NHS Lothian Board

Wed 25 June 2025, 10:30 - 12:30

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

Agenda

10:30 - 10:33
3 min

1. Welcome

Verbal *John Connaghan*

10:33 - 10:34
1 min

2. Apologies for Absence

Verbal *John Connaghan*

10:34 - 10:35
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

10:35 - 10:40
5 min

4. Items proposed for Approval or Noting without further discussion

Decision *John Connaghan*

4.1. Minutes of Previous Board Meeting - 16 April 2025

For Approval *John Connaghan*

4.1 16-04-25 Public Board Minutes (Draft to Meeting).pdf (10 pages)

4.2. Finance & Resources Committee Minutes - 26 March 2025

For Noting *Martin Connor*

4.2 Finance and Resources Committee Minutes - 26 March 2025.pdf (6 pages)

4.3. Healthcare Governance Committee Minutes - 18 March 2025

For Noting *Andrew Cogan*

4.3 Healthcare Governance Committee Minutes - 18 March 2025.pdf (7 pages)

4.4. Staff Governance Committee Minutes - 03 April 2025

For Noting *Val de Souza*

4.4 Staff Governance Minutes - 3 April 2025.pdf (4 pages)

4.5. Audit and Risk Committee Minutes - 14 April 2025

For Noting *Jonathan Blazeby*

4.5 Audit and Risk Committee Minutes - 14 April 2025.pdf (7 pages)

4.6. Midlothian Integration Joint Board Minutes - 20 February 2025

For Noting *Val de Souza*

4.6 Midlothian IJB Minutes 20-02-25.pdf (16 pages)

4.7. Edinburgh Integration Joint Board Minutes - 25 March 2025

For Noting *Katharina Kasper*

4.7 Edinburgh IJB Minutes 25-03-2025.pdf (4 pages)

4.8. West Lothian Integration Joint Board Minutes - 20 March 2025

For Noting *Martin Connor*

4.8 West Lothian IJB Minutes 20-03-25.pdf (6 pages)

4.9. East Lothian Integration Joint Board Minutes - 20 March 2025

For Noting *Andrew Cogan*

4.9 East Lothian IJB Minutes 20-03-25.pdf (9 pages)

4.10. NHS Lothian Resilience Framework

For Approval *Caroline Hiscox*

4.10 NHS Lothian Resilience Framework.pdf (22 pages)

4.11. Quarter 4 and Annual Whistleblowing Performance Report 2024/25

For Noting *Tom Power*

4.11 Quarter 4 & Annual Whistleblowing Performance Report 2024-25 (Inc. Appendices).pdf (16 pages)

4.12. Pharmacy Practices Committee - Terms of Reference Review

For Approval *Tracey Mckigen*

4.12 Pharmacy Practices Committee Terms of Reference.pdf (5 pages)

4.13. Board Appointments

For Approval *Darren Thompson*

4.13 Board Appointments.pdf (4 pages)

Items for Discussion

10:40 - 10:45
5 min

5. Board Chair's Report - June 2025

Verbal *John Connaghan*

10:45 - 10:55
10 min

6. Chief Executive's Report - June 2025

Discussion *Caroline Hiscox*

6. Board Chief Executive's Report.pdf (8 pages)

10:55 - 11:00
5 min

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

Verbal *John Connaghan*

11:00 - 11:20
20 min

8. NHS Lothian Board Performance Paper

Discussion *Jim Crombie*

8. Performance Report (Inc. Appendix).pdf (27 pages)

11:20 - 11:30
10 min

9. LSDF Annual Report

Discussion *Colin Briggs*

11:30 - 11:40
10 min

Break

11:40 - 11:45
5 min

10. NHS Lothian Corporate Objectives 2025/26

Discussion *Caroline Hiscox*

10. Corporate Objectives 2025-26 (Inc. Appendix).pdf (8 pages)

11:45 - 11:55
10 min

11. Corporate Risk Register

Discussion *Tracey Gillies*

11. Corporate Risk Register.pdf (28 pages)

11:55 - 12:05
10 min

12. Quality Report and Annual Plan

Discussion *Tracey Gillies*

12. Quality Report and Annual Plan (Inc. Appendices).pdf (81 pages)

12:05 - 12:15
10 min

13. 2024/25 Financial Outturn Position

Discussion *Craig Marriott*

13. 2024-25 Financial Outturn Position.pdf (10 pages)

12:15 - 12:25
10 min

14. Scottish Hospitals Inquiry (SHI) Interim Report

Discussion *Craig Marriott*

14. Scottish Hospitals Inquiry Update (Inc. Appendix).pdf (27 pages)

12:25 - 12:27
2 min

15. Any Other Business

Verbal *John Connaghan*

12:27 - 12:29
2 min

16. Reflections on the Meeting

Verbal *John Connaghan*

12:29 - 12:30
1 min

17. 2025 Meeting Dates

For Noting *John Connaghan*

- **13 August 2025**

- **08 October 2025**
- **03 December 2025 (10.30am start)**

DRAFT **4.1**

LOTHIAN NHS BOARD

Minutes of the meeting of Lothian NHS Board held at 09.00am on Wednesday 16 April 2025 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 E. Balfour; Mr J. Blazeby; Dr P. Cantley; Cllr H. Cartmill; Ms E. Gordon; Mr G. Gordon; Mrs K. Kasper; Prof A. Khan; Mr P. Knight; Prof. L. Marson and Cllr D. Milligan.

Executive Board Members: Prof. C. Hiscox (Chief Executive); Miss T. Gillies (Executive Medical Director); Mr C. Marriott (Director of Finance) and Ms D. Milne (Director of Public Health and Health Policy).

In Attendance: Mr J. Crombie (Deputy Chief Executive); Mr T. Power (Director of People & Culture); Ms M. Carr (Chief Officer, Acute Services)(from 10am); Miss F. Ireland (Nurse Director – Corporate Nursing); Dr J. Long (Director of Innovation & Transformation); Ms T. McKigen (Director of Primary Care); Ms J. Mackay (Director of Communications & Public Engagement); Ms M. Campbell (Director of Estates & Facilities); Ms M. Barrow (Chief Officer, Midlothian IJB); Mr D. Thompson (Board Secretary) and Mr C. Graham (Corporate Governance Team, minutes).

Apologies for Absence: Cllr S. Akhtar (Non-Executive Board Member); Mr P. Allenby (Non-Executive Board Member); Mr C. Briggs (Director of Strategic Planning); Mr A. Cogan (Non-Executive Board Member); Mr M. Connor (Non-Executive Board Member); Prof J. Innes (Non-Executive Board Member); Ms A. MacDonald (Executive Nurse Director); Ms T. A. Miller (Non-Executive Board Member); Ms V. de Souza (Non-Executive Board Member); Ms A. White (Chief Officer, West Lothian IJB) and Ms F. Wilson (Chief Officer, East Lothian IJB).

1. Welcome & Declaration of Interests

1.1 The Chair welcomed members, colleagues, and observers to the Board meeting. The Chair also welcomed Mr Tom Power, Director of People and Culture to his first meeting.

Retiral, Director of Public Health & Health Policy

1.2 The Board noted the forthcoming retirement of Dona Milne, Director of Public Health & Health Policy, with effect from 30 June 2025. The Chair, on behalf of the Board, expressed sincere thanks and appreciation for Ms Milne's significant contribution to the NHS over 24 years of service and particularly for her leadership during the Covid-19 pandemic. The Board extended its best wishes to Ms Milne. It was noted that a recruitment process had concluded, and that a formal announcement would follow in due course.

1.3 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.

ITEMS FOR APPROVAL OR NOTING

2. Items proposed for Approval or Noting without further discussion

2.1 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.

2.2 Minutes of Previous Board Meeting held on 05 February 2025 – Minutes were approved.

2.3 Finance & Resources Committee Minutes – 18 December 2024 & 12 February 2025 – Minutes were noted.

2.4 Healthcare Governance Committee Minutes – 28 January 2025 – Minutes were noted.

2.5 Staff Governance Committee Minutes – 11 December 2024 – Minutes were noted.

2.6 Audit and Risk Committee Minutes – 18 November 2024 – Minutes were noted.

2.7 Midlothian Integration Joint Board Minutes – 19 December 2024 – Minutes were noted.

2.8 Edinburgh Integration Joint Board Minutes – 1 November & 17 December 2024 and 25 February 2025 – Minutes were noted.

2.9 West Lothian Integration Joint Board Minutes – 26 November 2024 & 11 February 2025 – Minutes were noted.

2.10 East Lothian Integration Joint Board Minutes – 19 December 2024 & 20 February 2025– Minutes were noted.

2.11 Appointment of Internal Auditor – The Board noted the process undertaken to identify and appoint a new supplier of internal audit services for four years from 1 April 2025, including short term arrangements agreed with the current supplier, Grant Thornton, to bridge the short time between 1 April 2025 and the Board's formal appointment decision. The Board approved the appointment of BDO as the external supplier of internal audit services to NHS Lothian, as recommended by the Audit and Risk Committee at its meeting on 17 February 2025.

2.12 Health and Care (Staffing) (Scotland) Act 2019, Annual & Quarter 4 Report - The Board accepted the report as meeting the legislative requirement under the Act to receive an annual report. The Board noted that the annual report must cover all NHS functions and professional disciplines, and was based on the Scottish Government's own assurance format and template. The annual report also served as the Q4 Board Compliance Report.

The Board accepted Moderate Assurance on how NHS Lothian was meeting its legal duties under the 2019 Act, based on the Scottish Government's "Reasonable Assurance" rating. The report would be submitted to Scottish Ministers on 30 April 2025 and then published by NHS Lothian.

2.13 Pharmacy Practices Committee Outcomes – Quarter 4 Annual Report 2024/25 – Outcomes were noted.

2.14 Pharmaceutical Services Hours of Service Scheme paper - The Board approved the proposed revised Hours of Service Scheme for Community Pharmacy, as detailed within the paper circulated.

2.15 National Whistleblowing Standards – Quarter 3 2024/25 Performance Report - The content of the Quarter 3 2024/25 Whistleblowing Performance report was noted. The Board accepted moderate assurance that systems and process were in place to help create a culture in NHS Lothian which ensured staff had confidence in the fairness and objectivity of the procedure through which concerns were raised and acted upon and took significant assurance that the performance report met the requirement of the Standards.

2.16 Appointment of Members to Integration Joint Boards and Pharmacy Practices Committee – The Board approved the following extensions, reappointments and appointments to Integration Joint Boards and the Pharmacy Practices Committee:

- Extend (retrospectively) the current IJB terms for the following non-executives, reflecting their reappointments to the Board:
  - Elizabeth Gordon (East Lothian and Edinburgh) until 24 June 2025
  - Peter Knight (Edinburgh) until 30 April 2025
  - Val De Souza (Midlothian) until 31 July 2025
- Reappointment of Elizabeth Gordon as a Voting Member of the East Lothian IJB, from 25 June 2025 (for a further 3-year term).
- Reappointment of Peter Knight as a Voting Member of the Edinburgh IJB, from 1 May 2025 (for a further 3-year term).
- Reappointment of Val De Souza to as the Lead Voting Member of the Midlothian IJB, from 1 August 2025 (for a further 3-year term).
- Reappointment of George Gordon as a Voting Member of the Edinburgh and West Lothian IJBs, from 15 May 2025 to 31 December 2026.
- Appointment of Rebecca Grieve (Primary Care Pharmacist, NE EHSCP) and Rocio Toribio (Primary Care Pharmacist, NW EHSCP) as Non-Contractor Pharmacists, to the Pharmacy Practices Committee, for three-year terms from 16 April 2025 to 15 April 2028.

2.17 Review of NHS Lothian Board Operating Guidance - The Board noted its suite of Operating Guidance, accepting significant assurance that this met the requirements of the Blueprint for Good Governance. The Board formally approve revisions proposed to its Standing Financial Instructions and Scheme of Delegation, on the recommendation of the Audit and Risk Committee and formally approve the Terms of Reference for each of its standing committees, noting that each committee has reviewed its Terms of Reference during the year and adopted changes where necessary.

ITEMS FOR DISCUSSION

3. Board Chair's Report – April 2025

3.1 The Chair highlighted the following:

- Two new non-executive board members had been identified following the conclusion of a recent recruitment round in early March. However, necessary pre-appointment checks being undertaken by the Scottish Government, relating to new PVG disclosure requirements, had caused an unanticipated delay in finalising the appointments.
- NHS Board Leadership & Collaboration group – the establishment of the group was welcomed and there would be further discussion on this and the duality of NHS Lothian's role in that perspective, later on the agenda (Item 12).

4. Chief Executive's Report – April 2025

4.1 The Chief Executive introduced her report, highlighting a number of key items within this, including:

- **Veterans First Point Lothian** - A redesigned service delivery model had been introduced from 1 April 2025, following appropriate engagement with service users. Details had been communicated to the Scottish Government, although confirmation of funding allocations for 2025/26 was awaited. A revised standard operating procedure for financial decision-making was being developed and would be considered by the Finance and Resources Committee.

- **Princess Alexandra Eye Pavilion (PAEP) –** The timescale for the recommissioning and return of services to the PAEP site was communicated and was now expected to be achieved in early June. No overspend against the original funding envelope was anticipated. All pre-existing services would return to the PAEP, although an opportunity had been identified to retain an Intravitreal Treatment (IVT) service within East Lothian, which would benefit patients locally.

- **Annual Delivery Plan (ADP) –** The ADP remained in draft form as funding confirmation was awaited from Scottish Government. There would be further consideration of the ADP at the next Strategy, Planning & Performance Committee (SPPC) meeting before it came back to the June Board meeting for final approval.

- **Corporate Office Accommodation –** Due to the decision of Scottish Ministers not to approve NHS Education Scotland's intended lease extension at West Port, NHS Lothian was required to identify alternative corporate office accommodation in the near future. An updated business case would be provided to the Finance and Resources Committee and the Director of People and Culture would be the Senior Responsible Officer for the project.

- **Lothian Unscheduled Care Service (LUCS) – Review of Service –** Staff had been notified and the review would commence in April, with recommendations expected in July. Reporting would be through the LSDF Primary Care Programme Board and Corporate Management Team. Assurance on LUCS was also reported annually to Healthcare Governance Committee.

- **Celebrating Success Awards 2025 –** It was noted that over 500 nominations had been received this year. The Board welcomed the intention to return to an in-person event.

- **Mrs Cathie Lackie –** The Board formally acknowledged Mrs Lackie's 58 years' of service to NHS Lothian and her recent retirement at the age of 90. The Chief Executive had written to Mrs Lackie, thanking her for her contribution.

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

- **Finance & Resources Committee** – In March, the Committee had received an update on delivery of the NHS Scotland Climate Emergency and Sustainability Strategy 2022-2026 and on progress in relation to the NHS Lothian Sustainable Development Framework and Action Plan. The Committee had noted strong ambitions in this area but also the challenges arising due to financial constraints. The Committee planned to arrange a development session on these matters and an invitation would be extended to all board members in due course.

The Committee had also considered the Scottish Hospitals Inquiry (SHI) interim report with respect to the Royal Hospital for Children and Young People/Department of Clinical Neurosciences (RHCYP/DCN). The recommendations would be considered carefully with a view to ensuring that those most relevant to NHS Lothian were implemented in an efficient and effective manner. There would be a further report to the Board in June.

6. NHS Lothian Board Performance Report

6.1 The Deputy Chief Executive presented the Board Performance Report, reminding members of the underpinning frameworks that informed the collation of performance information and noting that the Board had been escalated to Stage 3 of the NHS Scotland Support and Intervention Framework in relation to mental health performance.

6.2 Despite success in meeting planned outpatient trajectories for March 2025, there remained a high volume of outpatients waiting, including those beyond 52 and 104 weeks. Achievement of the Treatment Time Guarantee (TTG) also remained challenging. Discussions were ongoing with the Scottish Government about the level of additional financial resource required to support achievement of its target to eliminate outpatient waits over 52 weeks by March 2026. Progress was being made against the targets for Key Diagnostic Tests but there continued to be delays, with impacts on patients. Whilst compliance with 32-day cancer waiting times was at 90.5%, the 62-day target had been poorer, reaching 71% in January.

6.3 It was reported that additional investment in Unscheduled Care to improve system flow had generated positive system impact, although increases in presentations and acuity at the RIE seemed to have caused further challenge. A further update on this improvement programme would come to the Strategy, Planning & Performance Committee (SPPC).

6.4 The Board discussed the report, seeking further information on a range of the performance data provided. It was requested that, alongside the Annual Delivery Plan, the next iteration of the Performance Report at SPPC should include TTG performance by speciality and reconcile the 2024/25 TTG position against the previous year, in order to understand the overall scale of change.

6.5 Board members wished to understand the process of Waiting List Validation and sought assurance that there was no risk of patients being removed from lists without appropriate clinical input and oversight. It was explained that the process followed Scottish Government guidance, and that appropriate clinical oversight and triage processes were applied. NHS Lothian's approach had also been subject to external scrutiny from the Centre for Sustainable Delivery (CfSD) and no unacceptable risks had been identified. It was confirmed that any patients contacted who expressed uncertainty about their ongoing need were not removed from waiting lists on this basis.

6.6 Members also sought assurance on the extent to which NHS Lothian had access to National Treatment Centre (NTC) capacity, to address capacity issues (e.g., in Ophthalmology). It was confirmed that NHS Lothian was making significant use of the Golden Jubilee capacity available but that there remained challenges in accessing the NHS Fife NTC capacity due to the acceptance criteria being applied. Discussions on this were ongoing with the Scottish Government and the CfSD.

6.7 The Board noted both the implications of the performance matters described and NHS Lothian's current levels of compliance against national performance standards and KPIs.

7. Corporate Risk Register

7.1 The Board received NHS Lothian's Corporate Risk Register, reviewing the February 2025 updates provided by the executive leads concerning risk mitigation, as set out in the assurance table within the report appendix.

7.2 The Executive Medical Director drew the Board's attention to the risks to be removed from the register, reminding members that work in individual teams did not stop when the risk has been removed and the risk may come back onto the Register in future with a different description, especially around nursing workforce. This approach was part of the risk register being more dynamic, avoiding having risks at the highest level for years with no way to mitigate and reduce such risks adequately. The next phase of approach to risk would be to think about how to separate out risks and be clearer around overall purpose, function and escalation on to the register. There was also work to be done around the development of the Board Assurance Framework.

7.3 The Board noted the following:

- The target risk gradings, which had been agreed by CMT where possible, based on a revised process noted at the February Board meeting.
- That management actions agreed in the internal audit report of the Corporate Risk Register process had now been implemented.
  The overview of changes applied to the CRR over the past two calendar years in Table 1 of the paper.

7.4 The Board agreed that the undernoted risks should be removed from the CRR:

- #5020 - Water safety and quality
- #3828 - Nursing workforce
- #5784 - Inappropriate and Inadequate Low Secure Accommodation in the Estate

8. Capital Prioritisation Process

8.1 The Director of Finance provided a verbal update, covering the established process and the latest iteration of the prioritisation rankings.

8.2 The Board noted that there was no substantial movement in rankings, however there was an anticipated movement of some category B projects into category A. Any escalated projects would be brought back to the Board for update. There was not the capital investment that had been hoped for and some of the capital programmes were now out of date. These were now being reviewed by the National Infrastructure Board which met last week, and which both the Director of Finance and Director of Strategic Planning sat on. There was a bidding process underway, for available sustainability funding, as part of the national "business continuity planning" approach set out by the Scottish Government. There would be ongoing updates at the Finance and Resources Committee and information would come back formally to the Board in December and SPPC in November 2025.

8.3 There was discussion on the availability of national sustainability funding and opportunities, the 'buckets' of available funding and backlog maintenance. The Board noted the update and the dates for future reporting.

9. NHS Lothian February 2025 Financial Position

9.1 The Director of Finance provided the Board with an update on NHS Lothian's financial position as at February 2025, along with the forecast position for 2024/25.

9.2 There was discussion on the Month 11 performance to get to a point of breakeven, concerns around non-pay overspend, drugs, supplies and GP prescribing issues along with the unknown impact of the Agenda for Change (AfC) Band 5 to 6 review that was part of the reduced working week programme.

9.3 The Board noted that the work with the external auditors had commenced and would be ongoing over the next couple of months to progress and conclude the preparation of the annual accounts. First impressions indicated a strong set of financial results.

9.4 The Board welcomed the positive financial position to the end of February 2025. Despite a noted £2.7m overspend at that point, there was some confidence and a level of assurance that the Board would deliver a deliver breakeven financial position for 2024/25.

10. 5 Year Financial Plan 2025/26 – 2029/30

10.1 The Director of Finance outlined to the Board the final update of the NHS Lothian Financial Plan for the next five years, with a specific focus on the financial outlook for 2025/26.

10.2 The Board noted the positive news that this was a balanced financial plan for 2025/26, which was not always the case at this point in time. There was discussion on the Scottish Government's desire to get as many Boards to financial balance as possible, the release of non-recurring sustainability funding, move away from brokerage arrangements, pressures on the system, the expected 3% financial recovery plans, the recent AfC pay offer and workforce costs. There was also discussion on the implications around weight loss drug costs.

10.3 The Board noted that:

- based on information currently available, NHS Lothian was able to provide moderate assurance on its ability to deliver a balanced financial position in 2025/26.
- the balanced financial position in 2025/26 was subject to delivery of 3% Financial Recovery Plans with £48m identified and a target of £16m included.
- for a delivery of a reduction to baseline pressures in the Financial Plan, Business Units must deliver their 3% Financial Recovery Plans target and these must be recurring.
- included in the Risk Register at Appendix 3 was the significant new financial risk, on the basis Scottish Government have confirmed additional performance and improvement funding would not be allocated if agreed outcomes are not met.

10.4 The Board approved the Financial Plan, noting prior approval by the Scottish Government and endorsement by the Finance and Resources Committee on 26 March 2025.

11. Corporate Objectives 2025/26

11.1 The Board received the paper setting out its Corporate Objectives for the year 2025/26, noting the expectation that the Board would work with its wider System Leadership cohort to ensure that the Corporate Objectives reflected the need for transformation within the system.

11.2 The Chief Executive explained that the objectives would be refined further, alongside the development of the Annual Delivery Plan, but that endorsement was being sought for the direction of travel. NHS Lothian had been on an improvement journey around the Corporate Objectives over the past few years and there was now clear line of sight from the strategic intent of the Lothian Strategic Development Framework (LSDF) through the Corporate and Executive Objectives, into the NHS Lothian system.

11.3 There was discussion on the Corporate Objectives and on the extent to which they covered all activity required during 2025/26 to progress the ambitions of the LSDF. Board members sought to understand how successful delivery would be measured and reported, particularly in relation to those objectives concerned with people and culture. It was confirmed that these corporate objectives would be supported by and triangulated against wider, underpinning objectives and metrics. In regard to early years outcomes, members sought reassurance that there were appropriate linkages to wider and non-health related outcomes, such as housing and education. It was explained that integrated Children's Services Plans existed, as part of the Board's statutory obligations, with input from the integration partners.

11.4 It was suggested and agreed that the ongoing development and implementation of the proposed Board Assurance Framework should be explicitly reflected within the corporate objectives, with appropriate acknowledgement of resource implications and realistic timescales. Board members also discussed the presence of prevention activity within the objectives and were reminded of the ongoing work to develop the NHS Lothian Prevention Plan, following previous discussions at the Board. This would include a range of measures and target milestones to be achieved. It was acknowledged that the ambition on reducing delayed discharges was of a significant scale, reflecting the attention of Scottish Ministers in this area.

11.5 The Board endorsed the draft Corporate Objectives for 2025/26, as presented in the paper, noting and accepting the caveats made regarding personnel and financial uncertainty. The inclusion of the Board Assurance Framework Objective was agreed. The final version would be brought back to SPPC once the ADP financial allocation was confirmed.

12. Health Board Collaboration and Leadership

12.1 The Chief Executive introduced the paper which was presented to the NHS Lothian Board by the NHS Scotland Executive Group for formal noting and endorsement. The paper had previously been considered and discussed by the Board's Strategy, Planning and Performance Committee (SPPC) on 19 March 2025.

12.2 The Board noted that this paper was being presented to all NHS Scotland boards, at the request of the NHS Scotland Executive Group and following collective discussion and endorsement by NHS Scotland Board Chief Executives.

12.3 Members noted that the paper:

- set out the context for NHS renewal and reform following the First Minister's public statement on this matter on 27 January 2025.
- briefed NHS Boards on the new governance arrangements with the establishment of the NHS Scotland Executive Group and wider efforts to support a more collaborative ethos in NHS Scotland.

- described the need for all NHS Boards to ensure a systematic approach to balancing local delivery with the need to contribute to meet the needs of larger populations – beyond their geographical boundaries – in the delivery of planned care.

12.4 Additionally, the NHS Lothian Board noted the ask around ongoing developments in this area, specifically acknowledging and endorsing:

- the duality of its role for the population/Board it serves as well as its contribution to population planning that will cross traditional Board boundaries and to approve local implementation of this approach, consistent with DL(2024)31 and 12 (J) of the 1978 NHS Scotland Act.
- the anticipated increased pace of change and requirement for regional and national collaboration in coming weeks and months as there was requirement to deliver the principles set out by the First Minister in his speech on 27 January, to deliver efficiencies and savings and to put into action the commitments set out in the three reform documents.

13. NHS Lothian Pharmaceutical Care Services Plan (PCSP)

13.1 The Director of Public Health & Health Policy and the Director of Primary Care presented the PCSP for approval ahead of its publication on the NHS Lothian internet site.

13.2 Members noted that provision of the plan was a statutory requirement and that it provided a comprehensive overview of the pharmaceutical care provided by community pharmacy, setting out an ambitious and innovative framework for the evolution of community pharmacy services across NHS Lothian.

13.3 Members discussed the details of the Plan. It was suggested that more work was required to increase both provision and awareness of the Pharmacy Plus service. However, it was acknowledged that capacity for community pharmacies to provide this service was dependent on pharmacists being qualified to prescribe. It was expected that this capacity would increase as new graduates entered the profession, with the ability to prescribe medicines.

13.4 It was explained that there was no further indication of Scottish Government's intentions to review the General Pharmaceutical Services (Scotland) Regulations 2009. This was considered important to ensuring that NHS boards were better able to plan and prioritise the community pharmacy provision for their populations. It was also confirmed that there were no concerns held about the current density of community pharmacy provision in Lothian's urban or rural areas, where different criteria applied.

13.5 Specific pharmacy workforce challenges were acknowledged, with reductions occurring in some areas and noted in the Plan. However, a general need for more pharmacists applied across the whole system. Training places at universities were set nationally and there were challenges in influencing the workforce models adopted by private pharmacy providers.

13.6 Members approved the Plan and its publication, strongly commending its clarity in assessing and responding to service need. It was considered that this should be a model adopted for assessing and planning other services.

14. Any Other Business

14.1 None.

15. Reflections on the Meeting

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

16. Date of Next Board Meeting

- Wednesday 25 June 2025 (10:30am start – Annual Accounts)

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 26 March 2025 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: Professor C. Hiscox, Chief Executive; Mr C. Marriott, Director of Finance; Ms T. Gillies, Medical Director; Mr J. Crombie, Deputy Chief Executive; Mr A. McCreadie, Deputy Director of Finance; Ms M. Campbell, Director of Estates and Facilities; Mr B. Barron, Director of Capital Planning; Ms E. Amor, Assistant Finance Manager; Mr D. Clifford, Lead Pharmacist (item 44.4); Mr S. Garden, Director of Pharmacy (item 44.4); Dr J. Hopton, Sustainability Programme Director, Facilities; Mr C. Kerr, Programme Director, Capital Planning; Ms A. Macdonald, Strategic Planning and Modernisation; Mr I. Mackenzie, Green Health Programme Manager (item 46.2); Ms I. Tricker, Interim Head of Property and Asset Management; Mr D. Thomson, Board Secretary and Ms B. Pillath, Committee Administrator (minutes).

Talent Management Programme Observers: Ms A. Falconer; Ms J. Blackwood; Ms L. Graham; Ms L. Jess; Ms W. Parkinson and Ms K. Russell.

Apologies: No apologies noted.

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.

43. Committee Business

43.1 Minutes and Actions from Previous Meeting (12 February 2025)

43.1.1 Members accepted the minutes from the meeting held on 12 February 2025 as a correct record subjected to one amendment at paragraph 38.2.4 to add that Mr Barron would include more information in the next report about review of operational or service delivery benefits and whether they were achieved as part of the post project review process.

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

43.2 Draft Finance and Resources Committee Annual Report

43.2.1 Mr Thompson presented the previously circulated draft report. Members made some suggestions and accepted the draft. The revised report would be circulated for final approval at the next meeting.

44. Emerging Issues

44.1 Westport Office Accommodation

44.1.1 Mr Marriott reported that the Scottish Government had asked that NHS Lothian look to move from Westport offices following the recent move there. This was because NHS Lothian was sub letting from NHS Education Scotland, who had not had the extension of the lease signed off by the Scottish Government. A new business case would now have to be started. Staff affected had been briefed that week. The current lease was agreed until July 2025, but an extension would be requested while the work was done to secure new accommodation.

44.1.2 It was noted that Westport had been the most cost effective option in the recent business case and would have resulted in savings of £12 million over 5 years. Any disadvantage of moving from Westport would be made clear in the new business case which would be reviewed by this Committee.

45. Capital

44.1 Property and Asset Management Investment Programme

44.1.1 Mr Marriott presented the previously circulated paper. The National Laboratory Information System (LIMS) implementation was costing more due to continuing to run the old system while paying for the new system as implementation was delayed. There was a need to have better processes and structures around funding national system implementation so that delays in one area did not increase costs in other areas.

44.1.2 The delay in the planned Liberton Hospital decant was due to time taken to agree the scope and requirements of the alterations taking place. The works at Ellen's Glen and Ferryfield House had to be completed one site at a time due to the decant requirements. The Ellen's Glen beds would be completed by the end of June 2025. Once the costs and programme had been agreed with the Walker Group PFI provider for the day hospital and hospital at home works then an end date for the full programme could be determined.

44.1.3 Members accepted the recommendations laid out in the paper and accepted significant assurance from the project tracker and moderate assurance from the rolling programme and work undertaken by the LCIG lease group.

44.2 Community Asset Transfer Process – Governance

44.2.1 Mr Kerr gave a presentation. It was advised that when there is a cost for a Community Asset Transfer this would be paid by the group taking on ownership, usually by fundraising.

44.2.2 If the Belhaven site was split between Community Asset Transfer and private sale the Community Asset Transfer would have an impact on the value of the remaining site, but this would depend on the site and possible uses.

44.2.3 Mr Campbell advised that an assessment group had been set up to consider the value of the site both to the local community and in monetary terms. This group was led by public health and had representatives from the property team and would include consideration of benefits to the community. The Community Empowerment Act had also been taken into account. Mr Marriott noted that it was important to work with the local community and to maximise the value of the Health Board's assets. All the required processes would be followed to reach this balance.

44.3 Capital Rolling Programmes – 2025/26 Investment Proposal

44.3.1 Ms Macdonald presented the previously circulated paper and gave a presentation. Mr Marriott noted that any opportunity to sell land to get capital for spending on high risk areas would be maximised. Sometimes buildings, such as the Eye Pavilion and the Infections Diseases Units, which were not high risk on the initial prioritisation, can emerge as high risk during the year.

44.3.2 Mr Marriott advised that environmental sustainability was part of the capital programme for 2025/26 for the first time. The sustainability risk was one of many to be balanced including all the high risk areas and the backlog maintenance. Sustainability projects were now being brought forward for assessment along with other projects and there may be separate funding coming from the Scottish Government for sustainability projects.

44.3.3 It was noted that a low level of investment against the needs of the estate due to lack of capital funding from the Scottish Government did expose the Board to legal risks, for instance the Board was cited on the legal requirements from the Scottish Fire and Rescue Service reviews. These risks were taken into account in the rolling programme.

44.3.4 Mr Marriott advised that systems and communications were in place with the Scottish Government to allow capital to be moved into the next year if it was being used for a large project. This had happened with the Eye Pavilion as some of the funding would be moved to the 2025/26 financial year.

44.3.5 Members accepted the recommendations laid out in the paper and accepted the proposed capital allocations.

44.4 HEPMA Benefits Realisation

44.4.1 The chair welcomed Mr Garden to the meeting, and he presented the previously circulated paper. Members noted the positive results of this transformational programme, both financially and for patient safety. The benefits realisation had been based on the business case objectives, and these had been followed through to ensure the expected benefits had been achieved.

44.4.2 Members accepted the recommendations laid out in the paper with the full business case for phase two of the implementation to be developed.

44.5 Hospital Sterilisation and Decontamination Unit (HSDU) Risk Mitigation 5388

44.5.1 Ms Campbell presented the previously circulated paper. Members thanked the team for their work in keeping the service operational and accepted the recommendations laid out. The risk remained classified as 'very high'.

44.6 Review of Corporate Risk 3600 Finance

44.6.1 Mr Marriott presented the previously circulated paper. It was hoped that the risk rating could be moved down from 25 to 20. Members accepted the laid out recommendations, and a further paper would be brought to the next meeting following the review of the financial plan. **CM**

45. Revenue

45.1 Year to Date Financial Position

45.1.1 Mr McCreadie presented the previously circulated paper. Members congratulated the team on reaching break even at year end in difficult circumstances. The need to continue to remind the Scottish Government that the increasing population in Lothian meant that NRAC funding allocations were not adequate, and the need to move on to invest in transformational change rather than in year efficiency projects were noted.

45.1.2 Members accepted the recommendations laid out in the paper.

45.2 Draft Financial Plan 2025/26

45.2.1 Mr McCreadie presented the previously circulated paper. This was the first time in some years that a financial plan had been presented which showed delivery of breakeven. Instead of brokerage being given to Boards not delivering financial balance, this year sustainability funding would be issued to all boards. The focus would be on 3% efficiency savings as there was a recurrent gap in funding which needed to be reduced.

45.2.2 The additional sustainability allocation being provided was specifically for meeting cost pressures in the system in areas where there was already spending. The financial benefits of the additional spend and improvement to the same amount allocated would have to be shown.

45.2.3 Professor Hiscox noted that the focus would be on delivery of the Sustainable Development Plan and working on how to invest in transformational change. This was being worked on through the Corporate Management Team in terms of making decisions on stopping other work and bridging opportunities. Scrutiny was needed to ensure the actual value and return of any transformational projects proposed.

45.2.4 Members accepted the recommendations laid out in the paper and the Financial Plan was accepted for presentation to the Board.

46. Sustainability

46.1 Climate Emergency and Sustainability update

46.1.1 Dr Hopton presented the previously circulated paper. She noted that there was demand on the small team for increasing reporting requirements, and that they were working on an organisational structure which would build climate and the environment into existing data collection processes for Finance and other teams.

46.1.2 A risk register was being worked on, but there was a lack of integration in Scottish Government teams which meant that environmental risks were seen separately to other board risks. The risk management framework was some way from completion due to the time needed to do this, but NHS Lothian was not behind other boards.

46.1.3 In terms of sustainability improvements due to digital developments, Dr Hopton noted that data was being collected on waste and consumption but also the carbon impact of digital solutions and digital infrastructure, which was not carbon neutral. Progress had been made, but better engagement with eHealth was needed.

46.1.4 The main positive impact from the HEPMA implementation would be in the ability to collect information on medicines which could lead to reduction of waste and unnecessary prescribing.

46.1.5 Members accepted the recommendations laid out in the paper.

46.2 Lothian Biodiversity Action Plan

46.2.1 Dr Hopton presented the previously circulated paper. The biodiversity action plan was now a requirement from the Scottish Government, which may lead to resources or opportunities in the future.

46.2.2 Members accepted the recommendations laid out in the paper and agreed the publication of the plan.

47. Scottish Hospitals Inquiry

47.1 Scottish Hospitals Inquiry update

47.1.1 Mr Marriott presented the previously circulated paper. There was a communications plan which would engage with the public in outlining NHS Lothian's response to the Inquiry recommendations. This paper would also be presented at the Board meeting in June 2025.

47.1.2 Members accepted the recommendations laid out in the paper.

48. Reflections on the meeting

48.1 Members did not identify any items to be raised at the Board or Board Sub Committees.

49. Date of Next Meeting

49.1 The next meeting of the Finance and Resources Committee would take place at **9.30** on **Wednesday 11 June 2025**.

50. Further Meeting Dates

50.1 Further meetings would take place on the following dates:
- 20 August 2025
- 22 October 2025
- 17 December 2025
- 11 February 2026
- 25 March 2026.

Signed by Chair
11 June 2025

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 13.00 on Tuesday 18 March 2025 by in Meeting Room 10, Mainpoint, 102 West Port, Edinburgh, EH3 9DN and by video conference.

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

In attendance: Ms E. Anderson, Associate Quality Improvement Advisor; Ms M. Carr, Chief Officer, Acute Services; Mr S. Davidson, Talent Management Programme (observing); Mr S. Garden, Director of Pharmacy; Ms J. Gillies, Associate Director of Quality; Ms T. Gillies, Medical Director; Ms S. Gossner, Chief Nurse, East Lothian Health and Social Care Partnership; Ms L. Guthrie, Associate Director, Infection Prevention and Control (item 74.5); Mr A. Hall, Head of Strategy, Edinburgh Health and Social Care Partnership (item ?); Ms L. Hutchinson, Equality, Diversity, Inclusion and Human Rights Lead (item 73.1); Ms L. Jess, Talent Management Programme (observing); Ms C. Laverty, Chief Officer, Edinburgh Health and Social Care Partnership; Ms G. McAuley, Associate Nurse Director, Acute Services; Ms A. MacDonald, Executive Nurse Director; Ms T. McKigen, Service Director, Royal Edinburgh Hospital and Associated Services (item 72); Ms D. Milne, Director of Public Health; Ms J. Morrison, Head of Patient Experience; Ms B. Pillath, Committee Administrator (minutes); Mr C. Stenhouse, Chief Nurse, Royal Edinburgh Hospital (item 72); Ms F. Stratton, Chief Nurse, Midlothian Health and Social Care Partnership; Mr D. Thompson, Board Secretary; Dr A. Watson, Associate Medical Director, Psychiatry (item 72); Ms A. White, Chief Officer, West Lothian Health and Social Care Partnership; Ms C. Whitworth, Medical Director, Acute Services.

Apologies: Ms H. Cameron, Director of Allied Health Professionals; Professor C. Hiscox, Chief Executive; Mr M. Massaro Mallinson, Service Director, Edinburgh Health and Social Care Partnership; Ms L. Yule, Chief Nurse, West Lothian Health and Social Care Partnership; Mr P. Wynne, Nurse Director, Primary Care.

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.

71. Committee Business

71.1 Minutes from Previous Meeting (28 January 2025)

71.1.1 The minutes from the meeting held on 28 January 2025 were approved as a correct record.

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

71.2 Preparing for Healthcare Governance Committee Annual Report and Assurance Need

71.2.1 Ms J. Gillies presented the previously circulated draft annual report. The final draft including updates from the March 2025 meeting and responses from the Committee Effectiveness members' survey would be submitted to the next meeting.

71.2.2 Members accepted the draft report.

71.3 Committee 2024-25 Workplan

71.3.1 The Committee workplan with agreed assurance levels from the previous year had been previously circulated.

72. Child and Adolescent Mental Health Service – inpatient service

72.1 The chair welcomed Ms McKigen and Dr Watson to the meeting and they presented the previously circulated paper. It was noted that following a BBC documentary on the CAMHS inpatient unit in Glasgow, the Mental Welfare Commission and Healthcare Improvement Scotland planned to carry out a joint inspection of all CAMHS inpatient units in Scotland, including the Melville Unit in NHS Lothian.

72.2 A fatal accident inquiry was currently ongoing in relation to an episode of care which was before 2020, with submissions due in April 2025. Access to beds was being investigated; the submissions would demonstrate the work that had been done to improve this.

72.3 Ms Macdonald noted that a reduction in use of agency staff had led to increased consistency of care and stabilisation in the unit. Work was in progress on reviewing models of care and staffing models.

72.4 Work had been undertaken in the unit on ensuring staff had access to training in management of Violence and Aggression. The majority of this training was face to face, with some online theory modules to be completed in advance of the sessions.

72.5 The majority of the actions identified in the paper were progressing well. The actions for implementation of the new model of care would take longer to complete. Once the decision making process on the split of the unit between eating disorders and CAMHS inpatients had been discussed at the relevant stakeholder groups then a paper on the implementation plan would be brought to the Corporate Management Team for agreement.

72.6 It was noted that the required recruitment for additional staff in the unit were ongoing, with progress being made.

72.7 The next update would be brought to the Committee as part of the scheduled Mental Health Services assurance report in January 2026. Any report from the

planned joint inspection would be brought to the Committee if completed before that date. **TMcK**

72.8 Moderate assurance was recommended in the paper submitted, but members agreed to accept limited assurance only. This would be reviewed at the next annual report from the service. Members noted the work being undertaken and the progress made to date.

73. Person Centred Care

73.1 Equality and Human Rights Annual Report and NHS Lothian Equality Outcomes 2025-28

73.1.1 The chair welcomed Ms Hutchinson to the meeting and she presented the previously circulated paper. She advised that NHS Lothian was not legally responsible for GP practice compliance with human rights legislation. GP practice staff were able to access training in NHS Lothian, and many NHS Lothian staff are employed in practices, which allowed some influence in primary care.

73.1.2 Information obtained as a result of the staff survey on human rights would be used to identify areas for targeted training and raising of awareness.

73.1.3 Data collection from patients was improving as more people were prepared to share their protected characteristics and staff were more comfortable in collecting this data as part of other work, for instance surveys on access to services. More work was needed in raising awareness on why it was important to collect this information.

73.1.4 There was close working with local authorities and Integration Joint Boards including regular meetings and sharing of draft guidance and information, communications and resources.

73.1.5 Members accepted the recommendations laid out in the paper and accepted significant assurance that NHS Lothian was taking action to deliver the equalities and human rights priorities, and moderate assurance that NHS Lothian had processes in place to fulfil its equality duties in assessing the impact of new policies and services changes.

73.2 Spiritual Care Annual Report

73.2.1 Ms Macdonald and Ms McAuley presented the previously circulated paper. Ms McAuley advised that the team was on track to achieve the timescales presented in the action plan. Reporting would be through corporate nursing and the annual report to the Healthcare Governance Committee.

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

74. Safe Care

74.1 Gender Identity Services

74.1.1 Ms T. Gillies gave a verbal update. The national group was reviewing pathways for patients under the age of 17 years. In Lothian, these patients were treated under adult services.

74.1.2 The Gender Identity Service was hosted by East Lothian Health and Social Care Partnership and would report back to the Committee in their annual report in September 2025.

74.2 Infected Blood Inquiry

74.2.1 Ms T. Gillies gave a verbal update. The national group was working through the recommendations from the Inquiry. Some of these recommendations were more relevant to services in NHS England than NHS Scotland. Submissions had been provided by Boards to the Scottish Government on proposals of limiting the use of blood.

74.2.2 In NHS Lothian there was oversight on blood transfusion through the Blood Transfusion Annual Report. The Scottish Government may recommend some external assurance be added in the future.

74.2.3 A recent blood related incident was currently being investigated and this would be reported in the Blood Transfusion Annual Report at the meeting in May 2025. **TG**

74.3 Edinburgh Health and Social Care Partnership Bed Occupancy Risk Mitigation Plan

74.3.1 Ms Laverty and Mr Hall presented the previously circulated paper. Mr Hall noted that he was confident that the ambitious target for reducing bed occupancy presented in table 5 of the paper could be achieved.

74.3.2 Mr Hall advised that the Discharge Risk Indicator Tool worked to encourage discussion on risk and improved consistency in management of risk. This tool had been developed in Lothian.

74.3.3 Bed occupancy was reviewed twice per week by a group chaired by the Deputy Chief Executive. This included monitoring of patients being treated in a different specialty to their own due to availability of beds, known as boarding. As bed occupancy was reduced overall this should reduce the need for boarding patients.

74.3.4 Work was being undertaken to develop an advanced care at home package which would allow patients to go home from hospital while waiting for a care home bed, rather than waiting in hospital for a space to become available.

74.3.5 In response to a question about the safety of the actions being implemented, Mr Hall advised that this was being monitored. Currently, the increased in discharge rate and reduction in length of stay had not resulted in an increase in readmissions or in adverse events.

74.3.6 Resources had been put into improving service capacity in the community for physical healthcare to reduce the reliance on hospital based care. A similar process needed to take place for community mental health services. This would take time to

allow both patients and clinicians to develop confidence in the efficacy of the alternative provision available.

74.3.7 Members accepted the recommendations in the paper and accepted limited assurance.

74.4 Hospital Bed Occupancy and 4 Hour Emergency Access Risk Mitigation Plan

74.4.1 Ms Carr presented the previously circulated paper. She advised that the LACAS system was now in place in the Emergency Department. She reported that the department was feeling positive about the progress made on the two risks and the work on a whole system approach.

74.4.2 More work was being done on the flow navigation system to ensure appropriate integrated pathways were available to patients that were not in acute services. The Flow Centre now had the facility for professional to professional conversation which helps patients to be directed to the appropriate service.

74.4.3 Ms Carr advised that the presentation of the data, the use of average or median the division of the data, for instance by pathway or by admitted or non admitted patients, was frequently discussed to ensure it was the most useful in identifying trends. Mr Hall advised that there was different coding for different cohorts of delayed patients, as well as those who were not delayed discharges but could be treated in a non hospital service.

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

74.5 Healthcare Associated Infection Update

74.5.1 The chair welcomed Ms Guthrie to the meeting and she presented the previously circulated paper. She advised that Lothian had low antimicrobial prescribing compared to other Boards in Scotland, but that there had been a small increase. This may be related to changes in the way of prescribing, including increasing non medical prescribing and remote consultations. The Antimicrobial Team monitored this and was able to focus resources to identify where improvement could be made.

74.5.2 It was noted that there were 6 infection control doctor sessions available per week, compared to the 23 sessions needed. There was a specialist training programme in place for doctors which included infection control as one element, but there were other outcomes. Discussions on whether infection control doctor sessions could be lead from outwith infection control were at early stages.

74.5.3 Mr Garden noted that a UK National Action Plan on Antimicrobial Resistance was looking to class antimicrobial drugs as high risk in terms of medicines safety. Discussions were at an early stage.

74.5.4 Members accepted the recommendations laid out in the paper and accepted limited assurance on the Infection Prevention and Control Team workforce and moderate assurance in relation to Board performance against local delivery plan targets. A further update would be brought to the Committee in September 2025. **AMcD**

74.6 Information Governance Annual Report

74.6.1 Ms T. Gillies presented the previously circulated paper. Business continuity and training exercises had been identified as areas of improvement and a date for an externally lead business continuity exercise had now been agreed for the end of April 2025.

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

75. Effective Care

75.1 Medicines Governance Annual Report

75.1.1 Mr Garden presented the previously circulated paper. He advised that the Acute and Primary Care Prescribing Forums worked on taking action to reduce the use of medicines deemed of limited clinical value. The Medicines Utilisation and Review Group also reviewed the data to identify whether action had been successful and where further action was needed.

75.1.2 Members accepted the recommendations laid out in the paper.

76. Exception Reporting Only

Members noted the following previously circulated reports for information:

75.1 Voluntary Services Annual Report;
76.2 Clinical Policy and Documentation Annual Report;
76.3 Scottish Intercollegiate Guidelines Network Annual Report.

77. Minutes of Management Meetings and Sub Committees

Members noted the previously circulated minutes from the following meetings:

77.1 Health and Safety Committee, 6 November 2024;
77.2 Clinical Management Group, 10 December 2024;
77.3 Policy Approval Group, 10 December 2024;
77.4 Area Drug and Therapeutics Committee, 6 December 2024;
77.5 Organ Donation Sub Group, 21 November 2024;
77.6 Public Protection Action Group, 6 June 2024, 29 August 2024.

78. Corporate Risk Register

78.1 Ms T. Gillies presented the previously circulated paper and members accepted the recommendations laid out.

79. Reflections on the meeting

79.1 No items were identified to be raised at the Board or other governance committees.

80. Date of Next Meeting

80.1 The next meeting of the Healthcare Governance Committee would take place at **1.00pm** on **Tuesday 20 May 2025** by videoconference.

81. Further Meeting Dates

81.1 Meetings would take place on the following dates:
- 22 July 2025
- 23 September 2025
- 21 October 2025
- 18 November 2025
- 27 January 2026
- 17 March 2026.

Signed by Chair

20 May 2025

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of the meeting of the Staff Governance Committee held at 15:00 on Thursday 3 April 2025 via Microsoft Teams.

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

In Attendance: Mr T. Power (Director of People and Culture, Human Resources); **Mr J. Crombie** (Deputy Chief Executive); **Ms A. MacDonald** (Executive Nurse Director, Nursing); **Ms F. Ireland** (Deputy Director, Corporate Nursing); **Miss T. Gillies** (Executive Medical Director); **Ms L. Cunningham** (Partnership Representative); **Ms M. Campbell** (Director of Facilities) **Ms F. Tynan** (Associate Nurse Director, Corporate Nursing); **Mr K. Dickson** (Health & Care Staffing Lead, Corporate Nursing); **Mr G. Archibald** (Union Branch Secretary / REAS Partnership Lead) and **Mr G. Ormerod** (Corporate Governance Team -Minute).

Apologies for absence was received from: Ms. Hiscox (Chief Executive); **Ms E. Gordon** (Non-Executive Board Member); **Mrs R. Kelly** (Deputy HR Director); **Ms T. Miller** (Employee Director) an **Ms K. Kasper** (Non-Executive Board Member).

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.

79. Declaration of Conflicts of Interest

79.1 No interests were declared.

80. Matters Arising

80.1 It is noted that the meeting was not quorate since the minimum number of Non-Executive Board Members were not present. Agreed to progress but any decisions made would need ratification at next meeting when this requirement for quorum is met.

81. ASSURANCE AND SCRUTINY

81.1 Health and Care Staffing Annual Report

81.1.1 The Associate Nurse Director, Corporate Nursing presented an update on the Health and Care Staffing Annual Report. She noted that the report is provided to the Committee as part of the legislation to the board regarding adequate staffing, high-quality care, and staffing responsibilities and the final report will be submitted to the Board and Scottish Government in April.

81.1.2 The Associate Nurse Director, Corporate Nursing confirmed that there is one change to the report since this has been circulated to members. She confirmed that 12IJ on the spreadsheet notes that all specific statements have been completed for speciality specific staffing level and professional judgement tools. Members noted that the emergency care provision tool at the Royal Infirmary of Edinburgh (RIE) were unable to complete their tool as planned and this will be completed in May. Members noted that St John's Hospital (SJH) and the Western General

Hospital (WGH) are complete, but the word “all” will be removed from this statement as not all tools have been run.

81.1.3 The Associate Nurse Director, Corporate Nursing confirmed the Red, Amber, Yellow, Green (RAYG) rating under 12IG will change from Green to Yellow however all scoring will remain as Reasonable.

81.1.4 The Chair commented that a further change in the report would be required as the date within the report for the next board meeting would need to be changed from 23 April to the 16 April.

81.1.5 The Director of People and Culture commended the engagement level and input from staff regarding the assurance and appropriateness of individual areas and their ratings. He asked how the quarterly meetings with Health Improvement Scotland (HIS) had gone in terms of organisation assurance, and he commented on the dense report template and enquired whether any work will be done on an easy-to-read format for the public, whilst suggesting to reduce the technical language so this report is easy to understand.

81.1.6 The Associate Nurse Director of Corporate Nursing confirmed that three meetings with Health Improvement Scotland (HIS) had taken place, with HIS being highly positive of NHS Lothian's commitment to compliance, assurance audits, and duties. HIS regularly challenges NHS Lothian at each meeting, but the responses have been confident and encouraging with a requirement to publish the reports on the intranet.

81.1.7 Members agreed with the Director of People and Culture and HR comments and suggested using this report as a monitoring mechanism to monitor progress as this work progresses.

81.1.8 The Associate Nurse Director of Corporate Nursing indicated that areas with lower levels of assurance will be tracked for improvement outside of the reporting cycle, along with audit data and compliance that will report through quarterly reports. She confirmed that the Scottish Government is considering a new Word reporting template for next year; this will be a lengthy version to complete, and there may be opportunities to create our own template. The Executive Nurse Director confirmed the service has reassessed the schedule of meetings, and this year has been a learning year due to challenges in the timetable of reporting. This has been reviewed with the programme board and professional leads for next year to drive forward improvement and scrutiny from senior directors.

81.1.9 The Chair congratulated the team on doing well with this work and commented that this is the third report that the Staff Governance Committee has seen, and there has been progress each time. She highlighted the value of this information as a staffing tool and its purpose. She commented on the 12F2A information that tracks conflict within the organisation that is clinically challenged, highlighting the importance of this for transparency and monitoring for patient and staff safety. She suggested adding percentages to the report to show the number of greens and yellows for monitoring and movement for tracking purposes.

81.1.10 Members were pleased with the process that was in place and the ability to review the report before it goes to the board. Members had oversight over the report, and the recommendations were endorsed.

82. Any Other Competent Business

82.1 The Director of People and Culture gave an update and informal discussion from the most recent Strategy, Planning, and Performance Committee (SPPC) meeting on the recent employment tribunal in NHS Fife in relation to access to single-sex changing spaces for those undergoing gender reassignment. He stated that Lothian is unable to minimise all risk, but guidance is currently in place for staff that is deemed competent by the Equality and Human Rights Commission (EHRC) and Central Legal Office (CLO). It was agreed at SPPC that this position would be noted and additional actions would be taken once the NHS Fife case was concluded.

82.2 He confirmed some of the actions taking place, including:

1. Estates and Facilities Audit – The director has been contacted about the existing facilities and is working alongside E&HR leads to pick this up with relevant senior managers, Estates and Facilities Director and a wider team to link with NHS Highland, who are undertaking the audit.
2. Develop training for managers to raise awareness, distribute online training modules with manager networks, and remind employees that they can discuss this with their Equality and Human Rights team and contact their line manager network when new policies or changes are implemented.
3. Ensure that teams dealing with complaints and feedback are prepared and that contact is made with the Speak Up team in order to contact the Equality and Human Rights teams.

82.3 The Director of People and Culture confirmed that this has been raised by MSPs in Lothian and at the Board Chair meeting at Forth Valley. The Chairs agreed that in the absence of conclusive case law and national guidance, the issue can be unclear and a matter of significant political discourse and debate and that there needs to be national direction from the Scottish Government to follow. The Chair of the Board Chair Group will also write to the Chair of Board Chief Executives, recommending that this be raised with the Director General for Health and Social Care.

82.4 The Director of People and Culture has confirmed an NHS Lothian seminar and board development session on equality, diversity, and inclusion in early May/June.

82.5 The Chair emphasised the need of minimising the organisation's risk while remaining aware of new developments, and agreed that a seminar would be the best approach to continue. She emphasised that discussions should be documented as a formal record in the event of any requests for information. She stated that Non Executive Board Members have been eager to discuss this but have been held back due to legal constraints, but the most recent update from MSPs pushes NHS Lothian into some discussions and is more nationally driven.

82.6 Members agreed and noted that it would demonstrate the board's sensible approach to this in the absence of case law, but that this work would require directives from the Scottish government and external guidance.

82.7 The Medical Director stated that this could be a valuable hierarchy of advice, but caution should be maintained because it is discussing a risk that most people have no direct experience with, which is important to remember.

82.8 The Director of People and Culture underlined the importance of the organisation's approach to diversity and inclusion legislation, as well as person-centred strands where people work and challenges arise. The focus should be on risk management, diversity, and inclusion. He noted caution, particularly with limited guidance.

82.9 Members agreed to hold a seminar to evaluate the effectiveness of staff members who had specific experiences.

83. Date of Next Meeting:

83.1 The next Committee meeting would be held on Tuesday 27 May 2025 at 9.30am

Signed by Chair
27 May 2025

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee meeting held at 9.30 am on Monday, 14 April 2025 via MS Teams.

Present: Mr J. Blazeby, (Chair) Non-Executive Board Member; Dr P. Cantley, Non-Executive Board Member; Councillor H. Cartmill, Non-Executive Board Member; Ms E. Gordon, Non-Executive Board Member, Ms K. Kasper, Non-Executive Board Member.

In Attendance: Mr S. Garden, Director of Pharmacy; Ms J. Gillies Associate Director for Quality Improvement & Safety; Professor C. Hiscox, Chief Executive; Ms P. Jackson, Grant Thornton; Mr C. Marriott, Director of Finance; Ms E. Mayne, Grant Thornton; Mr A. McCreadie, Deputy Director of Finance; Ms H. McKellar, Grant Thornton; Ms O. Notman, Head of Financial Services; Mr J. Old, Financial Controller; Mr D. Thompson, Board Secretary and Miss L. Baird, Committee Administrator.

Apologies: Mr J. Crombie, Deputy Chief Executive; Ms P. Gillen, Audit Scotland.

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

Welcomes and Introductions

The Chair welcomed Members to the April meeting of the Audit and Risk Committee.

1. Minutes of the previous meeting held on 17 February 2025

1.1 The minutes of the meeting held on 17 February 2025 were accepted as an accurate record.

2. Running Action Note

2.1 The Committee noted the actions marked complete or items on the agenda for further discussion and those that were not due for consideration detailed within the report.

2.2 Counter Fraud Activity – The Ariston case would come to a conclusion soon and an update would be provided at the June 2025 Audit and Risk Committee meeting. Thereafter the action would be closed off.

2.3 National Services Audit Reports 2023/24 – General IT Controls were discussed at the Technical Accounting Group at their last meeting. Where NHS Ayrshire and Arran advised that they were hoping that they could progress additional systems controls to address the gaps within the audit. Subsequently NHS Ayrshire and Arran confirmed that it would not be possible to carry out the additional work required for 2024/2025 and would now be undertaken in 2025/2026.

2.4 Counter Fraud Activity – Mr Old explained that fraud awareness modules would move over and go live on TURAS from 1 April 2025 and completion rates would be available from

June 2025 as part of the standard update.

2.5 The Committee accepted the running action note and the information therein.

3. Risk Management

3.1 Corporate Risk Register – The previously circulated report on the NHS Lothian's Corporate Risk Register (CRR) and associated processes was received.

3.1.1 The Committee:

- Reviewed the February 2025 updates provided by the executive leads concerning risk mitigation.
- Noted target risk gradings, agreed by CMT where possible, based on process detailed at the February 2025 meeting
- Noted that CMT recommend to the Board that risks 5020 - Water safety and quality and 3828 - Nursing workforce and 5784 - Inappropriate and Inadequate Low Secure Accommodation in the Estate are removed from the CRR
- Noted the overview of the changes in the CRR over the past 2 calendar years in table 1
- Noted that management actions agreed in the internal audit report of the corporate risk register process are now complete.

3.1.2 It was noted that water safety and quality issues flagged at the Princess Alexandra Eye Pavilion would continue to be monitored as the full service returns on site and the risk managed under the re-commissioning risk held on the CRR.

3.1.3 Attention was drawn to the core aspects of the Risk Framework and how the proposed changes would reflect the strategic nature of corporate risk instead of several operational risks currently reflected within the CRR. Timeline for completion remained the end of 2025 with updates being provided to the Board at key milestones.

3.1.4 It was noted that those risks that currently did not have a target rating assigned to them controls were out within the gift of NHS Lothian alone. As work on the framework progress the organisation would review what were strategic risks versus risks that were not being managed at a divisional level before considering how they would set potential targets within the management of NHS Lothian.

3.1.5 The Committee agreed that the CRR was a tool that enables an appropriate level of discussions in respect of risk held within the organisation, therefore it was important that what as the framework is developed it remains appropriate for the needs of the organisation. Members presents were assured that feedback on the direction of the work and contents of the framework would be sought from key stakeholders including the Chairs of the Governance Committee.

3.1.6 The Committee accepted the report

3.2 Risk Management Annual Report – The Committee received the report that set out assurances on the management of risk across NHS Lothian for the period covering 1 April 2024 to 31 March 2025.

3.2 The Committee:

- Accepted moderate assurance that there are systems in place to manage risk across NHS Lothian in accordance with the Risk Management Policy and Procedures approved in April 2023.
- Noted that internal audits of risk management processes for 2023/24 and 2024/25 reported in April and October 2024 respectively, both receiving moderate assurance overall.
- Noted that Healthcare Governance Committee which seeks assurance on the management of adverse events accepted assurance levels in November:
  - Significant assurance that local processes are in place to identify events which require to be reported to Healthcare Improvement Scotland (HIS) to comply with the national notification process and to note number and types of events reported.
  - Moderate assurance in the progress made in improving processes for the management of significant adverse events (SAEs) and backlog reduction, with further improvements being progressed under the Adverse Events Improvement Programme.
  - Moderate assurance on the process for safety alerts and the associated reports up to 30 September 2024.
- Noted that Healthcare Governance Committee approved NHS Lothian Duty of Candour Annual Report at it October 2024 meeting prior to its publication on NHS Lothian's internet site in line with national requirements.

3.2.1 It was noted that Healthcare Improvement Scotland (HIS) had published a revised framework in March 2025 and that since the distribution of this report Scottish Government had also published revised guidance in relation to the duty of candour. Although the revised HIS framework would not require any fundamental changes within policy, there were minor changes that would be taken forward through the improvement programme in relation to adverse events.

3.2.2 Professor Hiscox agreed to liaise with Mr Marriott to ensure that regular and timely updates are provided to the Audit and Risk Committee in terms of the Integrated Governance Framework. Ensuring that Members are consulted at key stages of its development and are satisfied that what direction taken and that tools developed are fit for purpose. **CH/CM**

3.2.3 The Committee accepted the report.

4. Internal Audit

4.1 Medicines Management Update – The Committee received a detailed verbal update on progress made against the agreed action plan for the follow-up internal audit of medicines management conducted in October 2024.

4.1.2 Attention was drawn to the creation of a Medicines Safety Officer Role within Lothian. It was noted that the postholder would provide support in driving forward the recommendations of the October 2024 audit and the wider aspect of medicines safety programme.

4.1.3 It was noted that since the February Audit and Risk Committee Pharmacy had:

- Established a Multi-Disciplinary Working Group (MDWG).
- Set up a schedule for the action owners to present their specific actions and recommendations held and escalate any barriers to progress at the MDWG.
- Circulated communications to key staff and forums to target those with medicines responsibilities and reinforce policies held.
- Implemented walkarounds on all sites.
- Progress work in respect of the LACAS audits including moving Midwifery on to the LACAS system.
- Developed a self-audit with a peer review approach.
- Agreed with Estates and Facilities that there would be a high priority response for secure medicines storage, including the ability to hold spare locks on site.

4.1.4 Attention was drawn to the weakened control framework and whether it had been reflected within other areas, specifically DATIX entries. The Committee were keen to link the actions introduced by the Medicines Management Team to measurable metrics in terms of adverse events, DATIX etc to support the organisation in identify trends, target areas of concern and improve compliance.

4.1.5 It was noted that the failure to comply i.e. broken lock etc. and how that translates into an instance of harm is not always obvious and can often be a barrier to making cultural change within the services. Going forward Pharmacy would be more data driven, utilising patient stories, duty of candour incidents and Subject Access Requests (SARS) etc to demonstrate cause and effect of non-compliance to medicines management within services. The Director of Pharmacy assured the Committee that the programme of work described would provide detailed measurements, a baseline to measure against and improvement data, to be reported on at a future Audit and Risk Committee.

4.1.6 Plans to review access rights to clinical rooms where medication is stored across all sites and restrict access to non-clinical staff and those not involved in the medication aspect of patient care and whether the organisation was clear on this at a policy level was discussed. Policy was clear that access would only be granted to healthcare professionals and those with delegated responsibility with legitimate need to access medicines. However, there would be continued focus on how policy is enacted in terms of key control and access.

4.1.7 There was some angst around the success of previous improvement plans and the likelihood of the revised plan succeeding where the original one had failed to make the necessary impact. The Director of Pharmacy explained that key controls and improvements demonstrated on the Royal Edinburgh Hospital (REH) site, would be replicated across the organisation as a whole. In additional to this work Pharmacy aspired to have dedicated medicine management roles across all sites, previously only held at the REH and St. John's Hospital (SJH).

4.1.8 The Committee discussed safe staffing tools and the impact that understaffing or a change in skill mix held would have on the management of medicines. Noting the organisations commitment to ensuring that staffing levels on site remain appropriate in terms of patient need and the safe and effective administration of medicines.

4.1.9 The Committee accepted the report and agreed that Ms Robertson, BDO as the new internal auditors review all outstanding actions with Mr McIntosh and Mr Garden and seek

a view on how they can assure members that all actions will be concluded. The outcome of these discussions would be shared at the June Audit and Risk Committee meeting via the running action note along with a timeframe for a further update on progress made against the actions to the Committee. **CR/ RM/SG**

4.2 GP Enhanced Services – The internal audit had identified two moderate and three low findings and had been awarded an overall rating of moderate.

4.2.1 The Committee accepted the report.

4.3 Outpatient Activity – The internal audit had identified one medium, three low and one advisory finding and had been awarded and overall rating of moderate.

4.3.1 It was noted that the initial decision to not use text message reminders for children and young people had been made as part of safeguarding. Management would continue to explore text reminders could be implemented within the service and bring the organisation in line with other NHS Boards.

4.3.2 The Committee accepted the report.

4.4 Internal Audit Progress Report (April 2025) – the previously circulated report was received. Since the November meeting Internal Audit had delivered 408 days of 450 days which equates to 91% of the overall plan. Of the 450 days, 29 of those had been marked as contingency. Fieldwork for the audit of Urgent Care Redesign was in progress and would be presented with the Head of Internal Audit Opinion in June 2025.

4.4.1 Mr Marriott would pick up all outstanding items in terms of the final audit of Urgent Care Redesign with Ms Mackellar out with meeting to ensure the report is finalised for the June Meeting. **CM/HMcK**

4.4.2 The Committee accepted the report.

4.5 Internal Audit Recommendation Tracker Report (April 2025) – The previously circulated report was presented. The report outlined work that Internal Audit had done in respect of the long-standing actions that had not been implemented within their allotted deadlines.

4.5.1 It was noted that since February management had implemented six actions. Grant Thornton continued to track 24 open recommendations, of which 22 actions had not reached their original due date.

