	Target Risk Grading		
1076	**Healthcare Associated Infection** There is a risk of patients developing a preventable infection while receiving healthcare as a result of: • sub-optimal clinical practice • exposure to healthcare environmental	**<u>Healthcare Governance Committee</u>** **May 2024** • **Moderate assurance accepted.** ***Next to be presented May 2025***	
		<u>Outcome of Executive Lead Discussions</u>	

	hazards • patient to patient or staff to patient transmission due to inadequate or inconsistent implementation and monitoring of HAI prevention and control measures, leading to potential harm and poor experience for both staff and patients. Executive Lead: Alison MacDonald Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian **Risk Response: Treat**	**September/October 2024** • Revised risk description agreed by the Board at October meeting. • Internal audit on HAI governance and assurance is commence October. **November / December 2024** • **Additional resource has now been identified to develop and strengthen the risk mitigation plan with a focus on embedding governance and assurance lines across the organisation. This work will commence in early 2025 and will be informed by internal audit recommendations.** • **A data exceedance in line associated bacterium has been identified in one area and is currently being explored with the service.** • **ECB, SAB and CDI data is within control limits with overall performance better than or similar to other boards of comparable size and complexity.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		High 16 (Likelihood: Likely (4) Impact: Major (4))	**High 16** (Likelihood: Likely (4) Impact: Major (4))
	Target Risk Grading		
5322	**Cyber Security** There is a risk of cyber-attacks on clinical and business critical systems within NHS Lothian and interdependent third-party digital systems because of an increase in new threats including malware and ransomware which bypass most traditional defence systems, resulting in critical systems being unavailable, causing significant disruption to patient care, privacy and wider services.	**Audit and Risk Committee** **June 2024** • **Moderate assurance accepted.** **Board** **October 2024** • **Private Board accepted moderate assurance.** **Outcome of Executive Lead Discussions**	

	New risk approved by Board February 2022. Executive Lead: Tracey Gillies Corporate objective: Digital **Risk Response: Treat**	**September/October 2024** • Existing risk mitigation plan continues to be implemented. • A desktop cyber security exercise will be planned during the next quarter. **November / December 2024** • **Existing risk mitigation plan continues to be implemented.** • **This includes bi -weekly review of effectiveness of security measures in place in blocking and preventing external threats and implementing additional controls if required.** • **New locally and nationally procured security tools are reviewed on an ongoing basis and implemented where required.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		High 12 (Likelihood: Possible (3) Impact: Major (4))	**High 12** (Likelihood: Possible (3) Impact: Major (4))
	Target Risk Grading		
5510	**Royal Edinburgh Bed Occupancy** There is a risk that patients do not receive safe and effective care due to high levels of bed occupancy, leading to increased risk of harm, poor patient and staff experience and impacting on flow, leading to overcrowding, patients having to be boarded overnight in other specialities, being placed out of area, or sleeping in areas within wards not designed for this purpose. New risk approved by Board December 2022. Executive Lead: Caroline Hiscox Corporate objective: Mental health, illness, and wellbeing	**<u>Healthcare Governance Committee</u>** **January 2024** • **Limited assurance accepted.** ***Next to be presented January 2025***	
		<u>Outcome of Executive Lead Discussions</u> **September/October 2024** • Acute bed capacity has been even more constrained with ongoing pressure on inpatient beds. • Work continues with Edinburgh HSCP to look at alternatives to admission as our admissions per 100,000 of the population are very slightly higher than the National average 215 vs 200. • Current mitigations remain the same. **November / December 2024** • **Ongoing pressure on inpatient beds continues with occupancy remaining at above 100%.**	

	Risk Response: Treat	• **Current mitigations remain in place.** • **CMT has approved 12 additional beds for a 3-month period over the winter period, which are planned to open early January 2025.**	
	Risk Grading:	**CMT November 2024** **Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))	**CMT December 2024** **Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading		
5737	**Royal Infirmary of Edinburgh Fire Safety** Two components: 1. There is a risk that the technical standards of the building provided by the PFI are not adequate and do not meet current fire safety standards. 2. There is a consequential risk that NHS Lothian has inadequate fire safety arrangements in place at the Royal Infirmary of Edinburgh (RIE) following the recent identification of risks and issues. This may lead to enforcement action by the Scottish Fire & Rescue Service, disruption to services/facilities where remedial work is identified and finally serious reputational damage. In the unlikely event of a fire, this may lead to an extreme risk of harm to patients, staff, and the general public, along with the potential for prosecution under the Fire (Scotland) Act 2005 and Fire Safety (Scotland) Regulations 2006.	**<u>Staff Governance Committee</u>** **December 2024** • **Limited assurance accepted.** ***Next to be presented March 2025*** **<u>Outcome of Executive Lead Discussions</u>** **September/October 2024** • All actions under the responsibility of NHS Lothian were updated in Corporate Risk Reporting Paper issued to the Staff Governance Committee in July 2024 • No further significant update on points raised in August 2024, however it must be noted that progress continues on the risk mitigation actions associated with this risk. **November / December 2024** • **Full detail is contained within the risk mitigation plan of the associated corporate risk reporting paper. This plan, and associated actions, are overseen by the RIE Programme Director and Senior PFI Estates Lead.** • **A paper will be provided to a private Board session in December, incorporating further updates from the SFRS.** • **It is likely that further work will need to be undertaken in respect of the infrastructure starting in January 2025.**	

	New risk approved by Board December 2023. Executive Lead: Caroline Hiscox Corporate objective: RIE **Risk Response: Treat**		
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading		
5784	**Inappropriate and Inadequate Low Secure Accommodation in the Estate** There is a risk that patients who require low secure accommodation will be inappropriately placed because there is a lack of low secure accommodation for any patient in Lothian. This could potentially lead to harm to patients themselves, other patients, and staff as well as the potential for legal challenge against the level of security which is a risk to the organisation. Executive Lead: Caroline Hiscox Corporate objective: Mental health, illness and wellbeing **Risk Response: Treat**	**Healthcare Governance Committee** **July 2024** • **Moderate assurance accepted.** ***Next to be presented January 2025***	
		Outcome of Executive Lead Discussions **September/October 2024** • We continue with the contracts for out of area placements and are reviewing some of those patients to see if they are now able to be safely managed on REH campus. • Mitigations remain same with block booking contract in place with Ayr Clinic and Surehaven for three years from 1st July 2024. **November / December 2024** • **Current arrangements continue with out of area placements where required, including regular review of some patients with a view to caring for on REH campus where appropriate.** • **There is no change to the Scottish Government position regarding lack of capital funding.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**

		High 15 (Likelihood: Almost Certain (5) Impact: Moderate (3))	**High 15** (Likelihood: Almost Certain (5) Impact: Moderate (3))
	Target Risk Grading		
5785	**Absence of Female High Secure Accommodation in the Estate** There is a risk that female patients who require high secure accommodation will be inappropriately placed because there is a lack of female high secure accommodation in Scotland. This could potentially lead to harm to patients themselves, other patients, and staff as well as the potential for legal challenge against the level of security which is a risk to the organisation. Executive Lead: Caroline Hiscox Corporate objective: Mental health, illness and wellbeing **Risk Response: Treat**	**<u>Healthcare Governance Committee</u>** **July 2024** • **Limited assurance accepted.** ***Next to be presented January 2025***	
		<u>Outcome of Executive Lead Discussions</u> **September/October 2024** • We continue to wait on feedback from State Hospital and SG on plans to create a high secure on the state hospital campus and the current mitigations remain the same. **November / December 2024** • **No further feedback has been received regarding State hospital/Scottish government plans and the current mitigations remain in place.**	
	Risk Grading:	**CMT November 2024**	**CMT December 2024**
		High 12 (Likelihood: Possible (3) Impact: Major (4))	**High 12** (Likelihood: Possible (3) Impact: Major (4))
	Target Risk Grading		

Risks removed and rationale.

Risk ID	Opened	Risk Title	Recommendation	Rationale
4813	**23/07/19**	**Royal Hospital for Children & Young People/Dept of Clinical Neurosciences**	Board approved closing the risk as per 7 April 2021 Board Corporate Register Paper	Services will be fully operational by the end of March 2021.
4694	**04/04/19**	**Waste Management**	Board approved closing the risk as per 7 April 2021 Board Corporate Register Paper	This risk was accepted onto the CRR due to unforeseen external provider availability which resulted in additional financial risk and H&S issues. The financial risk has been addressed, a new contractor is in place and any residual service risk is being managed at an operational level with clear management oversight.
3527	**26/07/13**	**Medical Workforce**	Board approved closing the risk as per 7 April 2021 Board Corporate Register Paper	Aspect of the Medical Workforce within our control are being managed at an operational level and captured on operational risk registers.
4693	**04/04/2019**	**Brexit/EU exit**	Board approved closing the risk as per 1 December 2021 Board Corporate Register Paper	The potential risks have not materialised and will be kept under review nationally and locally.
3454	**13/02/2013**	**Learning from Complaints**	Board approved closing the risk as per 6 April 2022 Board Corporate Register Paper	The January 2022 Healthcare Governance accepted Moderate assurance with respect to management of complaints and the improvement plan that has recently been put in place along with the moderate risk grading. Given the level of grading and assurance, the CMT will be recommending to the Board that this risk be removed from the corporate risk register and be placed on the corporate nursing register for regular review.
5034	**29/06/2020**	**Care Homes**	Board approved closing the risk as per	The January 2022 Healthcare Governance accepted

