April 2022

The Lothian Strategic Development Framework

Lothian Health & Care System:

- East Lothian Integration Joint Board
- Edinburgh Integration Joint Board
- Midlothian Integration Joint Board
- West Lothian Integration Joint Board
- NHS Lothian

System Vision:

Citizens lead longer, healthier lives, with better outcomes from the care & treatment we provide

We connect health and social care services seamlessly, wrapping around the citizen in their home

We improve performance across our system, with better experiences for citizens and those who work for and with us

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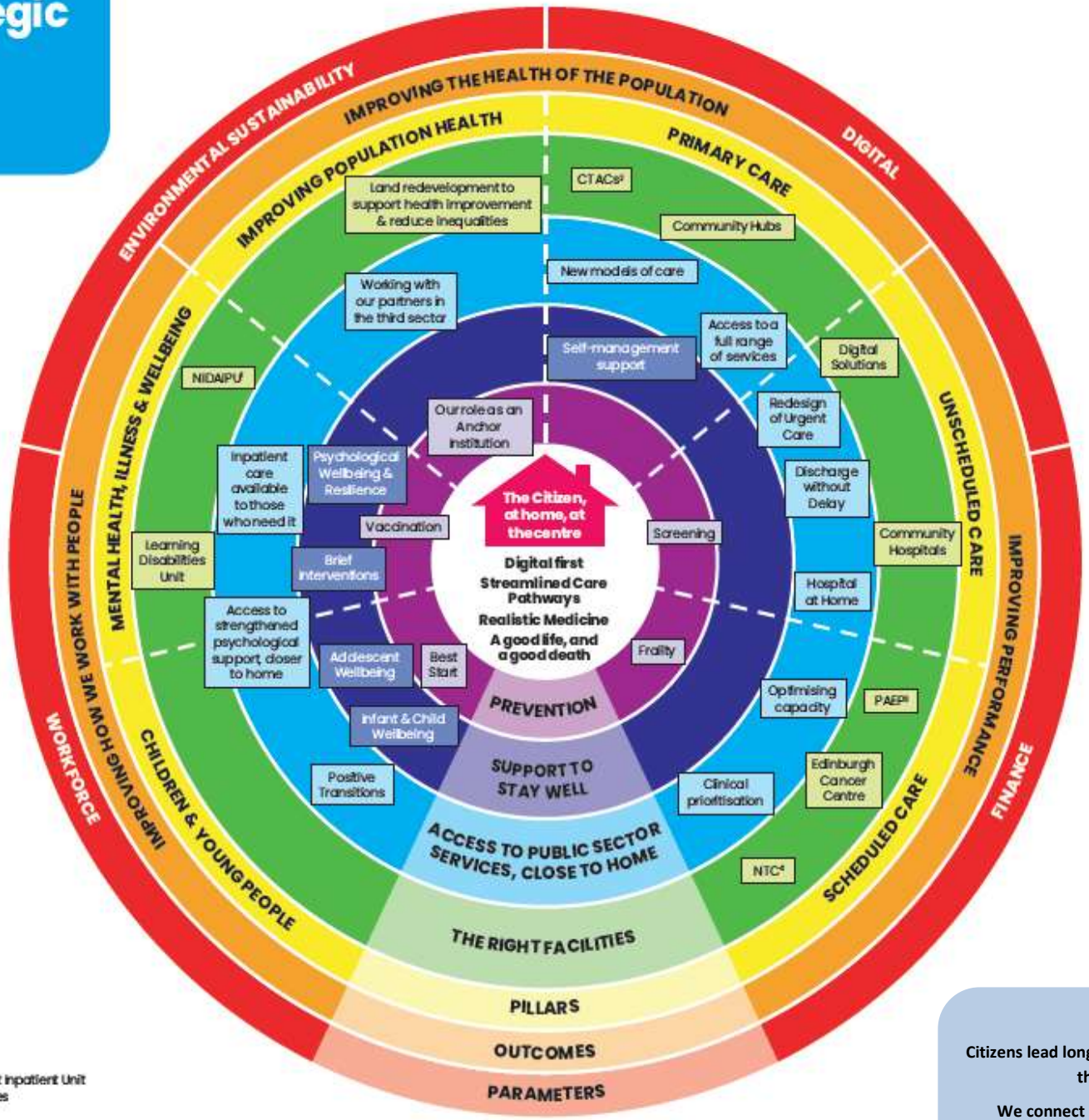

MIDLOTHIAN INTEGRATION JOINT BOARD

WEST LOTHIAN INTEGRATION JOINT BOARD

1. National Intellectual Disability Adolescent Inpatient Unit
2. Community Treatment and Care services
3. Princess Alexandra Eye Pavilion
4. National Treatment Centre

NHS LOTHIAN

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About this document

This document is the Lothian Strategic Development Framework and lays out what we want to happen across Lothian's Health and Care system over the next 5 years, up to and including the financial year 2027-28. It is a collaboration between the bodies with responsibility for the planning, commissioning, and delivery of health and care services in the Lothians;

- East Lothian Integration Joint Board;
- Edinburgh Integration Joint Board;
- Midlothian Integration Joint Board;
- NHS Lothian;
- West Lothian Integration Joint Board.

Collectively, we refer to these five organisations as the Lothian Health and Care System (LHCS).

Our vision for the system is that;

> **Citizens live longer, healthier lives, with better outcomes from the care and treatment we provide**
>
> **We connect health and social care services seamlessly, wrapping around the citizen in their home**
>
> **We improve performance across our system, with better experiences for citizens and those who work for and with us**

We call this document a Framework because it knits together the five interdependent approaches of the collaborating LHCS bodies and lays out a basis for us to collectively move forward. It represents our high-level thinking of what we want to happen and what we want to do over the next five years, but this Framework lays out a flexible and adaptive approach around key principles, assumptions, and fixed points.

We do need to be candid that as we are publishing this, public services are under enormous strain. The NHS and services which are crucial to promoting health, preventing disease, and providing treatment are no different. The ongoing challenges of the pandemic, combining the disease, the impact on our workforce, and "catching up" with other diseases, means that we are in a position where performance and outcomes are not what we would want them to be. However, we believe that the principles and assumptions we make support a general direction of travel in a post-COVID world, and that we can adhere to these.

As you read through this Framework, you will see some words and phrases are underlined. These are links to associated documents with much more detail on that particular word or phrase. These may be detailed plans, or they may be the glossary of terms we use to aid understanding.

The Framework describes;

- What we are trying to achieve;

- Where we are now and the impact of the COVID-19 pandemic on the services we provide;
- Our principles, assumptions, and fixed points;
- The needs of our population, and the longer-term demographic challenges we face;
- The parameters of our system in terms of our people, our financial resources, and our infrastructure;
- The actions we will take to deliver over the next five years across a range of settings;
    - Population health and anchor institution status;
    - Children and Young People;
    - Mental Health, Illness, and Wellbeing;
    - Primary Care;
    - Unscheduled Care;
    - Scheduled Care

We also present supporting assessment and evidence which outlines the parameters we work within;

- Our **workforce** context, where we have a population growing rapidly and aging simultaneously. We note that across the country we have a reducing number of people of working-age, which means there are fewer people to work in health and care services and settings;
- Our **financial** context, where we have an accumulated financial gap as a result of the national funding formulas as they have applied to the public sector in the Lothians, and growing financial challenges from new drugs and treatments;
- Our **capital** context, where, while we have significant Scottish Government investment pledged for large new clinical facilities such as a new Cancer Centre, a new Eye Pavilion, and a new short-stay scheduled treatment centre at St John's Hospital, we do not as yet have investment for improvements to the Royal Edinburgh Hospital and have a significant challenge to fund other community facilities;
- Our **digital** context, with technology more and more capable and supportive of clinical practice and practitioners;
- Our **environmental** context, where we have an obligation to ensure that we reduce our carbon footprint. 5% of all travel in the UK is healthcare-related.

NHS Lothian subscribes to a clear set of values which underpin everything we do. Each of the four IJBs in the LHCS has their own values as described in their individual strategic plans, which are under review, but those of NHS Lothian speak to the core of what we are committed to;

- Care and compassion
- Dignity and respect
- Quality
- Teamwork
- Openness, honesty, and transparency

What are we trying to achieve?

The health and care system is a key underpinning of the success and prosperity of Scottish society. To this end, it contributes directly to the National Outcomes which drive the national Programme for Government. At a more local level, our organisations seek to work together to improve the health and wellbeing of a population of nearly 1 million. Our population has grown by 12% since 2011 and we expect it to grow by 8% over the next ten years.

Our aims and objectives for the next five years are;

- An improvement to population health;
- Outcomes we aim for in how we will work with citizens and with patients;
- To deliver nationally-prevailing performance measures;

There are some broad themes about how we will work that are central to our approach;

- We want to move care closer to home where we can. The citizen's home should be the key fixed point for how services are designed and delivered. We believe that we should have very good clinical reasons to ask someone to come to one of our facilities;
- We see an ever-increasing role for self-care by citizens, and of their deeper engagement in the prevention of disease. We see this as particularly valuable in the provision of services for children and young people;
- We want to embed things we have learned from the covid-19 pandemic in everything we do;
- We want to work ever-closer with all of our partners in the public square – local authorities, the third sector, the Scottish Government, educational institutions, and the private sector – to maximise and augment the positive impact each sector can have on citizen's lives. We see this as crucial to meet our aspirations to work as an anchor institution; Particularly important in our future work will be Scottish Government policy changes, and the most obvious impact of this is in the development of the National Care Service;
- We will work to improve our health and care facilities whenever and wherever we can, and remain committed to our campuses at the Royal Edinburgh Hospital, Royal Infirmary of Edinburgh, St John's Hospital, and the Western General. This will mean some new buildings to replace of buildings which are no longer suitable ;
- When we do need to build new facilities, we want to work with our partners from across the public square to ensure that these are multi-use and bring together the services citizens access on a regular basis. It doesn't matter to the citizen what the nameplate on the building says – it matters that we make it easier for the citizen to get the right help;
- We will increasingly use technology and innovation to support our delivery of treatment and care. Citizens will see this in the increased use of digital communications technology to provide appointments where previously they had to travel to outpatient or general practice settings;
- Recovery from the impacts of the COVID-19 pandemic will take years, not months, and this will mean longer waits for scheduled care. We will work to prioritise treatment for cancer and life-threatening illness in this context.

Where are we now? The impact of COVID-19

We are all aware of the direct impact of COVID-19. It will be rare to not know someone who has been infected, and unusual to not know of someone who has been seriously ill, or died, as a result of the disease. Our people worked, and continue to work, to manage the spread of the disease and the impact of the illness where it appears. We continue to run the largest vaccination programme in history, and our hospitals continue to see high numbers of people admitted to wards and to critical care units.

What is less clear to many is the set of associated impacts, which include but are not limited to;

- A health debt built up in people who did not access our services during the most acute lockdowns, and who now have conditions which are more advanced than they would have been previously;
- A rapidly-increased series of waits for scheduled care – hip replacements, cancer treatments, outpatient appointments;
- Severe difficulties for many independent-sector care providers, who support people in their homes. Many of these organisations are struggling to sustain themselves;
- Impacts on the people who work in our services, ranging from exhaustion, through stress-related mental illness, to a desire to retire early or reduce their hours to protect their own wellbeing;

Changes in how society operates that previously may have taken years have happened in days and weeks and we have delivered some services in very different ways, with a much greater reliance on digital services, on self-management, on being remote from buildings, and on explicitly prioritising some forms of care above others. LHCS has also shown an ability to re-engineer and re-provide at a pace that hasn't existed previously. This work has also shown the importance of working effectively and at speed with our partners in the rest of the public sector, the third sector, and the private sector.

Before the pandemic we did find it increasingly difficult to meet national targets due to the nature of our funding settlement. This funding settlement sees us receive less revenue than we should according to the national resource allocation framework set by the Scottish Government. This has, over time, widened the gap between the money we should have, and the money we do have. Similar challenges apply for our local public sector partners and this, in particular, has contributed to widening inequalities.

We also have the same problems as before the pandemic in terms of finance and the fabric of our buildings, and the pressure put upon us by the changing demographics within the Lothians. We also need to step up our efforts to improve quality and play our part in tackling climate change.

Perhaps our biggest concern in sustaining and improving our services is ensuring we can recruit and retain an appropriately-skilled workforce. The demographic challenges we face in caring for and treating an expanding and aging population also apply to our workforce. Some key services are facing particularly acute challenges, where the workforce is unbalanced and where not enough young people are joining the workforce. These pressures mean that we need to radically redesign some of our services in order to sustain them.

How we built the LSDF

The extant NHSL strategy – *Our Health, Our Care, Our Future* – was intended to cover the years 2014-2024, which would have coincided with the end-point for the next iteration of IJB Strategic Plans. However, the impact of first wave of the pandemic was such that during the late summer of 2020, we began working with the Royal Society of the Arts, using their Future Change Framework, to see what we had learned. We were also open to the idea that, as well as the vast range of problems and difficulties that the pandemic had wrought, we had also learned a lot about ways we could positively change how our system works and the services we provide.

Based on this work the NHSL Board adopted a series of principles and assumptions, and agreed fixed points to give us a skeleton to work within.

We have also worked with our finance, workforce, and other teams to identify the parameters of what can be done over the next five years. We have worked on the basis of the best currently-available information on these areas and have drawn our conclusions in good faith, and are keen to be as transparent with citizens as we can be.

Over the last 3 years, we have established a series of programme boards which bring together the leadership teams from our IJBs and from NHSL to map out our actions to improve services. These programme boards – for scheduled care, unscheduled care, and mental health, illness, and wellbeing – have worked over the last year to build plans for the next five years to deliver on our aims and objectives. In addition, we have worked with partners to develop plans for primary care and children and young people's services .

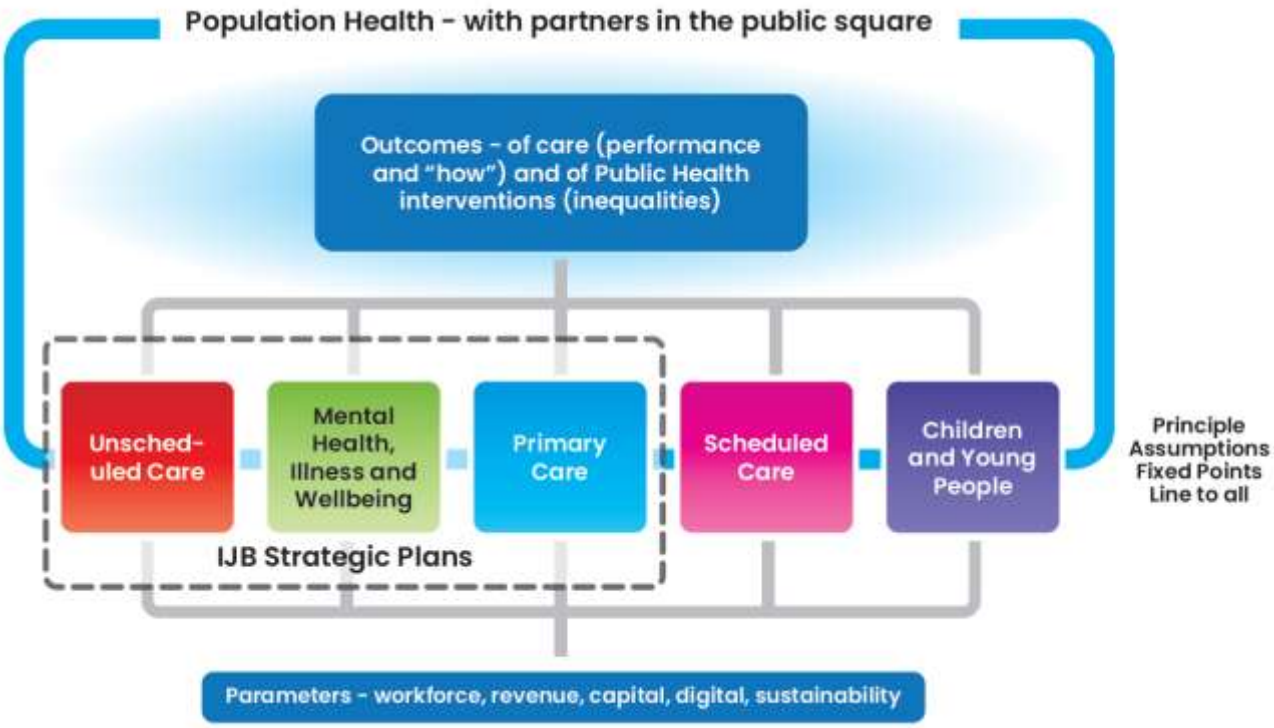
We have worked to ensure that we take account of citizens' views in our work so far, but it is really important to remember that what is presented here is meant to start a much broader conversation with citizens and partners. Not everything we have summarised in here will be "right", and some things are not completely clear to us yet. We need the help of citizens and partners to work to get the best answers we can, and so this document is really just the first instalment in a commitment we are making to work more closely with citizens and partners going forward.