4.5.2 The Committee accepted the report and requested that Mr Marriott highlighting those actions outstanding at the Corporate Management Team with the relevant Executives to ensure timely completion of actions. **CM**

5. External Audit

5.1 External Audit Progress Report 2024/25 – The Group received the previously circulated paper and a brief presentation of the report drawing members attention to the key areas therein.

5.2 The Committee accepted the report, noting that the audit was on scheduled for completion

with no significant issues highlighted to date.

6. Counter Fraud Services (CFS)

6.1 The previously circulated report on counter fraud activity was received.

6.2 The Committee noted that one intelligence alert had been received from Counter Fraud Services and disseminated to all relevant and interested parties within the organisation.

6.3 On fraud detection, the Committee noted the number of referrals and operations that were ongoing, and operations closed during the reporting period.

6.4 The Committee accepted the report as an update on the current status of counter fraud activity.

6.5 The Committee agreed that the report provides a moderate level of assurance that all cases of suspected fraud are accounted for, and appropriate action is taken.

6.6 The Committee approved the NHS Lothian's Counter Fraud Policy and Response Plan.

7. Corporate Governance

7.1 Accounting Policies – The Committee received a brief verbal update of the previously circulated paper drawing members to the key points within the report.

7.1.1 It was noted that there were no new standards, amendments of interpretations effective within the current financial year. Key changes to the Accounts Manual for 2024/2025 related to sustainability disclosures and would be reflected within performance report.

7.1.2 The Committee reviewed and approved the accounting policies and confirmed that they are appropriate for the Board at the present time for the purpose of giving a true and fair view.

7.2 Write Off of Oversea Debt – The Committee received a brief verbal update of the previously circulated paper drawing members to the key points within the report.

7.2.1 The Committee acknowledged the continued education of staff and work undertaken to recover losses by Ms Notman and the Overseas Team.

7.2.2 The Committee reviewed the proposed write-off of oversea debt and agreed that the Director of Finance may approach the Scottish Government for its approval to write-off these losses.

7.3 Audit and Risk Committee Members Survey 2024/25 - The Committee received a brief verbal update of the previously circulated paper drawing members to the key points within the report.

7.3.1 The Committee reflected on the results of the survey and agreed that there needed to be further consideration of individual development opportunities for non-executive colleagues joining the Committee to ensure that they fully understand their role and what is required of them.

8. Any Other Competent Business

8.1 Edinburgh Integrated Joint Board (IJB) Internal Audit Strategy and 2025/26 Internal Audit Plan – the Committee received the previously circulated report and noted the information therein.

8.2 Private Meeting with Internal Audit and External Audit – The Committee Administrator would liaise with Internal and External Audit colleagues including Ms Robertson BDO, to arrange a private meeting between with the non-executive colleagues to take place immediate after the June annual accounts meeting concludes. **LB**

8.3 There were no other items of competent business for consideration.

9. Reflections on the meeting

9.1 The Committee welcomed the detailed discussions held. The Committee agreed that accounting policies be presented to the Board at its next meeting for the purpose of giving a true and fair view and that the Director of Finance approaches the Scottish Government for its approval to write-off oversea debt.

10. Date of Next Meeting

10.1.1 The Chair reminded members present that 16 June 2025 Audit and Risk Committee would be held at 9:00 a.m. in Meeting Room 10, West Port and via Microsoft Teams and non-executive colleagues were encouraged to attend in person.

Signed by Chair
16 June 2025

Midlothian Integration Joint Board

Meeting	Date	Time	Venue
Midlothian Integration Joint Board	Thursday, 20 February 2025	14:00	Council Chambers, Midlothian House and Virtual Meeting held using Microsoft Teams

Present (voting members):		
Councillor McManus (Chair)	Dr Amjad Khan (NHS Lothian) (Virtual)	Councillor Winchester (Virtual)
Val de Souza (Vice Chair, NHS) (Virtual)	Kirsty Macdonald (NHS Lothian) (Virtual)	Andrew Fleming (NHS Lothian)

Present (non-voting members):		
Morag Barrow (Chief Officer)	Fiona Stratton (Chief Nurse)	Nick Clater (Head of Adult Services and Chief Social Work Officer)
Grace Chalmers (Partnership Representative)	Claire Ross (Chief AHP)	Keith Chapman (Lived Experience member)
Magda Clark (Third Sector Representative)	Chris King (Chief Finance Officer)	Councillor McKenzie (alternate for Councillor Parry)

In attendance:		
Gill Main (Integration Manager)	Fiona Kennedy (Group Service Manager)	Roxanne King Executive Business Manager (Virtual)
Elouise Johnstone (Performance Manager)		Hannah Forbes (Democratic Services Officer)

Midlothian Integration Joint Board

Nicola Thorburn (Democratic Services Officer)		

Apologies:		
Grace Cowan (Head of Older People and Primary Care Services)	Claire Gardiner (Audit Scotland)	Dr Rebecca Green (Clinical Director)
Councillor Parry		

1. Welcome and Introductions

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

2. Order of Business

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

3. Declarations of Interest

There were no declarations noted.

4. Minute of Previous Meetings

4.1 The Minute of previous Midlothian IJB Board Meeting held on 19th December 2024 was approved as an accurate record.

4.2 The Minute of the meeting of the MIJB – Strategic Planning Group held on 28th November 2024 was noted by the Board.

4.3 The Minute of the meeting of the MIJB – Audit and Risk Committee held on 12th September 2024 was noted by the Board.

5. Public Reports

	Decision	Action Owner	Date to be Completed/ Comments
5.1 Chair's Update – Councillor McManus, Chair The Chair opened by reminding the Board of the additional Midlothian IJB members Development Session scheduled for the 27th February 2025 to further consider i) Financial Recovery Plans and ii) Directions 2025/26 ahead of the March Special Board. The Chair noted the March Special Board has been rescheduled to the 27th March from the 13th March due ensure final or indicative offers from both Partners have been received. The Board were advised that a Midlothian IJB Members Development Session from, 14.00 – 14.50 will immediately precede the Special Board, held from 15.00 – 16.00. The Chair also noted the April Board Meeting has been rescheduled to the 24th of April 2025. The Chair passed thanks to Midlothian Health & Social Care Partnership (HSCP), for their efforts during Storm Eowyn, and particularly noted the strong collaborative working with Midlothian Council.			
5.2 Chief Officers Report – Morag Barrow, Chief Officer Morag Barrow, Chief Officer presented the report and advised the paper sets out the key strategic updates for Midlothian IJB Board. This report is for noting. The Chief Officer highlighted items for the attention of the Board. • The continuation of the financial recovery work being undertaken by the HSCP, • A number of Midlothian staff recognised for exceptional work and in receipt of national awards, • St Cuthberts Supported Living in Bonnyrigg is now open, this facility supports 8 people who			

	Decision	Action Owner	Date to be Completed/ Comments
experience learning disabilities with care or transitioned care, • The continued excellent work by the Substance Misuse Team, and their continued high performance in relation to medication assessed treatment (MAT) standards, • The innovative use of data in Midlothian through collaborative working between NHS Lothian and Midlothian Council, and • The challenges facing the nursing workforce. It was noted that NHS Lothian are undertaking staffing 'health checks' across all ward areas to ensure compliance with the Health and Care (Staffing) (Scotland) Act, 2019. Midlothian hospitals were noted to have appropriate and safe staffing models in place. The Chair thanked the Chief Officer for the report and opened up to any questions. The Board congratulated those that have been recognised for awards. A question regarding waiting times for children who are neurodiverse was raised and whether the HSCP are supporting people to wait well. The Head of Adult Services and Chief Social Work Officer noted that Children's Services are not delegated to Midlothian IJB meaning Child and Adolescent Mental Health Service (CAMHS) waiting times are out with the remit of both Midlothian IJB and HSCP although collaborative working is vital to support transitions. The Board requested information relating to the data sharing agreements required to progress key pieces of work. The Integration Manager explained that local data sharing agreement are being progressed and a solution regarding secure transfer of data means there is now clear way forward for future work that will enable developing our data capabilities in new ways. The Board queried the increase to GP charges, the impact, and the Midlothian approach. The Chief	Board update	Clinical Director	**24/04/2025**

	Decision	Action Owner	Date to be Completed/ Comments
Officer noted the Clinical Director will provide an update The Board noted feedback in relation to limited out of hours support for people who use substances and queried capacity to increase the support. The Head of Adult Services and Chief Social Work Officer advised that this is a known issue that this is being reviewed by the Midlothian and East Lothian Drug and Alcohol Partnership (MELDAP) and will review progress with the service manager.	Review progress	Head of Adult Services and Chief Social Work.	**24/04/2025**
5.3 Strategic Planning Group Update – Report presented by Gill Main, Integration Manager Gill Main, Integration Manager, presented the main activity of the Strategic Planning Group (SPG) since December 2024 to the Board. This included ongoing development of the Strategic Plan, review and evaluation of Directions 2024/25 reporting, developing proposed Directions for 2025/26, developing a draft Directions Policy, ongoing work on the Midlothian IJB Equality Outcomes 2025-29, and the Midlothian IJB Integrated Workforce Plan 2025-28. Additionally, a requested revision to the SPG Terms of Reference (ToR) to enable any Board member to take up the position of Vice Chair of SPG will be reviewed by the Audit & Risk Committee on the 6th March 2025. The Chair thanked the Integration Manager for the report. There were no questions from the Board in relation to the report.			
5.4 Audit and Risk Committee Update – Report presented by Gill Main, Integration Manager Gill Main, Integration Manager presented the main activity of the Audit & Risk Committee (A&R) on 5th December 2024 to the Board. Meeting. This included the ongoing recruitment of an Independent member, and review of the Midlothian IJB Risk Register.			

	Decision	Action Owner	Date to be Completed/ Comments
The Chair thanked the Integration Manager for the report. There were no questions from the Board in relation to the report.			
For Decision **5.4.1 Appointment to the Audit and Risk Committee of an Independent Member Paper by Duncan Stainbank, Chief Internal Auditor and Val de Souza, Audit and Risk Committee Chair** Duncan Stainbank, Chief Internal Auditor, presented the report detailing the process undertaken to identify and now recommend Antony Clark as the nominee for the role of Independent Member to the Audit & Risk Committee. The Board agreed to appoint Antony Clark to the role of Independent Member.	Approved		
For Decision **5.5 Midlothian IJB Meeting Schedule 2025 and 2026 - Paper presented by Democratic Services** The Democratic Service Officer presented the report detailing the dates for Board Meetings, Development Sessions, and Committees of Midlothian Integration Joint Board for 2025/26, as prescribed by the Midlothian Integration Joint Board Standing Orders (5.2). An omission of the July 2025 and 2026 SPG dates were noted, and dates of 24th July 2025 and the 23rd July 2026 were suggested. **As a result of the report, Members were asked to:** • Review and note the revised dates for 2025 set out in Appendix 1.			

	Decision	Action Owner	Date to be Completed/ Comments
• Approve the meeting schedule, development session and committee dates for 2026 as set out in Appendix 2. • Note that service visits will be scheduled as required or at the request of members of the Midlothian Integration Joint Board The Board agreed the proposed schedule for 2025 and 2026.	Approved		
For Decision **5.6 Midlothian IJB Membership Nomination - Paper presented by Democratic Services** The Democratic Service Officer presented the report noting changes to non-voting membership of Midlothian Integration Joint Board and seeking the Board's formal endorsement of recommendation **As a result of this report, Members were asked to:** • Note the successful recruitment of Chris King, Chief Finance Officer. • Endorse the nomination of Chris King as a non-voting member of Midlothian IJB as the new Chief Finance Officer. The report was approved by the Board	Approved		
For Decision **5.7 Midlothian IJB Draft Strategic Plan 2025/35 Update - Paper presented by Gill Main, Integration Manager** Gill Main, Integration Manager presented the report which set out the actions and progress in the development of Midlothian Integration Joint Boards Strategic Plan for 2025-35 noting revisions and			

	Decision	Action Owner	Date to be Completed/ Comments
amendment following public consultation and feedback from Partners, in line with the Strategic Plan Statutory Guidance. **As a result of this report, Members were asked to:** • Review the revised draft of the Strategic Plan 2025-35, noting the plan will continually evolve as it is presented to various committees and governance groups and Midlothian IJB budget decisions are taken. • Approve the draft Strategic Plan subject to required changes, for approval to progress through the governance routes of our Partners. The Board commended the work that has been undertaken to date, noted the adoption of early feedback and revision requests and were in agreement to endorse the next steps. The Chief Officer stated that details of operational actions will be finalised and added to the plan as financial decision are taken. It was further noted that as the mechanism to deliver the strategic plan, Directions for 2025/26 are also presented under item 5.12 on the agenda. The Chair thanked the Integration Manager for the report. The Board approved the recommendations.	Approved for progression	Integration Manager	**10/10/2025**
For Decision **5.8 Midlothian IJB Finance Update and Recovery Planning - Paper presented by Chris King, Chief Finance Officer** Chris King, Chief Finance officer presented this report to update Members on the 2024/25 financial position and proposed Financial Recovery Actions for 2024/25 and 2025/26 in the context of			

	Decision	Action Owner	Date to be Completed/ Comments
Midlothian Health and Social Care Partnership's ongoing transformation plans and operational delivery. **As a result of this report, Members were asked to:** • Note the delivery of Financial Recovery Actions in 2024/25. • Note the projected out-turn position for 2024/25. • Note the indicative 2025/26 financial position. • Consider the risks laid out in Section 8. • Support the short- and medium-term actions described to manage the financial challenges. • Approve the progression of discussion with providers to achieve a 5% reduction in volume or rates. The Chair thanked the Chief Finance Officer for the report and opened to any questions. It was noted by the Chair that Midlothian Council will meet to agree their final budget offer on Tuesday 25 February 2025. Further consideration of financial recovery will also continue at Midlothian IJB Development Session scheduled for Thursday on 27th February 2025. The Board considered the proposals and whether a 5% reduction for commissioned services should be applied be across the board. The Chief Finance officer clarified that proposals are not for a 5% reduction to all contracts, and the methodology will be reviewed in the 27th of February 2025 Development Session. The Board requested more information to gain a better understanding of likely opportunities and challenges in future years. The Chair stated that the financial position in Midlothian is consistent with the experience across the country with IJBs requiring additional funds to deliver statutory care and support. The Chair stated he	Information required at Midlothian IJB Development Session	Chief Finance Officer	**27/02/2025**

	Decision	Action Owner	Date to be Completed/ Comments
continues to engage with Scottish Government and will write to Neil Gray (MP) to raise the issue of IJB sustainability. The Chief Officer stated that the IJB has reported its financial position to both Partners and with elected members in regular briefing sessions across the year. The Board further noted that difficulties in relation to budget forecasting and the 2024/25 an overspend position, noting it was keen to improve financial forecasting to avoid this in the future. The Chief Officer noted increased prescribing costs, increasing demographic pressures and new costs as people moving into the area with complex support needs. The Board recognised the work of the Officers and the significant achievement of realising £6 million in savings in 2024/25. The Board agreed to progress the discussion with providers relating to the potential outcome of the Special IJB Board Meeting on 27th March 2025	Approved		
Decision **5.9 Midlothian IJB Integrated Workforce Plan 2025/28 - Paper presented by Gill Main, Integration Manager** Gill Main, Integration Manager presented this report and the draft Midlothian IJB Integrated Workforce Plan 2025/28 (**appendix 1**) and 'Annexe A' (**appendix 2**) for approval prior to submission to Scottish Government.			

	Decision	Action Owner	Date to be Completed/ Comments
It was noted that Scottish Government plan to review this information and provide feedback for action prior to publication. This plan has been reviewed by Midlothian HSCP Executive Leadership Team, Midlothian Integrated Workforce Governance Board and Midlothian IJB Strategic Planning Group (SPG) who recommended it to the Board for consideration at the SPG held on 16th of January 2025. **As result of this report Members were asked to:** • Review and approve, subject to required amendments, that the draft Integrated Workforce Plan 2025/28 and Annexe A are submitted to Scottish Government by the 17th March 2025. • Give delegated authority to the Integration Manager to submit these documents to Scottish Government. The Chair thanked the Integration manager for the report and opened it up to any questions or comments. The Board noted the hard to fill posts detailed in the Annexe A report and queried the rationale for this. The Integration Manager clarified that Scottish Government has asked for Annexe A to note pervasively difficult posts to recruit to and that this information was provided by Heads of Services. The Board noted mental health as the most common reason for sustained and long-term absence and queried the action being taken by Midlothian HSCP and employing Partners to address this. The Integration Manager referred to the section in the plan discussing wellbeing and staff engagement, and the HSCP plan to support staff in additional to the support mechanisms of both employing partners. The Board gave delegated authority to the Integration Manager to submit these documents to Scottish Government.	Approved for submission	Integration Manager	**17/03/2025**

	Decision	Action Owner	Date to be Completed/ Comments
For Discussion **5.10 Midlothian IJB Performance Report - Paper presented by Gill Main, Integration Manager** Gill Main, Integration Manager presented this report and provided an update on progress towards the IJB's performance goals for 2023-25, and reviewed performance relating to Midlothian IJB Directions 2024/25. **As a result of this report Members were asked to:** • Note performance against the Midlothian IJB Improvement Goals for 2023/25 (**appendix 1**) • Note the Midlothian IJB Strategic Governance Map (**appendix 2**). • Consider the 'progress' and 'confidence' ratings in Column 4 (**appendix 2**). • Note the inclusion of the Midlothian IJB Directions Year End Report (**appendix 3**). • Note the improvements to the processes of Directions reporting. The Chair thanked the Integration Manager for the report and opened for questions from the board. The Board queried the progress of work to improve frailty pathways, as no narrative was provided. The Chief AHP apologised that this has not been provided and described the positive progress to date and plan to continue this work in 2025/26. Board noted that Frailty pathways narrative to be included in future Direction reporting.	Frailty pathways to be included in Directions reporting	Chief AHP	**31/07/2025**
Discussion (Presentation) **5.11 Unscheduled Care Improvement Working Presentation by Morag Barrow, Chief Officer** The Chief Officer provided an introduction with to this collaborative, whole system initiative.			

	Decision	Action Owner	Date to be Completed/ Comments
Councillor Mckenzie Joined the meeting at 15:03pm. The Chief Officer further highlighting the 4 phases of this plan. The phases of 1,2,3 and 4 were described to the Board and noted the close working with external providers to see the desired change. The Chief Officer highlighted targets, progress to date, and where success has been achieved. The Board welcomed the additional funding from Scottish Government to develop this work, noted improvements, and queried the mechanisms in place to support staff with the potential impact of increased workload. The Chief Officer reported additional staff are being recruitment but noted the challenging recruitment market.			
For Discussion **5.12 Midlothian IJB Draft Directions 2025/26 Review - Paper presented by Gill Main, Integration Manager** Gill Main Integration Manager presented this paper for discussion outlining the work to date to develop Directions for 2025/26 and noted the opportunity for further discussion at the February 27th Development session ahead of the 27th March Special Board. **As a result of this report, Members were asked to:** • Review, discuss and provide feedback on the draft Directions 2025/2026. The Board highlighted Direction 1.4 and the importance of all information and advice should be evidence based, person-centred, and accessible in a way that was meaningful to them. It was requested the Integration Manager consider this addition to Direction 1.4.	Review Direction 1.4	Integration Manager	**27/03/2025**

	Decision	Action Owner	Date to be Completed/ Comments
The Integration Manager noted the production of a Midlothian IJB a writing for publication style guide for that sets out the legal requirement for accessibility and that this had been adopted for all IJB publications.			
Discussion **5.13 Midlothian IJB Draft Directions Policy - Paper presented by Gill Main, Integration Manager** Gill Main, Integration Manager presented the report and a draft Midlothian Integration Joint Board Directions Policy for review and approval **As a result of this report, Members were asked to:** • Review the proposed draft Midlothian IJB Directions Policy and, subject to any amendments, approve for publication. The Board queried whether there was an opportunity to present the work to connect the strategy, Directions and performance management of Midlothian IJB to Partners and demonstrate the connected approach of Midlothian IJB. The Integration manager advised that this work will be noted as the Strategic Plan is submitted to Partners governance meetings as part of the approval process The Board approved the publication.	Approved	Integration Manager	**30/06/2025**
For Discussion **5.14 IJB Members Self-Development Plan - Paper presented by Duncan Stainbank, Chief Internal Auditor**			

	Decision	Action Owner	Date to be Completed/ Comments
Duncan Stainbank, Chief Internal Auditor presented this report which provided an update on the progress of the Midlothian IJB Board Members Self Development Plan for 2023/24. The proposed methodology for updating the plan was also outlined to ensure Board members continued to meet best practice standards. **As a result of this report, Members were asked to:** • Agree to participate in an annual assessment of the Board and creation of a Board Improvement Plan. • Agree to attend a Development Session on an annual basis to undertake a review process. • Provide views on areas for self-improvement via a questionnaire. The Chair noted the Board agreed to continue with a self-development programme and for development at the planned Development Session on 8th May 2025.	Approved	Chief Internal Auditor	**08/05/2025**
For Noting **5.15 Future Plan for the National Care Service Letter from Minister for Social Care, Mental Wellbeing and Sport** The Chair noted that letter of response from the Minster of Social Care, Mental Wellbeing and Sport regarding the future plans for the National Care Service had been circulated to members by the Chief Officer. The chair opened to any questions or comments from the board. The Board queried the plans for ongoing engagement and requested regular updates. The Chair noted continued discussion between Scottish Government and stakeholders regarding the progress of the Bill.	Future updates to be noted	IJB Chair	**Ongoing**

	Decision	Action Owner	Date to be Completed/ Comments
The Head of Adult Services and Chief Social Work Officer noted the proposal to embed the National Social Work Agency within Scottish Government, and the professional view that this should be developed as an independent agency. The Chair closed the conversation advising that updates on progress will be brough to the board as they are received.			

5 Private Reports

No items for discussion.

6 Any Other Business

No items for discussion.

7 Date of Next Meeting

The next meeting of the Midlothian Integration Joint Board will be held on: Thursday 27 March 2025. Please note that this session will include a Development Session for Board Members only from 14:00-14:50pm which will be immediately followed by the Midlothian Integration Joint Board Special Board Meeting.

The meeting terminated at 15:54pm.

Edinburgh Integration Joint Board

Minute

Edinburgh Integration Joint Board

10.00am, Tuesday 25 March 2025

Hybrid Meeting – Main Council Chamber, City Chambers / Microsoft Teams

Present

Board Members

Katharina Kasper (Chair) (item 4-7), Councillor Tim Pogson (Vice-Chair) (in the chair items 1-3), Philip Allenby, Robin Balfour (item 4-7), Councillor Alan Beal, Jessica Brown, Hannah Cairns, Andrew Cogan (substituting George Gordon items 4 - 7), Bruce Crawford, Dr Andrew Coull, Elizabeth Gordon, George Gordon (items 1-3), Matt Kennedy, Peter Knight, Christine Laverty, Jacqui Macrae, Councillor Max Mitchell, Councillor Alys Mumford, Eugene Mullan, Councillor Vicky Nicolson and Moira Pringle.

Officers

Jessica Brown	Innovation and Sustainability Senior Manager EHSCP
Angela Brydon	Operations Manager, EHSCP
Carolanne Eyre	Assistant Committee Officer, City of Edinburgh Council
Andrew Hall	Service Director Strategic Planning, EHSCP
Andrew Henderson (Clerk)	Committee Officer, CEC
Mike Massaro-Mallison	Service Director Strategic Operations Manager, EHSCP
Rhiannon Virgo	Programme Manager, EHSCP

Apologies

Heather Gilfillan and Allister McKillop

1. Deputations

a) The Junction

(in relation to item 7.1 – Savings Programme 2025/2026)

The deputation highlighted that in December, they were informed that it would no longer be in receipt of £35,000 worth of funding from the Edinburgh Drug and Alcohol Partnership and that an annual payment of £12,000 is yet to be confirmed and that despite a one year service level agreement funding has been provided for this service by local authorities for more than two decades. The deputation expressed concern that services supporting young people and parents would be impacted. The deputation highlighted that northeast Edinburgh continues to have the highest levels of drug related deaths and hospitalisations in the city and that the numbers of young people accessing the service have increased and the complexities of the issues raised have also increased. The deputation highlighted that the loss in funding could result in a reduction in the provision of Services.

(see item 4 below)

2. Minutes

Decision

To approve the minute of the Edinburgh Integration Joint Board of Tuesday 25 February 2025 as a correct record.

(Reference – minute of the Edinburgh Integration Joint Board of 25 February 2025, submitted)

3. Rolling Actions Log

The Rolling Actions Log updated to March 2025 was presented.

Decision:

1) To agree to close the following item:

- Action 2 - Digital and Data Strategy

2) To keep Action 3 open – Financial Update to ensure that members are satisfied with the information provided.

3) To note the remaining outstanding actions

(Reference – Rolling Actions Log - March 2025, submitted)

4. Savings Programme 2025/2026

The 2025/2026 Savings Programme to the Edinburgh Integration Joint Board for approval. The Savings Programme forms part of the overarching Medium-Term Financial Strategy, which aims to take a longer-term and more strategic approach to financial planning. Details in relation to the 19 individual savings proposals which seek

to deliver £29m in 2025/26 were provided in addition to details of the associated Integrated Impacts Assessments.

Decision

1) To note savings proposals 1 – 12 which are presented for information.

2) To agree savings proposals 13 - 19, as set out in this report and in the associated appendices;

3) To agree the proposed plan to review Integrated Impact Assessments (IIAs) as set out in appendix 4;

4) To note that a full IIA was deemed not to be possible for this proposal as there had been no previous proposal for use of this funding;

5) To note that concerns have been consistently raised by carers and carers orgs that the replacement care funded by the Carers Act has instead been used for alternative care;

6) To note that it is currently not possible to determine a full picture of replacement care provision due to lack of a comprehensive system to record carer information;

7) To agree that officers work with carer organisations to bring a report to the IJB setting out a strategy for the provision of replacement care, including:

   a) Proposals for shared, accurate recording of carer information or for ways to use existing information, for example using Mosaic to record Adult Carer Support Plans;

   b) Proposals for distributing a portion of the funding for Health and Social Care for a Replacement Care Fund for use by statutory and voluntary sector agencies, or via a microgrants programme to meet the costs of caring;

8) To agree that, the Board are presented with a briefing note on how the HSCP are meeting the requirements of the Carers (Scotland) Act; and

9) To agree that officers provide an update in relation to the timeline of the report setting out a strategy for the provision of replacement care at the next meeting of the EIJB in April.

(Reference – Report by the Chief Officer, Edinburgh Integration Joint Board, submitted.)

5. Draft Medium Term Financial Strategy: 2025/26 to 2027/28

The draft medium-term financial strategy for 2025/26 to 2027/28 was presented. The draft medium-term financial strategy quantified the projected financial shortfall over a 3-year period. It had been prepared largely on an incremental basis and next steps would see improved alignment with the strategic plan. This in turn would inform how scarce resources are best targeted to support the Integration Joint Board's strategic aims.

Decision

1) To note the 2025/26 budget offers from the City of Edinburgh Council and NHS Lothian;

2) To agree to use £0.5m of the delegated budget to support costs associated with delivery of the savings programme;

3) To agree to issue a direction to the City of Edinburgh Council for the uplifting of contracts from 1st April 2025 in line with a minimum hourly rate of £12.60 for front line social care staff using the methodology agreed nationally;

4) To recognise the scale of the financial gap over the 3-year period 2025/26 to 2027/28;

5) To support the ongoing development of the medium term financial strategy, improving alignment with the strategic plan; and

6) To agree to receive an update on progress on a regular and appropriate basis throughout the year

(Reference – Report by the Chief Finance Officer, Edinburgh Integration Joint Board, submitted.)

6. Chief Risk Officer Recruitment

An overview was provided of the discussions to date regarding the recruitment of a Chief Risk Officer.

Decision

1) To agree not to proceed with the recruitment of a Chief Risk Officer;

2) To note that the current arrangements by which the Chief Finance Officer undertakes the role of Chief Risk Officer would continue; and

3) To note that the Audit and Assurance Committee would seek the appointment of an external member with the relevant expertise on a voluntary basis.

(Reference – report by the Chair, EIJB Audit and Assurance Committee, submitted.)

Declaration of Interest

Moira Pringle made a declaration of interest and recused herself for the above item as she is currently undertaking the role of Chief Risk Officer.

7. Date of the next meeting

Decision

To note Monday 29 April 2025 at 10am as the date of the next meeting.

The Minutes were approved on 29th April subject to the following amendment:
To approve the minute of the Edinburgh Integration Joint Board of Tuesday 25 March 2025 as a correct record subject to the inclusion of the following decision under section 4 Savings Programme 2025/2026: To note that the chair would consider how to improve effectiveness and efficiency of board meetings and how members could be included in this process.

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD held within COUNCIL CHAMBERS, WEST LOTHIAN CIVIC CENTRE, LIVINGSTON, on 25 MARCH 2025.

Present

Voting Members – Tom Conn (Chair), Martin Connor, Tony Boyle, John Innes, Amjad Khan and Andrew McGuire

Non-Voting Members – Lesley Cunningham, Hamish Hamilton, David Huddlestone, Jo MacPherson, Alan McCloskey, Ann Pike, Alison White and Linda Yule

Apologies – Damian Doran-Timson, George Gordon and Steven Dunn

Absent – Douglas McGown and Donald Noble

In attendance – Robin Allen (Senior Manager, Older People Services), Neil Ferguson (General Manager Primary Care and Community Services), Sharon Houston (Head of Strategic Planning and Performance), Yvonne Lawton (Head of Health), Karen Love (Senior Manager, Adult Services), Lesley Montague (Standards Officer), Mike Reid (General Manager for Mental Health and Addictions Services), Diane Stewart (NHS Health Improvement Lead) and Kerry Taylor (Project Officer)

1 DECLARATIONS OF INTEREST

There were no declarations of interest made.

2 MINUTES

The IJB approved the minute of its meeting held on 11 February 2025 as a correct record.

3 MINUTES FOR NOTING

a The IJB noted the minutes of the West Lothian Integration Joint Board Audit, Risk and Governance Committee held on 19 December 2024.

b The IJB noted the minutes of the West Lothian Integration Joint Board Strategic Planning Group held on 12 December 2024.

c The IJB noted the minutes of the West Lothian Integration Joint Board ADP Executive held on 28 November 2024.

4 MEMBERSHIP & MEETING CHANGES

The Clerk advised that there were no changes to report.

5 TIMETABLES OF MEETINGS

A proposed timetable of meetings for IJB and a proposed timetable of meetings for the Strategic Planning Group 2025/26 session had been circulated for approval.

Decision

1. To approve the IJB timetable of meetings for 2025/26.

2. To approve the Strategic Planning Group timetable of meetings for 2025/26.

6 2025/26 BUDGET AND MEDIUM-TERM FINANCIAL PLAN

The IJB considered a report (copies of which had been circulated) by the Chief Finance Officer presenting the outcome of the financial assurance process on the agreed West Lothian Council budget contribution and the proposed NHS Lothian budget contribution to the IJB for 2025/26. The report also sought approval for the 2025/26 budget plan. The report also sought approval for the issue of Directions to West Lothian Council and NHS Lothian for delivery of delegated services in 2025/26 and to implement 2025/26 savings measures.

The Chief Officer advised that she was in receipt of a petition requesting to keep the Rosewood café open.

It was recommended that the IJB:

1. Note the financial assurance undertaken on West Lothian Council and NHS Lothian budget contributions for 2025/26;

2. Agree that West Lothian Council and NHS Lothian budget contributions for 2025/26 be used to allocate funding to Partners to operationally deliver and financially manage IJB delegated services from 1 April 2025 (Appendix 1 and 2 of the report);

3. Agree that the 2025/26 Budget Directions be issued to West Lothian Council and NHS Lothian (Appendix 3 of the report);

4. Agree the 2025/26 budget plan and updated savings programme (Appendix 4 of the report) as part of a new three-year financial outlook;

5. Note the risks to deliverability of the proposed saving measures (Appendix 5 of the report);

6. Agree the amended Savings Directions be issued to West Lothian Council and NHS Lothian in respect of operational delivery of saving measures (Appendix 6 of the report);

7. Note the result of the integrated impact assessments of the proposed savings measures (Appendix 7 of the report);

8. Agree the proposals in respect of use of IJB reserves;

9. Note the update on compliance with the CIPFA Financial Management Code (Appendix 8 of the report); and

10. Agree the updated IJB Annual Financial Statement (Appendix 9 of the report).

Motion

To approve the terms of the report.

- Moved by the Chair and seconded by Martin Connor.

Amendment

To approve the terms of the report subject to also agreeing to keep the Rosemount café open for another three months to see if any expressions of interest have been received at the end of this period.

- Moved by Tony Boyle and seconded by Andrew McGuire.

After further discussion, the IJB agreed to approve the terms of the report subject to agreeing an additional recommendation to keep the Rosemount café open for two months starting 25 March 2025, with a review and update provided at the end of the first month, and to agree that the facility will be closed if no viable expressions of interest to take over the running of the café have been received at the end of this period.

Decision

To unanimously approve the terms of the report subject to agreeing an additional recommendation to keep the Rosemount café open for two months starting 25 March 2025, with a review and update provided at the end of the first month, and to agree that the facility will be closed if no viable expressions of interest to take over the running of the café have been received at the end of this period.

7 WEST LOTHIAN ALCOHOL AND DRUG PARTNERSHIP DELIVERY PLAN

The IJB considered a report (copies of which had been circulated) by the General Manager for Mental Health and Addictions Services providing information on the West Lothian Alcohol and Drug Partnership Delivery Plan 2025–2028 and seeking approval for that plan.

It was recommended that the IJB note the contents of the report and approve the plan.

Decision

To approve the terms of the report.

8 CHIEF OFFICER REPORT

The IJB considered a report (copies of which had been circulated) by the Chief Officer providing a summary of key developments relating to West Lothian IJB and updating Board members on emerging issues.

It was recommended that the IJB note and comment on the key areas of work and service developments that had been taking place within West Lothian in relation to the work of the Integration Joint Board.

Decision

To note the terms of the report.

9 WEST LOTHIAN PRIMARY CARE STRATEGY

The IJB considered a report (copies of which had been circulated) and presentation by the General Manager for Primary Care and Community Services providing an update on the development of West Lothian HSCP's inaugural Primary Care Strategy 2025–2028.

It was recommended that the IJB:

1. Note the content of the paper and accompanying presentation and support the described direction of travel in developing a Primary Care Strategy;

2. Note the intention to implement internal and external engagement consultations to support development of the strategy; and

3. Note the intention to present a proposed strategy to the board for ratification in the Spring of 2025.

Decision

To note the terms of the report and presentation.

10 IJB INTERIM PERFORMANCE REPORT

The IJB considered a report (copies of which had been circulated) by the Chief Officer providing a performance report based on the latest published data available on the Core Suite of Integration Indicators, the latest Ministerial Strategic Group Integration Indicators and Primary Care Improvement Plan Performance. The report also contained an overview of the Directions issued to both West Lothian Council and NHS Lothian and

noted the progress made in the development of the Health and Social Care Partnership Performance Dashboard.

It was recommended that the IJB note the contents of the report.

Decision

To note the terms of the report.

11 DEBT RECOVERY (MENTAL HEALTH MORATORIUM) (SCOTLAND) REGULATIONS CONSULTATION

The IJB considered a report (copies of which had been circulated) by the General Manager for Health and Addictions Services informing members of the draft Debt Recovery (Mental Health Moratorium) (Scotland) Regulations and the submission of the draft consultation response on behalf of West Lothian Health and Social Care Partnership.

It was recommended that the IJB note the contents of the report.

Decision

To note the terms of the report.

12 WORKPLAN

A workplan had been circulated for information.

Decision

To note the workplan.

13 DATES OF FUTURE MEETINGS

A list of dates of future meetings had been circulated for information.

Decision

To note the dates of future meetings.

14 CLOSING REMARKS

At the conclusion of the meeting, the Chief Officer advised participants that two of the Health and Social Care Partnership officers – Mike Reid and Kerry Taylor – would be leaving to take up new posts within the NHS.

The Chair on behalf of the IJB thanked Mike Reid and Kerry Taylor for their work on the IJB and wished them well in the future.

MINUTES OF THE MEETING OF THE
EAST LOTHIAN INTEGRATION JOINT BOARD

THURSDAY 20 MARCH 2025
VIA DIGITAL MEETINGS SYSTEM

Voting Members Present:
Councillor S Akhtar (Chair)
Mr J Blazeby
Mr A Cogan
Councillor J Findlay
Ms E Gordon
Mr G Gordon (*substitute)
Councillor L Jardine
Councillor C McFarlane

Non-voting Members Present:
Ms M Allan
Ms L Byrne
Mr D Hood
Mr L Kerr
Ms M McNeill
Mr D Binnie
Dr J Hardman
Dr K Kasengele
Dr C Mackintosh
Ms F Wilson

Officers Present from NHS Lothian/East Lothian Council:
Ms L Berry
Ms L Kerr
Ms I Nisbet
Ms C Goodwin
Mr N Munro
Mr G Whitehead

Clerk:
Ms F Currie

Apologies:
Dr P Cantley*
Mr D Bradley
Ms C MacDonald
Mr T Miller

Declarations of Interest:
None

The Chair welcomed everyone to the meeting. She advised that the meeting was being recorded and would be made available as a webcast in order to allow the public access to the democratic process in East Lothian. East Lothian Council and NHS Lothian were the data controllers under the Data Protection Act 2018. Data collected as part of the recording would be retained in accordance with the Council and Health Board's policies on record retention. The webcast of this meeting would be publicly available for six months.

1. MINUTES OF THE EAST LOTHIAN IJB MEETING ON 20 FEBRUARY 2025 (FOR APPROVAL)

The minutes of the IJB meeting on 20 February were approved.

2. MATTERS ARISING FROM THE MINUTES OF 20 FEBRUARY 2025

The following matters arising from the minutes on 20 February were discussed:

Item 2 – The Chair asked when the update on unscheduled care would be presented to the IJB. Fiona Wilson said that she would discuss this with her out with the meeting.

Item 3 – The Chair asked when the IJB would receive an update on the proposal for a Musselburgh, Wallyford & Whitecraig Day Centre. Laura Kerr advised that discussions were ongoing, and she hoped to provide an update to the IJB in May.

Jonathan Blazeby asked if his request at the last meeting to create an action note had been given further consideration. Members agreed that it would be helpful to have a rolling action note similar to those used by Edinburgh and West Lothian IJBs, which could be attached to the minutes. The Chair agreed to take this forward.

3. CHAIR'S REPORT

A report was presented on the activities undertaken by the Chair of East Lothian Integration Joint Board (IJB) and any relevant updates.

The Chair presented her report drawing attention to some of the activities and events summarised including the recently published Audit Scotland report on IJB finances, a meeting of the IJB Chairs & Vice Chairs and her visit to Dunbar Day Centre with some other IJB members.

Councillor Carol McFarlane encouraged members who had not already done so to visit day centres in the county. She commended their work in supporting clients and carers as well as helping to tackle loneliness. She said that her visit to Dunbar Day Centre had left her feeling very positive.

Responding to a question from Mr Blazeby, the Chair advised that the National Care Service proposals had been pared back but that the introduction of a National Advisory Board was new. She said that Chairs and Vice Chairs had made clear at the meeting that they did not want to see any unnecessary duplication as a result of these revised proposals. Andrew Cogan suggested that it was too soon to be concerned as there was nothing official yet. He would ask officers to bring forward a paper to the IJB in due course when the proposals were clearer.

Maureen Allan referred to the Audit Scotland report and asked for more engagement with the third sector in the decision-making process and said she would be happy to discuss this further with the Chair and Mr Cogan. The Chair agreed that it was important to work in partnership and that perhaps the details of engagement with the voluntary sector needed to be made clearer in reports presented to the IJB.

The Chair concluded by highlighting her recent discussions with both Staff Representatives on the IJB and the two presentations from VCEL and Enjoy which had been shared with members and which might be worth covering in a future development session.

Decision

The IJB agreed to:

i. Note the activities and updates that had taken place since the last meeting.

ii. Note that the report was to help raise awareness of the wide range of work carried out across East Lothian that contributed to the strategic directions of the IJB.

4. IJB MEMBERSHIP AND CHAIR/VICE CHAIR ROLES

A report was submitted by the Chief Officer advising the IJB of the reappointment of three voting members; and to seek agreement for the appointment of a new Chair and Vice Chair for a period of two years from 1 April 2025.

Ms Wilson presented the report outlining the background and recommendations.

She responded to a question from Mr Blazeby proving clarification of the term of office for the reappointment of the voting members.

In reply to questions from Ms Allan, Mr Cogan said his view was that the role of Chair was defined by the IJB's Standing Orders. He was content for issues to come forward to the IJB in the usual way – via reports from officers – and he encouraged members to work with officers on any issues that they may wish to raise. He added that the direction of the IJB was for the IJB to determine and not the Chair.

Ms Kerr added that the IJB had statutory duties which required engagement with the third sector at particular times, and that there may also be a role for Strategic Planning Group (SPG) in improving engagement levels.

Councillor Akhtar thanked officers for their support during her tenure as Chair and offered her thanks to all Partnership staff. She said that she would continue to be mindful of the role of the IJB and the Partnership and she wished Mr Cogan success in his new role.

On behalf of the community, Marilyn McNeill thanked Councillor Akhtar for her work as Chair over the past two years.

Mr Blazeby asked about quarterly reporting to the IJB by the Clinical Care & Governance Committee and whether there could be a standing item on IJB agendas providing an update, verbal or written, from the Chair of the Audit & Risk Committee.

Ms Kerr confirmed that the Clinical Care & Governance Committee met within the Partnership and that its terms of reference and function were currently being revised. She hoped to start bringing reports forward to the IJB from the middle of the year.

Councillor Lyn Jardine agreed that there needed to be further consideration of how information was reported and how meetings were structured. She also felt that there was a similar issue with the SPG. She said she would welcome arrangements to ensure a regular flow through of information.

Ms Kerr suggested that it might be possible to share with members the minutes of the Audit & Risk Committee and the SPG meetings.

George Gordon suggested looking at best practice elsewhere and said that West Lothian IJB included the minutes of their Audit & Risk Committee as part of the IJB meetings and gave the committee Chair the opportunity to comment.

The Chair moved to a roll call vote and the recommendations were approved unanimously.

Decision

The IJB agreed to:

(i) note the reappointment of Councillors Shamin Akhtar, Lyn Jardine and Carol McFarlane, East Lothian Council voting members, for a further term of office

(ii) approve the appointment of Andrew Cogan as Chair of the IJB from 1 April 2025

(iii) approve the appointment of Councillor Shamin Akhtar as the Vice Chair of the IJB from 1 April 2025.

5. 2025/26 BUDGET OFFERS TO THE IJB

A report was submitted by the Chief Finance Officer setting out the budget offers from East Lothian Council and NHS Lothian to East Lothian IJB for 2025/26.

Mike Porteous presented the report giving a detailed summary of the formal budget offer from East Lothian Council and the indicative offer from NHS Lothian. In assessing the offers against Scottish Government guidelines, he noted that the Council's offer passed on all uplifts it had received and had provided additional monies to fully fund pay rises for directly employed staff, and to address historical growth and financial pressures. Mr Porteous felt that this was a fair offer, and he recommended its acceptance. The NHS Lothian indicative offer included a commitment that any uplift for delegated budgets would be passed on in full to the IJB which complied with Scottish Government guidelines. He advised that NHS Lothian would set their own budget in April and a formal offer to the IJB would follow shortly thereafter. He concluded by saying that while the offers allowed the IJB to address baseline funding, they did not offer headroom to invest in any way.

Mr Cogan welcomed the offers from both partners. He said he was more than happy with them and the IJB could now move on to setting its own budget for 2025/26.

Mr Blazeby agreed saying that the IJB needed to look at transformational change and what these offers meant for service delivery and how the public might be feeling about

what the IJB intended to deliver this year. He queried the difference between the two offers and why NHS Lothian's offer would not be confirmed until two months into the new financial year.

Mr Porteous explained the criteria for assessing the offers and whether they were fair. He said that as the Scottish Government only provided single year settlements for the NHS and local authorities it was difficult to plan ahead on that basis. In terms of the disparity between the offers, he said that the IJB would need to wait until it received the final offer from NHS Lothian to see what it would mean for additionality. He confirmed that the Council had given the IJB additional funding for 2025/26.

Mr Blazeby commented that it was a distraction to be talking about finances and efficiencies at every meeting and he hoped that next year would be different.

Councillor Jardine said that the public sector in general was in a moderately better position this year due in part to the UK government's financial decisions. She said that while there was a desire to move to multi-year settlements it was dependent on the result of the UK government's spending review. She hoped that the Council's offer would provide breathing space for the and she asked if officers could provide an idea of what transformational change might look like and the IJB's role in that.

Mr Porteous said that while these offers would hopefully provide breathing space for the IJB to consider the challenges ahead, pressures would inevitably come along during the financial year and would require the IJB to review what was happening on the ground. However, he hoped the offers would give the IJB the chance to take stock and to put plans in place to better manage the financial challenges ahead.

Ms Wilson agreed but acknowledged that the IJB did now need to consider transformational change, how that would work within the new Strategic Plan and how to ensure that the IJB's vision aligned with what was on offer. She said that to have these budget offers was quite remarkable compared to where they expected to be and was partly due to the relationships and conversations with the IJB's partners. She added that transformational change was harder when getting 1-year settlements, and that these conversations would continue throughout the year.

Kalonde Kasengele commented that unless the IJB somehow found a way of moving towards transformational change, meetings would always include discussions around efficiencies and finances.

Mr Blazeby said that the link to the Strategic Plan would be key and would be where he would expect to see some of that transformational change. He reiterated his views expressed at the last meeting on the need to speed up that work.

Ms Wilson reflected that sometimes the IJB could influence things and sometimes things developed as a result of external factors.

Ms Allan asked about the role of communities in decision-making and said that some of the transformational change needed to be community-led. Ms Wilson said she would pick this up with Ms Allan out with the meeting.

The Chair summarised the comments and concerns expressed during the debate. She also welcomed the offer from East Lothian Council and said she looked forward to seeing the final offer from NHS Lothian.

The Chair moved to a roll call vote and the recommendations were approved unanimously.

Decision

The IJB agreed to:

i. Accept the 2025/26 Budget Offer from East Lothian Council.

ii. Note the NHS Lothian indicative budget offer and its principles, with a formal offer to follow in due course.

6. BUDGET SETTING 2025/26

A report was submitted by the Chief Finance Officer setting out: the work undertaken to date on the budget setting process; the proposal that the IJB sets a balanced budget for 2025/26 based on the delivery of identified savings plans; and an updated 5 Year Financial Plan for the IJB.

Mr Porteous presented the report and began by reflecting on 2024/25 where despite the delivery of significant efficiencies, the year-end position was a forecast overspend of £3.5M. He said that the IJB needed to continue to plan ahead to meet its challenges and part of that would be to set a balanced budget at the start of the year. Following the budget offers, the IJB was in a good starting position for 2025/26 and would look to close the projected funding gap of £4.1M with further efficiencies. He advised that when applied, the Council offer presented a balanced position for social care, but the NHS Lothian indicative offer showed a small gap for health which was completely within set aside services. He said that, as in the past, he would work collaboratively with finance colleagues to deliver a balanced position at year end. He drew attention to the efficiencies listed in the report indicating that these were expected to deliver in full and would have no impact on the current Strategic Plan.

Lastly, Mr Porteous highlighted the section of the report on the IJB's 5-year financial plan. He referred to some of the key risks and confirmed that he would bring updates to future meetings of the IJB. He concluded that the situation would remain challenging and that there may be difficult decisions ahead.

Mr Porteous responded to questions from Ms Allan. He said he was aware that a number of efficiency schemes had not delivered during the year, and some had not been taken forward. He would reflect on those schemes, why they had not delivered and whether they could be delivered going forward. This work would provide a starting point for future efficiencies and financial planning. He agreed that the current year budget gap could have been somewhat reduced if these efficiencies had been delivered by the year end.

Ms Wilson reminded members about some of the context and discussions on why some schemes did not deliver, for example where they may have caused harm, adding that that these were difficult decisions to take.

The Chair suggested that further information on the efficiencies could be circulated to members.

Replying to Mr Cogan, Mr Porteous confirmed that they intended to maintain the current level of service through a combination of the budget offers and delivery of agreed efficiencies.

Mr Cogan said that the IJB needed to take this year to consider how to manage the concept of transformational change through the Integration Scheme, and to consider

what that would look like for the next 3-5 years. He said he would welcome this being to focus of the next couple of development sessions.

Elizabeth Gordon stated that at its recent meeting the Audit & Risk Committee had received an internal audit report on recovery plan monitoring which had recommended that the IJB receive updates on the progress of efficiencies as part of its regular financial reporting. She said that she would welcome this as well as regular reporting to the Committee.

Councillor Jardine said that she was increasingly anxious of the impacts on communities, with some more vulnerable than others. Given that the IJB was going to be looking at much more transformational change in future, she would expect officers to provide comprehensive evidence-based Integrated Impact Assessments (IIAs) as part of their reports.

Ms Kerr agreed advising members that all completed IIAs had risks and mitigations highlighted were reviewed within 6-12 months. She assured members that these were active documents which were available online and open to challenge from the IJB. She added that the mainstreaming equalities report would be coming back to the IJB soon and it might be helpful to have this as the focus of the development session in April.

David Binnie shared with members the situation which Carers of East Lothian had found themselves in when re-tendering for a new contract. The challenges of rising costs, such as employer NICs, and reduced tendering budgets has led to the organisation starting to lose staff and there would be further challenges ahead. He said that this was an illustration of the on just one of the county's third sector organisations who were delivering key services.

Ms Kerr agreed that it was a very difficult situation as organisations had year on year increases to meet but the IJB didn't have increased year on year funding to offer. Although the IJB was not cutting these services, organisations would end up delivering less with what they were given.

Ms Allan suggested that, if not already available, there needed to be an IIA specific to impact on community organisations. She said that the IJB needed to be mindful that if community services and support were reduced the impact on statutory services would rise significantly.

The Chair highlighted the importance of further integration and seeing progress on the work on set aside and shifting the balance of care. The IJB needed to fully utilise transformation work done by all its partners and take full advantage of opportunities to participate in this work. She agreed that it would be helpful to delve a bit deeper into these issues during a development session.

The Chair moved to a roll call vote and the recommendations were approved unanimously.

Decision

The IJB agreed to:

i. approve a balanced budget on the basis of the approach highlighted in paragraph 3.10 of the report.

ii. approve the Efficiency plans highlighted in Table 2 and detailed in Appendix 1 of the report.

iii. note the scale of the projected financial challenges set out in the updated IJB 5 Year Financial Plan.

7. HEALTH AND SOCIAL CARE INTEGRATION – STAFF AND CLAIMS PROTOCOLS - EAST LOTHIAN COUNCIL AND NHS LOTHIAN

A report was submitted by the Chief Officer formalising Staff and Claims Protocols for East Lothian Council and NHS Lothian which set out HR and contractual matters for East Lothian Council and NHS Lothian employed staff of East Lothian Health and Social Care Partnership.

Ms Kerr presented the report outlining the background and advising members that these protocols should have been in place earlier but for various reasons had not come to fruition. Their purpose was to support the HSCP and partner's employees and would sit alongside other protocols as set out in the report.

In response to questions from Mr Blazeby, Ms Kerr confirmed that the IJB did have authority to approve these documents, and it was part of its role within the terms of the Integration Scheme. The partners had been very involved in the development of the protocols and had given their agreement to the drafts now being presented to the IJB. She explained that the protocols were designed to address process issues and ease the provision of services for staff.

Ms Gordon said that she was reassured by the knowledge that both the Council and NHS Lothian's HR departments had reviewed the documents. She felt that they were useful documents which provided clarity for employees.

Replying to questions from Liam Kerr and the Chair, Ms Kerr confirmed that the IJB's Staff Representatives had both previously had sight of the protocols.

The Chair comments that the protocols offered a practical way to deal with issues. She moved to a roll call vote and the recommendations were approved unanimously.

Decision

The IJB agreed the Staff and Claims Protocols for ratification.

8. APPOINTMENT OF IJB STANDARDS OFFICER

A report was submitted by the Chief Officer nominating a replacement Standards Officer, as required by the Ethical Standards in Public Life (Scotland) Act 2000. This nomination was subject to approval by the Standards Commission for Scotland.

Ms Wilson presented the report outlining the background to the requirement for a Standards Officer in recognition of the IJB as a devolved public body. It had been acknowledged that there needed to be a more independent officer in this role rather than the Chief Officer of the IJB and the recommendation was to nominate the Council's Head of Corporate Support, subject to approval by the Standards Commission.

Mr Blazeby agreed that this was a sensible approach and asked about Ms Barnett's experience. Ms Wilson advised that Ms Barnett had recently supported an information and engagement session for councillors on standards and their Code of Conduct and both the Council and NHS Lothian were supportive of the proposal.

Councillor Jardine said that Ms Barnett had taken over as the Council's Monitoring Officer last year and had made a very positive impression. Councillor Jardine was supportive of this nomination.

The Chair said that Ms Barnett had also worked in the City of Edinburgh Council. She also suggested that it might be useful to have a future session for members with Ms Barnett.

The Chair moved to a roll call vote and the recommendations were approved unanimously.

Decision

The IJB agreed to:

i. Nominate East Lothian Council's Head of Corporate Support, Hayley Barnett, as a replacement to the IJB Chief Officer, as Standards Officer to East Lothian's IJB.

ii. Note the appointment was subject to approval by the Standards Commission Scotland.

Signed .....

Councillor Shamin Akhtar
Chair of the East Lothian Integration Joint Board

NHS Lothian

4.10

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 2025**
Title:	**NHS Lothian Resilience Framework**
Responsible Executive:	**Caroline Hiscox, Chief Executive**
Report Author:	**Ian Orr, Head of Resilience**

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 Civil Contingencies Act (2004), Contingency Planning (Scotland) Regulations (2005), Preparing Scotland (2008), and Preparing Emergencies (2023) sets out the framework on how NHS Lothian should deliver its obligations under the Civil Contingencies Act (CCA).

The NHS Lothian Resilience Framework v1.1 outlines how the organisation will deliver its statutory duties under the CCA and associated Regulations.

2.2 Background

The NHS Lothian Resilience Framework v1.1 (Appendix 1) was developed to give a strategic overview of NHS Lothian's approach to resilience. The Framework details how the organisation fulfils its statutory duties outlining the roles, responsibilities and governance arrangements.

In addition, the Framework incorporates incident definitions as outlined within *"NHS Scotland National Incident Response Levels – Guidance for Health Boards in Scotland April 2024"*

2.3 Assessment

NHS Lothian's Resilience Framework ensures that we:

- **Safeguard** our responsibilities under the CCA and associated Regulations, for example Emergency Planning, Business Continuity Management (BCM), Pandemic Influenza Planning, and additional areas such as Counter Terrorism (CONTEST/PREVENT), security awareness.
- **Co-ordinates** our ongoing organisational planning, giving due consideration to our partner agencies, that is, the East of Scotland Regional Resilience Partnership (EoSRRP) and Lothian Local Resilience Partnership (LRP).
- **Review** and maintain emergency and associated plans to an agreed schedule.
- **Ensure** a jointly owned and agreed Resilience Team annual work plan for the delivery of our organisational demands from the top down and from the bottom up throughout the organisation.
- **Evaluate** the effectiveness for our resilience duties that is tangible, explicit, and meaningful.
- **Ensure** the Resilience Team keep abreast of all good practice, locally and nationally in order that we can benefit from others experience.
- **Ensure** that there is appropriate capacity and resources available for staff to discharge their organisational responsibilities.
- **Review** high level risks to the organisation in the form of the RRP Risk Register and Local Risk Registers and ensure appropriate actions are in place to mitigate those risks.
- **Develop** a robust training, exercise, audit, and review regime to stimulate a culture of continuous quality improvement across the organisation for contingency planning.

Furthermore, it was agreed at the Strategic Resilience Group in November 2024 that NHS Lothian would move from Operational Resilience Plans to Business Continuity Plans. A detailed Implementation Plan has been developed by the Strategic Resilience Group and was reviewed and approved by the Corporate Management Team in April 2025. This outlines the key deliverables, timescales and measures of success for 2025/26.

The mechanism by which the Board receives ongoing assurance in this area is provided through the Annual Resilience Report to HGC. The last Annual Report went to HGC for scrutiny in January 2025 and Moderate Assurance was accepted. The next Annual Report will be presented to HGC in January 2026.

2.3.1 Quality/ Patient Care

The provision of robust Resilience and Business Continuity Plans ensures the provision of essential services outside of normal working hours and in the event of service disruptions thereby enabling the continuation of a high-level of safe, effective patient care.

2.3.2 Workforce

Resilience and Business Continuity Plans and arrangements allow staff to respond to emerging issues and incidents in a controlled and effective manner. Training and exercising enable staff to develop and maintain skills and knowledge in a coordinated and supporting way. This approach allows staff to function in a potential high-pressured environment with the necessary skills.

2.3.3 Financial

There is no financial impact. The evolving Business Continuity work involves changes to existing processes.

2.3.4 Risk Assessment/Management

Risk management is a key driver for resilience work. Any risks are captured within local risk registers.

2.3.5 Equality and Diversity, including health inequalities

There is no impact or considerations relating to Equality, Diversity and health inequalities as this does not relate to a new policy or service redesign.

2.3.6 Other impacts

There are no other impacts for consideration.

2.3.7 Communication, involvement, engagement and consultation

This is an internal matter and does not require formal external communication, involvement, engagement and 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.

- Strategic Resilience Group, 11 November 2024
- Corporate Management Team, 06 May 2025

2.4 Recommendation

- **Decision** – The Board approves the NHS Lothian Resilience Framework.
- **Assurance** – The Board is asked to agree and accept significant assurance that NHS Lothian has in place a suitable Framework to support and enable the Board's compliance with the Civil Contingencies Act 2004 and its associated Regulations, as well as the Scottish Government's published guidance on Preparing for Emergencies.

3 List of Appendices

The following appendices are included with this report:

- Appendix 1 – NHS Lothian Resilience Framework v1.1

NHS Lothian
Resilience Framework

May 2025

Version 1.1(draft)

(Review date: May 2028)

Document Control

Date of First Issue:	
Approved:	
Current Issue Date:	
Review Date:	
Version:	
Author/Contact:	Ian Orr, Head of Resilience
Group Committee:	NHS Lothian Strategic Resilience Group

NHS Lothian

CONSULTATION AND CHANGE RECORD

Contributing Authors:		Nicola Watt	
Consultation Process:		SRG	
Distribution:		On intranet	
Change Record			
Date	**Author**	**Change**	**Version**
November 24	Nicola Watt	New document	1.0
February 25	Ian Orr	Updated after SRG 03.02.25	1.1

Note: This document should be read in conjunction with **UK Influenza Pandemic Preparedness Strategy** 2011 which provides extensive background information.

Contents

1. Introduction

The Civil Contingencies Act (2004), Contingency Planning (Scotland) Regulations 2005, Preparing Scotland 2008, and Preparing Emergencies 2023 sets out the framework on how NHS Lothian should deliver its obligations under the Civil Contingencies Act (CCA).

The principle of Integrated Emergency Management (IEM) identified in Preparing Scotland, highlights the importance of *"The development of flexible response planning based on responders' day to day activities defined as functions under the CCA"*. This overall approach is supported by focusing on five main functions, *assessment, prevention, preparation, response, and recovery*.

A key underlying principle of this approach is the integration of Emergency Planning (EP) and Business Continuity Management (BCM) functions across NHS Lothian. This ensures reduced duplication and increased capacity to respond to major incidents and infrastructure failures when they arise.

The Resilience Team has been established to deliver the work programme of the Strategic Resilience Group (SRG) and support improvement in organisational resilience.

This must be seen in the context of significant additional duties for Category 1 Responders, organisational and service development and NHS Lothian and partners who deliver integrated health and social care services.

2. Purpose

NHS Lothian's Resilience Framework ensures that we:

- Safeguard our responsibilities under the Civil Contingencies Act 2004 and Contingency Planning (Scotland) Regulations 2005 for example, Emergency Planning, Business Continuity Management (BCM), Pandemic Influenza Planning, and additional areas such as Counter Terrorism (CONTEST/PREVENT) and security awareness.
- Co-ordinate our ongoing organisational planning, giving due consideration to our partner agencies and taking cognisance of the work of the East of Scotland Regional Resilience Partnership (EoSRRP) and Lothian Local Resilience Partnership (LRP).
- Regularly review and maintain emergency and associated plans.
- Ensure a jointly owned and agreed annual work plan that will detail shared priorities, agreed responsibilities and accountability for the delivery of our organisational demands from the top down and from the bottom up throughout the organisation.
- Have a robust evaluation of effectiveness for our resilience duties that is tangible, explicit, and meaningful.
- Keep abreast of all good practice, locally and nationally in order that we can benefit from others experience.

- Ensure that there is appropriate capacity and resources available for staff to discharge their organisational responsibilities.
- Review high level risks to the organisation in the form of the RRP Risk Register, Corporate Risk Register and local Risk Registers and ensure appropriate actions are in place to mitigate those risks.
- Develop a robust training, exercise, audit, and review regime to stimulate a culture of continuous quality improvement across the organisation for contingency planning.

3. Roles and Responsibilities

3.1. NHS Lothian Resilience Governance and Organisational Structure

An organisational chart documenting the Resilience governance structure within NHS Lothian is detailed in Appendix 1. A summary of the roles of each group is described below.

3.1.1. NHS Lothian Health Board

NHS Lothian, as a Category 1 Responder, has the overall strategic responsibility and statutory duty for ensuring the delivery of the resilience agenda for NHS services, patients, and staff.

These may be revised during an incident if necessary.

3.1.2. Healthcare Governance Committee (HCG)

The Healthcare Governance Committee fulfils the relevant non-executive scrutiny and assurance function, on behalf of the Board. It will receive an annual report and any escalation of issues if required.

3.1.3. Corporate Management Team (CMT)

The Corporate Management Team acts as the Management Team of the organisation. The purpose of the CMT is to ensure that robust systems and processes are in place to allow review of performance, ensure continued improvement and to take an overview of strategic planning to support effective and transparent decisions.

In addition, the CMT will provide direction in the event of resilience planning, preparedness, and response. Furthermore, the CMT will ensure that as a Category 1 responder, NHS Lothian will support its partners in line with national and regional response protocols and statutory duties.

The CMT will be kept informed on issues arising via the Chair of the Strategic Resilience Group, as required, and will receive a formal annual report from the SRG, produced by the Head of Resilience.

3.1.4. NHS Lothian Strategic Resilience Group (SRG)

This forum and structure bring together responsible Executive Directors from CMT to ensure the organisation can drive forward the development, implementation, monitoring, and review of organisational responsibilities under the Civil Contingencies Act 2004, Contingency Planning (Scotland) Regulations 2005 in terms of resilience matters.

3.1.5. NHS Lothian Acute Sites Tactical Resilience Groups (TRG)

The Acute Sites Tactical Resilience Groups lead the acute operational response in relation to major emergency planning, major incidents, business continuity management and pandemic influenza. The group also co-ordinates the resilience work stream, exercise, and training for acute services.

3.1.6. Integrated Joint Boards/Health and Social Care Partnerships (IJB/H&SCP)

Health and Social Partnerships have operational responsibility for a range of services and facilities. In 2021 Integrated Joint Boards became Category 1 responders under the Civil Contingencies Act 2004. These services play a key role in the planning, activation and response to a major emergency or ongoing incident, for example, severe weather or pandemic influenza. Edinburgh, Midlothian, East and West Lothian Health & Social Care Partnerships have a lead role, in conjunction with other Category 1 Responders, in activation, response and recovery mechanisms when responding to incidents for their area of responsibility.

3.1.7. Primary Care and other Health Care Services

All primary care independent contractors, including General Practice, General Dental Practitioners, Optometrists and Community Pharmacies should have contingency, business continuity and escalation plans in place to respond to a major incident. It is the contractor's responsibility to ensure that business continuity plans are revised in a timely way.

HSCP primary care teams will also have plans in place to support general practice over the medium to long term if required. The Primary Care Contracts Organisation (PCCO) will ensure all contractors are reminded of their responsibilities on an annual basis.

3.2 External Partners

3.2.1 East of Scotland Regional Resilience Partnership (EoSRRP)

The purpose of the East of Scotland Regional Resilience Partnership is to establish and maintain a strategic formal partnership as an aid to planning for the effective management of a major incident response. They also ensure that the partners, in its continuing development and implementation, are fully prepared to respond always to major incidents. In addition, to further ensure the effective delivery of those duties under the CCA are developed in a multi-agency environment. NHS Lothian may also offer mutual aid support to partners within the RRP area.

Lothian & Borders Local Resilience Partnership (LRP)

Lothian and Borders Local Resilience Partnership is responsible for the management, development, and implementation of plans that are determined by the EoSRRP, within the Lothian & Borders Area. The LRP contains 'tactical level' representation for example, Directors, Senior Managers, Heads of Service as well as Resilience Practitioners and has a significant role to play in advising and implementing actions as identified by the EoSRRP. The LRP also has the lead role in coordinating activation, response, and recovery plans on a multi-agency basis in Lothian & Borders area.

3.3 Staff Roles

Category 1 Responders have a duty to ensure that all staff are aware of their role when involved in situations that relate to the Civil Contingencies Act 2004), associated regulations and the wider resilience agenda. A summary is provided below:

3.3.1 Chief Executive

The Chief Executive has the overall responsibility on behalf of NHS Lothian to ensure that all the statutory and non-statutory responsibilities brought by the Civil Contingencies Act 2004 and Contingency Planning (Scotland) Regulations 2005 (as they relate to all resilience matters) are met.

3.3.2 Director of Public Health (DPH)

The Director of Public Health is the designated Executive Lead and is responsible for the leadership and co-ordination of all resilience matters on behalf of NHS Lothian. The DPH will fulfil the role of Chair of the SRG.

3.3.3 Directors

All Directors and Chief Officers will be responsible for the co-ordination, development, monitoring, and review of all matters relating to resilience matters within their areas of responsibility. They will be supported in these efforts by the Resilience Team however, the primary responsibilities for services/functions will remain with the respective Director.

3.3.4 Health & Social Care Joint Directors

In 2021, IJB's became Category 1 responders under the Civil Contingencies Act 2004. By contributing a strategic view to emergency response, IJB Chief Officers will identify solutions to be delivered during an emergency to support NHS Lothian's response, but their primary function should be the strategic planning of emergency responses.