Risk ID	Opened	Risk Title	Recommendation	Rationale
			9 February 2022 Board Corporate Register Paper	Moderate assurance with respect to management of complaints and the improvement plan that has recently been put in place along with the moderate risk grading. Given the level of grading and assurance, the CMT will be recommending to the Board that this risk be removed from the corporate risk register and be placed on the corporate nursing register for regular review. A paper in May 2022 will come to HGC setting out the proposed reporting schedule for complaints management as part of the wider Patient Experience Strategy reporting.
3189	**16/02/2012**	**Facilities Fit for Purpose**	Board approved closing the risk as per 3 August 2022 Board Corporate Register Paper	Formal risk mitigation plan now in place and accepted by F&R committee and CMT. F&R accepted moderate assurance at the 31 May 2022 meeting. Ongoing monitoring of risk mitigation plans will be through facilities operational management structures. The June 2022 CMT agreed reduction of grading to medium (9) likelihood – possible, impact moderate.
5187	**23/06/2021**	**Access to Psychological Therapies**	Board approved closing the risk as per 23 August 2023 Board Corporate Register Paper	The grading of the risk was reduced to medium (8) and removal from the CRR agreed due to continued improvement of performance leading to de-escalation by Scottish Government from level 3 to level 2. There is an agreed performance trajectory based on confirmed funding by SG plus a clear escalation process based on performance which is monitored through the Performance Oversight Board. The risk will remain on the REAS risk register for continued management and monitoring.
5188	**23/06/2021**	**Access to CAMHS**	Board approved closing the risk as per 23 August 2023 Board Corporate Register Paper	The grading of the risk was reduced to medium (8) and removal from the CRR agreed due to continued

Risk ID	Opened	Risk Title	Recommendation	Rationale
				improvement of performance leading to de-escalation by Scottish Government from level 3 to level 2. There is an agreed performance trajectory based on confirmed funding by SG plus a clear escalation process based on performance which is monitored through the Performance Oversight Board. The risk will remain on the REAS risk register for continued management and monitoring.
5360	**06/04/2022**	**Public Health (Covid-19)**	Board approved closing the risk as per 23 August 2023 Board Corporate Register Paper	It was agreed to stand down the COVID risk in line with national, UK and global direction. In May 2023, the WHO declared an end to COVID-19 as a global health emergency. The WHO noted that the pandemic had been on a downward trend over the last 12 months, with immunity increasing due to the highly effective vaccines. Death rates had decreased and the pressure on once overwhelmed health systems, had eased. The National Incident Management Team was stood down on 27th April 2023, in line with the other nations and the UK wide response. Reporting of COVID data was incorporated into business-as-usual reporting and moved to monthly publications.
5687	**21/08/2023**	**Inappropriate and Inadequate Accommodation in the Secure Estate**	Board approved closing the risk as per 24 April 2024 Board Corporate Register Paper	As different risks and mitigations were in place for high and low secure provision it was agreed that the risk should be closed and split into two risks: 1. New Risk - Inappropriate and Inadequate Low Secure Accommodation in the Estate 2. New Risk – Absence of Female High Secure Accommodation in the Estate
3829	**15/10/2015**	**Sustainability of Model of General Practice**	**Board approved closing the risk as per 10 October 2024 Board Corporate Register Paper**	**It was agreed to regrade the risk from high (12) to medium (9), based on a reduction of the impact from major to moderate. Furthermore, it was agreed that**

Risk ID	Opened	Risk Title	Recommendation	Rationale
				the risk is de-escalated to the Primary care services risk register and noted that it would continue to be included in HSCP risk registers. Although some challenges remain, particularly around funding to fully deliver Primary care improvement plans and increased costs for practices for facilities management services, these are being managed. Workforce supply is improving, and patients can access Primary care services.

NHS Lothian

14.

Meeting:	**NHS Lothian Board**
Meeting date:	**05 February 2025**
Title:	**Performance Report**
Responsible Executive:	**Jim Crombie, Deputy Chief Executive**
Report Author:	**Lauren Wands, Performance and Business Manager**

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☒	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☒
Primary Care	☒	Digital	☒
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☐	Effective	☒
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

This report is being provided for information to facilitate Board Member oversight across agreed metrics. Please note;

Performance Area	National Standard Compliance	ADP / Trajectory Compliance
Scheduled Care Outpatients	Not Met – Nov 2024	On track – Dec 2024
Scheduled Care Inpatients/Day cases	Not Met – Nov 2024	On track – Dec 2024
8 Key Diagnostic Tests - Endoscopy	Not Met – Dec 2024	On track – Dec 2024
8 Key Diagnostic Tests - Radiology	Not Met – Dec 2024	Off plan – Dec 2024
31-Day Cancer Performance	Not Met – Nov 2024	On track – Nov 2024
62-Day Cancer Performance	Not Met – Nov 2024	On track – Nov 2024
Accident and Emergency 4 Hour Performance	Not Met – Nov 2024	Off plan – Dec 2024
Delayed Discharges	N/A	N/A
IVF Waiting Times Performance	Met – Oct 2024	N/A
Early Access to Antenatal Services	Met – Oct 2024	N/A
Primary Care *General Practice Activity Measures*	N/A	N/A
Psychological Therapies Waiting Times Performance	Not Met – Nov 2024	Off plan – Nov 2024
CAMHS Waiting Times Performance	Not Met – Nov 2024	Off plan – Nov 2024
Smoking Cessation Performance	Not Met – Q1 2024/25	N/A

Members should note that an error was presented within the Radiology figures in the December 2024 performance report appendix. Details of the data which were presented, alongside the correct figures have been included in *Appendix 1*.

2.2 Background

The national **NHS Board Delivery Framework**[1] sets out the indicators for 2024/25 that NHS Boards should monitor when assessing impacts of their Delivery Plans to improve services for patients. The Scottish Government Planning and Delivery Cycle within this document sets out the expectation for monitoring NHS Lothians performance on a quarterly basis. These indicators have been included in the **NHS Lothian Annual Delivery Plan 2024/25** (ADP) and the quantitative indicators from this plan will be reported against at each Board meeting until June 2025. Additional local and national standards (LDP) have been included in the standard report. This will support Board level discussions on performance on a bi-monthly basis, with further performance reporting provided via the Boards Strategic Planning & Performance Committee.

The indicators included in this report are a high-level set of performance standards which are supported by a comprehensive framework of measures reviewed across existing committees, directorates and Health & Social Care Partnerships. These are reported to and monitored by the relevant responsible officers and their clinical and senior professional staff.

The **NHS Scotland Support and Intervention Framework**[2] is one of the key elements of the Scottish Government's approach to monitoring performance across NHS Scotland. The framework provides five stages of a 'ladder of escalation' that provides a model for

[1] https://www.wihb.scot.nhs.uk/wp-content/uploads/2023/12/Item-8.1.1-23-172-Appendix-1-ADP-NHS-Scotland-Delivery-Planning-Guidance-2024-25-BM-13.12.23.pdf
[2] https://www.gov.scot/publications/nhs-scotland-support-and-intervention-framework/

support and intervention by the Scottish Government. NHS Lothian is not currently escalated for any factors at Stage 3 or above; which is the stage at which boards are considered to require a higher level of support and oversight from Scottish Government and other senior external support.

2.3 Assessment

We, where possible and appropriate, use the identification of Special Cause Variation in our data to understand our performance. Where SPC charts are not deemed the most appropriate use of data, alternative charts and display mechanisms have been included in Appendix 1. Also included, where benchmarking data is available (for instance through nationally published datasets), an indication of compliance with those standards against NHS Scotland position.

2.3.1 Quality/ Patient Care

Healthcare Governance Committee (HCG) receive ongoing updates regarding quality and safety. In addition, it was agreed by HCG in March 2024 that the Patient Experience Team would provide an annual report in September each year detailing patient/service-user feedback and NHS Lothian's response and learning to this. The Patient Experience Strategic Plan Annual Report is available from the 17 September 2024 meeting.

2.3.2 Workforce

The most recent workforce report is available from Staff Governance Committee in October 2024. The next report will be available in January 2025.

2.3.3 Financial

There has been no confirmation of additional 'Winter Funding' nationally for 2024/25 to support flow and unscheduled care; this may impact service performance in late 2024/25. There has however been an allocation received from the Scottish Government to support unscheduled care improvement works which aim to improve whole system flow throughout the Lothian Health and Care System (LHCS).

In both CAMHS and Psychological Therapies, it has been forecast that due to the reduced financial envelope we should anticipate that the national 18-week standard will not be met moving forward.

NHS Lothian continues to wait for clarity over the future of nationally funded Capital Projects, which we would expect to provide resilient capacity for services in future years.

2.3.4 Risk Assessment/Management

Relevant Board Corporate Risks have been referenced in *Appendix 1*, with risk assessments and mitigation plans detailed at the appropriate Board Subcommittees at the required frequency. There are no additional factors included in this report which have not been recognised by these risks and therefore impact the previously reported risk grading and assurance level provided.

2.3.5 Equality and Diversity, including health inequalities

No specific decision(s) are being sought from this paper.

2.3.6 Other impacts

N/A.

2.3.7 Communication, involvement, engagement and consultation

With regards to the drafting of this summary of information for the Board, there has been no requirement to involve and engage external stakeholders, including patients and members of the public.

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Contributing Directors/Chiefs (CMT members), including Deputy Chief Executive Office the week of 19 November 2024.