Figure 1: Engagement

Purpose	It is important that we don't do what we think is right without seeking the views of the people we work for. Engaging our communities in this work will help us to understand what is important to people who live in Lothian, and help to inform the choices we make.
Expectations	By sharing with residents what we and our partners have learned during the pandemic, we hope to build understanding about how we might tackle the challenges we face to deliver efficient and effective services to support good health and wellbeing in future. By seeking views on what is important to our residents, we hope to shape our ideas to ensure they meet the needs and wants of our communities. By engaging in dialogue with our communities, we hope to envisage new models of wellbeing and care, and to begin to discuss what we might let go of in order to make way for new innovations and models. By working with partners across the public and third sector, we hope to improve understanding of our shared challenges, and tease out synergies and opportunities for collaboration to address these challenges. Some elements of our future direction are fixed by policy directives, and will be out of scope of this work. We will be open about what these elements are.
Anticipated Outcomes	**For Lothian residents:** Able to influence choices within a harsh reality, informed by relevant data and information. **For NHS Lothian:** Confidence that our future direction is cognisant of the priorities of our communities, and focussed on delivering the outcomes they value.
Actions	**Inform:** We will share information about the LSDF via our website, social media and by engaging with the media, and invite local networks to participate in engagement opportunities. **Engage:** We will review existing local and national engagement activity, and distribute an online survey to seek a broad understanding of what is important to people in Lothian, in terms of health and care. Working with the RSA, we will bring together partners from across the public and third sector to understand our shared challenges and tease out synergies and opportunities for collaboration. Working with the RSA, we will convene a reference group to engage in a dialogue with residents, to envisage new models of care and consider what we might let go of to make way for new innovations.

Taken altogether, the work we have done builds into a strategic framework where the outcomes we aim to achieve are delivered by our 5-year plans for scheduled care and children's services - where NHSL is the planner and commissioner – and for unscheduled care, primary care, and mental health, illness, and wellbeing – where our IJBs are the planners and commissioners. These plans are sensitive to and supported by our parameters – workforce, revenue, capital, technology, and sustainability. Figure 2 below shows how this all fits together.

Figure 2: How the Lothian Strategic Development Framework fits together



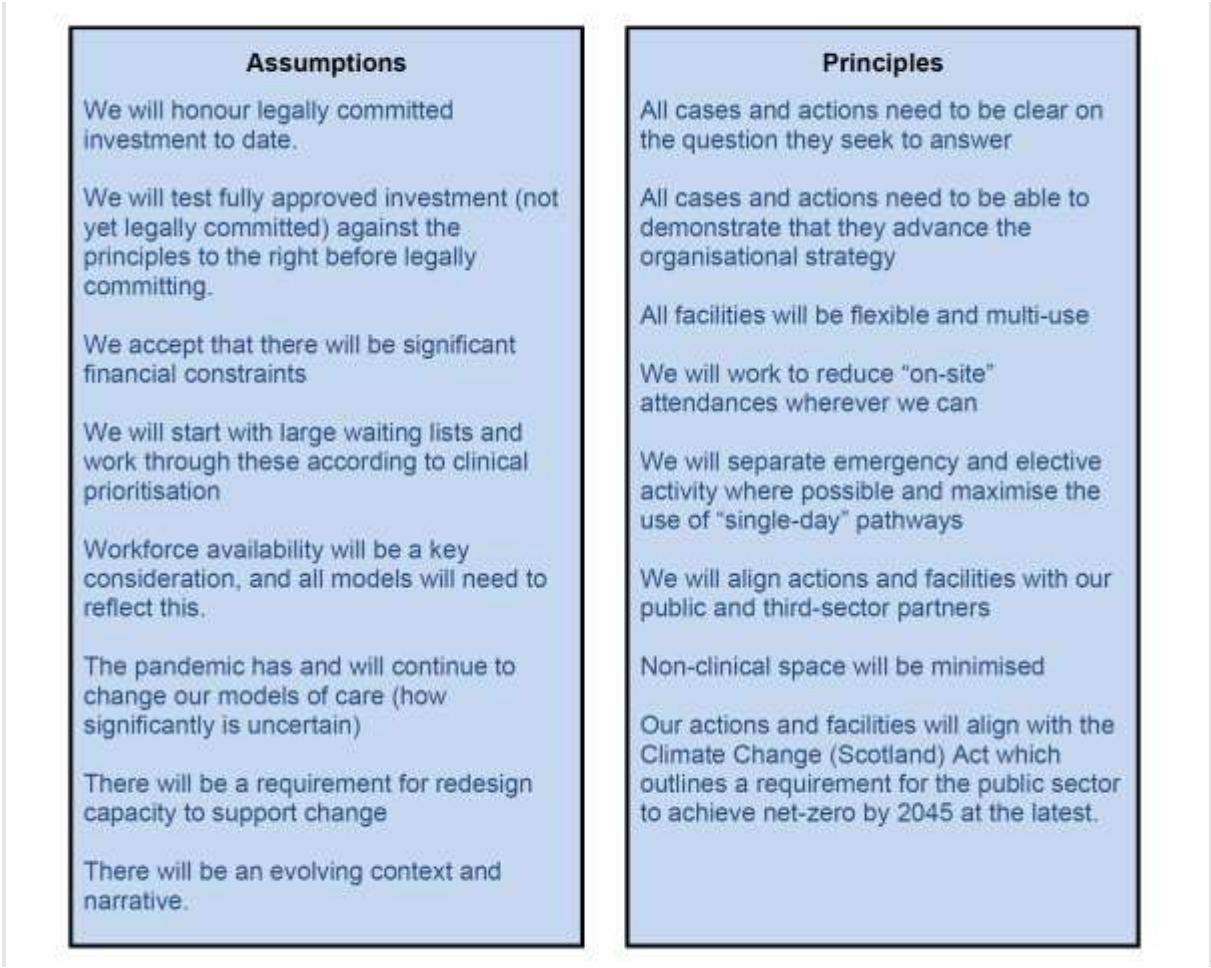
Our principles, our assumptions, and our fixed points

We have agreed a series of principles and assumptions to guide our work in developing this strategy and delivering it over the next 5 years. These will help us deliver on the outcomes of care we are committed to delivering. These are shown in Figure 3, on the following page.

We also have a series of fixed points that we will work with over the next five years. The most important of these fixed points is the citizen's home, and we want to make sure that everything we do is focussed on getting people the help they need in their own home, if at all possible. We believe that we will continue to work to enhance our four major hospital campuses as the backbone of our acute hospital system.

1. We will retain the four campus sites – The Royal Edinburgh Hospital, the Royal Infirmary of Edinburgh, St John's Hospital at Howden, and the Western General Hospital.
2. Per *the Lothian Hospitals Plan*, we will use the sites as;
    a. The Royal Edinburgh Hospital will be the specialist acute mental health facility with specialist learning disabilities and rehabilitation services;
    b. The Royal Infirmary of Edinburgh will be South-East Scotland's major unscheduled care centre, incorporating the Major Trauma Centre, and specialist neurosciences and children's services;
    c. St John's Hospital will be West Lothian's district general hospital, with specialist regional surgical services and a short-stay elective centre;
    d. The Western General will be South-East Scotland's Cancer Centre, with breast, urology, colorectal surgical services on-site
3. We will have community inpatient facilities in East Lothian, West Lothian, and Midlothian;
4. We will only provide general anaesthetics at RIE, SJH, and WGH, with provision at REH to support treatments such as electro-convulsive therapies;
5. We are clear that the Western General will be the home for the new Edinburgh Cancer Centre, which will be the Cancer Centre for the South-East of Scotland;
6. We will <u>not</u> provide high-secure forensic mental health accommodation
7. The strategic planning and commissioning of unscheduled care, primary care, general practice, rehabilitation, and mental health services are delegated to the four IJBs – East Lothian, Edinburgh, Midlothian, and West Lothian
8. All other services are the strategic planning and commissioning responsibility of NHS Lothian.

Figure 3: Assumptions & Principles



Specific proposals for change

We have a system serving a million people, employing over 35,000, and with budgets totalling over £2billion, would have a broad range of actions it intends to take forward. There is a lot of detail provided in the supporting documents, but key highlights are;

- We expect to increasingly emphasise prevention and self-management of disease, supporting this with community services and new technologies like closed-loop insulin pumps;
- We will work to develop our ways of accessing our services and this will mean an increasing use of digital communication technologies for outpatient and primary care services, in particular;
- Where we need to replace buildings that we deliver community services in, we will look to bring as many services together from across public services together in community centres and use these as flexibly as we can;
- We will continue to change the model of care in primary care generally and general practice in particular, emphasising the role of the GP as the "expert medical generalist" and developing alternatives delivered through pharmacy, nursing, mental health, physiotherapy, and other services;
- We will work to strengthen communications and links between the different parts of our system to deliver streamlined pathways for citizens;
- We will continue with our work to provide more services for people with mental health needs or learning disabilities in the community. This includes increasing the number of community placements and reducing the size of the Royal Edinburgh Hospital;
- We want to move from buildings that are no longer fit for purpose and utilise land to create modern, flexible, multi-use, accommodation to replace them. This affects the Royal Edinburgh Hospital, and a series of community facilities in West Lothian, East Lothian, and the City of Edinburgh. It will also see us develop business cases for REH, for a new West Lothian Community Hospital, and for the development of East Lothian Community Hospital, as well as community treatment centres;
- We want continue to implement systems to schedule urgent care, with citizens given same or next-day appointments to attend, and will work with NHS24 and the Scottish Ambulance Service to deliver this;
- We want develop a new Cancer Centre on the Western General Hospital campus;
- We want to deliver surgical treatments where the patient will stay less than 48 hours in hospital in the new National Treatment Centre at St John's Hospital in Livingston. This will include procedures in gynaecology, general surgery, colorectal surgery, urology, and orthopaedics;
- We want develop a new specialist eye hospital in Edinburgh to replace the Princess Alexandra Eye Pavilion;
- We will work to improve the efficiency and productivity of our elective services, but our recovery from the impact of COVID-19 will take years, and not months or weeks, to reach the levels we would want;
- We will explicitly consider the sustainability impacts of our services and commit to deliver the commitments made by the Scottish Government on carbon zero service provision.

Working to become an Anchor Institution

LHCS has a combined spending power of £2 billion, employs roughly 35,000 people, and serves a population of nearly a million people. The actions we take are fundamentally focussed on improving the health and wellbeing of our population, as we have described in the rest of this document. We will continue to undertake our work in preventing ill-health through our services, but we also recognise that prevention needs to work beyond service provision. Engaging with and influencing the wider social determinants of health such as housing, employment, income, sustainable placemaking and sustainable transport systems is crucial to population health improvement.

A key element of this is recognising the LHCS can have a direct impact through our spending power, our providing jobs, and how we work with partners to maximise our economic "weight" for social good. The LCHS should seek to be a good neighbour, a good consumer, and a good employer by deploying its influence in purchasing and procurement, its assets and facilities, its significance as a regional employment hub to impact positively the health and wellbeing of the local population. The Sustainable Development Framework is a key component of this approach. We will also bear in mind our Anchor Institution responsibilities in the disposal of property we no longer have a use for. As an example, we would want to influence the ultimate use of the Astley Ainslie site, considering the need for affordable housing that many of our health and care staff need access to.

This work comes under the banner of seeing LHCS as anchor institutions for our communities, where we impact on lives not just through the way we provide care and treatment but through our engagement with health in all policies at local partnership, regional and national level to shape and influence a health promoting environment across Lothian.

Our analysis is that several key actions are fundamental to how we can deliver on this aspiration;

- Focussing on providing the best possible start to life, as outlined in the Children and Young People's section of this LSDF;
- Focussing on supporting people in their own homes and neighbourhoods, as described in our Mental Health, Illness, and Wellbeing, Primary Care, Unscheduled Care, and Scheduled Care sections;
- Maximising income for the low-paid, some of whom are within our own workforce;
- Becoming accredited Living Wage employers, and working to ensure that our suppliers and contractors are also Living Wage employers;
- Ensuring that our community benefits clauses really provide benefit for our population;
- Ensuring that NHS Lothian contributes actively to emerging community planning partnership discussions about community wealth building by utilising its influence as an anchor institution
- Considering whether and how our buildings can bring together a broader range of public services to deliver on shared aims;
- Considering whether and how our land disposal and redevelopment can support a larger series of broader public goals including population health improvement and reduction of health inequalities.

Children's Services

We see the provision of appropriate support, care, and treatment when required for children as the major investment we can make in the health of the Lothians. To this end, we will continue to work closely with our partners in education, the third sector, social care, and with parents and families, to ensure that we provide the best possible support for our young people.

Foremost in this area is the radical redesign of mental health services for children and young people. It is well-known that our performance in providing treatment for children waiting for psychological support has not been at the level we would have wanted for some time. Our analysis shows that this is at least in part because the other layers of care have weakened, and in turn that our highly specialised services are unable to cope. We have therefore set out to strengthen the less specialised levels, and will work to provide support closer to where young people are – in communities, in schools, in youth clubs, and by remote means where appropriate.

We will design and implement a new pathway for children and young people with neurodevelopmental challenges.

Children & Young People 5 Year Plan

Year 5	• Next cycle of Statutory Plans commenced. • Early Intervention and prevention core to delivery of Children and Young Peoples services. • Improved outcomes for mothers and babies; reduced developmental concerns; improved educational attainment & positive destinations • Improved partnership working and commissioning. • UNCRC drives service change.
Year 2/3	• Delivery of Statutory plans focusing on NHSL priority areas • Incorporation of UNCRC • Best Start Workforce models implemented • National neonatal pathway established • Neurodevelopmental service created • Improved family support models developed with Local Authority and 3rd sector partners • Bespoke adolescent care models developed
Now and Year 1	• LSDF process to identify priority areas for NHS Lothian: Early years, support for families and tackling poverty; Mental health and wellbeing; School readiness, educational attainment, and positive destinations; The Promise: supporting care experienced children and young people • Start delivery of 4x Children's Services Plans, 4x Corporate Parenting Partner Plans, Child Poverty Plans. • Develop NHS Lothian Corporate Parenting plan and governance • Implementation of Best Start Strategy – midwifery workforce model • Delivery of RMP4 through Specialty Level Recovery Plans
Now (Year Zero)	• Unstable baseline (demand & workforce challenges) • non-compliance with some performance indicators & worsening position • Complex planning landscape: 4 x Local Authority partners + statutory requirement to produce multiple plans on 3-year cycle