3.3.5 Service Managers, Locality Managers and Heads of Service

All managers will be responsible for the operational delivery of resilience issues within their service areas and to ensure staff are aware of their respective roles and duties.

3.3.6 All Staff

All staff are responsible for making themselves familiar with their individual roles as set out in Resilience Plans, for example Tactical and Operational Plans etc. They should be aware of where the Action Response Cards are in their workplace and the details on how they are expected to respond to an incident. Regular participation in training, exercising and incident debriefs will ensure familiarity and lessons learned.

3.3.7 Specific Operational Roles

Several operational roles are initiated when a specific response is required to a major emergency or infrastructure failure for example, Director, Hospital Medical Coordinator, Senior Manager, Site & Capacity and Administrative Loggist. These roles are described in the appropriate policy, plan, or protocol available under emergency plans on the intranet. (NB this is not an exhaustive list):

- Major Incident Plan
- Persons of Interest to the Media & Security (PIMS)
- Controlled Movement and Access Procedures (CMAP)
- Business Continuity Plans (Service/Site specific) – under development
- Pandemic Influenza Plan
- Bomb Threat, Suspicious Packages – under review
- Radiation Monitoring Unit Plan (RMU)
- Chemical, Biological, Radiological and Nuclear-Hazardous Material (CBRN-HazMat) Protocol v8 October 2022 – under review

4 Incident Response

Incident planning and response is based on the Scottish Government National Incident Response Levels, Guidance for Health Boards in Scotland April 2024. Levels may change as the incident evolves. Incident response levels describe at which level coordination takes place.

There are three main types of incidents that may affect Health Boards, summarised below:

4.3.1 Business Continuity

An event or occurrence that reduces or might reduce a Health Board's normal service delivery to below acceptable levels. This would require special arrangements (such as temporary re-deployment of local/regional resources and mutual support) to be put in place until services can return to an acceptable level. There may also be impacts from wider issues such as supply chain disruption or provider failure.

4.3.2 Critical Incident*

Any localised incident where the level of disruption results in a Health Board losing its ability to deliver critical services, or, where patients and staff may be at risk of harm. It could also be linked to the environment potentially being unsafe and requiring special measures and support from other agencies to restore normal operating functions.

A Critical Incident is principally an internal escalation response to increased system pressures/disruption to operations delivered by the Health Board. Unlike a major incident, a Critical Incident does not have any actions prescribed by either legislation or national guidance that must be taken as a result.

*Critical Incident response forms part of NHS Lothian system pressures escalation process.

4.3.3 Major Incident

A Major Incident is defined in the Joint Emergency Services Interoperability Principles (JESIP) as: **"An event or situation with a range of serious consequences that require special arrangements to be implemented by one or more emergency responder"**.

For Health Boards in Scotland, this will cover any occurrence that presents serious threat to the health of the community, or is otherwise likely to cause, such numbers or types of casualties as to require special arrangements to be implemented.

This may involve a single health board, although it is more likely to require a multi-agency response, which may be in the form of mutual aid or multi-agency support to lead responder organisation, for example a local authority or Police Scotland.

The severity of the consequences associated with a Major Incident are likely to constrain or complicate the ability of responders to resource and manage the incident, although as a Major Incident is unlikely to affect all Health Boards or other responders equally, so mutual aid may still be available from elsewhere.

Levels of Response

The levels in the Scottish Government guidance below must be used by all NHS Boards when referring to incident.

Table 1

Level	Type of Response	Responders
1	**Impact felt in a single, limited location**. Can be responded to and managed locally within respective business as usual capabilities and business continuity/emergency plans of the affected Health Board.	Local Health Board Multi-Agency/Regional (if part of Business Continuity Plans
2	**Impact felt across a single Health Board.** Requires the response of more than one Territorial Board within a Resilience Partnership area; or Local impact on a National Board where support and coordination is required at local/regional level	Territorial/National Health Boards Multi-Agency/Regional
3	**Impact felt across more than one Health Board and / or regionally.** Requires a response from multiple Territorial Boards across regions and/or where there is sector impact from a National Board.	Territorial/National Health Boards Multi-Agency/Regional Awareness/Advisory Role NHS Chief Executive & Chief Operating
4	**Impact felt across several Health Boards and/or impacting national capacity and capability**. An incident that impacts the health sector across Scotland and requires national level command and control	Chief Executive, NHS Scotland Chief Operating Officer, NHS Scotland SGHSCD: Health EPRR Scottish Government/Ministers Ongoing Support Territorial/National Health Boards Multi-Agency/Regional

While several Health Boards may be experiencing significant or sustained pressure, this does not mean that NHS Scotland (as a single national entity) is operating at the same response level. The table above provides an overview of response levels used to help determine the level of local, regional, national and/or multi-agency involvement.

Local and regional governance structures will lead the response for Levels 1-3 and provide ongoing support to national response at Level 4. National response would normally not be required below Level 3, however, reporting of and communication of incidents at these levels should be part of Board arrangements. This will ensure that at a national level, there is an awareness of escalating incidents at the earliest opportunity. National C3 response structures would be fully activated at Level 4.

Health Boards must be able to demonstrate that they have identified, fully considered, and exhausted all mitigation measures and response options available to them before escalation.

** Local/Regional response will continue to provide ongoing support to national response structures as required.

Any incident meeting category 2-4 will automatically enact the Incident Command model of Operational/Tactical/Strategic Plans.

Further detail on the incident command structure is available in Appendix 1. This structure & response is fully embedded in the Major Incident Plan

5 Business Continuity Planning

NHS Lothian are progressing a hybrid model of Business Continuity Plans. These are being developed by services/departments using templates and guidance hosted on a dedicated Business Continuity Intranet Site. In addition, infrastructure Business Continuity Plans are being developed for all of NHS Lothian premises, these will be cross referenced within departmental plans. This approach aims to avoid duplication of utility infrastructure information and allows services to consider pan Lothian flexibility should it be required. Review of timescales are also set to ensure key priority areas are reviewed regularly with updates if required. The maximum period for review has been set at 3 years for low priority areas.

Business Continuity Plans will be prepared following a Business Impact Assessment being undertaken and will consider areas such as:

- Staffing requirements.
- Key tasks and the impact of not completing them.
- Alternative locations for patients and staff.
- Communications.
- Critical Equipment.

- Critical Software.
- Critical Records.
- Critical Supplies.
- Internal and External Suppliers.

The Business Impact Assessment aims to draw out information on:

- What needs to be done?
- When?
- Where are the alternative resources located?
- Who is involved?
- How is continuity to be achieved?

All NHS Lothian Business Continuity Plans will be reviewed by the Resilience Team and will be held locally by the service and centrally with Resilience team who will maintain a summary log of Business Continuity Plans showing when last completed and when next review is scheduled. Governance will be provided by the SRG through regular summary reports.

6 Training

As an employer there is a duty placed on NHS Lothian, Local Authorities, and other Category 1 Responders to assess their workforce training requirements and ensure that staff have access to appropriate training that allows them to fulfil their role by:

- Regularly assessing training requirements.
- Provide organisational awareness training for new and existing members of staff.
- Deliver focused training for identified key members of staff, within Directorates, Partnerships, and service areas.
- Further specific training may be provided in response to any training gap identified after debriefing of a live incident or exercise of any plan.
- Development of eLearning training packages to meet specific training requirements.

Training opportunities are regularly reviewed. Any training undertaken both internally and externally by NHS Lothian staff is reported to each SRG. There is also the opportunity to identify training needs within the organisation by departmental representatives. Larger internal exercises will be highlighted in the Annual Report.

7 Exercising

Exercises are undertaken to validate organisations' capability to manage incidents and emergencies. Specifically, exercises will seek to validate training undertaken, and the procedures and systems within emergency or business continuity plans.

The minimum accepted frequency for any of these exercises can vary dependent on legislative requirements. However, it is recognised that different levels may be influenced by the following factors:

- Frequency of exercise should depend upon the organisation's needs.
- Environment in which it operates.
- Stakeholder requirements.
- Rate of change within the organisation; and
- Outcome of previous exercises.

8 Monitoring and Review of Resilience Plans, Incidents and Processes

Resilience policy documents must be submitted to the SRG for approval.

As part of the continuous quality improvement process, if a Major Incident or Business Continuity failure has taken place, a formal debrief process will be established and an action plan produced to take forward any lessons identified by the affected service. The outcome from the debrief process should be considered by the appropriate group and reported to the SRG.

The Resilience Team will:

- Produce an annual report to the Strategic Resilience Group on progress, which will in turn inform annual assurance reporting to the CMT and to the HGC.
- Take the lead role in developing and reviewing the implementation of any action plan based on audit findings that relate to resilience.
- Co-ordinate and participate in internal and external audit processes that take place in relation to resilience for example the Scottish Government NHS Standards for Organisational Resilience.

9 Recovery from Major Incidents

Recovery addresses the human, physical, environmental, and economic impact of emergencies. Recovery is not a discrete element of emergency preparation and response; it should be an integral part of the combined response as actions taken always can influence the

longer-term outcomes for communities.

Experience of emergencies in Scotland has demonstrated the importance of involving the community in its own recovery and NHS Lothian will work with other Resilience Partners in developing our recovery arrangements after a major incident as defined in Local Care for People.

10 Review

This framework will be reviewed every 3 years or sooner if required.

11 Membership of NHS Lothian Strategic Resilience Group and Terms of Reference

The Strategic Resilience Group is chaired by the Director of Public Health and Health Policy. The Group comprises CMT Members across NHS Lothian, including Primary and secondary care services, and staff with specialist knowledge of risk and resilience.

Director Public Health & Health Policy **(Chair)**	Chief Executive
Deputy Chief Executive	Medical Director
Director of Nursing	Director of People & Culture
Director of Finance	Chief Officer, Acute
Director of Estates and Facilities	Director, Digital (E Health)
Director ELH&SCP	Director EDINH&SCP
Director WLH&SCP	Director MLH&SCP
Director Communications & Public Affairs	Director of Transformation
Director of Primary Care	Employee Director (Partnership)
Head of Resilience	

Terms of reference

Purpose

To enable NHS Lothian to comply with its statutory duties, to deliver services and to fulfil NHS Lothian's objectives to the highest practicable level during major emergencies and at times of disruption, and to do so in ways consistent with its stated values.

Objectives

The objectives of the Strategic Resilience Group are to:

- Provide strategic leadership and governance of resilience work across NHS Lothian, including both Emergency Preparedness and Business Continuity.
- Ensure full compliance with statutory duties, including The Civil Contingencies Act 2004 and Civil Contingencies Act (Contingency Planning) (Scotland) Regulations 2005 and legislation.
- Provide formal and evidenced assurance to the Corporate Management Team, the Healthcare Governance Group and Board through the Resilience Annual Report and Resilience Framework.
- Ensure resilience work is conducted in ways consistent with current best practice, considering national and other relevant guidance.
- Ensure resilience preparations and responses are consistent with NHS Lothian's organisational aims and stated values.
- Provide direction to the NHS Lothian Tactical Resilience Group(s) or equivalent Groups regarding specific pieces of work to be carried out, their timescales, priorities, and resourcing.
- Work with other senior committees of NHS Lothian and other relevant organisations to improve resilience.
- To review relevant aspects of the corporate risk register and identify high risks outlined in other risk registers across all services within NHS Lothian.
- To identify gaps in emergency preparedness training and develop a strategy to ensure staff involved in emergency response are provided with suitable training opportunities.
- To ensure that emergency preparedness, resilience and response arrangements are regularly tested.

Meetings

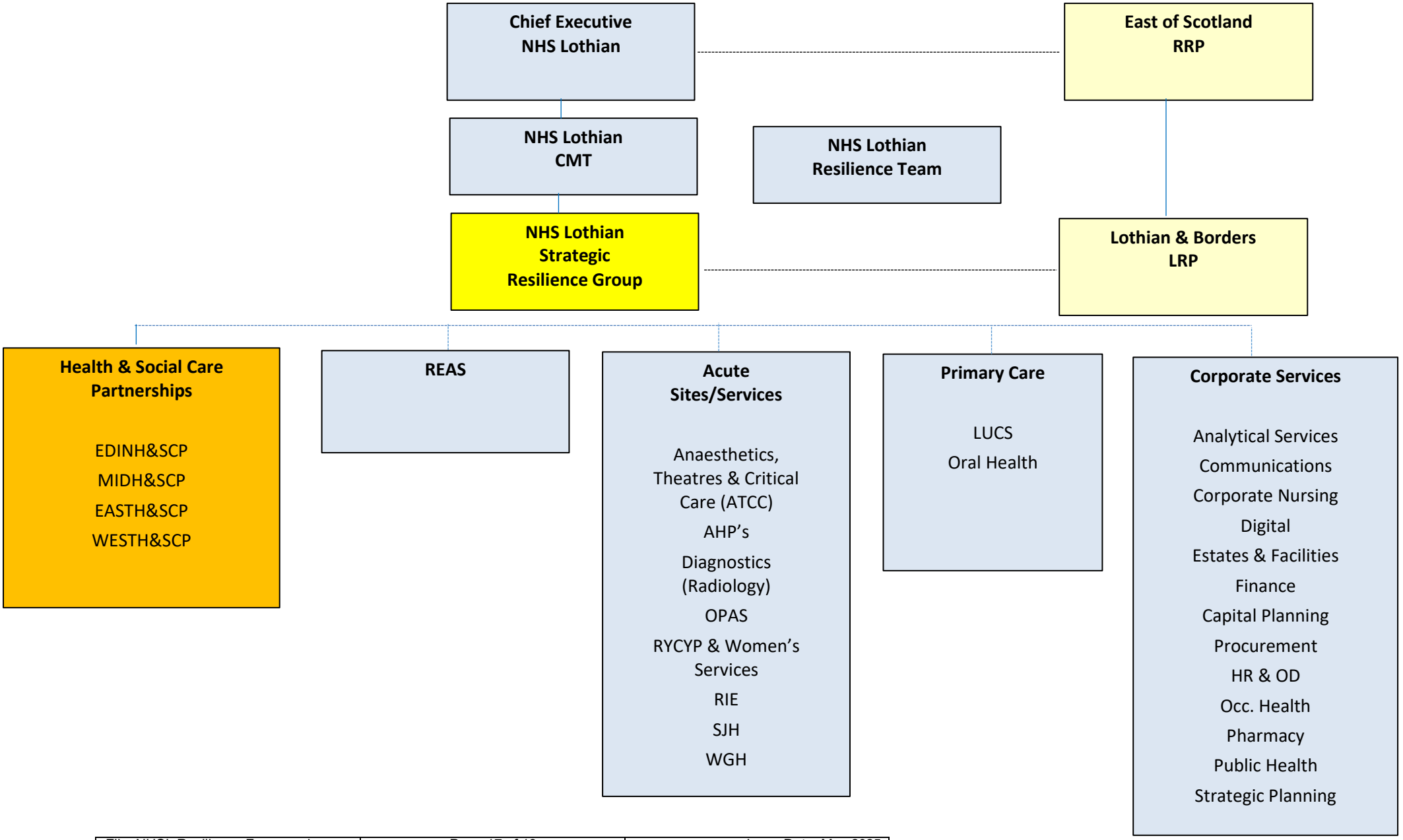
The Strategic Resilience Group will meet as necessary to fulfil its purpose. Routinely, the Group will meet quarterly, but this can be varied at the discretion of the Chairperson (a minimum of 3 times per year).

The Business Support Officer for the Resilience Team will provide administrative support to the

Strategic Resilience Group. The agenda and supporting papers will normally be sent out at least five working days in advance of the meeting.

For the meeting to be quorate at least 25% of the membership of the group should be present.

12 Appendix 1 – NHS Lothian Resilience Governance and Organisational Structure



13 Appendix 2 – Incident Management Levels, Groups and Role

Levels	Examples of Groups/Teams	Role (Examples)
Operational (Bronze) Level	As detailed in Appendix 1	This level is usually the first to be activated because they respond to events at the operational level as they unfold. The Operational (Bronze) level of command refers to those who provide the immediate "hands-on – boots on the ground" response to the incident, carrying out specific operational tasks in delivering services.
Tactical (Silver) Level	Major Incident Management Team (including H&SCP)	The Tactical (Silver) role is those who oversee managing the incident as part of the Hospital Control Team. They are responsible for making tactical decisions regarding the Major Incident, determining operational priorities, allocating staff and physical resources, and developing a tactical plan to implement the agreed strategy. This team will be established to oversee the overall clinical and management response to the Incident. This is essential to ensure a consistent and coordinated response within an ethical framework across the entire areas affected. They provide the pivotal link between Strategic (Gold) and Operational (Bronze) levels. Tactical command should oversee, but not be directly involved in, providing any operational response at the Operational (Bronze) level. Similarly, the Silver Group Chair will be pivotal to Strategic (Gold) level, as and when required.
Strategic (Gold) Level	Corporate Management Team Strategic Health Group (SHG)/Health Information Cell (HIC) (Major Incident-Mass Casualty)	The Strategic (Gold) Command level is responsible for determining the overall management, policy, and strategy for the incident. In addition, they will ensure the maintenance of normal services at an appropriate level which would be a two-way communication between tactical and strategic level. They will ensure appropriate resources are made available to enable and manage the response to a Major Incident-Mass Casualty incident, i.e. Managing the delivery of the Strategic Health Group and Health Information Cell where needed. Additionally, they will identify the longer-term implications and determine plans for the return to normality as soon as reasonably practicable.

NHS Lothian

4.11

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 2025**
Title:	**Quarter 4 and Annual Whistleblowing Performance Report 2024/25**
Responsible Executive:	**Tom Power, Director of People & Culture**
Report Author:	**Ruth Kelly, Deputy Director of People & Culture**

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 provides the members of the NHS Lothian Board with a copy of the Annual Whistleblowing Report (which includes the Q4 data) for 2024/25, and an overview of current whistleblowing cases with INWO involvement.

2.2 Background

The National Whistleblowing Standards for the NHS in Scotland (the Standards) introduced in April 2021 require all Boards to produce and publish on a quarterly and annual basis a Whistleblowing Performance report, which covers the key performance indicators on which all Boards are required to report to the Independent National Whistleblowing Officer (INWO).

In line with the Standards, the Quarterly and Annual Whistleblowing Performance reports are made available to both staff and members of the public via the NHS Lothian Staff pages on the Internet under the Raising Concerns page at the following link Whistleblowing Performance Reports and are shared with the INWO.

Details of all the performance measures associated with the National Whistleblowing Standards are contained within the attached Annual Report (Appendix 1).

Annual Whistleblowing Report – 2024/25 including Q4 data

In 2024/25, seven Whistleblowing cases were raised, all at Stage 2, meaning that early resolution was not deemed appropriate. This is down from 2023/24, when 10 whistleblowing cases were received. Six of this year's concerns were received in the second half of the reporting year, meaning that activity is not evenly distributed through the reporting period.

During Quarter 4, three new stage 2 concerns were recorded, and two stage 2 concerns were closed, both of which were from the previous reporting year. In Q4, there were six ongoing whistleblowing investigations, three in relation to concerns received in Quarter 3 this reporting year and the three concerns received in Q4.

Processes are in place to collect data from Primary Care and Local Contractors, under the requirements of the Standards, both must provide annual returns to the Board, even if to report that there were no concerns raised.

Timescales for undertaking an investigation continue to be challenging. As reflected in the attached Report, timescales to conclude an investigation this year (on average 182 working days) are higher than last year (on average 132 working days). This may be due to the increasing complexity of cases received (all cases in the last year have been raised at Stage 2); the limited number of investigators able to support investigations given other work priorities; and for some cases, the number of witnesses the investigators need to meet.

We are currently testing these assumptions with a review of the data over the last two reporting years to identify if there are any steps we can take to reduce timescales and will provide an update in a future report to the Staff Governance Committee.

Learning regarding the process during 2024/25 has reinforced the criticality of confidentiality and regular communications to the confidence of those raising a whistleblowing concern. It is also important for investigators, supported by the Commissioner and with reference to the

concern raised to get the Heads of Concern right so the outcomes appropriately reflect the issues raised. NHS Lothian will continue to build investigator capacity and experience.

The themes from cases highlight that the majority of concerns, many of which are raised with our Speak Up advocates in the first instance, relate to genuine matters of public interest, namely patient safety matters and standards of practice.

NHS Lothian iMatter data for 2024 indicated that the majority (80%) of respondents continued to be confident in how to raise concerns, with a slightly smaller majority (74%) confident that they will be handled appropriately. This is a percentage point above the NHS Scotland average and consistent with our previous year results.

INWO Cases - Update

In relation to cases currently with the INWO

May 2024 INWO Published Report

Following the publication of this report, an Action Plan was agreed. Over the last 12 months, the INWO have monitored our completion of this action plan and on 19 March 2025, confirmation was received from the INWO that all recommendations and actions had been completed satisfactorily and the case was now concluded.

October 2024 INWO published Report

Following the publication of this report, an Action Plan was agreed. Over the last 6 months, the INWO have monitored our completion of this action plan and on 1 April 2025, confirmation was received from the INWO that all recommendations and actions had been completed satisfactorily and the case was now concluded.

Ongoing INWO Investigations

There are currently 3 whistleblowing cases that have been referred to the INWO. Two of these cases are currently being investigated by the INWO and we await feedback from their investigations and any report. The third case is at an earlier stage and the INWO are currently reviewing the documentation that has been provided to them in relation to this case and will advise in due course whether they plan to proceed to an investigation or not.

2.3 Assessment

2.3.1 Quality/ Patient Care

Accessing and using the Whistleblowing Standards does not in itself address patient care and quality issues. However, it is recognised that poor staff experience has a direct impact on patient care/experience.

2.3.2 Workforce

The aim of the Standards is to offer support and protection to all who raise a concern or who are directly involved in a concern at all stages of the process.

2.3.3 Financial

There is no specific financial resource associated with this report.

2.3.4 Risk Assessment/Management

In respect of the implementation of the Standards, there is a risk that if the standards are not promoted across the organisation, then staff will be unaware of how to raise a concern and consequently the organisation may lose the opportunity for improvement and learning. To mitigate this risk, there is an annual communication and training plan which is implemented over the course of the year. There is no requirement for anything to be added to the Risk Register at this stage.

2.3.5 Equality and Diversity, including health inequalities

As this is an update paper on progress only there are no implications for health inequalities or general equality and diversity issues arising from this report.

2.3.6 Other impacts

Not applicable.

2.3.7 Communication, involvement, engagement and consultation

Not applicable.

2.3.8 Route to the Meeting

This is not applicable as this is an update paper only.

2.4 Recommendation

- **Awareness** – The Board is asked to note the content of the attached Annual Whistleblowing Performance Report 2024/25 which is in line with the requirements of the Standards and will be available on the NHS Lothian Staff pages of the Internet.
- **Assurance** – The Board is asked to agree and accept **moderate** assurance based on the evidence presented that systems and process are in place to help create a culture in NHS Lothian which ensure staff have confidence in the fairness and objectivity of the procedure through which their concerns are raised and acted upon and take **significant** assurance that the performance report meets the requirements of the Standards based on the evidence presented.

3 List of appendices

The following appendices are included with this report:

Appendix 1 – Annual Whistleblowing Performance Report 2024/25

Appendix 1

Whistleblowing Performance Report 2024/25

(Includes Q4 performance data)

Kerran Reeder
Whistleblowing Programme and Liaison Manager

Contents

Whistleblowing Concerns – 2024/2025

Context

This is the 4th annual report, produced in line with the National Whistleblowing Standards (the Standards). The Standards set out how all NHS service providers in Scotland must handle concerns that have been raised with them about risks to patient safety and effective service delivery. They apply to all services provided by or on behalf of NHS Scotland and must be accessible to all those working in these services, whether they are directly employed by the NHS or a contracted organisation.

The Standards specify high level principles plus a detailed process for investigating concerns which all NHS organisations in Scotland must follow. Health Boards have particular responsibilities regarding the implementation of the Standards:

- ensuring that their own whistleblowing procedures and governance arrangements are fully compliant with the Standards.
- ensuring there are systems in place for primary care providers in their area to report performance data on handling concerns.
- working with higher education institutions and voluntary organisations to ensure that anyone working to deliver NHS Scotland services (including students, trainees and volunteers) has access to the Standards and knows how to use them to raise concerns.

To comply with the whistleblowing principles for the NHS as defined by the Standards, an effective procedure for raising whistleblowing concerns needs to be:
'open, focused on improvement, objective, impartial and fair, accessible, supportive to people who raise a concern and all people involved in the procedure, simple and timely, thorough, proportionate and consistent.'

A staged process has been developed by the INWO. There are two stages of the process which are for NHS Lothian to deliver, and the INWO can act as a final, independent review stage, if required.

- Stage 1: Early resolution – for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action – 5 working days.
- Stage 2: Investigation – for concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response – 20 working days.

The Standards require all NHS Boards to report quarterly and annually on a set of key performance indicators (KPIs) and detailed information on three key statements:

- Learning, changes or improvements to services or procedures as a result of consideration of whistleblowing concerns
- The experience of all those involved in the whistleblowing procedure
- Staff perceptions, awareness, and training

Areas covered by the report.

Processes are in place to gather the details of and outcomes from whistleblowing concerns raised across all NHS services to which the Standards apply. Within NHS Lothian across the four Health and Social Care Partnerships (HSCPs) any concerns raised about the delivery of a health service by the HSCPs are reported and recorded using the same reporting mechanism which is in place for those staff employed by NHS Lothian.

The Director for Primary Care has specific responsibilities for concerns raised within and about primary care service provision. Mechanisms are in place to gather information from our primary care contractors and those local contracted suppliers, not contracted through National Procurement.

Implementation and Raising Awareness

During 2024/25 we have

- Continued to promote the Standards and how to raise concerns safely within the organisation and a systematised approach to sharing learning.
- Established an investigators network, which not only includes those who undertake whistleblowing investigation but anyone who could undertake an investigation.
- Worked with our Speak Up Service, Partnership/Trades Union colleagues and services to run a successful Speak Up Week in October 2024.
- Continued to review and improve our processes based on learning and experience.
- Continued to work with our Speak Up Ambassadors to support improvement, learning and to take any appropriate actions in response to concerns raised.
- Continued to provide performance updates and reports to PSEAG, Staff Governance Committee and the Board.
- Developed and introduced additional feedback mechanisms for whistleblowers and other involved in the whistleblowing process.

Our plans for 2025/26

- Continue to promote the Standards and how to raise concerns safely.
- Continue to work with our Speak Up Ambassadors understand the barriers to raising concerns and what actions can be put in place to mitigate.

- Continue with our annual communications plan, raising awareness of TURAS training modules, lunch and learn sessions and general awareness of how to raise concerns.
- Continue with the work undertaken by the investigators network, to train and share best practice with investigators.
- Participate in any review of the National Whistleblowing Standards.

Performance Information April 2024 – March 2025

Under the terms of the Standards, the quarterly performance report must contain information on the following indicators:

1. Total number of concerns received.
2. Concerns closed at stage 1 and stage 2 of the whistleblowing procedure as a percentage of all concerns closed.
3. Concerns upheld, partially upheld and not upheld at each stage of the whistleblowing procedure as a percentage of all concerns closed in full at each stage.
4. The average time in working days for a full response to concerns at each stage of the whistleblowing procedure.
5. The number and percentage of concerns at each stage which were closed in full within the set timescales of 5 and 20 working days.
6. The number of concerns at stage 1 where an extension was authorised as a percentage of all concerns at stage 1.
7. The number of concerns at stage 2 where an extension was authorised as a percentage of all concerns at stage 2.

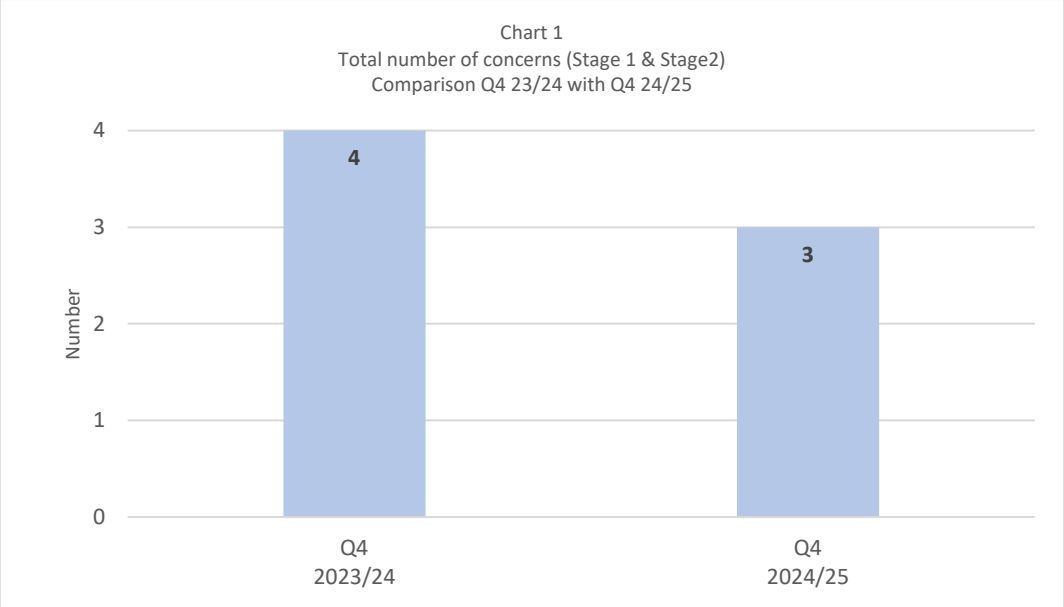
Our Annual Report also covers information specifically relating, where applicable to Quarter 4 - 2024/25. Comparisons are also provided on performance against the previous reporting year.

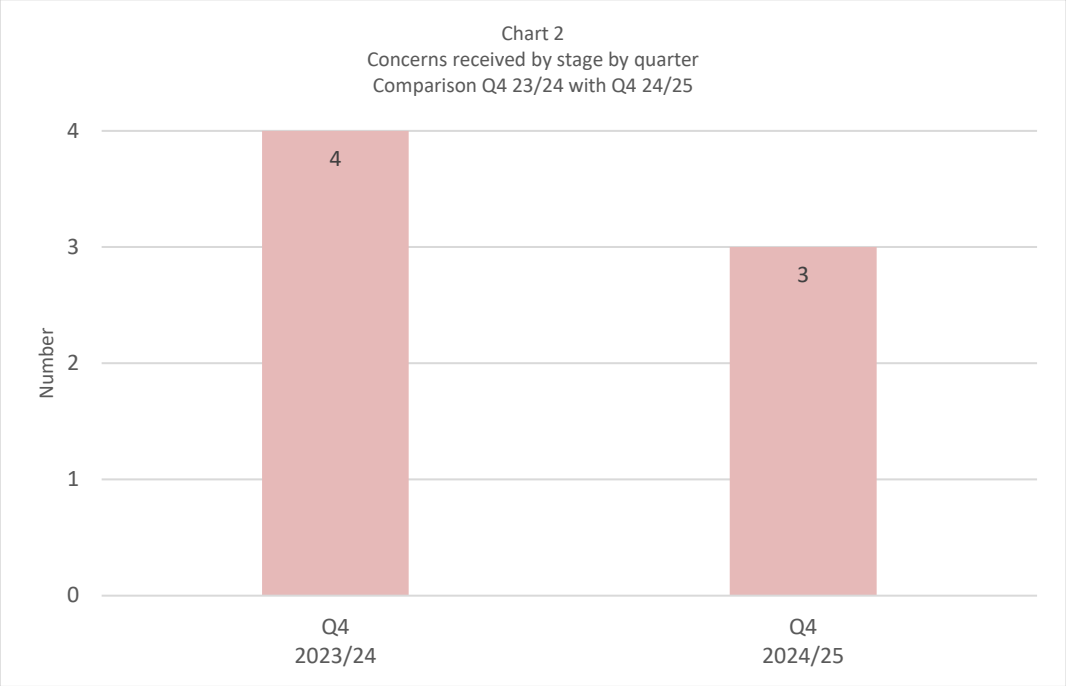
Indicator 1 - Total number of concerns, and concerns by Stage

During Q4 2024/25, three new stage 2 whistleblowing concerns was received. During the same Quarter in 2023/24, four stage 2 concerns was received.

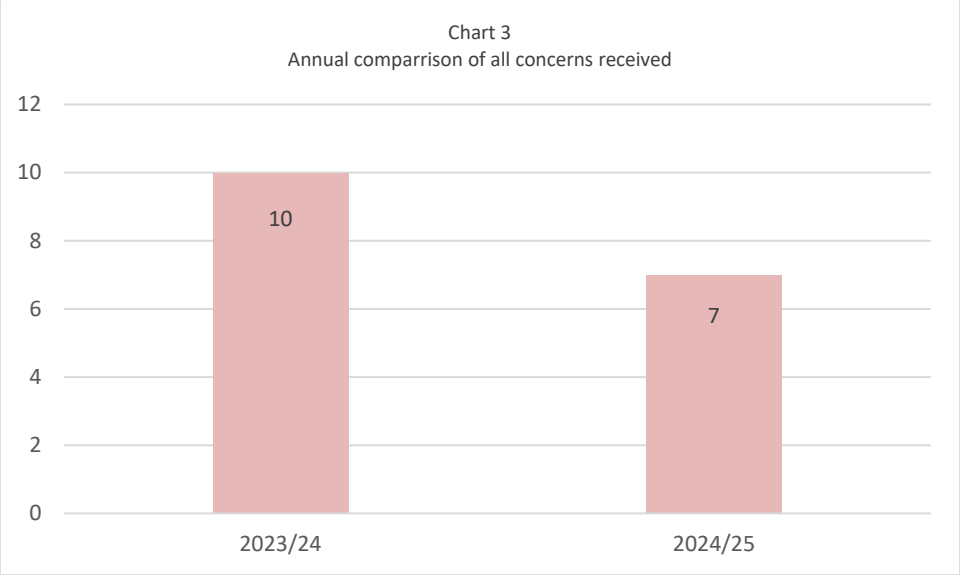
Chart 1 shows the total number of concerns received in Q4 2024/25 compared with Q4 2023/24. Chart 2 provides a break down of the number of concerns received at each stage of the whistleblowing process over the same period.

No stage 1 concerns were received in either year during Q4. Chart 3 provides year on year comparisons.



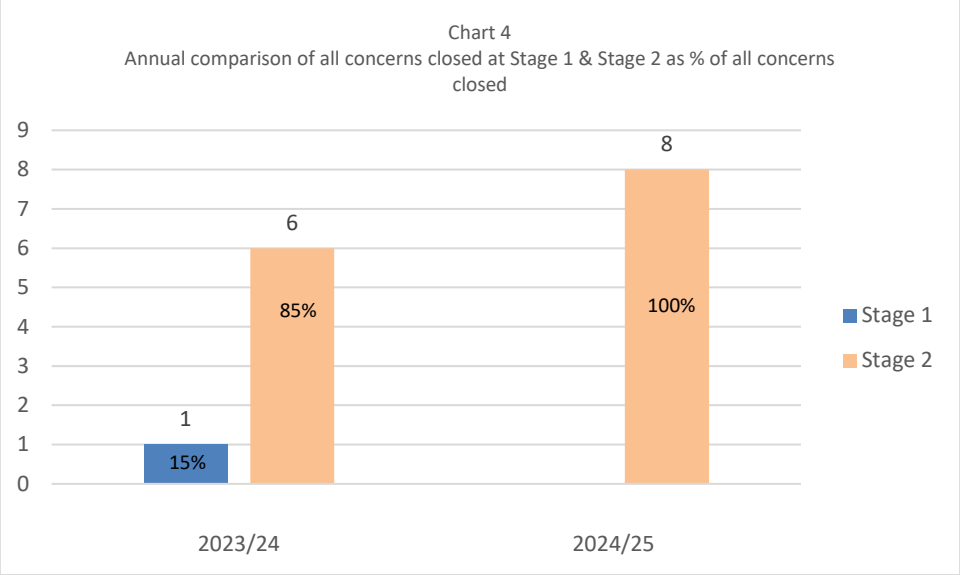


No stage 1 concerns were received during Q4 in either year.



Indicator 2 - Concerns closed at Stage 1 and Stage 2 as a percentage of all concerns closed.

During Q4, two stage 2 concerns were closed. In comparison none were closed during the same period of the previous reporting year. Chart 4 provides year on year comparison for this indicator.



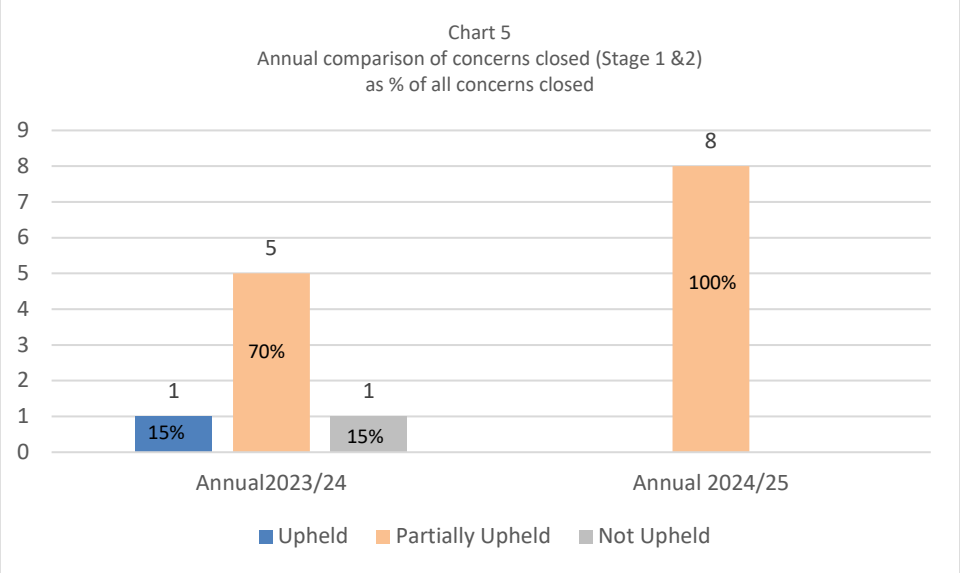
Indicator 3 - Concerns upheld, partially upheld and not upheld as a percentage of all concerns closed in full at each stage.

The definition of a stage 1 concern - Early resolution is for simple and straightforward concerns that involve little or no investigation and can be handled by providing an explanation or taking limited action, within 5 working days. No stage 1 concerns were received in Q4 either this or last year.

During the current reporting year, no stage 1 concerns were received.

The definition of a stage 2 concern – are concerns which tend to be serious or complex and need a detailed examination before the organisation can provide a response within 20 working days.

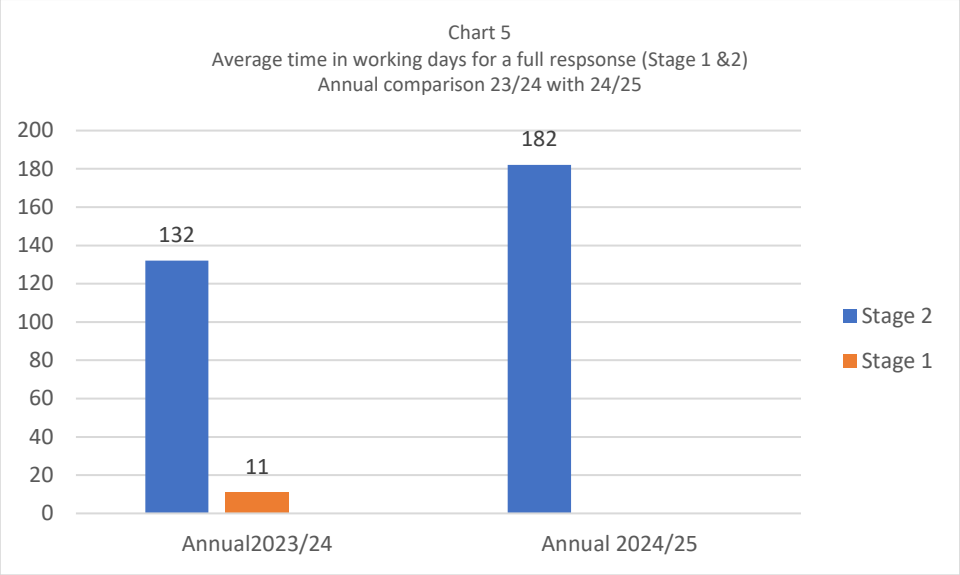
Chart 5 below provides a comparison of concerns closed at stage 1 and stage 2 as a percentage of all concerns closed over this and the last reporting year. There are currently six stage 2 concerns subject to ongoing investigation, all were received during this reporting year.



Indicator 4 - The average time in working days for a full response.

During Q 4, two stage 2 concerns have been closed. In comparison no concerns were closed in the same quarter last year.

Chart 6 below details the average number of working days across both reporting years for a case to close. As can be seen from the Chart 6, the average number of days to close concerns continues to rise. It is likely that this can attributed to the complexity of the cases received (all cases in 2024/25 were raised at Stage 2), the limited number of trained investigators, which as a Board is being addressed, and the availability of those with whom the investigators wish to meet. It should also be recognised that whistleblowing investigators, take on this additional work, alongside their substantive roles.



Indicator 5 - Number and percentage of concerns closed in full within set timescales.

No concerns were closed in this quarter or across the reporting year within the set timescales of 5 or 20 working days. This has been attributed to the complexity of the cases being raised under the whistleblowing policy and which are currently being investigated. Other factors out with the control of the investigators, for example periods of annual leave or more people coming forward and wishing to speak to them during their investigation, are also seen as contributing to the time taken to complete investigations.

Concerns where an extension was authorised.

Under the terms of the standards, for both Stage 1 and Stage 2 concerns there is the ability, in some instances, for example staff absence or difficulty in arranging meetings, to extend the timeframe in which a response is provided. The person raising the concern must be advised that additional time is required, when they can expect a response, and for Stage 2 concerns must be provided with an update on the progress of any investigation every 20 working days. Extensions to all concerns received this quarter were authorised. In all instances the whistleblowers were advised of the need to extend the timescales and continue to be kept up to date with the progress of the investigation throughout the process.

Primary Care Contractors

Primary care contractors (GP practices, dental practices, optometry practices and community pharmacies) are also covered by the Standards. In total 143 returns were received for quarter 4, details are outlined below, this compares to a total of 125 returns over the same quarter last year.

	Quarter 4 2024/25					Quarter 4 2023/24			
	No	%*	Stage 1	Stage 2	Outcome	No	%	Stage 1	Stage 2
GP Practices	84	72	0			81	69	0	0
Dental Practices	36	21	0	0		34	20	0	0
Optometry Practices	20	19	0	0		12	10	0	0
Community Pharmacies	3	2	0	0		3	2	0	0

Other Contracted Services – Not part of the wider National Procurement Framework

Under the terms of the Standards', contracted services are only required to submit annually concern data to the board, even if to report that there were no concerns raised. On a quarterly basis the requirement is only to report to the board if concerns were raised in that quarter, if no concerns have been raised there is no need to report, although it is good practice to let the Board know.

As at the end of Q4 there were 18 locally contracted suppliers who are not contracted through National Procurement. The number of local suppliers varies throughout the year, as contracts end, and new contracts commence. Where relevant the tender document for new contracts includes information on locally contracted suppliers' responsibilities in relation to whistleblowing and the process for raising concerns. No concerns have been recorded for Q4.

Anonymous Concerns

Concerns cannot be raised anonymously under the Standards, nor can they be considered by the INWO. However good practice is to follow the whistleblowing principals and investigate the concern in line with the Standards, as far as practicable.

NHS Lothian has decided that anonymous concerns should be recorded for management information purposes. The definition of an anonymous concern is 'a concern which has been shared with the organisation in such a way that **nobody** knows who provided the information'.

No anonymous concerns were received in Q4, and during the reporting year 2024/25.

Learning, changes or improvements to services or procedures

System-wide learning, changes or improvements to services can be limited by the need to maintain confidentiality of individual whistleblowers. However, as a Board we have identified four key areas of process and procedure learning, **Confidentiality, Communications**, **Clarity and Capacity.**

- The **confidentiality** of a whistleblower or witnesses involved in an investigation are paramount. The identity of those raising a concern is not important, the important thing is that concerns are investigated and where necessary, actions are put in place to address them.
- **Regular communications** are key. By sharing investigation findings, while retaining the integrity and confidentiality of individuals involved in the process, we can learn from concerns raised.
- It is important to have **clarity on** what the strands to the concern are and what resolution the whistleblower is looking for. Guidance on Stage 2 investigations and an FAQ has been published.
- **Building investigator capacity** and experience is essential. We have established an investigators network to share knowledge, experience and learning to help support the process as we move forward.

For each complaint that is upheld or partially upheld a documented action plan is put in place to address any shortcomings or apply the identified learning. The action plan is agreed and overseen by the Executive Director responsible for commissioning the investigation under the Standards, this is principally the Executive Medical or Nurse Directors.

Action plans continue to be monitored by the Executive Director, whilst actions transition from the whistleblowing process to business-as-usual action/improvement plans.

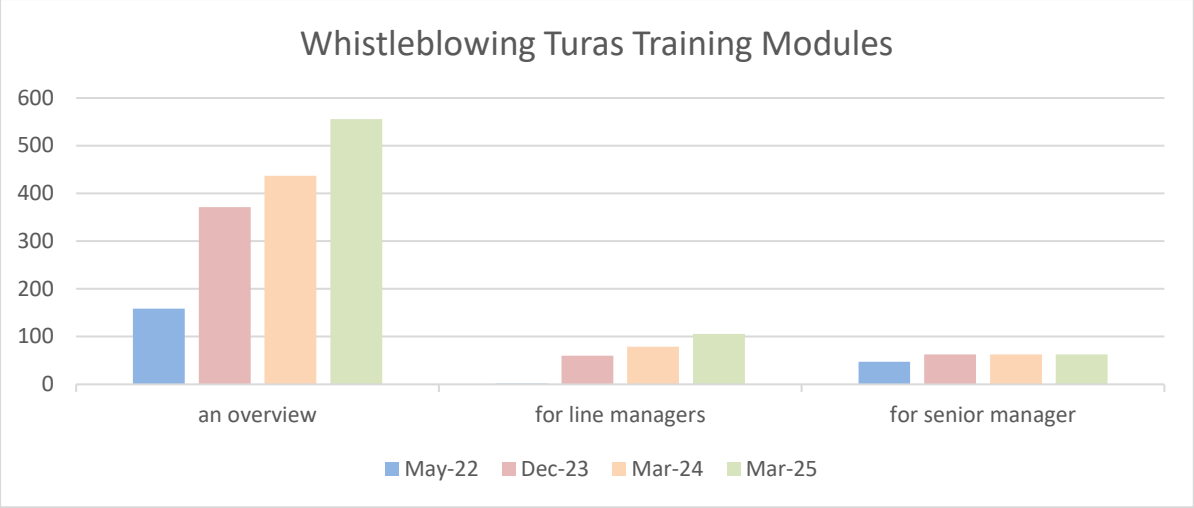
In relation to local and system-wide learning, processes are now in place to capture and through the Executive Director commissioning the investigation, will be shared at the appropriate forums.

Level of staff perception, awareness and training

It is difficult to quantify staff perceptions, however prior to implementation of the standards, lunch and learn sessions were established and attendance at these was good. Managers and staff guides have been produced and have been widely publicised. Softer skills and investigation training for those who may be involved in taking or investigating whistleblowing concerns have been or are being set up. We will continue to monitor uptake, effectiveness and appropriateness of training and will review and refine as required.

Communications continue to promote raising concerns in NHS Lothian and how this can be done.

The chart below outlines the improvement in the number of staff who have completed the online training, with a significant increase in the numbers of who accessed and completed the Overview and Line Manager module. Through our communications on whistleblowing and how staff can raise concerns in general, we continue to promote the TURAS learning modules.



Whistleblowing and Speak Up

The stage 2 concerns received this quarter were raised through the Speak Up Service, the Board's identified confidential contacts.

Work will continue during 2025/26 with the Speak Up Ambassadors to more fully understand the barriers which staff perceive to raising concerns through the line management structure.

Whistleblowing Themes, Trends and Patterns

Analysis of the concerns raised by key themes is provided below and shows comparisons between quarter 2023/24 and quarter 2024/25.

Theme*	Q4 23/24	Q4 24/25	Year 23/24	Year 24/25
Patient Care / Safety	6	5	14	12
Poor Practice	2	0	5	4
Unsafe Working Conditions	0	1	3	2
Breaking Legal Obligations	0	0	0	1
Abusing Authority	0	1	1	2

*[1] more than one theme may be applicable to a single Whistleblowing concern

Concerns raised by Division

Division	Number
Health and Social Care Partnerships	*
Acute Hospitals	*
Corporate Services	*
REAS	*
Facilities	*

*to maintain anonymity where case numbers are lower than 5 actual case numbers have not been included.

NHS Lothian

4.12

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 2025**
Title:	**Pharmacy Practices Committee – Terms of Reference**
Responsible Executive:	**Tracey McKigen, Director of Primary Care**
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: *Approval of Committee ToRs*	☒

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 Board's Pharmacy Practices Committee's (PPC) Terms of Reference were last reviewed in 2019. They are presented to the Board for review and for approval of proposed amendments intended to support the effective operation of the Committee.

2.2 Background

The PPC is a Committee of the Board, with delegated responsibility for considering applications received to join the Board's Pharmaceutical List. The Committee is constituted under Schedule 4 of the General Pharmaceutical Services (Scotland) Regulations 2009 as amended.

Non-executive members of the Board are appointed to co-Chair oral hearings convened by the PPC in order to consider applications to join the Pharmaceutical List. Other members appointed to the PPC under the relevant Regulations include lay members, non-contractor pharmacists, and contractor pharmacists. Further information on the PPC is available here: Pharmacy Practices Committee – Pharmacy Application Process.

2.3 Assessment

The NHS Lothian Primary Care Team has experienced difficulties in identifying and appointing new members to the PPC, which has implications for the continued effectiveness of the Committee and the Board's ability to dispose of Community Pharmacy applications in a timely manner.

It is therefore proposed that amendments be made to the PPC's Terms of Reference to permit existing Committee members to be reappointed for a third term, effectively increasing the maximum period of office from six to nine years. This will provide greater continuity and flexibility, whilst the primary Care Team continues its efforts to replenish the Committee membership and ensure that a suitably wide pool of members is available to support hearings.

Further minor changes are proposed to reflect the current co-Chair model and on the appointment of deputies.

Material amendments to the Terms of Reference are marked as tracked changes in Appendix 1.

2.3.1 Quality/ Patient Care

There are no direct impacts on the quality of care and services.

2.3.2 Workforce

Staff working in the Primary Care Team will be better able to facilitate and coordinate PPC hearings, in line with Regulations.

2.3.3 Financial

Membership of the PPC is not remunerated and therefore there are no direct cost implications.

2.3.4 Risk Assessment/Management

The proposed changes are intended to address actual or anticipated gaps in the membership of the PPC, and it is not considered that there needs to be an entry on a risk register.

Key Risks

- The PPC 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 available, 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

None identified

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. The proposed changes have been developed in consultation with the Primary Care Team.

2.4 Recommendation

Decision – The Board is asked to approve the various appointments and reappointments to Board committees and IJBs noted above.

3 List of appendices

The following appendices are included with this report:

- **Pharmacy Practices Committee Terms of Reference (amended)**

Appendix 1 – Pharmacy Practices Committee Terms of Reference (amended)

PHARMACY PRACTICES COMMITTEE
Terms of Reference

1. REMIT

The Pharmacy Practices Committee (PPC) has the delegated authority from Lothian NHS Board ("the Board") to consider applications for inclusion in the Pharmaceutical List in accordance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 as amended.

2. CORE FUNCTIONS

To consider applications for inclusion in the Pharmaceutical List of the Board.

3. MEMBERSHIP

The Committee shall comprise seven Members appointed by the Board of whom:

(a) one shall be the Chair appointed by the Board from the Non-Executive Members of the Board *(the Board may appoint multiple chairs, known as "co-chairs", one of whom shall attend and preside at each meeting of the Committee)*;

(b) three shall be pharmacists of whom:

(i) one shall be a pharmacist who is not included in any pharmaceutical list and who is not an employee of such person (known as "Non-Contractor Pharmacist");

(ii) two shall be pharmacists each of whom is included in the Pharmaceutical List, or is an employee of a person who is so listed (known as "Contractor Pharmacists");

(c) three shall be persons appointed by NHS Lothian, but not from the Members of the Board (known as "Lay Members").

The Board ~~shall~~ may appoint deputies for the Members of the Committee.

In making appointments of Members and Deputies to the Committee, the Board shall ensure that the eligibility criteria in paragraph 3 of Schedule 4 of the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009 (as amended) are met.

All Members shall be appointed for a term of up to three years. Any Member may be reappointed prior to the end of their term, provided that no member serves for more than nine consecutive years.~~, with an option for extension for a secondthree years.~~ The Board shall reserve the right to remove any member at any time.

Provided a quorum is present at any meeting, the proceedings of the Committee shall not be invalidated by any vacancy in its membership, or any defect in a Member's appointment.

Where an application concerns premises that are located in the same neighbourhood as premises from which a dispensing doctor provides this service, the PPC shall have an additional member appointed by the Board from persons nominated by the Area Medical Committee.

Administrative Support will be provided by officers of the Board.

An independent legal assessor may be appointed to provide legal advice during PPC hearings.

4. QUORUM

The quorum for Meetings of the PPC shall be five members comprising:

Chair
One Non-Contractor Pharmacist Member
One Contractor Pharmacist Member
Two Lay Members

Voting provisions are set out in paragraph 5.

5. VOTING

Each application shall be discussed by all Members present at the meeting but shall be determined only by the Lay Members.

The Chair shall not be allowed to vote, except in the case of an equality of votes, in which case he or she shall have a casting vote.

6. FREQUENCY OF MEETINGS

The PPC will meet as required on receipt of a competent application for inclusion in the Pharmaceutical List.

The agenda and supporting papers will be sent to the PPC members, at least ten days before the date of a meeting.

7. REPORTING ARRANGEMENTS

The PPC shall notify the relevant officers of the Board within ten days of its decision for each case providing full reasons for their decision.

8. DATE OF APPROVAL OF THESE TERMS OF REFERENCE

~~3 April 2019~~ 25 June 2025

9. REVIEW DATE

June 2028, or earlier if there is a relevant change in regulations or Scottish Government instructions.

NHS Lothian

4.13

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 2025**
Title:	**Board Appointments – June 2025**
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 – Board Business	☒

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

Board Committees

The following changes to membership of the Board's standing committees are presented for approval:

- Removal of Katharina Kasper as a member of the Board's Remuneration Committee, with immediate effect.

- Appointment of Lorna Marson as a member of the Board's Remuneration Committee, with immediate effect.

Integration Joint Boards

In line with The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 the following Non-Executive nominations to Integration Joint Board memberships are presented for the Board's approval:

- Reappointment of Katharina Kasper as the Lead Voting Member on the Edinburgh IJB, from 27 June 2025.

- Extension of Elizabeth Gordon's current appointment as a Voting Member of the Edinburgh IJB, to 31 July 2025 (thereby supporting completion of a full three-year term).

- Appointment of Patricia Cantley as a Voting Member of the Edinburgh IJB, from 1 August 2025.

- Appointment of John Innes as the Lead Voting Member of the West Lothian IJB, from 1 September 2025.

- Reappointment of Dr Rebecca Green, General Practitioner as a Non-Voting Member of the Midlothian IJB, from 18 July 2025 (for a three-year term).

- Reappointment of Dr Robin Balfour, General Practitioner, as a Non-Voting Member of the Edinburgh IJB, from 1 October 2025 (for a three-year term).

Pharmacy Practices Committee

The following reappointments are sought in relation to the membership of the Board's Pharmacy Practices Committee:

- Reappointment of Hazel Garven, Lead Pharmacist, Edinburgh HSCP, as a Non-Contractor Pharmacist Member of the Pharmacy Practices Committee, from 22 June 2025 (for a final three-year term).

- Reappointment of Mike Embrey, John Connolly and Kaye Greig as Contractor Pharmacist members of the Pharmacy Practices Committee, from 22 June 2025 (each for a final three-year term)

- Reappointment of John Niven as a Lay Member of the Pharmacy Practices Committee, from 22 June (for a final three-year term).

2.2 Background

Integration Joint Boards

Nominations to Lothian's four Integration Joint Boards are recommended by the Board Chairman, following discussions with 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.

The Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014 determines the membership of integration joint boards. In addition to the appointing a number of Voting Members, the NHS Board is required to appoint a person to each of the following non-voting positions on an IJB, under Regulation 3(1):

- *"(f) a registered medical practitioner whose name is included in the list of primary medical services performers prepared by the Health Board in accordance with Regulations made under section 17P of the National Health Service (Scotland) Act 1978;*
- *(g) a registered nurse who is employed by the Health Board or by a person or body with which the Health Board has entered into a general medical services contract; and*
- *(h) a registered medical practitioner employed by the Health Board and not providing primary medical services."*

The Order provides that the term of office for members of integration joint boards is not to exceed three years (this does not apply to the Chief Officer, Chief Finance Officer, and the Chief Social Work Officer). At the end of a term of office, the member may be re-appointed for a further term of office.

Pharmacy Practices Committee

There are specific Regulations which prescribe the membership and operation of the Pharmacy Practices Committee (PPC). It has seven members, being one NHS Non-Executive Board member, three pharmacists, and three lay members. A Non-Executive Board member convenes the PPC each time it meets. The Regulations allow deputies to be used, provided that when the PPC meets the prescribed membership categories are appropriately filled. 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 also allows a fresh panel to consider any appeals.

Reappointment decisions are sought for the members identified above in order to ensure the ongoing effective operation of the Committee.

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 attends to actual or anticipated gaps in the membership of Integration Joint Boards and Pharmacy Practices Committee, and it is not considered that there needs to be an entry on a risk register.

Key Risks

- An IJB or PPC 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 Board committee and IJBs. Where members are new to committees or IJBs, 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 various appointments and reappointments to Board committees and IJBs noted above.

3 List of appendices

- None.

NHS Lothian

6.

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 2025**
Title:	**Chief Executive's Report**
Responsible Executive:	**Professor Caroline Hiscox, Chief Executive**
Report Author:	**Professor Caroline Hiscox, Chief Executive**

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 – June 2025**

Appendix 1

Chief Executive's Report
NHS Lothian Board Meeting, 25 June 2025
Professor Caroline Hiscox

1. NHS Scotland Board Chief Executives / Executive Group Update

I continue to engage closely with these key national groups which are supporting an increased focus on collaborative discussion and action in response to national challenges. In particular, recent meetings have provided opportunities to discuss and shape emerging national frameworks, referenced below.

2. Publication of the Health and Care Reform and Renewal Frameworks

Board members will be aware from recent communications that two key frameworks were published by the Scottish Government on 17 June:

- Scotland's Population Health Framework (PHF)
- Health and Social Care Service Renewal Framework (SRF)

Also published on 19 June, was the Public Service Reform (PSR) Strategy, following a Ministerial Statement in the Scottish Parliament.

These frameworks call for collective, co-ordinated action across all levels of the system, including from NHS boards, to respond to current pressures and build the foundations for long-term sustainability and improvement.

Collectively, these key documents provide an important framework for NHS Lothian's developing approach to transformation and service renewal. I look forward to having detailed discussions with the Board, CMT and wider colleagues in the system about how we can embed the key tenets of these within our future ambitions and delivery programmes.

3. Mental Health Services

Mental Health Services across NHS Lothian remain under significant pressure, particularly in relation to access to Acute Mental Health beds. Demand regularly exceeds available capacity, leading to long waits for admission and poor experiences for both patients and staff. Wider challenges in Mental Health Services are illustrated by the Board's escalation (for CAMHS) to Stage 3 of the NHS Scotland Support and Intervention Framework. In response to these issues, we are taking a two-fold approach.

Firstly, to address immediate capacity challenges, I am chairing weekly "System Pressures - Gold" meetings, thereby providing strategic command and control. This group has a clear and documented remit to maximise bed capacity, reduce delays, address unmet need in the system and, ultimately, to protect patients, staff and the public. Clear actions and plans flow to and from the meetings and whilst the service

remains under considerable pressure, we have seen some reduction in the number of patients waiting extended periods for admission. This group is supported and informed by an operational "System Pressures – Silver" group which meets twice weekly. This arrangement will remain in place until the Corporate Management Team is satisfied that there is appropriate stability within the system.

Secondly, a focused transformation project is underway and formal assurance on NHS Lothian's Mental Health Services continues to be closely monitored by the Board's Healthcare Governance Committee, in line with its remit.

4. Planned Care

The Board's current and future performance on Planned Care has been the subject of frequent reporting and discussion at both CMT and the Strategy, Planning & Performance Committee (SPPC) in recent months. More detailed performance information is available within the Board Performance Report, elsewhere on the agenda.

Members will be aware of the Scottish Government's targets for 2025/26, to eradicate outpatient and inpatient waits of over 52 weeks and achieve a position where 95% of radiology and 100% of endoscopy referrals are seen within six weeks, by the end of March 2026. The Scottish Government committed £100M in recurring funding to support achievement of these aims and invited proposals from NHS boards. At the same time, NHS Lothian agreed to commit an additional £10M this year, on a non-recurring basis, to support improvements in Planned Care and Cancer Care.

In early March, we submitted comprehensive proposals to the Scottish Government seeking £36.8M in 2025/26, with a recurring requirement of £22.4M. Proposals were based on deliverable aims, including the use of external capacity, but acknowledged that, even if all funding was provided, the complete removal of waits over 52 weeks could not be achieved in all specialties within the timeframe required. Therefore, we also set out our requirements for national support, including the utilisation of any available capacity at the GJNH and other boards.

Formal confirmation of the Government's funding decisions was received on 13 May 2025. NHS Lothian has been allocated £27.8M to support Planned Care improvements in 2025/26, with a recurring element of £14.4M. Areas of particular variance from the original bids submitted include Dermatology and Endoscopy. We continue to make the case for investment in these areas and others to the Scottish Government. We are also considering the most effective use of the non-recurring £10M internal allocation to address high priority waits and working with individual services, where proposals were unfunded, to consider alternative approaches to improving performance within available resources.

The Board's Planned Care trajectories for 2025/26 have been updated, based on the allocated funding, and were resubmitted to the Scottish Government on 4 June.

5. Annual Delivery Plan (ADP) 2025/26

It had been our intention to bring a final Annual Delivery Plan to the Board in June for review and approval. However, NHS boards' ADPs remain unconfirmed with the Scottish Government, particularly due to the decision-making process around Planned Care funding submissions, referenced above.

6. Princess Alexandra Eye Pavilion (PAEP)

The remedial works required within the PAEP are now complete and we are in the final stages of a comprehensive recommissioning process. The total costs of this work are still expected to be within the original budget, including the allocated contingency spend.

Services will begin to reopen within the PAEP for patients from Monday 23 June, with all services returning and operational for patients by Wednesday 25 June. Appointments are already scheduled from these dates, with patients having received appointment information by letter, text or both.

As part of the planning process for the return of services to PAEP, we have engaged with relevant Third Sector organisations, recognising their valuable input and expertise, as well as their ability to support and promote our messaging in relation.

Following completion of the move, we will be issuing a number of communications, including a press release and social media content. Our dedicated PAEP webpages will also be updated.

7. Astley Ainslie Hospital (AAH) – Relocation of Inpatient Services

In April 2024, the East Lothian Health and Social Care Partnership (HSCP) assumed management responsibility for AAH and Robert Fergusson Unit (RFU). The relevant delegated services are:

- Inpatient and outpatient specialist rehabilitation services in the AAH for amputee and neuro-rehabilitation injury.
- The Cardiac Rehabilitation Service in the AAH.
- The inpatient and outpatient specialist acquired brain injury rehabilitation service at the Robert Ferguson Unit, in the Royal Edinburgh Hospital.

Since then, and particularly during 2025, the CMT has discussed a number of reports detailing a range of significant physical infrastructure and resilience risks to the long-term viability of the physical environment at the AAH and the implications for the continued delivery of inpatient services on the site. Board members will be aware that NHS Lothian's divestment of the AAH site has been a strategic intention since 2010.

In February 2025, the CMT approved recommendations from the East Lothian HSCP Management Team that, in principle, inpatient services should be transferred from

the AAH to the East Lothian Community Hospital (ELCH) – as the only option with the capacity to support the inpatient services currently on the AAH site. This approval was subject to the completion of an Integrated Impact Assessment (IIA), appropriate consultation and collaboration with other affected patients, services and staff, and the completion of appropriate stakeholder and community engagement processes. A summary of the IIA's findings can be found here.

Following the completion of these processes and full consideration of the findings, a final detailed report with recommendations was presented to the CMT on 17 June, including extensive workforce modelling. On this basis, CMT has now agreed the transfer of inpatients from rehabilitation beds on the AAH site to ELCH in Haddington, with the transfer to occur in September 2025. Detailed planning and preparations for the transfer are continuing in advance of this date.

8. Corporate Office Accommodation

As the Board is aware from my last report in April, NHS Lothian is required to find alternative corporate office accommodation due to the fact that NES's intended lease extension at West Port was not approved by Scottish Ministers.

There was an initial period of significant uncertainty following this decision, during which we undertook some immediate planning to consider potential contingency arrangements. However, subject to the conclusion of formal negotiations, we now anticipate being able to remain at West Port in the short term and likely for the next 12 months. This allows us to turn our immediate attentions to securing longer term accommodation and I am grateful to the Director of People & Culture who continues to lead this work.

9. Celebrating Success Awards 2025

I am delighted to report that the shortlist of finalists for our 2025 Celebrating Success Awards was announced in May. This year, a record number of nominations came in from staff across Lothian, recognising colleagues who go the extra mile, and from members of the public who wanted to show their appreciation for the care and support they, or their loved ones, have received. The shortlist is available online here.

As I reported in April, we are glad to be returning to an in-person ceremony this year. The event will take place on Friday 3 October at 2.30pm in the Paderewski Lecture Theatre at Western General Hospital.

10. Annual Equality, Diversity & Inclusion Conference

This year's annual conference is titled: *NHS Lothian – Celebrating Diversity & Creating Change*. The event will take place on Thursday 26 June (10.00am-4.00pm) at the Chancellor's Building, Royal Infirmary of Edinburgh. Further information can be found here.