2.4 Recommendation

- **Discussion** – Examine and consider the implications of the performance matters described in this paper.
- **Awareness** – For Members' information on compliance against performance standards and KPI's.
- **Awareness** – Members should note that an error was presented within the Radiology figures in the December 2024 performance report appendix. Details of the data which were presented, alongside the correct figures have been included in *Appendix 1*.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Lothian Board Performance Summary 2024/25

Appendix 1

NHS LOTHIAN BOARD PERFORMANCE SUMMARY

February 2024/25

Scheduled Care – 8 Key Diagnostic Tests

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**October 2024**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment – Very High

Radiology – 4 Key Diagnostic Tests

Data Included in the December 2024 Performance Report

KPI	Latest Performance (Oct 2024)	ADP Trajectory (Sept 24/25)	ADP Trajectory Forecast (end March 2025)
Total List Size	6377	4851	8808
Waits > 6 weeks	4433	4193	8374
Waits > 26 weeks	2226	2420	5435
Waits > 52 weeks	442	536	2178
% waits within 6 weeks	30.5%	N/A	N/A

Correct Data for the December 2024 Performance Report

KPI	Latest Performance (Oct 2024)	ADP Trajectory (Oct 24/25)	ADP Trajectory Forecast (end March 2025)
Total List Size	18347	14990	19490
Waits > 6 weeks	11797	12951	11075
Waits > 26 weeks	1264	0	5350
Waits > 52 weeks	191	0	0
% waits within 6 weeks	36%	N/A	N/A

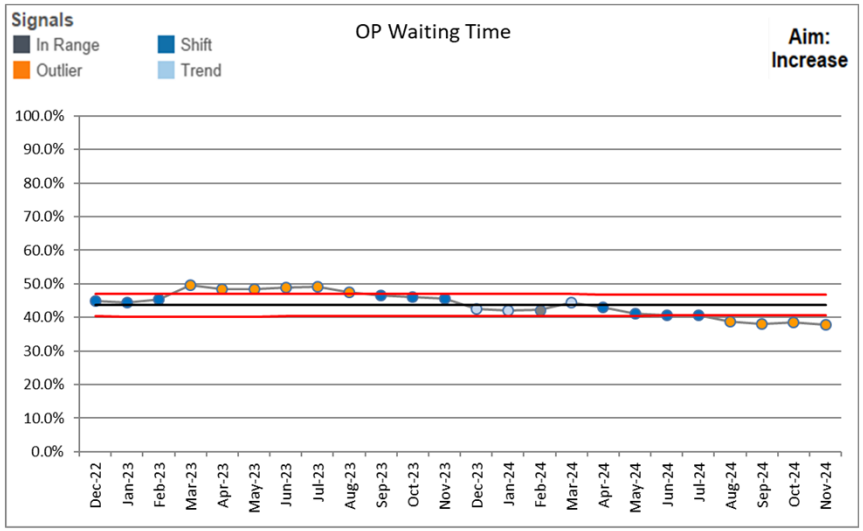
Overview 2024-25 NHS Lothian Board Indicators

Indicator	Linked to Corporate Risk	Performance vs ADP/Local Trajectory			Performance vs National		
		Latest Actual	ADP/Local Trajectory	Assurance for Delivery Against Standard/Trajectory by end of 2024/25	NHS Lothian Latest Published Performance	NHS Scotland Latest Published Performance	National Target/ Standard
12 Weeks 1st Outpatient Appointment (Local Delivery Plan (LDP) Standard)	5185 – Access to Treatment	37.9% (Nov 24)	N/A	Limited assurance – national standard	36.0% (Dec 24)	35.1% (Dec 24)	95%
Treatment Time Guarantee (Local Delivery Plan (LDP) Standard)	5185 – Access to Treatment	57.1% (Nov 24)	N/A	Limited assurance – national standard	55.3% (Dec 24)	58.6% (Dec 24)	100%
8 Key Diagnostic Tests - Endoscopy (ADP measure)	5185 – Access to Treatment	*Please see individual slide for breakdown.*					
8 Key Diagnostic Tests - Radiology (ADP measure)	5185 – Access to Treatment	*Please see individual slide for breakdown.*					
31 Day Cancer Performance (Local Delivery Plan (LDP) Standard)	5185 – Access to Treatment	94.3% (Nov 24)	93.2% (Q3 24/25)	Limited assurance – national standard	94.3% (Nov 24)	95.0% (Nov 24)	95%
62 Day Cancer Performance (Local Delivery Plan (LDP) Standard)	5185 – Access to Treatment	80.9% (Nov 24)	79.8% (Q3 24/25)	Limited assurance – national standard	80.9% (Nov 24)	73.3% (Nov 24)	95%
Accident and Emergency 4 Hour (Local Delivery Plan (LDP) Standard)	5186 – 4 Hours Emergency Access 3726 – Hospital Bed Occupancy	58% (Nov 24)	71% (Dec 24)	Limited assurance – national standard	58% (Nov 24)	65.1% (Nov 24)	95%
Delayed Discharges	5186 – 4 Hours Emergency Access 3726 – Hospital Bed Occupancy	252 (average)	N/A	Limited assurance	281 of 2,020 delays in Scotland (13.9%)		N/A
IVF Waiting Times Performance (Local Delivery Plan (LDP) Standard)	-	100%	N/A	Significant assurance – national standard	100%	100%	90%
Early Access to Antenatal Services *(Local Delivery Plan (LDP) Standard)*	-	91.27% (Oct 24)	N/A	Significant assurance – national standard	91.27% (Oct 24)	87.62% (Oct 24)	80%
Primary Care *General Practice Activity Measures*	-	*Please see individual slide for breakdown.*					
Psychological Therapies Waiting Times Performance (Local Delivery Plan (LDP) Standard)	-	79.5% (Nov 24)	80.3% (Nov 24)	Moderate assurance – trajectory by end 2024/25	79.5% (Nov 24)	78.8% (Nov 24)	90%
CAMHS Waiting Times Performance (Local Delivery Plan (LDP) Standard)	-	63.1% (Nov 24)	75.7% (Nov 24)	Limited assurance - trajectory by end 2024/25	63.1% (Nov 24)	90.1% (Nov 24)	90%
Smoking Cessation Performance (Local Delivery Plan (LDP) Standard)	-	61% (Apr – June 24)	180 / 295	Moderate assurance - against delivery by end March 2025	61% (Apr – Jun 2024)	11 of 14 Health Boards	295/295

Scheduled Care – New Outpatients

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**December 2024**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

12 Weeks 1st Outpatient Appointment - *(Local Delivery Plan (LDP) Standard)*



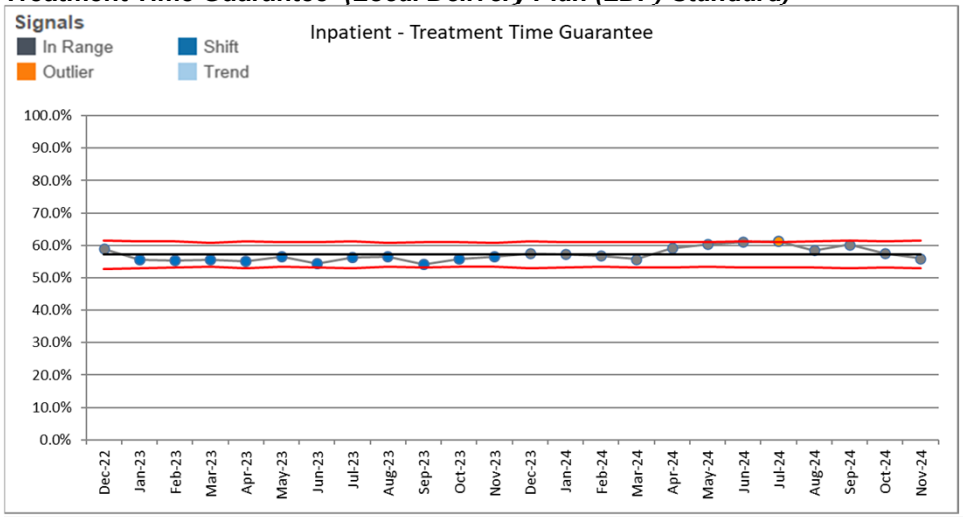
KPI	Latest Performance (December 2024)	ADP Trajectory (December 2024)	ADP Trajectory Forecast (end March 2025)	National Benchmarking (September 2024)
Total List Size	94,026	122,380	132,940	NHSL accounted for 17.1% of Scotland
Waits > 52 weeks	13,779	26,049	39,534	NHSL accounted for 21.7% of Scotland
Waits > 78 weeks	4,829	10,866	16,273	NHSL accounted for 21.6% of Scotland
Waits > 104 weeks	1,141	3,739	7,152	NHSL accounted for 13.3% of Scotland
95 per cent of patients to wait no longer than 12 weeks from referral (all sources) to a first outpatient appointment (measured on month end Census). ***(Waits <12 weeks at month end)***	37.9% (Nov 24)	N/A	N/A	39.0% Scotland Average

Summary	Actions	Assurance
Activity: Activity delivered in December 2024 was 5.9% below the projected plan, equating to -0.3% year to date (and 8.0% below last year to date). **Additions:** Additions to the waiting list are 3.8% lower overall for the year to date compared to last year. A shift in demand profile towards increasing Urgent and Urgent Suspicion of Cancer referrals in certain specialties has been articulated previously. **Long Waits:** All OP long wait areas (over 52, 78 & 104 weeks) are exceeding the ADP trajectory, although the numbers are, as projected, increasing.	• The Outpatient Redesign Programme is nearing completion with a focus on benefits realisation, embedding and increasing improvements, such as patient focused booking and patient initiated follow up. • Some additional outpatient activity is being delivered through further Scottish Government funding, and this is being closely monitored. • Waiting list validation is well underway. In last 3 months, 15,549 patients have been reviewed resulting in c 5,000 removals from the waiting list.	Limited assurance. Monitoring processes are in place through local Delivery Groups and a series of internal reports. 4

Scheduled Care - Treatment Time Guarantee

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**December 2024**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment – Very High