Mental Health, Illness, and Wellbeing

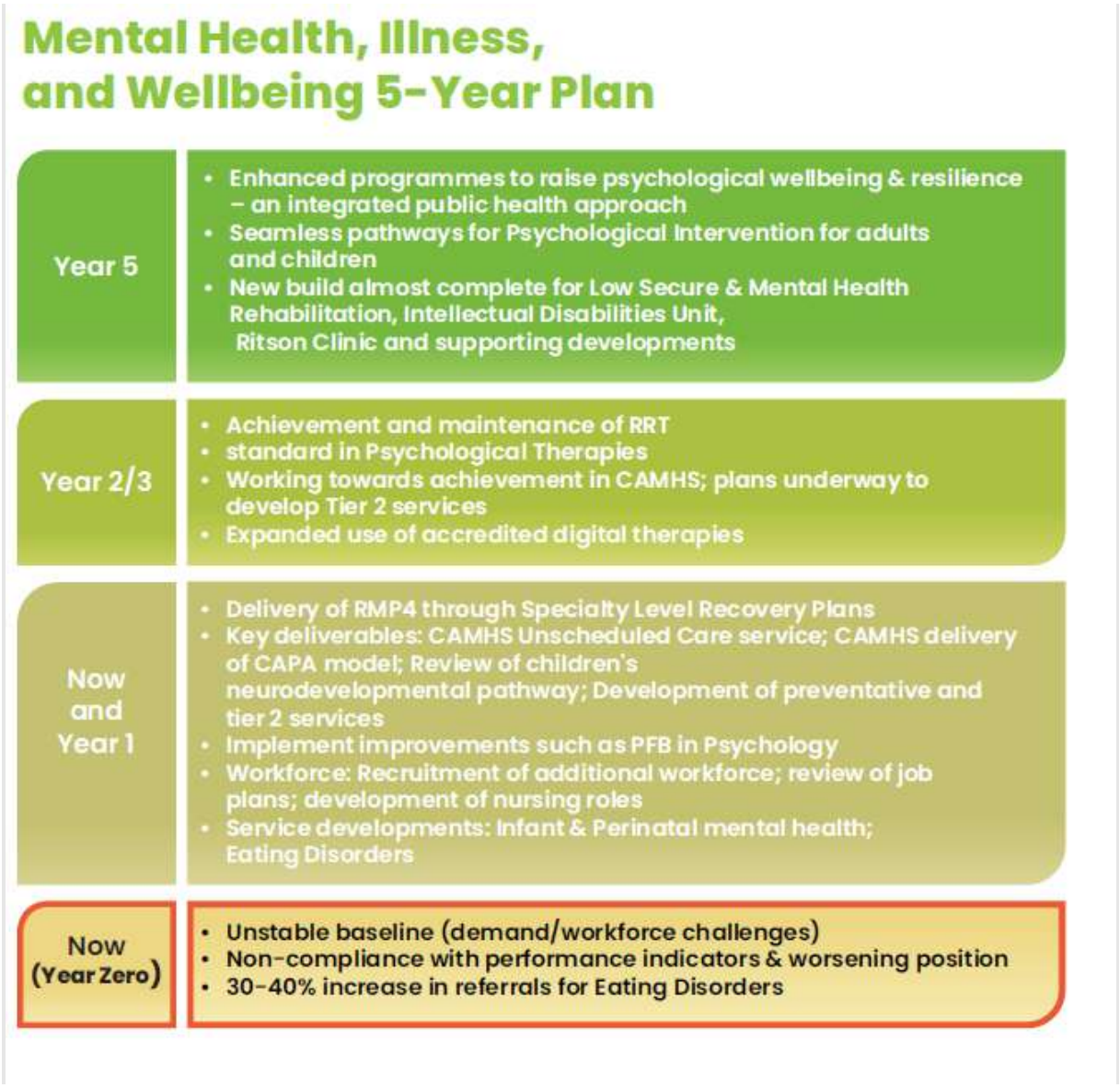
All four of our IJB areas are committed to developing programmes focussed on sustaining people's wellbeing. These programmes are tailored to the particular circumstances of each community, but bring together NHS services, volunteering, lived experience, the third sector, local authorities, and the private sector to expand access for support at a less acute level.

We will invest to expand our capacity in respect of psychological therapies, with a focus on meeting the Scottish Government's target that no one should wait longer than 18 weeks for this key form of treatment.

All five partners in the Lothian system are committed to improving the standard of facilities provided for inpatient treatment at the Royal Edinburgh Hospital, which looks after patients diagnosed with serious mental illness. We aim to commence construction of new facilities for mental illness rehabilitation, and of a new national unit for young people with learning disabilities and mental illness, by 2024.

The changes to the Royal Edinburgh Hospital come out of our desire to implement a radical redesign of care. For people with learning disabilities, care will increasingly be provided away from hospital, in homes with support provided by care workers, as opposed to doctors and nurses.

Similarly, our 4 IJBs will invest heavily in providing non-medicalised care and support outside of hospital for those recovering from long-term mental illness, with people settled into new homes and supportive environments designed around them.


Mental Health, Illness, and Wellbeing 5-Year Plan
Year 5
• Enhanced programmes to raise psychological wellbeing & resilience – an integrated public health approach
• Seamless pathways for Psychological Intervention for adults and children
• New build almost complete for Low Secure & Mental Health Rehabilitation, Intellectual Disabilities Unit, Ritson Clinic and supporting developments
Year 2/3
• Achievement and maintenance of RRT
• standard in Psychological Therapies
• Working towards achievement in CAMHS; plans underway to develop Tier 2 services
• Expanded use of accredited digital therapies
Now and Year 1
• Delivery of RMP4 through Specialty Level Recovery Plans
• Key deliverables: CAMHS Unscheduled Care service; CAMHS delivery of CAPA model; Review of children's neurodevelopmental pathway; Development of preventative and tier 2 services
• Implement improvements such as PFB in Psychology
• Workforce: Recruitment of additional workforce; review of job plans; development of nursing roles
• Service developments: Infant & Perinatal mental health; Eating Disorders
Now (Year Zero)
• Unstable baseline (demand/workforce challenges)
• Non-compliance with performance indicators & worsening position
• 30-40% increase in referrals for Eating Disorders

Primary care services

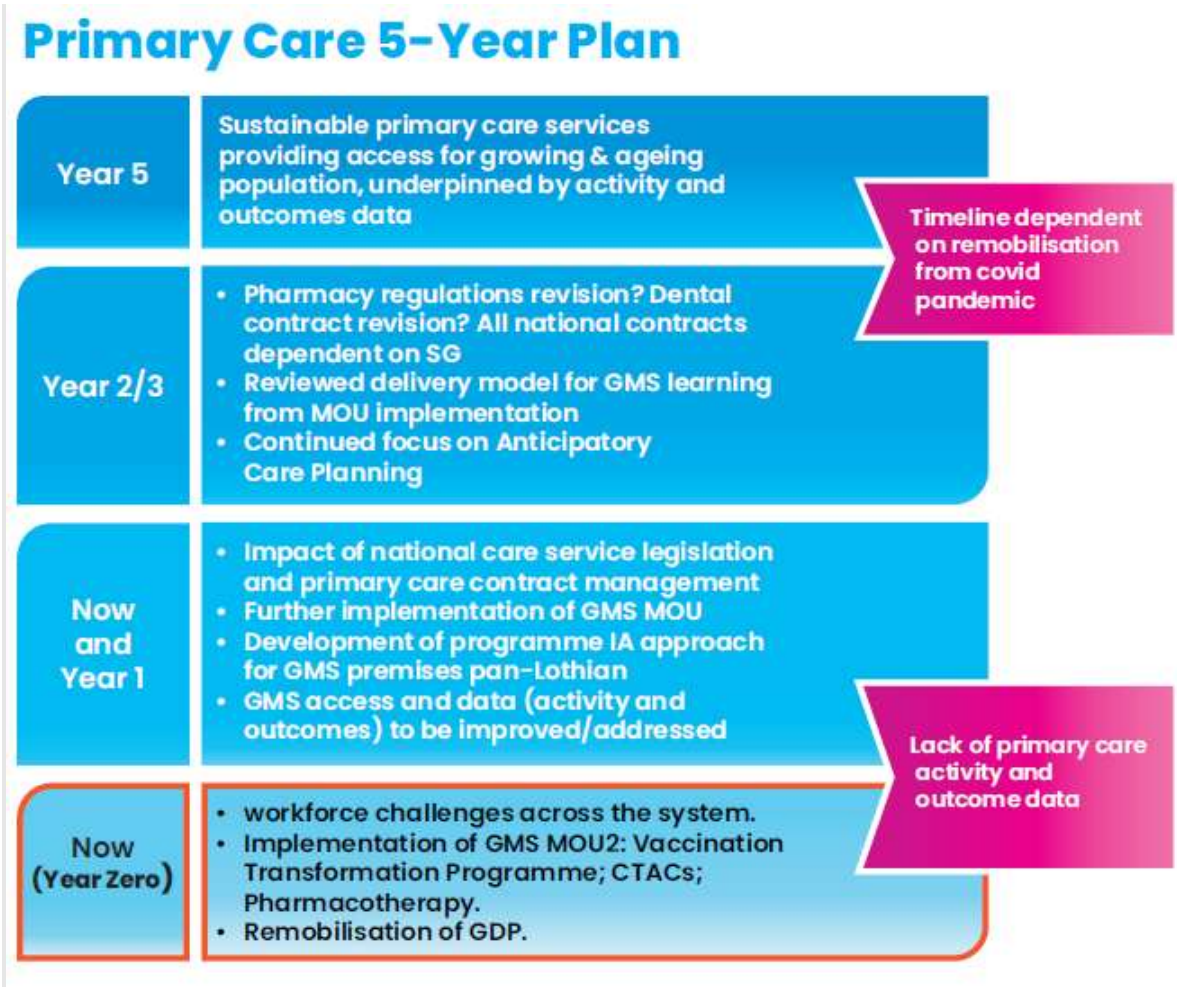
We will implement the next stage of the GP contract. We are conscious that GP contracting arrangements are negotiated nationally and not locally, and that as we complete this document, the Scottish Government's proposals for general practice would see these contracts managed in new Community Health and Social Care Boards. What we propose as a direction of travel, however, is one that we believe stands as the right direction to ensure a sustainable and high-quality service. The way in which we deliver general practice services will continue to evolve. As with the model for hospital outpatients, we will seek to ensure that people only travel to their general practice if they absolutely have to, with alternatives via digital technologies – and the telephone – increasingly offered. This will also mean that we continue to use telephone triage to stream citizens to the most appropriate professional, which will not always be the general practitioner.

We also recognise that general practice is one of the key elements of any community, and we also recognise that many of our general practice buildings are in need of replacement. When we require to replace a facility of this type, we will seek to do so in conjunction with our partners and create new buildings which bring together education, social care, other primary care services, the third sector and other services. Experience of the pandemic has been that citizens seek one place for support.

We have collectively sought to move from buildings which are not suitable for the delivery of modern care and treatment, and this affects general practices and hospitals both large and small.

We will look to further develop the services that are provided through pharmacies and opticians across the Lothians, recognising that these are a vital part of communities.

We will also work to help the recovery of our dental services. Currently our estimate is our services are running at 40% of pre-pandemic levels, with a Scottish Government expectation of at least 20% .


Primary Care 5-Year Plan
Year 5
Sustainable primary care services providing access for growing & ageing population, underpinned by activity and outcomes data
Timeline dependent on remobilisation from covid pandemic
Year 2/3
• Pharmacy regulations revision? Dental contract revision? All national contracts dependent on SG
• Reviewed delivery model for GMS learning from MOU implementation
• Continued focus on Anticipatory Care Planning
Now and Year 1
• Impact of national care service legislation and primary care contract management
• Further implementation of GMS MOU
• Development of programme IA approach for GMS premises pan-Lothian
• GMS access and data (activity and outcomes) to be improved/addressed
Lack of primary care activity and outcome data
Now (Year Zero)
• workforce challenges across the system.
• Implementation of GMS MOU2: Vaccination Transformation Programme; CTACs; Pharmacotherapy.
• Remobilisation of GDP.

Supporting access to unscheduled care

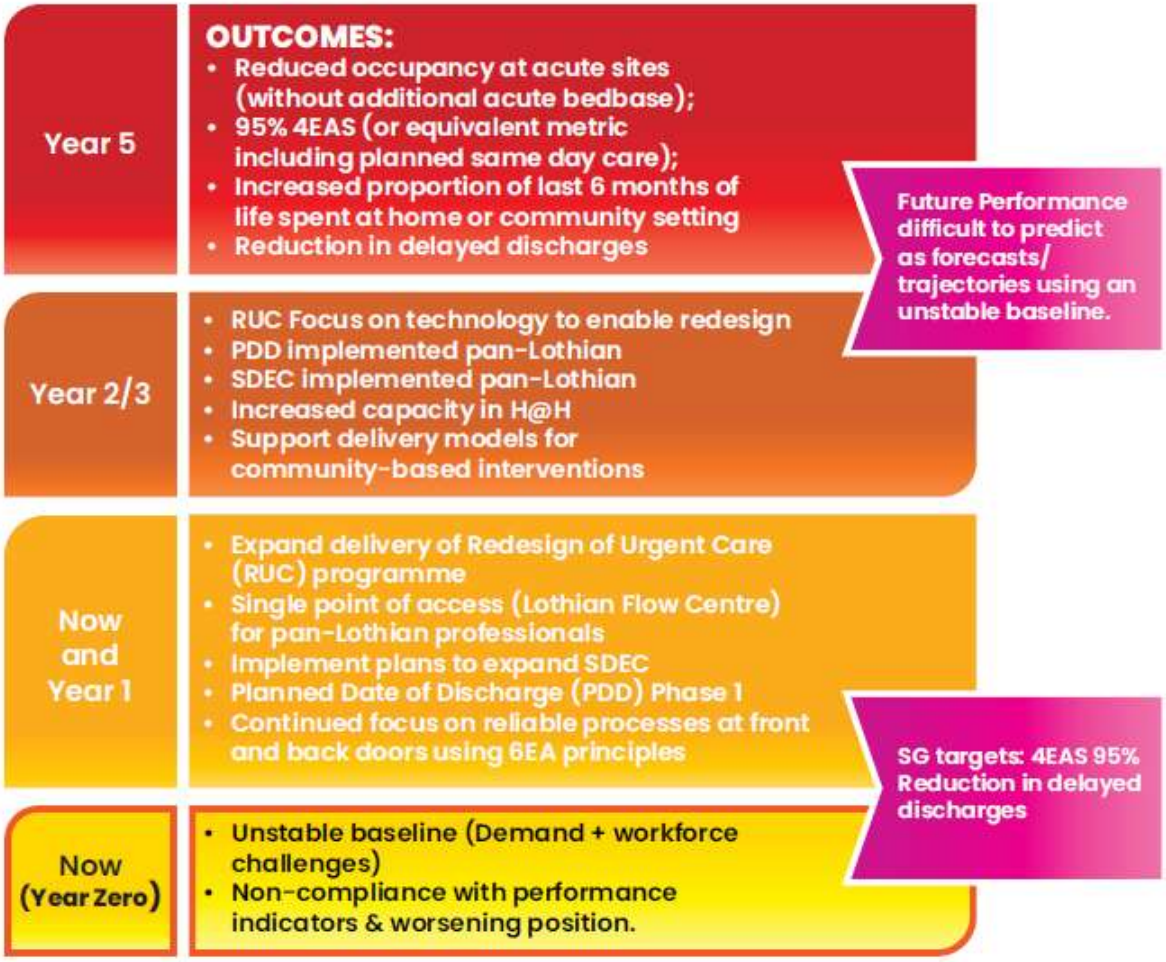
We will continue to aim to deliver improved patient experience and safety as measured against the 4-hour emergency access standard.

Our system is consistent in its belief that people should only come to a hospital if they absolutely have to, and should not stay in hospital any longer than absolutely necessary. We will therefore continue to develop the approach to redesign urgent care we introduced during the pandemic, with citizens asked to use the 111 phone number to be assessed and directed appropriately, with as many attendances as possible scheduled according to clinical priority and patient convenience.

To support this change, we will also roll out the Same-Day Emergency Care programme that has been very effective at the Western General Hospital. We will introduce the service at the Royal Infirmary of Edinburgh and St John's Hospital, and look to deliver as much as possible of this work at East Lothian Community Hospital and Midlothian Community Hospital. We will develop a business case for a new West Lothian Community Hospital and seek to develop further the services delivered at the East Lothian Community Hospital. We believe that this will improve the quality of care we can offer in these areas and allow us to replace buildings which are no longer fit for purpose.

We will continue to develop the approaches introduced successfully in each of the four IJB areas to get people home quickly after they have been in hospital. This means we will expand our Hospital to Home, HomeFirst, and Discharge to Assess approaches, allowing elements of acute hospital care and social care assessment to take home in the patient's own home.