11. Professor Sir Geoff Palmer – Obituary

We were very sad to learn of the death of Professor Sir Geoff Palmer, who passed away recently at the age of 85. As Board members know, he was an esteemed scholar, a renowned human rights and equalities activist and a positive supporter of NHS Lothian's anti-racism work. In particular, we valued his guidance and support of NHS Lothian's research into transatlantic slavery and subsequent anti-racism plan.

Sir Geoff's legacy will continue to inspire our work to tackle racism and reduce inequalities and we extend our sincere condolences to all his family, friends, colleagues and all who had the privilege of knowing him.

12. Celebrating the wider achievements of our colleagues

I want to take the opportunity to formally acknowledge the recent wider achievements of some of our NHS Lothian colleagues. The list below is not exhaustive, and I apologise for any unintentional omissions:

- **Yvonne Leavy**, Advanced Epilepsy Specialist Nurse, Department of Clinical Neurosciences, NHS Lothian, has been awarded an OBE in the King's Birthday Honours 2025 for services to Epilepsy Nursing.
- **Professor Juliet McArthur**, Chief Nurse – Research received the RCN's top honour of being made a Fellow of the Royal College of Nursing. This honour is in recognition of her dedication, extraordinary vision, and profound impact on the field of nursing.
- A number of NHS Lothian staff were recognised at the RCN Scotland Nurse of the Year Awards 2025:
    - **Kath Williamson**, Senior Clinical Nurse Specialist in Bariatric Care, picked up the Inspiring Excellence – Nursing Innovation and Research Award. This recognised her establishment of the NHS Lothian Bariatric Forum, a multidisciplinary group working to improve care coordination and outcomes for patients with complex obesity.
    - **Stacey Boyle**, Midwife, and **Marianne Hay**, Senior Charge Midwife at St. John's Hospital, were recognised as runners-up for their innovative scrubs, made from recycled NHS fleeces, that enable partners to provide vital skin-to-skin contact with their newborns after a caesarean section.
    - **Gillian McAuley**, Nurse Director Acute, NHS Lothian, was named runner-up for the Clinical Leadership Award. Gillian was recognised for leading the development of a five-year Nursing and Midwifery Strategic Plan, driving key initiatives like care assurance systems, digital care planning, and a BME career programme.
    - **The South East Forensic Healthcare Team** at the Royal Edinburgh and Associated Services, also came second for the Nursing Team of the Year Award.
- **Kath Williamson**, Senior Clinical Nurse Specialist in Bariatric Care, has also become the first nurse in Scotland to be awarded a prestigious three-year Chief Scientist Office Early Postdoctoral Research Fellowship. The Fellowship, hosted by the School of Health and Wellbeing at the University

of Glasgow, has typically been awarded to doctors, but Kath Williamson was one of four recipients chosen in the 2024 round, starting her Fellowship in February 2025.

- **Euan McGivern**, Head of Podiatry at NHS Lothian, was elected as Vice Dean of the Faculty of Podiatric Medicine for The Royal College of Physicians and Surgeons of Glasgow (RCPSG) having previously served on the College's Faculty of Podiatric Medicine Executive Board.

NHS Lothian

8.

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 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 – March 2025	On Track – Q1 2025/26
Scheduled Care Inpatients/Day cases	Not Met – March 2025	On Track – Q1 2025/26
8 Key Diagnostic Tests - Endoscopy	Not Met – May 2025	On Track – Q1 2025/26
8 Key Diagnostic Tests - Radiology	Not Met – May 2025	On Track – Q1 2025/26
31-Day Cancer Performance	Not Met – April 2025	On Track – Q1 2025/26
62-Day Cancer Performance	Not Met – April 2025	Off Plan – Q1 2025/26
Accident and Emergency 4 Hour Performance	Not Met – April 2025	On Track – April 2025
Delayed Discharges	N/A	N/A
IVF Waiting Times Performance	Met – Jan 2025	N/A
Early Access to Antenatal Services	Met – Jan 2025	N/A
Primary Care *General Practice Activity Measures*	N/A	N/A
Psychological Therapies Waiting Times Performance	Not Met – April 2025	Off Plan – April 2025
CAMHS Waiting Times Performance	Not Met – April 2025	Off Plan – April 2025
Smoking Cessation Performance	Not Met – Q3 2024/25	N/A

2.2 Background

The national **NHS Board Delivery Framework**[1] sets out the indicators for the financial year 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 2025/26** (ADP) and the quantitative indicators from this plan will be reported against at each Board meeting until June 2026.

Focusing on the short term, the **NHS Scotland Operational Improvement Plan**[2] details specific commitments for NHS Scotland that build on the wider delivery plans of Scotland's health boards. The plan focuses on four main areas:

- Improving access to treatment
- Shifting the balance of care from hospitals to primary care

[1] Item-6-Appendix-2-25-26-NHS-Board-Delivery-Plan-Guidance.pdf
[2] NHS Scotland Operational Improvement Plan

- Improving access to health and social care services through digital and technological innovation
- Working with people to prevent illness and more proactively meet their needs.

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**[3] 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 support and intervention by the Scottish Government. NHS Lothian was escalated to Stage 3 for the CAMHS service in December 2024; 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.

2.3.2 Workforce

The most recent workforce report is available from Staff Governance Committee in May 2025 (using data from March 2025).

2.3.3 Financial

There has been an allocation received from the Scottish Government to support unscheduled care improvement works which aim to improve whole system flow throughout

[3] https://www.gov.scot/publications/nhs-scotland-support-and-intervention-framework/

the Lothian Health and Care System (LHCS). Further bids have been put forward to Scottish Government for both recurring and non-recurring funding with feedback awaited.

NHS Lothian have also received an allocation from the Scottish Government focused on the Outpatient, Inpatient and Diagnostics targets for March 2026. Improvement trajectories have been developed and submitted to Scottish Government. These will be subject to a detailed briefing and discussion at the next SPPC session.

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.

- CMT members on the 08 April 2025.
- SPPC members on the 21st May 2025.

Improvement trajectories for Scheduled Care performance have been developed and submitted to Scottish Government. These will be subject to a detailed briefing and discussion at the next SPPC session.

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.

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

June 2025/26

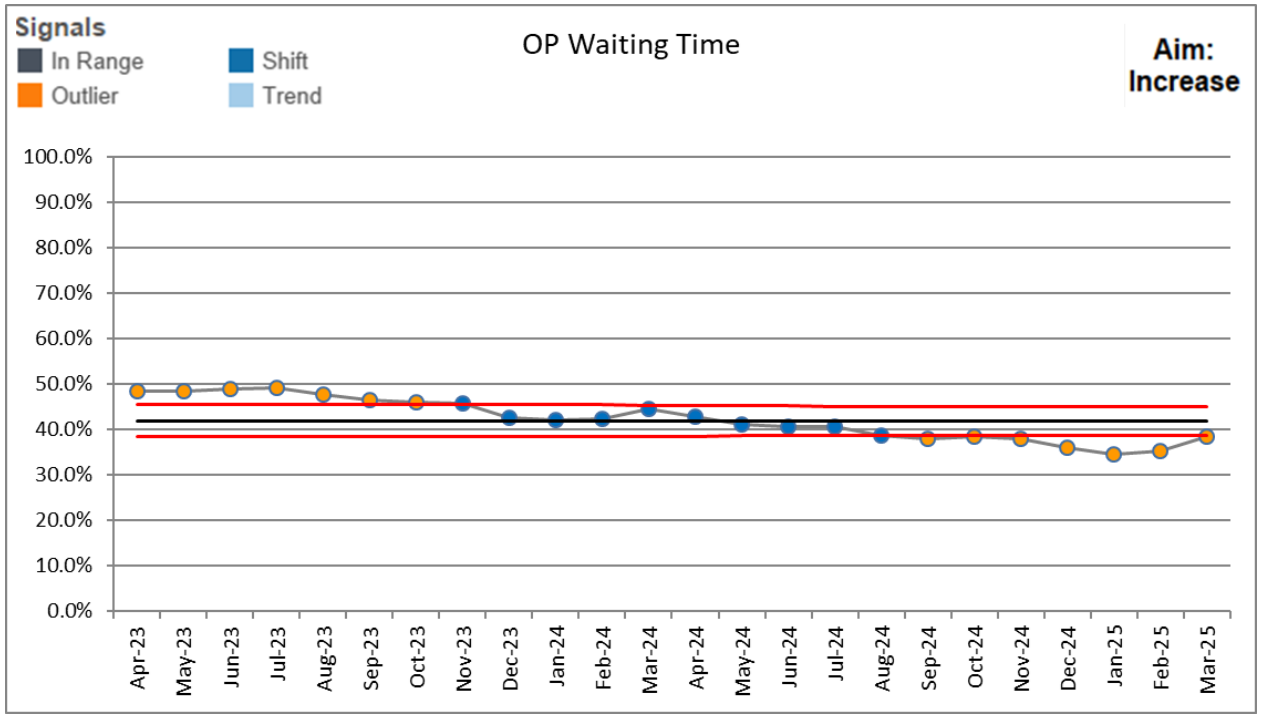
Overview of 2025/26 NHS Lothian Board Indicators

ADP Planning Priority	Indicator	Rationale for Inclusion	Linked to Corporate Risk	Performance vs ADP/Local Trajectory			National Performance	
				Latest Actual	ADP/Local Trajectory	Assurance for Delivery Against Standard/Trajectory by end of 2025/26	NHS Scotland Latest Published Performance	National Target/ Standard
Planned Care	12 Weeks 1st Outpatient Appointment	Local Delivery Plan (LDP) Standard Annual Delivery Plan (ADP) Measure	5185 – Access to Treatment	38.4% (Mar25)	N/A	Limited	41.4% (Mar25)	95%
	Outpatient >52 Week Performance	Scottish Government Focus	5185 – Access to Treatment	19793 (May25)	22688 (Q1 25/26)	Limited	63406 (Mar25)	N/A
	Treatment Time Guarantee (TTG)	Local Delivery Plan (LDP) Standard Annual Delivery Plan (ADP) Measure	5185 – Access to Treatment	51.9% (Mar25)	N/A	Limited	33.5% (Mar25)	100%
	TTG >52 Week Performance	Scottish Government Focus	5185 – Access to Treatment	5538 (May25)	6089 (Q1 25/26)	Limited	8838 (Mar25)	N/A
	Diagnostic Tests - Endoscopy	Annual Delivery Plan (ADP) Measure Scottish Government Focus	5185 – Access to Treatment	5679 (May25)	4707 (Q1 25/26)	Limited	N/A	N/A
	Diagnostic Tests - Radiology	Annual Delivery Plan (ADP) Measure Scottish Government Focus	5185 – Access to Treatment	11044 (May25)	12136 (Q1 25/26)	Limited	N/A	N/A
Urgent and Unscheduled Care	Accident and Emergency Waiting Times	Local Delivery Plan (LDP) Standard Annual Delivery Plan (ADP) Measure Scottish Government Focus	5186 – 4 Hours Emergency Access 3726 – Hospital Bed Occupancy	70.1% (Apr25)	N/A	Limited	70.6% (Mar25)	95%
	Delayed Discharges	Annual Delivery Plan (ADP) Measure	5186 – 4 Hours Emergency Access 3726 – Hospital Bed Occupancy	211 (Apr25)	N/A	Limited	N/A	N/A
Cancer Care	31 Day Cancer Waiting Times	Local Delivery Plan (LDP) Standard Annual Delivery Plan (ADP) Measure	5185 – Access to Treatment	91.1% (Apr25)	94% (Q1 25/26)	Limited	94.7% (Q3 24/25)	95%
	62 Day Cancer Waiting Times	Local Delivery Plan (LDP) Standard Annual Delivery Plan (ADP) Measure	5185 – Access to Treatment	75.8% (Apr25)	80% (Q1 25/26)	Limited	73.5% (Q3 24/25)	95%
Mental Health	Psychological Therapies Waiting Times	Local Delivery Plan (LDP) Standard	-	77% (Apr25)	77.9% (Mar26)	Moderate	81.3% (Mar25)	90%
	CAMHS Waiting Times	Local Delivery Plan (LDP) Standard Annual Delivery Plan (ADP) Measure	-	64.8% (Apr25)	77.7% (Mar26)	Limited	94.1% (Mar25)	90%
Primary and Community Care	Primary Care	Annual Delivery Plan (ADP) Measure	-	See slide for breakdown				
Women and Children's Health	IVF Waiting Times	Local Delivery Plan (LDP) Standard	-	100% (Mar25)	N/A	Significant	100% (Mar25)	90%
	Early Access to Antenatal Services	Local Delivery Plan (LDP) Standard	-	89.9% SIMD1 94.23% SIMD5	N/A	Significant	86.5% SIMD1 94.9% SIMD5	80%
Population Health and Reducing Health Inequalities	Smoking Cessation	Local Delivery Plan (LDP) Standard Annual Delivery Plan (ADP) Measure	-	163 (Q3 24/25)	295	Limited	N/A	295/295

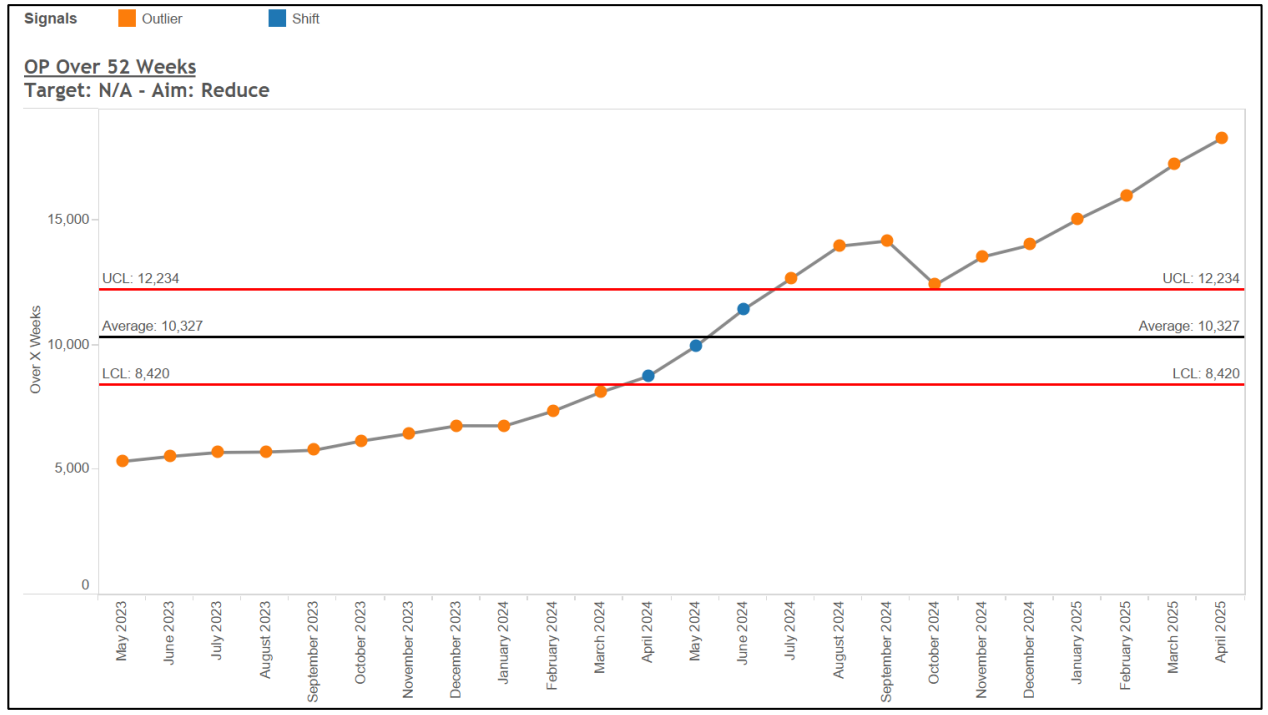
Planned Care – New Outpatients

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

12 Weeks 1st Outpatient Appointment - *LDP Standard*



Outpatient Waiting List Size >52 Weeks



Planned Care – New Outpatients

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**May 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

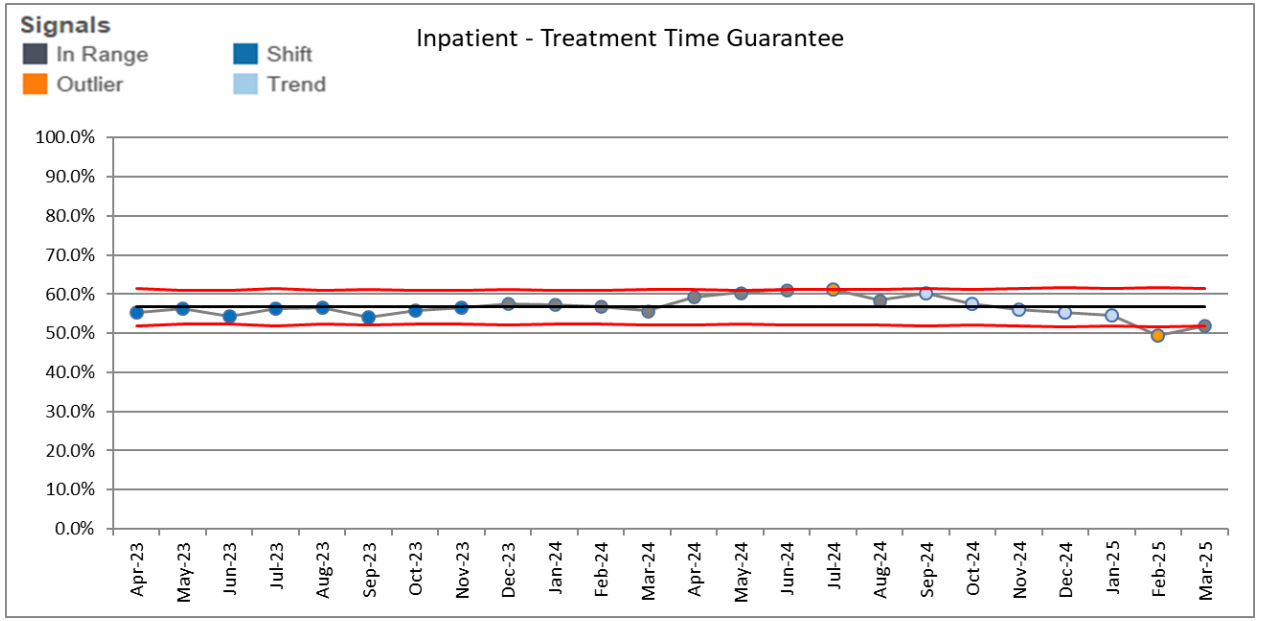
KPI	Latest Performance (May 2025)	Trajectory (Q1 2025/26)	Trajectory Forecast (March 2026)	National Benchmarking (March 2025)
Total List Size	96,980	N/A	N/A	N/A
Waits > 52 weeks	19,793	22,688	15,601	N/A
Waits > 78 weeks	8,251	N/A	N/A	N/A
Waits > 104 weeks	2,553	N/A	N/A	N/A
95 per cent of patients to 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)	38.4% (March 2025)	N/A	N/A	61.2%

Summary	Actions	Assurance
Proposals were submitted to the Scottish Government to support delivery towards a challenging target of zero Outpatients waiting over 52 weeks by March 2026. Agreed funding has been confirmed and NHS Lothian will receive up to £22.3m funding in 2025/26 to deliver additional activity in both Outpatients and Inpatients. The proposed Dermatology plan was not supported however a further £2.5m has been allocated to address long waits in this specialty. In May 2025, activity delivered was 2.3% higher than planned with additions to the waiting list also higher (3.0%). The number of Outpatients waiting over 52 weeks was 19,793 which better than plan.	• Trajectories for 2025/26 have been revised to take into account additional funding received and were submitted to Scottish Government on 4th June 2025. • Recruitment is underway for the posts supported by recurring funding within the proposals. • A number of high impact lists have already been carried out with more scheduled to address the waiting times challenges. • Waiting list validation is underway as a rolling programme for all Outpatients waiting over 26 weeks. • KPIs are in place for the Outpatient Delivery Group with stretch targets for services in areas such as reducing DNAs. • The Performance Management Framework has been updated for 2025/26 including key sets of reports and dashboards to support teams. • Weekly and monthly Access meetings are in place reviewing performance of both core and additional planned activity, any mitigating actions and productivity and efficiency measures.	Limited

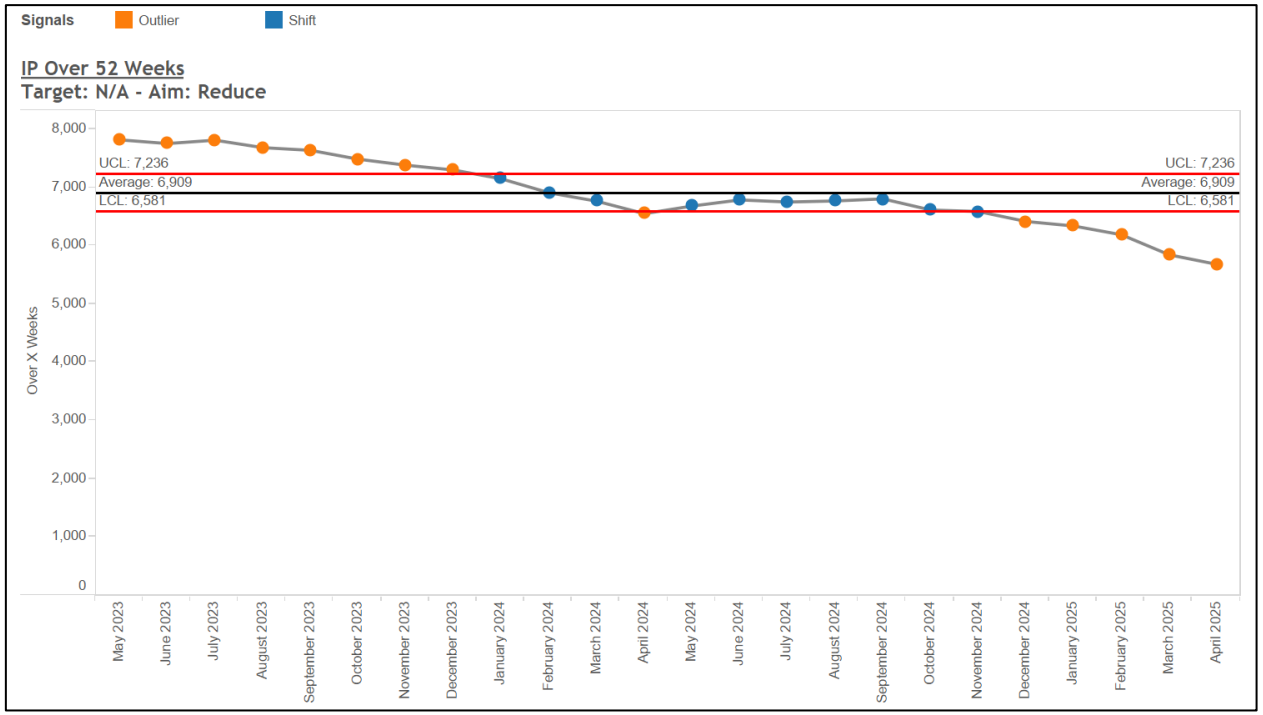
Planned Care – New TTG

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

12 Weeks 1st TTG Appointment - *LDP Standard*



TTG Waiting List Size >52 Weeks



Planned Care – New TTG

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**May 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

KPI	Latest Performance (May 2025)	Trajectory (Q1 25/26)	Trajectory Forecast (March 2026)	National Benchmarking (March 2025)
Total List Size	22,317	N/A	N/A	N/A
Waits > 52 weeks	5,538	6,089	3,830	N/A
Waits > 78 weeks	2,076	N/A	N/A	N/A
Waits > 104 weeks	476	N/A	N/A	N/A
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)	51.9% (March 2025)	N/A	N/A	33.5%

Summary	Actions	Assurance
Proposals were submitted to Scottish Government to support delivery towards a challenging target of zero Inpatients waiting over 52 weeks by March 2026. Agreed funding has been confirmed and NHS Lothian will receive up to £22.3m funding in 2025/26 to deliver additional activity in both Outpatients and Inpatients. In May, activity delivered was 2.7% lower than planned. Additions to the waiting list for May were also lower than anticipated however it is anticipated this will increase as further outpatient activity is delivered. The number of Inpatients waiting over 52 weeks was 5,538 which is better than plans.	• Trajectories for 2025/26 have been revised to take into account additional funding received and were submitted to Scottish Government on 4th June 2025. • Recruitment is underway for the posts supported by recurring funding within the proposals. • A number of high impact lists are already planned to address the long waiting specialties in key specialties. • All available capacity at Golden Jubilee and Fife NTC is being maximised with good uptake in first couple of months of the year. • Agreed KPIs are in place for the Inpatient Daycase Delivery Group with focus on maximising theatre utilisation. • The Performance Management Framework has been updated for 2025/26 including key sets of reports and dashboards to support teams. • Weekly and monthly Access meetings in place reviewing performance of both core and additional planned activity, any mitigating actions and productivity and efficiency measures.	Limited

Planned Care – Diagnostics (Endoscopy)

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**May 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

Diagnostics (Endoscopy) Waiting Over 6 Weeks - *ADP Measure*

KPI	Latest Performance (May 2025)	Trajectory (Q1 2025/26)	Trajectory Forecast (March 2026)
Total List Size	7,606	N/A	N/A
Waits > 6 weeks	5,679	4,707	2,234
Waits > 26 weeks	3,723	N/A	N/A
Waits > 52 weeks	1,704	N/A	N/A
% waits within 6 weeks	25.3%	N/A	N/A

Summary	Actions	Assurance
Proposals were submitted to the Scottish Government to support delivery towards a challenging target of zero patients waiting over 6 weeks by March 2026. NHS Lothian will receive up to £2,835,483 non-recurring funding in 2025/26 to deliver 2,691 additional scopes within 2025/26. This will be targeted to fund insourced provision to operate out of Endoscopy Suite 4 at WGH, up to 13 High Impact Lists per month, and the recruitment of a nurse specialist to expand our cytosponge pathway. Trajectories have been revised following this allocation. The majority (68%) of the Endoscopy waiting list is triaged as Urgent, which is a key driver of the long wait position, though the service does remain ahead of trajectory. There is a surveillance backlog of 4064, of which 1386 are deemed High Risk. This represents a slight increase across the last quarter.	Scheduled Care monies have been identified to facilitate recruitment of additional consultant operators, which is anticipated to offer an additional 133 new scopes per month from summer 2025. 2 sessions will be delivered for Oesophago-gastro-duodenoscopy (OGD) commencing September 2025. Recruitment ongoing for additional consultant. Monies have been transferred to Colorectal for 0.5 WTE B5 and 0.5 WTE B2. This will facilitate the increased number of qFit tests under USoC and Urgent referrals that are coming from GI diagnostics, in effect enhanced triaging to reduce numbers of patients being added to waiting lists. A Band 8A nurse endoscopist has been recruited from existing vacancies and is due to start in June 2025. Clinical revalidation of the waiting lists continues. To date, 2128 patients have been revalidated. Of the patients revalidated this has resulted in removal of 28% (318) OGD removed, 33% of OGD converted to oesophageal sponge (372), 20% colonoscopies removed (188) and 11% (123) procedures expedited.	At present, there is limited assurance of delivery due to the mismatch between capacity and demand for both new and surveillance waiting lists. Currently >150 patients expedited are waiting on endoscopy dates from revalidation surveillance lists. These will be first patients to be appointed to insourcing lists week commencing 14th July 2025. Uncertainty remains over the sustainability of the Nurse Endoscopist service, as funding allocation has been for short-term, non-recurring solutions.

Planned Care – Diagnostics (Radiology)

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**May 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

Diagnostics (Radiology) Waiting Over 6 Weeks - *ADP Measure*

KPI	Latest Performance (May 2025)	Trajectory (Q1 25/26)	Trajectory Forecast (March 2026)
Total List Size	19,407	N/A	N/A
Waits > 6 weeks	11,044	12,136	0
Waits > 26 weeks	2,066	N/A	N/A
Waits > 52 weeks	152	N/A	N/A
% waits within 6 weeks	43.1%	N/A	N/A

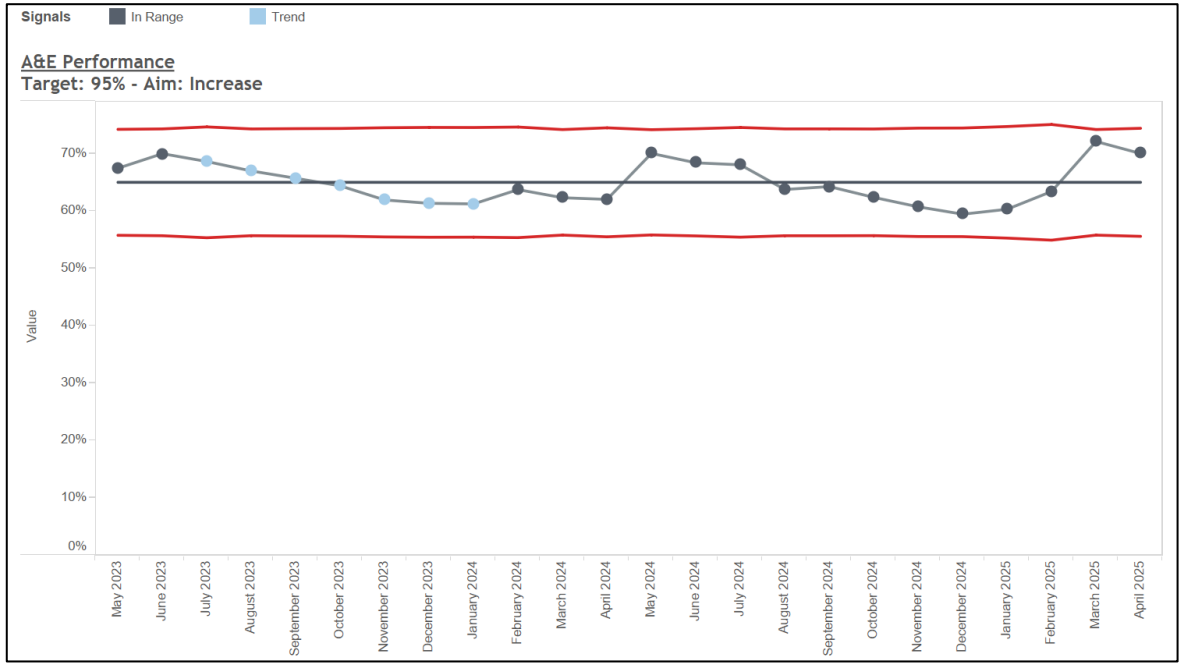
Summary	Actions	Assurance
• The total waiting list size was previously forecast to meet trajectory at end of March 2025 – the closing position for 2024/25 was 17,793 against a planned 19,490. • The over 6-week position was also previously forecast to meet trajectories at the end of March 2025 – the closing position for 2024/25 was 10,345 against a planned 17,894. • The long wait position across modalities continues to be a pressure, with the current over 6-week position at end of May 2025 (11,044) broken down as follows: - CT (2,482) rising slowly but still within trajectories - MR (5,505) rising slowly but still within trajectories - US (3,053) still within trajectories and continuing to fall	• Patients continue to be booked in accordance with clinical priority (USoC, Urgent, IP) • Mobile MR unit in situ on WGH site providing capacity 12 hours per day/6 days per week. Continued use of the mobile MR unit provided through the national imaging plan for 15 days per month at Midlothian Community Hospital (MCH). • Recruitment of staff to provide rota growth in MR and CT imaging is underway (appointments planned for July 2025). • Procurement underway for the provision of the external CT capacity of 2285 scans (anticipated August 2025).	Limited Assurance Recruitment is underway however this will impact other aspects within radiology and there will be a training and induction period. Monitoring of capacity gains and losses is in place. RWW and moving staff away from continual overtime to a 5/7 will require investment in staffing.

Urgent & Unscheduled Care – Accident and Emergency Waiting Times

Responsible Director(s):	Chief of Acute Services Unscheduled Care Programme Director	**Reporting Period:**	**May 2025**
Data Source:	PHS and Internal Management	**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 Waiting Times – *LDP Standard*

KPI	Latest Performance (April 2025)	Trajectory (April 2025)	Trajectory Forecast (March 2026)	National Benchmarking (March 2025)
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)	70.1%	N/A	N/A	70.6%
RHCYP	90.7%	N/A	N/A	N/A
RIE	62.3%	79%	N/A	N/A
SJH	64.7%	N/A	N/A	N/A
WGH	75.4%	N/A	N/A	N/A



Urgent & Unscheduled Care – Accident and Emergency Waiting Times

Responsible Director(s):	Chief of Acute Services Unscheduled Care Programme Director	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**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 Waiting Times – *LDP Standard*

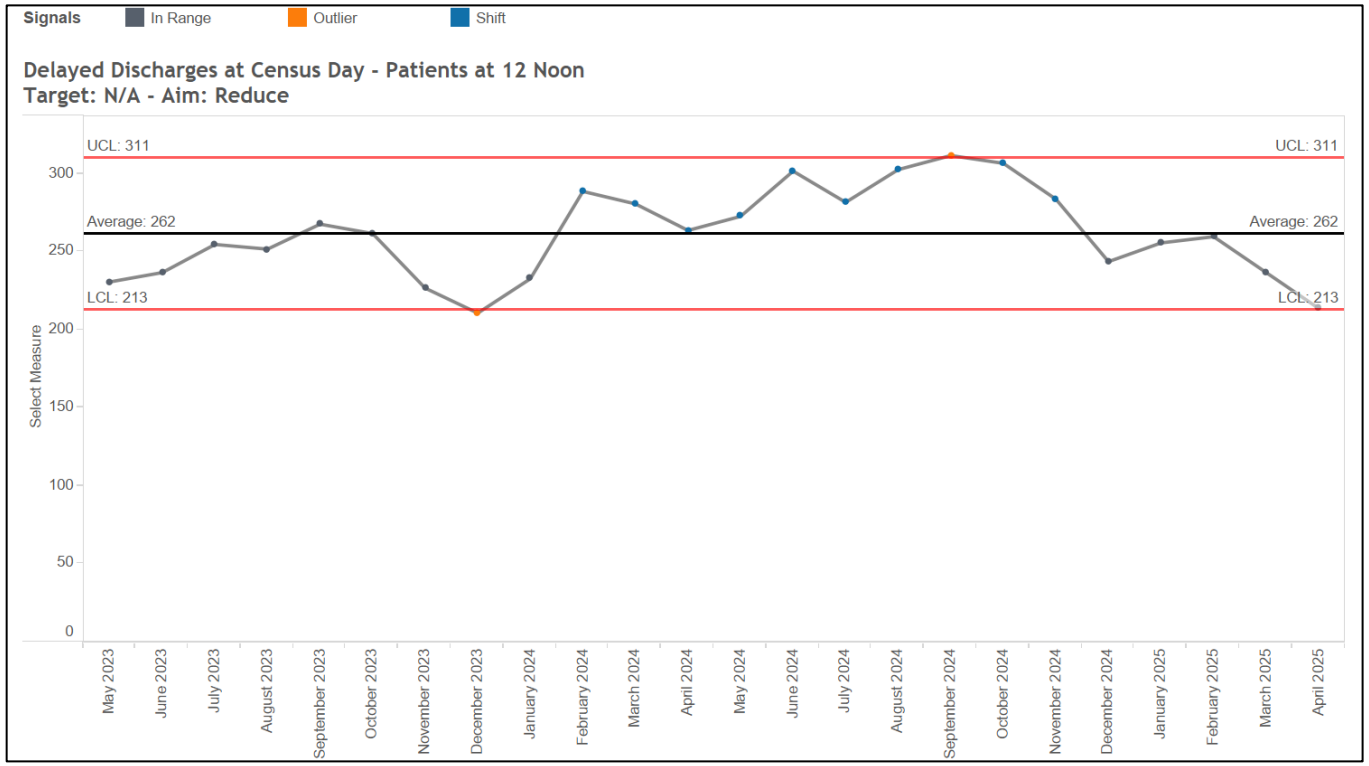
Summary	Actions	Assurance
While challenges persist in achieving the 4-hour Emergency Access Standard (EAS) trajectory, early signs point to meaningful improvements in patient flow and safety across the system. **As of the 28th April 2025:** Latest 7 days (vs average for March and April 2025) is showing a; • Reduction in social delays by 18% across Lothian • 85% reduction in waits over 12 hours at RIE • 80% reduction in waits over 8 hours at RIE • 62% reduction in waits over 4 hours at RIE • 4-hour EAS at the RIE over the latest 7 days was 67% which is showing signs of beginning to increase again following a challenging 10 days in mid-April. • HSCPs in Lothian are now "outliers" with low levels of delays and flagging as "significantly" lower than the Scotland average. • A reduction in occupancy has been seen at both the RIE (2.3%) and the WGH (8.1%). Work is currently ongoing to rebalance this. • An increase in admissions at the RIE (~19 extra per day) has been noted. The current hypothesis is that this is due to previous unmet demand, i.e. queues for admission (however further work required to understand what "good" should look like). • A reduction of around 85 beds being utilised for USC across the adult acute system. • A reduction of around 67 beds being utilised by delayed discharges across acute sites. • An increase in "frailty" patients being discharged within 48 hours by 12.5% at RIE & 3.9% at WGH as the frailty teams have come online. • An increase in "general medicine" patients being discharged within 48hours.	• The Unscheduled Care System Improvement Programme continues to advance, under the oversight of the Executive Oversight Group. Lothian's unscheduled care performance has shown notable improvement, though challenges persist. • Boards were invited in late February 2025 to bid for additional funding to improve unscheduled care services. This included developed proposals aligned with Scottish Government priority areas and recent announcements (particularly around developing front door frailty services, and an expansion of virtual capacity). • NHS Lothian developed a comprehensive £25m whole system proposal which sought to build on the successful component of the £14.5m investment focused on the RIE and spread throughout the Lothians. After a series of negotiations, the proposal was reduced to a final level of £15m. At the time of writing this report – no confirmation has been received from Scottish Government as to the funding decisions. Key initiatives contained within this additional £15m proposal include; • **Expanding community capacity and admission avoidance**: Increasing care-at-home provision and targeted 7-day community capacity. • **Enhancing social work and therapy in-reach**: Scaling up community therapy services, including 7 day "in-reach" provision and increasing social work capacity (including Mental Health Officers). • **Delivering proactive frailty and falls interventions**: Rolling out a new falls prevention pathway and strengthening community and acute frailty services. • **Expanding primary care capability**: Scaling up the Primary Care Frailty Enhanced Service and introducing incentives for GPs to manage minor injuries. • **Scaling virtual wards and same day emergency care**: Expanding RACU capacity at the WGH and SJH while also enabling inter-city flow redistribution to maximise resources across the system. • **Integrated Interface Services Expansion**: Expansion and integration of the Interface Services in line with the First Minister Announcement. • **Flow Navigation Centre Augmentation**: 7-day consultant cover and increased HSCP input, with a focus on frailty through the deployment of specialist frailty ANPs. This initiative along with the expansion and integration of the interface services will enable the development of a transformational virtual hospital model.	Limited 10

Urgent & Unscheduled Care – Delayed Discharges

Responsible Director(s):	Chief of Acute Services Unscheduled Care Programme Director	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**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 – *ADP Measure*

KPI	Latest Performance (April 2025)	Trajectory ()	National Benchmarking ()
Total Delayed Discharges (Lothian)	211	N/A	N/A
Delays at monthly census point per 100,000 18+ East Lothian HSCP	16.5	34.6 total delays per 100,000 adults	N/A
Delays at monthly census point per 100,000 18+ Edinburgh HSCP	30.6		N/A
Delays at monthly census point per 100,000 18+ Midlothian HSCP	27.1		N/A
Delays at monthly census point per 100,000 18+ West Lothian HSCP	17.2		N/A



Urgent & Unscheduled Care – Delayed Discharges

Responsible Director(s):	Chief of Acute Services Unscheduled Care Programme Director	**Reporting Period:**	**May 2025**
Data Source:	PHS and Internal Management	**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

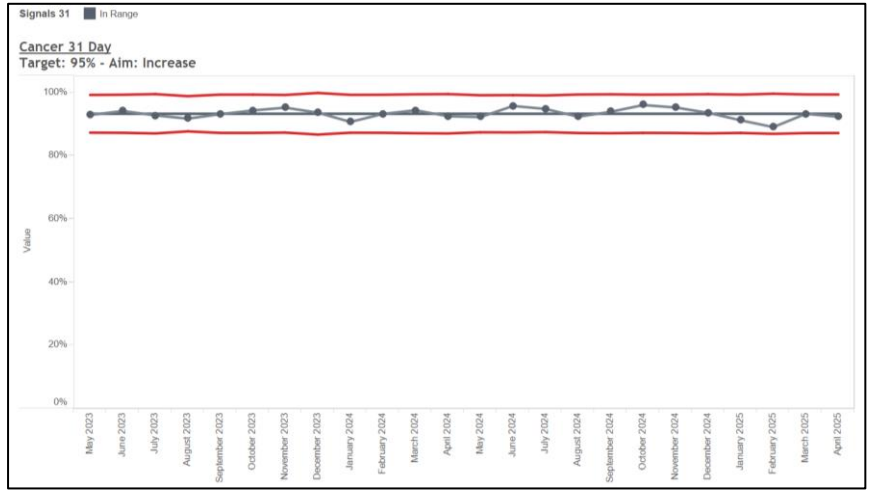
Delayed Discharges – *ADP Measure*

Summary	Actions	Assurance
Delayed discharges have notably decreased across acute sites, since 1st April 2025, there was a 60% reduction in delays to discharge from hospital for social work reasons (excluding POC waits). There is continued sustained improvement in health delays and social delays however, occupancy remains above optimal levels to elicit desired performance levels. • **West Lothian Health and Social Care Partnership –** There has been significant improvement in the delayed discharge position in West Lothian. Over the last three full months and comparing with the same months in (March - May) 2024, there has been a 15% reduction in the total beds occupied by delayed discharges. • **Midlothian Health and Social Care Partnership –** Bed occupancy remains high despite improvements in a number of measures, including health delays and social delays. Increased admissions seems to be masking improvements in system flow. A period of high vacancies coupled with high sickness absence in Home Care slowed package of care (POC) availability for a period in May. Long-Term Care beds remain scarce. An additional 33 patients have been supported home via the British Red Cross (BRC) pathway in May 2025 alone. • **East Lothian Health and Social Care Partnership –** Delayed Discharges remain low and along with other HSCPs are ahead of the Scottish average in performance around delayed discharges. Occupancy continues to be a challenge however minimal waits for downstream beds. • **Edinburgh Health and Social Care Partnership –** Edinburgh's delayed discharges have decreased substantially since the start of the year. Delays were 122 as of 26th May 2025 compared to 162 on 27th January 2025, a 25% decrease. In particular, the number of care home delays have decreased as flow into care homes has improved and patients have been diverted onto other pathways to be assessed for long term	• **West Lothian Health and Social Care Partnership –** Redesign of the care assessment model is now embedded within the Integrated Discharge Hub. Involvement of the MDT Care Home Team in assessing and supporting the placement of patients in care homes, working with families and care home managers. Working towards a revised model of MDT working in the community across two West Lothian localities (East and West) with teams co-located and based on GIRFE principles. The work will be supported by an integrated access point based on the previous single point of contact model and an enhanced model of intermediate care. There is focus on admission avoidance and early supported discharge. • **Midlothian Health and Social Care Partnership** – A system wide improvement plan is in place with actions identified to maximise capacity for discharge, identify Midlothian residents in hospital earlier, enhance admission prevention and improve downstream flow. This includes the development of an in-reach model of care, introduction of weekly review processes to seek alternative pathways and increased scrutiny of systems and processes. The British Red Cross (BRC) pathway is in place to support discharge from hospital via the third sector. Further data analysis is planned to identify additional actions. • **East Lothian Health and Social Care Partnership –** The ICAT team have received increased investment to support acute hospital flow across 7 days. D2A capacity is increasing with USC monies and staff coming into post. Work continues with SPOC to support a single discharge pathway and progress to a single point of access. ELCH teams are sharing examples in real time where there are opportunities missed. Focus remains on downstream wards to ensure system flow. East Lothian continue to work with acute colleagues on optimising the LoS in the acute and ELCH wards. Significant improvement on Care at Home waits has been supported by USC monies. • **Edinburgh Health and Social Care Partnership –** Significant work has been underway through the unscheduled care programme to improve flow out of hospital, including implementing the reablement model within the internal home care service and undertaking MDT reviews to identify care pathways before patients enter delay. In Edinburgh, delays have remained on a downward trend since the start of the year providing assurance that the USC actions have been successful in improving hospital flow.	Limited

Cancer Care – 31 Day Cancer Waiting Times

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

31 Day Cancer Waiting Times – *LDP Standard*



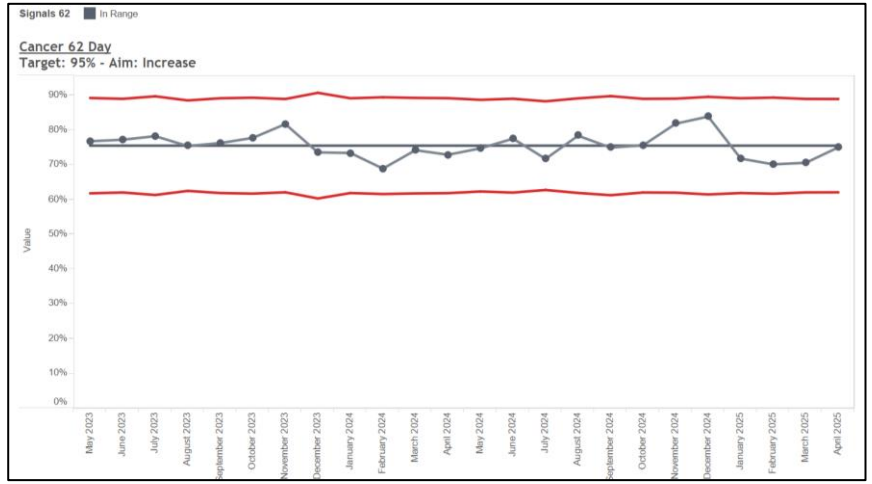
KPI	Latest Performance (April 2025)	Trajectory (Q1 2025/26)	Trajectory Forecast (March 2026)	National Benchmarking (Q3 2024/25)
95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat	91.1%	94%	94.7%	94.7%
Median 31-Day Wait	8	N/A	N/A	N/A
95th Percentile 31-Day Wait	33	N/A	N/A	N/A

Summary	Actions	Assurance
NHS Lothian's performance against the 31-day target in April 2025 was 91.1%, which was, unfortunately, below the NHS Lothian trajectory for the quarter (94.0%) and below the Scotland average for that month of 94.4%. Of the 12 cancer types, 10 met the 95% standard, 10 met the cancer-specific trajectory and 8 met or exceeded the national average performance. The main drivers for not meeting trajectory were the clearance of the RARP backlog (more breached patients currently being treated), delays in Breast and Colorectal surgery, and delays to RFA in Upper GI.	• The Urology service is focusing on clearing the outstanding RARP backlog of complex patients. Straightforward cases are being booked within 4-5 weeks, with several patients now making the 31-day standard. RARP remains the biggest cause of 31-day breaches so this will improve overall performance. • There is ongoing work to reduce wait for Radiofrequency Ablation (RFA) in Upper GI through additional ad-hoc theatre lists when possible.	Limited

Cancer Care – 62 Day Cancer Waiting Times

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	ID 5185 - Access to Treatment - Very High

62 Day Cancer Waiting Times – *LDP Standard*



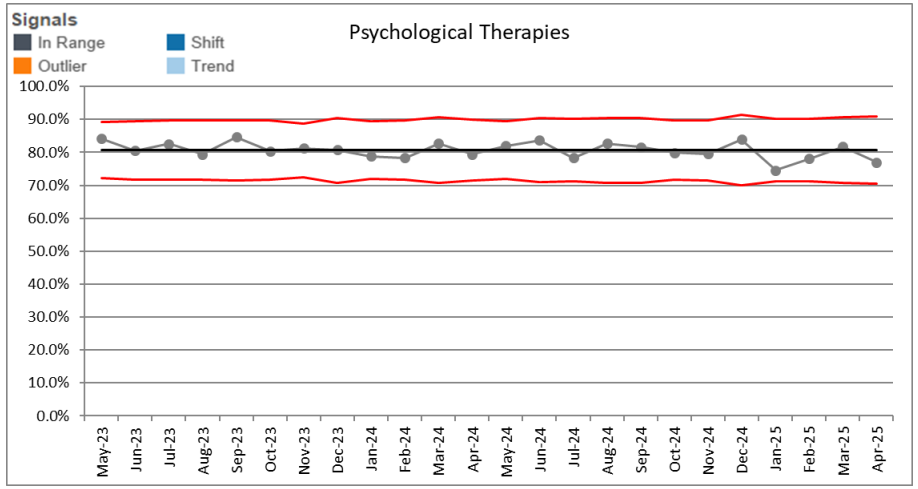
KPI	Latest Performance (April 2025)	Trajectory (Q1 2025/26)	Trajectory Forecast (March 2026)	National Benchmarking (Q3 2024/25)
95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral.	75.8%	80%	89.4%	73.5%
Median 62-Day Wait	46	N/A	N/A	N/A
95th Percentile 62-Day Wait	162	N/A	N/A	N/A

Summary	Actions	Assurance
NHS Lothian's performance against the 62-day target in April 2025 was 75.8%, which was below the NHS Lothian trajectory but was above the Scotland average of 68.1%. Of the 11 cancer types, 3 met the 95% standard, 4 met the cancer-specific trajectory and 8 met or exceeded the national average performance. The main drivers for not meeting trajectory were long waits for Endoscopy impacting the Colorectal and Upper GI pathways, Imaging delays across several tumour groups and scan types, and the backlogs across the Prostate pathway steps.	• Additional activity is planned across the Urology Prostate pathway to clear backlogs at triage, MRI, TRUS and TP biopsy, and surgical Outpatient clinics, as well as Flexible Cystoscopies in the Bladder pathway. • Continued usage of the mobile MRI unit at WGH, which is primarily supporting the Prostate pathway and is planned to support other USoC pathways (Breast and Colorectal). • Insourcing has started within Radiology to reduce reporting turnaround times. • Insourcing scoping underway in Endoscopy, with additional lists provisionally planned for July 2025.	Limited

Mental Health – Psychological Therapies

Responsible Director(s):	REAS Services Director	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	N/A

Psychological Therapies Waiting Times – *LDP Standard*



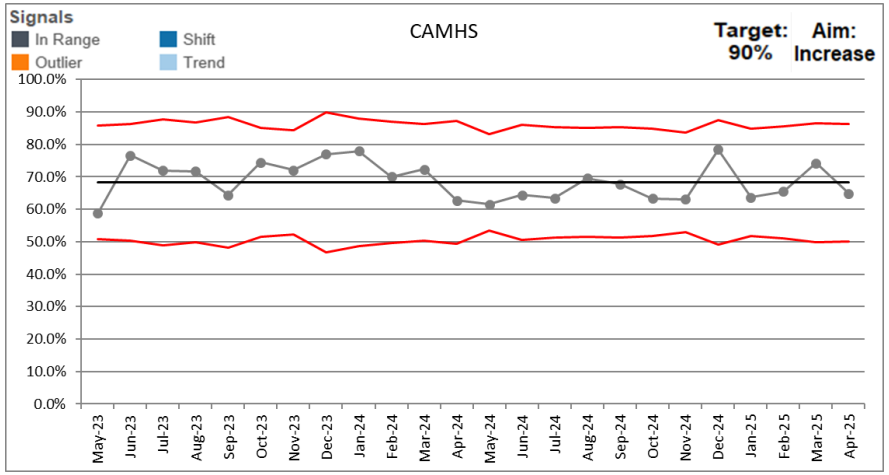
KPI	Latest Performance (April 2025)	Trajectory (March 2026)	National Benchmarking (March 2025)
90 per cent of patients to commence Psychological Therapy based treatment within 18 weeks of referral.	77%	77.9%	81.3%
Total Waits	4021	N/A	NHSL accounted for 17.3% of Scotland
Waits > 52 weeks	103	N/A	Lothian accounted for 4.22% of Scotland

Summary	Actions	Assurance
The treatment waiting list has remained relatively static over the last 4 months from 4,110 (January 2025) to 4,021 (April 2025). Analysis of the breakdown of the list highlights that although there is a reduction in the number of total waits under 18 weeks, there is an increase in the number of patients waiting 19-52 weeks (1,075 in January 2025 to 1,296 in April 2025) and the number of patients waiting over 52 weeks (83 in January 2025 to 103 in April 2025). This impact to waiting times was anticipated and reflects the loss of workforce and the increase in demand seen across the services. Due to reduced Mental Health Outcome Framework funding and historic reliance on slippage which is no longer available, Psychological Therapies have been required to reduce the workforce by approx. 20 WTE to reach financial balance moving forward. Several individual AMH Psychology services have recently met the 18-week target during the last reporting year; however, this will not be sustained, and it is anticipated that the total number of patients waiting over 18 weeks will grow. There is also additional pressure on general Psychological Therapy Services across the four HSCP's due to the funding cuts and reconfiguration of the Psychology Staff Support Service and Veteran's First Point. This is currently under review to understand how NHS Lothian can support these populations as a profession within statutory services.	There has been agreement across the 4 HSCP's and NHS Lothian on funding reductions. The impact on workforce across services is now being worked through. There are robust processes in place with monthly performance meetings ensuring all service leads can highlight issues in data and access the support required for ensuring accuracy of waiting lists and capacity plans at both individual and team level. There will be a review into the job plan modelling and capacity planning to inform future trajectories, with discussion on the Scottish Government capacity model being considered (based on the original Lothian model). There are ongoing requirements from eHealth to support TRAK builds and correcting historic errors that continue to impact the accurate recording of activity. 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.	It is anticipated that the LDP standard will not be met within the next five years due to the current capacity and projected financial impact. There is moderate assurance that adequate controls are in place, even though the standard is not currently being met.

Mental Health – CAMHS

Responsible Director(s):	REAS Services Director	**Reporting Period:**	**April 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	N/A

CAMHS Waiting Times – *LDP Standard*



KPI	Latest Performance April 2025	Trajectory (March 2026)	National Benchmarking (March 2025)
90 per cent of young people to commence treatment for specialist Child and Adolescent Mental Health services within 18 weeks of referral.	64.8%	77.7%	94.1%
Total Waits	1839	N/A	Lothian accounted for 40.84% of Scotland
Waits > 52 weeks	149	N/A	Lothian accounted for 87.52% of Scotland

Summary	Actions	Assurance
Across all CAMHS Lothian, the overall performance for the LDP standard is at 64.8% (April 2025). There continues to be a focus on allocating priority to clinically urgent and the longest waiting patients. Overall, there were a total of 1,839 patients waiting at the end of April 2025 with 149 patients waiting > 52 weeks. CAPA job planning process is subject to a 3 monthly planning cycle and undergoes constant refinement. In the quarter to end of March 2025, there was 100% delivery of job plans. Work is ongoing with the Scottish Government to review application of LDP standard, specifically the criteria for start of treatment. As with Psychological Therapies, the reduction in Mental Health Outcome Framework funding has determined a requirement to reduce the workforce and this will impact access to CAMHS services.	Being able to retain staff to sustain capacity remains a critical factor for ongoing performance to meet the LDP standard. 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 ensures the best use of existing resources and regular review of the developing financial position. Monitoring of the CAMHS sector team capacity is ongoing to identify where teams can offer appointments to those patients waiting over 52 weeks in West Lothian to help recover their position. West Lothian are streamlining meetings, reducing CAPA Away Days, testing running zone regulations group with Band 5's and utilising the family systemic therapist to facilitate small group sessions. The LDP Standard Workshops in May 2025 provided staff with an opportunity to discuss the guidance, share ideas, concerns and identify risks. Future workshops will involve young people, families and carers.	It is currently anticipated that the target will not be met due to reduced funding having affected service waiting times performance. There is limited assurance on continued management of performance.

Primary and Community Care

Responsible Director(s):	Director of Primary Care	**Reporting Period:**	**May 2025**
Data Source:	DataLoch & Adastra	**Linked Corporate Risk(s):**	N/A

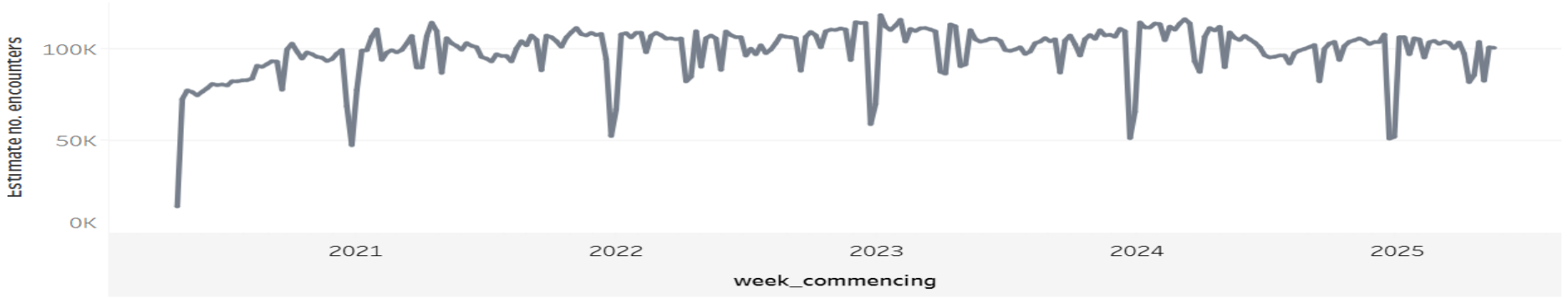
KPI	Latest Performance (May 2025)
Estimated General Practice (in hours) activity	Week commencing 19th May 2025, there were an estimated 100,036 patient consultations across the 116 General Practices in Lothian. This represents a rate of 95 weekly consultations per 1,000 population in Lothian. This level of activity is within normal variation.
General Practice Out-of-Hours (LUCS) activity	Week commencing 19th May, LUCS activity was 2211, with the weekly mean excluding public holidays at 2406. This is within normal variation.
Closed Practice Lists	In May 2025, there were 3 practices with closed lists, with one scheduled to reopen during June 2025. Therefore 98% of lists within Lothian remain open.

Summary	Notes	Assurance
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.	Moderate

Primary and Community Care

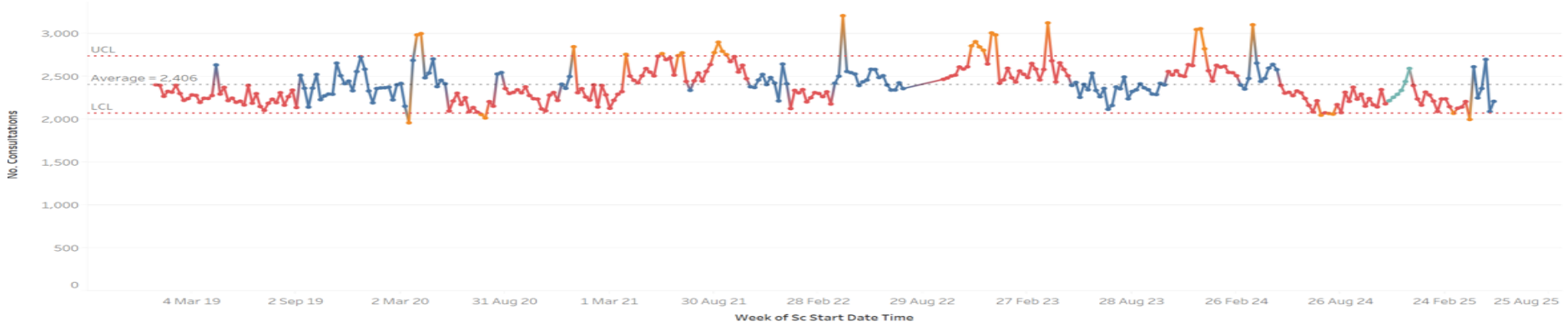
Responsible Director(s):	Director of Primary Care	**Reporting Period:**	**May 2025**
Data Source:	DataLoch & Adastra	**Linked Corporate Risk(s):**	N/A

Chart A provides an indication of General Practice in-hours (8am-6pm, Monday-Friday) weekly direct patient activity (all clinical staff) across Lothian



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.

Chart B provides the Lothian GP Out-of-Hours (LUCS) weekly service activity

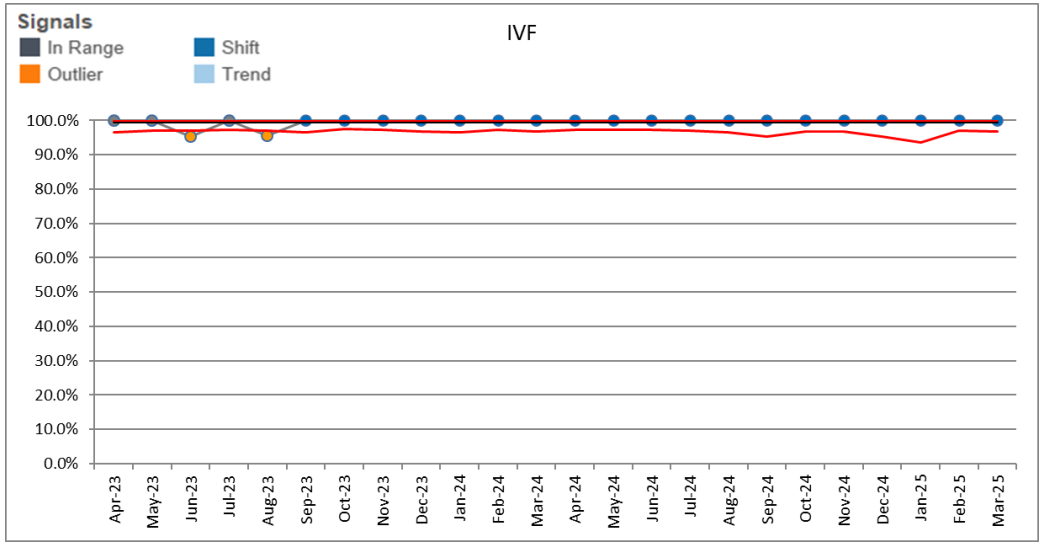


Women & Children's Health – IVF Waiting Times

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**March 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	N/A

IVF Waiting Times – *LDP Standard*

KPI	Latest Performance (March 2025)	National Benchmarking (March 2025)
90% of eligible patients to commence IVF treatment within 12 months of referral.	100%	100% Scotland Average



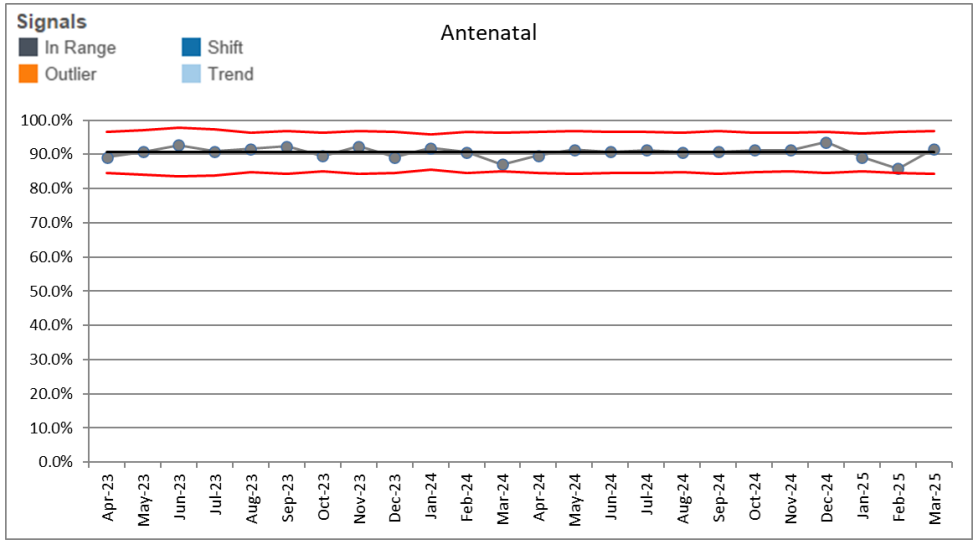
Summary	Actions	Assurance
NHS Lothian performance for March 2025 was 100% against national target of 90%. The national average was also 100%. Compliance with the target has been consistent over the past 24 months, with only single figure breaches noted which did not result in a failure to comply with the performance standard. No individual patient has breached the 12-month target since August 2023.	Ongoing monitoring of bookings in in place to ensure continued compliance against the performance target. No outstanding actions.	Significant

Women & Children's Health – Early Access to Antenatal

Responsible Director(s):	Chief of Acute Services	**Reporting Period:**	**March 2025**
Data Source:	PHS and Internal Management	**Linked Corporate Risk(s):**	N/A

IVF Waiting Times – *LDP Standard*

KPI	Latest Performance (March 2025)	National Benchmarking (March 2025)
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.	89.80% (SIMD 1) 94.23% (SIMD 5) 93.15% (Overall)	86.5% (SIMD 1) 94.9% (SIMD 5)

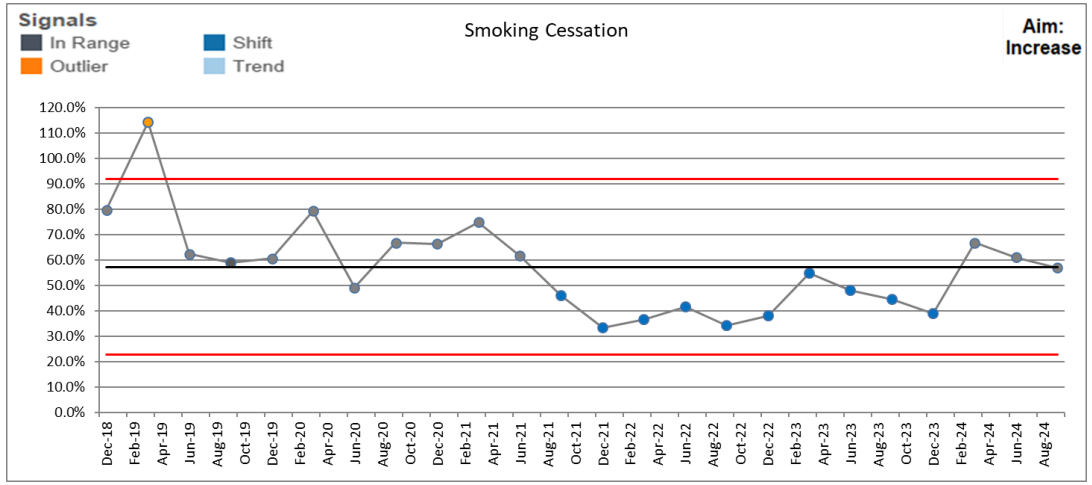


Summary	Actions	Assurance
Performance data for March 2025 broken down by SIMD is shown below: SIMD 1 – 89.80% SIMD 2 – 95.35 % SIMD 3 – 90.99% SIMD 4 – 93.29% SIMD 5 – 94.23% Overall compliance of 93.15% against a target of 80%. Antenatal access for all SIMD quintiles remains above the target and in line with national benchmarking. At no point over the 24-month reporting period has the standard not been met.	Ongoing monitoring of bookings in in place to ensure continued compliance against the performance target. No outstanding actions.	Significant

Population Health & Reducing Health Inequalities – Smoking Cessation

Responsible Director(s):	Director of Public Health & Health Policy	**Reporting Period:**	**Q3 2023/24**
Data Source:	Published PHS Data	**Linked Corporate Risk(s):**	N/A

Smoking Cessation – *LDP Standard*



KPI	Latest Performance (Oct-Dec 2024)	Trajectory (Q3 2024/25)	Trajectory Forecast (end March 2025)	National Benchmarking (Q3 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)	55%	163/295	295/295	13 of 14 Health Boards had not met the target at Q3 2024/25.