Treatment Time Guarantee- *(Local Delivery Plan (LDP) Standard)*



KPI	Latest Performance (December 2024)	ADP Trajectory (December 2024)	ADP Trajectory Forecast (end March 2025)	National Benchmarking (September 2024)
Total List Size	23,592	29,496	30,096	NHSL accounted for 15.4% of Scotland
Waits > 52 weeks	6,384	7,934	8,234	NHSL accounted for 17.6% of Scotland
Waits > 78 weeks	2,525	3,325	3,426	NHSL accounted for 13.9% of Scotland
Waits > 104 weeks	498	634	680	NHSL accounted for 6.8% of Scotland
100 per cent of patients to wait no longer than 12 weeks from the patient agreeing treatment with the hospital to treatment for inpatient or day case treatment. *(Waits <12 weeks at month end)*	57.1% (Nov 24)	N/A	N/A	57.1% Scotland Average

Summary	Actions	Assurance
Activity: Activity delivered in December 2024 was 11.3% below the projected plan, equating to 6.5% below year to date (and 7.8% below last year to date). **Additions:** Additions to the waiting list are 14.0% lower overall for the year to date compared to last year. **Long Waits:** The waiting list continues to decrease, with 2558 less patients compared to April 2024. All IPDC long wait areas (over 52, 78 & 104 weeks) are better than ADP trajectory. This position is, however, challenged in some specialties (including Orthopaedics and Plastics), and this is under close review.	• Performance is being closely managed through the Access Delivery Group and the Scheduled Care Delivery Board. • Steps have been taken to maximise utilisation of available capacity at the Fife NTC and Golden Jubilee Hospital with recent positive increases seen for both Orthopaedics and Ophthalmology. • Additional activity is being delivered with funding from Scottish Government, and this is being closely monitored. • The Inpatient Daycase Delivery Group continues to drive performance against the agreed KPIs and trajectories with a real focus on theatre utilisation and same day cancellations.	Limited assurance. Monitoring processes are in place through local Delivery Groups and a series of internal reports. 5

Scheduled Care – 8 Key Diagnostic Tests

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**December 2024**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment – Very High

Endoscopy – 4 Key Diagnostic Tests

KPI	Latest Performance (December 2024)	ADP Trajectory (December 2024)	ADP Trajectory Forecast (end March 2025)	National Benchmarking (December 2024)
Total List Size	7019	7,528	8,808	NHSL accounted for 20.4% of Scotland
Waits > 6 weeks	4929	6,805	8,374	NHSL accounted for 24.9% of Scotland
Waits > 26 weeks	2714	3,821	5,435	NHSL accounted for 28.9% of Scotland
Waits > 52 weeks	732	1,091	2,178	NHSL accounted for 19.1% of Scotland
% waits within 6 weeks	29.7%	N/A	N/A	39.9% Scotland Average

Summary	Actions	Assurance
The total waiting list size and those patients waiting over 6, 26 and 52 weeks are currently lower than the ADP trajectory, although showing significant increases compared to last year. Patients referred with a priority of Urgent Suspicion of Cancer (USoC), Bowel Screening and urgent high-risk surveillance patients are being prioritised. Urgent Suspicion of Cancer referrals are approximately 60% of all new referrals.	• Active clinical referral triage (ACRT) is in place with close review of all referrals and diverting to appropriate pathways. • Ringfencing of capacity is in place for urgent and high-risk surveillance patients. • Daily monitoring is in place to review and flex available capacity. • Revalidation of the waiting list is underway. 727 patients have already been validated with 25% moved to cytosponge and 12% removed from the waiting list.	Limited assurance

Scheduled Care – 8 Key Diagnostic Tests

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**December 2024**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment – Very High

Radiology – 4 Key Diagnostic Tests

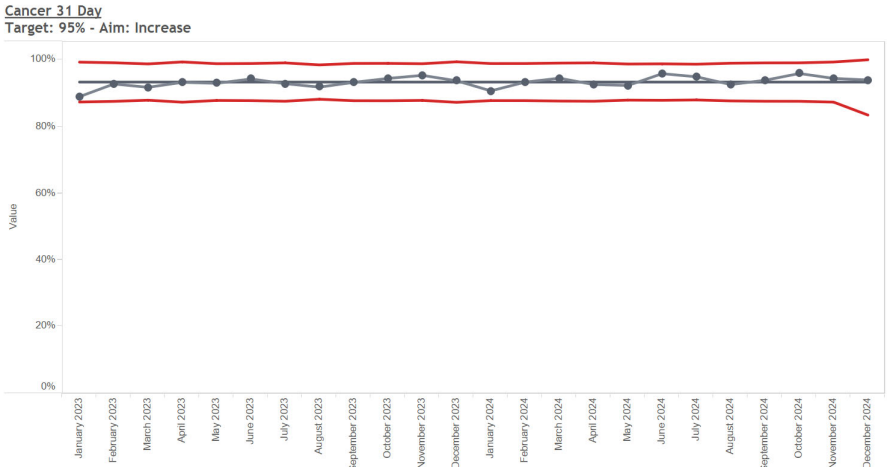
KPI	Latest Performance (December 2024)	ADP Trajectory (December 2024)	ADP Trajectory Forecast (end March 2025)	National Benchmarking (December 2024)
Total List Size	19,136	17,240	25,478	NHSL accounted for 19.8% of Scotland
Waits > 6 weeks	11,104	9325	17,894	NHSL accounted for 25.9% of Scotland
Waits > 26 weeks	1,465	3,600	4,977	NHSL accounted for 51.0% of Scotland
Waits > 52 weeks	38	0	0	NHSL accounted for 39.2% of Scotland
% waits within 6 weeks	41.9%	N/A	N/A	57.4% Scotland Average

Summary	Actions	Assurance
Areas of Note (as of 9th January 2025): • CT – 79 cases over 26 weeks • MRI – 737 cases over 26 weeks • General US – 462 cases over 26 weeks • Whilst performance against trajectory for >6 weeks is not as predicted; the trajectories were updated following receipt of additional funding and improved methodology used. Focus remains on driving down waits wherever possible. • As previously reported, process and TRAK system issues has resulted in some long waiting errors. These are being reviewed and corrected (reduced from 191 to 38) and changes implemented to prevent similar errors in the future. • Routine patients are experiencing waits of over 26 weeks. This has arisen from ongoing capacity restrictions in 2024/25.	Non-recurring monies have been assigned to support additional activity 24/25: • US scanning (sonographers, medical registrars and locum sonographers) • MR and CT additional evening and weekend outpatient scanning lists. £600k recurring funding has been recently confirmed via Scheduled Care which will provide 350 US scans, 243 MRI scans and 130 CT scans per month. This will be operational through short term staffing arrangements until April 2025 when permanent recruitment of staff will be completed.	Limited assurance Monitoring mechanism in place to proactively review and report on a weekly basis.

Scheduled Care – 31-Day Cancer Waiting Times

Responsible Director(s):	**Chief of Acute Services**	**Reporting Period:**	**November 2024 (Published Data)**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 – Access to Treatment – Very High

31-Day Cancer Performance - *(Local Delivery Plan (LDP) Standard)*



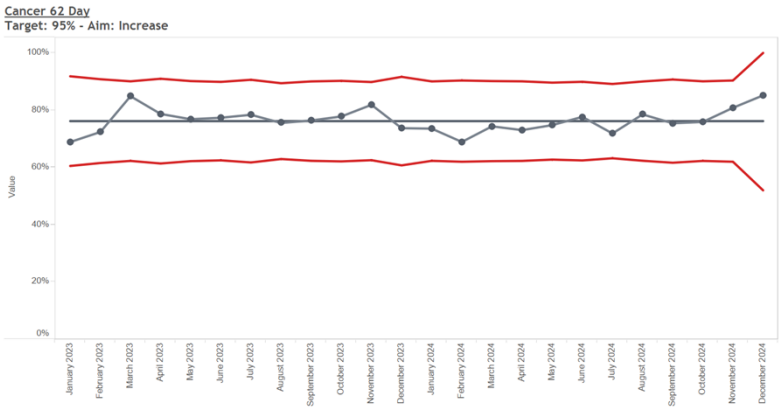
KPI	Latest Performance (November 2024)	ADP Trajectory (Q3 24/25)	ADP Trajectory Forecast (end March 2025)	National Benchmarking (Q3 2024)
95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	94.3%	93.2%	93.4%	95.0% Scotland average (Nov 2024)
Median 31-Day Wait	13 days	N/A	N/A	4 days
95th Percentile 31-Day Wait	70 days	N/A	N/A	34 days

Summary	Actions	Assurance
In November 2024, NHS Lothian treated 351 patients on 31-day pathways, of which 331 made their treatment target date. **Areas of note and drivers for this:** - Robotic Assisted Radical Prostatectomy (RARP) procedures have a substantial wait of around 5-6 months, meaning any patients for this procedure will breach at present. This has improved from a position of 6-8 months.	• NHSL Urology service is currently collaborating with NHS GG&C around utilising their surgeons within Lothian to treat patients. • Radiofrequency Ablation capacity is being increased via additions to theatre lists where Radiology support is available for Upper GI HPB. • Monitoring mechanisms in place to proactively review and support include the Weekly Patient Tracker List (PTL) meetings, Weekly Cancer Performance Huddle, Quarterly Performance Reviews and oversight through the Access & Delivery Group and Cancer & Diagnostics Delivery Group.	Limited assurance 8

Scheduled Care – 62-Day Cancer Waiting Times

Responsible Director(s):	**Chief of Acute Services**	**Reporting Period:**	**November 2024 (Published Data)**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 – Access to Treatment – Very High