Unscheduled Care 5-Year Plan



Scheduled Care

We want to:

Begin the construction of a new regional Cancer Centre on the Western General campus, which will include specialist diagnostics, breast care, and chemotherapy and radiotherapy services;

Build and commence operating a new National Treatment Centre at St John's Hospital, which will see the vast majority of elective treatment for patients we expect to stay less than two days. We expect this centre to see the bulk of people receiving treatment in general surgery, orthopaedics, urology, colorectal surgery, and gynaecology;

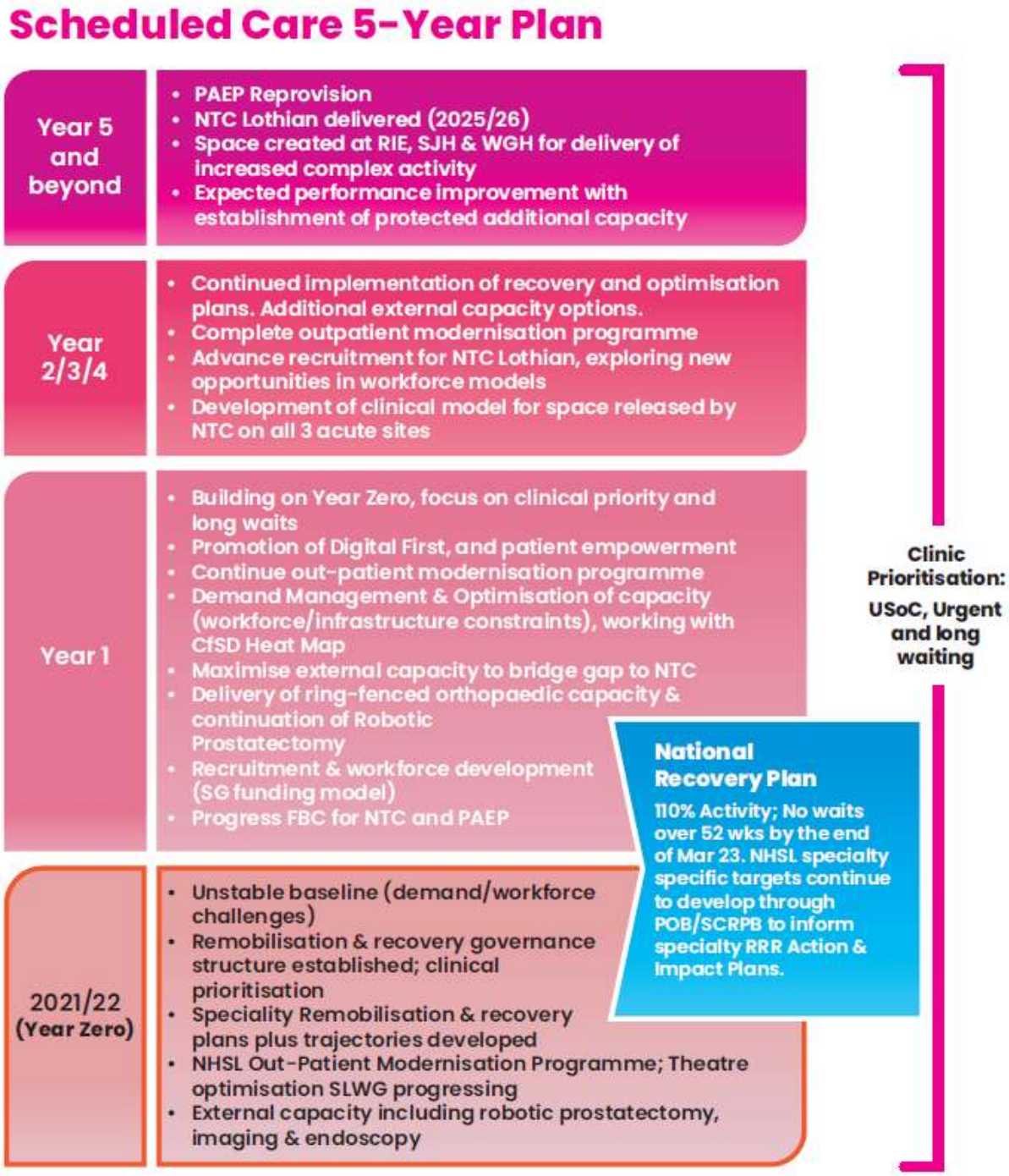
Work to recruit additional staff to operate this NTC;

Build and commence operating a new Princess Alexandra Eye Pavilion on the Royal Infirmary of Edinburgh campus, to bring together all aspects of specialist eye treatment for the people of Lothian;

Work to achieve prevailing national targets for diagnostics and treatment, prioritising those with life- and limb-threatening conditions, and supporting those who wait longer than we would want;

Use the physical space freed up in the Royal Infirmary, St John's Hospital, and the Western General to increase our capacity for the most complex conditions, thereby accelerating treatment for those with cancer or complex orthopaedic needs;

As part of our move to improve the waiting time for outpatient assessment, we will look to build on learning from the pandemic and use digital communications technologies such as NearMe to replace appointments in person, when this is appropriate to do so.


Scheduled Care 5-Year Plan
Year 5 and beyond
PAEP Reprovision
NTC Lothian delivered (2025/26)
Space created at RIE, SJH & WGH for delivery of increased complex activity
Expected performance improvement with establishment of protected additional capacity
Year 2/3/4
Continued implementation of recovery and optimisation plans. Additional external capacity options.
Complete outpatient modernisation programme
Advance recruitment for NTC Lothian, exploring new opportunities in workforce models
Development of clinical model for space released by NTC on all 3 acute sites
Year 1
Building on Year Zero, focus on clinical priority and long waits
Promotion of Digital First, and patient empowerment
Continue out-patient modernisation programme
Demand Management & Optimisation of capacity (workforce/infrastructure constraints), working with CfSD Heat Map
Maximise external capacity to bridge gap to NTC
Delivery of ring-fenced orthopaedic capacity & continuation of Robotic Prostatectomy
Recruitment & workforce development (SG funding model)
Progress FBC for NTC and PAEP
National Recovery Plan
110% Activity; No waits over 52 wks by the end of Mar 23. NHSL specialty specific targets continue to develop through POB/SCRPB to inform specialty RRR Action & Impact Plans.
2021/22 (Year Zero)
Unstable baseline (demand/workforce challenges)
Remobilisation & recovery governance structure established; clinical prioritisation
Speciality Remobilisation & recovery plans plus trajectories developed
NHSL Out-Patient Modernisation Programme; Theatre optimisation SLWG progressing
External capacity including robotic prostatectomy, imaging & endoscopy
Clinic Prioritisation:
USoC, Urgent and long waiting

What next?

This summary lays out the framework as we see it. We are keen to work with our citizenry, our partners, and our staff, to refine this and make sure we have captured all the elements required for a credible strategy that we would all endorse.

To this end, we are undertaking an initial engagement exercise in Spring 2022. We have therefore prepared a suite of documents which provide further detail on the concepts and initiatives explained here. The entire suite is linked to in the following list and available on the following pages;

- Where we are now
- Where we want to be - Outcomes/population health/performance
- Developing NHS Lothian as an Anchor Institution to improve Population Health
- Children and Young People
- Mental Health, Illness, Wellbeing
- Primary Care
- Unscheduled Care
- Scheduled Care
- A summary of our parameters – finance, capital monies, our workforce, sustainability, and digital
- Engagement process
- Questions we need your help to answer

You do not have to read all of the documents we have identified, but you are very welcome to do so.

Where we are now

About this chapter

This chapter sets out our current position in terms of Performance, Finance, Workforce Supply & Wellbeing and Sustainability. It also outlines our next steps in these areas, and considers what the future might look like for the Lothian Health & Care System.

Performance

NB Performance information included in this section is based on our position in October 2021.

Prior to Covid, NHS Lothian was experiencing a number of challenges in relation to performance and our ability to deliver against national standards for scheduled care, unscheduled care and mental health. In many areas, Covid has created new setbacks and brought us further challenges.

From mid-August 2021, positive COVID-19 cases have increased rapidly across Lothian, reaching a peak rate of 750 cases per 100,000 on 5th September with a downturn during September 2021. Test positivity remains high. Due to the success of the COVID-19 vaccination programme, the steep increase in positive cases resulted in only a modest increase in hospital admissions, in keeping with the national picture.

Covid continues to impact how we can provide services. For example, space and activity within our Emergency Departments continues to be separated into red (for people presenting with Covid) and amber streams (for non-Covid patients). This separation limits physical capacity and workforce flexibility. Within our outpatient departments, we continued to observe 2 metre physical distancing until the end of August 2021, limiting physical capacity and requiring new ways of working.

High-level performance standards are reported regularly to the NHSL Board. The most recent report demonstrated that:

Unscheduled Care

Performance against the 4-hour Emergency Access Standard continues to deteriorate with the August 2021 position at 72.4%, significantly below the national standard of 95%. Emergency Department attendances across Lothian have returned to, and on occasion exceeded, pre-pandemic levels.

The number of patients who are delayed in their discharge from acute hospital care has increased over 2021, and remains consistent with average delays over 2019/20.

Scheduled Care

An increasing number of people are waiting longer than twelve weeks for outpatient appointments, with 40,886 people waiting at the end of August 2021. As we continue to focus on maintaining and improving performance for those with the greatest need under our clinical prioritisation arrangements, and then on the longest routine waits, we have seen a significant reduction in the number of patients waiting over 52 weeks for an outpatient appointment. However, outpatient demand has increased over the summer as pent up demand emerges, which will add to the normal winter pressures if trends continue. While we are now maintaining pre-COVID activity levels, there remains a significant backlog of patients still waiting for their outpatient appointment.

The percentage of patients waiting for more than 12 weeks for inpatient treatment or for a day case procedure was 6.4% higher in August 2021 than the previous month, and higher than previous yearly figures. A steady increase continues to be observed in the number of patients waiting over 52 weeks.

The clinical prioritisation framework introduced in February 2021 supports prioritisation of treatment for the most urgent patients, and a significantly larger proportion of procedures undertaken under the Treatment Time Guarantee are urgent, compared to pre-Covid.

Cancer performance measures seek for 95% of patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and for 95% of those referred urgently with a suspicion of cancer to begin treatment within 62-days from urgent receipt of referral for newly diagnosed primary cancers. Performance deteriorated from June 2021 to July 2021 for both 31 and 62-day pathways, by 1.7% and 5.9% respectively, although 31-day performance remained above target at 96.6%.

Mental Health

90% of patients should commence treatment with Child and Adolescent Mental Health Services (CAMHS) within 18 weeks of referral. This standard has not been met within Lothian for some years, although a long-term improvement programme is currently in place and it is expected that the target will be met by March 2023.

It is expected that 90% of adults with mental health conditions that meet the clinical threshold of the Psychological Therapies service should commence treatment within 18 weeks of referral. This standard has not been met in Lothian for some years. Rebalancing capacity and demand has seen an improvement in performance, and 81.6% of patients were seen within 18 weeks in August 2021. It is expected that waits longer than 18 weeks will be eliminated by March 2023.

Finance

Prior to Covid, *Scotland's Fiscal Outlook - the Scottish Government Medium Term Financial Strategy* published in May 2019 indicated a strong economy, but one which faced challenges in terms of global growth and the uncertainty of Brexit, which it was assumed would bring a risk of economic loss as a result of falling business and consumer confidence. The strategy also noted that the effects of austerity meant that there would be £18.3 billion less funding for Scottish public sector services by 2023/4 than if spending had remained at 2010/11 levels.

Following Covid-19, and associated restrictions imposed to manage it, 'There have been unprecedented falls in economic activity in Scotland' and 'the scale and speed of any recovery remains both fragile and uncertain'. (*Scotland's Fiscal Outlook – the Scottish Government Medium Term Financial Strategy*, January 2021)

Health is the biggest area of spending within the Scottish budget. In its consideration of future spending scenarios, the Scottish Government's Third Medium Term Financial Strategy, published in January 2021, sets out potential annual growth in health spending of either 3%, 4% or 5.5%, and notes that 'Cost pressures, such as increases in paybills, inflationary uplifts or increase in demand-led provision, must be met from within these budgets'. This means that there is uncertainty about the future budget that will be available to NHS Lothian, to meet increases in both baseline costs and demand for services.

In Lothian, the Financial Plan presented to the Board in April 2021 showed a projected deficit for the year ahead of £91m, which included estimated Covid-19 costs of £66m. The Scottish Government (SG) is expected to fund all costs associated with Covid-19 in 2021/22, leaving the Financial Plan gap in the core underlying position of £25m. The Board has accepted limited assurance that NHS Lothian will be able to deliver a breakeven position in 2021/22.

The population in Lothian is expected to grow, and to live longer, leading to increasing demand for our services. With limited resources, we need to take this opportunity to consistently assess the value of current service models and consider whether current models can efficiently deliver expected performance and outcomes, and remain financially sustainable over the longer-term.

NHS Lothian is developing a Medium Term Financial Framework, which will seek to describe the financial implications of achieving our operational targets, and quantify the likelihood of the need to make difficult choices within a financial context. This framework will be built on the five pillars identified within the LSDF.

Capital

Indications suggest that significant additional capital funding will not be available over the next five years, over that already committed to approved projects and existing formula allocations. National Infrastructure Board principles emphasise a focus on investing in current estate and infrastructure. Going forward, we will need to be clearer than ever on how best we use capital resources available to address our priorities.

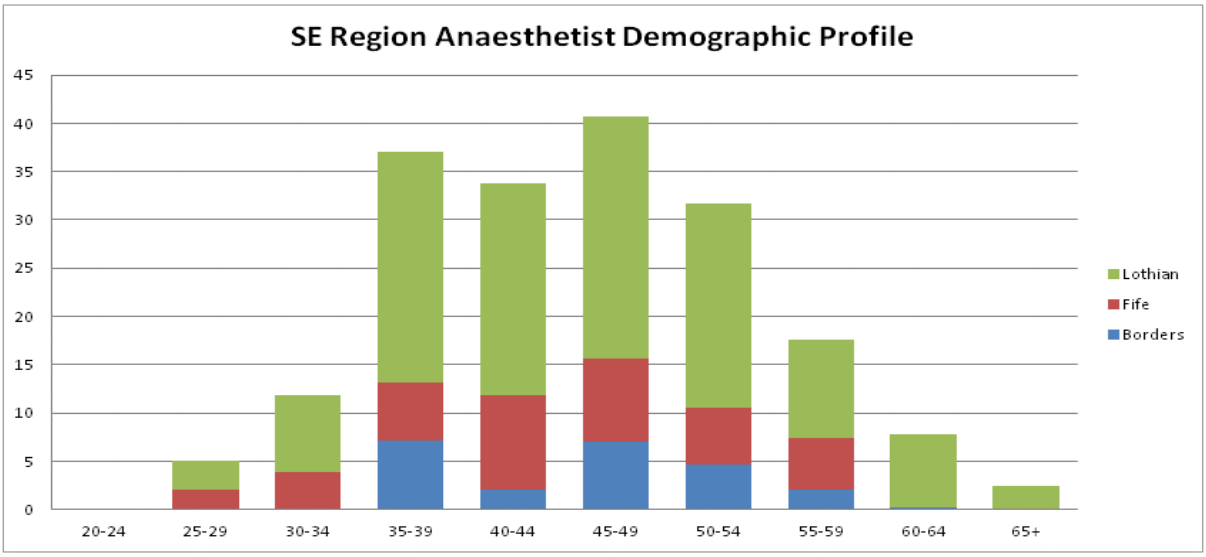
Workforce

Workforce Supply

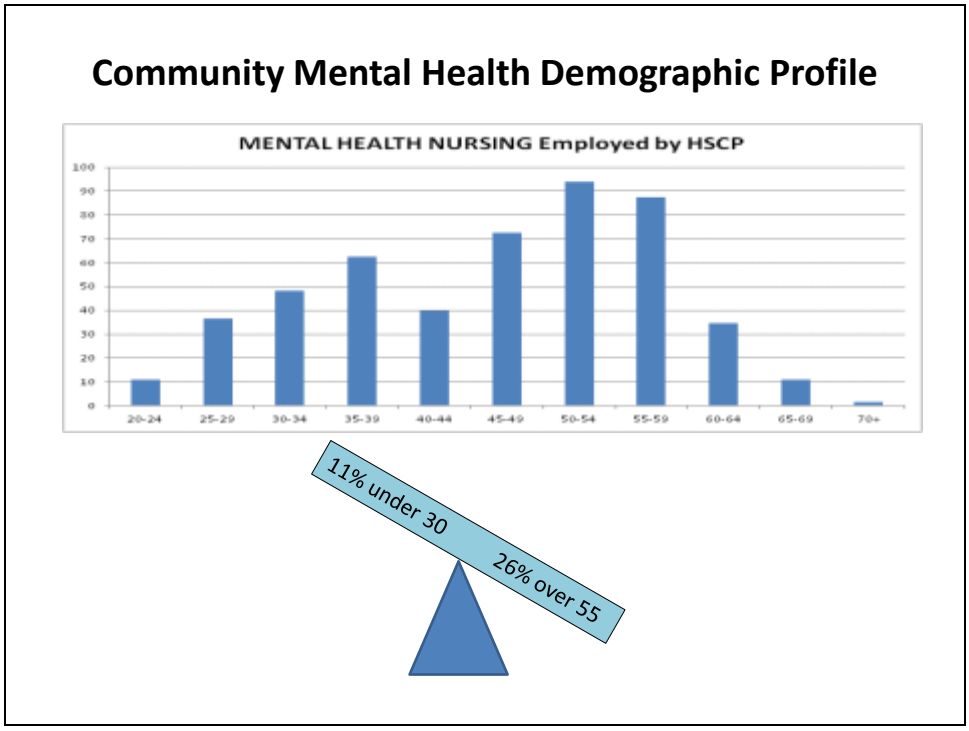
NHS Lothian's existing workforce plan, published in 2019 for the period 2020-23, noted significant challenges in relation to workforce, including a labour market with low levels of joblessness and difficulty managing the establishment gap, particularly as we look to establish new services; seek to increase advanced nursing roles; and achieve safe levels of staffing. An ageing workforce, pension changes and the potential recruitment challenges presented by Brexit were all concerns prior to the pandemic, as we sought to develop a modern, safe and resilient workforce capable of meeting the need for service expansion alongside the current and future needs of the Lothian population.