Summary	Actions	Assurance
49.5% of the ADP target was achieved in 2023/24. For the time period between Q1 and Q3 2024/25, Lothian has achieved 58% of the ADP target however there are still significant differences in performance between the QYW Specialist aspect of the service and Community Pharmacy. Specialist community and acute quit numbers have been maintained above 75% for the last four quarters. Quit numbers have been above the Scotland average and fourth among NHS Boards for 2024/25 so far. There is a continued focus on improving the Edinburgh quit numbers to achieve targets for the Specialist service. Community Pharmacy quit numbers have declined since Q2 2021/22. There has been a small improvement in performance over last four quarters however staffing challenges have impacted on expected improvement. QYW service targets in Lothian are split 50:50 between Specialist community/acute quits and Community Pharmacy quits. Note seasonal variation in quits: Q4 (Jan to March) is consistently higher.	Quality improvement plans for Edinburgh and Community Pharmacy have been implemented. There has been some unexpected staffing absence in the Pharmacy Assist Team with mitigations put in place. Varenicline is now available as a prescription from the specialist QYW service in conjunction with GPs. A new Patient Group Direction (PGD) has recently been approved in Lothian so planning for implementation in community pharmacies is underway. The Public Health and Health Policy Population Health Senior Leadership Team and Senior Management Team receive bi-annual updates on performance.	Limited level of assurance against delivery by end 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)

NHS Lothian

10.

Meeting: NHS Lothian Board

Meeting date: 25th June 2025

Title: Corporate Objectives

Responsible Executive: Colin Briggs, Director of Strategic Planning

Report Author: Colin Briggs, Director of Strategic Planning

1 Purpose

To confirm the Corporate Objectives for 2025-26

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 [please describe]	☐

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

As a matter of good practice, each organisation should have a set of Corporate Objectives refreshed at an appropriate interval. NHSL needs to set its Corporate Objectives for the year 2025-26.

Corporate Objectives provide headlines and clarity about where we are going, and act as a north star for everyone in the organisation. SPPC and the Board have both been briefed on the approach for this year and this paper seeks final approval.

2.2 Background

The Corporate Objectives have been discussed in several settings over the last few months, with refinement ongoing. We have been slightly delayed with the confirmation of additional funding from SG for Scheduled Care and Unscheduled Care. We have now had that confirmation for Scheduled Care and expect that we may have that confirmation for Unscheduled Care by the time of the Board.

2.3 Assessment

The latest iteration of the Corporate Objectives is attached at Appendix 1.

It should be explicitly noted that the CMT and teams across the organisation continue to work on the LSDF programmes designed to improve patient and staff experience and the performance of the organisation and which are linked to the Corporate Objectives.

2.3.1 Quality/ Patient Care

Our Corporate Objectives are intended to support improvement in the quality of our services and patient care, including patient experience

2.3.2 Workforce

As set out above, Corporate Objectives provide headlines and clarity for the workforce about where we are going and act as a north star for everyone in the organisation. Through our Corporate Objectives, we also aim to improve staff experience.

2.3.3 Financial

Corporate Objectives should support us to deliver the best possible health and care within financial resources.

2.3.4 Risk Assessment/Management

No direct impacts from this paper, but all the proposed objectives reflect risk management approaches to key issues in some way.

2.3.5 Equality and Diversity, including health inequalities

No direct impacts from this paper.

2.3.6 Other impacts

None

2.3.7 Communication, involvement, engagement and consultation

Our systems leadership team have contributed their thinking in developing new Corporate Objectives related to People and Culture, Prevention and Transformation. We will continue to build on this approach.

CMT members have worked to craft appropriate objectives and SPPC received a paper outlining the approach and key areas of focus at its March meeting.

2.3.8 Route to the Meeting

Discussed at CMT, SPPC, and Board

2.4 Recommendation

- **Agree** the Corporate Objectives for 2025-26.

3 List of appendices

Appendix 1 – Corporate Objectives 2025-26

NHS Lothian Corporate Objectives 2025-26

LSDF reference	Objective	Lead Officer	Support
Children and Young People	Advance LSDF priorities by strengthening neurodevelopmental and transition supports, improving digital tools, and embedding shared performance measures. We will identify and scale effective practices, deepen strategic partnerships through children's plans to lay the groundwork for a more resilient, person-centred system that delivers better outcomes for children and young people.	Colin Briggs	DPH, Fiona Wilson, Morag Barrow, Alison White, Tracey Gillies, Alison MacDonald
Primary Care	Sustain and improve primary care access including supporting national initiatives such as Pharmacy First, Community Glaucoma Services, and others	Jenny Long -> Tracey McKigen	Colin Briggs, Scott Garden, Tracey Gillies, Alison Macdonald, Craig Marriott, Morag Barrow, Christine Laverty, Alison White, Fiona Wilson
Mental Health, Illness, and Wellbeing	Improve flow through the Royal Edinburgh Hospital to bring occupancy sustainably below 98% in acute adult mental health; deliver CAMHS and PT performance improvements as agreed with Scottish Government	Alison White	Colin Briggs, Tracey Gillies, Alison Macdonald, Craig Marriott, Morag Barrow, Christine Laverty, Fiona Wilson

LSDF reference	Objective	Lead Officer	Support
Unscheduled Care	Deliver the plan set out by the Programme Board to meet 90% performance against the 4-hour standard and a bed occupancy of 90%, with 0 12-hour waits and no more than 60 delayed discharges in acute sites by 31st March 2026.	Fiona Wilson	Colin Briggs, Michelle Carr, Jim Crombie, Tracey Gillies, Alison Macdonald, Craig Marriott, Morag Barrow, Christine Laverty, Alison White
Scheduled Care	Develop and implement plans to deliver agreed performance levels in scheduled care, with a focus on improving cancer waiting times performance, minimising the number of people waiting for diagnostic tests for more than 6 weeks, and the number waiting over 52 weeks for appointments and treatment.	Michelle Carr	Colin Briggs, Jim Crombie, Tracey Gillies, Alison Macdonald, Craig Marriott
Revenue	Deliver financial balance as at 31st March 2026, with a 3% efficiency programme	Craig Marriott	All
Capital	Develop contingency plans for all physical infrastructure recorded as high-risk through the BCP process and progress the OBC for PAEP	Colin Briggs/ Craig Marriott/ Jim Crombie	Morag Campbell, Tracey Gillies, Alison Macdonald, Michelle Carr, Morag Barrow, Christine Laverty, Alison White, Fiona Wilson

LSDF reference	Objective	Lead Officer	Support
People and Culture	Develop a plan that sets out the long-term leadership and culture development required for NHS Lothian's role in system wide reform and transformation, and continue to provide targeted support for services that maintains quality and safety	Tom Power	All
Transformation	Develop and implement a practical transformation approach for NHS Lothian, focused on improving care outcomes, enhancing experiences for those who use our services and work for and with us, and ensuring long-term financial sustainability. Using data-driven insights and digital innovation, we will optimise decision-making, improve care pathways, and maximise resources.	Jenny Long	All
Becoming an Anchor Institution	Progress our addressing of inequalities through delivery of the 2025-2026 LSDF Anchor Institution pillar, with a specific focus on meeting and demonstrating outcomes related to workforce, expenditure and land and assets.	Director of Public Health	All

LSDF reference	Objective	Lead Officer	Support
Prevention	Develop a system-wide strategic prevention plan by summer 2025 which articulates how we will deliver and demonstrate the impact of a renewed focus on prevention activity to address the building blocks of health, improve early years health outcomes and tackle the burden of disease through an inequalities lens	Director of Public Health	Programme Board Chairs
Royal Infirmary of Edinburgh	To continue mitigation measures to increase safety at the RIE by; 1. Working with other duty holders and the Scottish Fire and Rescue Service to improve fire safety 2. Finalising a commercial agreement with the PFI provider to facilitate lifecycle and remedial works 3. Putting in place arrangements to ensure the continued operation of the facility beyond the end of the primary contract provider and to deliver a smooth transition to NHS management	Craig Marriott	Jim Crombie, Morag Campbell, Michelle Carr

LSDF reference	Objective	Lead Officer	Support
Integrated Assurance Framework	Develop and implement revised and integrated strategic performance, quality and risk reporting arrangements for the Board and its committees during 2025/26, as key components of a new Board Assurance Framework	Chief Executive and Chair	Darren Thompson, Colin Briggs, Tracey Gillies, Alison MacDonald, Craig Marriott, Tom Power, Jim Crombie, Board sub-committee chairs.

NHS Lothian

11.

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 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 April 2025 updates provided by the executive leads concerning risk mitigation, as set out in the assurance table in appendix 1.

2.1.2 Note that the grading of risk **3600 – Finance** has reduced from **Very High 25** (Likelihood: Almost certain (5), Impact: Extreme (5)) to **Very High 20** (Likelihood: Likely (4), Impact: Extreme (5))

2.1.3 Note the overview of the changes in the CRR over the past 2 calendar years in table 1.

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 Board members are asked to note that the grading of **risk 3600 – Finance** has reduced from Very High 25 (Likelihood: Almost certain (5), Impact: Extreme (5)) to Very High 20 (Likelihood: Likely (4), Impact: Extreme (5)). This change is based on an improved financial landscape and the Board's approval of a balanced financial plan at the April meeting.

2.3.3 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 – CMT meetings 2023-25

Risk Title	Apr-23	Jul-23	Aug-23	Oct-23	Dec-23	Feb-24	Apr-24	Jun-24	Sep-24	Nov-24	Dec-24	Mar-25	May-25
3600 - Finance	25	25	25	25	25	25	25	25	25	25	25	25	20
5186 - 4 Hours Emergency Access Target	25	25	25	25	25	25	25	25	25	25	25	25	25
3726 - Hospital Bed Occupancy	25	25	25	25	25	25	25	25	25	25	25	25	25
5185 - Access to Treatment	25	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
5785 - High Secure Female Accommodation	Split of risk 5687, approved by Board April 2024					12	12	12	12	12	12	12	12
5388 - HSDU Capacity	20	20	20	20	20	20	20	20	20	20	20	20	20
5737 - Royal Infirmary of Edinburgh Fire Safety	New risk approved by Board Decer			20	20	25	25	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
5322 - Cyber Security	12	12	12	12	12	12	12	12	12	12	12	12	12

Risk Removed from CRR (April 2025)													
5020 - Water Safety and Quality	12	12	12	12	12	12	12	12	12	12	12	8	
3828 - Nursing Workforce	20	20	20	20	20	20	12	12	12	12	12	6	
5784 - Low Secure Accommodation	Split of risk 5687, approved by Board April 2024					20	15	15	15	15	15	10	

2.3.3 Quality/ Patient Care

The CRR includes risks to quality and patient care and risk mitigation plans will positively impact on quality of care.

2.3.4 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.

2.3.5 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.

2.3.6 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.

2.3.7 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.

2.3.8 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.

2.3.9 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

Awareness – Board members are asked to:

- Note that the grading of risk 3600 – Finance has reduced from **Very High 25** (Likelihood: Almost certain (5), Impact: Extreme (5)) to **Very High 20** (Likelihood: Likely (4), Impact: Extreme (5))

Discussion - Board members are asked to:

- Review the April 2025 updates provided by the executive leads concerning risk mitigation, as set out in the assurance table in Appendix 1

- Note the overview of the changes in the CRR over the past 2 calendar years in Table 1

3. List of appendices

The following appendices are included with this report:

- Appendix 1: Risk Assurance Table

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. **March 2025** • **Interim paper considered with full update to be provided following re-evaluation of the risk once 2025/26 financial plan is agreed.** **Outcome of Executive Lead Discussions** **February 2025** • Significant assurance now agreed for achievement of a breakeven financial position for 24/25, due to additional funding received from the SG for CNORIS and RWW. • For 25/26 the financial plan gap has reduced to £104m due to the confirmed uplift of 3% for non-pay costs in the SG budget. • The financial strategy in 25/26 will focus on reducing the size of the Boards recurrent deficit from c£100m. This will be achieved by a focus on delivery of recurrent savings • Clarity on the increase in NI has been confirmed and the Board will be funded at 60% **April 2025** • **In closing off 2024/25 financial year, the Board has delivered against all of it's financial targets subject to external audit review** • **For financial year 2025/26, the Board has approved a balanced financial plan. This has been achieved due to the release of sustainability funding of £40m non-recurring. This has allowed the Board to reset its efficiency challenge to 3% from a previous high of 7% in 2024/25** • **Recognising the improved financial landscape in 2025/26, it is recommended that the risk rating is reduced to Very High 20 (Likelihood: Likely (4), Impact: Extreme (5))** • **The desire to improve service performance while still living within available resources will require organisational focus**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		• **It is also planned to concentrate on reducing the size of the board's recurrent gap of circa £100m. This will require the 3% efficiency challenge to be delivered recurrently and in full.**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 20** (Likelihood: Likely (4), Impact: Extreme (5))
	Target Risk Grading	**Very High 20 (Likelihood: Likely (4), Impact: Extreme (5))**	
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. **March 2025** • **Limited assurance accepted.** ***Next to be presented October 2025*** **Strategic Planning and Performance Committee** – Performance **January 2025** • Limited assurance **May 2025** • **Limited assurance** ***Next to be presented September 2025*** **Outcome of Executive Lead Discussions** **February 2025** • Performance against the Emergency Access Standard remains challenging albeit improving • Reduction in the following since the beginning of the year: o Average wait for a bed at both RIE & WGH	

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th>Committee Assurance Review Date</th></tr>
<tr><td></td><td></td><td>

Average LoS in emergency department at RIE

Average number in the queue at RIE has reduced by 50% over last 10 days
RIE adopting a “push” model to create flow early in the day

<table>
<tr><td colspan="2">January 2025 Performance</td></tr>
<tr><td>RIE</td><td>48%</td></tr>
<tr><td>WGH</td><td>63%</td></tr>
<tr><td>SJH</td><td>59%</td></tr>
<tr><td>NHS Lothian</td><td>60%</td></tr>
</table>

In response to current performance and concerns regarding winter pressures a programme of improvement work is underway, funded by SG, and a SLWG has been established to drive this 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 and was subsequently funded late December 24
Programme has commenced and whilst off trajectory – positive signs are emerging.
Improving performance at RIE, WGH & SJH in February

April 2025

Albeit seeing an improvement, there is a lack of delivery of the 4 Hr EAS performance trajectory against the backdrop of improving process measures.

<table>
<tr><td colspan="2">March 2025 Performance</td></tr>
<tr><td>RIE</td><td>66%</td></tr>
<tr><td>WGH</td><td>73%</td></tr>
<tr><td>SJH</td><td>68%</td></tr>
<tr><td>CYP</td><td>89%</td></tr>
<tr><td>NHS Lothian</td><td>72%</td></tr>
</table>
</td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date	

		• **Reduction in the following (RIE) continue to be noted since the beginning of the year:**
		  ○ **Average wait for a bed**
		  ○ **Average LoS in emergency department**
		  ○ **8 and 12 hour breaches**
		• **A funding proposal has been submitted to Scottish Government which aims to expand the initial RIE improvement programme across all Acute sites within NHS Lothian.**	

	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading	**It is not possible to set at this stage as potential impact of current work unknown**	
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**	**Healthcare Governance Committee** – person-centred, safe, and effective care. **March 2025** • **Limited assurance accepted.** ***Next to be presented October 2025*** **Strategic Planning and Performance Committee** – Performance **January 2025** • Limited assurance accepted **May 2025** • **Limited assurance** ***Next to be presented September 2025***	

Datix ID	Risk Title & Description	Committee Assurance Review Date
		<u>Outcome of Executive Lead Discussions</u> **February 2025** • Bed occupancy rates continue to exceed 85% in all sites. – no overall change to date • The Length of Stay programmes (Led by Site Directors) on the adult acute sites continue to be received positively by specialty teams with work ongoing. • Initiatives aimed at reducing admissions, such as the Rapid Assessment Care Unit (RACU) and Hospital at Home, are still performing well, however work has been commissioned to review the cohort of patients presenting at RACU, as well as the referral pathways. • Work commissioned to review clinical pathways across RIE and WGH to reduce "postcode" attendance and move to a clinical pathway led model of streaming patients to the most appropriate site. • While occupancy has not dropped to predicted levels in line with the agreed SG plan – the queue in EDs has dropped significantly (>50%), and if this continues a rapid reduction in bed occupancy is expected to follow. • All 4 HSCPs reporting challenges due to lack of care home places and closure of in-patient beds although additional capacity is due to come online between Feb – April 25. Pathways are being reviewed with a view to reducing care home demand. • Closure of Ward 74 (WGH) at the end of October to accommodate RIDU further challenged bed availability with all mitigations not yet in place. **April 2025** • **Bed occupancy rates continue to exceed 85% in all sites. – no overall change to date.** • **WGH has been consistently seeing reductions to the bed occupancy resulting in a downstream transfer system being developed to help increase flow at RIE.** • **All 4 HSCPs continue reporting challenges due to lack of care home places and closure of in-patient beds. Work is ongoing to understand whether the type of additional capacity which has come online in stages since January is appropriate for the type of patients awaiting discharge.** • **A funding proposal has been submitted to Scottish Government which aims to expand the initial RIE improvement programme across all Acute sites within NHS Lothian.**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading	**High 15** **(Likelihood: Possible (3), Impact: Extreme (5))**	
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 **May 2025** • **Limited assurance accepted** ***Next to be presented October 2025*** **<u>Strategic Planning and Performance Committee</u>** – Performance **January 2025** • Limited assurance accepted **May 2025** • **Limited assurance** ***Next to be presented September 2025***	
		<u>Outcome of Executive Lead Discussions</u>	

February 2025

		Jun-24	Sep-24	Oct-24	Nov-24	Dec-24	Jan-25
Outpatient	Over 52 weeks	11,398	14,073	12,284	13,385	13,830	14,816
	Trajectory	12,254	18,245			25,608	
	Variance	-856	-4,172			-11,778	
	Over 78 weeks	2,532	3,278	3,659	4,235	4,856	5,400
	Trajectory	3,766	7,144			11,797	
	Variance	-1,234	-3,866			-6,941	
	Over 104 weeks	128	499	699	929	1,143	1,308
	Trajectory	311	1,094			3,710	
	Variance	-183	-595			-2,567	
Inpatient Daycase	Over 52 weeks	6,765	6,783	6,591	6,563	6,388	6,291
	Trajectory	7,901	7,872			7,934	
	Variance	-1,136	-1,089			-1,546	
	Over 78 weeks	2,354	2,446	2,343	2,410	2,527	2,443
	Trajectory	3,240	3,258			3,325	
	Variance	-886	-812			-798	
	Over 104 weeks	467	459	461	485	502	519
	Trajectory	631	662			634	
	Variance	-164	-203			-132	

- Further information on performance against waiting time standards and ADP trajectories are included in the Public Board Performance paper at every meeting
- All acute outpatients waiting over 26 weeks have now been validated. A rolling programme for outpatients and expanding to inpatients and diagnostics where appropriate will be established.
- NHS Lothian have accepted the National Treatment Centre allocation offered for 25/26, however, it is disappointing to note the decreased allocation in Orthopaedics for 25/26 compared to 24/25.
- Development of ADP trajectories is underway with draft scheduled care trajectories shared with SG in January 2025. There are some specialties with a significant challenge to achieve the target set without significant levels of additionality and NHS Lothian is liaising with SG re what funding may be available to support this.
- The transfer of services back to PAEP April/ May 2025 will inevitably impact activity.
- Maximising utilisation of available capacity remains a key area of focus for NHS Lothian 25/26.

April 2025

		Jun-24	Sep-24	Dec-24	Jan-25	Feb-25	Mar-25
Outpatient	Over 52 weeks	11,433	14,151	13,955	14,982	15,909	17,203
	Trajectory	12,254	18,245	25,608			39,023
	Variance	-821	-4,094	-11,653			-21,820
	Over 78 weeks	2,539	3,301	4,895	5,463	5,991	6,710
	Trajectory	3,766	7,144	11,797			17,698
	Variance	-1,227	-3,843	-6,902			-10,988
	Over 104 weeks	132	504	1,150	1,317	1,577	1,810
	Trajectory	311	1,094	3,710			7,085
	Variance	-179	-590	-2,560			-5,275
	Activity (cumulative)	54,026	106,183	158,537	175,436	191,091	207,013
	Planned	52,857	106,473	159,814	177,901	195,399	213,582
	Variance	+1,169	-290	-1,277	-2,465	-4,308	-6,569
Inpatient Daycase	Over 52 weeks	6,780	6,798	6,405	6,317	6,160	5,865
	Trajectory	7,901	7,872	7,934			8,234
	Variance	-1,121	-1,074	-1,529			-2,369
	Over 78 weeks	2,360	2,459	2,543	2,468	2,368	2,252
	Trajectory	3,240	3,258	3,325			3,426
	Variance	-880	-799	-782			-1,174
	Over 104 weeks	471	464	507	524	500	498
	Trajectory	631	662	634			680
	Variance	-160	-198	-127			-182
	Activity (cumulative)	10,855	20,642	29,778	32,767	35,639	38,584
	Planned	10,543	21,408	31,853	35,331	38,744	42,288
	Variance	+312	-766	-2,075	-2,564	-3,105	-3,704

- **Further information on performance against waiting time standards and ADP trajectories are included in the Public Board Performance paper at every meeting**
- **Achievement of ADP trajectories at year end as per table above noting trajectories predicted a deteriorating position from that of March 2024.**
- **NHS Lothian submitted detailed scheduled care proposals to Scottish Government on 6th March 2025. Most of these bids focussed on sustainable and recurring solutions to our recurrent capacity gap.**
- **Positive informal indications are the majority of NHS Lothian bids will be funded as requested and as agreed at CMT the Board are progressing delivery of some bids whilst awaiting written approval.**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		• **These actions, if fully funded and implemented, will go a long way to addressing the long wait position in Lothian. They will not, however, deliver the 52 (and 6) week position in some more challenged specialties – Orthopaedics, Dermatology, Endoscopy, General Surgery, Plastic Surgery, ENT, Gynaecology, Neurosurgery, Ophthalmology and Urology.** • **NHS Lothian has indicated this within the proposals and requested support to utilise any available capacity at GJNH and other Boards.** • **The transfer of services back to PAEP has been delayed by c2weeks and will inevitably impact activity.**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading	**It is not possible to set at this stage as still in ADP process – will be reviewed in June 2025 when allocation known**	
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	**<u>Finance and Resources Committee</u>** **March 2025** • **Limited assurance accepted.** ***Update provided to every meeting alternating paper and verbal – next paper August 2025***	
		<u>Outcome of Executive Lead Discussions</u> **February 2025** • Future risk comes in the form of deterioration of infrastructure within the HSDU. As time progresses it is likely that the key infrastructure will degrade. The mitigation surrounding this comes in the form of current maintenance activities alongside the wider Critical Infrastructure review. • 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). • In terms of the mitigation plan the staff shift pilot is now complete and results compiled. This has shown	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	Corporate objective: Capital **Risk Response: Treat**	that it is possible to continue to run HSDU out of hours using staff overtime, however, if adopted would require increased staffing establishment • There has been no significant upturn in demand, so no changes are planned following the outcome of the pilot at this stage. **April 2025** • **It is anticipated that additional information will be added regarding proposals to increase staffing as a result of upcoming increased Theatre activity. While this will not increase the overall risk, it is a consideration in the wider context of the HSDU particularly in terms of resilience should the unit be out of action.** • **One area of additional risk will exist in the form of resilience. With proposals currently in place for additional staffing and predicted significant increases to production within the unit (via increased Theatre activity) there will be increased risk of being able to locate suitable, external (neighbouring Boards) contingency to meet demand. This should be considered alongside the general infrastructure issues impacting the current unit.**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		Very High 20 (Likelihood: Certain (5) Impact: Major (4))	**Very High 20** (Likelihood: Certain (5) Impact: Major (4))
	Target Risk Grading	**Unlikely to change with current mitigation plan as wholly dependent on capital funding**	

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td rowspan="2">5189</td><td rowspan="2">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</td><td colspan="2"><u>Finance & Resources Committee</u>

February 2025
• Limited assurance accepted.

Update provided to every meeting alternating paper and verbal – next paper June 2025</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>

February 2025
• Detail of updates to the mitigation plan are detailed within the afore noted paper.
• A review of grading will take place following completion of IA in May 2025, as this may result in control of some of the funding to prioritise work. Any proposals from this review will be brought to the next available CMT and mitigation plan to be presented to future Finance & Resource Committee for assurance.

April 2025
• It is anticipated that recommendations will be included to amend/update the risk to ensure it is reflective of the current risk profile of Hard FM delivery on the site. This will be scoped and proposed by the E&F Business Manager, Senior PFI Estates Lead and Programme Director.</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">Risk Grading:</td><td>CMT February 2025</td><td>CMT May 2025</td></tr>
<tr><td>High 15
(Likelihood: Possible (3) Impact: Extreme (5))</td><td>High 15
(Likelihood: Possible (3) Impact: Extreme (5))</td></tr>
<tr><td></td><td>Target Risk Grading</td><td colspan="2">Unlikely to change with current mitigation plan.</td></tr>
<tr><td colspan="4"></td></tr>
</table>

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td rowspan="2">3455</td><td rowspan="2">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>

March 2025
• Moderate assurance accepted.

Next to be presented July 2025</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>

February 2025
• Programme board has completed work to establish risk controls. The final element of the work has been the implementation of the training strategy, this has moved into the final phase.
• Processes now business as usual. Programme Board will have 2 further meetings (April and July) to close off - review Q1 of H&S reporting, baseline data and measurement framework
• Work continues with acute services managers to address challenges in identifying work-based trainers

April 2025
• The improvement work of the programme board is now complete with risk controls now in place
• Following review of H&S quarter 1 returns (V&A risk assessment, local actions and training needs analysis) through local H&S Committees and by the NHS Lothian H&S committee in May it is proposed that the ongoing monitoring of controls will be business as usual and the programme board will be stood down after final meeting in July, as planned
• Implementation of controls will continue to be monitored through H&S committee infrastructure and requirement for further risk mitigation plans at a corporate level considered through Health and Safety functions if required</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">Risk Grading:</td><td>CMT February 2025</td><td>CMT May 2025</td></tr>
<tr><td>High 15
(Likelihood: Almost Certain (5) Impact: Moderate (3))</td><td>High 15
(Likelihood: Almost Certain (5) Impact: Moderate (3))</td></tr>
<tr><td></td><td>Target Risk Grading</td><td>High 12
((Likelihood: Likely (4), Impact: Moderate (3))</td><td></td></tr>
<tr><td colspan="4"></td></tr>
</table>

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td rowspan="2">3328</td><td rowspan="2">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 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</td><td colspan="2"><u>Staff Governance Committee</u>

December 2024
• Limited assurance accepted

May 2025
• Limited assurance accepted

Update provided to every meeting alternating paper and verbal – next paper May 2025</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>

February 2025
• The project is progressing surrounding the recently funded works for Hospital Main Drive at WGH.
• Engineering solutions continue to be developed for the 3 x red risks live on the Little France Campus.
• The risk will be further evaluated as risk mitigation activities, including those mentioned above, are carried out.

April 2025
• The project to improve the road network at the WGH (Hospital Main Drive) has been delayed and will now progress in 2025/26.
• The red risks which exist on the Little France Campus, specifically the ED, are subject to a short life working group who are reviewing and taking forward contingency and rectification measures.</td></tr>
<tr><td rowspan="2"></td><td rowspan="2">Risk Grading:</td><td>CMT February 2025</td><td>CMT May 2025</td></tr>
<tr><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 colspan="2">To be assigned following further evaluation</td></tr>
<tr><td colspan="4"></td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date

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 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
		<u>Healthcare Governance Committee</u>
		
		May 2024
		• Moderate assurance accepted
		
		March 2025
		• **An interim paper was considered and limited assurance was accepted in relation to IPC workforce, and moderate assurance in relation to Board performance against local delivery plan targets to end Q3 2024**
		
		Next to be presented September 2025
		
		<u>Outcome of Executive Lead Discussions</u>
		
		February 2025
		• Work will start in March 2025 with the appointment of an additional senior staff member to support both the workforce redesign and also establishment of a robust governance framework.
		• We have received an exception report from ARHAI for Q3 2024 for community acquired CDI – a response and action plan is being prepared. No epidemiologic or prescribing concerns have been raised at this stage and initial review suggests that this is a seasonal anomaly previously observed in NHS Lothian in Q3.
		• SG have not advised the LDP targets or mandatory surveillance programme for 2025/26. None were set by SG for 2024/25 though local monitoring continues.
		• All other measures remain with control and are comparable to other Boards as at Q3 (from national dashboards).
		• A data exceedance in line associated bacteraemia has been identified in one area and is currently being explored with the service.
		
		April 2025
		• **A programme of work has been established, led by a dedicated Professional Advisor (Corporate Nursing) A comprehensive work plan is now in place to**
		  ○ **establish a robust governance framework for HAI**
		  ○ **address the immediate workforce requirements**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		○ **develop the workforce redesign to meet the requirements of the national strategic IPC workforce plan** ○ **review / revise the local audit and action planning functions** • **A Stakeholder Oversight Group has been established chaired by the Nurse Director (Corporate Nursing) reporting to PLICC** • **New mandatory healthcare associated infection and antimicrobial standards and indicators have been published through DL 2025 (05)** • **NHS Boards are required to report no increase in the incidence of *Clostridioides difficile* infection, *Staphylococcus aureus* or Escherichia coli bacteraemias by March 2026 from the baseline of 2023/2024.** • **The wider HCAI surveillance programme requirements (including surgical site surveillance) remain under consideration and are expected to be published in November 2025.**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		High 16 (Likelihood: Likely (4) Impact: Major (4))	**High 16** (Likelihood: Likely (4) Impact: Major (4))
	Target Risk Grading	**Medium 9** **(Likelihood: Possible (3) Impact: Moderate (3))**	
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.	**<u>Audit and Risk Committee</u>** **June 2024** • **Moderate assurance accepted.** ***Next to be presented June 2025*** **<u>Board</u>** **October 2024** • **Private Board accepted moderate assurance.** ***Next to be presented October 2025***	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	New risk approved by Board February 2022. Executive Lead: Tracey Gillies Corporate objective: Digital **Risk Response: Treat**		
		<u>Outcome of Executive Lead Discussions</u> **February 2025** • Continued implementation of risk mitigation plan, including bi -weekly review of effectiveness of security measures in place in blocking and preventing external threats and implementing additional controls if required. • Preparing for scheduled NIS audit submission in April 2025 • Arranging Executive cyber security exercise early in 2025. **April 2025** • **Continued implementation of risk mitigation plan, including bi -weekly review of effectiveness of security measures in place in blocking and preventing external threats and implementing additional controls if required.** • **NISR 2025 audit submission response April 2025 is complete. Report is pending and an executive management meeting with Scottish government auditor to discuss is scheduled for 5th June 2025** • **Executive Cyber tabletop exercise with external security contractor has been completed**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		High 12 (Likelihood: Possible (3) Impact: Major (4))	**High 12** (Likelihood: Possible (3) Impact: Major (4))
	Target Risk Grading	**Unlikely to be able to reduce**	
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	**<u>Healthcare Governance Committee</u>** **March 2025** • **Limited assurance accepted** ***Next to be presented July 2025***	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	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 **Risk Response: Treat**	**<u>Outcome of Executive Lead Discussions</u>** **February 2025** • 12 additional beds were opened as planned; however, occupancy remains above 100% with acuity being high. • A plan is in place to review community models, jointly commissioned by EHSCP Chief officer and REAS service director. • A group to lead the work is in place with terms of reference agreed and alternative community models are being explored. **April 2025** • **12 additional beds closed end March, occupancy remains significantly above 100% and acuity remains high** • **Consequently, there is increased pressure on RIE with diverts frequently in place from REH since early 2025** • **The mental health transformation board, has refreshed it's TOR and membership and is now meeting monthly to maintain oversight of transformation agenda** • **Alongside this, a weekly progress meeting on immediate actions is in place, chaired by the Chief Executive** • **The review of CMHTs has begun across all 4 HSCPs and the first update to share key learning themes is due in early June** • **Work to improve data to enable real time, data driven decision making is in progress** • **Management capacity on REH site has been increased with a key focus on bed occupancy and flow**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading	**Medium 9** **Likelihood: Possible (3), impact moderate (3)**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
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. New risk approved by Board December 2023. Executive Lead: Caroline Hiscox Corporate objective: RIE **Risk Response: Treat**	**<u>Staff Governance Committee</u>** **March 2025** • Limited assurance accepted **May 2025** • **Limited assurance accepted** **<u>Finance & Resource Committee</u>** **February 2025** • **Limited assurance accepted** ***Update provided to every meeting alternating paper and verbal – next paper June 2025***	
		<u>Outcome of Executive Lead Discussions</u> **February 2025** • The risk mitigation plan is updated on an ongoing basis • Progress continues on lifecycle work (detail contained within the associated risk update paper). • A feasibility study is now underway surrounding the creation of fire hazard rooms for general and clinical waste. • Fire Incident Response Team are fully functional. • Fire safety training also continues to be progressed on the site with oversight by the Fire Safety Training Manager. • April/May results of review AECOM external fire engineers stable but not at L1. **April 2025** • **Significant work continues to progress with the associate Risk Mitigation Plan(s) as detailed in both Committee update papers.**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))	**Very High 25** (Likelihood: Almost Certain (5), Impact: Extreme (5))
	Target Risk Grading	**To be assigned in June following receipt of AECOM report**	
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>** **January 2025** • **Limited assurance accepted.** ***Next to be presented July 2025***	
		<u>Outcome of Executive Lead Discussions</u> **February 2025** • No further progress regarding national solution. **April 2025** • **No further progress regarding national solution**	
	Risk Grading:	**CMT February 2025**	**CMT May 2025**
		High 12 (Likelihood: Possible (3) Impact: Major (4))	**High 12** (Likelihood: Possible (3) Impact: Major (4))
	Target Risk Grading	**Unable to assign without national solution**	

Risks removed and rationale

Risk ID	Opened	Risk Title	Recommendation	Rationale
5020		**Water safety and quality**	Board approved closing the risk as per 16 April 2025 Board Corporate Register Paper	The grading for this risk was reduced from to **High 12** (Likelihood: Possible (3) Impact: Major (4)) to **Medium 8** (Likelihood: unlikely (2), impact major (4)) as controls around water safety have improved significantly, demonstrated via procedures and processes now in place. The risk will continue to be monitored through inclusion on the estates and facilities risk register.
3828		**Nursing workforce**	Board approved closing the risk as per 16 April 2025 Board Corporate Register Paper	The grading for this risk was reduced from **High 12** (Likelihood: Possible (3) Impact: Major (4)) to **Medium 6** (Likelihood: Unlikely, Impact: Moderate) based on current staffing. It is recognised that there will be future challenges with reduced numbers being trained in 2024/25 which will affect 2027 outturn numbers. The situation will continue to be monitored by the nursing and midwifery board and included in local risk registers where required.
5784		**Inappropriate and Inadequate Low Secure Accommodation in the Estate**	Board approved closing the risk as per 16 April 2025 Board Corporate Register Paper	The grading for this risk was reduced from **High 15** (Likelihood: Almost Certain (5) Impact: Moderate (3)) to **High 10** (likelihood: almost certain (5), impact minor (2)) given that the contract for out of area placements is in place and implemented. The risk will be retained on the REAS operational risk register for ongoing monitoring, as there are still some patients in inappropriate level of accommodation.
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 the risk is de-escalated to the Primary care services risk register and noted that it would continue to be

Risk ID	Opened	Risk Title	Recommendation	Rationale
				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.
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
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 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

Risk ID	Opened	Risk Title	Recommendation	Rationale
				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.
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.
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

Risk ID	Opened	Risk Title	Recommendation	Rationale
				be placed on the corporate nursing register for regular review.
5034	**29/06/2020**	**Care Homes**	Board approved closing the risk as per 9 February 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. 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.
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.
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.
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.

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.

NHS Lothian

12.

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 2025**
Title:	**Quality Report and Annual Plan**
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	☐

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 outline plans to support the delivery of the NHS Lothian Quality Strategy (2018-2027), including the Quality Directorate 2024-25 Annual Report (Appendix 1) and the 2025-26 Quality Directorate Annual Plan (Appendix 2).

The Board is asked to:

- Review the range of work undertaken to improve patient safety across NHS Lothian and the way that this contributes to reducing mortality, preventing harm, and improved experiences and outcomes of care.

- Note the focus and attention given to supporting and enhancing NHS Lothian's learning system, which involves capturing lessons from adverse events, identifying themes, and implementing improvements through planned programmes.

- Support the continued emphasis on creating the conditions for staff to engage actively in improvement activities with the consequent professional satisfaction and development.

2.2 Background

NHS Lothian's Quality Strategy (QS) aims to embed a comprehensive Quality Management (QM) approach across the organisation. This approach encompasses the four key components of Quality Planning, Quality Improvement, Quality Control, and Quality Assurance.

The Quality Directorate (QD) strives to integrate assurance and improvement functions, with a particular focus on strengthening connections across service areas to foster a culture of continuous learning and improvement. The aim is to deliver consistently high-quality care that minimises morbidity and mortality, ensures a positive patient experience, and meets or exceeds all six dimensions of quality: safe, effective, person-centred, timely, efficient, and equitable care.

This is being progressed through the practical application of a Quality Management System (QMS) that supports services to reduce harm by learning from adverse events, identifying recurring themes through analysis, and implementing change through targeted improvement programmes. In addition to the priorities outlined in the annual plan, the QD supports a range of core (business-as-usual) activities aligned with the four components of the QMS. These include risk management, safety alerts, litigation support, and the development of a Quality Assurance Framework.

2.3 Assessment

Assurance Framework – Healthcare Governance Committee

Over the past year, QD has supported the development of a clinical assurance framework to guide service reports submitted to the Healthcare Governance Committee (HGC). This work has taken an iterative approach, initially focusing on safe care. This year, the framework is being expanded to include effective and person-centred care.

The clinical assurance framework was developed to clarify the structures, processes, and types of evidence that should underpin reports presented to HGC. A key component of this approach is a clinical assurance mapping document, included within service reports as an appendix. The assurance map summarises what evidence on safe, effective, and person-centred care is reviewed, where it is reviewed, and how frequently. It provides HGC members with insight into the processes in place within services to provide assurance of safe, effective, and person-centred care.

Reducing avoidable harms

This paper summarises key patient safety improvement programmes, including the Scottish Patient Safety Programme (SPSP), which aims to:

- Reduce avoidable harm.
- Ensure the Hospital Standardised Mortality Ratio (HSMR) remains within Scottish limits.

The aim of the Acute Adult Safety programme is to reduce the Hospital Standardised Mortality Ratio (HSMR) across Scottish hospitals (no national target set) through the reduction in common healthcare associated harms, the details of which will follow in this report.

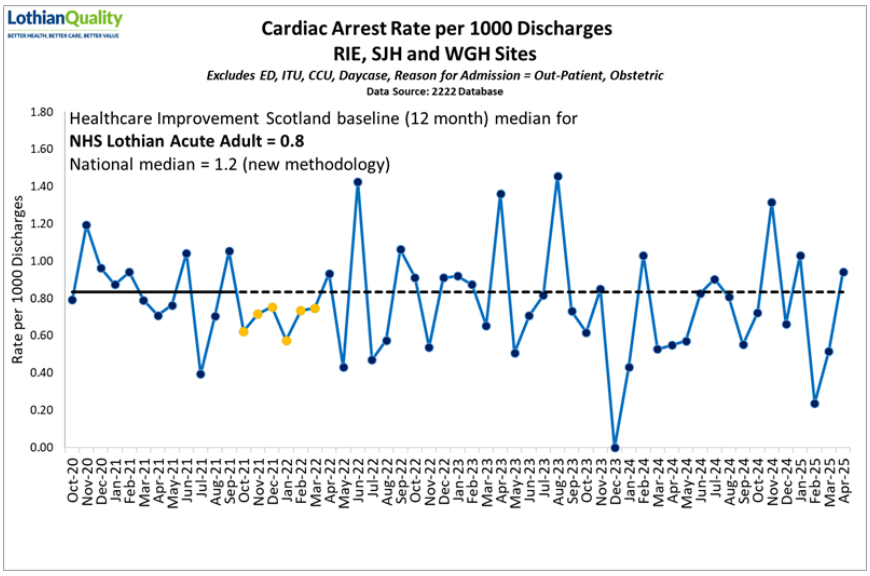
HSMR

The HSMR for NHS Lothian is currently 1.02 (a combined figure for three acute adult sites) for the period January to December 2024, and no Lothian sites were beyond the control limits for this indicator. However, the HSMR for the Royal Infirmary of Edinburgh (RIE) has been above the warning limit. Over the past year, the Quality Directorate has undertaken a series of investigations and reports have been presented to Healthcare Governance Committee outlining the findings of these investigations at the RIE. No consistent evidence of avoidable mortality was found and alternative explanations for the increased HSMR were identified. As a result, a number of recommendations were implemented, including sharing the outputs of these investigations with Public Health Scotland who have indicated they plan to report on updates to the HSMR model in 2025.

SPSP Deteriorating Patient Programme

NHS Lothian has prioritised improvements in the care and management of patients who deteriorate and has committed to participating in Healthcare Improvement Scotland's Deteriorating Patient Collaborative. The overarching aim is to sustain the current reduction in cardiac arrest rates (a national objective) and to reduce the number of significant adverse events (SAEs) related to patient deterioration (a local NHS Lothian objective). A review of the current deteriorating patient programme has been performed to inform the planning of the next phase of improvement work, and the improvement plans for the three Acute Adult sites have been presented to Acute CMG earlier this year and further details can be found in the Appendix 2: 2025/26 QD Annual Plan.

The National median cardiac arrest rate has now been fixed at 1.2 per 1,000 discharges. NHS Lothian's Acute Adult median rate remains lower at 0.8 per 1,000 discharges, as shown in Chart 1 below.



SPSP – Perinatal Improvement Programme

In September 2023, HIS launched the SPSP Perinatal Programme, and to align with this programme, NHS Lothian conducted quality planning. This process involved reviewing, theming, and learning from significant adverse events (SAEs) and complaints, as well as aligning with improvements identified from the national programme. The process informed the improvement activities for the Maternity and Neonatal Improvement Programme which is overseen by a Programme Board and co-chaired by the NHS Lothian Medical and Nursing Directors.

The programme is delivered using improvement methods, guided by a driver diagram that identifies the primary areas of focus and outlines change ideas being tested to achieve the overall improvement aim of reducing avoidable harm in maternity and neonatal services.

Medicine Safety Programme

In November 2023, the Medicines Safety and Risk Group was established with responsibility for optimising medicines safety within NHS Lothian. The group has supported a range of activities, including extensive Quality Planning, with support from the Quality Directorate. This work has involved theming medicine-related adverse events and triangulating these with other relevant data sources. In April this year, a stakeholder workshop was held to share the findings of the Quality Planning and to collaboratively develop a Pan-Lothian medicine safety programme.

The Quality Planning identified high-risk medicines—opiates, anticoagulants, and diabetes medicines—in acute settings as a key priority. It also highlighted the need for improvements in transitions of care (across settings, teams, and prescribing systems), multi-team prescribing, optimising care processes, and enhancing patient involvement. The aim of the Pan-Lothian Medicine Safety Programme is to reduce avoidable harm experienced by patients from medicines in NHS Lothian by June 2026.

The next steps include providing baseline data set for each site and service to support the development of local plans aligned with priority areas identified. To support the learning system for the Pan-Lothian Medicine Safety Programme, a follow-up learning session is scheduled for September.

In addition, NHS Lothian is contributing to the development of a national Scottish Patient Safety Programme (SPSP) medicine safety programme, helping to inform priorities and approaches at a national level based on local insights and learning.

Mental Health Services

The aim of the SPSP Mental Health programme is to reduce avoidable harm and enhance the delivery of safe, effective, and person-centred care within the Royal Edinburgh Hospital and Associated Services (REAS).

The QD is supporting a review of Significant Adverse Events (SAEs), Local Case Reviews, Mental Welfare Commission recommendations, and complaints to identify key areas for focussed improvement. An initial focus will be in Adult Acute Mental Health Services, Child and Adolescent Mental Health Services (CAMHS) and Prison Healthcare.

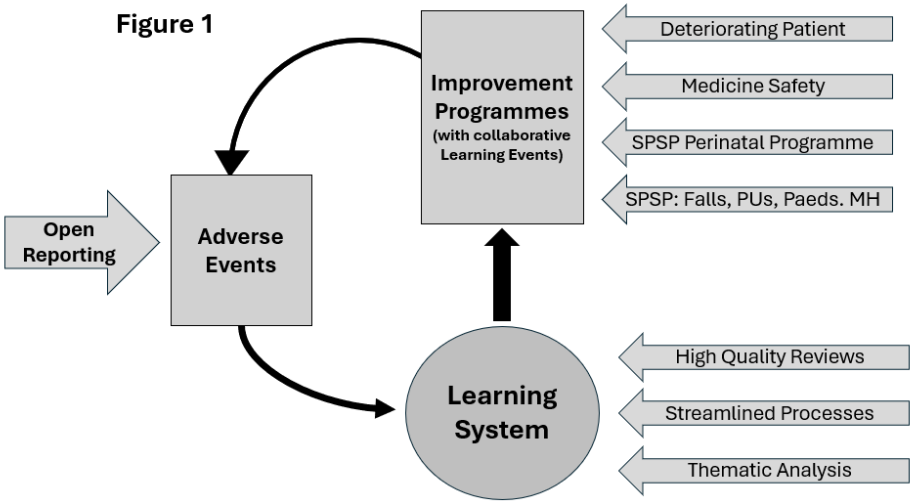
The QD continues to monitor and provide data on recorded incidents of physical violence, restraint, and self-harm, aligning with the identified SPSP mental health harm priorities.

Learning System

Key to effective Quality Management is a functioning learning system, which acts as the integrative element connecting the core components of the Quality Management System - Quality Planning, Improvement, Control, and Assurance. Within NHS Lothian, work continues to build and strengthen this learning system as a foundation for continuous improvement.

A well-functioning learning system supports a culture that enables individuals and teams to learn through shared experiences and collaborative networks. It is underpinned by evaluation and reflective practice, drawing on both qualitative and quantitative data—as well as patient and staff insights—to understand what is and is not working. The approach involves developing structured processes that support evidence-informed decision-making and enable the translation of knowledge into meaningful action. Figure 1 below depicts this.

Figure 1



A key component of the NHS Lothian learning system is the **adverse events review** process, which the QD provides support to deliver. In February 2025, Healthcare Improvement Scotland (HIS) launched the 5th edition of the National Framework for Reviewing and Learning from Adverse Events in Scotland. While applicable to all adverse events, the framework places particular emphasis on significant adverse events. A dedicated improvement programme is being developed to align with the framework's expectations. Key elements of this proposed programme are outlined below.

High-Quality Reviews - NHS Lothian remains committed to ensuring appropriate levels of review and transparency in decision-making, while focusing resources on the review of events with the greatest potential for learning and improvement. To enhance the quality of these reviews, additional training will be provided to develop further reviewers' skills in safety incident investigation.

Streamlined Processes - Securing adequate resources to complete reviews within the required timescales continues to present a challenge, particularly in relation to the availability, skills, and experience of staff. Planned improvements include streamlining existing processes and optimising the deployment of staff supporting AEs to provide more direct assistance to review teams.

Thematic Analysis - To optimise learning from adverse events, the QD will develop a structured methodology to support services in theming events. This approach will inform the design and delivery of targeted improvement programmes.

Creating the Conditions
Building capacity and capability for improvement is fundamental to a high-functioning health system. Quality Management training equips staff with skills to understand complex systems, investigate adverse events, redesign services, and apply data-driven improvements.

The Quality Academy continues to enhance staff capability in quality planning, improvement, and assurance. Participants receive tools and methods to lead improvements in their service areas. In addition, the QD has aligned with the Medical Education Directorate to explore and understand the potential of simulation as a quality tool for system safety. The aim is to consider how both directorates can work collaboratively to use transformational simulation to enhance service delivery and improve patient care.

2.3.2 Workforce

There are no direct workforce-related impacts arising from consideration of the paper.

2.3.3 Financial

There are no direct financial impacts arising from consideration of the paper or endorsements of the annual plans.

2.3.4 Risk Assessment/Management

A number of the programmes of work supported by the QD are linked to corporate objectives and as a result will contribute to plans to mitigate a number of the risks on the corporate risk register.

2.3.5 Equality and Diversity, including health inequalities

This is not applicable for this report. No specific decision is sought that is expected to have an impact on the Board's Public Sector Equality Duty, its Fairer Scotland Duty, or the rights of children.

2.3.6 Other impacts

No other significant impacts have been identified.

2.3.7 Route to the Meeting

A mid-year report was presented to the Healthcare Governance Committee in January 2025.

2.3.7 Communication, involvement, engagement and consultation

This is undertaken through individual programmes.

2.4 Recommendation

Awareness and discussion – the Board is invited to note the annual report for 24/25 and plans for 25/26.

3 List of appendices

The following appendices are included with this report:

Appendix 1- Quality Directorate 2024-25 Annual Report
Appendix 2 - 2025-26 Quality Directorate Annual Plan

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate 2024-2025 Annual Report June 2025

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

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Period:	1 April 2025 - 31 March 2026
Service / Area:	Quality Academy
Programme Title:	Quality Academy
Programme / Improvement Leads:	Cheryl Tudor

1. Aims:

1. **QI Skills Course:** Review and revise content based on stakeholder feedback. Deliver 2 QI Skills Courses.
2. **Bite sized & QI Essentials Training:** Review content of both bitesize and local essentials training courses. Agree core content with Improvement Advisors. Co-ordinate and centralise booking process on the Quality Academy website.
3. **Public Engagement Training**: Design and deliver high-level awareness raising sessions for staff in relation to public engagement, and an in-depth skills course.
4. **Manage & Enhance QI Coaching:** Review current coaching resources and recruitment process for coaches. Identify all planned coaching sessions for 2024-2025.
5. **SAE Reviewer Training:** Carry out a needs assessment, comparing what is currently being delivered against what is required to meet organisational needs. Develop knowledge and skills in system focused approaches to learning from adverse events.
6. **NHS Lothian recruitment to NES Taught Courses:** Establish current NES taught courses and recruitment cycle for the year. Manage local recruitment to SCIL and SQFS.
7. **Joy in Work Training:** Design and deliver training to implement a Joy in Work improvement programme within NHS Lothian to support staff wellbeing, retention, effective teamworking and patient safety.
8. **Medtribe [New aim - added Jan 2025]**: Introduce use of the booking system by June 2025 to support management of courses, simplify reporting and enhance learning.

2. Background and Purpose:

The Quality Academy exists to build and support the understanding, capability, and capacity of NHS Lothian staff in all aspects of quality planning, improvement and assurance. This will be achieved through offering participants opportunities to learn about the essential knowledge, tools, and methodology to lead, plan, and deliver a focussed piece of improvement work in their service area.

Additionally, providing participants with a system of understanding healthcare and outlining how quality improvement tools can be used to improve these systems and measure progress.

Key Actions and Improvements to Date:

1. **QI Skills Course**: Cohorts 25, 26, 27 & 28 were delivered (virtual). Subsequently, activity was paused, and recruitment placed on hold to allow content and structure to be reviewed.
2. **Bite sized & QI Essentials**: Two Bitesize sessions (virtual) were delivered by the Academy in 2024. As above, activity has subsequently paused, and recruitment placed on hold to allow content and structure to be reviewed.
3. **Public Engagement Training**: Two high-level awareness raising sessions (virtual) were designed and delivered in 2024 in partnership with the Public Engagement & Engagement Manager. A further 2-day in-depth skills course commenced in 2025 (in-person). Day 1 was delivered in March and Day 2 is scheduled for June 2025. All participants are undertaking engagement work to support decision making and service improvement / design.

4. **Manage & Enhance QI Coaching**: Coaches were identified for QI skills course participants to support the completion of improvement work. The Academy team supported SQFS applicants to connect with local mentors for support with the application process. Participants of the in-depth public engagement training engage in peer coaching, embedded in the design of the course.
5. **SAE Reviewer Training**: In house training is currently delivered by the assurance team with support with organisation from the Academy team. 2 courses (virtual) have been delivered. Additionally, one-to-one sessions have taken place as required.
6. **Manage NHS Lothian recruitment to NES Taught Courses**: A communication plan is in place with NES. The Academy team promote courses via the intranet on the QI Academy website and act as a key point of information and advice. Additionally, they ensure applicants have the correct signoffs before submission to NES.
7. **Joy in Work Training**: Scoping work has been completed, and discussions taken place between Organisational Development, The Quality Directorate and the Medical Education Directorate. Concerns raised about capacity for services to engage, level of effort required vs impact, and maintenance of improvements. Development of training materials underway, and small-scale test of change being shaped to test and refine approach to more effectively implement the improvement programme, by equipping staff to anticipate and plan for challenges they may encounter.
8. **Medtribe**: The Medical Education Directorate led the process of gaining DPIA signoff from Information Governance –approved in March 2025. Academy staff training to take place in May 2025.

3. Measures / Impact / Data:

1. **QI Skills course:** Number of people trained on QI Skills cohorts (virtual) 25,26,27,28 = 55.

   Feedback - what worked well:
   - Participants valued the practical application of QI tools and the supportive learning environment.

   Feedback - areas for improvement:
   - Suggestions included reducing the frequency of participant presentations, increasing course content, and providing more opportunities for interaction. Some mentioned that they would have preferred face-to-face sessions, as they felt it would have allowed for better engagement and hand on practice.

2. **Bitesize & QI Essentials:** No of people trained on bitesize and local training sessions (QI Essentials): Bitesize: 43 and Local Training = 16.

   Feedback - what worked well:
   - The sessions were informative at each stage of the QI process.
   - Visual examples and practical exercises helped with understanding.
   - The ability to revisit recordings for reinforcement.
   - Support from the QI team and bespoke, face-to-face sessions tailored to the team.
   - Using QI tools practically, which was found useful.
   - Resources like the website and toolbox were helpful.
   - Systematic approaches with tools helped keep projects on track.

Feedback - areas for improvement:

- Having some participants on MS Teams and others in person caused some challenges.
- Sometimes the sessions moved quickly through slides or concepts, requiring more detail.
- The spread-out schedule made continuity and momentum difficult.
- Technical glitches with recordings occasionally.

3. **Public Engagement Training:** 47 people attended the two high-level awareness raising sessions. Following this a two full day in person comprehensive training course was offered to participants, and to staff who had completed equality impact assessment training. Whilst interest in the course was high, capacity to attend was not. Six participants attended the first day. The second day, also scheduled in March had to be postponed due to cancellations. All have signed up to attend the re-scheduled date in June 2025.

   Feedback - what worked well:

   - Participants enjoying learning about tools and resources and having a guest speaker who balances clinical work with engagement to improve services.

   Feedback - areas for improvement:

   - Participants expressed wanting to have more time to use the tools, more real-life scenarios and case studies with positive outcomes.
   - The feedback will be factored into day two.

4. **Manage and enhance QI Coaching:** All participants of the academy were assigned a coach to guide them through improvement project completion.

5. **SAE reviewer training:** No of people attended in Feb 2025 (20 staff). Feedback not collected by Academy team.

6. **Manage NHS Lothian recruitment to NES Taught Courses:** Nine people were shortlisted for the SCiL programme in 2024. Six applications were submitted to SQFS in 2025.

7. **Quality Academy Programme Board**: Future academy courses to be aligned to individual services needs and aimed at reducing significant adverse events.

8. **Joy in Work Training**: N/A – training has not yet commenced.

9. **Medtribe**: N/A – use has not yet been adopted.

4. Reflections / Learning Points:

Leadership of the Quality Academy changed in November 2025. Resourcing, along with knowledge of developments taking place elsewhere in the system, such as NES revising and relaunching a menu of quality improvement courses, necessitated pausing some activity (eg: improvement training revision and relaunch) and prioritising others (eg: piloting public engagement training and developing knowledge and skills in system focused approaches to learning from adverse events).

Digital solutions to manage the organisation of training delivery (in use elsewhere in Lothian) can significantly reduce the administrative load, streamline evaluation / certificate provision and enhance reporting of activity taking place across the directorate.

5. Next Steps:

1. **QI Skills Course**: To be reviewed, revised and relaunched. Future offers will take account of existing training available, gaps, local need and developments in approaches to system safety. Trainer resources to be developed to support the provision of high quality inclusive and respectful educational delivery.

2. **Bite sized & QI Essentials:** Currently being offered as and when required by site QI teams. Content to be reviewed to ensure that the same learning outcomes are achieved across sites. Medtribe will be implemented to streamline organisation and simplify reporting.

3. **Public Engagement Training**: Learning from the pilot courses will be shared with the Delivering Engagement in Lothian Group and integrated into proposals for future resourcing to provide training and support for public engagement activity. This will be shared with CMG and the board. The Academy will seek to promote and equip training participants with relevant knowledge and skills to engage with key stakeholders within their skills courses.

4. **Manage & Enhance QI Coaching:** Plans to be shaped in accordance with need/ developments.

5. **SAE Reviewer Training:** Newly appointed Quality & Safety Improvement Lead progressing this workstream, along with staff who attended NES pilot training in system focused approaches to learning from adverse events. Academy team to work in partnership to help shape and host future training offers and deliver content in line with best practice.

6. **Manage NHS Lothian recruitment to NES Taught Courses**: Continue to review and evaluate the process and identify opportunities for improvement. Work alongside NES for potential collaborative projects.

7. **Joy in Work Training:** Pilot and evaluate JiW training / approach.

8. **Medtribe**: Pilot use, develop local protocols and roll out across the directorate.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Quality Directorate - Assurance
Programme Title:	Adverse Events Improvement Programme
Programme / Improvement Leads:	Quality Assurance Team

1. Aims:

- Improve learning from and management of Significant Adverse Events (SAE) resulting in unexpected harm or death to enhance patient and staff safety.
- Increase compliance with review process related Key Performance Indicators (KPI).
- Timely and reliable provision of necessary data around AE to sites and services.

2. Background and Purpose:

NHS Lothian has an open reporting system for adverse events, including unexpected events across all services where a person has suffered major harm or death. This has continued to ensure visibility of unexpected harm. Efficient management of SAE processes and effective learning from SAE reviews is crucial to increase patient and staff safety.

3. Key Actions and Improvements to Date:

Quality planning:

- Quality planning for the improvement programme undertaken using data and extensive process mapping across NHS Lothian stakeholder groups to identify variation and key risks
- Programme PID and Driver Diagram created
- Data collated and reviewed on variation in SAE approval process and review commissioning decisions
- Extensive feedback gathered from stakeholders and improvement priorities refined
- HIS framework 5th edition reviewed to identify changes to Lothian policy/procedures/guidance required

Toolkit and guidance improvements:

A toolkit and guidance have been created, reviewed and improvements made to several documents including:

- Revision of SMRT template based on data and feedback
- Updating of guidance for Local Case Reviews (mental health)
- SBARs created for improving HAI reviews (to incorporate into revised SMRT template) and non-clinical review
- Toolkit drafted and currently being reviewed by team prior to wider consultation

Training and support:

- SAE Training opportunities made available online with admin transferred to Quality academy and using a new system called MEDTRIBE
- Ongoing support to PSEAGs by QA Facilitators to embed and promote SAE processes
- Ongoing training and support to review teams undertaking level 1 reviews

Data:

- Programme's Outcome Map, Logic Model and Measurement plan drafted to help with programme evaluation
- Assurance framework data for Adverse Events for services annual assurance reports agreed and provided
- Core data set developed for acute services and tested with RIE PSEAG to inform standard data to be included in revised CMG reporting templates
- Quail - Presentation to corporate PSEAG/CMT, ongoing testing, 'End of project' feedback shared with Quantium to identify issues falling within scope of project and where additional work required

Reporting:

- Six-monthly papers (May and November) for Healthcare Governance Committee (HGC) on AE- including a paper on evaluation of changes made in April 2023 to SAE review process

Other work that has also been carried out/ supported:

- Mortality and Harm related processes and projects:
  - Mortality Screening Tool published
  - Stroke Mortality Case Reviews conducted
  - Learning from Harm flowchart developed
  - Mortality and Morbidity meeting guidance and sample Terms of Reference developed

SNAP Audits process

- Supported as an ongoing activity to ensure timely, reliable and quality submission of Board response to SNAP Audit outlier status.

SIGN

- SBAR agreed for improvements to process including strengthened governance and inclusion of SIGN recommendations in effectiveness section of assurance framework
- Annual report to HCG March 2025

4. Reflections / Learning Points:

- Programme Management group formed to keep projects well-aligned with business needs
- Project plan agreed and documented with the team which is then used for tracking activity along with action logs.
- Measurement plans and regular data collection and review very helpful for ongoing evaluation
- Challenges with changes in team leadership and membership

All learning will be taken forward for the 25-26 iteration of the Adverse Events Improvement Programme

5. Next Steps (Summary):

A further programme of work is being scoped which continue over 25-26.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Assurance
Programme Title:	Assurance Reporting
Programme / Improvement Leads:	Elaine Anderson, Liz Bream and Jill Gillies

1. Aim:

The aim for this programme is that by the end of 2025/2026 all areas of clinical care which the Healthcare Governance Committee (HGC) has oversight of, and governance responsibility for, will be using an agreed assurance framework for their reports. The assurance framework will outline the relevant evidence to support HGC to determine what level of assurance it can take for safe, effective and person-centred care**.**

2. Background and Purpose:

This work supports the NHS Lothian corporate objective "Working towards safe and quality service delivery resulting in safe and effective person-centred care" by strengthening healthcare governance through reliable reporting of person centred and effective care in annual reports from services. (1)

The framework offers a structure for providing details of relevant issues, in an appropriate, helpful format, in a timely manner, to the right people. The reports support identification and monitoring of current and future risks within a service and outline appropriate action to address any issues highlighted within them.

(1) NHS-Lothian-Corporate-Objectives-2023-24-Final-21.06.23.pdf (nhslothian.scot)

3. Key Actions and Improvements to Date:

This is a 2-year programme. Work undertaken in 2024/2025 focused on safety and a suite of templates for the report document, service scope and an assurance mapping framework were developed and tested in 2024/2025. The documents have been revised for 2025/2026 based on feedback from HGC members and services, as well as content being extended to include effective and person-centred care. More detail of the templates is provided below:

1. The report document outlines:

   - information about the structures and processes for management and oversight of safety in the service
   - detail of how the service use data and evidence, to allow an assessment of the quality and safety of care provided in the service, and outline work being undertaken to address risks and improve quality and safety

2. The service scope appendix orientates the committee to the service that the report covers.

3. The assurance mapping framework provides evidence that the service is reviewing evidence about safety in appropriate for a.

4. Measures / Impact / Data:

The revised reporting structure was used by all service reports in 2024/2025. An interim review of the revised reporting format, held with non-executive members of HGC in July 2024, indicated the revised structure was helpful. A full analysis was undertaken in March 2025 once all services had submitted a report using the new template. Responses to questionnaires sent to committee members and services were analysed. The main feedback points were:

- Committee members advised the revised reports supported decision making. The format and service scope were very useful. The Assurance Mapping Appendix, data provision and narrative in the reports was also useful.
- Services reported the new format provided a more consistent approach, included more logical and relevant questions, allowed the opportunity to reflect on a range of issues and offered more clarity about safety and outcomes.

5. Reflections / Learning Points:

Committee members and services acknowledged utilising the revised reporting structure is an iterative process. Support and time required to complete the reports, familiarity with required report content, and enhanced data analysis are likely to evolve as services become more accustomed with the new reporting arrangement.

6. Next Steps:

- The reporting documentation has been updated to reflect feedback (e.g., more guidance has been provided for the detail required for some sections) and now includes effective and person-centred care.
- SIGN Impact Assessment and SNAP audit processes will be incorporated into 2025/2026 reports.
- Engagement with services has begun to facilitate writing reports for 2025/2026.
- Evaluation of the new template will be ongoing throughout 2025/2026.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Western General Hospital
Programme Title:	Deteriorating Patient
Programme / Improvement Leads:	Emma Hearn

1. Aim:

1. Sustain the established reduction in cardiac arrest rates on the WGH site
2. Reduce medical emergency calls with preceding deterioration
3. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system
4. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into WGH site huddles to aid deteriorating patient management
5. To improve the documentation of Treatment Escalation Plans (TEPs) aiding future care planning discussions
6. To provide a reduction in Score to Door (S2D) time for unplanned critical care admissions
7. Work to improve NEWS processes over the WGH site

2. Background and Purpose:

NHS Lothian and the Western General Hospital (WGH) site actively participate in the Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative which began in September 2021. The Deteriorating Patient programme of work aims to improve the safety and reliability of deteriorating patient care while reducing avoidable harm. The aims listed above cover a selection of the outcome, process and balancing measures published within the SPSP Acute Adult Deteriorating Patient Measurement Package.