62-Day Cancer Performance - *(Local Delivery Plan (LDP) Standard)*



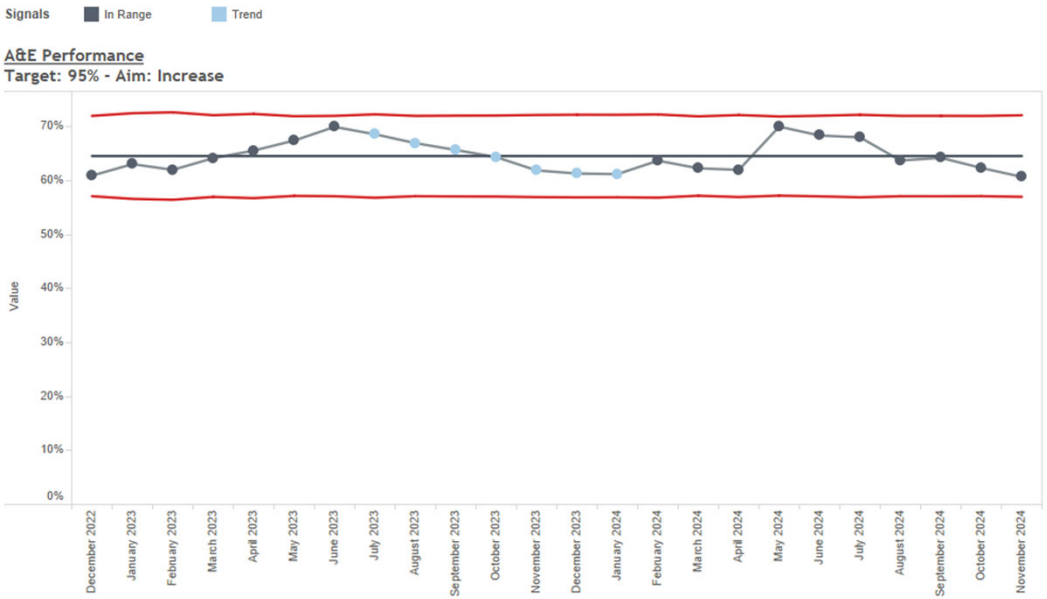
KPI	Latest Performance (November 2024)	ADP Trajectory (Q3 24/25)	ADP Trajectory Forecast (end March 2025)	National Benchmarking (Q3 2024)
95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.	80.9%	79.8%	79.3%	73.3% Scotland average (Nov 2024)
Median 62-Day Wait	57 days	N/A	N/A	49 days
95th Percentile 62-Day Wait	212.5 days	N/A	N/A	135 days

Summary	Actions	Assurance
In November 2024, NHS Lothian treated 236 patients on 62-day pathways, of which 191 made their treatment target date. **Areas of note and drivers for this:** • Urology Prostate diagnostic pathway currently has long waits for most pathway stages (Biopsy, OPD clinics, MRI, Oncology clinic), as well as Flexi Cystos for Urology Bladder patients. • Endoscopy waits are impacting the Colorectal diagnostic pathway, although the position has substantially improved over the last 12 months. Colorectal is also impacted by some Imaging delays.	• Increased internal Nursing training is being completed within Urology to improve resilience/capacity across the pathway steps. A new Consultant is starting in January with a Specialty Doctor role out to advert. • Additional Endoscopy and Radiology MRI lists are being run to reduce backlogs to improve waits for Colorectal and Urology. • Monitoring mechanisms are in place to proactively review and support include the Weekly Patient Tracker List (PTL) meetings, Weekly Cancer Performance Huddle, Quarterly Performance Reviews and oversight through the Access & Delivery Group and Cancer & Diagnostics Delivery Group.	Limited assurance • Consistently failing the target, with a current backlog of 67 confirmed breaches, although performance has improved over 2024. The service would require significant resource investment in Urology service clinical staff and maintaining/ improving in all other pathways to deliver 95%.

Unscheduled Care – 4-Hour A&E Performance

Responsible Director(s):	Chief of Acute Services, Unscheduled Care Programme Director, HSCP Chiefs	**Reporting Period:**	**November 2024**
Data Source:	PHS and Internal Management Information	**Linked Corporate Risk(s):**	Risk 5186 – 4-Hours Emergency Access Target (via HGC & SPPC) – Very High Risk 3726 – Hospital Bed Occupancy (via HGC & SPPC) – Very High

Accident and Emergency 4 Hour Performance - *(Local Delivery Plan (LDP) Standard)*



KPI	Latest Performance (November 2024)	Trajectory Forecast (December 2024)	National Benchmarking (November 2024)
95% of patients to wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment. Boards to work towards 98%. (all sites)	**58%**	**71%**	65.1% Scotland Average (12 of 14 Boards)
RHCYP	**86%**	**94%**	
RIE	**44%**	**65%**	
SJH	**55%**	**65%**	
WGH	**61%**	**65%**	

Unscheduled Care – 4-Hour A&E Performance

Responsible Director(s):	Chief of Acute Services, Unscheduled Care Programme Director, HSCP Chiefs	**Reporting Period:**	**November 2024**
Data Source:	PHS and Internal Management Information	**Linked Corporate Risk(s):**	Risk 5186 – 4-Hours Emergency Access Target (via HGC & SPPC) – Very High Risk 3726 – Hospital Bed Occupancy (via HGC & SPPC) – Very High

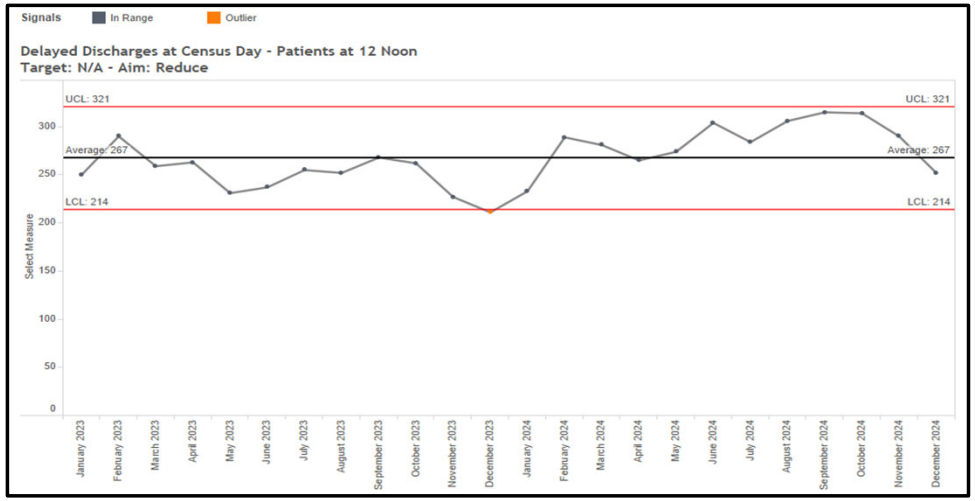
Accident and Emergency 4 Hour Performance - *(Local Delivery Plan (LDP) Standard)*

Summary	Actions	Assurance
Performance • The average 4-hr EAS performance Pan-Lothian in Nov 24 was 58%. • The average Pan-Lothian performance for non-admitted flow in Nov 24 is 68%. **Areas of Note and Drivers for Performance** Across all sites, issues related to high hospital occupancy and long waits for admitted patients (those requiring beds) spill over into the non-admitted flow, affecting the efficiency of other areas such as assessment units and emergency care.	**RIE** • Discharge Forum and Safe & Effective Patient Flow work streams are now consolidated as part of EAS Improvement Planning (focus on reducing LoS, PDD roll out, ESD, Discharge Lounge utilisation, Pre-noon discharges). • Winter planning priorities and funding agreed for 2024/25 – Implications of USC System Improvement SLWG. • Scheduling via FNC of Interface go-live on 20th January 2025. • Escalation framework is in place describing actions to address delays on Time to Triage or First Assessment. • Enhanced Frailty model in place at the front door. • Virtual Ward investigation into potential for reducing LoS. **WGH** • Manchester Triage Score has been introduced to reduce risk/ improve patient safety. • Steps being taken to reduce site occupancy - Flowthian, PDD, Promote Home First/D2A, LoS specialty improvement work, long Length of Stay group with Edinburgh HSCP. • Introduction of a Front Door frailty team. • Stress/distress work on inpatient wards and escalation for mental health capacity. • Surgical test of change - hot clinics to reduce the volume in SAU/use of day bed. • Promotion of D2A, Home First, improved signage/guidance for self-presenters and RACU. **SJH** • DwD programme: focus on PDD implementation across the site. • Focus on LoS work with weekly meetings reviewing over 14-day patients on site. • Redirection policy has been implemented with the aim to reduce unnecessary admissions. Focus on early triage enabling 12% redirection in Q3. • Winter pressure mitigation by having a 3rd Medical Consultant rostered on in response to current performance and concerns.	**At RIE** • Delays remain challenging across the site circa 152 (December 2024) with additional funding received by Scottish Government targeted to reduce these and overall occupancy. • Initiatives aimed at reducing admissions, such as the Interface Service for Direct GP, Frailty at the Front Door and Early Supported Discharge (ESD) in place and working well. • The PDD TRAK solution go-live on 29th January 2025 will support both the implementation of PDD principles across the site but also provide robust analytics for measuring success. **At WGH** • At WGH, discharge has increased by 35%, since 2023 when PDD work started on the site, and data continues to show the PDD process is embedded within phase 1 and 2 and continues to have an impact on the average Length of Stay (LoS). • Initiatives aimed at reducing admissions, such as the Rapid Assessment Care Unit (RACU) and Hospital at Home, are performing well. Direct GP referrals to these services are increasing. **At SJH** • The average Length of Stay (LoS) on wards with PDD implemented remains below what it was prior to the implementation work (average LoS of 8 days not in delay), however has increased from 5.9 to 6.5 average LoS currently. Whilst the introduction of PDD leads to a significant reduction in average LoS, maintaining some key components of the framework is linked to the improvement being sustained. • The Length of Stay programmes (Led by Site Directors) on the adult acute sites has been received positively by specialty teams and sites who are developing LoS action plans with each of the specialties that will be supported by the site leadership teams. **Limited Assurance:** The ability to deliver the mitigation plan to the full extent required to effect the necessary change remains a challenge. Ongoing difficulties in managing flow is a contributing factor.