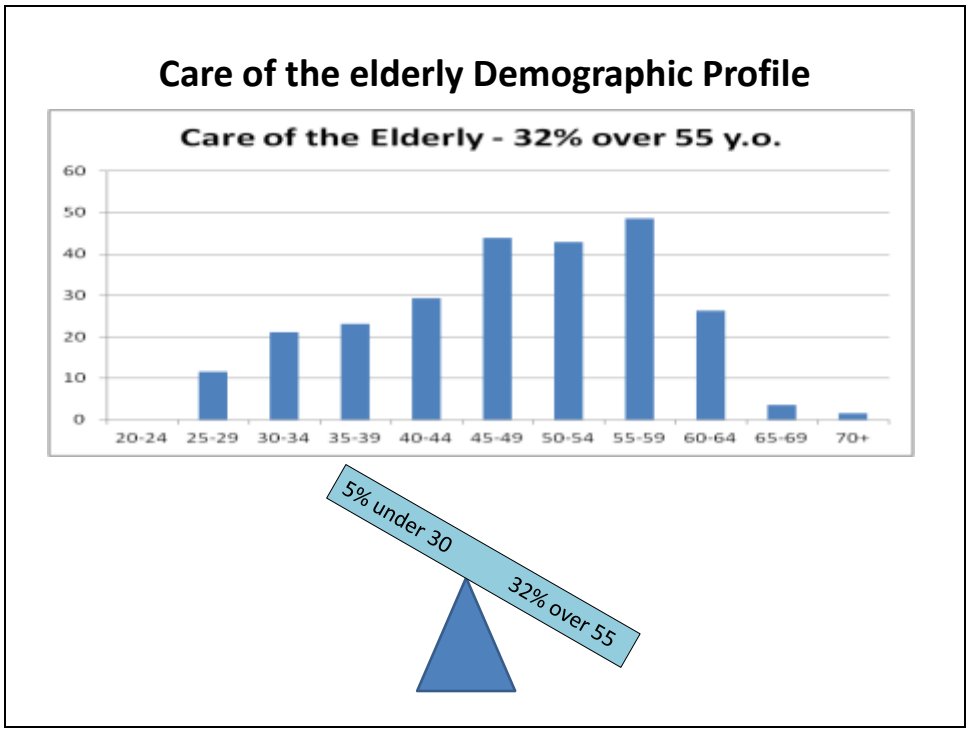
Growing a highly trained and educated workforce is challenging, with training pipelines ranging from months in some cases to up to 10 years in some medical specialties, many of which are commissioned nationally. In some areas, workforce supply is already a concern. For example:

In Consultant Anaesthesia, the current consultant establishment gap in the southeast of Scotland is 23 WTE. Some consultants undertake "Extra Programmed Activities" or EPAs, which is additional work beyond the consultant's full-time contract, in order to respond to service demands. Since April 2019, EPAs have reduced by 25% (the equivalent of 3.5 WTE consultants), partly as a result of pension tax regulations. With demand already outstripping supply, and a demographic profile where 15% of consultant anaesthetists are currently over the age of 55, and 32% over the age of 50, we could see a significant recruitment challenge in coming years.



Within some Community Nursing teams, workforce demographics are imbalanced, with a significantly higher proportion of nursing staff aged over 55 compared to those aged under 30:



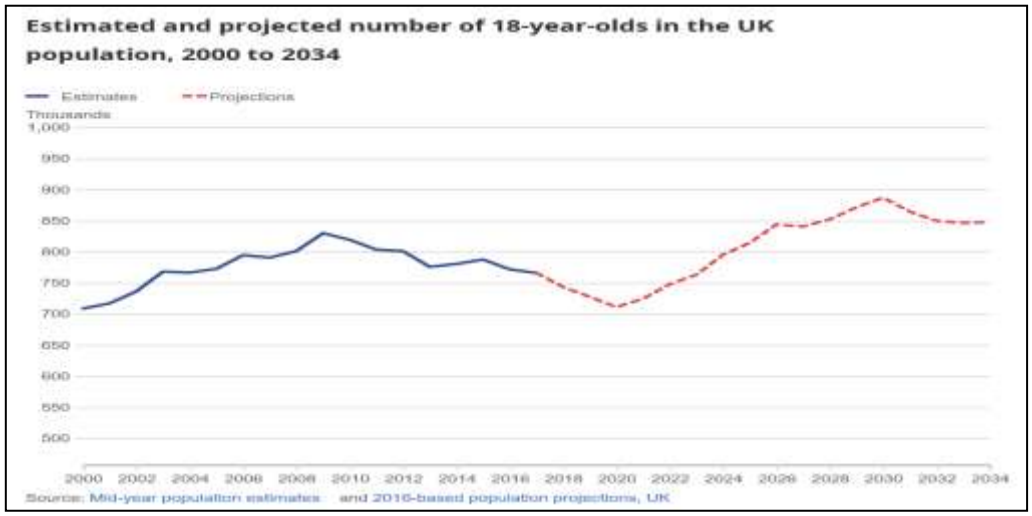


This imbalance means that we could see a significant reduction in the workforce available in these areas over the next five years.

Mental Health nursing is another area of concern. Modelling undertaken by our workforce planning team demonstrates the number of newly-trained mental health nurses we would need to recruit each year, if expected outflows (staff leaving and retiring) continue along existing trends. Within the model, there is a significant gap between the number of mental health nurses we would need to

recruit over the next five years and the number currently in training locally; such that there could be a shortfall of over 400 mental health nurses by the end of 2024-25 if we continue with existing models of care.

Increasing training places is one avenue that could be explored to support balance between workforce supply and demand. However, data published by the Office of National Statistics in 2018 demonstrated that the number of 18 year olds in the UK had been decreasing since 2009. This decrease was attributed to decreasing fertility rates in previous years, which reached a record low in 2001 and 2002. This means that there are relatively few 18 year olds in the current UK population, which is likely to lead to fewer young people entering training:



Source: https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationprojections/articles/being18in2018/2018-09-13

Prior to the pandemic, redesigning the ways in which we deliver services and making appropriate use of technology were seen as key to mitigating workforce challenges, and we expect that this will be an increasing priority. Staff may require development, to ensure that they are confident and capable working with technology.

Our workforce planning team is currently working to refresh existing workforce plans to reflect the direction of travel set out within the LSDF; assess the challenges, opportunities and risks for our workforce; and further define the actions required to develop and transform our workforce to meet the future needs of our citizens.

Workforce Wellbeing

Prior to January 2020, the NHS was already seeing an epidemic of burnout with levels of stress amongst staff reaching record levels.

Covid-19 has reinforced how important our workforce is. During 2020 and 2021, staff throughout the organisation have consistently worked under additional pressure. The pandemic 'will continue to influence the demand for, and deployment of, the health and care workforce for the foreseeable

future' (*Update on Revised Workforce Planning Guidance*, DL(2020)27; Scottish Government, October 2020). Evidence from other long-term crises suggests that up to a third of staff will experience high levels of distress.

Through our *Work Well* strategy, we intend to provide a clear plan that will continuously improve staff wellbeing: one that will highlight priorities and provide a framework to measure impact and progress across NHS Lothian.

Environmental Sustainability

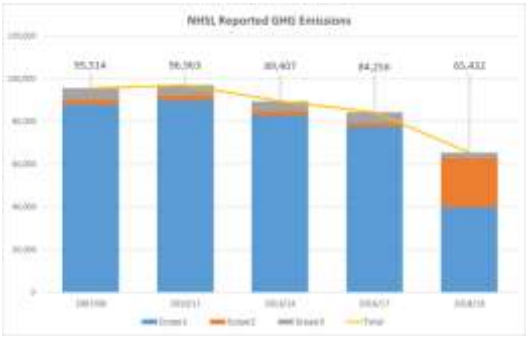
As noted in the draft *NHS Scotland Climate Environment and Sustainability Strategy 2022-26,* the need to act to address the climate emergency and loss of biodiversity is clear and pressing. The draft strategy proposes bringing forward NHS Scotland's target date for achieving net zero emissions from 2045 to 2040.

NHS Lothian's Sustainable Development Framework and Action Plan outlines our vision 'to be a lead organisation in sustainable health care' and our intention to put in place actions to minimise our environmental impact, protect the natural environment and enhance social value.

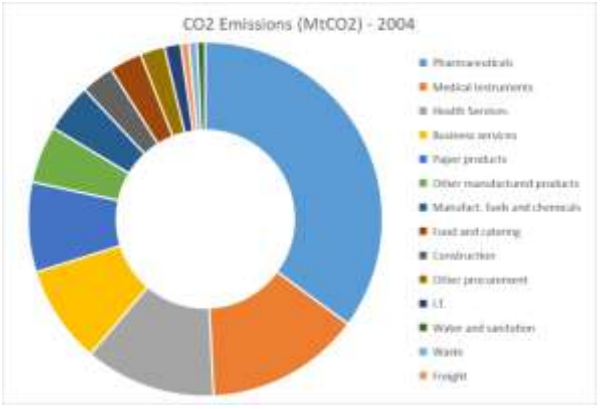
To date, in managing and reducing our emissions we have reduced our impact on the environment, managed resources more effectively, contributed to actions on climate change and shown leadership as a major public sector organisation responsible for health.

NHS Lothian has been reporting on its annual Greenhouse Gas emissions since 2007/2008 following the internationally recognised approach for documenting the Carbon Footprint of an organisation, the Greenhouse Gas Protocol (GHG Protocol 12) as part of its Carbon Management Plan.

This chart demonstrates that for the Green House Gases we have been monitoring and reporting on we have made substantial progress. However, the emissions in scope relate only to our buildings and transport and represent less than 30% of the NHS Carbon Footprint and an even smaller proportion of our total resource utilisation.



We need to recognise the wider contribution services have on the environment and broaden our scope of measurement. In 2018, we included emissions from Anaesthetic Gases in our report, but this chart, showing NHS Scotland emissions for 2004, demonstrates how much wider our scope needs to be.



Over 70% of NHSScotland emissions come from indirect sources, the products and services used, rather than being produced directly. The addition of a wider range of emissions sources in our reporting increases the challenge but is essential if we are to embed sustainability across the whole organisation and harness the enthusiasm and determination of our staff.

Digital

Scotland's Digital Health & Care Strategy was published in April 2018. The strategy recognised that digital technology 'must be central, integral and underpin the necessary transformational change in services in order to improve outcomes for citizens'. Prior to the pandemic, digital transformation within the NHS had been challenging in its complexity, and due to our existing culture of delivering care face-to-face in clinical settings.

NHS Lothian's eHealth Strategy for 2018-21 noted the extensive digital footprint already in place in Lothian, and the need to maintain the current environment and keep digital tools working well. Seeking opportunities to use emerging technologies to deliver efficient, sustainable services and improve care for the future was also an area of focus.

Covid-19 has brought a wider sense of purpose and urgency to digital transformation, has upended our understanding of good quality care and has driven forward fundamental change as barriers to innovation have been removed and innovations that may have felt too radical have become the 'new normal'. For example, the roll-out of NearMe was intended to be gradual during 2020 but these plans were rapidly accelerated to transform how people are engaging with services. Across Scotland, NearMe consultations rose from 300 per week in March 2020 to 14,000 per week in May 2020. In addition, there have been developments in remote monitoring and asynchronous outpatients.

The NHS Lothian IT estate has more than doubled over the last twelve years, and as a result there are significantly more devices, systems and users on the core infrastructure, resulting in a requirement for additional core systems capacity. Major infrastructure upgrades have been completed in recent months, to support the additional requirements presented by Covid-19, including a significant number of staff working from home. Going forward, there will be a continued focus on delivering and maintaining a modern, robust, supported and secure enterprise platform to support and facilitate the use of modern healthcare applications and systems, utilising a significant proportion of Digital Directorate resources. We also expect to continue to build on new functionality and ways of working introduced during the pandemic, including Office 365, Microsoft Teams and NearMe, extending the use of existing functionality and taking advantage of new developments.

In future, we expect to focus on digital as the first option for our interactions with patients, with the ability for clinical teams to switch effortlessly between face to face, telephone, NearMe and asynchronous appointments. To facilitate this, we will work towards delivering a patient platform, to provide patients with a single way of accessing services, including the ability to book appointments online, engage with asynchronous appointments, and connect with healthcare teams to remotely monitor their condition.

We will also seek to improve the speed and availability of clinical data, and develop applications to improve existing manual processes and procedures to support effective working for our clinical staff. Through the provision of supporting infrastructure, we will enable services to use data to inform future service planning.

Where we want to be

About this chapter

As detailed in the summary chapter, the Lothian Strategic Development Framework (LSDF) seeks to determine how NHS Lothian can achieve its aims to:

- improve population health,
- improve how we work with people, and
- improve performance.

To achieve these objectives, we need to consider the challenges presented and/or exacerbated by Covid, and the opportunities and innovations brought about during our response to the pandemic, as set out in the parameters section.

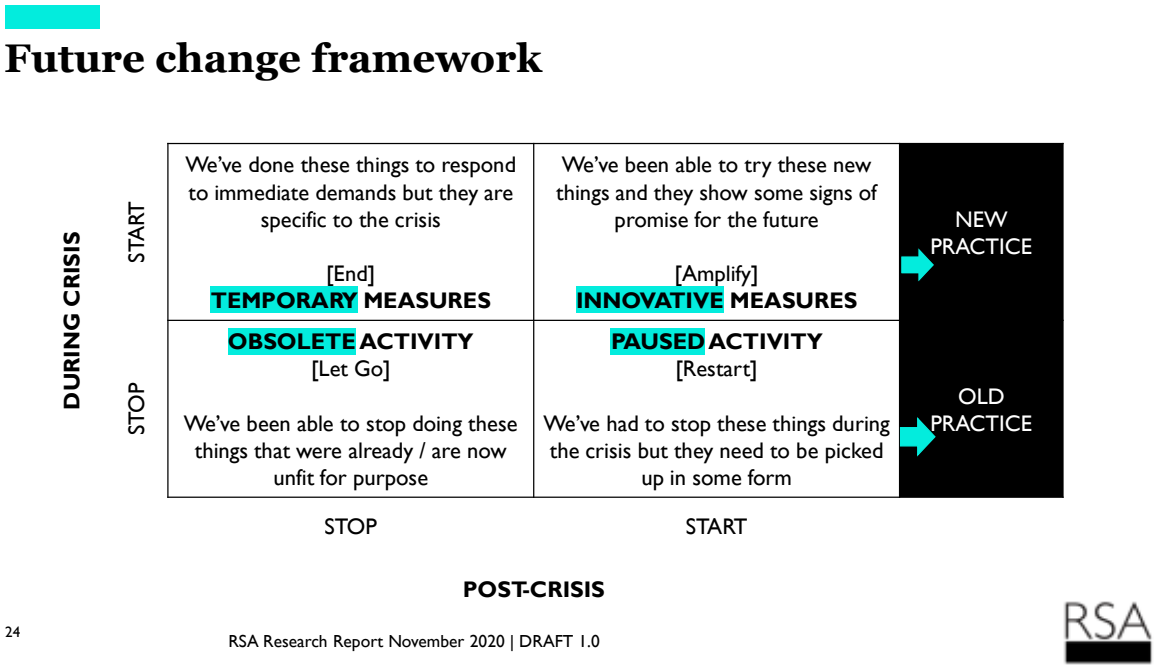
NHS Lothian believe that it important that we don't do what we think is right without seeking the views of the people we work with and for, and has sought to engage both staff and our communities to help us to understand what is important to people who live in Lothian and/or work within our services, to help inform our direction.