3. Key Actions and Improvements to Date:

1. A sustained reduction in the rate of cardiac arrests per 1000 discharges has been achieved.
2. Reduce medical emergency calls with preceding deterioration - baseline data collection ongoing.
3. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system
   - Robust data validation system to identify every 2222 call placed on the WGH site
   - WGH site based cardiac arrest review team established
   - NEWS on TRAK transformational in the team's ability to review each SPSP criteria meeting cardiac arrest
   - Established safety process to embed cardiac arrest learning into site PSEAG or speciality Morbidity and Mortality meeting (outcome dependent)
4. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into WGH site huddles to aid deteriorating patient management
   - Process mapping techniques used to document real-time use of the overview board within site huddles
   - Recommended minimum process implemented ensures each patient with a NEWS2 score of 7 or greater is discussed at site safety huddle to promote optimal deteriorating patient care.

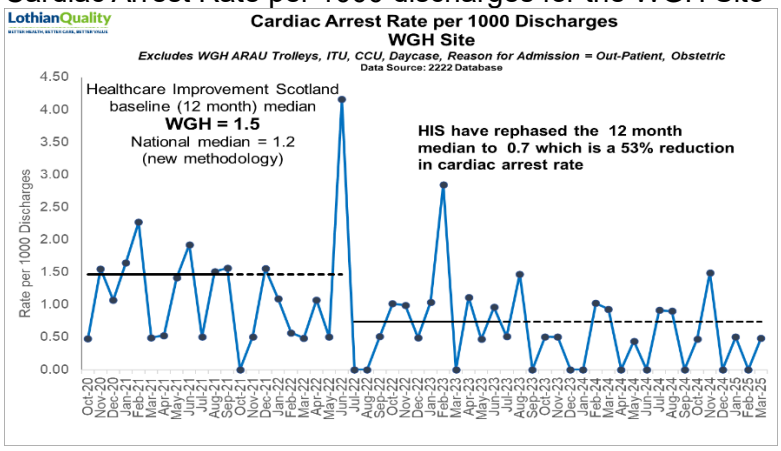
5. To improve the documentation of Treatment Escalation Plans (TEPs) aiding future care planning discussions
   - Ongoing projects and existing TEP materials are being collated to reduce duplication
   - Collection of baseline TEP data underway
   - Publication of TEP information via TEP leaflet and within the TURAS deteriorating patient module

6. To provide a reduction in Score to Door (S2D) time for unplanned critical care admissions
   - Local ICU quality improvement project

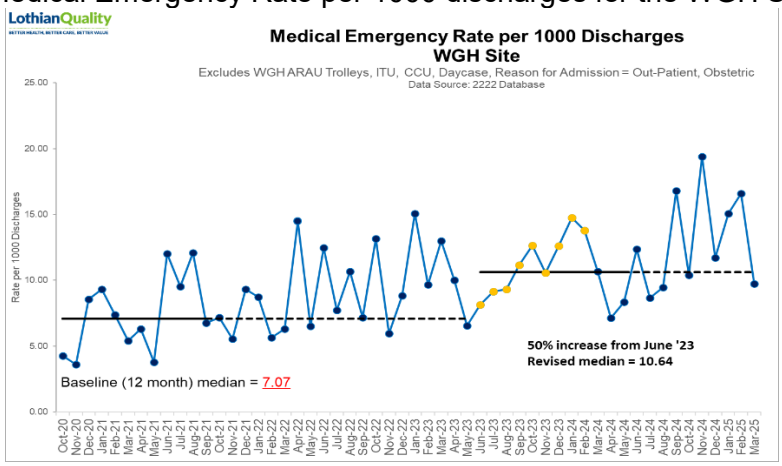
7. Work to improve NEWS processes on the WGH site
   - Collaborative improvement project with LACAS
   - Roll out of NEWS on TRAK
   - Pre and post implementation data collection

4. Measures / Impact / Data:

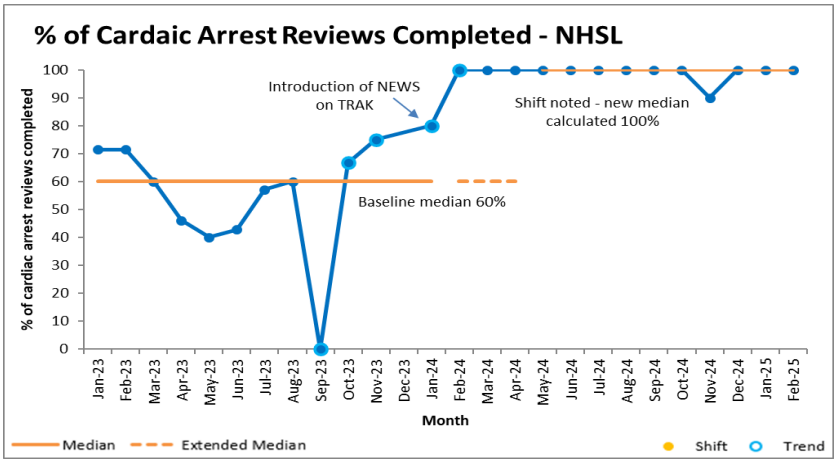
Cardiac Arrest Rate per 1000 discharges for the WGH Site



Medical Emergency Rate per 1000 discharges for the WGH Site



Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system



5. Reflections / Learning Points:

- Validated 2222 emergency data and cross team collaboration is essential in underpinning the deteriorating programme of work

6. Next Steps:

1. Sustain the established reduction in cardiac arrest rates on the WGH site.
2. Reduce medical emergency calls with preceding deterioration.
3. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system.
4. Continue to work to implement and integrate the National Early Warning Score (NEWS) Overview Board into WGH site huddles to aid deteriorating patient management.
5. To improve the documentation of Treatment Escalation Plans (TEPs) aiding future care planning discussions.
6. To provide a reduction in Score to Door (S2D) time for unplanned critical care admissions.
7. Continue to improve NEWS processes over the WGH site.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Medicine Western General Hospital
Programme Title:	WGH Front Door Medicine
Programme / Improvement Leads:	Malvika Bhatia

1. Aim

1. **Front door governance group**: To develop a clinical governance framework and use a quality management system approach to improve patient safety for the Medicine front door
2. **Medical Assessment Unit (MAU) self-presenters**: To improve safety for self-presenters attending MAU
3. **Acute Medical Patient Flow**: To improve patient flow and optimize care delivery for acute medical presentations to the Western General Hospital (WGH), while ensuring safe, high quality, timely, and equitable care for patients with varying levels of urgency, across a spectrum of clinical needs.
4. **Manchester Triage System (MTS)**: To improve safety and care outcomes at the front door for patients presenting with acute medical problems, while also providing equitable care to patients presenting to the front door with less urgent medical needs.
5. **MAU frailty In-reach team**: To improve the experience of and access to person-centred, coordinated health and social care for people aged 65 and over who are living with frailty or at risk of frailty at attendance to WGH.

2. Background and Purpose:

1. **Front door governance group**: Recognising opportunities to strengthen existing governance processes across front door services, the Acute Internal Medicine/General Internal Medicine teams at WGH proposed the establishment of a Front Door Governance Group. This initiative aims to address gaps against the Quality Standards outlined by the Society for Acute Medicine, with the goal of enhancing the quality of patient care through systematic monitoring, greater accountability and transparency, implementation of structured quality management strategies, and fostering a stronger culture of clinical excellence.

2. **MAU self-presenters**: The increasing number of patients self-presenting to WGH highlighted the importance of understanding patient motivations and experiences to ensure services are safe, responsive and aligned with patient needs. In recognition of this, doctors working within the MAU initiated a project to gather direct feedback through patient interviews, aiming to explore the factors influencing self-presentation and identify opportunities to enhance patient care and pathways.

3. **Acute Medical Patient Flow**: Continuous Improvement aimed at patient flow and optimised care delivery for acute medical presentations to the WGH MAU.

4. **Manchester Triage System (MTS)**: To address variability in triage decisions and promote greater consistency in patient prioritisation, the MTS was introduced within MAU at WGH. By providing an objective framework, the MTS supports equitable clinical decision-making, reduces potential for subjective bias, and improves departmental efficiency. The system is subject to regular review and refinement to reflect emerging clinical evidence and evolving best practice, ensuring it continues to meet the needs of both patients and the service.

5. **MAU frailty In-reach team**: Recognising the growing complexity and needs of patients living with frailty presenting to Acute Care, WGH had undertaken local initiatives to strengthen early identification and management of frailty. Building on this foundation, NHS Lothian was recruited to the Frailty at the Front Door Collaborative, led by Healthcare Improvement Scotland, to accelerate and align these efforts with national improvement priorities. As part of this work, the frailty In-reach team is being trialled in MAU as a test of change, supporting enhanced coordination of frailty care at the front door of acute services.

3. Key Actions and Improvements to Date:

1. **Front door governance group**
   - Gap analysis undertaken and completed, mapping existing local Standard Operating Procedures (SOPs) in Acute Medicine against the Society for Acute Medicine's Quality Standards to identify areas of improvement.
   - Multidisciplinary governance group established, with regular meetings attended by representatives from clinical staff, senior management, and allied health professionals (AHPs).
   - Specialty-specific Standards and SOPs were identified, mapped, and prioritised for development based on risk and service need.
   - Acute Medicine intranet page restructured to improve accessibility, including integration of relevant Right Decision Support (RDS) resources.

2. **MAU self-presenters**
   - Patient consent form was developed to support telephone interviews and distributed to patients self-presenting to MAU, ensuring consent was obtained prior to participation.
   - Telephone questionnaire script was created and trialled to ensure effectiveness and clarity in data collection.
   - Data collection was successfully carried out, engaging a total of 21 patients.
   - Data analysis was completed and shared with both the project and service leads for review and feedback.

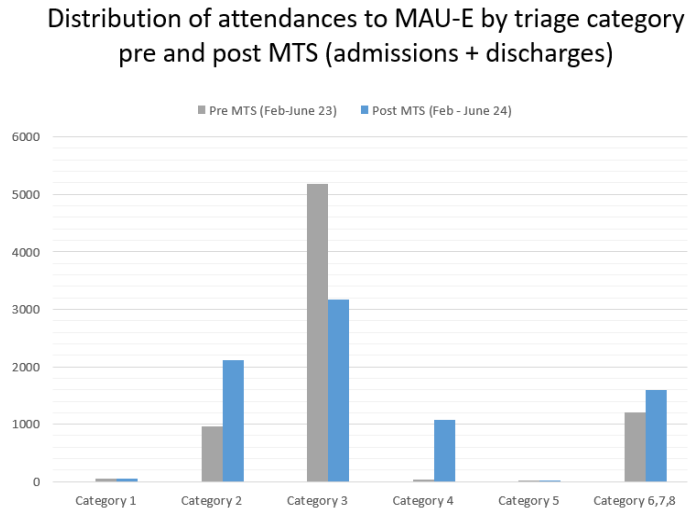
3. **Acute Medical Patient Flow**:

   Manchester Triage System (MTS)
   - MTS implementation was explored with WGH Medicine leadership, trialed in MAU, and supported by a QD led measurement plan and data analysis.
   - Findings informed a clinician-developed improvement plan; testing was delayed due to winter pressures, staffing, and competing projects.

4. **MAU frailty In-reach team:**
   - Measurement plan created by QD to support ongoing data collection and evaluation.
   - Testing of changes and implementation of improvement ideas are actively being carried out as part of the continuous quality improvement efforts.

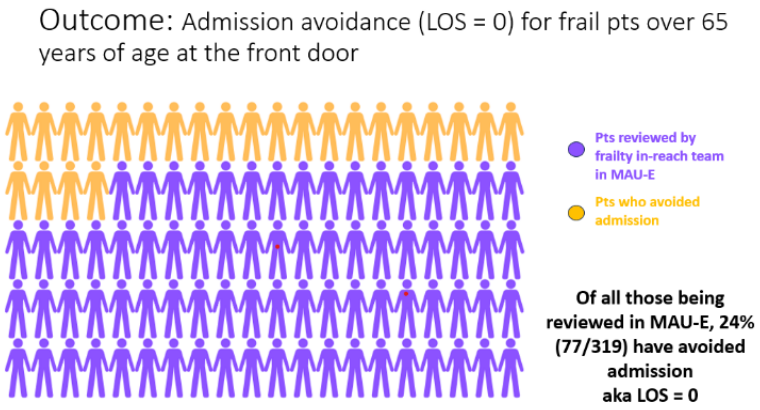
4. Measures / Impact / Data:

Manchester Triage System (MTS)



Redistribution and Impact: Implementation of the MTS, a more objective triage method, has led to a redistribution of patients previously largely classified as Category 3 across Categories 2, 3, and 4. This allows for more equitable and clinically appropriate care by aligning resource allocation more closely with patient acuity.

MAU frailty In-reach team



5. Reflections / Learning Points:

1. **Front door governance group**: Establishing the governance group has enabled broader engagement and highlighted the importance of shared accountability to sustain progress. Doctors in training have welcomed greater involvement in the corporate and assurance aspects of clinical practice, providing a strong foundation for a more resilient and inclusive governance model.

2. **MAU self-presenters**: Communication between the hospital and general public emerged as a critical factor influencing patient self-presentation to MAU at WGH, particularly the service's scope and distinction from a traditional emergency department. Additionally, the unit's reputation for delivering high-quality and timely care has contributed to increased patient return rates, reflecting both the service's success and a potential emerging challenge.

3. **Acute Medical Patient Flow**: Appreciating the challenge of obtaining baseline data and carrying out improvement work in a dynamic department with extremely high variability.

4. **Manchester Triage System (MTS)**: Training a large cohort of staff to full competency has presented logistical challenges. Nevertheless, the enhanced objectivity and consistency introduced by the MTS have been positively received by staff, supporting improved triage processes.

5. **MAU frailty In-reach team**: An approach centred on close collaboration, continuous data review, incremental introduction of complexity, and multidisciplinary team (MDT) engagement has proven highly effective in driving quality improvement efforts within the department.

6. Next Steps:

1. **Acute Medical Patient Flow:** A time-in-motion study has been proposed in MAU to better understand breach reasons, patient flow challenges, and key bottlenecks within the system. The proposal is currently awaiting clinician sign-off.

2. **Manchester Triage System (MTS):** Data analysis will resume to inform the development of a targeted improvement plan, supporting evidence-based decision-making and ensuring future changes align with service needs and best practices.

3. **MAU frailty In-reach team:** Pan-Lothian bid submitted to Healthcare Improvement Scotland to be involved in a Focus on Frailty programme. Ongoing data analysis and continuous improvement work are focused on identifying opportunities for service optimisation and addressing emerging challenges.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Cancer Services Western General Hospital
Programme Title:	Cancer Improvement Programme
Programme / Improvement Leads:	Elise O'Leary

1. Aim:

1. **Breast pre-operative assessment**: By January 2025 increase the average number of pre-operative appointments within breast services by 10%.
2. **Cancer tracker process improvement**: By September 24, all urology and colorectal patients tracked for cancer have relevant escalation processes followed reliably
3. **Endoscopy to pathology**: To enhance early identification and regrading of patients after endoscopy and before the pathology referral stage when cancer is no longer suspected
4. **Prostate cancer pathway**: Current: QI Team to support quality control data Previously: To reduce time from referral to diagnosis by December 2023
5. **SPoC Improvement**: Cancer navigators to support completion of holistic needs assessments for patients with cancer
6. **Urology MD**M: QI Team to support quality control data and processes
7. **Uro-oncology postal service**: To reduce the time spent by nursing and administration on the uro-oncology prostate cancer postal service

2. Background and Purpose:

1. **Breast pre-operative assessment**: Breast surgery have insufficient pre-operative assessment clinic slots to match the demand. Pre-operative assessment clinics are scheduled providing the same amount of time for all patients, regardless of their individual factors. There is a theory that some patients are receiving more resource than is required i.e. patients who do not have comorbidities, may be fit and otherwise well could benefit from streamlined processes. Over-resourcing some patients may impact on their experience (e.g. having to come into hospital for an appointment that does not add significant value).

2. **Cancer tracker process improvement**: The cancer tracking teams are responsible for tracking patients throughout the pathway from referral to treatment. A key element of their role is to escalate patients who are not meeting expected targets in their pathways. Cancer trackers currently use a complicated array of processes and spreadsheets to do this, not all of which are felt to add value. In addition, not all patients requiring escalation are able to be escalated in a timely manner due to the nature of recording

3. **Endoscopy to pathology**: A significant number of GI biopsies are continuing to be cancer tracked when cancer is no longer suspected after the endoscopy. This is leading to several inefficiencies: unnecessary tracking and escalation by Cancer Trackers, misallocation of resources in pathology, and delays in diagnostic reporting for patients who genuinely require urgent cancer investigation.

4. **Prostate cancer pathway**: The Quality Directorate supported improvement work to reduce the amount of time from referral to prostate cancer diagnosis. This has been important as there have been a high number of patients breaching the 62-day cancer pathway target. The team continued involvement for quality control data to monitor this pathway

5. **SPoC Improvement**: Cancer Services planned to test changes to some roles and responsibilities for cancer navigators. A key change was for cancer navigators to spend part of their time co-located with clinical nurse specialists to complete patient holistic needs

assessments (HNAs) and use this to develop a personalise care and support plan (PCSP). The service wanted to understand whether these changes added value to the patient journey, while also ensuring that single point of contact (SPOC) services were not negatively impacted.

6. **Urology MDM**: Work across 2023/24 saw the quality team involved in supporting improvements to the urology MDM. To continue to support this work, the team continues regular data updates for the urology MDM to engage in quality control

7. **Uro-oncology postal service**: The uro-oncology prostate postal service contacts and advises on the care of patients who are not on active oncological treatment for their prostate cancer. On average, 350 letters are posted monthly. This requires significant nursing and administrative resource to manage. The current resource allocation does not match the workload. The team believe there are opportunities for improvement in this service

3. Key Actions and Improvements to Date:

1. **Breast pre-operative assessment**:
   - Tools and data to understand the system
   - Introduction of change idea using patient questionnaires to facilitate phone consultations
   - Spread of practice across consultants
   - Process changes have allowed for 17% of appointments per week by phone – up from 0% (See data below)

2. **Cancer tracker process improvement:**
   - Tools to understand the system and change ideas identified
   - Supported ways of working conversations, as the team had assumptions about each other's knowledge and experience

3. **Endoscopy to pathology**:
   - Understanding system activities including process mapping with associated data
   - Project paused due to national Solus software upgrade, scheduled to be rolled out in Lothian in June 2025

4. **Prostate cancer pathway**:
   - Continued quality control data sharing with key stakeholders to prepare if further improvements are required
   - Changes in data source meant revision for continued quality control data, able to successfully source regular data
   - Average time to diagnosis has decreased from 122 days to 88 days to 72 days (see chart below)

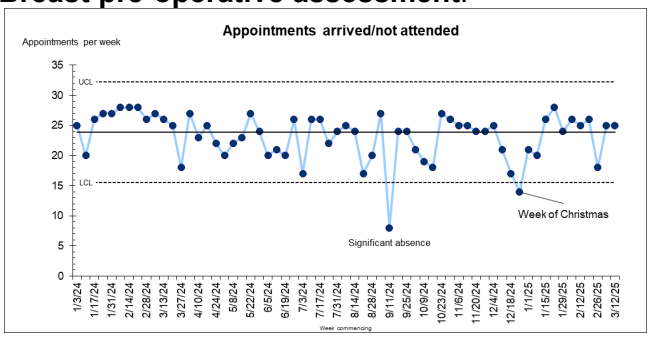
5. **SPoC Improvement**:
   - Measurement plan was developed with the team
   - The service decided to change their approach and no longer required Quality Directorate input

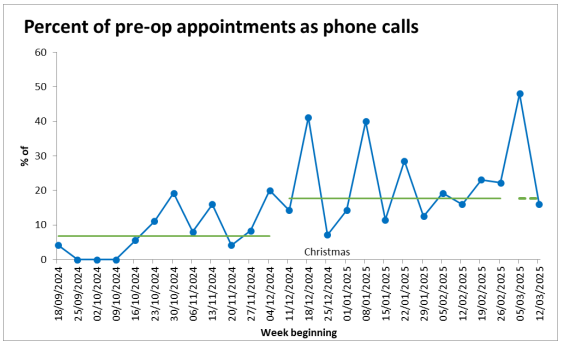
6. **Urology MDM**: Quality control data updated each month

7. **Uro-oncology postal service**:
   - Multiple change ideas identified and tested. These focused on improvement of patient correspondence, better use of technology and better management of demand
   - Saving of approximately 30 hours per week

4. Measures / Impact / Data:

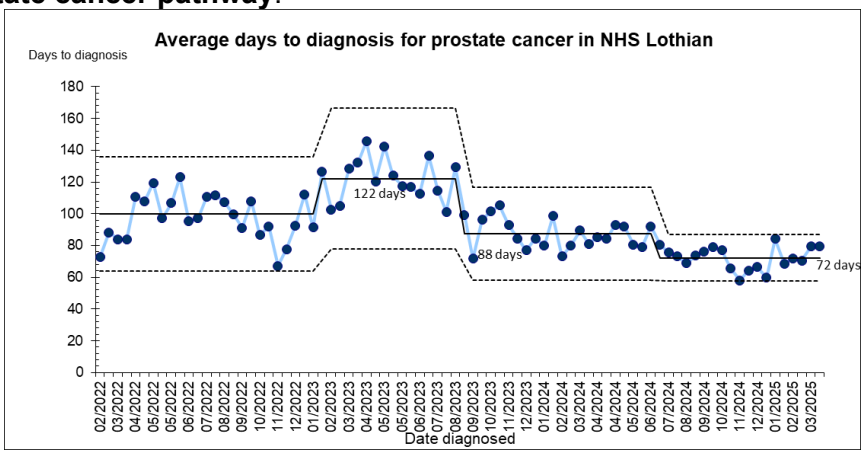
Breast pre-operative assessment:



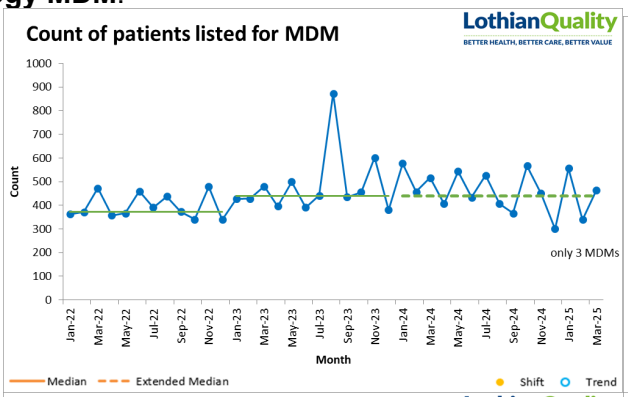


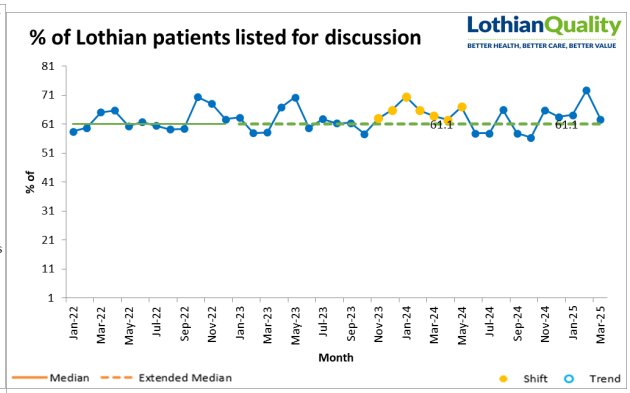
While we are yet to see the number of available appointments increase, we have seen an increase in the percentage of patients receiving a telephone pre-op assessment

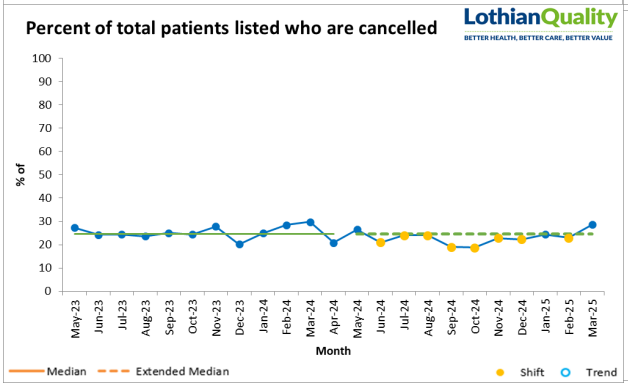
Prostate cancer pathway:

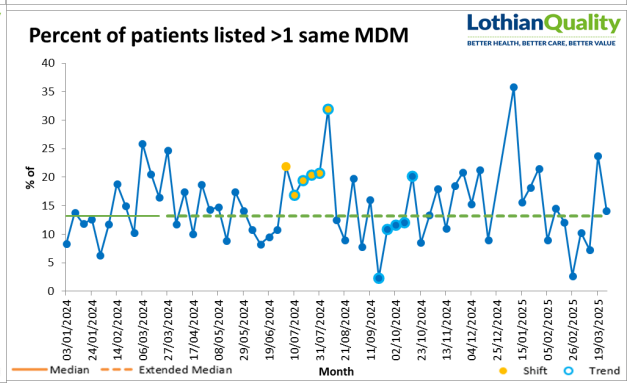


Urology MDM:

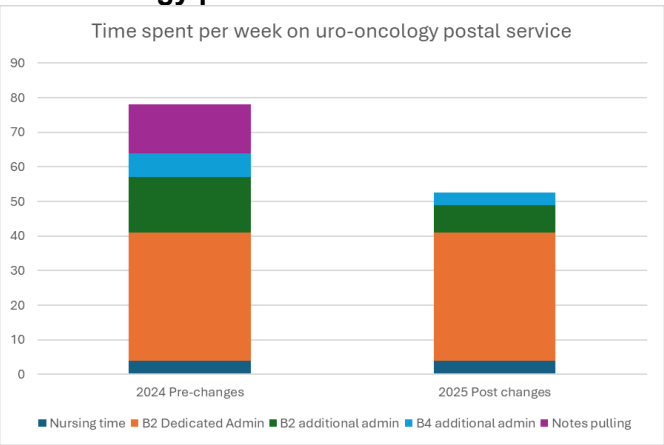








Uro-oncology postal service:



5. Reflections / Learning Points:

- **Breast pre-operative assessment**: The concept of phone pre-operative assessments has been thoroughly tested and accepted for suitability by the multidisciplinary team. The team are ready to increase the phone pre-operative assessment activity
- **Endoscopy to pathology**: Despite leading to delays in the test of change, the national rollout of the new software was well-timed to support embedding the additional question ('Does this biopsy require tracking?') into the scope report. The rollout in Lothian is planned for June 2025, when the test of change will begin.
- **Prostate cancer pathway**: Continuing quality control data has supported the team to celebrate the improvements made. It has also allowed them to quickly see signals of concern relating to increased referrals into the system
- **Uro-oncology postal service**: learning points included
  - Perseverance is crucial
  - Hidden work can be a barrier to change and improvement
  - No idea was too small
  - Technology must be maximised and considered the first option for intervention

6. Next Steps:

1. **Breast pre-operative assessment**: This project will continue into 2025/26. Introduction of a waiting list coordinator will support new processes to ensure that all patients have the opportunity have a phone appointment offered.
2. **Cancer tracker process improvement**: Work returned to the service for performance management approach
3. **Endoscopy to pathology**: To continue with quality improvement as appropriate after software update in June 2025
4. **Prostate cancer pathway**: Quality control data to continue, with the Quality Directorate team available to recommence improvement work if required and supported
5. **SPoC Improvement**: Support to recommence if requested
6. **Urology MDM**: to continue supporting quality control data
7. **Uro-oncology postal service**: A short life working group has started to progress the digital innovation "Connect Me" which will see automation of much of the process. The Directorate will continue to be involved with this improvement project.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Surgical Services WGH
Programme Title:	Surgical Pathways Improvement
Programme / Improvement Leads:	Thivya Jevanesan

1. Aim

1. **SAU flow**: To improve patient flow for the Surgical Assessment Unit at the WGH.
2. **Theatre start times**: To improve the theatre start times for electives surgery.
3. **Pre-surgery pathway**: To improve the robustness of the pre-surgery pathway to improve patient experience and reduce avoidable on the day cancellations
4. **POPS**: To optimise the perioperative care of the older person in surgery
5. **Endourology pathway**: QI Team to support quality planning and identification of improvement opportunities within the pathway to reduce unnecessary appointments, save clinical and administrative time. As well as improve the patient experience and reduce risk from delayed procedures.

2. Background and Purpose:

1. **SAU flow**: In recent years, there has been a significant increase in the number of patients who were seen in the surgical assessment unit at the WGH. This increase in demand has led to delays in patients getting their first assessment and senior review, leading to breaches, queues at the front door and lower staff and patient experience. While there was some improvement work undertaken to reduce the number of inappropriate referrals into SAU via the flow centre, this project aims to increase flow within SAU.

2. **Theatre start times**: Improving theatre start times enhances patient care by reducing delays, optimising resource use, and increasing staff efficiency. Benefits include higher patient satisfaction, better surgical outcomes, and cost savings.

3. **Pre-surgery pathway**: Recent SAEs have raised fragility with the interface processes for patients moving through the pre-surgery pathway (including preassessment clinic [PAC], high risk anaesthetics, peri-operative care of the older person in surgery [POPS], surgeons, waiting list office). Stakeholders found it difficult to describe the system and the problem within it. The purpose of the work is to describe the patient journey and related processes to determine areas for improvement.

4. **POPS**: Shared decision making is a vital element in the delivery of Realistic Medicine and Value Based Health & Care across NHS Scotland. POPS (Peri-operative Care of Older People in Surgery) clinic where those over 65 years old referred for surgery, go through an in-depth shared decision-making process prior to treatment. The POPS clinic is an exemplar service in terms of advanced shared decision making, which consistently results in a 25-30% reduction in treatment uptake (based on local data). With existing resources, capacity within the POPS team cannot match current demand, and some patient referrals are rejected during triaging.

5. **Endourology**: Within the endourology pathway there are concerns that there is unnecessary duplication (clinic visits, repeat diagnostics, return patients) that extends the pathway and puts pressure on the urology and radiology services. Improvement of the pathway, including opportunities to streamline or reduce input from the services, would improve the care and experience of the patient.

3. Key Actions and Improvements to Date:

1. **SAU flow**:
   - Abscess pathway tested and operating as business as usual
   - Scheduled radiology slots for return patients running as business as usual
   - Observations of surgical ward rounds to understand resource allocation
   - Engagement with colorectal registrars to understand current challenges and identify change ideas to improve flow

2. **Theatre start times**:
   - Produced SPC charts for theatres A, B, C, D, H and J and breast theatres (14, 15) broken down by day of the week
   - Discussed data at the WGH Inpatient Day case Operational meeting

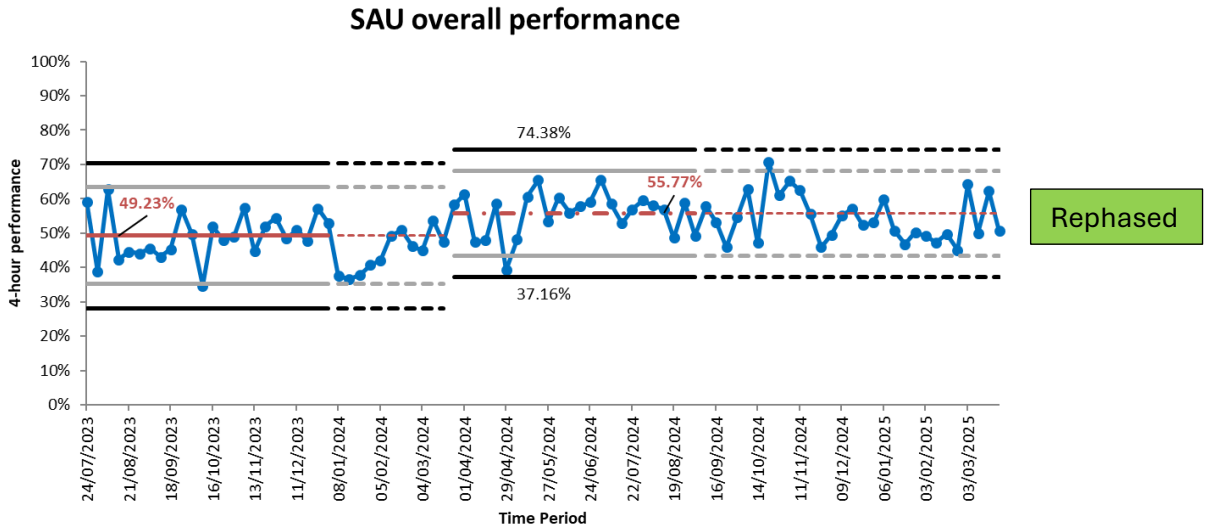
3. **Pre-surgery pathway**:
   - Detailed process mapping of pre-surgery pathway
   - Initial stakeholder meeting to build conditions for change and identify opportunities for change

4. **POPS**: Project brief agreed to by project team and draft process maps begun

5. **Endourology**:

   - Understand the current systems and processes
   - Detailed Process Map with data and timescales
   - Endourology pathway
   - Staff Experience Survey - thematic analysis
   - Identification and analysis of data – demand, activity and queue

4. Measures / Impact / Data:



5. Reflections / Learning Points:

- **SAU**: While internal changes to SAU have positively impacted the performance of the department, SAU continues to see patients who should not have been referred to the unit. SAU continues to see non-emergencies which impact on patient flow and will require further collaboration with the flow centre and primary care.
- **Theatre start times**: Breaking down the data by day of the week exposed delays which would not have been visible otherwise. Some of these delays are linked to individuals rather than inefficiencies in the process.

6. Next Steps:

- **SAU flow**: While a review of the data shows a sustained reduction in breaches due to first assessment since March 2024, this has led to an increase in the number of breaches due to waits for specialist reviews. The next step of this project will be to understand challenges and explore improvement opportunities to support time to senior review.
- **Theatre start times**: Service to discuss delays with individuals to ensure more consistent adherence to 9.00 am start time.
- **Pre-surgery pathway**: To continue along the quality improvement journey, with greater data, refinement of the aim, testing changes, scale up and spread.
- **POPS**: To continue along the quality improvement journey, with greater data, development of a theory of change, testing of ideas, scale up and spread.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Western General Hospital
Programme Title:	Systems Response
Programme / Improvement Leads:	Thivya Jevanesan

1. Aim

1. **Falls quality control data**: To provide the WGH wards with falls data and run charts
2. **Formulary Application Form (FAF) process**: To understand the current FAF process and identify opportunities for improvement
3. **Planned Date of Discharge (PDD)**: 90% of inpatients in surgery and oncology will have a PDD set within 48 hours of admission by April 2025
4. **Sickness absence management**: Reduce delays in the absence management process for nursing
5. **Site CMG support for monthly focused reports**: To provide QMS advice to the site CMG and to provide harms data to services
6. **Team 65 administration**: To articulate the work of Team 65 and to reduce time spent on administrative tasks

2. Background and Purpose:

1. **Falls quality control data**: Falls is the biggest harm at the WGH. Making data readily available for clinical teams to use to make data-driven decision and to monitor if change has made an improvement.

2. **Formulary Application Form (FAF) process**: New medications are approved for use in Scotland by the Scottish Medicines Consortium (SMC). After they have been approved by SMC, the East Region Formulary (ERF) determines whether a drug is for use in the East Region (NHS Lothian, Fife and Borders). This requires an application form that, in NHS Lothian, is completed in majority of cases by a member of the pharmacy team. It is believed this is not the most efficient process for completion. The key focus of this work included Formulary Application Form completion process, Understanding the who, when and how long of the current process, Supporting design of the ideal process for FAF completion

3. **Planned Date of Discharge (PDD)**: As part of the Discharge without Delay programme, each inpatient ward is required to set a planned date of discharge (PDD) within 48 hours of admission to the ward to prevent any delays through early and effective planning. A key aim is to limit hospital stays to what is clinically and functionally essential and getting patient home at the earliest and safest opportunity.

4. **Sickness absence management**: Sickness absence management in nursing is currently subject to delays, partly due to the complexity of coordinating meetings. This contributes to increased reliance on bank staff, impacting overall staff and patient experience.

5. **Site CMG support for monthly focused reports**: The Quality Directorate provides data to support service presentations for CMG to have up-to-date understanding of harms on the site.

7. **Team 65 administration**: A request arose from the WGH Acute Frailty Model Meeting for a greater understanding of the Team 65 processes and working to reduce time spent on administrative tasks.

3. Key Actions and Improvements to Date:

1. **Falls quality control data**:
   - Development of WGH Falls dashboard (Feb 2025) for monthly distribution

2. **Formulary Application Form (FAF) process**:
   - Process mapping was completed for the service and stakeholders to identify areas to improve.

3. **Planned Date of Discharge (PDD)**:
   - Roll out of PDD across surgery and cancer wards
   - Engagement with nursing staff, AHPs, ward clerks and medics
   - Set up of daily reports to each ward listing all patients who require a PDD
   - PDD integration into the WGH discharge hub tracker for ongoing monitoring

4. **Sickness absence management:**
   - Quality planning using process mapping and Fishbone analysis to identify areas for improvement with Clinical Nurse Management team
   - Exploring use of Robotic Process Automation to reduce repetitive administrative steps and enable visual management of timelines and triggers

5. **Site CMG support for monthly focused reports**:
   - Data reporting for services as per the CMG schedule
   - As of November 2024, coaching for data and improvement offered to all services to improve the experience of services presenting, but also for attendees of the CMG

6. **Team 65 administration:**
   - Process maps and visualisations of workload produced of Team 65 work, which was shared with stakeholders.
   - Agreed with General Manager that focus to continue administrative processes and manager and CNM to continue work understanding is the 'right person doing the right task'

4. Measures / Impact / Data:

Falls quality control data: Screenshot of the falls dashboard with run charts for each of the wards (highlighted in green): data include details of patients with multiple falls

5. Reflections / Learning Points:

- **Falls quality control data**: Ensuring data is readily and easily accessible to clinical teams in the format of a dashboard was well received and has helped engagement and data-driven decision-making.
- **Planned Date of Discharge (PDD)**: Limited engagement with clinical teams in surgery and oncology prior to rolling out PDD has resulted in resistance from the medical teams. The PDD Trak solution has not been received well by all teams resulting in some resistance and the need for workarounds to support documenting PDD on Trak

6. Next Steps:

- **Falls quality control data**: Continue to provide monthly falls data through the falls dashboard and adjust the information provided based on service needs.
- **Sickness absence management**: Explore and test new ways of working with automation to monitor timelines and reduce delays to reach resolution.
- **Site CMG support for monthly focused reports**: Quality Directorate to continue to support by providing data, providing coaching for data and encouraging teams to progress improvement priorities based on harms data

Period:	1 April 2024 - 31 March 2025
Service / Area:	Western General Hospital
Programme Title:	Capacity and Capability
Programme / Improvement Leads:	Elise O'Leary

1. Aim

The capacity and capability programme at WGH is primarily made up of two key delivery functions:

1. **Essentials of QI**: To build and support the understanding, capability and capacity of NHS Lothian staff in aspects of Quality planning, improvement and control of processes relating to health and care in our region
2. **Improvement Coaching**: To provide dynamic advice and feedback to WGH colleagues to independently lead and participate in improvement projects

2. Background and Purpose:

1. **Essentials of QI**: This programme has been developed to support the capacity and capability of Quality Improvement across WGH. The purpose is to provide introductory instruction relating to key quality improvement methods, techniques and thinking within a safe environment. Attending these sessions may have encouraged staff members to further their formal quality improvement education by attending NHS Lothian's Quality Academy or NES' Scottish Improvement Leadership programme (ScIL).

2. **Improvement coaching** has been core within the NHS Lothian Quality Directorate. Improvement coaching aims to maximise Quality Improvement activity across NHS Lothian Health and Social Care by ensuring staff can access QI coaching easily within their service. QI coaching includes many components including teaching, facilitating, advising, mentoring, advocating and signposting.

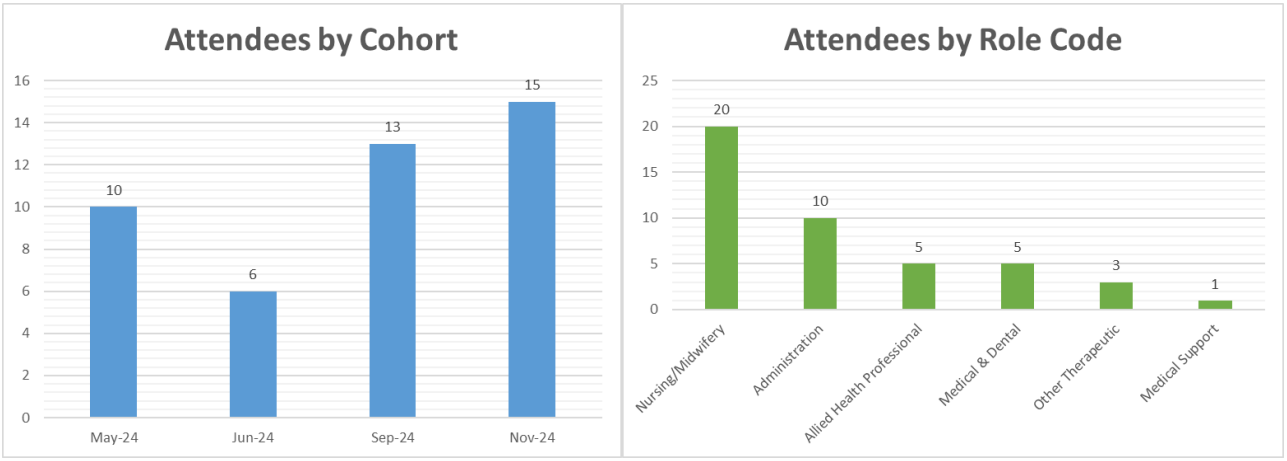
3. Key Actions and Improvements to Date:

1. **Essentials of QI 2024-2025**:
   - Two sessions focusing on quality planning; objectives focusing on
     - team working in improvement projects
     - the improvement journey and the double diamond
     - planning tools including process maps, fishbone diagrams
     - data for improvement including run charts, SPC charts and Pareto charts
   - Two sessions focusing on quality improvement projects; objectives focusing on
     - using the Model for Improvement in their improvement work
     - identifying appropriate tools for each stage of the Model for Improvement
     - formulate a project charter

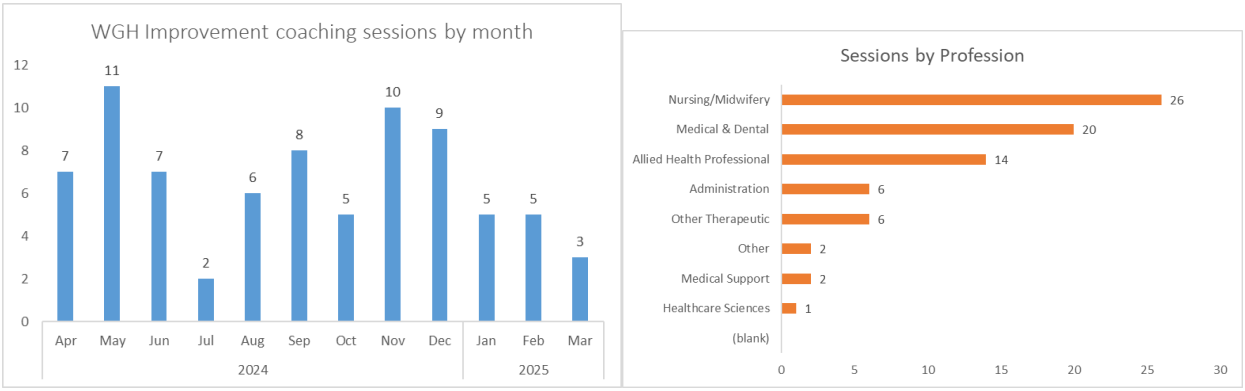
2. **Improvement coaching:**
   - 78 coaching sessions over three primary coaches
   - Sessions distributed across profession types
   - 13 attendees had more than one coaching session, 43 with one coaching session
   - Improvements have been made to streamline the booking process for coaching sessions

4. Measures / Impact / Data:

1. **Essentials of QI April 2024 – March 2025**:



2. **Improvement coaching April 2024 – March 2025**



5. Reflections / Learning Points:

1. **Essentials of QI** has continued to evolve and improve over this 12-month period. After requests for the use of clinical examples, the team has successfully trialled using an array of fictional clinical examples to support learning which has been well received.

2. **Improvement coaching** continues to be popular and valued by staff.

6. Next Steps:

1. **Essentials of QI**: Due to interest, four sessions have already been scheduled between May – July 2025, with plans for further sessions in the second half of the 2025 calendar year

2. **Improvement coaching**: Plans to invite recent WGH ScIL graduates to support improvement coaching on site, along with increasing skills of AQIAs to offer more coaching at WGH.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Western General Hospital
Programme Title:	Efficiencies Programme
Programme / Improvement Leads:	Thivya Jevanesan

1. Aim

1. **Carriage charges**: To reduce the carriage charges for consumables
2. **CNS workload**: To understand the activity of the Oncology CNS' to determine whether there are any opportunities to reduce non-clinical administration and increase specialist clinical activity.
3. **qFIT**: To improve the efficiency of qFIT administrative processes

2. Background and Purpose:

1. **Carriage charges**: Over the 23/24 financial year, cancer services have spent around large sums on carriage. Initial review of procurement data showed that with a more coordinated ordering approach, the service can achieve some saving over the 24/25 financial year.

2. **CNS workload**: The Clinical Nurse Specialists (CNSs) are an important part of our Oncology MDT, providing specialist clinical knowledge and judgement to inform decision making. To ensure best use of resource, service leads sought to understand the amount of time spent on clinical practice; compared with non-specialist administrative tasks.

3. **qFIT**: The QI team reviewed processes around the qFIT service to explore opportunities to streamline processes and create efficiencies.

3. Key Actions and Improvements to Date:

1. **Carriage charges**:
   - Explored opportunities for improvement around medical supplies, ordering and stock management in MAU, GI& Rheumatology and oncology wards
   - Undertook stock rationalisation in oncology wards
   - Coordinated bulk order test of change to reduce carriage charges
   - Test of change showed minimal saving over 3 months for increased admin workload

2. **CNS workload**:
   - Active observation of H&N, AO and Breast Oncology CNSs, alongside discussions with Cancer Service and Nursing Leads, Consultants & Cancer Navigators
   - Detailed activity breakdown of the current work as done and identified areas for improvement

3. **qFIT**:
   - Quality planning including process mapping with associated data
   - Discussion on risk and viability of test of change (sending 2 test kits at the same time to reduce postage and nursing and administrative time)

4. Reflections / Learning Points:

1. **Carriage charges**:
   - Coordinated bulk order increased the admin workload and resulted in minimal savings. The idea was not viable.

2. **CNS workload**: Key reflections included
   - All three 'tumour group' CNS' spend a notable amount of their time on admin tasks, some of which could be done by someone else or made smarter using IT
   - Working across four digital platforms (Trak, Chemo Care, Aria & SCI Gateway) limits the ability to automate existing processes
3. **qFIT**:
   - While the change idea had potential to save the department postage cost, the risk of sending two test kits at the same time was seen as too high, risking incorrect sample taking by patients. The idea was not viable.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Royal Infirmary of Edinburgh
Programme Title:	Deteriorating Patient
Programme / Improvement Leads:	Emma Hearn

1. Aim:

1. Sustain the established reduction in cardiac arrest rates on the RIE site
2. Reduce medical emergency calls with preceding deterioration
3. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system
4. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into RIE site huddles to aid deteriorating patient management
5. NEWS2 observation frequency to have process reliability at 95% or greater across 24 wards by June 2025
6. To improve the documentation of Treatment Escalation Plans (TEPs) aiding future care planning discussions
7. To provide a reduction in Score to Door (S2D) time for unplanned critical care admissions

2. Background and Purpose:

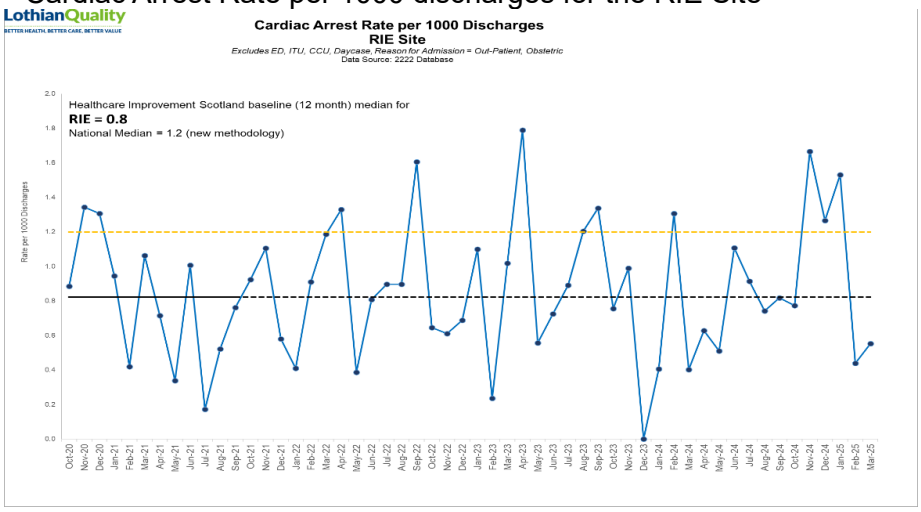
NHS Lothian and the Royal Infirmary of Edinburgh (RIE) site actively participate in the Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative which began in September 2021.
The Deteriorating Patient programme of work aims to improve the safety and reliability of deteriorating patient care while reducing avoidable harm. The aims listed above cover a selection of the outcome, process and balancing measures published within the SPSP Acute Adult Deteriorating Patient Measurement Package.

3. Key Actions and Improvements to Date:

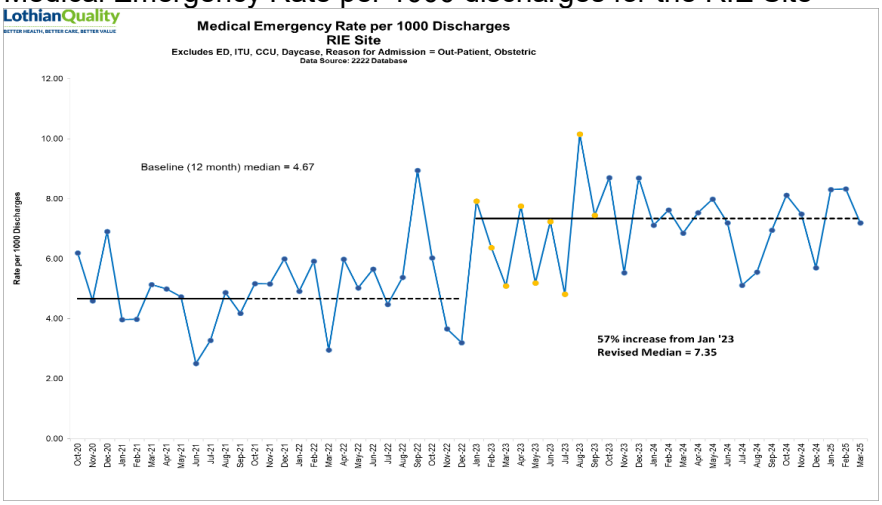
1. A sustained reduction in the rate of cardiac arrests per 1000 discharges has been achieved.
2. Reduce medical emergency calls with preceding deterioration
3. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system.
4. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into RIE site huddles to aid deteriorating patient management
5. NEWS2 observation frequency to have process reliability at 95% or greater across 24 wards by June 202
6. To improve the documentation of Treatment Escalation Plans (TEPs) aiding future care planning discussions.
7. To provide a reduction in Score to Door (S2D) time for unplanned critical care admissions

4. Measures / Impact / Data:

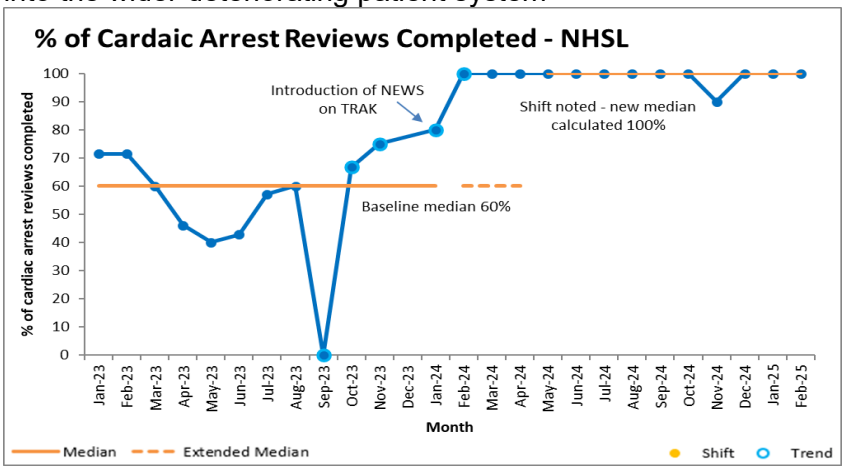
Cardiac Arrest Rate per 1000 discharges for the RIE Site



Medical Emergency Rate per 1000 discharges for the RIE Site



Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system



5. Next Steps:

1. Sustain the established reduction in cardiac arrest rates on the RIE site
   - Continue with current data collection and validation processes to ensure the RIE site meets HIS reporting requirements

2. Reduce medical emergency calls with preceding deterioration
   - Baseline data collection to inform quality planning to target data based, site improvements

3. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system
   - Continue cardiac arrest review group collecting site based data

4. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into RIE site huddles to aid deteriorating patient management
   - Overview board recommendations awaiting publication within the NHS Lothian NEWS2 Escalation Policy
   - The site will work to align NEWS overview board practice to policy recommendations

5. NEWS2 observation frequency to have process reliability at 95% or greater across 24 wards by June 2025
   - Continue to work collaboratively with LACAS and wards to drive targeted NEWS improvements over the site
   - Explore possibilities to support automated NEWS audit

6. To improve the documentation of Treatment Escalation Plans (TEPs) aiding future care planning discussions
   - The site will continue local TEP improvement work feeding back to the QD Clinical Lead for Deteriorating Patient

7. To provide a reduction in Score to Door (S2D) time for unplanned critical care admissions
   - The site will continue local S2D improvement work feeding back to the QD Clinical Lead for Deteriorating Patient

Period:	1 April 2024 - 31 March 2025
Service / Area:	Royal Infirmary of Edinburgh
Programme Title:	Medicines Safety
Programme / Improvement Leads:	Lesley Morrow

1. Aim

1. To **reduce avoidable harms from Insulin errors and omissions** on Wards 207 & 208 RIE
2. To improve **Insulin prescription/dispensing at discharge** from hospital from AMU

2. Background and Purpose:

A site quality planning exercise was completed in 2024 with the aim to enhance and support quality management on the RIE site. Medicines safety was identified as an area of focus and a review of medicines safety Adverse Events (AEs) showed Insulin to be the drug with the most AEs with moderate or major harm & death.

3. Key Actions and Improvements to Date:

- Audits in general medicine wards 207 & 208 revealed variation in insulin self-administration documentation and issues with double signing on HEPMA and insulin charts.
- Increased staff awareness and education sessions from Diabetes Specialist Nurses led to improved ward practices and data outcomes.
- The planned discharge process project in AMU was delayed due to winter pressures and staffing challenges but is expected to progress as conditions improve.

4. Measures / Impact / Data:

Audits in January and April show some improvement (see charts below). To support sustained progress, the AMGM Prescribing Practice Review Group will form a short-life working group focused on insulin improvement, with findings reported back to the main group.

Chart 2

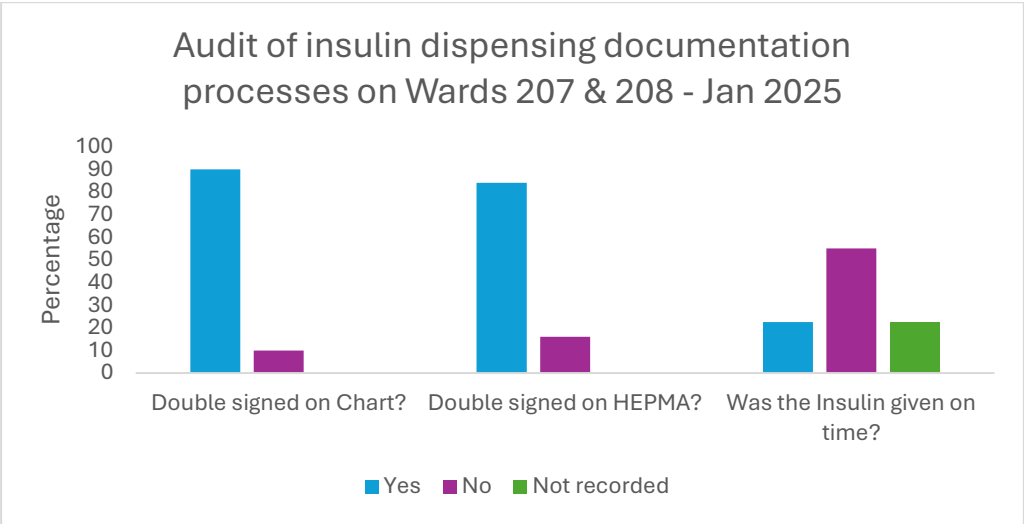
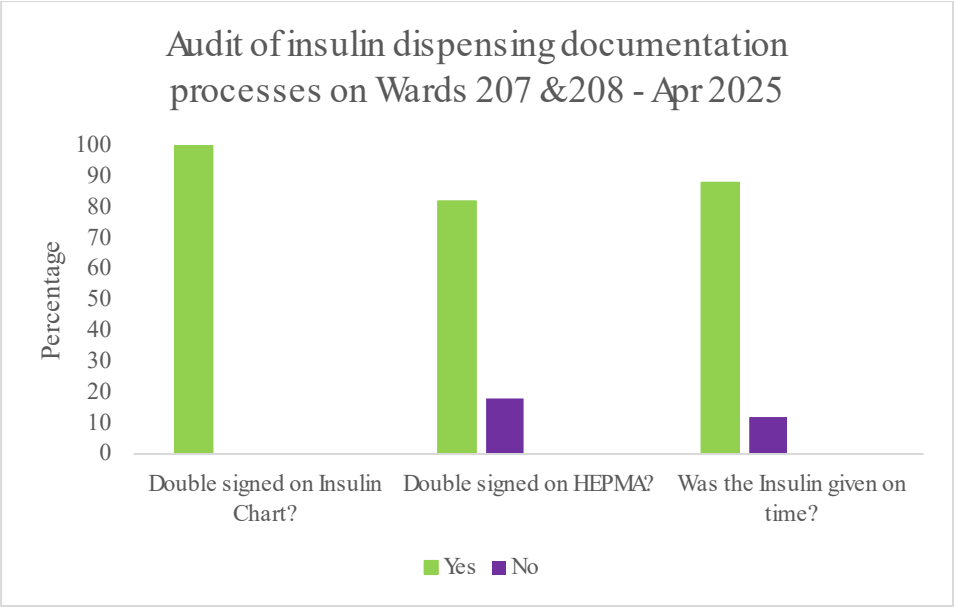


Chart 3



5. Reflections / Learning Points:

The quality planning process often raises staff awareness of issues, which can lead to immediate improvements—even before formal interventions begin. As a result, the initial data collected may not reflect the true baseline. This is a common side effect of working in a live clinical environment, where staff are naturally motivated to enhance patient care right away, sometimes bypassing quality improvement principles that recommend observing baseline conditions first and developing a clear theory of change before making changes.

6. Next Steps:

- The next step in the general medicine wards is to explore the use of a discharge checklist to ensure diabetic patients are discharged with appropriate support and that any medication changes are clearly communicated to community teams.
- Resources have been identified to begin quality planning in AMU, with the aim of progressing to a formal improvement project.
- A Medicines Safety and Risk Group has been established, with the Quality Directorate and Pharmacy Directorate supporting collaboratively. A workshop on 01/04/2025 was held to agree a pan-Lothian approach to improving medicines safety.
- NHS Lothian plans to participate in the emerging HIS SPSP medicines workstream.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Royal Infirmary of Edinburgh
Programme Title:	RIE Improvement Programme - Falls
Programme / Improvement Leads:	Vasudha Singh

1. Aim

1. Reduce all falls in RIE Ward 202 (Medicine of the Elderly) by 20% by end of June 2025
2. Reduce all falls in RIE Ward 207 (General Medicine) by 20% by end of June 2025

2. Background and Purpose (Why?):

A site quality planning exercise was completed in 2024 with the aim to enhance and support quality management on the RIE site. Falls was identified as the 2nd largest harm category, and therefore identified as a key workstream. Ward level analysis of adverse events and LACAS nursing standards data helped identify Wards 202 and 207 as priority areas for improvement support in the 1st cohort.

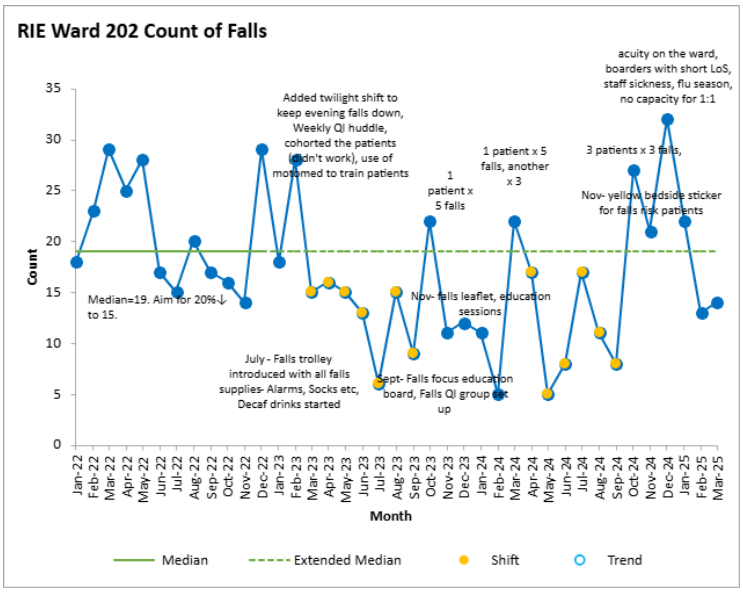
3. Key Actions and Improvements to Date:

- In Ward 202, improvements focused on re-engaging with the existing MDT Falls project team, collecting baseline data, analysing falls incidents, gathering staff feedback, and developing a project aim and change theory.
- Improvement activities included testing change ideas such as a Meaningful Activity Trolley, a Falls Risk Assessment Framework with baseline audit, and a new TRAK-coded Medical Falls Checklist to improve reliability and accessibility.
- Ward 207 underwent similar quality planning, with initial testing focused on cohorting high-risk patients ("Baywatch") and auditing impact through floor plans and risk assessments; decaffeinated drinks were also introduced.
- Collaborative efforts include linking with HSCP, HIS, and other Health Boards to explore segmented falls risk assessment models and participating in the Lothian Falls Inpatient Group, and HIS Falls Collaborative.
- NHS Lothian has volunteered to test a new national definition of falls, with the Quality Directorate supporting the initiative in partnership with HIS.

4. Measures / Impact / Data:

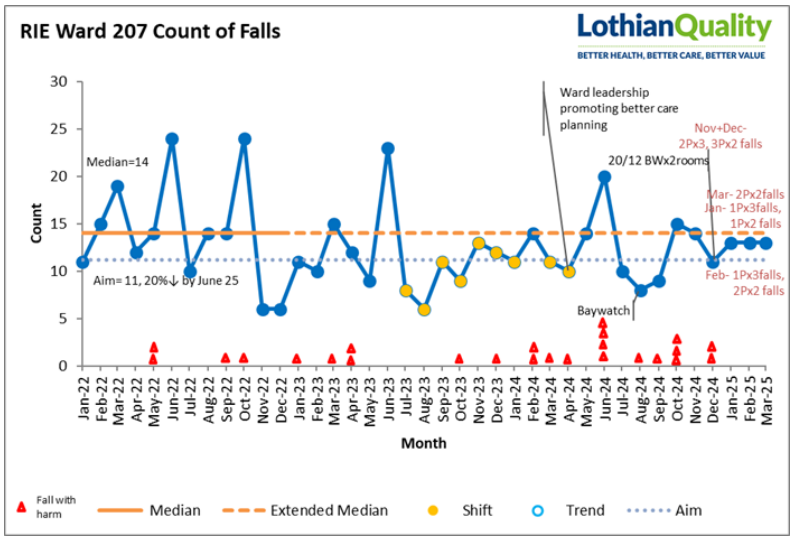
Ward 202- the ward has seen previous shifts downwards i.e reduction in their falls count from February 2023 to September 2023 and from April 24 to September 24. There have been no recent signals of improvement.

Chart 2- Count of Falls in Ward 202



Ward 207- the ward has seen 4 consecutive months below the median since December 2023 and 3 months without falls with harm since January 2025. Data over a longer period needs to be recorded to identify any signals of improvement. Staff in their feedback mention that Baywatch is being used more efficiently. Communication has improved at all stages and culture change is visible e.g. patient identification as high falls risk before coming to the ward, highlight at safety brief and handovers, whether any patient needs to be stepped up to Baywatch or any that can be stepped down.

Chart 3- Count of Falls in Ward 207



5. Reflections / Learning Points:

In Ward 202, it has been a positive experience of working with an engaged MDT with strong leadership. The project team gave positive feedback on the impact of having Quality Directorate (QD) support with project management, quality improvement (QI) methodology support and coaching, data and measurement, staff feedback collection, use of QI tools like Driver Diagrams, making connections with and driving discussions with external teams.

In Ward 207, it has been helpful to use data visuals like run charts and floor plans highlighting locations of falls to engage with the ward team and to sustain engagement. It has been helpful to celebrate successes along the way.