Unscheduled Care – Delayed Discharges

Responsible Director(s):	Unscheduled Care Programme Director, HSCP Chiefs, Chief of Acute Service	**Reporting Period:**	**December 2024**
Data Source:	PHS and Internal Management Information	**Linked Corporate Risk(s):**	Risk 5186 – 4-Hours Emergency Access Target (via HGC & SPPC) – Very High Risk 3726 – Hospital Bed Occupancy (via HGC & SPPC) – Very High

Delayed Discharges at Census Day (all sites):



KPI	Latest Performance (December 2024)	Trajectory (2024/25)	National Benchmarking (November 2024)
Total Delayed Discharges (Lothian)	**252**	N/A	NHSL accounted for 13.9% of Scotland
Delays at monthly census point per 100,000 18+ East Lothian HSCP	**25.3**	34.6 total delays per 100,000 adults	-
Delays at monthly census point per 100,000 18+ Edinburgh HSCP	**36.1**		-
Delays at monthly census point per 100,000 18+ Midlothian HSCP	**33.5**		-
Delays at monthly census point per 100,000 18+ West Lothian HSCP	**33.8**		-

Unscheduled Care – Delayed Discharges

Responsible Director(s):	Unscheduled Care Programme Director, HSCP Chiefs, Chief of Acute Service	**Reporting Period:**	**December 2024**
Data Source:	PHS and Internal Management Information	**Linked Corporate Risk(s):**	Risk 5186 – 4-Hours Emergency Access Target (via HGC & SPPC) – Very High Risk 3726 – Hospital Bed Occupancy (via HGC & SPPC) – Very High

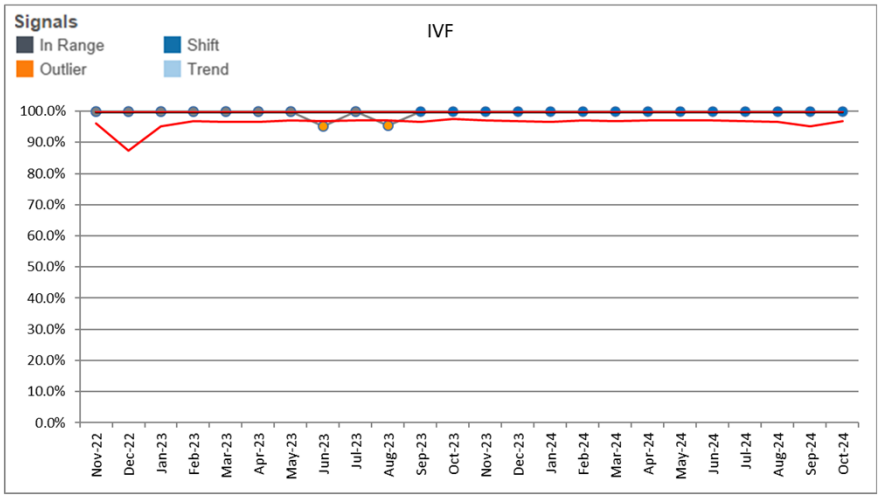
Delayed Discharges at Census Day (all sites):

Summary	Actions	Assurance
Edinburgh Health and Social Care Partnership Key Challenges: Increased delayed discharges mainly due to lack of care home capacity in and around Edinburgh at the National Care Home Rate. This has resulted from the closure of an external care home in May 2024. Financial pressures are restricting increasing capacity. **West Lothian Health and Social Care Partnership** Key Challenges: Increase in delayed discharges due to lack of care home places, especially for dementia care. **East Lothian Health and Social Care Partnership** Key Challenges: Continue to be challenged by high numbers of delayed discharge but balanced with 85-90% occupancy and maintaining flow. **Midlothian Health and Social Care Partnership** Key Challenges: Delays due to lack of care home beds, increasing population, and financial pressures.	**Edinburgh HSCP** Mitigating Actions: Opened 10 nursing care home beds, with 10 more planned for December 2024, alongside medium-term plans to right-size reablement functions, enhance care home brokerage, expand Hospital at Home, and conduct regular capacity huddles. **West Lothian HSCP** Mitigating Actions: Ongoing development of assessment processes and focus on discharge to assess, short-term improvement plan and enhancements at St John's front door, Single Point of Contact development with MDT response to support admission avoidance in appropriate circumstances. Enhancing intermediate care by bringing together health and social care teams under a single access point to minimise duplication, boost efficiency/capacity and create a shared understanding of assessment, demand and streamlined response. Additional 8 dementia HBCCC beds are operating over winter period. **East Lothian HSCP** Mitigating Actions: Continuous monitoring of bed occupancy and discharge figures, expanded the In-Reach team at Royal Infirmary of Edinburgh adding in a flow team. East Lothian Care at Home Huddle continues. Additional shared MDT screening is taking place focused on optimising length of stay (LoS) with the objective of looking at alternatives to hospital admission. There continue to be opportunities to reduce LoS in Acute and shared feedback and learning continues. **Midlothian HSCP** Mitigating Actions: Continued monitoring of Midlothian residents within Bed Based Services using Midlothian's Flow App to proactively identify and triage patients who could be pulled into Home First services for assessment and ongoing rehabilitation. Continued collaboration with Acute seeking solutions to prevent admission and facilitate earlier appropriate discharge. After a fluctuating delays position in October 2024 due to reduced availability of care home beds, some improvement in the delays position was seen in November 2024. However, there are still signs of fluctuation, so it is not yet a stable position. A Delays Improvement Plan is in place to mitigate for this. A review of Home First services is also ongoing. This transformational project aims to maximise clinical capacity through streamlining, improved scheduling of activity, and reduced duplication across the Home First services.	• Health and Social Care Partnerships (HSCPs) continue to implement a range of measures to improve patient flow and care delivery, including - discharge-to-assess models, single points of contact, and streamlined assessment processes designed to expedite hospital discharges. • Intermediate care services have been expanded, with enhanced care-at-home options and additional dementia-specific resources, including new HBCCC beds introduced to address winter demand. • Monitoring tools such as a digital Flow App and the CRAG data are being utilised to manage bed usage and associated risks effectively. • To address capacity challenges, HSCPs have introduced initiatives such as In-Reach teams, Care at Home Huddles and Delays Improvement Plans. • Notably, 10 new nursing care home beds have been opened, with plans for 10 more by December 2024, alongside medium-term strategies focused on reablement, care home brokerage, and expanded Hospital at Home services. **Limited assurance can be given however in relation to;** • The ability to deliver the mitigation plan to the full extent required to effect the necessary change. • Even if the mitigation plan is fully delivered, it still may be insufficient to improve performance to the extent of achieving the 4-hour Emergency Access Standard and consistent bed occupancy levels.

Fertility & Pregnancy– IVF Waiting Times

Responsible Director(s):	**Chief of Acute Services**	**Reporting Period:**	**October 2024**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	N/A

IVF Waiting Times Performance *(Local Delivery Plan (LDP) Standard)*:



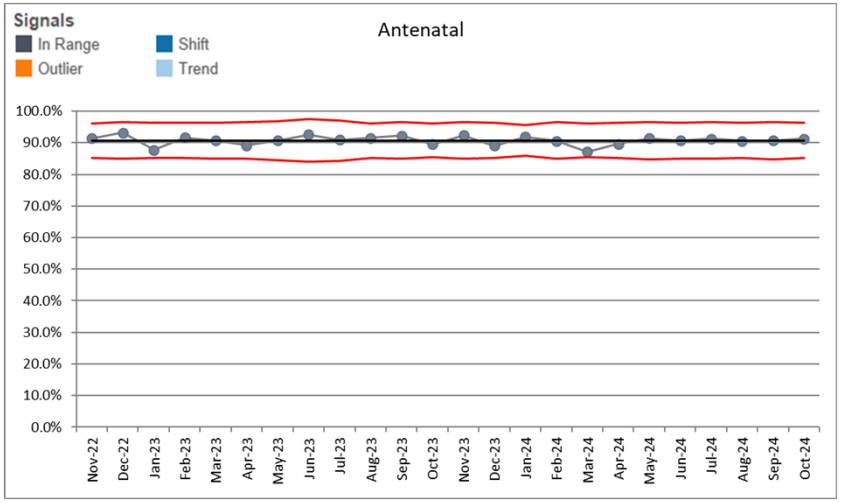
KPI	Latest Performance (October 2024)	National Standard/ Target	National Benchmarking (Q2 2024/25)
90% of eligible patients to commence IVF treatment within 12 months of referral.	100%	90%	100% Scotland Average

Summary	Actions	Assurance
Compliance with the target has been consistent over the past 24 months, with only single figure breaches noted which did not result in a failure to comply with the performance standard. No patient has breached the 12-month target since August 2023.	Monitoring is ongoing via monthly reporting; however, no current actions are in place or outstanding.	Significant As noted, compliance with the standard has been consistent over the past 24 months. Monthly reporting maintains an appropriate level of monitoring and individual breaches of the standard are investigated.