This chapter summarises what we have learned from engaging with our staff and communities, outlines the outcomes we wish to achieve, and sets out how we intend to measure those outcomes during the period of the LSDF.

Engaging with NHS Lothian staff:
Strategy Development Workshops 2020

In 2020, NHS Lothian formed a strategic partnership with the RSA (Royal Society for Arts, Manufactures and Commerce) to work with senior leaders to apply the RSA Future Change Framework to our activities and shape our strategic direction going forward.

Figure 1: RSA Future Change Framework
Source: Pandemic Possibilities, RSA, November 2020



The RSA facilitated a series of strategy development workshops with over 100 senior leaders from across the organisation in October and November 2020 to explore what we know about crisis and change, learn from our experiences to date, identify where we need to develop new approaches, accelerate change or move on from approaches that are no longer fit for purpose, and clarify our aspirations and expected future challenges.

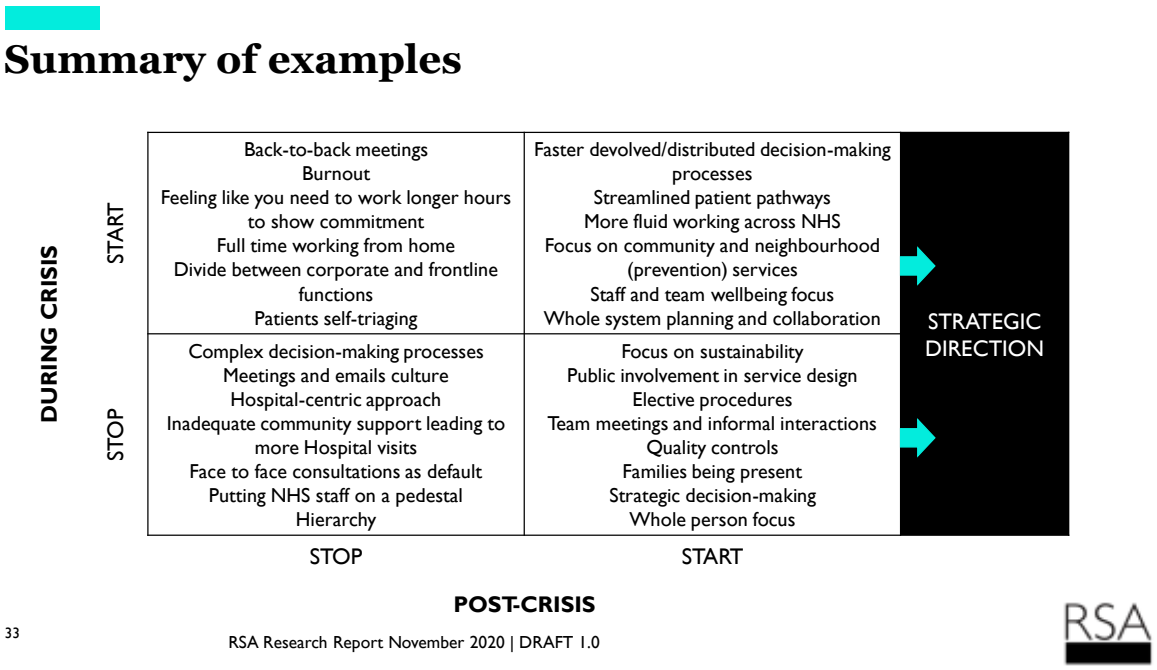
The active engagement of staff in these sessions was a testament to our workforce at a time when there were so many competing priorities, and there was a sense of genuine desire to seize and act on the opportunity for change. The tension between desire for change and the capacity for change was clear across all of the workshops, with 'the capacity of staff and teams to innovate and spread new practice compromised by fiscal, operational and time constraints and compounded by individual cognitive overload' (*Pandemic Possibilities: Applying the RSA Future Change Framework to support NHS Lothian's strategic review and improve population health outcomes*, RSA, November 2020).

> *I feel as though I am in a fast moving river - the current momentum is behind me but there are rocks in the way - hopefully the rocks will be pulled along in the current but if they mass together they provide a dam and we form a reservoir of inaction instead*

The sessions rightly demonstrated pride in the efforts of staff in response to the pandemic, and our achievements in terms of teamwork and staff adaptability, resilience and rising to the challenge. Figure 2 below provides a summary of examples listed within the Future Change Framework, following the conclusion of the strategy development workshops.

Figure 2: RSA Future Change Framework Output

Source: Pandemic Possibilities, RSA, November 2020



The Assumptions and Principles set out in the LSDF summary document emerged from parameters we now find ourselves working within, alongside the outputs of the RSA-facilitated strategy development workshops.

Engaging with our communities:
How can we make Lothian a healthier and happier place, now and in the future?

In 2021, NHS Lothian commissioned the RSA to run a series of public and stakeholder engagement sessions to inform the direction of NHS Lothian's Strategic Development Framework. These engagement sessions were intended to inform the policy and practice of NHS Lothian and wider stakeholders. In parallel an online survey has been disseminated to gather the views of a broader range of people from across Lothian.

The NHS Lothian Discussion Group comprised of three public discussion sessions hosted in October 2021 with 19 residents from across Lothian. The overarching question for all three sessions was *"how can we make Lothian a healthier + happier place, now and in the future?"* To avoid unduly steering the content of discussion, we chose a broad and open question that would allow participants to apply their own interpretation and understanding of the key concepts ('we', 'healthiness' and 'happiness') and to prioritise themes that fell within this expansive remit.

The group approached this question by first reflecting on the past, then casting their ideas towards the future, before considering what could be done in the present to move towards a healthier and happier future.

Between the second and third workshops, the RSA sorted through all of the public input from the first two sessions and related homework activities, to identify all of the ideas for change and group them into themes. Figure 3 below provides a summary of the ten themes identified and the ideas that sat underneath each.

Figure 3: Themes and Ideas collated from NHS Lothian Discussion Group
Souce: *Citizens Views of Health and Wellbeing (Autumn 2021)*

Better coordination between different authorities working in Lothian • Improved coordination between authorities • Joint comms strategy • Smoother data sharing between organisations • Joined up care planning for individuals	**Staff training and workforce changes** • Staff training on diversity and inclusion topics. • Opening staff training up to community groups. • Training reception staff to level of auxiliary nursing. • Visible diversity in staff. • More generalist doctors.	**Using data in new ways** • Access to portal with health records/updates • Data from personal devices taken seriously • Smoother data sharing between organisations • GPs embedded in areas and aware of community assets.	**Incentivising healthy behaviour** • NHS working with advertisers. • NHS designing food packages/ eating plans. • Incentives to cycle/walk • Sports facilities free to those in greatest need. • More sports facilities.	**Diversity, inclusion and equal access** • Support system for patients with special access needs • Local tech support kiosks • Childcare services in GPs/schools • Staff/community training • Access to sexual health clinics and birth control
Comms, Education and Engagement • Healthy living curriculum in schools • Coaching/ classes in community and individuals • GP ombudsmen • More consistent engagement • Better signposting of different services • Cohesive local health information systems • More choice on NHS communication channels • NHS working with advertisers. • More holistic language • More transparency on spending	**Scheduling, signposting, referrals** • Local one stop hubs to signpost available services • Cohesive local health information systems • Community book with local health opportunities • Joined up care planning for individuals • Personalised 'portal' for booking and health data • Standardised booking system • All minor injury assessments scheduled • More self-referral opportunities • Data from personal devices taken seriously	**Supporting community resources** • Working with, supporting and investing in community groups and resources. • Health and social care organisations support Local Area Coordination. • Drop-in hubs (GPs of future?) for leisure and health • Deep understanding of local health needs/assets • Smoother data sharing with third sector • Developing health infrastructure through planning consent	**NHS in community and social prescribing** • Local nursing homes by large housing estates • Home visits and Hospital at Home • Dental check-ups at school • Access to care in leisure/sports facilities • GPs embedded in areas and aware of community assets. • More social prescribing • Prescribed holidays • Subsidised self-care • Cohesive local health information systems • Joined up care planning for individuals	**Different ways of accessing services** • Different consultation options: email, text, phone, video, in-person. • Local tech support kiosks • Tech/digital training • Home visits and Hospital at Home • Direct phone line for new parents • More walk-in centres • 24-hour crisis centres • Lothian buses coordinated with NHS Lothian • Open staff buses to public. • Free travel to onward referrals

From these ideas, the group prioritised seven particular actions that they would support:

1. ***Personalised NHS Portal*** *- All appointments can be booked on a personalised NHS portal which has some health data for yourself and dependents and shows past appointments and what appointments are available*

2. ***More joined up care plans for individuals*** *which span different services, clinics and third sector support – i.e. when a patient leaves hospital, care is filtered down to clinics and services in the community for aftercare. This stops being patient's responsibility*

3. ***Self-referral*** *– ability to self-refer and apply directly for physio and low-level mental health services without going through a GP*

4. ***Health infrastructure*** *- developers to take into consideration the inclusion of health provision in their planning with support from NHS to ensure provision of essential services and transport links*

5. ***Hospital at home scaled up*** *- to give people a comfortable and supported way to access healthcare from the comfort of their own home*

6. ***Increase Walk in Centres*** *- to provide triage system for access to further services, urgent care for minor issues and most importantly, a more human element at a point of stress and emergency*

7. ***Community hub support and signposting -*** *Creation of community hubs as one of a centralised system to discover the range of services available to you, support with social prescribing and facilitate better communication between services*

We are conscious that the work undertaken with this group sought to understand what people want, and did not necessarily fully explore the difficult choices we might need when resources are limited, to prioritise what is needed to support our intended outcomes.

That said, many of the ideas here are reflected in our intended strategic direction, and we will seek to make connections between the priorities outlined here and the actions we will take. Where there are ideas that we are not able to take forward, we will make the rationale for that clear to our communities.

Some of the priorities identified by the discussion group are not necessarily best delivered by the NHS. We will look to work with our partners to progress these where we can.

As we move forward, we intend to to continue to engage with people who live in Lothian to shape our ideas and our plans.

In the rest of this section, we will seek to connect our intended outcomes with the priorities identified by both staff and citizens.

Improving Population Health

Population Health was identified as a priority both by our staff and by the citizens we engaged with. For example:

Staff Engagement	Citizen Engagement
Focus on community and neighbourhood (prevention) services A focus on sustainability Whole person focus	Incentivising healthy behaviour, including incentives to cycle or walk Deep understanding of local health needs and assets Access to sexual health clinics and birth control

At a population health level, our challenges are:

- **Population increase**:[1]
  Estimates suggest that the population in Lothian in 2028 will have increased by 65,000 on the 2018 population, mostly as a result of in-migration of working age people;
- **Population ageing:**
  Lothian's population is ageing more quickly than the rest of Scotland. In 2028 it is projected that there will be almost 10,000 fewer people aged under 30 and 40,000 more people aged 60 and older. But there will be an increase in the working age population.

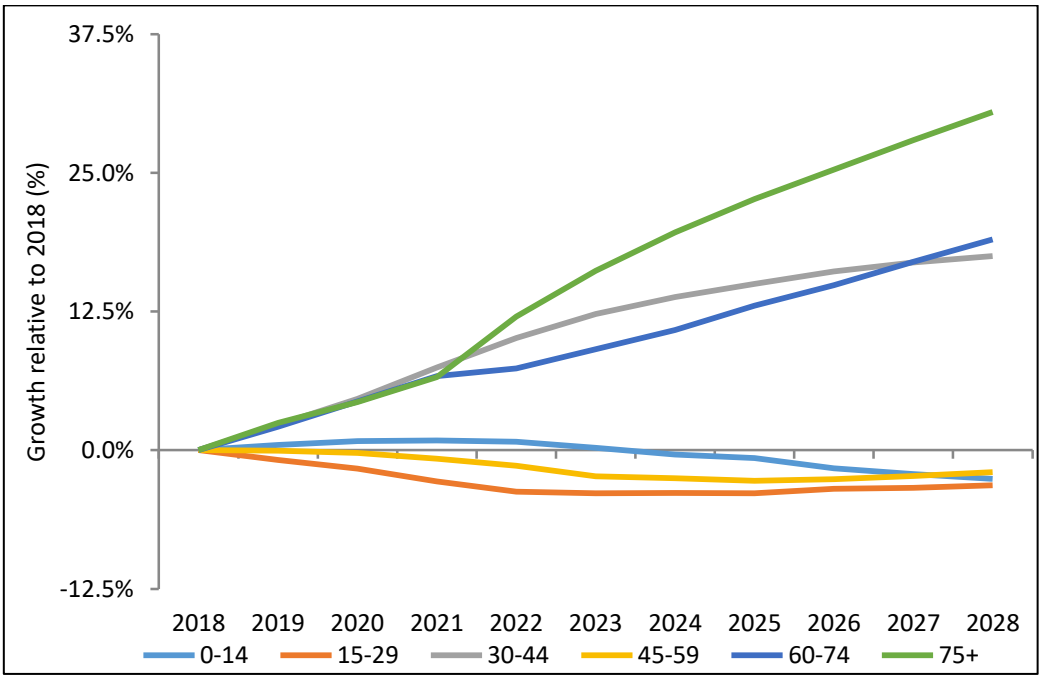


Figure 4: Projected population growth of Lothian by age, 2018-2028 (NHS Lothian PH Intelligence Team)

[1] The Lothian mid-year population estimate for 2020 was 907,580 people, which equates to 16.6% of the total Scottish population. This is an increase from 15.9% of Scotland population in 2012. Population increases in 2020 were lower than projected. The most likely explanation is the lack of movement due to COVID-19 restrictions.

- **Health inequalities:**
  Morbidity and mortality is consistently worse for people in our most deprived communities. Life expectancy gains reached a plateau around 2013 and life expectancy differs by more than 10 years between our most and least deprived communities. There are indications that healthy life expectancy for females is decreasing.

- **COVID-19:**
  The pandemic has exacerbated existing inequalities. People from the most deprived communities are 2.4 times more likely to die from COVID than people in least deprived communities. Workers in lower paid occupations have been most at risk of occupational exposure and illness. Unemployment, loss of income and domestic violence have also increased. Child mental health and educational inequalities have worsened.

Working as a health and care system and a wider public sector to take collective responsibility for the health of our population is crucial. The evidence base shows that approaches that focus not only on the individual but on place-based solutions and on social determinants of health such as income, employment, housing and education, are more likely to be effective in improving population health and addressing health inequalities longer term.

Population health improvement must focus on

a) Support for the health and social care system; and

b) Health in all policies and targeting the wider policy environment (work, housing, transport) that shapes health.

Support for the health and social care system

Within the health and social care system, population health improvement must be proportionate to need with high quality, universally available services that support people throughout their lives. Then, at times when health need – driven by the complexity of individual-level and social factors – is greatest, more targeted, flexible service responses are required. There should be a focus on making every conversation count at all life stages as a way of supporting people to take control of their health:

- **Family health:**
  Vaccination uptake and sex and relationship health (including pre conception health)
- **Working age:**
  Importance of screening uptake; recognition of early multimorbidity with particular emphasis on mental health;
- **Older people:**
  Older people's mental health pathways, frailty prevention and delivery of community-based interventions; support polypharmacy reviews as part of key prevention approach to falls in older people.

Health in all policies

Health in all policies means NHS Lothian having clarity about how population health needs can be influenced most effectively outside the health and care system. It is necessary to tackle social causes of ill health such as low income, homelessness, poor housing and worklessness as well as significant individual-level risk factors that lead to poor health such as smoking, high blood pressure, obesity, poor diet, lack of activity and excessive alcohol consumption.

NHS Lothian has committed to pursuing this work through its Anchor Institution Programme Board to ensure NHS Lothian is a good neighbour, a good consumer, and a good employer by deploying its influence in purchasing and procurement, its assets and facilities, its significance as a regional employment hub to impact positively the health and wellbeing of the local population. The Sustainable Development Framework is a key component of this approach.