6. Next Steps (Summary):

- Ward 202: Ongoing improvement activity focusing on obtaining evidence of impact of changes tested.
- Ward 207: Ongoing improvement activity focusing on investigating and reducing falls overnight.
- Consider scale and spread if data demonstrates sustained improvement.
- Falls Improvement Toolkit to enable scale and spread of Falls QI work supported by new team members.
- Investigate practices in other NHS Boards demonstrating reduction in falls.
- Contribute to Falls Definition testing agenda.
- Ongoing activities to network and share Falls improvement learning include attendance and participation at the Lothian Falls Prevention and Strategic Group (FPSG), the Lothian Falls Inpatient group and HIS Falls Collaborative meetings.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Royal Infirmary of Edinburgh
Programme Title:	RIE Improvement Programme- Pressure Care
Programme / Improvement Leads:	Vasudha Singh

1. Aim

1. By end of June 2025, 95% patients in Ward 109 (Orthopaedics) will have documented skin checks on admission & any existing pressure ulcers (PUs) reported on Datix and noted in Clinical Notes
2. To reduce the number of acquired PUs developed in Acute Medical Unit (AMU) by 20% by June 2025

2. Background and Purpose:

A site quality planning exercise was completed in 2024 with the aim to enhance and support quality management on the RIE site. Pressure Ulcers was the largest harm category, and therefore identified as a key workstream. Ward level analysis of adverse events and LACAS nursing standards data helped identify Wards 109 and AMU as priority areas for improvement support in the 1st cohort.

3. Key Actions and Improvements to Date:

- In AMU, quality planning began with baseline audits, data analysis (Datix and TRAK), and staff feedback, supported by input from the Tissue Viability Nursing (TVN) team. Findings were shared with SCNs in February 2025 to identify improvement opportunities.
- Key improvement actions include enhanced pressure care education, Link TVN training, ward-based sessions, memory aids for Waterlow assessments, and new prompts for patient weighing at admission.
- In Ward 109, similar quality planning was conducted, with focus on improving skin check documentation and the accuracy of Waterlow risk assessments, supported by staff engagement and feedback.
- Ongoing actions include using Safety Briefs and 1:1 conversations to reinforce pressure care practices across both wards.
- A pan-Lothian Pressure Ulcer Collaborative has been established, with the Quality Directorate providing planning support, data analysis, staff surveys, and system reviews to inform local improvement.

4. Measures / Impact / Data:

AMU – It is too early to detect signals of improvement in the outcome data (Chart 2). However, certain process measures are showing ongoing signals of improvement. These include the percentage of patients with Waterlow risk assessment completed (Chart 3).

Chart 2

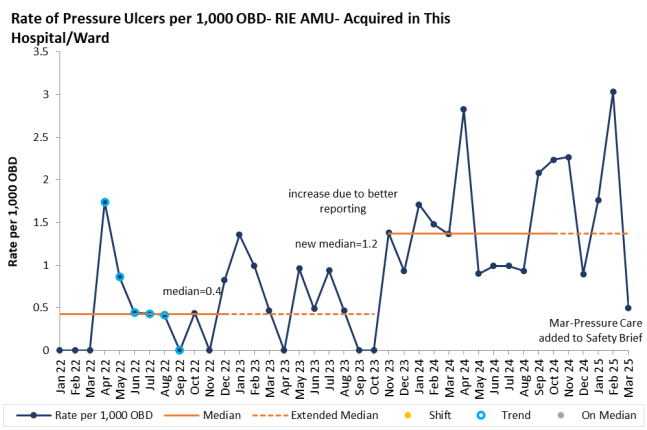
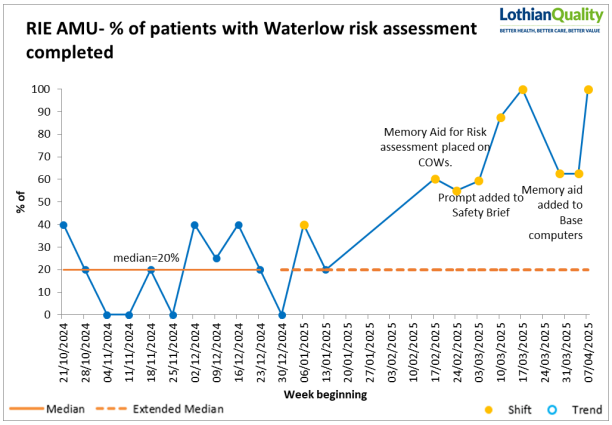


Chart 3



Ward 109 - Ward 109 is also not showing any signals of change in its data.

5. Reflections / Learning Points:

The project in both AMU and Ward 109 has had to keep pace with and follow the rhythm of capacity available within teams at any given time which increases or decreases due to many factors. It has been helpful to work with the Tissue Viability nursing team and LACAS who have similar goals of improving patient care but also the expertise in pressure care to help inform quality planning.

6. Next Steps:

AMU

- Link TVN training in May 2025
- Continue improvement activity in the areas of more reliable and consistent reporting, preventive pressure care, wound identification and grading

Ward 109

- Link TVN training in May 2025
- Planned audit of accuracy of skin check documentation by matching actual skin check vs documentation at admission and discharge
- Planned audit of Waterlow accuracy

Pressure Ulcer Collaborative

- Pan-Lothian stakeholder engagement session planned in June 2025 to identify and prioritise improvement opportunities.

Period:	1 April 2024 - 31 March 2025
Service / Area:	St John's Hospital
Programme Title:	St John's Quality Improvement Programme
Programme / Improvement Leads:	Lesley Morrow

1. Aim

1. **Gentamicin**
   Draft Aim: By February 2025, there will be an *x% reduction in errors recorded in Datix for Gentamicin on St John's Hospital site – * *to be confirmed.*
2. **Frailty**
   To improve patient experience and communication around frailty plans for frail patients assessed by the frailty team at St John's Hospital.
3. **Missed medications**
   To reduce the number of missed doses of analgesia and aperient medications for patients, who lack capacity, in Ward 25 St John's Hospital.
4. **Deteriorating patient collaborative**
   Recorded observations for all patients to meet the national standard of 95%, for wards in the deteriorating patient collaborative by February 2025.
5. **QI in Medicine**
   To improve quality improvement capability, capacity and recording for the St John's medical teams by June 2025
6. **Building a QI network in St John's Hospital**
   To improve the capability, capacity, and engagement of staff in Quality Improvement across St John's site.

2. Background and Purpose:

1. **Gentamicin**
   The process for the prescribing, administering, and monitoring of Gentamicin (Gent.). is complex. Improving these processes, has the potential to save time and reduce avoidable harms. Errors associated with Gent. are related to patient safety concerns. If levels are too high this can result in Acute Kidney Injury (AKI) and/or ototoxicity (vestibular or hearing loss). If levels are too low this can mean infection is not treated and potential for further deterioration.

2. **Frailty**
   The frailty team recognise that the recommendations within the frailty assessments are not routinely acted on which can result in unnecessary delays, duplication of steps and lack of continuity of care for frail patients. Focus is to improve the overall patient experience by testing out case loading.

3. **Missed medications**
Missed medications can lead to distressed behaviour for patients who lack capacity due to living with dementia or delirium. To improve patient outcomes and experience it is imperative to ensure that they receive all prescribed medications or to ensure covert pathways are considered. It is evident that some patients with incapacity are frequently missing medicines which leads to a poor experience for both patients and their carer's.

4. **Deteriorating patient collaborative**
A deteriorating patient collaborative has been developed to co-ordinate and share learning around processes and practice in relation to observation frequency. This is in line with the Scottish Patient Safety Programme, which aims to reduce mortality and harm for people in acute hospitals by reliable recognition and response to acutely unwell patients. This collaborative involves 6 ward areas.

5. **QI in Medicine**
The newly appointed medical QI leads recognised the need for improved pathways and processes to support Doctors in Training to engage with quality improvement projects. This encompasses knowledge and skills to engage, sharing of results and learning and ensuring clear handover at the end of rotation. This project will ensure continuity of projects, less duplication and reduce waste and ensure more efficient use of resources.

6. **Building a QI network in St John's Hospital**
Over the last 4 years the Associate Quality Improvement Advisor (AQIA) has focused on developing a QI network in St John's. The network development involved establishing positive working relationships across the site and crucially with site management. Increasing knowledge and skills of staff in relation to QI aimed to support their meaningful engagement in QI projects and initiatives. This was supported by the provision of Bitesize, Introduction to QI courses, coaching support for local projects and QI leadership on projects where required.

3. Key Actions and Improvements to Date:

1. **Gentamicin**
- Staff experience survey
- Snapshot audit data to identify common errors in processes.
- Measurement plan developed.

2. **Frailty**
- Process mapping completed.
- Staff experience data collected.
- Patient journey data collected and to be collated.

3. **Missed Medications**
- Multi-disciplinary project team developed.
- Qualitative data in form of patient stories collected.
- Tests of change to be identified.

4. **Deteriorating patient collaborative**
- Data charted and shared with ward team at QI huddles and with senior nursing leadership team.
- Ward process maps and specific fishbones developed.

5. **QI in Medicine**
   - MEDAS QIT re-designed and commenced meeting.
   - 'How to get started with a QI project' guide developed
   - Medicine specific project charter developed for testing.
   - SJH Medicine QI page on Lothian QI website established.
   - Database for collation and co-ordination of projects developed.

6. **Building a QI network in St John's Hospital**
   - Regular Bitesize QI sessions delivered.
   - QI coaching to teams and clinicians
   - Leading on quality planning

4. Measures / Impact / Data:

Copies of the supporting documentation and data can be made available on request by emailing loth.qist-admin@nhs.scot

Building a QI network in St John's Hospital

- Coaching - 68 coaching sessions held April-Oct 2024
- Bitesize - 32 attendee's April – Oct 2024

5. Reflections / Learning Points:

The progression of building a QI network in St John's has made steady progress over the years and is in a positive place currently. Staff are engaged and motivated to consider projects and work toward improvements.

6. Next Steps:

There has been a gap in QI resource as the Associate Quality Improvement Advisor (AQIA) left post and a new AQIA will take up post in June 2025. A review of all the existing projects will be undertaken as part of the SJH Quality Planning process.

Period:	1 April 2024 - 31 March 2025
Service / Area:	St John's Hospital
Programme Title:	Deteriorating Patient
Programme / Improvement Leads:	Emma Hearn

1. Aim:

1. Sustain the established reduction in cardiac arrest rates on the SJH site
2. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system
3. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into SJH site huddles to aid deteriorating patient management
4. Work to improve NEWS processes over the SJH site

2. Background and Purpose:

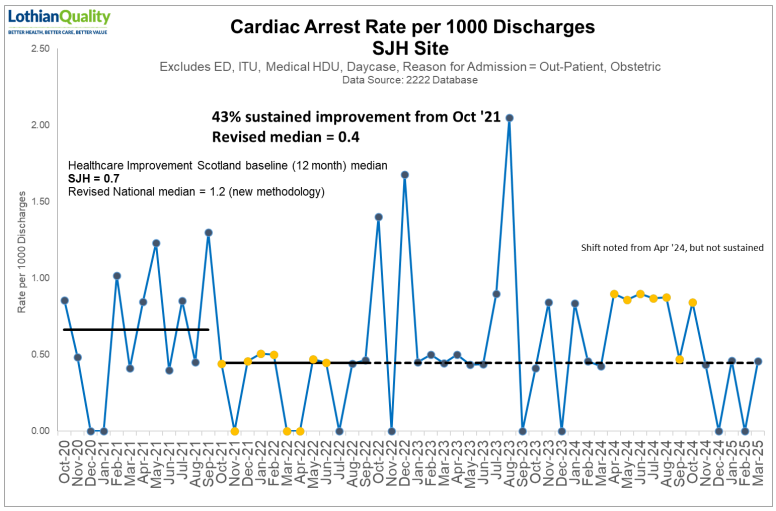
NHS Lothian and the St Johns Hospital (SJH) site, actively participate in the Scottish Patient Safety Programme (SPSP) Acute Adult Collaborative which began in September 2021. The Deteriorating Patient programme of work aims to improve the safety and reliability of deteriorating patient care while reducing avoidable harm. The aims listed above cover a selection of the outcome, process and balancing measures published within the SPSP Acute Adult Deteriorating Patient Measurement Package.

3. Key Actions and Improvements to Date:

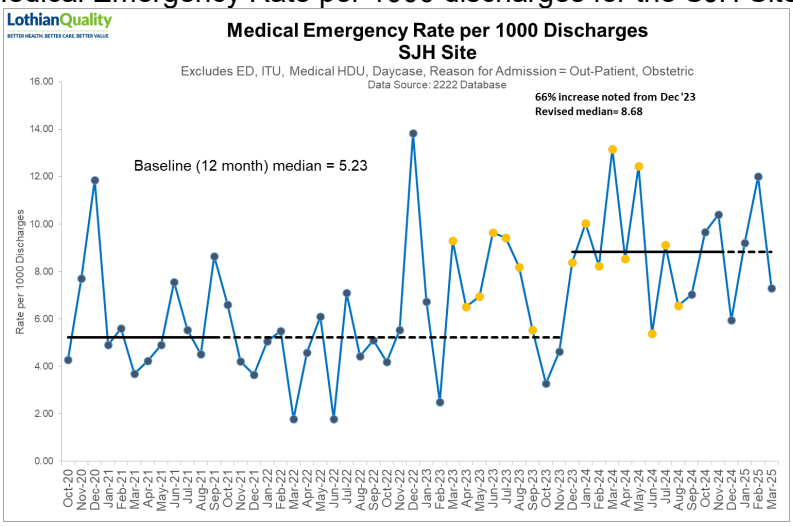
1. A sustained reduction in the rate of cardiac arrests per 1000 discharges has been achieved.
2. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system
3. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into SJH site huddles to aid deteriorating patient management
4. Work to improve NEWS processes on the SJH site

4. Measures / Impact / Data:

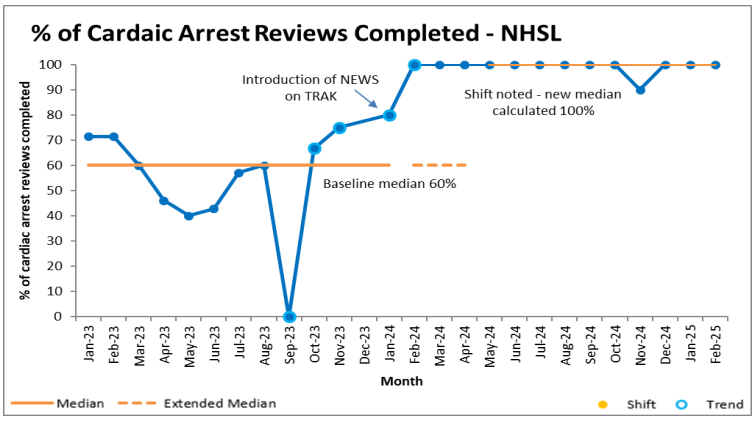
Cardiac Arrest Rate per 1000 discharges for the SJH Site



Medical Emergency Rate per 1000 discharges for the SJH Site



Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system



5. Reflections / Learning Points:

- Validated 2222 emergency data and cross team collaboration is essential in underpinning the deteriorating programme of work
- The improvement programme that is underway has clear leadership and support at nursing level
- Ongoing QI support will soon be available with recruitment into AQIA post

6. Next Steps:

1. Sustain the established reduction in cardiac arrest rates on the SJH site
2. Complete cardiac arrest reviews for SPSP criteria meeting site cardiac arrests feeding learning into the wider deteriorating patient system
3. Work to implement and integrate the National Early Warning Score (NEWS) Overview Board into SJH site huddles to aid deteriorating patient management
4. Work to improve NEWS processes over the SJH site

Period:	1 April 2024 - 31 March 2025
Service / Area:	RHCYP (Royal Hospital Children and Young People)
Programme Title:	HIS SPSPPP (Healthcare Improvement Scotland, Scottish Patient Safety Programme Paediatric Programme) Deteriorating Patient Programme
Programme / Improvement Leads:	Laura Fraser CD, Peter Campbell AD, Anne Porter AQIA

1. Aim

To reduce harm from deterioration by improving the recognition, response and review of the deteriorating child and young person by September 2025 ("SPSP Paediatric Programme Deteriorating Child & Young Person Change Package").

2. Background and Purpose

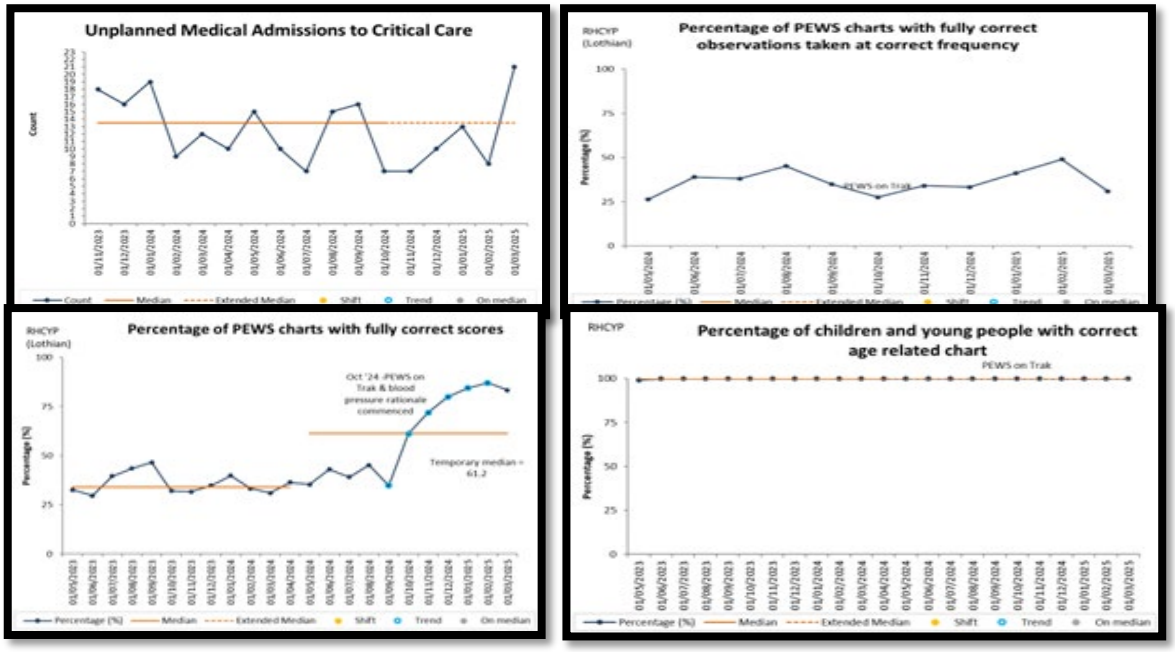
As part of the HIS SPSPPP, RHCYP along with thirteen other boards across Scotland are taking part in this collaborative to improve the recognition, response and review of the deteriorating child and young person.

3. Key Actions and Improvements to Date

1. Setting up a dedicated database to record 2222 activity and themes to inform future improvement activity. Final database format tbc.
2. PEWS (Paediatric Early Warning Scores) routine weekly ward audits conducted to measure compliance against documented local PEWS policy.
3. A backslash for PET (Patient Escalation Team) calls form is now live on TRAK to enable clinicians to effectively record PET calls. As it is still not routinely used it will be introduced to the new medics at the time of the next FY rotation.
4. There is ongoing work relating to appropriate response to trending PEWS and outreach case note reviews following escalation. Learning from this will also inform future training.
5. When improving recognition of deteriorating patients, PEWS score is not the only indicator, staff & carer concern are important factors to include.
6. Systematic review of unplanned admissions from RHCYP wards to Crit Care have identified evolving themes. Learning points from these events have been incorporated into MDT (Multi-Disciplinary Team) PET training and have informed a change of a SOP at ward level.
7. Successfully expanded the PET faculty in 2024 to include ANP's, ANP trainees and deputy charge nurses. Feedback is routinely collected and used to inform learning points which are then fed back into the hospital wide learning points document which is circulated via 'Everyone Email.'
8. **For Improvement** - BP continues to be the most frequently missed parameter. Rationale for missed BP is provided as a drop-down option on PEWs on TRAK but this option is yet to be consistently utilised. Refresher training is in the early planning stages.

4. Measures / Impact / Data

Charts are compiled from the results of the weekly PEWS audits and submitted quarterly to meet the requirements of the HIS SPSPPP collaborative. Examples of the charts illustrating the most recent data are included below.



5. Reflections / Learning Points

- Good engagement from the RHCYP ward teams and medics especially following the establishment of the joint Det Pat/resus group.
- Following the publication of the local documented policy relating to BP, compliance relating to this parameter has improved but further training is planned.
- Some clarity at national level in relation to BP would be helpful as all boards work to own local policies.

6. Next Steps

- Continue to audit twenty-five patients per week across the five in scope wards using PEWS on TRAK.
- Continue to engage, work with and support actions generated via the Det Pat/Resus meetings.
- Continue to collect data and information, submit quarterly update reports to HIS SPSPPP.
- Record all 2222 activity and themes via newly established database. Monitor themes to inform potential improvement work.
- Commence use of Toolkit for Structured Review of Deterioration Response.
- Following a HIS SPSPPP learning session where there was a focus on Psychological Safety, discuss locally at DET PAT RESUS group meeting and consider next steps.
- 125 previously audited CHIs from the five inpatient wards reviewed by medic to identify signs of early staff or family concern. Learning points from potential near misses to be shared and implemented.
- Work with 5 wards and with LACAS to ensure accountability for missed BP is documented correctly on PEWS on TRAK. Local BP frequency policy has now been finalised and available on the intranet.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Royal Hospital for Children and Young People (RHCYP)
Programme Title:	QIT (Quality Improvement Team) and Site Priority QI (Quality Improvement) Activity Coaching
Programme / Improvement Leads:	Sonia Joseph (QIT Chair) Nicola Davidson (QIT Co Chair) Anne Porter AQIA

1. Aim

To support, inform, communicate, and work closely and collaboratively with the RHCYP QIT Chair and Co-Chair to ensure that reporting of all active site priority activity is timely and correct.

2. Background and Purpose

Following the move to the new site the RHCYP QIT was paused. With an updated TOR (Terms of Reference) the RHCYP QIT was restarted and meets monthly in person and on TEAMS.

QI project updates are provided, and new work is discussed to ensure it aligns with site priorities. This is a joint surgical/medical QIT as the site was deemed too small to accommodate two separate QITs. Attendance from team members at all band levels and wards/departments is encouraged.

3. Key Actions and Improvements

- Ensure timely project updates are available in advance of each QIT.
- Maintain and share a database of all the projects, audits, research, and service improvement work on the site.
- The database has now been redesigned and automated to generate a follow up email requesting a progress report.
- New projects, audits and service evaluation registration forms are available on the Intranet via Children's Services. The project owner will register and has the option to request QI support.
- The Children's QIT Project team information is also located on the Intranet and contains, contact details, examples of past QI projects and links to the wider Lothian Quality Website.
- Continued to support site priority projects and ad hoc coaching requests as required.

4. Measures / Impact / Data

Since its inception in March 2021 the project database currently has 213 recorded QI activities: -

- 5 Research projects
- 52 Audits
- 78 Service Evaluations
- 78 QI projects

Coaching and ad hoc QI support remains available as required and coaching requests received directly by email from RHCYP, or the wider Children's Services continue to be offered via TEAMS or in Person.

As the number of coaching attendees increases it allows the opportunity for shared experience. Coachees are regularly linked when projects align.

5. Reflections / Learning Points

- The QIT is a useful and valuable meeting that quickly provides a good summary of activity across the site and an excellent opportunity to engage with the senior team.
- Although the QIT is agenda led it provides a good opportunity to ask questions and make suggestions.
- The learning points gained from each QIT are due to the input from the cross section of MDT that attend and contribute.

6. Next Steps

- Continue to work with and contribute to the QIT by attending the monthly meetings, supporting QI activity, and coaching requests on the RHCYP site and from the wider Children's Services.
- Monitor use of the new Project Database, collect user feedback, and liaise with the project team to ensure database is meeting the needs of the user and the service.
- Home IV and the Bereavement projects are coming close to an end. The QIT chair has recently circulated a scoping email to the site for suggestions for future QI work. Initial feedback suggested revisiting the paused Theatres Utilisation project, Ward Flow from ED (Emergency Department to PARU (Paediatric Acute Receiving Unit)
- One of the Quality Directorate priorities for 2025-26 focuses on Medicines Safety. Quality Planning for this project on the RHCYP site has commenced and feedback relating to findings, progress and learnings will be shared with the QIT.

Period:	1 April 2024 - 31 March 2025
Service / Area:	RHCYP (Royal Hospital for Children and Young People)
Programme Title:	Paediatric at home IV CEF (Intravenous Ceftriaxone) - Ambulatory IV Cef
Programme / Improvement Leads:	Sonia Joseph CD, Nicola Davidson CNM, Jenny Gallagher, CCNS, Anne Porter AQIA

1. Aim

Paediatric OP (Outpatient) IV Therapy – reducing numbers of children under the age of sixteen attending hospital for Ambulatory IV CEF by introducing a home IV CEF service in the community.

2. Background and Purpose

Progressing the work on home IV administration is an essential part of better patient experience.

The hospital is experiencing significant bed pressures, the provision of administration of home IV antibiotics would release capacity within the Dirleton ward (Mon to Thu) and eventually the RHCYP inpatient wards that provide the service on Friday and over the weekend.

The government have allocated money to look at hospital at home programmes and improvement work. Funding has been secured and used to purchase the B BRAUN syringe drivers required.

A further bid for additional funding was submitted recently as part of a wider RHCYP bid. Currently awaiting the outcome.

3. Key Actions and Improvements to Date

- Approval given to proceed with SIM testing on the ward prior to testing on one patient in the ward before transferring the service to the community. Suggested with the team that the PDSA (Plan Do Study Act) template be used to document the work and capture required changes.

- Administration of Intravenous Antibiotics (Children Community) Policy and Single Checking Procedure has been written and amended following review by the wider home IV team. Further amendments were required following feedback from medical and nursing teams while PDSA cycles were conducted on the ward.

- Drafted and finalised Community Children's Nursing specific SOP, discharge checklists and patient information leaflets. The process relating to the use and distribution of the documents was assessed during the PDSA cycles.

- B BRAUN syringe drivers have been purchased and adjusted to suit the needs of the paediatric population. Community nursing team is in the process of completing B BRAUN competencies.

- Community team allocated work schedules that now include future home IV fixed timeslots. First PDSA cycle with a suitable patient will be on site using the allocated timeslot to ensure suitability and procedure is robust. Community nurses will travel to RHCYP site to conduct this procedure.

4. Measures / Impact / Data:

Family feedback was collected using (online surveys. A summary of which was added to the Home IV Quality Planning Slide pack used in a presentation to the RHCYP Senior Management Team. The full slide pack used in the presentation is available on request.

5. Reflections / Learning Points

As this is a project to introduce a new service an extensive case was built to support the need for it. The learning from this was the extent of the data required, time commitment to collect it and the extent of the MDT (Multi-Disciplinary Team) from RHCYP site and Community Nursing involvement required.

6. Next Steps

- Since the IV CEF project was presented (by Programme Leads) and approved at the RHCYP Senior Management Team meeting substantial progress has been made.
- Community Nurse onsite training to complete B BRAUN competencies is ongoing, attendance for training is dependent on suitable IV CEF patient availability on site. Training is conducted by RHCYP Dirleton team.
- 2 PDSA cycles to assess the process have been completed as a simulation on the ward. The next PDSA will be on a ward and will involve a suitable patient identified by medics as meeting the required criteria and will include the community nurses.
- Community nurse work diaries prepopulated with home IV 2-hour time slots in advance of PDSA cycle with a patient on the ward prior to transfer to full community home IV.
- Two nurses to attend initial appointments in the home. Possibility of one nurse only remaining for duration of appointment.
- Family/carer/patient feedback continues to be collected and QD continue to support project team through QI methods.

Period:	1 April 2024 - 31 March 2025
Service / Area:	RHCYP (Royal Hospital for Children and Young People)
Programme Title:	Bereavement Pathway
Programme / Improvement Leads:	Nicola Davidson CNM, Jennifer Pyper Bereavement Lead, Anne Porter AQIA

1. Aim

Improving the patient, family, carer and staff experience of death and bereavement at RHCYP by streamlining the bereavement process.

2. Background and Purpose

With frequent changeover of staff, new ward layouts and the move to a new site it was felt that in the case of a child death there was no clear pathway for teams to follow. A Bereavement Lead (2-year post, June 23-June 2025) position was advertised and successfully recruited.

3. Key Actions and Improvements to Date

- Aim was to streamline the bereavement pathway and improve the family, carer, and staff experience. The first process map illustrated the lack of flow in the bereavement pathway. To ensure continuity of QI coaching the bereavement team attended the Quality Academy.
- On successful completion of the Quality Academy the Quality Directorate support continued as required to meet the needs of the Bereavement Team
- Process mapping continued with input from ED, Lochranza, Crit Care, Calareidh and Sunndach as these are the areas where most deaths are expected.
- The bereavement team conducts regular bereavement training days to increase staff knowledge and confidence. Appetite for attendance at time of booking is strong but attendance numbers fluctuate.
- New paperwork that accompanies the patient has been introduced by the bereavement team & made available to ward teams, saving time and uncertainty. Letter templates have also been created.

4. Measures / Impact / Data

Staff experience has been collected via online surveys to inform future training. The staff experience feedback Slide pack is available on request.

5. Reflections / Learning Points

- This has been a challenging piece of work due to the nature and sensitivity of the work.
- The Bereavement Team lead presented a summary of their project at a recent QIT (Quality Improvement Team) meeting and were able to demonstrate to the audience the benefit of using QI (Quality Improvement) methodology.

6. Next Steps:

The next steps are currently in development but data relating to the process continues to be collected and collated.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Primary Care
Programme Title:	Quality Improvement and Safety Enhanced Service
Programme / Improvement Leads:	Sue Perkins

1. Aim

- 2024-2025 QI & Safety Enhanced Service (SESP)- At least 80% of QI projects carried out by GP practices as part of the QI & Safety Enhanced Service have an IHI score of 3.0 or above.
- Cluster Quality Lead support - To enhance & support quality management, leadership, & change management knowledge to enable CQLs to respond to and lead data-driven, effective and robust improvement.
- Quality Improvement Essentials training - To train at least 15 participants per cohort in QI who report an increase in QI knowledge and at 6 months post-training have used QI tools to support improvement.
- Provide requested improvement support to primary and community care for safety issues, quality planning and/or quality improvement.

2. Background and Purpose:

This programme supports the sustainable development of a strong culture of continuous and measurable quality improvement across all Primary Care services in Lothian. Our aim is to ensure care is safe, effective, patient-centred, timely, efficient and equitable with associated improved patient outcomes.

3. Key Actions and Improvements to Date:

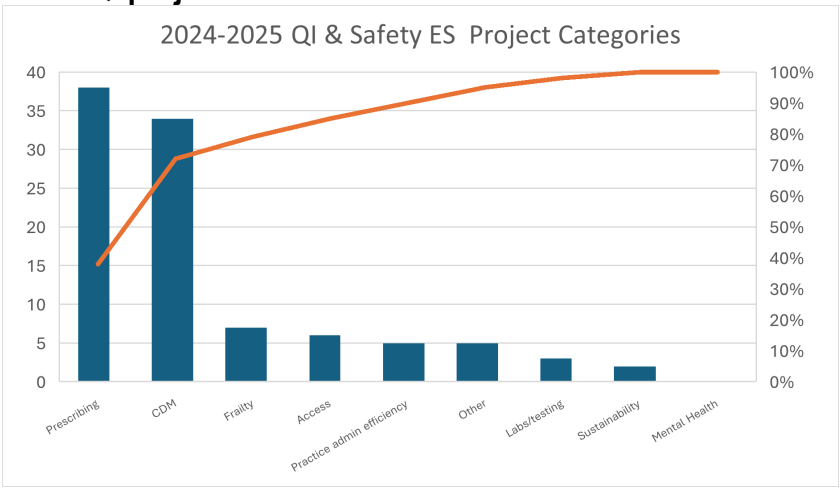
QI & Safety Enhanced Service 2024-2025:

101 GP practices signed up to the 2024-2025 QI & Safety Enhanced Service (SESP). 1 practice has failed to engage since sign up. 1 practice has an extension agreed to end of project requirements.

As of 6th May the following contract requirements have been met:

- 100 Project Charters with a planning tool, baseline data, measurement framework and proposed patient/staff experience activities
- 100 practices have attended a coaching clinic with the primary care QI team and submitted a PDSA cycle.
- 99 practices have submitted data over time (at least 3 data points plus baseline), an end of project poster and evidence of patient/staff experience.

SESP QI project themes:



QI & Safety Enhanced Service 2025-2026:

- Updated contract has been agreed by the GP Subcommittee/LMC and the Primary Care Contracts Office as part of a revision of all Enhanced Services offered to GP practices
- Practice/cluster topics must be selected from within 5 key themes: Access, Medication Safety, Screening and Prevention, Chronic Disease Management prioritising diabetes and respiratory conditions and Mental Health. There will be resources provided, including Quality Toolkits, to support each theme.

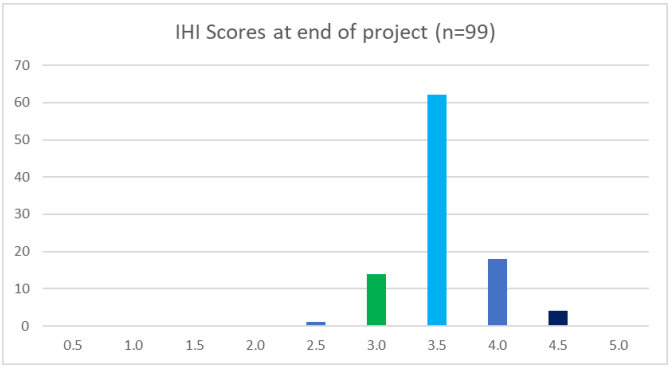
QI Essentials Training

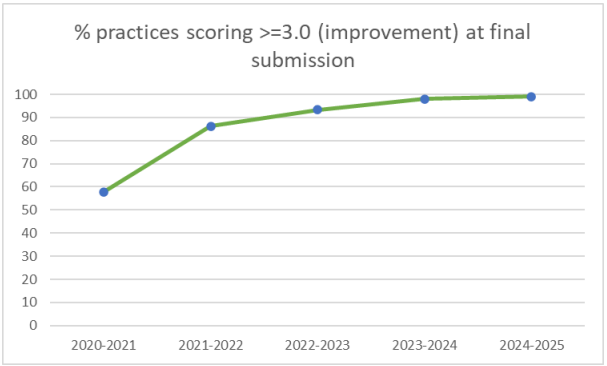
- Two cohorts held in May and September – 4 x 90-minute sessions held over MS Teams.
- 40 hours of non-Enhanced Service coaching provided
- Introduction to Quality Improvement training provided to: GP practice teams, GP Trainers, LUCS (at their 20th anniversary event) and Trainee Practice Nurses (2 sessions)
- Training session on Demand, Capacity, Activity and Queue delivered in May with 27 attendees.
- Two service resilience meetings facilitated with in-hours and out of hours primary care services (CQLs and LUCS) to support more informed data-driven decisions, improvements to transfers of care for patients and demand management.

4. Measures / Impact / Data:

Enhanced Service

IHI scores at the end of projects – a score of 3.0 and above represents improvement

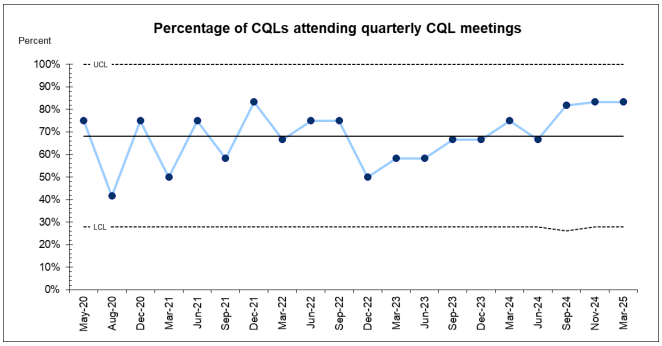




The number of projects scoring above 3.0 has increased partly due to an improved maturity of data enabling teams to demonstrate improvement more clearly. Examples of specific improvements made through practices' QI projects is available on request.

Cluster Quality Lead Support

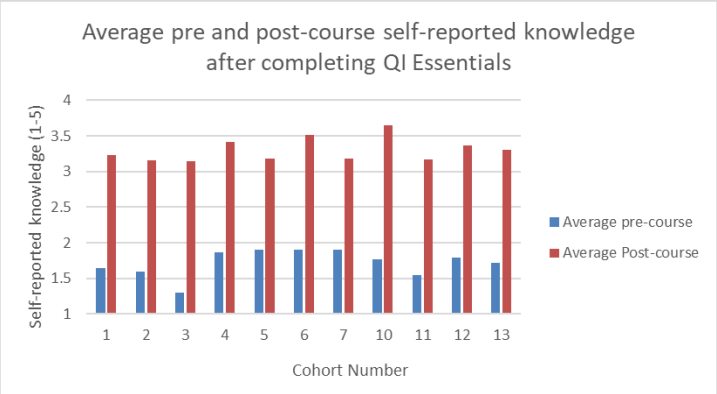
Quarterly meeting attendance continues to have an average (mean) attendance of 68% of CQLs in post attending meetings. 7 coaching sessions have been provided to new Cluster Quality Leads.



Cluster Quality Leads complete annual reporting outlining intrinsic and extrinsic activities, including cluster improvement work – this is available for 2024-2025 on request.

QI Essentials training

- May cohort - 12/14 attendees completed ≥3 out of 4 sessions. Average self-reported knowledge across the different topics increased by 88% from 1.79/5 to 3.36/5 (1 = no knowledge/awareness. 5 = expert, could teach on this)
- Sept cohort - 21 people attended at least 3 out of 4 sessions. Average pre-course knowledge increased by 140% from 1.72/5 to 3.3/5



5. Reflections / Learning Points:

Enhanced Service

- Although engagement with the SESP has remained consistent there are challenges with the use of improvement methodology, particularly with data collection, analysis and display
- The % practices achieving IHI 3.0 or above has increased over time due to improved data and therefore we may need to increase our improvement aim to reflect the maturity of the system and competence/capability in QI.

Cluster Quality Lead support

- There continues to be challenges with new GMS contract implementation and the role of clusters, particularly with regards to CQLs extrinsic activities
- Some CQLs struggle to engage all PQLs in cluster improvements
- Better data is needed for cluster improvement work in order to understand whether changes have led to sustainable improvement

QI Essentials training

- Although we request follow up data on how QI Essentials training has been put into practice by attendees through a follow-up survey, this has a low response rate

6. Next Steps:

Enhanced Service

- End of year Showcase Events to be held in June 2025 – testing out holding these on the same day as 2025-2026 Launch Workshops. Two in person events are held with 3 speakers and individual practice posters on display.
- Develop scale and spread toolkits for any projects from 2024-2025 that meet scale and spread criteria
- 103 out of 113 practices have signed up for the 2025-2026 QI & Safety Enhanced Service

CQL support

- Two new CQLs have recently started in post in East Lothian and West Lothian East. They have been offered coaching and access to CQL resources including our CQL Handbook.

QI Essentials

- 2025 cohorts will run in May (21 registrants) and September (currently 14 registrants)

Period:	1 April 2024 - 31 March 2025
Service / Area:	Mental Health
Programme Title:	Capacity and Capability
Programme / Improvement Leads:	Susan Marr and Evonne Rendall

1. Aim

Empower services to be self-sufficient in QI capability. Provide teams with QI coaching and individuals with QI clinics. Capture feedback from QI coaching and clinics with an aim that 80% of feedback will be positive.

2. Background and Purpose:

To encourage engagement with Quality Improvement within Mental Health Services the Quality Directorate (QD) supports individuals, wards and teams with small scale quality improvement projects, prioritising those projects that sit within the Mental Health programme areas.

The aim of supporting individual projects through 1-hr clinics is to provide coaching in QI tools and methodology, providing a basic understanding of QI, develop a workforce that identifies QI as a useful tool and build enthusiasm for using QI, as well identify projects with potential to share, scale up and spread to other MH services.

3. Key Actions and Improvements to Date:

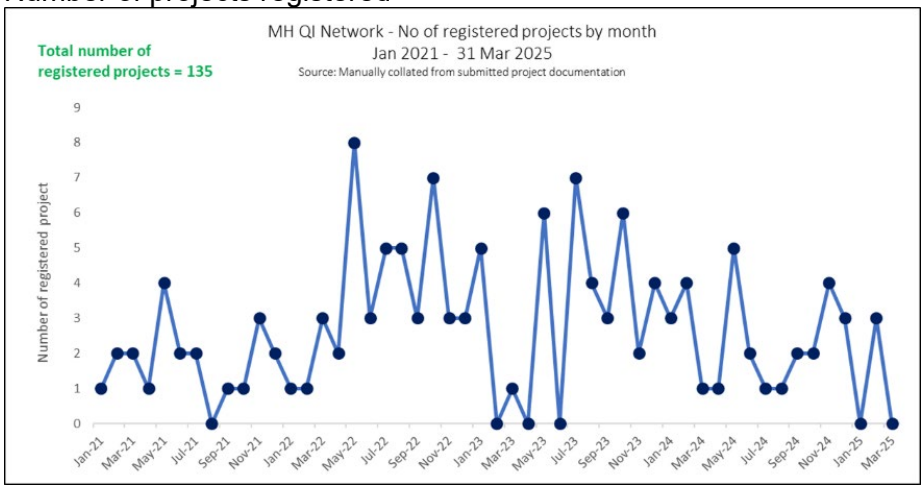
- The QD continue to support individual QI clinics across MH services as well as ward-based projects.
- From SAER review, clinics have been held with teams looking at different components of the Falls work, including increasing Physiotherapist referrals and assessment and reducing falls in older people mental health wards.
- A falls risk assessment on admission in one ward identified the first improvement project to be tested. Data collection not started.
- Approached by CAMHS to provide refresher training to Community and Ward based band 7 nursing staff to encourage application of QI to implementation of SG guidance and individual projects.
- Providing support for Practice Development and Improvement nurses improving quality and consistency of patients notes / care plans.
- Supporting the Senior Management Team with bed capacity escalation, to identify key projects to scope and plan improvement.

The following are examples of projects supported by the QD through individual clinics and data collection tools.

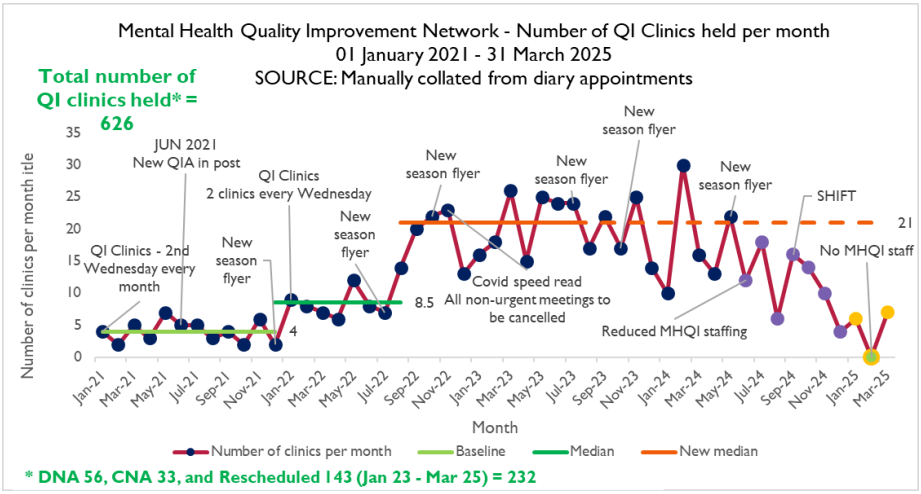
- Reducing wastage of medicines due to expire on a ward – changes to prescribing identified and tested with pharmacy and one ward team.
- Improving access to reports on HEPMA for Senior Clinical Staff during out of hours shifts allows for quicker access to medication needed at short notice.
- Creating a safe handover – Resident doctor project to improve handover reducing errors and improving patient safety.
- Improved communication between IPCU and Adult Acute wards – improving safe transitions of care between IPCU and main Adult Acute wards.

4. Measures / Impact / Data:

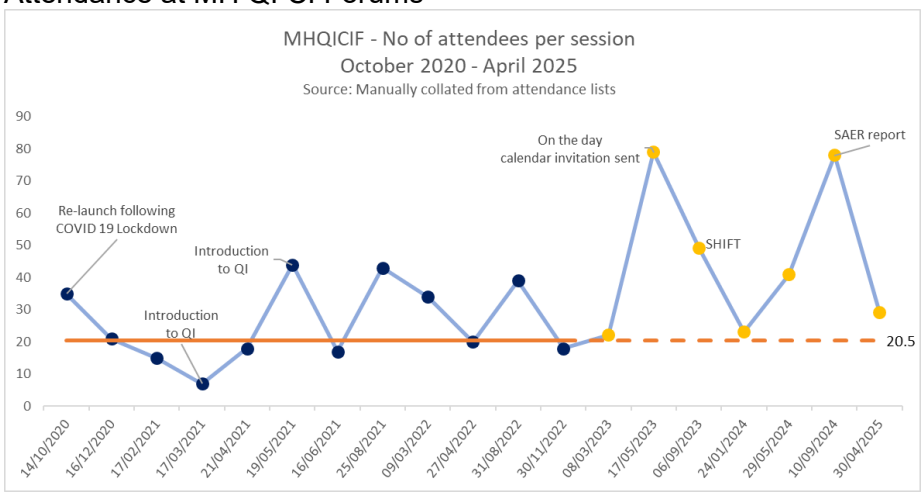
Number of projects registered



Number of QI clinics – April 2024 – March 2025 – 137.



Attendance at MH QI CI Forums



5. Reflections / Learning Points:

- The QI team continues to see engagement from teams keen to work with us to drive small scale improvement projects within wards or services.
- The current bed capacity and staffing challenges within REAS have impacted on staff capacity to work with the team on QI projects.
- The loss of the HIS funding for the Clinical Lead and reduced capacity of the QI team has hampered engagement with frontline teams and management alike.

6. Next Steps:

- Continuing to provide access to QI clinics and identify those that link to MH programmes of work.
- Reviewing existing projects and conduct quality planning to ensure QI activity is supporting a reduction in avoidable harm in MH Services.
- Develop measurement plan for building capacity and capability across MH services.
- Develop QI Huddles and QI Boards within MH Services.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Mental Health
Programme Title:	Readiness response - Adult Mental Health (AMH)
Programme / Improvement Leads:	Susan Marr

1. Aim

Robust service escalation due to bed occupancy (readiness response), and the introduction of prep stat, to ensure safer management of patient flow.

2. Background and Purpose (Why?):

This workstream is in response to the Adult Mental Health Service needs to introduce a structured response to capacity issues within adult acute wards, with support from the Quality Improvement team.

Royal Edinburgh Hospital is experiencing consistent over-capacity in Adult Mental Health beds. The team has been asked to support planning work to reduce overcrowding and improve the Senior Management Team response.

Increased bed occupancy can heighten the risks to both staff and patients of incidents of harm. Staff capacity to address gaps in performance or safety concerns within their own area is hampered by the immediate needs of patients.

The QD team provides Quality Control data on admissions, discharges, mean length of stay, delayed discharges, occupied bed days and occupancy rates for both Adult Mental Health and Older Peoples Mental Health services. The team also provides data on recorded incidents of physical violence, restraint and self-harm for AMH as well as Falls and Falls with harm for OPMH as identified by the SPSP as harms within Mental Health Services.

3. Key Actions and Improvements to Date:

- Development of escalation poster and cards for management – explore which parts of the process can be tested and developed as change ideas.
- Support to develop a structured response when over-capacity within AMH services and identify changes to system – this will help to reduce the occupancy rate across adult acute inpatient services to agreed safe levels.
- Continue to provide QC control data at this time to support understanding of the situation.

4. Measures / Impact / Data:

Data submitted by the Quality Directorate in a slide pack and available on request, includes:

Outcome:

- Reduce bed occupancy rate
- Reduce Mean length of stay of ward discharges
- Reduce delayed discharges

Process:

- Number of pts identified for discharge at RRD.
- Number of RRD held.
- % of actions from daily huddle completed.
- Further measures will be determined, including methods of collecting staff feedback.

Balancing:

- Occupied bed days
- Increased staff wellbeing
- Reduced staff absence
- Increased staff retention

SPSP harms –

- Physical violence
- Restraint,
- Self-harm
- Falls

5. Reflections / Learning Points:

Ward teams are keen to improve safety within their wards, however they struggle to find time to collect baseline data or consider improvement ideas whilst the adult acute wards are over capacity, which then has a knock-on effect across all wards on the site.

6. Next Steps:

- Improving rapid rundowns on wards to inform discharges.
- Introduction of a revised standard operating procedure for rapid rundowns with Quality Directorate supporting data collection once rolled out.
- Identify change ideas from readiness response to test.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Mental Health
Programme Title:	Reducing Falls - Older People Mental Health (OPMH)
Programme / Improvement Leads:	Susan Marr

1. Aim

Reduce avoidable harm and improve safe, effective, person-centred care within the Royal Edinburgh Hospital and Associated Services (REAS) by March 2025.

2. Background and Purpose (Why?):

The comprehensive review of SAERs (see report "MH Safe Care") identified falls and falls with harm within Older Peoples Mental Health as the one of the largest contributors to harms data.

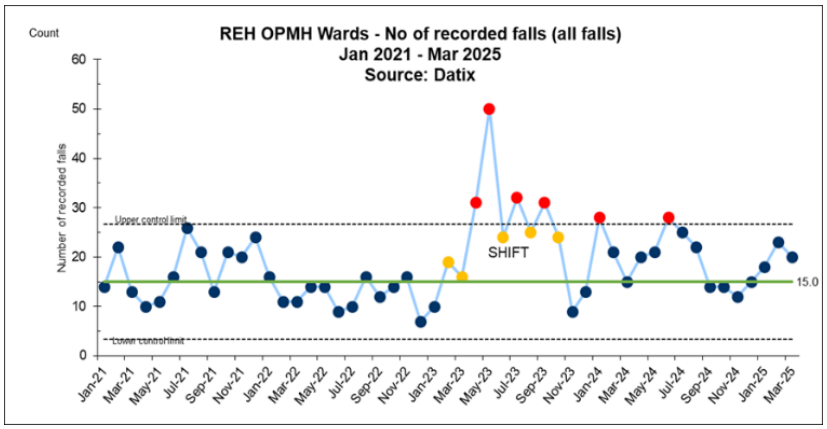
The Royal Edinburgh Hospital and Associated Services (REAS) Falls group discussed improvements in OPMH. The group have a number of ideas around risk assessment/management and documentation and have identified a potential project with OPMH Physios to increase awareness of patients falls risk with nursing staff to actively reduce falls.

3. Key Actions and Improvements to Date:

- The QD provided data e.g. times of falls in the OPMH areas, and a ward has been identified with most falls recorded, to target interventions.
- A REAS 'Task and Action group' has been set up to address gaps in documentation of risk assessment and recording with an aim to increase staff awareness of patients requiring additional physio or OT input.
- A driver diagram was developed, and initial testing of risk assessment completion started on one ward. Baseline data to be collected.
- A falls champion is being identified on wards and additional training provided.
- A physio project to increase visibility of patients at risk of falls to be started.

4. Measures / Impact / Data:

Outcome: Number of falls OPMH wards



Process measures to be collected:

- Completed risk assessments
- Number of patients with OT / Physio referral and/or assessment
- Percentage of Post falls paperwork completed

Balancing:

- Number of pressure ulcers
- Increase in frailty

5. Reflections / Learning Points:

Datix recording requires improvement with the area where fall happened being accurately recorded, to support the tracking of 'hot spots'.

The task and action group highlighted three initial ideas for improvement:

- completion of falls risk assessment on admission,
- post-falls paperwork, and
- increased referral to physiotherapist team for patients identified at risk of falls.

6. Next Steps (Summary):

- Measures and change ideas for each project need to be identified to monitor whether changes are an improvement.
- Improvement team engagement with the Falls Network and Task and Action group.
- Develop driver diagram with OPMH teams and test change ideas.

Period:	1 April 2024 - 31 March 2025
Service / Area:	RIE and SJH
Programme Title:	Maternity Improvement Programme
Programme / Improvement Leads:	Ross Davies / Alison Redpath

1. Aim

The overall aim of this programme is to reduce avoidable maternal and fetal harm, through the delivery of the clinical drivers of reliable:

1. **Planned antenatal care processes.**
2. **Unscheduled antenatal care processes.**
3. **Intrapartum care processes.**

2. Background and Purpose:

Maternity Services and the Quality Directorate undertook comprehensive Quality Planning to understand and reassess priorities against system data, process and outcome measures, patient feedback and national information. This identified key improvement priorities to improve patient care and reduce avoidable harm.

3. Key Actions and Improvements to Date:

The programme is supported by an infrastructure of frequent meetings from project and improvement delivery to operational delivery and managerial governance and support. This is overseen by an executive group.

Project Initiation Documents (PIDs) and Project Plans were developed with the service that maximises the current maternity services structure. Robust programme management supports the timely delivery of the programme and risks.

1. **Planned antenatal care processes**.

- **Small for Gestational Age (SGA) Improvement Project**
  An awareness campaign started in September 2024 and included practical changes including where plotting documentation is held and markers on appointment sheets. The guideline for clinicians was updated and an additional flowchart was added to clarify appropriate management of growth concerns. An educational package was created and has been watched by >90% of community and hospital midwives.

  Analysis of babies born small for gestational age after their estimated date of delivery for January to March 2025 has given new focus areas for exploring change ideas. Individual feedback is provided to all midwives where process has not been followed.

- **Standardising the antenatal booking risk assessment process**
  Covering all community areas and teams, the antenatal booking risk checklist has been standardised to reduce variation in practice. The use of the assessment is being reviewed regularly to monitor reliability.

  Changes to the electronic Trak system are underway to assist midwives to carry out risk assessments reliably. New booking appointments are reviewed each month to understand more about factors that are being missed and if change ideas can be targeted to these.

2. **Unscheduled antenatal care processes**.

- **Triage Improvement Project**
  Comprehensive quality planning to understand the system has been undertaken in the triage stage of women's care to enable a focus for improvement. There has been consistent improvement in time to triage and it is hardest to achieve at busiest times of day.

  Practical changes continue to be embedded e.g. handovers, twice daily huddles (also ensure staff breaks and wellbeing), triage rooms identified by signage, 2nd triage room in use, dedicated room for medical reviews.

  Continue implementing the use of the Birmingham Symptom-specific Obstetric Triage System (BSOTS) which is a standardised way to assess women presenting with unexpected pregnancy related problems or concerns, ensuring they are prioritised in order of clinical urgency.

  Weekly QI huddles have been established to improve the links between front-line and QI project staff to generate change ideas and momentum. These have primarily focused on the use of MEWS and the gestational hypertension pathway for patients who present with raised BP. A new protocol has been created with focus on escalation.

3. **Intrapartum care processes**.

- **Fetal Wellbeing Improvement Project**
  A senior midwife is dedicated to supporting staff across RIE and SJH with ensuring safe recognition, interpretation, and escalation of fetal concerns. Data is monitored weekly, and all adverse events are reviewed by the senior midwife for fetal wellbeing practice.

  Audit has shown the reasons for 'fresh eyes' not being done every hour and plans are in place to address that. Various change ideas have been trialled and implemented e.g. using a sticker on the CTG trace that provides a checklist for staff to review fetal trace, physiology, and maternal health.

  A structured method of assessing characteristics of a CTG was introduced - this is now embedded in practice. A revised Partogram (documentation) is in place and includes risk assessment and the escalation guidance (RAG based) that enables staff to escalate appropriately and empowers staff to escalate to senior staff. Training and individual feedback continues and is refined regularly.

- **Urgency of Birth Improvement Project**
  Comprehensive Quality Planning to understand the system and issues, including detailed process mapping, case note reviews and observational data, were completed. The use of stickers in this part of the project will be reviewed when we consider all the documentation in use. Documentation on paper is to be rationalised to reduce duplication and enable staff to document clearly and in a timely manner.

- **Accountable Items Improvement Project**
  A SOP has been developed to include when items were used intentionally on transfer between departments. Each intrapartum area has been auditing their accountable items documentation and feeding back learning through safety briefs and teaching.

  Practice 'drills' have been completed with staff (a consultant and QI Midwife in the ward) to show staff the process, to practice, and to understand barriers to when processes do not work.

4. Measures / Impact / Data:

Full data pack available on request to: loth.qist-admin@nhs.scot

5. Reflections / Learning Points:

- Despite focusing areas to ensure success, the nature of maternity and neonatal care is wide-ranging and emotive, with changing priorities.
- Communication and engagement with all staff groups is essential. Visiting all the community teams in person has been valuable for testing changes and engagement.
- Multidisciplinary working is key e.g. improvement staff with service staff and medics, midwives, and leads all working together towards the same aim.

6. Next Steps:

1. **Planned antenatal care processes**.
    - **Small for Gestational Age Improvement Project**
      Focussing in on the new learning from babies born small for gestational age in the latest quarter to identify change ideas to test.
    - **Standardising the antenatal booking risk assessment process**
      Development of risk assessments on Trak, monitoring the use of these and comparing to the data from the ongoing audit of booking appointments to identify future focus areas.
2. **Unscheduled antenatal care processes**.
    - **Triage Improvement Project**
      Continued focus on gestational hypertension, MEWS and time to medical review. Weekly huddles to identify change ideas and monitor progress.
3. **Intrapartum care processes**.
    - **Fetal Wellbeing Improvement Project**
      Restart audits of CTG practice; continue training of new staff.
    - **Urgency of Birth Improvement Project**
      Regular review of cases where urgent birth was not achieved within guideline to identify areas for improvement.
    - **Accountable Items Improvement Project**
      Further iterations and development of the birth bundle of paperwork, following feedback from intrapartum care settings.
    - **Third- and Fourth-Degree Tears**
      Through QI huddles and case note review identify improvement opportunities.
4. **Maternity Early Warning Score (MEWS) frequency, escalation and SBAR-D**
    - Develop and implement at detailed plan that introduces tests of change to support improvement in MEWS frequency, escalation and communication using SBAR-D.
    - April – Dec 2025 – MEWS reliability implemented in all areas.

Period:	1 April 2024 - 31 March 2025
Service / Area:	Lothian
Programme Title:	Executive Leadership WalkRounds
Programme / Improvement Leads:	Carolyn Swift

1. Aim

To conduct one Executive Leadership WalkRound per month, facilitating discussions with executives and clinical-based staff, and following up actions agreed by members.

2. Background and Purpose (Why?):

Executive Leadership WalkRounds™ were introduced as part of the Scottish Patient Safety Programme (SPSP) in 2008, for the reasons outlined above. NHS Lothian has consistently supported these on a regular basis since that time.

The purpose of a Leadership WalkRound™, includes:

- Connecting senior leaders with staff as a way both to engage senior leadership about safety issues and to signal to staff senior leaders' commitment to a patient safety culture.
- Achieving a strong culture for safety which aims to reduce adverse events.
- Creating a culture that puts patient safety at the centre of everything we do.
- Allowing executive leaders to have a structured conversation around patient safety with frontline staff and enquire as to the barriers to caring for patients as safely as possible.
- Increasing awareness of safety issues among all clinicians and establish a strong commitment by senior leadership to a culture that encourages patient safety.

3. Key Actions and Improvements to Date:

Period: 1st April 2024 – 30th March 2025

9 x WalkRounds were held

3 x WalkRounds were cancelled

17 x actions were taken by Executives
(12 open actions + 5 closed actions)

All WalkRounds had 1 NXD attending
(but from April 2025 this will increase to 2 x NXDs)

Sites/Services visited:
DATCC, RIE, REH, RHCYP, SJH, WGH

Specialties visited:
Medical Day Case, Paediatric acute medical receiving unit, Inpatient Rehabilitation, Medical Physics MR Department, Theatres, MAU trolleys & beds

4. Measures / Impact / Data:

Examples of those actions that are accepted by executives are included in the following table.

Theme	Example
Communication within and between teams	• Feedback requested from LCIG on the reasoning for not accepting an application • Better communication and links with the Flow Centre • Ward staff welcome a review from peers to improve. • Request to be included in LACAS.
Staff	• Skill mix issues • Low staffing levels continue • Staff seeking access to V&A training at ward • Delays for new starts getting HEPMA access
Business and process	• Checking status of dedicated MRI sessions • Issues with blood tracking

5. Reflections / Learning Points:

All except one of the next year's WalkRounds has 2 non-executives which will maximise opportunities.

6. Next Steps:

For 2025-26, we have selected areas that:

- Deliver indirect patient / support services.
- Report a high number of adverse events.
- Have not had a visit since before 2019 or have never had a visit.

These include Catering, Hospital Portering, RIE Emergency Department, AAH Flow Centre, Comely Bank Staff bank, WGH Main Theatre, RIE Pharmacy, Lauriston Audiology, RIE Health Records / coding, RIE Mortuary and Transport Services.

More information and the full timetable are available on the intranet here:
SPSP Executive Leadership WalkRounds™

Appendix 2

Quality Directorate
2025-2026 Annual Plan

2025 – 2026 - Quality Directorate Overview Plan

Area of Focus	Key Activities
Sites: Royal Infirmary of Edinburgh and St John's Hospital	Focus on delivering planned programmes to Reduce Avoidable Harm, including: • Falls improvement aligned to implementation of NHSL Falls Strategy and National Falls Definition. • Reducing Pressure Ulcers including supporting Pan Lothian PU Collaborative. • Site-specific priorities, including Deteriorating Patient. Medicines and others outlined in site project plans. • Continue to report to, and learn from, HIS/SPSP as part of the national collaboratives for Falls and Deteriorating Patients and contribute to the emerging SPSP Medicines Programme.
Western General Hospital	Focus on delivering planned programmes to Reduce Avoidable Harm, including: • Site-specific priorities, including Deteriorating Patient. Medicines and others outlined in site project plans. • Continue to report to, and learn from, HIS/SPSP as part of the national collaboratives for Falls and Deteriorating Patients and contribute to the emerging SPSP Medicines Programme.
Royal Hospital for Children and Young People	Focus on delivering planned programmes to Reduce Avoidable Harm, including: • Deteriorating Patient • Medicine Safety • Continue to provide quality improvement advisory support, as directed by the Quality Improvement Team (QIT), to specific projects. • Report to HIS/SPSP on a quarterly basis as part of SPSP Paediatrics for the Deteriorating Child.
Royal Edinburgh and Associated Services (REAS)	• Map existing governance arrangements, identify clear governance structures and support application. • Undertake Quality Planning including reviewing and theming SAEs to identify MH Safety Improvement Priorities,. • Support Quality Improvement interventions, including QI coaching, QI huddles, updating QI boards with relevant data, etc.
Maternity Services	• Planned Antenatal Care - SGA: SFH plotting & follow-up, booking risks identified for correct pathway. • Triage – within 15 mins, time of ongoing midwifery care, time of medical review, MEWs and suspicion of sepsis and SBAR-D. • Intrapartum Care – reducing 3rd & 4th degree tears, MEWS, SBAR-D, Urgency of Birth, Accountable Items, Fetal Wellbeing, PPH. • Inpatient – MEWS, SBAR-D and Induction of Labour. • Cross cutting – Patient (including learning from families after an AE).

2025 – 2026 - Quality Directorate Overview Plan

Area of Focus	Key Activities
Primary Care	• Implement Quality Improvement LES – at least 80% of QI projects have an IHI score of 3.0 or above. • Support Cluster Quality Leads meetings to enable and empower CQLs to lead data-driven, evidence-based improvement. • Support Cluster Quality Leads coaching to enhance & support quality management, leadership, & change management knowledge, to enable CQLs to respond to and lead data-driven, effective and robust improvement. • Train at least 10 participants per cohort in QI.
Deteriorating Patient	• Outline and update Acute CMT of plans (particularly in relation to Policy Development). • Evaluate implementation of NEWS overview Board in 3 Acute sites - including Site safety huddles and out of hours working models. • Support development of NEWS, MEWS, PEWS escalation policy. • Reduce medical emergencies (ME) with preceding deterioration. • Maintain the reduction in cardio-pulmonary resuscitation rate (CPR) in acute care.
Medicines Safety	• Undertake Quality Planning to identify Pan Lothian Medicine Safety Priority Programme. • Support site/service specific Quality Planning to identify local improvements • Develop Measurement Plan • Promote Medicine Safety Learning System through presentations and engagement at various forum. • Support Quality Improvement interventions, including QI coaching, leading huddles, updating QI boards, etc. • Provide progress reports to the Medicine Safety and Risk Group. • Coordinate Learning Session September 2025.
Analytics	• Develop Site and Service Quality reports that meet users' needs, including additions as they arise (e.g. HSMR coding). • Develop directorate process to regularly review key safety data and process for identifying areas of concern. • Support the quality directorate staff develop measurement plans, for example, REAS, Medicines, etc.
Quality Academy	• Redesign QI offer – evaluate QI Skills, QI Bitesize, QI Essentials – develop new offer following evaluation. • Manage recruitment to NES taught programmes. • Develop training requirements to support SAERs training for various audience levels – starting summer 2025. • For consideration - Joy in Work, Public Engagement Training and integrating QI with SIM.

2025 – 2026 - Quality Directorate Overview Plan

Area of Focus	Key Activities
Adverse Events (AEs)	• Clarify methodology for theming adverse events – support services to undertake this process. • Share current Quail Tool with site PSEAGs – gather user feedback. • Develop a standard data set and dashboard for AEs and providing to sites/services each month. • Review the requirements to undertake an AE for HAIs, Falls, and PUs. Revised process for HAI, falls and pressure ulcers to be explored. • Implement specific requirements outlined in the HIS framework into our revised processes. • Define what constitutes a Level 1 SAE review in Lothian – review other boards process, etc. • Provide more in-depth incident investigation training delivered through the Quality Academy. • Provide clarity on the roles and responsibilities of the service risk managers and the QI Assurance Facilitators with a focus on supporting Level 1 reviews. • NES deliver bespoke session on incident investigation to CDs via the CD development day – Dec tbc. • Contribute to the national (HIS) network to develop standard definition for SAE.
Datix	• Map reprovision requirements for Datix replacement. • Cleanse current data within Datix system. • Reduce dependency on a staffed Help Desk by introducing automated processes.
Assurance Framework	• Finalise assurance framework and support services to complete this year's reporting cycle, incorporating Safe, Effective and Person-centred care into services assurance maps. • Incorporate SIGN Impact Assessment and SNAP audit processes.
SIGN	• Undertake impact assessments for 4 guidelines published 2024/25 • Prepare reports for consideration by relevant management and governance groups (CMGs/Acute CMG/SMTs) for risk assessment and improvement planning. • Services to report on local compliance/improvement plans with relevant recommendations as part of assurance framework
Risk Management	• Develop strategic risk register aligned to developing Board assurance framework • Continue to develop corporate risk management processes to ensure that management of escalated operational risks underpins Board assurance framework • Collaborate with internal audit to scope annual RM audit and support implementation of recommendations

2025 – 2026 - Quality Directorate Overview Plan

Area of Focus	Key Activities
Safety Alerts	• Ongoing engagement with senior service management to improve timely action and improve assurance. • Participate in discussions to explore opportunities to streamline processes through national 'Scan for safety' work.
Litigation	• Arrange schedule of presentations to site/service management teams to improve engagement with process. • Explore opportunities to work with Medical education to improve support for staff involved in claims.
System Response Activity	• Manage capacity to respond to emerging system priorities. • Responding to queries – PSEAGs, SAEs, FOIs, etc. • Responding to queries to external access address Lothian.Quality@nhs.scot from various sources.
Executive Leadership WalkRounds	• Continue to deliver monthly WalkRounds across Acute and REAS, including one exec and two NXDs, to allow the executive team to meet staff. • Collate actions to report to site teams and ensure that actions are closed, reporting back to each area. • Seek continuous feedback to from all participants and implement improvements.