Fertility & Pregnancy– Antenatal Access

Responsible Director(s):	**Chief of Acute Services**	**Reporting Period:**	**October 2024**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	N/A

Early Access to Antenatal Services *(Local Delivery Plan (LDP) Standard)*:



KPI	Latest Performance October 2024	National Benchmarking 2023 (full year)
At least 80% of pregnant women in each SIMD (Scottish Index of Multiple Deprivation) quintile will have booked for antenatal care by the 12th week of gestation.	SIMD 1: 91.84% SIMD 2: 92.70% SIMD 3: 87.86% SIMD 4: 93.33% SIMD 5: 90.40% Overall, 91.27% in Oct 24	SIMD 1: 86.5% SIMD 5: 94.9%

Summary	Actions	Assurance
Antenatal access for all SIMD categories remains above the target and broadly in line with national averages. At no point over the last 24 months has booking dropped below this standard.	Ongoing monitoring of booking is in place and any unexpected changes are discussed by the Service Management team. No current actions are outstanding.	Significant As noted, no breaches in the standard have been recorded over the past 24 months. Monitoring is ongoing via a monthly report with any unexpected changes being escalated to the Service Management team for review and action.

Primary Care

Responsible Director(s):	**Director Primary Care**	**Reporting Period:**	December 2024
Data Source:	DataLoch & Adastra	**Linked Corporate Risk(s):**	N/A

Measure	**Latest position**
Estimated General Practice (in hours) activity	For w/c 30 December 2024, there were an estimated 52,514 patient consultations across the 116 General Practices in Lothian. This is significantly lower than the median weekly activity due to the festive public holidays when GP practices were closed. The full working weeks within December show activity is within normal variation.
General Practice Out-of-Hours (LUCS) activity	For w/c 30 December LUCS managed 3,548 patient consultations. This is significantly above the weekly mean of 2,526 due to the festive public holidays when LUCS was operational and is in line with seasonal fluctuations in demand. To note 24/25 festive patient demand was reduced compared with 23/24 demand.
Closed Practice Lists	2 practices (out of 116) have closed lists to new patients. The maximum number of practices with closed lists within the last 12 months has been 5.

Summary	**Notes**
Chart A provides an indication of General Practice in-hours (8am-6pm, Monday-Friday) direct patient activity (all clinical staff) across Lothian based upon a sample of the 66 practices where data reporting is robust. Chart B provides the Lothian GP Out-of-Hours (LUCS) activity. The charts clearly show the seasonal fluctuations and the impact of public holidays – the spikes in LUCS activity represent public holidays and show the inverse of in-hours General Practice activity. Activity levels are largely stable and within normal variation.	Direct encounters are defined as a direct contact with a patient by any member of the general practice clinical multi-disciplinary team: face to face surgery consultation, telephone, video, clinic, home visit, e-consultation. Records entered by admin staff are excluded. These figures for Lothian have been estimated based on general practice activity from a sample of 66 GP practices. Please note this sample represents approx. 56% of the Lothian GP practice registered patients. Figures should be interpreted with caution and only used as a general indication of level of activity.

Primary Care (2)

Chart A provides an indication of General Practice in-hours (8am-6pm, Monday-Friday) weekly direct patient activity (all clinical staff) across Lothian

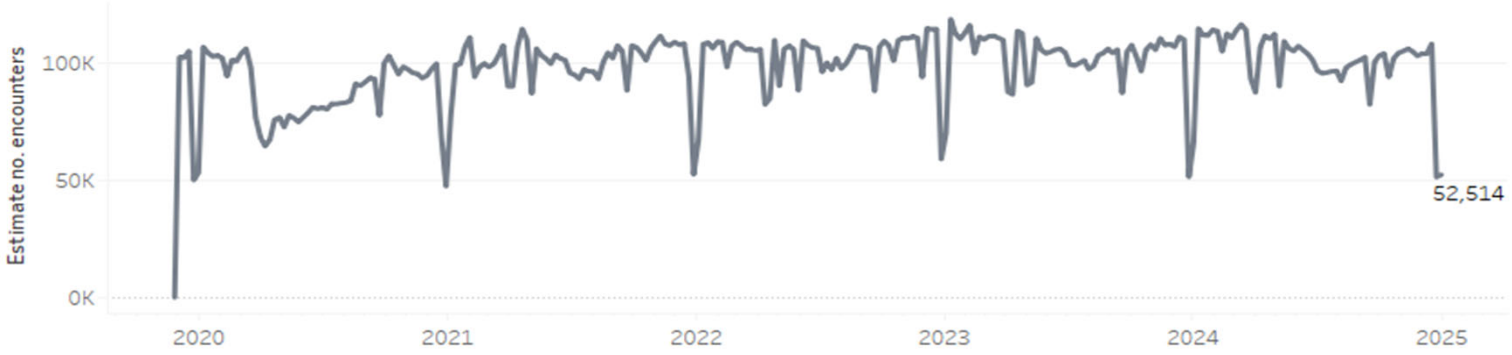
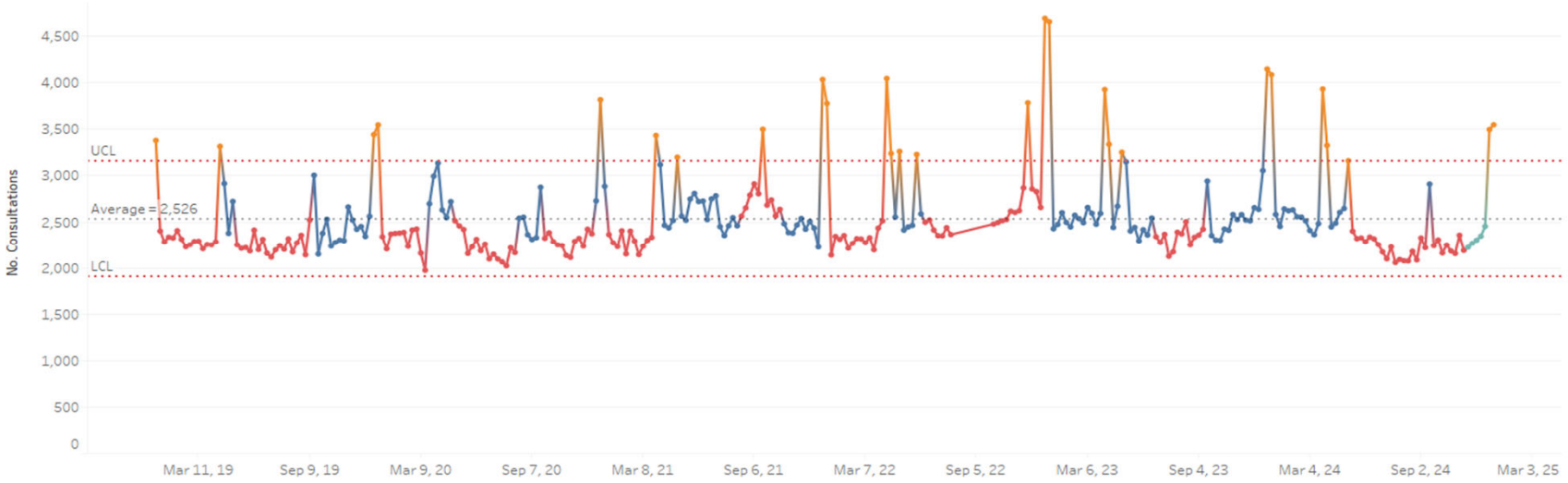


Chart B provides the Lothian GP Out-of-Hours (LUCS) weekly service activity

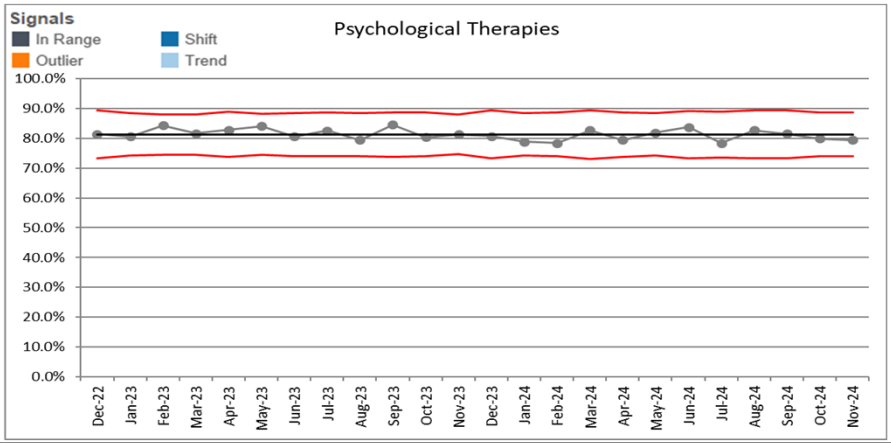


NOTES:
There was an outage of the clinical management system (Adastra) over August to September 2022. Data for that period is not available in this format.