The burden of health harm from climate change falls disproportionately on those from more vulnerable communities and groups. Focussing on the health of our population alongside the health of our planet to improve air quality and develop neighbourhoods where everyone has access to good quality housing, greenspace and work will help mitigate these impacts and reduce inequalities.

The Board's Anchor Institution work will be extended to wider partnerships through the public health teams working with each local authority area. The Board is committed to working in community planning partnerships to focus on the preventative, upstream measures that can improve outcomes across Lothian.

Improving the way we work with people

When we work with people to deliver health and care services, we believe that all of our interactions should be underpinned by the IHI six dimensions of quality, put forward by the Institution of Health Improvement and included at the heart of the Healthcare Quality Strategy for NHS Scotland, published in 2010.

Engagement with both the public and with some of our staff reveal what these dimensions of quality mean to some of those that use and work within our services:

Figure 5: **Dimensions of Quality illustrated by Public and NMAHP Feedback**

Dimensions of Quality	Definition	Examples from Public	Examples from NMAHP staff
Safe	Avoiding harm to people from care that is intended to help them	More joined up care plans for individuals which span different services, clinics and third sector support – i.e. when a patient leaves hospital, care is filtered down to clinics and services in the community for aftercare. This stops being patient's responsibility.	• Safety for patients and visitors and staff but everyone understands and manages risk. • Safety and maintenance of the environment
Effective	Providing services based on evidence that produce a clear benefit.	More social prescribing from GPs rather than medication – prescribing healthy options in the community.	• Delivering the right care in the right place at the right time. • Promoting opportunities for participation in clinical trials and other research
Person-Centred	The individual patient's culture, social context, and specific needs deserve respect, and the patient should play an active role in making decisions about her own care	NHS Lothian staff training on diversity and inclusion topics, including how to accommodate people with language and cultural barriers, how to avoid biases (including fatphobia), how to engage isolated communities (i.e. refugees) and the experience of trans patients.	• Best evidenced based way for patients, mothers and babies. To have the knowledge for them to be able to choose what they would like to do for themselves and their babies. • Patients can and should be leading their care. • Patient centred and non-judgemental – see the person, not a tick box.

Dimensions of Quality	Definition	Examples from Public	Examples from NMAHP staff
Timely	Unintended waiting that doesn't provide information or time to heal is a system defect. Prompt attention benefits both the patient and the caregiver.	Moving to all minor injury appointments being scheduled to minimise waiting time and overcrowding in waiting areas and reduce pressure on A&E. Referral can be done after a brief video consultation.	• Services are available for patients and can be accessed when it's needed. • Clear clinical pathways especially for patients with needs that cut across a range of services.
Efficient	Constantly seeking to reduce the waste — and hence the cost — of supplies, equipment, space, capital, ideas, time, and opportunities	Standardise appointment booking – research what works for patients and create common timings and process for booking appointments across services to avoid confusion and wasted time.	• Service needs tested to make sure will work for public.
Equitable	Race, ethnicity, gender, and income should not prevent anyone in the world from receiving high-quality care. We need advances in health care delivery to match the advances in medical science so the benefits of that science may reach everyone equally	Each larger housing estate should have a local nursing home for the elderly who cannot remain within their own home so that neighbours can visit easily and residents of the home still feel part of their community.	• Equality of access to service- gaps currently, identify and address. • Fairness of access regardless of socio-economic group, education background, ethnicity etc. • Equality and fairness of access for all service users

Health Improvement Scotland (HIS) have identified four essential drivers of safe care that our services and staff will be supported to deliver:

Drivers	Aim	Examples from Public	Examples from NMAHP staff
Person Centred Care	Person centred systems and behaviours are embedded and support safety for everyone	• Joined up care plans which span different services, clinics and third sector	• Involvement patients in decision-making around their own care, including understanding of risk and benefit • Designing our services to be person-centred • Providing patients opportunities to give meaningful feedback on their care
Safe Communication	Safe communications within and between teams, focussing on language, format, content and standardised tools	• Effective communication between NHS, Local Authorities & Government • Accessible and cohesive health information system for people and patients • Choice of communication methods – including email, texts	• Effective communication through feedback from safety huddles and executive decision-making • Having time to be with patients and listen to them effectively
Leadership and Culture	Leadership to promote a culture of safety at all levels that addresses psychological safety, staff wellbeing and systems for learning	• Diversity and inclusion training for staff – for working with all patients • Visible diversity amongst NHS staff	• Feedback from iMatters and exit surveys

Drivers	Aim	Examples from Public	Examples from NMAHP staff
Safe Clinical and Care Processes	Safe consistent clinical and care processes across health and social care settings, including infection prevention and control and safe staffing	• Co-ordination between different parts of the health system and third sector • Personalised system for booking appointments • Ability to self-refer for some services (e.g. physiotherapy)	• **Effective transitions** of care for all patients: inter-hospital; hospital & primary care; paediatric to adult services

All these components will be underpinned by the corporate enablers that are identified in the NHS Lothian Work Well Strategy (2021):

- Work has meaning and purpose
- Work is a healthy place to be
- We are able to show leadership
- We listen to staff and they feel heard

Realistic Medicine

One of the main aims of Realistic Medicine is for people using healthcare services and their families to feel empowered to discuss their treatment fully with healthcare professionals, including the possibility that a suggested treatment might come with side effects – or even negative outcomes. Everyone should feel able to ask their healthcare professional why they've suggested a test, treatment or procedure, and all decisions about a person's care should be made jointly between the individual and their healthcare team. We will seek to ensure that all those who use our services are truly informed and active participants in their healthcare.

Realistic Medicine may also mean seeking to shift our collective focus from clinical interventions at the end of life, to reimaging a better death. One in three people in Scottish hospitals is likely to be in the last year of life, and 16% in the last three months of life. (Clarke et al, 2014). We recognise the view expressed in the Report of the Lancet Commission on the Value of Death (2022) that the role of health care in care of the dying has become unbalanced: 'interventions at end of life are often excessive, exclude contributions from families and friends, increase suffering and consume resources that could otherwise be used to meet other needs'. Conversations about death and dying can be difficult. We want to work with our partners and our communities to support people in Lothian to talk about their wishes for care to the end of life, so that those wishes can be understood and respected, and to enable people to die well.

The **NHS Lothian Accreditation and Care Assurance Standards** (LACAS) provide a framework to ensure that high-quality person-centred nursing care is being delivered consistently across all services. Standards are being developed through the Patient Outcomes Programme Board.

Clinical Outcomes

Clinical audit and measurement of clinical outcomes contributes to our assessment of the quality of the services we are providing. Where there are recognised benchmarks for clinical outcomes, we will seek to benchmark our services against those provided by our peers, with the intent to achieve performance within the top quartile.

Performance

Key performance metrics, relevant to the Lothian Performance Recovery Programme and Remobilisation Plans are reported regularly to the Board. These metrics comprise a suite of high-level performance standards, supported by a comprehensive framework of measures.

These metrics include:

- The 4 hour Emergency Access Standard
- Length of wait for an outpatient appointment
- Delayed Discharges
- Length of wait for treatment as an inpatient or day case procedure
- Cancer Waiting Times
- Waiting time for treatment within Child & Adolescent Mental Health Services
- Waiting time for treatment with Psychological Therapies Services
- Acute Adult Mental Health Bed Occupancy
- Healthcare Associated Infections per 100,000 bed days
- Paediatrics and St John's Hospital
- Waiting time for eight key diagnostic procedures

NHS Lothian is currently undertaking to evaluate the way in which performance is managed and reported throughout the Board and its sub-committees. The output of this work will inform how we report performance in future. The revised performance framework is anticipated to be published throughout NHS Lothian in the second quarter of 2022/23.

Summary

The following table summarises what we are trying to achieve, and how we will measure achievement.

Aims	Objectives	How will we measure?	Led by
An improvement in Population Health	Support the health and care system to make every conversation count, and support people who live in Lothian to take control of their health	Uptake of interventions, including vaccinations, health screening and community-based interventions.	TBC
	Develop our role as an Anchor Institution, deploying our influence in purchasing and procurement, assets and facilities, and as an employer to impact positively the health and wellbeing of the local population	To be developed through the Anchor Institution Programme Board	Anchor Institution Programme Board
	Work towards achieving net zero Greenhouse Gas emissions by 2040	NHSL Carbon Management Plan	TBC
An improvement in how we work with people	Ensure all interactions are delivered in line with: - The Six Dimensions of Quality - The Four Essential Drivers of Safe Care - The Person Centred Practice Framework - The principles of Realistic Medicine	Development and roll-out of the Lothian Accredition and Care Assurance Standards	Patient Outcomes Programme Board
	Ensure staff are supported to Work Well, in line with the Work Well Strategy	At a system level: iMatter Wellbeing & Burnout Scale At a local level: Local level measures	Staff Governance Committee
An improvement in performance	Ensure performance, in terms of clinical outcomes, is in line with the top quartile of our peers	Benchmarking data	Healthcare Governance Committee
	Improve performance against key performance metrics	Performance Framework	NHSL Board

Developing NHS Lothian as an Anchor Institution to improve population health

About this chapter

This chapter provides an overview of population health priorities for the Lothian Strategic Development Framework. This paper starts with a brief summary of high-level mortality and life expectancy data. The paper refers to a life course approach and references data to illustrate health and inequalities trends and the way that they impact different age groups. Finally, it outlines priorities for population health work.

Key population health issues for Lothian

- Population health in Lothian is generally has better than elsewhere in Scotland. But there is significant deprivation in the area which means there are health inequalities in Lothian are significant especially when compared with Scotland.
- Overall, average life expectancy in Lothian compares favourably with Scotland. But life expectancy for females is lower in West Lothian than Scotland.
- The difference in average life expectancy between people living in the most deprived areas and the least deprived areas is up to 10 years for females and 12 years for males.
- There is evidence of a plateau in life expectancy since 2013. Some more deprived populations have seen declining life expectancy since 2013.
- Although females have a higher life expectancy than makes, they spend on average more than 20% of their lives experiencing poor health.
- The differences in life expectancy reflect the social and economic inequalities across the region.
- As people live longer, they live with chronic conditions. Multimorbidity is the norm for the Lothian population from middle age. Mental health is a more common co-morbidity for people living in more deprived communities. Preventive actions can ensure people live healthily in their own homes rather than frequenting hospitals and other acute care services.
- Health inequalities cannot be attributed to a single clinical or behavioural risk factor. They are influenced by social circumstances. Health will improve if people are supported to be physically active, eat and drink healthily and not smoke. However, these behaviours are significantly shaped by social circumstances such as income, housing, education, employment, spatial planning and transport all of which impact on people's ability to exercise healthy choices.
- Loneliness and isolation and widening social inequalities are placing increased pressures on primary care services. There is evidence of increasing numbers of people seeking support for mental health issues much of which is associated with loneliness and isolation and distress due to money, employability, and housing worries.

The impact of COVID-19 and our current challenge

Analysis of the health impacts of COVID-19 highlight that the pandemic has exacerbated existing health and social inequalities.[1-4] Those in insecure employment, unable to work from home, experiencing digital exclusion, lacking financial and other resources such as their own transport, were worst equipped to follow isolation and distancing guidelines. In turn this has meant they are both more exposed to and more susceptible to the negative social and health impacts associated with COVID-19.[5] Age is a risk factor for severe COVID-19 illness along with a number of underlying health conditions. Males, people aged 70 years and older, people working in lower paid jobs [6-8] and people from some ethnic minority groups are more likely to die from COVID-19 than other population groups.[9-13] The most recent data from National Records of Scotland indicate that people from the most deprived communities are 2.5 times more likely to die from COVID-19; the size of this gap has slowly widened from 2.1 to 2.5 over the period of the pandemic.[14] There is evidence of longer-term health complications from COVID-19, including Long COVID. [11, 15-17] While children and young people have been far less affected by the direct impacts of the pandemic in terms of severe morbidity and mortality, they have been disproportionately affected by the wider impacts including lockdowns and longer term economic implications. These impacts are exacerbating existing inequalities amongst children and young people.

COVID-19 has also directly impacted the life circumstances of the Lothian population in differential fashion. Unemployment, loss of income and challenges associated with caring responsibilities are socially patterned. The burden of social impacts associated with COVID-19 has been disproportionately borne by women, notably in terms of loss of income and jobs and increased childcare and domestic responsibilities. There is some evidence of increased domestic abuse and research shows that women's mental health has worsened during the pandemic.[18-21] The impacts of institutional racism – poorer housing conditions, lower paid jobs, more unemployment – manifest themselves in terms of greater risk from COVID infection and a harder financial and social impact associated with loss of income and unemployment. Crucially, the higher mortality risk for people from ethnic minority groups is not explained by biological differences but social determinants.[2, 9, 10, 22-24]

Factors that influence population health and inequalities

Biological, social and environmental determinants interact to influence people's health and wellbeing (see Figure 1).[25] Measures of health must consider age, gender, geography, socio economic position, occupation, education and other determinants to capture the full range of health needs – and differences -- across the population.

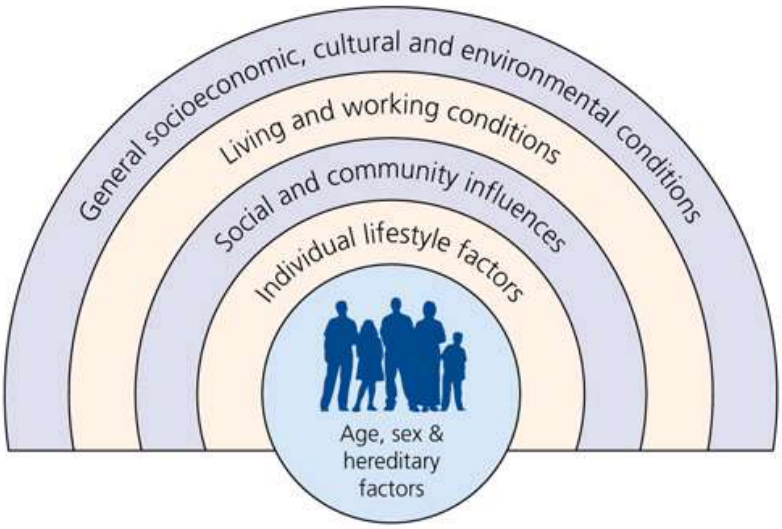


Figure 1: Dahlgren and Whitehead: the social determinants of health

Inequalities develop over a life course as the result of 'systematic, unfair differences in the health of the population that occur across social classes or population groups'. The circumstances into which people are born and grow have a significant impact on outcomes.[26] The accumulation of positive and negative effects on health and wellbeing contributes to widening inequalities across the life course. The influence of early years' experience on later life health outcomes is well documented. In recent years the recognition that adverse childhood experience manifests as multiple negative health impacts has been a crucial extension of this knowledge.[27, 28]

The 'fundamental causes' of health inequalities such as power and wealth affect the distribution of wider environmental influences such as the availability of jobs, good quality housing, education and learning opportunities, access to services and social status (see Figure 2).[29]

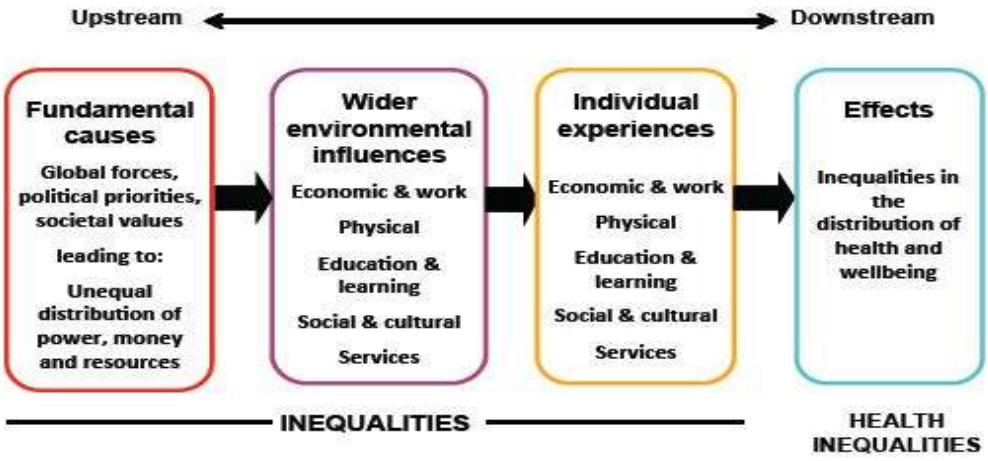


Figure 2: Fundamental Causes of Health Inequalities [37]

This results in differences in individual experiences of, for example, discrimination, prejudice, stigma, low income, and opportunities. These differences in individual experiences affect people's health in three main ways:

- Differential exposure to environmental, cultural, socio-economic and educational influences that impact on health.
- The psychosocial consequences of differences in social status. There is now strong evidence that 'status anxiety' leads to psychological and physiological changes that affect health.
- The inequalities in health that are observed now will reflect not only current status but also differences in experiences at earlier stages in life. This is why interventions targeting families and the early years are so important.[30]

Social Inequalities in Lothian

In comparison with the rest of Scotland, Lothian has notably less areas classified among the most deprived in the country. Around 11% of Lothian's population, just over 100,000 people, live in areas categorised as among the most 20% deprived in Scotland. The greatest number of these areas are located within Edinburgh (approximately 58,000) but proportionately West Lothian has the highest share of its population (28,000) living in the most deprived communities.