NHS Lothian

13.

Meeting: NHS Lothian Board

Meeting date: 25th June 2025

Title: 2024/25 Financial Outturn 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 final financial position for 2024/25.

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 end position subject to review by external audit.

2.3 Assessment

The reported financial position for NHS Lothian for 2024/25 is an underspend of £771k. The financial position is comprised of an operational overspend of £20.7m, offset by the release of corporate reserves flexibility of £21.4m. Table 1 below shows this breakdown in summary with further information in the body of this paper.

Table 1 – Month 12 Summary Financial Performance

	2024/25 variance from Budget £'000
Pay	18,477
Non Pays	(64,268)
Income	25,117
Operational Position	**(20,674)**
Reserves	21,445
Total	**771**

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 March 2025

Within pay, Medical and Dental was the main area of overspend, reporting an overspend of £14m for the year. There was some improvement in the levels of the monthly overspend position in the later months of the financial year 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 arrears for the 2024/25 pay award for all Medical and Dental staff was also paid during 2024/25 with funding from the Scottish Government received for all Medical and Dental staff.

Overall, non-pay budgets reported a £64m overspend, with Drug costs (£18m) and Medical Supplies (£24m) being the significant areas of financial pressure. Overall, Drugs and Medical Supplies together showed an 8% (£24m) increase in spend from 2023/24. The non-pay budget pressures were impacted by contractual price increases and the 0% funding uplift for 2024/25. GP Prescribing reports a £16m overspend driven during the year by price per item fluctuations and higher than expected growth in the number of items, overall though the level of variation each month improved. 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 12 Variance from Budget £000's
Medical & Dental	(14,125)
Nursing	15,878
Administrative Services	7,625
Support Services	(1,077)
Other Therapeutic	3,384
Other Pay	6,793
Total Pay	**18,477**
Drugs	(17,817)
Medical Supplies	(23,606)
Property Costs	(12,922)
Administration Costs	15,726
Other Non-Pay	(7,720)
Pharmaceuticals	(16,162)
Other FHS	(1,770)
Total Non-pay	**(64,272)**
Income	**25,117**
Other	**(1,115)**
Profit/loss On Disposal	**1,118**
Operational Position	**(20,674)**
Corporate Reserves Flexibility	21,445
Total Variance	**771**

There is now only minimal amounts of transitional allowance overtime or excess hours payments being paid, as part of the Agenda for Change (AfC) non pay reform for the reduced working week (RWW). March payments relate to February transitional allowances or corrections from previous months and totalled only £11k in month with £8.7m year to date costs included within the position. Work continues through the AfC Reform Programme Board to support the process of managing the RWW, along with the other non-pay reform elements. Transitional Allowance overtime payments have now ceased apart from specific approved arrangements in place for a small number of areas. Band 5 to 6 regrading has started to build momentum with applications now starting to be approved and paid. To date £146k of funding has been passed out for additional costs associated with successful applications from non recurrent AfC Reform funding from the Scottish Government this year.

Financial Position Journey 2024/25

2024/25 started with £140m of a projected gap following the December 2023 budget announcement and improvements have been carefully monitored throughout the year. Improvements to Business Units operational positions as well as delivery of their Financial Recovery Plans and benefits from the 4% executive led workstreams were recorded. Plus with reductions in CNORIS costs and release of additional corporate funding flexibility, NHS Lothian has been able to meet the statutory requirement for financial balance again this year. Appendix 3 shows the movement of the financial position during 2024/25.

Integration Joint Boards Health Year End Outturn

As it currently stands, all four IJBs have achieved a balanced position in relation to their Health delegated budgets. To enable this, three of the four IJBs have required additional non-recurring support from NHS Lothian. West Lothian IJB utilised £2.1m of its earmarked reserves to reach a balanced position following agreement by the IJB. Earlier in the financial year East Lothian IJB agreed to release £3m of general reserves to support operational performance this year and this has been supplemented by the additional allocation by NHS Lothian to achieve balance.

The level of NHS Lothian additional non-recurring support provided to the IJBs is shown below:

- East Lothian IJB £0.8m
- Edinburgh IJB £2.4m
- Midlothian IJB £2.9m
- West Lothian IJB -

Appendix 3 sets out the outturn position by IJB, showing the outturn position before any additional resource that has resulted in a balanced health budget position across all IJBs.

Financial Recovery Plans (FRPs)

At a summary level and against £58m of planned Business Unit FRP savings, just under £60m has been recorded as delivered, representing an over-achievement of £2m on those schemes identified. Table 3 shows the delivery against Business Units and Table by category.

Table 3 – Financial Recovery Plans (FRPs)

Financial Year 24/25					
	Schemes Identified £'000	Achieved April - March £'000	Over /Under Achieved £'000	Full Year @ M12 £'000	% Achieved
Acute Services Division	25,122	27,300	2,178	26,232	3.20%
Corporate Services	6,310	6,306	-4	3,070	3.60%
East Lothian Partnership	4,294	3,853	-441	4,133	2.80%
Edinburgh Partnership	4,854	5,720	866	4,719	3.60%
Midlothian Partnership	3,453	2,942	-511	2,854	1.70%
West Lothian Partnership	4,141	4,169	28	4,026	3.90%
Facilities	5,027	5,404	377	5,736	3.00%
REAS	3,311	2,966	-345	2,017	2.70%
Directorate Of Primary Care	953	937	-16	450	3.60%
Income/Healthcare Purchases	388	388	0	388	3.00%
Grand Total	**57,852**	**59,984**	**2,131**	**53,624**	**3.00%**

The 3% target achievement overall for 2024/25 was £59.2m, so with £60m achieved the 3% target overall has been met.

Table 4 – Financial Recovery Plans % Achievement

Category		Achieved April – March £000
Workforce	Medical	3,323
	Nursing	12,212
	Other	6,672
Acute Drugs		13,085
Primary Care Drugs		7,330
Procurement		5,077
Property / Infrastructure		1,650
Other		10,635
		59,984

Based on the latest update £60m of savings have been delivered in year with £54m forecast to be achieved recurrently. The recurrency of FRP delivery is an important issue going into 2025/26 and is key in reducing the recurring deficit.

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. Achievement of the 3% FRP target at a Business Unit level is a key vehicle in support of achieving financial balance, with FOB escalation for breaching set thresholds in place and continuing into 2025/26.

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

Regular finance update reporting is provided to the Board after consideration by the Finance & Resources Committee (F&R). The month 12 financial position was reported to F&R in June.

- Month 12 - F&R 11th June 2025

2.4 Recommendation

The report asks the Board for:

- **Assurance** – For Members to note the achievement of financial balance by NHS Lothian, reporting a small underspend of £771k for 2024/25 subject to final audit review.
- **Awareness** – For Members to note the delivery of £60m of efficiency savings for 2024/25.
- **Awareness** – for Members to note that all IJBs have achieve a balanced Health Position.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Lothian Income & Expenditure Summary to 31st March 2025
- Appendix 2, NHS Lothian Summary by Operational Unit to 31st March 2025
- Appendix 3, NHS Lothian Financial Position during 2024/25
- Appendix 4, IJB Health Year End Position Summary

Appendix 1 - NHS Lothian Income & Expenditure Summary to 31st March 2025

Description	Annual Budget £'000	YTD Budget £'000	YTD Actuals £'000	YTD Variance £'000
Medical & Dental	407,773	407,773	421,899	(14,125)
Nursing	679,371	679,371	663,493	15,878
Administrative Services	190,903	190,903	183,278	7,625
Allied Health Professionals	123,526	123,526	119,422	4,104
Health Science Services	58,542	58,542	56,958	1,584
Management	8,055	8,055	7,028	1,027
Support Services	105,244	105,244	106,322	(1,077)
Medical & Dental Support	20,098	20,098	19,741	358
Other Therapeutic	72,966	72,966	69,582	3,384
Personal & Social Care	3,433	3,433	2,634	799
Other Pay	(3,388)	(3,388)	(3,908)	520
Emergency Services	0	0	36	(35)
Vacancy Factor	(1,609)	(1,609)	(45)	(1,564)
Savings Target Pay	0	0	0	0
Pay	**1,664,915**	**1,664,915**	**1,646,438**	**18,477**
Drugs	169,926	169,926	187,744	(17,817)
Medical Supplies	110,432	110,432	134,037	(23,606)
Maintenance Costs	7,845	7,845	12,229	(4,384)
Property Costs	50,353	50,353	63,275	(12,922)
Equipment Costs	39,095	39,095	43,895	(4,801)
Transport Costs	6,748	6,748	9,670	(2,922)
Administration Costs	145,384	145,384	129,659	15,726
Ancillary Costs	11,998	11,998	18,189	(6,191)
Other	(9,603)	(9,603)	(18,120)	8,517
Service Agreement Patient Services	41,726	41,726	48,576	(6,850)
Savings Target Non-pay	11,808	11,808	0	11,808
Resource Transfer/LA Payments	125,478	125,478	128,375	(2,897)
Non-pay	**711,190**	**711,190**	**757,529**	**(46,340)**
Global Sum	0	0	0	0
Premises	0	0	4	(4)
Other Payments/reimbursements	0	0	0	0
GPs Other Payments	0	0	0	0
Additional Services	0	0	1	(1)
GMS2 Expenditure	176,966	176,966	178,462	(1,495)
NCL Expenditure	813	813	1,087	(275)
Other Primary Care Expenditure	87	87	81	6
Pharmaceuticals	165,650	165,650	181,813	(16,162)
Primary Care	**343,516**	**343,516**	**361,448**	**(17,932)**
FHS Non Discretionary Allocation	(19)	(19)	0	(19)
Bad Debts	4	4	1,100	(1,096)
Other	**(15)**	**(15)**	**1,100**	**(1,115)**
Income	(430,659)	(430,659)	(455,777)	25,117
Income	**(430,659)**	**(430,659)**	**(455,777)**	**25,117**
Extraordinary Items	**(124)**	**(124)**	**(1,242)**	**1,118**
Operational Position	**2,288,822**	**2,288,822**	**2,309,496**	**(20,674)**
Corporate Reserves Flexibility	21,445	21,445	0	21,445
Total Variance	**2,310,267**	**2,310,267**	**2,309,496**	**771**

Appendix 2 - NHS Lothian Summary by Operational Unit to 31st March 2025

Month 12 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	(13,787)	148	(51)	133	193	1,439	(877)	341	(155)	0	(1,510)	0	(14,125)	0	**(14,125)**
Nursing	3,347	4,070	5,381	876	3,041	125	(505)	181	(100)	(1)	(538)	0	15,878	0	**15,878**
Administrative Services	2,606	652	2,070	(71)	495	(985)	(38)	3,182	242	(38)	(489)	(1)	7,625	0	**7,625**
Allied Health Professionals	141	694	1,375	177	698	838	137	20	67	(0)	(43)	0	4,104	0	**4,104**
Health Science Services	1,504	(9)	401	0	(13)	(8)	(26)	(205)	(19)	0	(41)	0	1,584	0	**1,584**
Management	(179)	122	345	(9)	2	111	10	389	230	0	6	0	1,027	0	**1,027**
Support Services	126	(3)	181	174	6	(24)	291	443	(2,273)	0	0	0	(1,077)	0	**(1,077)**
Medical & Dental Support	(695)	33	10	0	0	926	47	37	0	(0)	0	0	358	0	**358**
Other Therapeutic	76	566	938	21	546	(83)	1,428	(266)	(22)	(0)	181	0	3,384	0	**3,384**
Personal & Social Care	66	106	165	0	0	49	34	391	0	(0)	(11)	0	799	0	**799**
Other Pay	43	0	174	42	7	115	8	46	0	0	86	0	520	0	**520**
Emergency Services	0	0	0	0	0	0	0	0	(35)	(0)	0	0	(35)	0	**(35)**
Vacancy Factor	(0)	0	(1,668)	0	0	105	0	0	0	0	0	0	(1,564)	0	**(1,564)**
Savings Target Pay	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Pay	**(6,753)**	**6,379**	**9,320**	**1,344**	**4,975**	**2,607**	**508**	**4,559**	**(2,065)**	**(39)**	**(2,358)**	**(1)**	**18,477**	**0**	**18,477**
Drugs	(15,049)	(443)	(579)	(240)	(263)	(571)	(604)	376	(2)	(496)	0	0	(17,872)	55	**(17,817)**
Medical Supplies	(19,339)	(638)	(1,359)	(368)	(890)	22	(95)	(280)	(700)	50	(9)	0	(23,606)	0	**(23,606)**
Maintenance Costs	(940)	(76)	(128)	(42)	(189)	179	(171)	(415)	(2,599)	0	(2)	0	(4,384)	0	**(4,384)**
Property Costs	(89)	(22)	55	208	(102)	(53)	(13)	(41)	(12,030)	(836)	0	0	(12,922)	0	**(12,922)**
Equipment Costs	(3,313)	(548)	(490)	22	(244)	134	(197)	381	(428)	(79)	(38)	0	(4,801)	0	**(4,801)**
Transport Costs	(1,288)	(442)	(284)	(139)	(8)	(1)	(112)	27	(376)	(237)	(11)	(52)	(2,922)	0	**(2,922)**
Administration Costs	(1,224)	398	142	245	2,234	591	(511)	(953)	4,029	(5,787)	2,186	29	1,378	14,348	**15,726**
Ancillary Costs	(584)	(47)	(2)	5	(20)	(19)	(84)	(2,055)	(3,386)	0	(0)	0	(6,191)	0	**(6,191)**
Other	7,071	(0)	(7)	32	4	133	3	739	542	0	0	0	8,517	0	**8,517**
Service Agreement Patient Serv	(3)	989	(308)	537	(328)	(4)	723	(70)	(12)	(7,623)	(525)	(227)	(6,850)	0	**(6,850)**
Savings Target Non-pay	(95)	0	0	8	0	0	0	1,509	0	10,386	0	0	11,808	0	**11,808**
Resource Trf + L/a Payments	(81)	(1,292)	(71)	(1,279)	60	0	(93)	(79)	(64)	0	0	0	(2,897)	0	**(2,897)**
Non-pay	**(34,933)**	**(2,121)**	**(3,032)**	**(1,011)**	**256**	**411**	**(1,153)**	**(861)**	**(15,026)**	**(4,622)**	**1,601**	**(250)**	**(60,742)**	**14,402**	**(46,340)**
Global Sum	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Premises	(4)	0	0	0	0	0	0	0	0	0	0	0	(4)	0	**(4)**
Other Payments/reimbursemen	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Gps Other Payments	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Additional Services	0	0	0	0	0	0	0	0	(1)	0	0	0	(1)	0	**(1)**
Gms2 Expenditure	(11)	(280)	(765)	(453)	73	8	(16)	(51)	(0)	0	0	0	(1,495)	0	**(1,495)**
Ncl Expenditure	0	0	0	0	0	(275)	0	(0)	0	0	0	0	(275)	0	**(275)**
Other Primary Care Expenditure	6	0	0	0	0	0	0	0	0	0	0	0	6	0	**6**
Pharmaceuticals	0	(2,509)	(7,227)	(2,040)	(3,863)	(524)	0	0	0	0	0	0	(16,162)	0	**(16,162)**
Primary Care	**(9)**	**(2,789)**	**(7,991)**	**(2,493)**	**(3,790)**	**(791)**	**(16)**	**(52)**	**(2)**	**0**	**0**	**0**	**(17,932)**	**0**	**(17,932)**
Fhs Non Discret Allocation	0	0	(19)	0	0	0	0	0	0	0	0	0	(19)	0	**(19)**
Bad Debts	(18)	0	(0)	0	(9)	(1)	(1)	(1)	(887)	0	0	(180)	(1,096)	0	**(1,096)**
Other	**(18)**	**0**	**(19)**	**0**	**(9)**	**(1)**	**(1)**	**(1)**	**(887)**	**0**	**0**	**(180)**	**(1,115)**	**0**	**(1,115)**
Income	1,724	44	(685)	26	30	29	5	1,408	2,161	12,928	757	6,691	25,117	0	**25,117**
Income	**1,724**	**44**	**(685)**	**26**	**30**	**29**	**5**	**1,408**	**2,161**	**12,928**	**757**	**6,691**	**25,117**	**0**	**25,117**
Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Interest	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Capital Charges	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Rrl	0	0	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Revenue Resource Limit	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Profit/loss On Disposal	0	0	0	0	0	0	0	0	0	1,118	0	0	1,118	0	**1,118**
Extraordinary Items	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1,118**	**0**	**0**	**1,118**	**0**	**1,118**
Operational Position	**(39,988)**	**1,512**	**(2,407)**	**(2,134)**	**1,463**	**2,255**	**(656)**	**5,053**	**(15,819)**	**9,384**	**0**	**6,260**	**(35,077)**	**14,402**	**(20,674)**
Corporate Reserves Flexibility	0	0	0	0	0	0	0	0	0	0	0	0	0	21,445	**21,445**
Total Variance	**(39,988)**	**1,512**	**(2,407)**	**(2,134)**	**1,463**	**2,255**	**(656)**	**5,053**	**(15,819)**	**9,384**	**0**	**6,260**	**(35,077)**	**35,847**	**771**

Appendix 3 - NHS Lothian Financial Position during 2024/25

	£m
Financial Plan projected Gap	**(140)**
Health Consequentials	22
Additional NMF announced	15
Financial Outlook before Financial Recovery Plans	(102)
Financial Recovery Actions at March 2024	53
Pause & Assess Capacity - Scheduled Care	8.6
NSD Risk Share	2.4
Financial Outlook Gap submission to Scottish Government	(38.8)
Further NMF	7.5
SLA recovery	3
Q1 projected overspends	(3.5)
Q1 Forecast at July 2024	(31.8)
Increase to BU 3% FRPs & 4% Workstreams delivery	8.4
Q2 Forecast at October 2024	(23.4)
Increase to BU 3% FRPs & 4% Workstreams delivery	4.5
Q3 Forecast at December 2024	(18.9)
Improvement to BU Forecast Positions	6.3
National cost reduction - CNORIS	3.8
Release of other Funding Flexibility	9.6
Year End – March 2025	**0.8**

Appendix 4 – IJB Health Year End Position Summary

	East Lothian Variance £'000	Edinburgh Variance £'000	Midlothian Variance £'000	West Lothian Variance £'000
Core	(551)	(1,721)	(2,574)	(860)
Hosted	280	1,522	160	1,058
Set Aside	(523)	(2,212)	(535)	(2,305)
Initial IJB Variance	**(794)**	**(2,411)**	**(2,949)**	**(2,107)**
Non Recurring Additional Resource Allocated	794	2,411	2,949	0
Drawn down from IJB earmarked reserves				2,107

NHS Lothian

14.

Meeting:	**NHS Lothian Board**
Meeting date:	**25 June 2025**
Title:	**Scottish Hospitals Inquiry Update**
Responsible Executive:	**Craig Marriott, Director of Finance**
Report Author:	**Bruce Barron, Director of PPP and Capital Planning**

1 Purpose

To review the recommendations from the Scottish Hospital Inquiry (SHI) interim report with respect to Royal Hospital for Children and Young People/Department of Clinical Neurosciences (RHCYP/DCN), and the steps taken by NHS Lothian to date to address these recommendations.

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 [please describe]	☐

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 Scottish Hospital Inquiry (SHI) into the Queen Elizabeth University Hospital Campus (QEUH), Glasgow and the Royal Hospital for Children and Young People/Department of Clinical Neurosciences (RHCYP/DCN), Edinburgh has now published the interim report in relation to NHS Lothian.

The Chair of the SHI, Lord Brodie, issued his interim report on 3 March 2025: SHI Interim Report. The interim report brings together all the evidence heard to date about RHCYP/DCN and sets out the opinion of Lord Brodie in response to the Terms of Reference and he makes 11 formal recommendations. The Executive Summary is included as Appendix 1.

There are no further planned hearings in relation to RHCYP/DCN. The hearings in relation to QEUH are ongoing.

2.2 Background

2.2.1 Remit for the Inquiry

The SHI was established to consider the planning, design, construction, commissioning and, where appropriate, maintenance of both the Queen Elizabeth University Hospital Campus (QEUH), Glasgow and the Royal Hospital for Children and Young People and Department of Clinical Neurosciences (RHCYP/DCN), Edinburgh.

The full Terms of Reference (TOR) can be found here: Remit & Terms of Reference | Hospitals Inquiry

There have been four hearings in relation to RHCYP/DCN:

1. SHI heard from patients and families affected by the delay in opening the RHCYP/DCN

2. Edinburgh I - The background to the requirements of the RHCYP/DCN and the change in funding model.

3. Edinburgh II – looked at the Reference Design, use of Environmental Matrix, procurement up to Financial Close, ventilation system and governance.

4. Edinburgh III - the Delay Hearing which heard evidence on the development of the design of the ventilation system in critical care, the delays to the construction including entering into Settlement Agreement 1 and associated governance, the reasons for the delay in opening the hospital, the works undertaken to open the hospital and whether the hospital is now a suitable environment for the delivery of safe, effective person-centred care.

2.2.2 NHS Lothian input

NHS Lothian assisted SHI through a number of different ways including:

1. Providing a vast number of documents and numerous timelines/ narratives of events in response to Requests for Information issued by SHI to aid their investigations.

2. Along with the legal team, submitted detailed response to SHI's Provisional Positioning Papers (PPPs). The purpose of the PPPs is to set out the Inquiry's understanding of the factual position in order to focus the key issues in advance of the next set of oral hearings.

3. The following witnesses prepared witness statements and provided oral evidence at the hearings (with some witnesses appearing three times):

    - Jackie Sansbury (Head of Commissioning since retired)
    - Sorrel Cosens (Senior Programme Manager)
    - Janice MacKenzie (Project Clinical Director since retired)
    - Brian Currie (Project Director since retired)
    - Ronnie Henderson (Senior Capital Programme Manager since retired)
    - Iain Graham (Director of Capital Planning and Projects since retired)
    - Susan Goldsmith (Director of Finance since retired)
    - Tim Davison (Chief Executive since retired)
    - Alex McMahon (Director of Nursing since retired)
    - Tracey Gillies (Medical Director)
    - Donald Inverarity (Consultant Medical Microbiologist and Lead Infection Prevention & Control Doctor)
    - Lindsay Guthrie (Associate Director - Infection Prevention & Control)
    - Sarah Jane Sutherland (Geographical Lead Infection Prevention & Control Nurse)

4. During the course of the hearings and review of the PPPs there were a number of areas where counsel to the Inquiry was critical of NHS Lothian. However, the witness interviews, witness statement process and drafting of narratives and position papers hugely assisted in shifting the Inquiry's understanding of various matters. As a result, as a result we are pleased that Lord Brodie recognised the contribution from NHS Lothian in his final recommendations.

5. NHS Lothian's legal team (CLO and Counsel) prepared written closing statements on behalf of NHSL and NHSL's Counsel provided oral submissions when required.

2.3 Assessment

- **Key Points**

The key points for NHS Lothian are:

1. RHCYP/DCN is safe environment – first and foremost the RHCYP/DCN is safe for patients, families and staff.

2. The error in the Environmental Matrix (EM), albeit not identified by any project party, was ultimately related to NHS Lothian not providing a clear 'design brief':

    a. Lack of clarity in the procurement documents and in particular the decision by NHS Lothian (recommended by the Board's technical adviser Mott MacDonald (MML)) to include an incomplete EM for the tenderers.
    b. A lack of clarity in the brief - be it the error in the EM or the lack of Room Datasheets (RDS) or the fact that SHTM 03-01 itself is open to interpretation,

Lord Brodie considers if the brief was clear before entering into the contract it would have avoided the issue.

c. What environmental parameters (including air change rates and pressure differentials) were to be achieved in particular spaces of the hospital forms part of the design brief. The design brief is a matter for NHSL, as procuring authority. Determining the physical mechanisms of how that was to be achieved, was an aspect of the developed design, responsibility for which, and its associated risk, lay with the contractor (IHSL).

3. Contract – relationship of parties and duties under the risk transfer contributed to issues:
    a. Lord Brodie is clear he was not providing an opinion on contract dispute.
    b. Allocation of design risk in the contract between NHSL and IHSL – the differing understanding of the contract by all parties contributed to the problem which led to a breakdown in communication between NHSL & MML on the one hand and IHSL on the other.
    c. Lack of clarity on instruction and advice between NHSL and MML – this was picked up by Grant Thornton and NHSL have undertaken significant work to address this issue.

4. Risk assessments:
    a. Lack of formal risk assessments, including for example the use of the EM when funding changed from revenue to capital, the change from 6ach to 4ach in single and multi-bedrooms, or no technical and Infection Prevention & Control (IPC) review prior to entering into SA1.
    b. Lack of input of individuals – not all relevant disciplines were involved at the correct times. This includes IPC involvement prior to handover of the building.

5. Communications to Patients and Families in relation to the delay – Lord Brodie was critical of the lack of direct communication with long term patients and their families and made a recommendation but acknowledged that NHS Lothian were limited in what they could communicate due to restrictions imposed by the Scottish Government. He recognised the communications strategy undertaken to re-appoint scheduled care patients and to prevent patients presenting to the new Hospital for urgent and emergency care was effective.

6. Lord Brodie found there to be no issues with project governance and no issues with culture within NHS Lothian where issues were escalated and relevant whistleblowing policies in place.

7. No criticism of NHS Lothian in relation to the escalation of the ventilation issue to the Scottish Government.

8. No criticism of NHS Lothian in terms of openness or transparency.

9. No criticism that employees felt unable to raise concerns about the Project.

10. NHS Lothian reiterates its sincere and unreserved apology to patients, their families and staff for the delay in the transfer of patient services to the new facility, recognising this caused them significant concern. It is of particular regret that patients and their families experienced this at a time when they were already worried and vulnerable.

- **SHI Recommendations**

There is no legal obligation on NHS Lothian to implement any of Lord Brodie's recommendations. However, not doing so would leave the Board open to criticism from an organisational learning and governance perspective. There will be a general expectation in the public and Scottish Parliament that NHS Lothian will consider the recommendations and implement what it can. NHS Lothian should therefore review the recommendations carefully with a view to implementing those relevant to NHS Lothian.

It is important to note that many of the recommendations are directed at other bodies, primarily NHS Scotland Assure (part of NHS NSS) and Scottish Government / Scottish Futures Trust (SFT). NHS Lothian will assist and cooperate with other bodies as required in order to implement Lord Brodie's recommendations.

Below is a summary of Lord Brodie's 11 recommendations in bold, with further commentary (as appropriate) and an indication (in italics) as to which body is likely to be responsible for implementation and how NHS Lothian has/will address.

Recommendation 1: An effective communication strategy must consider the lived experience of patients and their families and their need for information, transparency and support. In the event of any adverse situation that could affect the wellbeing of patients and their families, there is a communication strategy in place to liaise with this crucially important group (*NHS Lothian)*; NHS Lothian will ensure the communication strategy includes the particular needs of this group and will liaise with Scottish Government for thoroughness of approach.

Recommendation 2: A risk assessment is required if there is a change in the arrangements for funding a project. (*NHS Lothian possibly with input from NHS Scotland Assure, Scottish Government and SFT*); Although project funding ultimately sits with Scottish Government, NHS Lothian is alert to the impact that funding changes can have on commercial arrangements and, in this instance, output-based contract specifications. NHS Lothian has developed its inhouse expertise to address such specifications through its PPP and Capital Planning Teams and should such a situation arise in the future, risk reviews by these teams would take place together with peer input by subject matter experts from advisory organisations.

Recommendation 3: A health board's brief for the construction or refurbishment of a healthcare facility must be clear and identify the output specifications to be met, in accordance with guidance. The onus is on the health board to present its requirements for key building systems (*NHS Lothian with input from NHS Scotland Assure);* NHS Lothian have contacted relevant colleagues to discuss and agree how best to jointly take this recommendation forward. Template documentation from NHS Scotland Assure will be utilised where helpful.

Recommendation 4: Development of a standard form for derogations from guidance. The structure of standard forms for this purpose is for NHS Scotland Assure to determine (*NHS Scotland Assure*); NHS Lothian have previously developed a standardised derogations operational procedure which forms part of the overall Assurance Framework. The Project Manager will determine which guidance documents that are to be complied with from the NHSS Publication and Guidance Index. At each stage of the project, proposals will be checked by the designers against each relevant

publication and areas where the design does not meet the guidance are identified and individually detailed as a derogation. The derogations will be reviewed by Clinical/Client, IPCN/Microbiology, local Estates and Facilities, Fire Safety, Health & Safety, eHealth, Directors of Capital planning and Facilities and Project Board. The ultimate responsibility for acceptance of the derogations will sit with the relevant NHS Lothian Safety Group.

Recommendation 5: The procurement process should accommodate a gateway meeting prior to Financial Close at which a common understanding of the health board's brief is agreed and recorded. *(NHS Lothian, Scottish Government / SFT, NHS Scotland Assure);* NHS Lothian have contacted relevant colleagues to discuss and agree how best to jointly take this recommendation forward, although it is anticipated that the process detailed in response to recommendation 4 should assist with this.

Recommendation 6: Role specifications for technical advisers within health boards must be clearly defined. Role of advisers be it advice or assurance – there should be a clear record of the advice requested, and the advice tendered. This should ensure that there is clarity around what expert input advisers are providing in circumstances where such input is required. This relates to the appointment of MML as the Board's Technical Advisors (*NHS Lothian*); NHS Lothian has previously developed a document outlining the role of technical advisors (and others) as part of the overall Assurance Framework (referred to below) to provide specificity.

Recommendation 7: The duplication of procedures should be avoided. It is important that procedures (including HAI Scribe and SHFN30) are reviewed, streamlined, and potentially merged, to ensure they are thorough and robust whilst avoiding duplication and unnecessary delay and cost *(NHS Scotland Assure*); NHS Lothian will support as required.

Recommendation 8: Role specifications for different disciplines involved in healthcare build projects in the NHS must be clearly defined. Role of IPC within built environment and demands on role – clear job and role specifications and protections of scarce IPC resources (*NHS Scotland Assure possibly with input from NHS Lothian*) This is included as part of the NHS Lothian Assurance Framework and will be updated specifically in light of the SHI recommendations in relation to IPC.

Recommendation 9: **Relevant training must be provided for disciplines involved in a healthcare build project.** IPC professionals should receive some basic training on the recommendations made by the NHS's own guidance for engineering systems, insofar as they are made in the interests of patient safety and care, before they are recruited to work on large scale hospital projects. Also, engineers would benefit from basic training on infection control principles and clinical requirements before embarking on new build hospital projects. Clinicians involved in projects would also benefit from basic training in the recommended output parameters of building engineering systems which have a direct bearing on the safety and care of patients in their departments (*NHS Scotland Assure*). NHS Lothian will support as required.

Recommendation 10: **NHS Assure should consider, in consultation with relevant stakeholders, whether and how to provide health boards with more detailed information about common errors and issues experienced by other health boards than is currently provided.** Previous versions of SHFN included information on common errors occurring in the design and construction of projects (*NHS Scotland Assure*); NHS Lothian Finance and Estate colleague have attended a number of NHS Scotland Assure virtual workshops on, for example, PFI projects and will be actively encouraged to attend and share information on future courses. NHS Lothian has also

welcomed and encouraged SFT input and support to its existing projects and would extend this to future projects as applicable.

Recommendation 11: There should be a contractual requirement for validation for revenue-funded projects. Whatever the method adopted for funding, contracts for the construction of new hospitals should permit independent validation by an Authorising Engineer, appropriately witnessed and with safeguards for all parties (*Scottish Government, SFT and NHS Scotland Assure*). Also, for revenue funded standard form of contract to be reviewed to strengthening the healthcare provider's power to ensure that the completed facility is fit for purpose and constructed in accordance with the healthcare provider's requirements, before the provider accepts handover (*Scottish Government, SFT and NHS Scotland Assure*). Again, NHS Lothians derogations management process referred to in recommendation 4 will assist in addressing this recommendation. In addition to design aspects, these principles could be further developed to address commercial aspects of a project.

- **Other Actions**

It is clear from the recommendations above that responsibility for the development of an appropriate action plan does not sit wholly with NHS Lothian and it is intended that a series of meetings take place with NHS Assure and Scottish Government to discuss these and any appropriate actions.

An initial meeting took place on 16 May 2025 with Scottish Government who advised that the Cabinet Secretary had accepted all the recommendations and had committed to return to parliament with a fuller update on progress prior to the summer recess.

Previously, NHS Lothian had developed and implemented an Assurance Framework in response to recommendations made in the Grant Thornton internal audit report – July 2020 -Governance and Internal Controls: Royal Hospital for Children & Young People, and Department of Clinical Neurosciences, Edinburgh.

The Assurance Framework is a suite of guidance documents developed to support the establishment and management of projects in a consistent manner, ensuring compliance with both internal and external governance requirements. Included within this is a high-level visual overview which includes the key assurance milestones anticipated for most capital projects at each stage of project delivery.

An Assurance Checklist provides details, but not exhaustive examples of important evidence that can be documented in relation to each of the key milestones of management control.

A previous paper presented to FRC in March 2024, outlined progress against these recommendations as detailed below. It should be noted that a number of these recommendations are consistent with the SHI recommendations and has allowed NHS Lothian to proactively address potential failings in advance of the SHI interim report publication:

Recommendation 1 – Strengthening internal control environment
This recommendation focusses on the governance of Capital Projects via the scheme of delegation and standing orders of the Board. It highlights the need for clear responsibility for both decision making in projects and also distinction between management and assurance. For future capital projects, an approved road map would give clarity of

management verses assurance responsibilities and set out the roles of individuals and committees in relation to the project.

The Framework document "Establishing the Project Board" outlines the roles, responsibilities and composition of the Project Board. Key roles and associated responsibilities are identified with those members identified to undertake the roles formally appointed by the Project Director. Further information of the roles can also be found in NHS Lothian's Scheme of Delegation. This aligns with SHI recommendations 6 & 8.

Recommendation 2 – Advisors, decisions and documentation
This recommendation is concerned with responsibility for making and approving decisions. It includes the requirement to provide clarity of decision making including how advice by technical advisors is formally captured, how technical assurance is assessed and how project changes and/or derogations are documented, assessed and approved.

In addition to the documents highlighted above, The Framework includes a Technical Assurance document. This recognises the importance of both supply chain partners and clinical colleagues in the effective design, delivery and management of capital projects and provides a common understanding of the key issues to be addressed. The document defines what compliance means in the context of NHS Scotland built environment projects and provides a Standard Operating Procedure and flowchart of the process to be followed in the case of derogation. This is consistent with SHI recommendations 4 and 6.

Recommendation 3 - Clinical involvement and guidance
A Clinical Engagement framework has been developed, to provide a clear pathway for clinicians to be involved in the planning, implementation, and review of future services within new premises to support the best possible patient outcomes.

The document provides a person specification for the role of the clinical lead and provides examples of roles and responsibilities. Whilst the role of Infection Prevention and Control (IPC) is not specifically included in this document, the expectation around their role in relation to being a member of the Project Board is included in the relevant framework document, and further clarity is required in relation to the inclusion of the relevant safety groups that are now established within NHS Lothian. Links to SHI recommendation 8.

Recommendation 4 – Technical Advisers
A guide to engaging with internal and external advisers and their assurance role has been developed taking into account the role of NHS Assure, as understood at this time. The guidance covers all Capital projects - as well as new builds it includes backlog maintenance/lifecycle replacement projects and large equipment replacement projects.

Key within this guidance is the assurance matrix which specifies when assurance may be required and a description of when, who and how that assurance can be obtained. Links with Recommendation 2. Again, this supports SHI Recommendation 6.

Recommendation 5 – Programme Boards and Governance
The role of the Programme Board is well developed in SCIM. This has been developed to meet NHS Lothian requirements, and clearly articulates the role of the Programme Board together with the agreed governance structure.

This document also differentiates between the main roles on the Programme Board, outlining the responsibilities and accountability of the SRO, Programme Director and Capital Planning Project Manager. Again, links to SHI recommendation 8.

Recommendation 6 – External governance arrangements
This recommendation recognises that a number of agencies beyond Statutory Authorities are involved in Capital Projects including Scottish Futures Trust, Health Facilities Scotland, Architecture and Design Scotland and NHS Scotland Assure and continues to evolve. Engagement will continue with NHS Scotland Assure regarding the streamlining of their processes and will be impacted by the current financial position with capital projects "paused" for at least the next 2 years.

In addition, a Framework document was developed to support Post Project Evaluation which includes lessons learned, with an update provided to FRC on an annual basis. Links to SHI Recommendation 10.

2.3.1 Quality/ Patient Care

As highlighted previously, the Inquiry has concluded that the RHCYP/DCN is a safe environment for patient care.

2.3.2 Workforce

Not relevant to this report.

2.3.3 Financial

No direct financial impact from this report.

2.3.4 Risk Assessment/Management

The purpose of the measures detailed in this report are to reduce the risk of errors in the specification of future health construction projects.

2.3.5 Equality and Diversity, including health inequalities

No impact assessment has been carried out or deemed necessary.

2.3.6 Other impacts

None

2.3.7 Communication, involvement, engagement and consultation

The paper does not relate to a service change and therefore the duty to consult does not apply.

2.3.8 Route to the Meeting

This is the first internal governance report as a result of the publication of the SHI interim report on 3 March 2025.

2.4 Recommendation

Awareness
Note the findings and recommendations from the SHI interim report with respect RHCYP/DCN.

Assurance
The actions taken to date to proactively address the recommendations in the report; and the proposed actions to be undertaken in the development of future health construction projects.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Executive Summary

Executive Summary

Background

On 4 July 2019 the Cabinet Secretary for Health announced that the opening of the new Royal Hospital for Children and Young People (RHCYP) and Department of Clinical Neuroscience (DCN) in Edinburgh would be postponed due to the fact that it had been discovered that features of the ventilation system of the hospital did not comply with the authoritative guidance provided by Scottish Health Technical Memorandum 03-01 (SHTM 03-01), "Ventilation for Healthcare Premises". The hospital had been due to open fully on 9 July 2019 and the announcement came the day before equipment, staff and patients were to begin moving onto the site. The financial cost of the delay was reported to be £16.8 million. In addition to this there can be added the commencement of periodical payments to the contractor, notwithstanding the new hospital not being occupied, and the need to retain in operation the facilities which the new hospital was intended to replace.

Following remedial works the hospital was only fully opened on 23 March 2021.

Patients and their Families

The decision not to open the hospital as planned had a significant impact on patients and their families, who were shocked, scared and deeply disappointed that long-promised new facilities were not to be available for the treatment, in some cases, of children suffering from very serious conditions.

Approximately 2255 appointments required to be rescheduled immediately. Of these, 1586 related to paediatric patients and 669 to DCN patients. NHS Lothian (NHSL) informed all patients of the fact that appointments would not be taking place at the RHCYP and DCN as planned. A strategy was put in place to seek to ensure that patients and families knew where to attend for treatment. No evidence was led of any adverse issues surrounding that communication.

In relation to the population which it was intended should be accommodated in the RHCYP, patient care continued in the Royal Hospital for Sick Children, a Victorian building at Sciennes Road in Edinburgh ("the Sick Kids"). While these facilities were suboptimal, there is no indication of adverse clinical outcomes for patients arising from the built environment of the Sick Kids. The issues were more acute for the DCN. It had problems with the water system, including contamination with Pseudomonas bacteria. There was a reduction in capacity for operations. There were therefore risks associated with its continued use.

No formal complaints were received by NHSL or the Scottish Government (SG) in relation to the decision not to open the hospital. However, patients and their families were left in the dark as to the reasons the RHCYP and DCN did not open as planned. Neither SG nor NHSL engaged with the Family Council, whose role was to "represent the patients and families and engage with those running the hospital", on matters relating to the delay. Communication with patients and families was unsatisfactory in this regard.

Recommendation 1: an effective communication strategy must consider the lived experience of patients and their families and their need for information, transparency and support.

- There is a cohort of young patients who are very seriously ill and spend a significant portion of their time, sometimes much of their lives, in hospital. They are supported by family members or guardians. The hospital becomes, for these patients and their families or guardians alike, their second home.
- The impact of unclear or poor communication on the wellbeing of patients and their families during what may already be a very difficult, emotional, and uncertain period in their lives, is not to be underestimated.
- Health boards must ensure that in the event of any adverse situation that could affect the wellbeing of patients and their families, there is a communication strategy in place to liaise with this crucially important group.
- The Scottish Government should ensure that this liaison is supported in any overarching communication strategy it may wish to introduce.

The Inquiry has heard further evidence with respect to communication with patients and families in relation to incidents at the QEUH and will make further recommendations in its final report.

Deliberate concealment or failure to disclose wrongdoing

There is no evidence indicating any deliberate concealment or failure to disclose wrongdoing. There is no evidence indicating that there were issues with organisational culture that discouraged staff from raising concerns. NHSL had whistleblowing policies in place during the project and there were a variety of channels through which concerns could be raised.

Remedial Works

Significant remedial works were carried out to the ventilation system at the RHCYP and DCN to remedy the non-compliance with SHTM 03-01. This involved extensive works to replace the ventilation system for the relevant areas. The results of independent testing, and the expert evidence heard by the Inquiry, indicate that the remedial works have been successful. The ventilation system in the hospital now complies with published guidance, including SHTM 03-01. The hospital environment is suitable for the delivery of safe, effective, person-centred care. No evidence is available to the Inquiry indicating any contrary position.

The issue

The issue that led to the decision to delay related principally to the design of the ventilation system of the paediatric critical care department of the new hospital and, in particular, the pressure differentials and air change rates that the system was capable of achieving. It is generally accepted that specialised ventilation systems in hospitals have a role to play in protecting vulnerable patients from airborne sources of infection. This is reflected in the recommendations set out in SHTM 03-01. The ventilation system in the critical care department of the newly built RHCYP provided fewer than half the recommended air changes per hour in certain rooms. The level of pressure differentials did not conform to the guidance in SHTM 03-01, although this had been risk assessed and found to be preferable for some clinical functions.

The ventilation system in the critical care department was therefore defective in the sense set out in the Inquiry's Term of Reference 1B, that is, in the period from its installation until the remedial works were completed, it did not conform "to relevant statutory regulation and other applicable recommendations, guidance, and good practice." It was not adequate and had the potential adversely to impact on patient safety and care.

Patient safety and care and the need to follow guidance

The evidence before the Inquiry indicated that safety is not a binary issue. Rather, there is a sliding scale of risk from safe to unsafe, which can be influenced by many factors. SHTM 03-01 sets out recommended parameters for the outputs of ventilation systems which reflects a general consensus about what is required in order to create an acceptable level of patient safety. These are consistent with parameters set in other countries. A departure from such recommendations, taken in isolation, has the potential to increase risk. However, other control measures can be introduced to make a space that does not have ventilation compliant with SHTM 03-01 sufficiently safe for the patients being treated there. For example, the Sick Kids had no mechanical ventilation but nevertheless provided a safe environment in which to treat patients.

The available evidence indicates that achieving 4 air changes per hour when 10 are recommended, creates an unacceptable level of risk to the safety of patients unless other sufficient control measures are introduced.

Scientific basis for the guidance

The scientific basis for the current recommendations as to particular ventilation parameters is limited and to a significant extent depends on work published in the early 1970s when hospital environments and other aspects of medical care were very different from what would be expected today. It is however generally accepted that a ventilation system that maintains changes of air within spaces in a hospital and pressure differentials between certain adjacent spaces has an important contribution to make, together with other available measures, to reducing the risk of healthcare associated infections. This is particularly so in the case of patients who are especially vulnerable to infection by reason, for example, of their compromised immune systems. For the present, there is a strong consensus that the recommendations in current guidance are appropriate and that material deviations from these recommendations will be likely to increase the risk of infection, albeit that the increase is unquantifiable and will be dependent on what other control measures are in place.

There would be value in carrying out further research into the healthcare benefits of ventilation output parameters and systems. Interest in the role of ventilation in infection prevention and control has been stimulated by the experience of the COVID-19 pandemic and research is ongoing. There has been an increased focus on air change rates and the use of technologies, such as air scrubbers (also known as portable HEPA[1] filter devices), to support existing ventilation systems by reducing the concentration of contaminants in the air. The NHS Scotland Assure Research Service is currently reviewing a potential project which aims to understand, from an engineering perspective, the various factors which may influence the quality of air, in order to develop the evidence base which might inform future research topics and guidance.

Interpretation of guidance

A guidance document providing recommendations which are intended to be apposite in a variety of situations, such as SHTM 03-01, requires interpretation. A lack of clarity in guidance introduces the risk of misunderstanding.

In the RHCYP and DCN project the subcontractor that designed the mechanical and electrical building services interpreted the guidance in such a way that it understood itself to be designing and delivering a ventilation system that was compliant with SHTM 03-01, whereas the weight of the evidence available to the Inquiry indicated that it was not.

1 high-efficiency particulate air or absorbing

SHTM 03-01 Parts A and B have been updated since the new hospital was opened. An interim 2022 version is available, and it is anticipated this will shortly be superseded by the further versions of Parts A and B currently under preparation.

Among other developments, the revised guidance improves clarity around recommended parameters. Such changes should reduce the risk of misunderstandings on future projects.

However, notwithstanding the greater clarity of the current text of SHTM 03-01, engineers and contractors should not be expected, on their own, to have the necessary understanding of the clinical requirements of a hospital to be able to identify the appropriate output specifications for all areas without the risk of misunderstanding. The provision, introduced by the 2022 version of SHTM 03-01 of a multi-disciplinary Ventilation Safety Group (VSG) to oversee the management of the ventilation systems of a healthcare provider is therefore to be welcomed. As part of its remit to assess all aspects of ventilation safety and resilience, the VSG should inform the design process for the construction and refurbishment of new and existing premises. It is to be expected that it will bring to bear relevant clinical, infection prevention and control, and engineering perspectives on the interpretation and application of guidance.

Arrangements for funding the project

The project underwent a change in funding model a few years after it began. Initially intended to be procured as a capital-funded project through Framework Scotland, the project was instead procured through a revenue funded route, using the non-profit distributing (NPD) model developed by the Scottish Futures Trust. Following a procurement process Lothian Health Board (NHSL) entered into a Project Agreement with IHS Lothian Limited (IHSL) for the construction of the new hospital and its provision for a period of years in return for annual service payments.

The overall contractual structure adopted for the financing and construction of the building (the NPD contract) did not directly contribute to the relevant defects that arose but it did introduce complexity to the resolution of issues when they arose.

The RHCYP and DCN project does however demonstrate that risks can arise if design or specification-related material generated in the context of one funding model is used, without proper assessment of the risks of doing so, after the funding model has been materially changed. An environmental matrix capturing the output specifications for the ventilation system, which was developed during the capital funded phase of the project, was used after a change to a revenue funded model without any sufficient assessment of why this was being done and how doing so might impact on parties' understanding of its significance and on their contractual relationship. The lack of a suitable risk assessment was the genesis of many of the problems that arose on the project.

Recommendation 2: A risk assessment is required if there is a change in the arrangements for funding a project.

- In situations where the funding model or procurement route changes mid-project, a risk assessment should be conducted to assess whether work done on the project up to that point is suitable for the revised project. The rationale for decisions taken in this regard should be formally recorded.
- The party carrying out the risk assessment should be the party on whom the potential risk falls, and which is in a position to mitigate the risk, unless there are sound reasons why this should not be the case.

Arrangements for the strategic definition, preparation and brief, and concept design

The presentation of NHSL's requirements for the ventilation system lacked clarity. This brief was provided to tenderers and then the preferred bidder during the procurement exercise.

NHSL was subject to an instruction from the Scottish Government to prepare room data sheets (RDS) using Activity Database[2] (or an equivalent) in order, for example, to brief prospective tenderers as to the ventilation outputs required for the various rooms of the new hospital. Room data sheets are the commonly used briefing tool for hospital projects. NHSL initially intended to produce room data sheets for the project. However, a decision was made instead to require bidders and, later, the preferred bidder to produce their own room data sheets. As part of the procurement process an environmental matrix (EM) was provided to bidders to assist in the preparation of room data sheets. This was the same EM included with a draft of the Board's Construction Requirements (BCRs).

There was a lack of clarity in relation to whether tenderers required to fully comply with published guidance (including SHTM 03-01) or whether the EM was a derogation from published guidance. IHSL (Project Co) understood the EM, which was issued both with procurement documentation and the Project Agreement, to be a statement of the ventilation outputs required by NHSL for the rooms in the hospital.

2 A briefing and design software system mandated for use in a letter to the chief executives of health boards (Chief Executive Letter), CEL 19 (2010).

That EM contained an error in relation to the parameters for certain critical care rooms. The error arose from a mistake in the transcription of information into the relevant cells of the spreadsheet in which the ventilation requirements for each room in the hospital were set out. Had this error not been made, problems with the ventilation system are unlikely to have arisen.

The potential for the error in the EM to give rise to the issues and defects which occurred was exacerbated by the decision that the Reference Design Team (including the engineers who produced the original EM) would be ring-fenced from the procurement exercise. They had no involvement in the procurement exercise and did not know how the EM would be used during that exercise. Bidders had no opportunity to discuss matters with the engineers who produced the EM. Had they been able to do so, the engineers would have been available to explain that the environmental matrix was not a fixed client brief. There was no scope for prospective bidders to discuss with the engineers whether the values which were set out in the EM, and did not comply with SHTM 03-01, were deliberate or a mistake.

A further feature of the arrangements that contributed to the issues with the strategic definition and brief was the lack of input from clinicians into the EM. The engineers who produced the EM used a “Room Function Reference Sheet” to summarise the environmental parameters for repeatable room types in the hospital. Once a room function was ascribed to an area, the ventilation parameters for that room function were used regardless of the area’s intended use. This judgment as to room function was made by an engineer with no clinical input and no input from an infection prevention and control specialist or other clinician. Had clinician input been obtained through dialogue with the relevant engineer, it is unlikely that inappropriate room functions would have been ascribed to rooms in the critical care department.

NHSL concluded the Project Agreement without providing and agreeing a clear and robust ventilation brief. This led to a continuing lack of clarity as to what were NHSL’s requirements for the ventilation system.

It is critical that a health board formulates and then articulates its requirements for the key building systems in a proposed healthcare facility (its “brief”) in terms which are full, clear, and unambiguous, and that the brief is finalised before a contract is signed and Financial Close is achieved. While development of the design can be carried over to a later phase, clarification of the health board’s brief should not be.

In a project for the construction or refurbishment of a healthcare facility, the health board, in consultation with relevant stakeholders and its clinical and technical advisers, is best placed to identify which output parameters of key building systems are required for the particular clinical uses it intends for the facility (and how these may change and develop). These should be specified by the board as part of its brief and not left to the judgment of the project company and its subcontractors during the design phase.

Identification of environmental output parameters should not be regarded as a matter of design; design should address how previously determined environmental parameters are to be achieved, not what should be achieved.

Recommendation 3: A health board's brief for the construction or refurbishment of a healthcare facility must be clear and identify the output specifications to be met in accordance with guidance.

- The brief provided by a health board should include a clinical output based specification for departments or other areas having a clinical function, which sets out the patient cohorts and activities which these areas are intended to accommodate, together with a Schedule of Accommodation identifying how areas are to be laid out, but, in addition, there must be documentation identifying the environmental parameters of all spaces within such areas, including the ventilation parameters. There should be precisely specified references to air change rates, pressure differentials, levels of air filtration and temperature, the specifications being set out either in room data sheets or in an environmental matrix which comprehensively and exactly identifies every space within the proposed building.
- In determining what the specified environmental parameters should be, the board should follow the recommendations in Scottish Health Technical Memoranda, including SHTM 03-01, in their most recent versions (which can and should be regarded as statements of current good practice), subject to any derogations agreed in writing by, in respect of ventilation, the health board's Ventilation Safety Group (VSG).
- In the event of a derogation being proposed, the relevant recommendation should be specifically identified and the derogation should only be agreed where there is convincing evidence that the proposal will provide a degree of safety no less than if the recommendation had been followed. If a proposed derogation is agreed, the reasons for it and any limitations on its application should be recorded, all as is currently required by SHTM 03-01 Part A Interim Version (February 2022) paragraph 4.10.
- In formulating its brief, the health board may, separately, choose to include a general obligation on the contractor to comply with SHTMs, but it should never rely on such an obligation as a substitute for a full articulation of the brief as set out above.

The guidance now states that there should be a body of evidence showing that the proposal for a derogation will provide a degree of safety no less than if the guidance had been followed, and that this should be recorded. However, there is no method designated for how derogations are agreed, captured and recorded. A number of witnesses spoke of the potential advantages of a standard form for derogations from guidance.

Recommendation 4: Development of a standard form for derogations from guidance.

- A standard form for derogations, for use throughout the NHS, would be beneficial.
- This should ensure that derogations are captured and recorded in a uniform way, bring clarity to how a derogation is agreed, and ensure that the approval of all parties is recorded in an appropriate and familiar way.

While, as a matter of contract, design responsibility may lie with the project company, ensuring that the health board's requirements are met should be regarded as a joint objective of parties to be arrived at collaboratively. Accordingly, the procurement process should accommodate a gateway meeting prior to Financial Close at which a common understanding of the health board's brief is agreed and recorded.

Recommendation 5: The procurement process should accommodate a gateway meeting prior to Financial Close at which a common understanding of the health board's brief is agreed and recorded.

Governance and operational management

The governance, oversight and support provided by the Scottish Government, and the governance and management structures and processes adopted by NHSL, appear to be in line with what is to be expected with such an infrastructure project. No suggestion was made that they were not fit for purpose. However, these structures and their operation did not prevent or detect the issue with the ventilation system. The following key issues were identified:

The role of advisers

NHSL inadvertently agreed, in Settlement Agreement 1 signed in February 2019, that multi-bed rooms in the critical care department should be provided with an air change rate less than half of that recommended in national guidance. In agreeing to this solution

the Board of NHSL believed it could take assurance from its technical advisers, Mott MacDonald Limited (MML) that it complied with the Board's Construction Requirements (which included a requirement to comply with relevant guidance). MML had made clear to the project team that it was not providing this assurance. Therefore, there was a lack of clarity at Board level as to what assurance could be taken from the advice provided by its technical advisers. Furthermore, much of the advice provided by MML was ad hoc and informal, and it was often unclear when and if NHSL was instructing, and when and if MML was providing, formal advice on technical matters which NHSL was entitled to rely upon. This issue was highlighted in a report by Grant Thornton following its audit of internal control and governance in relation to the project. NHSL has taken steps to address this but it is not apparent from the available evidence that any such changes have taken place more widely within NHS Scotland.

Recommendation 6: Role specifications for technical advisers within health boards must be clearly defined.

- A uniform policy or procedure should be adopted for boards undertaking new build hospital projects in relation to obtaining, and recording, technical advice on key issues.
- There should be a clear record of the advice requested from technical advisers and the advice tendered by them which should generate a sufficient body of evidence to support and document relevant decisions. This is particularly important where technical advisers work closely day-to-day with the health board's project team and are engaged in commenting on design or construction proposals. Such arrangements can lead to informality and a lack of clarity about the scope and role of the advice, and the reliance which can be placed upon it.

Assurance and support with respect to technical matters

The former Cabinet Secretary identified gaps in how the Scottish Government obtains assurance and provides support to health boards on technical matters.

Significant and substantial steps have been taken to address the gaps with respect to assurance, and to improve support to health boards on technical matters through the establishment of NHS Scotland Assure (Assure).

Some developments occurred during the lifespan of the project, for example the NHS Scotland Design Assessment Process (NDAP) was made mandatory in 2011 but was not applicable to the project given the stage it had then reached.

A range of procedures now exists to help ensure health board projects meet appropriate standards. One is NDAP. There is also a Sustainable Design and Construction Procedure (SDAC). Assure now conducts Key Stage Assurance Reviews (KSARs) on projects to seek to ensure that similar problems to those that arose on the RHCYP and DCN do not arise in the future.

However, the number of new procedures can be time-consuming and demanding to complete. There is a risk they become unduly bureaucratic and focused on process rather than substance.

Recommendation 7: The duplication of procedures is to be avoided.

- It is important that new procedures be streamlined, and potentially merged, to ensure they are thorough and robust whilst avoiding duplication and unnecessary delay and cost.
- In developing new procedures consideration must be given to the commercial and other pressures likely to affect projects.

A partnership approach was not consistently applied

There was guidance in SHFN 30 that there should be a partnership approach to new-build hospital contracts, with all relevant disciplines involved.

Despite input being provided by clinicians, infection prevention and control (IPC) specialists, estates officers and technical experts, the issue which led to the postponement of opening the hospital was not identified. This was because not all relevant disciplines were involved at the correct times.

Significant and substantial steps have been taken which facilitate a partnership approach to healthcare projects. The recently revised SHTM 03-01 introduces a Ventilation Safety Group which provides a forum for all relevant disciplines to meet, consider and approve ventilation decisions. This should avoid the type of issues which arose on the RHCYP and DCN project, arising in the future.

There is not always clarity however within SHTM 03-01 and SHFN 30 about the specific tasks each discipline should undertake and the extent of their involvement at various stages of a hospital build project. This risks undermining the partnership model as there is scope for

different disciplines to consider that a specific issue or decision is not within their sphere of knowledge, and/or that it is not for them to be actively involved in that issue or decision.

There is also a risk that disciplines are required to be involved at some stages of a project where this is not necessary or beneficial. This risks wasting limited resources.

The demands placed on infection prevention and control practitioners to apply their expertise to construction and refurbishment projects, to which have recently been added the demands associated with the Assure KSAR process, cannot help but be at the cost of diverting them from their core clinical duties. The Inquiry also heard evidence that the precise nature of these demands can seem to practitioners to be unreasonable.

Several witnesses raised concern about there being insufficient IPC staff to implement the procedures introduced by Assure. As is obvious, if there are insufficient personnel to resource the system, it will not work effectively.

It is acknowledged that work, for example to clarify role specifications, is already underway. The Chief Nursing Officer advised that it is proposed to produce a role specification for IPC teams. NHS NSS is currently in the early stages of producing a replacement for Frameworks Scotland 3, the primary procurement vehicle for major capital projects. Roles and responsibilities will be further considered as part of this work in collaboration with stakeholders. The Inquiry also heard evidence that NHS National Education Scotland is working on a knowledge and skills framework for the built environment. At a project level, it is the responsibility of the senior responsible owner, project director and project board, committee or steering group to define the specific roles, responsibilities and project governance. This should be done when setting up procedures such as the Project Initiation Document and Project Execution Plan.

Recommendation 8: Role specifications for different disciplines involved in healthcare build projects in the NHS must be clearly defined.

- What is expected by way of consideration and advice from individual disciplines at various stages of a project should be made clear. Priority is to be given to protecting scarce IPC resources.
- Job and role specifications for various disciplines, particularly infection prevention and control, should be identified.
- Consideration should be given to whether there are sufficient infection prevention and control professionals to resource the current system. It is less than satisfactory to impose further duties on a service which is already over-stretched.

Healthcare engineering does not feature in the mandatory training for microbiologists or IPC professionals. There is the potential for individuals with little or no training, or practical experience of the key building systems in a hospital (e.g. water and ventilation), to be asked to undertake key roles on projects. There are similar gaps in training provided for clinicians and engineers.

Recommendation 9: Relevant training must be provided for disciplines involved in a healthcare build project.

- Infection prevention and control professionals should receive some basic training on the recommendations made by the NHS's own guidance for engineering systems, insofar as they are made in the interests of patient safety and care, before being recruited to work on large scale hospital projects.
- Similarly, engineers would benefit from basic training on infection control principles and clinical requirements before embarking on new build hospital projects.
- Clinicians involved in projects would also benefit from basic training in the recommended output parameters of building engineering systems which have a direct bearing on the safety and care of patients in their departments.

Knowledge transfer arrangements and the opportunity to learn from the experience of QEUH

There were no systematic knowledge transfer arrangements in place to learn lessons from healthcare construction projects in the period prior to the creation of Assure although NSS would share relevant learning with health boards when considered appropriate. Therefore, any board faced with a new build hospital project would not have been able readily to access learning from previous projects.

Opportunities to learn from the experiences at the Queen Elizabeth University Hospital (QEUH) and avoid similar issues at the RHCYP and DCN were limited. There was little concrete evidence available to NHSL about the problems with the QEUH ventilation system, because these were not yet fully understood at the time when the RHCYP and DCN were being constructed. The Inquiry has yet to hear detailed evidence about the issues relating to ventilation at the QEUH. This conclusion will, therefore, be kept under review until this evidence is heard.

The landscape has changed with the creation of Assure as a specialist body which is intended to gather knowledge and experience about the construction of healthcare facilities and make it available to health boards undertaking new projects. This should allow lessons to be learned on an ongoing basis.

NSS is conscious of the value of making information on common project errors generally and readily available to health boards. On 13 December 2022 NSS published a paper, "NHS Scotland Assure Lessons Learned: Overview for the Interim Review Service". The Inquiry was advised that work is underway both to update this publication and to refine the mechanisms for sharing lessons learned.

The current examples of lessons learned however are referred to in very brief terms. While brevity is desirable, a list of problems identified by short bullet points provides little by way of learning as to why it was that the problems came about, how they could have been avoided and whether and how they were resolved.

Recommendation 10: NHS Assure should consider, in consultation with relevant stakeholders, whether and how to provide health boards with more detailed information about common errors and issues experienced by other health boards than is currently provided.

- NHS Scotland Assure could develop its documentation on learning from common errors to include information on why it was that the problems came about, how they could have been avoided and whether and how they were resolved.
- This information should be updated as new, significant errors are identified.
- This should focus on material errors which, if repeated, would have a material impact, and for which there are identified solutions which are capable of being readily implemented.

Assurance and evidence regarding the inspection, testing and functioning of building systems

The Project Agreement contained provisions relating to quality control and commissioning, and made provision for an "Independent Tester" who would provide a certificate confirming the hospital was complete in accordance with completion criteria. These completion criteria included the provision of commissioning data demonstrating compliance with the Environmental Matrix. The Independent Tester signed a Certificate of Completion on 22 February 2019.

NHSL considered that the system had been designed to fully comply with SHTM 03-01 except for known derogations for the neutropenic ward, and from 6 to 4 air changes for certain bedrooms. Other than these known derogations, NHSL did not understand there to be any difference between the contractual requirements and the requirements set out in the published guidance.

SHTM 03-01 (2014) pointed to the requirements for commissioning and validation, albeit that it had little to say about the detail of validation of critical ventilation systems beyond that it should be carried out, on behalf of the health board, by a suitably qualified independent Authorised Person.

There was a degree of uncertainty on the part of NHSL as to how the ventilation system would be validated in the context of a revenue-funded project. NHSL had responsibility for providing healthcare at the hospital. However, it did not own the building. The building was owned by IHSL. Mr Henderson, NHSL's commissioning manager, was therefore unclear as to what reports should have been instructed or obtained by NHSL as opposed to IHSL.

NHSL ultimately instructed IOM to conduct an independent validation of the ventilation system in line with SHTM 03-01. The testing conducted by IOM identified that for certain spaces in the hospital the pressure regime and air changes did not conform to the guidance set out in SHTM 03-01.

The updated interim version of SHTM 03-01 issued in 2022 provides detail that was lacking in the 2014 version which it supersedes. It explains that commissioning and validation are distinct processes. Following a section on commissioning, it addresses how validation should be carried out and by whom, beginning with a clear recommendation at paragraph 12.1 that all new and refurbished ventilation systems should be independently validated prior to acceptance by the client. The purpose of validation is identified in the current version of SHTM 03-01 as proving prior to handover that the system in its entirety is fit for purpose and achieves the operating performance originally specified. What is not addressed is the possible disjunction between this purpose and the terms of the contract for the construction of the relevant facility.

Recommendation 11: There should be a contractual requirement for validation for revenue-funded projects.

- Whatever the funding method, contracts for the construction of new hospitals should permit validation, appropriately witnessed and with safeguards for all parties, to be undertaken on behalf of the health board in accordance with the guidance contained in SHTM 03-01 (2022) with a view to a report or reports being sent to the board's lead project manager.
- It is acknowledged that simply to permit a healthcare provider to carry out independent validation does not bring with it any contractual consequences in the event of failure to meet requisite standards; it is merely a way of providing the client with information. I see there to be merit in considering whether the standard form of contract for revenue-funded projects requires more radical revision, with a view to strengthening the healthcare provider's power to ensure that the completed facility is fit for purpose and constructed in accordance with the healthcare provider's requirements.

Summary of Recommendations

- **Recommendation 1:** An effective communication strategy must consider the lived experience of patients and their families and their need for information, transparency and support.
- **Recommendation 2:** A risk assessment is required if there is a change in the arrangements for funding a project.
- **Recommendation 3:** A health board's brief for the construction or refurbishment of a healthcare facility must be clear and identify the output specifications to be met, in accordance with guidance.
- **Recommendation 4:** Development of a standard form for derogations from guidance.
- **Recommendation 5:** The procurement process should accommodate a gateway meeting prior to Financial Close at which a common understanding of the health board's brief is agreed and recorded.
- **Recommendation 6:** Role specifications for technical advisers within health boards must be clearly defined.
- **Recommendation 7:** The duplication of procedures is to be avoided.
- **Recommendation 8:** Role specifications for different disciplines involved in healthcare build projects in the NHS must be clearly defined.
- **Recommendation 9:** Relevant training must be provided for disciplines involved in a healthcare build project.
- **Recommendation 10:** NHS Assure should consider, in consultation with relevant stakeholders, whether and how to provide health boards with more detailed information about common errors and issues experienced by other health boards than is currently provided.
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