Mental Health – Psychological Therapies

Responsible Director(s):	**REAS Services Director**	**Reporting Period:**	**November 2024**
Data Source:	PHS and internal management	**Linked Corporate Risk(s):**	N/A – removed from CRR in August 2023

Psychological Therapies Waiting Times Performance - *(Local Delivery Plan (LDP) Standard)*



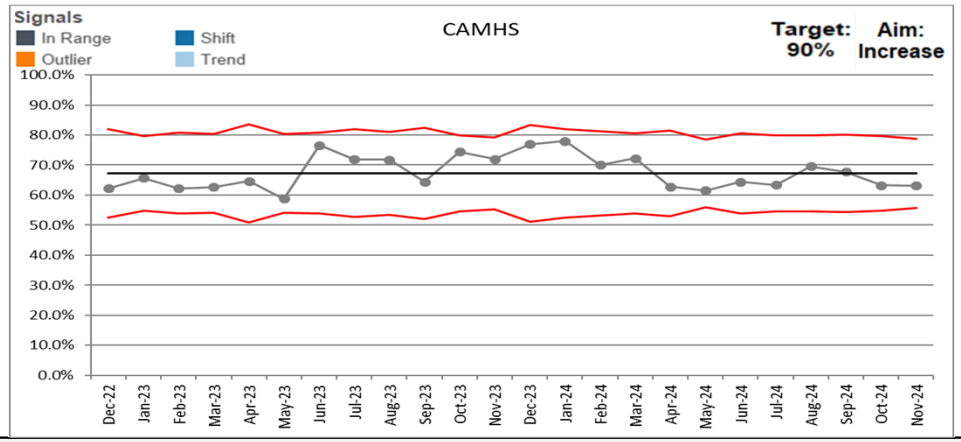
KPI	Latest Performance (November 2024)	Trajectory (November 2024)	Trajectory Forecast (end March 2025)	National Benchmarking (November 2024)
90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral.	79.5%	80.3%	82%	78.8% Scotland Average
Total Waits	4056	2392	2364	NHSL accounted for 16.6% of Scotland
Waits > 52 weeks	62	49	32	NHSL accounted for 1.5% of Scotland

Summary	Actions	Assurance
The treatment waiting list remained relatively static since the last quarter from 4042 (September 2024) to 4056 (November 2024). The growth in wait times was anticipated and reflects the increased unfilled vacancies across the services. Due to reduced Mental Health Outcome Framework funding and historic reliance on slippage which is no longer available, Psychology are required to reduce the current workforce in order to reach financial balance moving forward. Several individual AMH Psychology services have recently met the 18-week target; however this will not be sustained. Encouragingly the longest waits, have reduced in the last quarter from 81 to 62 patients currently waiting >52 weeks. Moving forward, there may be increased pressure on general Psychological Therapy Services across the four HSCP's due to the reductions in workforce and the reconfiguration of the Psychology Staff Support Service and Veteran's First Point. We are currently reviewing how we can support these populations as a profession within statutory services.	There is a requirement to reorganise staffing to fit within the current financial envelope. There are robust processes in place with monthly waiting list meetings ensuring all service leads can highlight issues in data and access the support required for ensuring accuracy of wait lists and capacity plans at both individual and team level. Following service reconfiguration, there will be a deep dive into the job plan modelling and capacity planning to inform future trajectories. There are ongoing requirements from eHealth to support TRAK builds and the fixing of historic errors that continue to impact the accurate recording of activity.	We anticipate that we will not meet the LDP standard within the next five years due to current capacity and projected financial impact. The national target is for 90% of patients to start treatment within 18 weeks; however, our average remains around 80%. The Psychology SMT conducts ongoing monthly reviews of performance across all services to identify areas requiring additional support or facing challenges, and to understand their impact on the broader Lothian picture. There is moderate assurance that adequate controls are in place even though we will not currently meet the standard. 18

Mental Health – CAMHS

Responsible Director(s):	**REAS Services Director**	**Reporting Period:**	**November 2024**
Data Source:	PHS and internal management	**Linked Corporate Risk(s):**	N/A – removed from CRR in August 2023

CAMHS Waiting Times Performance - *(Local Delivery Plan (LDP) Standard)*



KPI	Latest Performance (November 2024)	Trajectory (November 2024)	Trajectory Forecast (end March 2025)	National Benchmarking (November 2024)
90 per cent of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.	63.1%	75.7%	77.9%	90.1% Scotland Average
Total Waits	1801	1472	1591	NHSL accounted for 42.0% of Scotland
Waits > 52 weeks	78	65	61	NHSL accounted for 61.4% of Scotland

Summary

Across all CAMHS Lothian, the overall performance for the LDP standard is at 67% (November 2024). This has remained static since the last report (September 2024) and there continues to be a focus on allocating priority to clinically urgent and longest waiting patients. Overall, there were a total of 1,801 patients waiting at the end of November 2024, an increase from 1,720 patients waiting in September 2024.

At the end of November 2024, 604 patients were waiting >18 weeks with 78 patients waiting > 52 weeks – this compares to the end of October 2024 with 622 patients waiting > 18 weeks and 55 patients waiting > 52 weeks.

In comparison with March 2021, the number of patients who waited more than 18 weeks was 2161; this is a reduction of 72% on the November 2024 figures.

In the previous 12 months, average treatment demand has been 95 – this compares to 119 across the previous 6 months.

CAPA job planning process is subject to a 3 monthly planning cycle and undergoes constant refinement. In the quarter to the end of December 2024 it is expected that the delivery of job plans will exceed 100% across the teams with progress to the end of November of 93% achieved. Work is ongoing with the Scottish Government to review job plans & compare to other Boards. We are also looking at CAPTND to see if there are any learning opportunities for Lothian.

Due to reduction in MHOF funding, we are required to reduce the workforce and this will impact access to CAMHS.

Actions

- Being able to retain staff to sustain capacity remains a critical factor for ongoing performance to meet the LDP standard and measures to support staff and promote wellbeing for all teams are in place to balance performance expectations.
- Weekly waiting times compliance meetings are taking place between CSM/SM.
- Ongoing monitoring and review of job plans and the ongoing financial position.
- Reviewing capacity across all 5 outpatient teams and plan for capacity is to be re-directed to the West Lothian team to recover over 52 week waits.
- Enhancing the group treatment programme in the West Lothian team to treat higher numbers of CYP to support reduction of over 52 week waits.
- Meeting with colleagues in Glasgow to review potential differences in treatment pathways.

Assurance

Limited assurance

It is currently anticipated that the target will not be met with staffing levels due to reduced funding having affected service wait times performance.

We are able to offer moderate assurance on continued management of performance despite not being able to meet the standard within current financial envelope.

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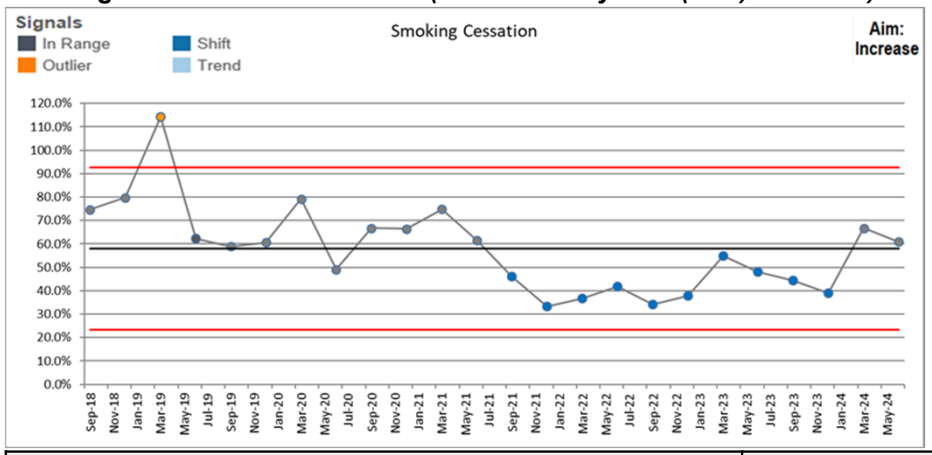
Public Health – Smoking Cessation

Responsible Director(s):	Director of Public Health & Health Policy	**Reporting Period:**	**Q1 2024/25**
Data Source:	Published PHS Data	**Linked Corporate Risk(s):**	N/A

Smoking Cessation Performance - *(Local Delivery Plan (LDP) Standard)*



KPI	Latest Performance (Apr – Jun 2024)	Trajectory (Q1 2024/25)	Trajectory Forecast (end March 2025)	National Benchmarking (latest Q1 2024/25)
NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40 per cent most deprived SIMD areas (60 per cent in the Island Boards)	61%	180/295	295/295	11 of 14 Health Boards. NHS Board performance against their annual LDP Standard ranged from 39.5% to 128%.

Summary	Actions	Assurance
49.5% of the ADP target was achieved in 2023-24. QYW performance targets are modelled 50:50 between Specialist community/acute quits and Community Pharmacy quits. Note seasonal variation in quits for Q4 (Jan to March) is consistently higher. Specialist community and acute quit numbers are improving and quit numbers have been above Scotland average and were among the better performing NHS Boards for 2023-24. Community Pharmacy quit numbers have declined since Q2 2021-22. This is a national trend however NHS Lothian performance was low compared to other NHS Boards. The last two quarters however are higher than previous comparable quarters	Quality improvement plans for Edinburgh and community pharmacy are being implemented. Varenicline is now available on a prescription from specialist QYW in conjunction with GPs. A new Patient Group Direction (PGD) is being developed to allow community pharmacies to prescribe Varenicline. Public Health and Health Policy Population Health Senior Leadership Team and Senior Management Team receive bi-annual updates on performance.	Moderate level of assurance against delivery by the end of March 2025 due to consistently failing to meet the target.

Additional Information

Data & Definitions

- Published data and definitions are available: https://publichealthscotland.scot/publications/
- The median wait is the middle value; for example the middle of referral to treatment days (62-day) or decision to treat to treatment days (31-day).
- A percentile is the value of a variable below which a certain percent of observations fall. For example, the 95th percentile is the value (referral to treatment days [62-day cancer] or decision to treat to treatment days [31-day cancer]) below which 95 percent of the waits may be found. The 50th percentile is also known as the median.

Glossary of Common Terminology and Acronyms

- AMU (Acute Medical Unit)
- AHP (Allied Health Professional)
- CNS (Clinical Nurse Specialist)
- DTOC (Delayed Transfer of Care)
- DNA (Did Not Attend)
- LoS (Length of Stay)
- MDT (Multi-Disciplinary Team)
- SMT (Senior Management Team)
- SG (Scottish Government)
- OP (Outpatient)
- IPDC (Inpatients & Day Cases)
- RARP (Robotic Assisted Radical Prostatectomy)
- WTE (Whole Time Equivalent)
- SDEC (Same Day Emergency Care) / RACU (Rapid Access Care Unit)
- QYW (Quit Your Way – smoking support service)
- CAPA (Choice & Partnership Approach - Job Planning)