	SIMD 2020 datazones by population share in Lothian				
	SIMD 1	SIMD 2	SIMD 3	SIMD 4	SIMD 5
Edinburgh	11.4	12.0	14.5	17.5	44.6
East Lothian	6.0	28.7	24.0	22.2	19.1
Midlothian	8.5	35.0	22.4	19.3	14.7
West Lothian	15.7	27.4	18.7	18.7	19.5
Lothian	11.3	19.4	17.3	18.5	33.5

But only around a third of income deprived residents live in those areas of Lothian shaded dark red in the mapping of Scottish Index of Multiple Deprivation (SIMD) in the region. In other words, around 65% (almost two thirds) of people who are income deprived live outside of the 20% most deprived areas of the region.[31].

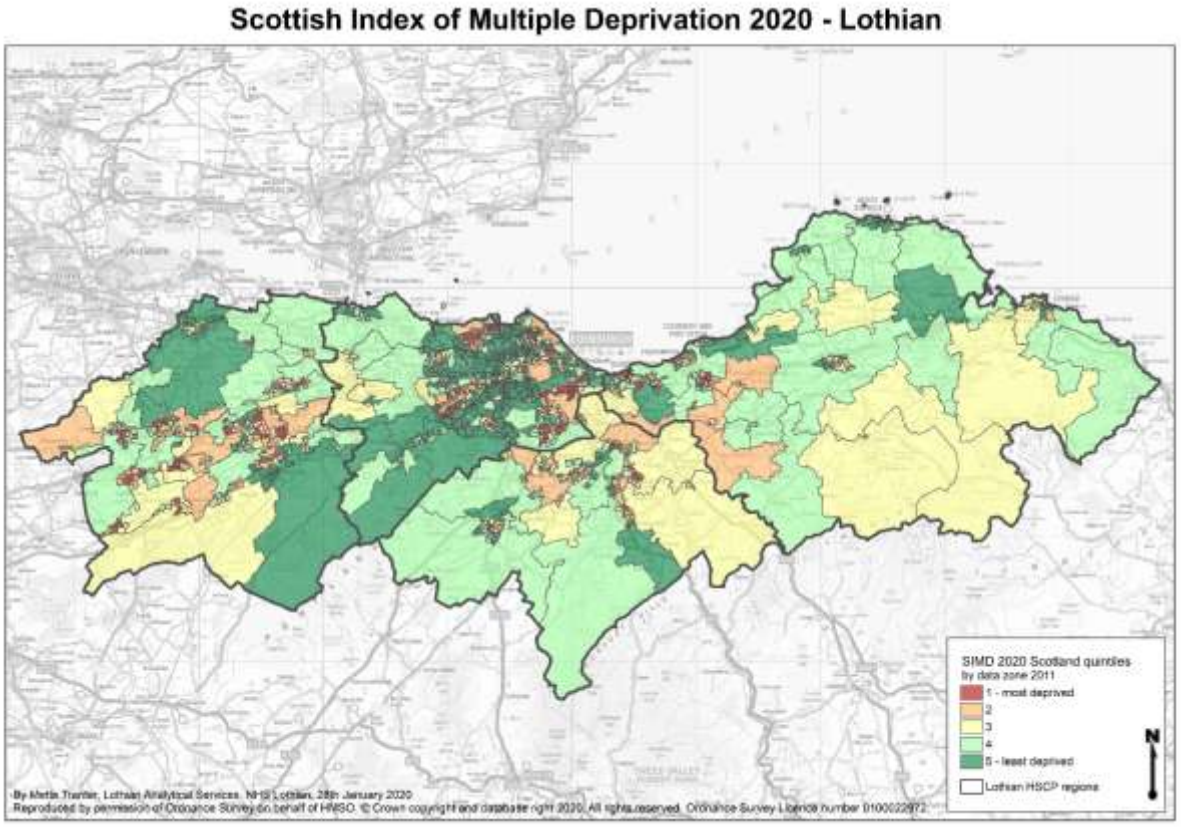
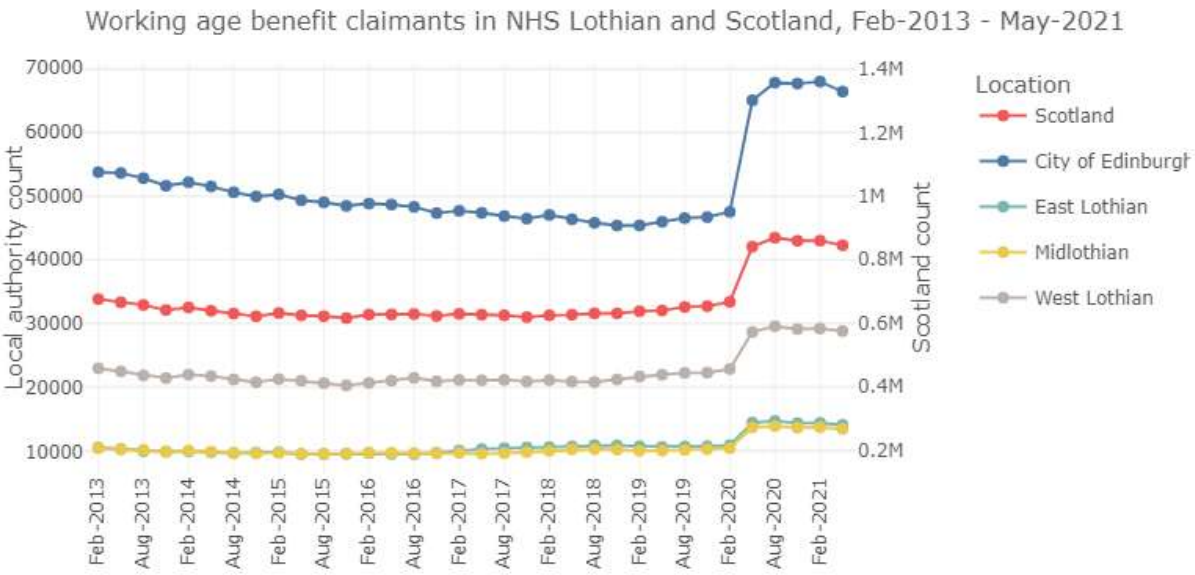


Figure 3: Scottish Index of Multiple Deprivation 2020 quintiles for Lothian

Health inequalities cannot be described solely in terms of geography. Work by Poverty Commissions in East Lothian and Edinburgh highlighted the extent of poverty not captured by the measures included in the Scottish Index of Multiple Deprivation. Child poverty data further shows that between one in four and one in five of the children in Lothian experience household poverty. The increase in universal credit and other benefit claims in Lothian associated with the pandemic is another marker of financial stress. The increase in emergency Scottish Welfare Fund payment and ongoing demand for food banks are other manifestations of extreme poverty.



Disability is another life circumstance that propagates health inequalities and structural inequalities are also driven by racial and sexual discrimination. The intersection of different experiences and life circumstances drives inequality and poverty at an individual and population level.

Population Health Improvement in the Lothian Strategic Development Framework

NHS Lothian's population health work is led by the Directorate of Public Health and Health Policy. There is a long-standing challenge to reduce inequalities that is central to this work. The impacts of the pandemic have reiterated the inequality challenge. The pandemic has also highlighted the continued risks from longstanding infectious and communicable disease challenges. A strong, co-ordinated response to COVID-19 and other new or emerging disease is essential. However, population health improvement is a whole system task extending beyond public health work. Health in all policies means NHS Lothian having clarity about how population health needs can be influenced most effectively outside the health and care system. It is necessary to tackle social causes of ill health such as low income, homelessness, poor housing and worklessness as well as significant individual-level risk factors that lead to poor health such as smoking, high blood pressure, obesity, poor diet, lack of activity and excessive alcohol consumption. NHS Lothian has committed to pursuing this work through its Anchor Institution Programme Board alongside a programme of work led by Public Health Partnership and Place teams based in each Community Planning Partnership Area. For the Lothian Strategic Development Framework, population health improvement must therefore focus on

Priority 1: support for the health and social care system; and

Priority 2: establishing NHS Lothian as an Anchor Institution as the basis for its inequalities and anti-poverty work

Priority 3: Health in All Policies across Lothian partnerships

Priority 1: support for the health and social care system

Within the health and social care system, population health prevention and improvement work must be proportionate to need with high quality, universally available services that support people throughout their lives. Then, at times when health need – driven by the complexity of individual-level and social factors – is greatest, more targeted, flexible service responses are required. There should be a focus on all life stages as a way of supporting people to take control of their health. For example:

- Family health: vaccination uptake and sex and relationship health
- Working age: importance of screening uptake; recognition of early multimorbidity with particular emphasis on mental health;
- Older people: older people's mental health pathways, frailty prevention and delivery of community-based interventions; support polypharmacy reviews as part of key prevention approach to falls in older people.

In addition to the life-course focus, however, it is important to ensure that a focus on alleviating the impacts of health inequalities is embedded into the health and social care system. Much of this work is delivered through other sections of the Lothian Strategic Development Framework. But highlighting barriers to engagement with services, supporting work to develop person-centred services, supporting needs assessments are building blocks for service improvements.

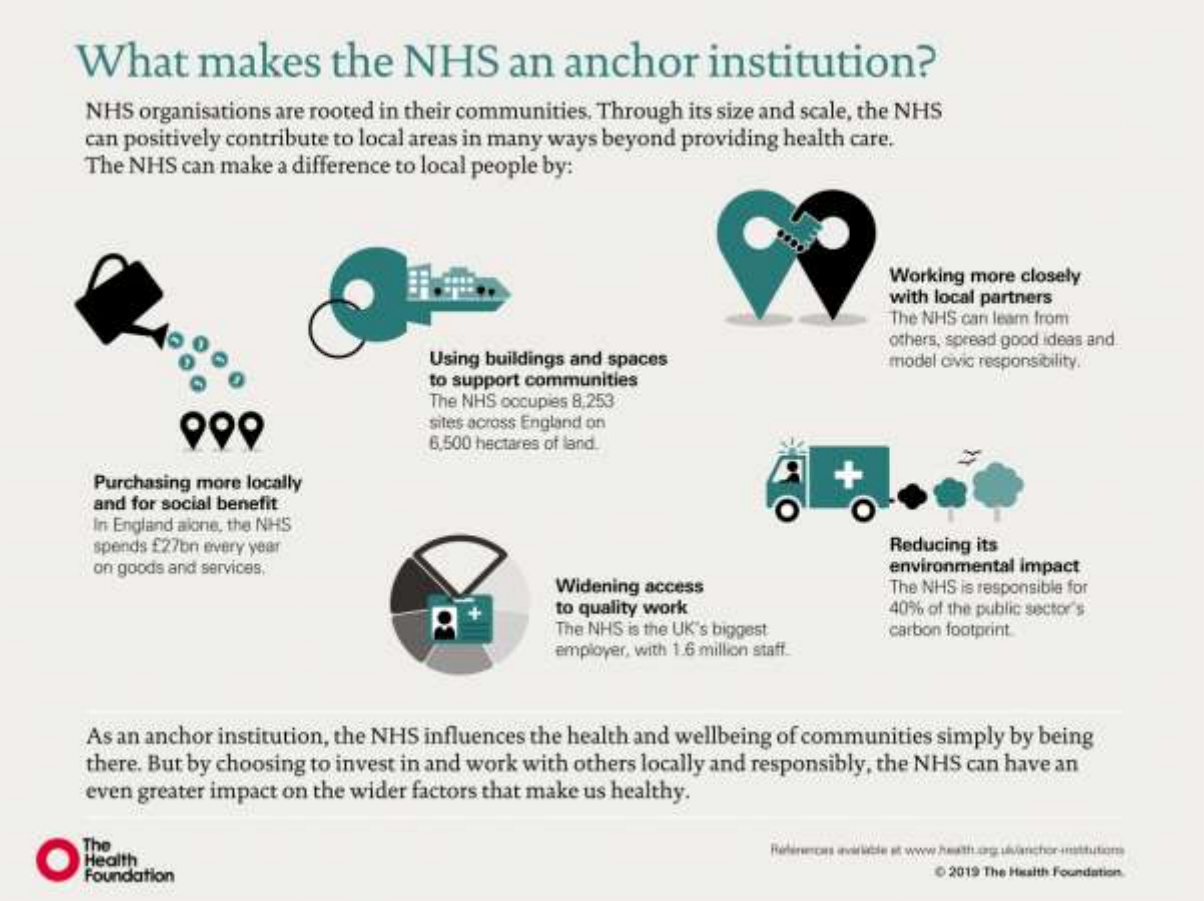
Priority 2: establishing NHS Lothian as an Anchor Institution as the basis for its inequalities and anti-poverty work

NHS Lothian is an Anchor Institution due to its influence in purchasing and procurement, considerable assets and facilities. The Board's influence in purchasing and procurement, strategic use of its assets and facilities, its significance as a regional employment hub can be deployed to impact positively on the health and wellbeing of the local population, above and beyond providing health and care, therefore addressing the determinants of health and contributing to the prevention of ill-health. NHS Lothian's role as an Anchor Institution is central to our contribution towards improving population health and wellbeing and tackling poverty and inequalities. A co-ordinated approach to Anchors work will ensure that NHS Lothian uses its strategic influence to ensure population health improvement and reducing health inequalities underpin our commitment public to service reform.

The Health Foundation has outlined the following principles around which the NHS can advance its role as an Anchor Institution; NHS Lothian's approach is grounded in these principles:[2]

- Using buildings and spaces to support local communities
- Working more closely with local partners
- Purchasing more locally and for social benefit
- Widening access to quality work
- Reducing its environmental impact

[2] Reed S, Göpfert A, Wood S, Allwood D, Warburton W (2019) Building healthier communities: the role of the NHS as an anchor institution. Available: https://www.health.org.uk/publications/reports/building-healthier-communities-role-of-nhs-as-anchor-institution.



The Anchor Institution Programme Board oversees a work plan with actions under each of The Health Foundation themes.

The Sustainable Development Framework is aligned to this approach. The burden of health harm from climate change falls disproportionately on those from more vulnerable communities and groups. Focussing on the health of our population alongside the health of our planet to improve air quality and develop neighbourhoods where everyone has access to good quality housing, greenspace and work will help mitigate these impacts and reduce inequalities. The Board's Anchor Institution work will be extended to wider partnerships through the public health teams working with each local authority area.

<u>Priority 3: Health in All Policies across Lothian partnerships</u>

The Review of Public Health in Scotland emphasised the importance of focusing on the determinants of health such as income, employment and housing. The Public Health Priorities for Scotland include

- A Scotland where we live in vibrant, healthy and safe places and communities
- A Scotland where we have a sustainable, inclusive economy with equality of outcomes for all.

Since the Christie Commission on the future delivery of public services, Scottish Government legislation has required NHS Lothian to engage formally in community planning partnerships, health and social care partnerships and child poverty work; the legislation reinforces the message about prevention-led public services recommended by the Christie Commission. The national Public Health

Priorities further stated the importance of preventative partnership working to deliver population health improvement.

> This document is intended to be a foundation for the whole system, for public services, third sector, community organisations and others, to work better together to improve Scotland's health, and to empower people and communities. It is a starting point for new preventative approaches, and a new awareness around wellbeing. …
>
> [The priorities] are a consensus on the most important things Scotland as a whole must focus on over the next decade if we are to improve the health of the population.

The delivery of NHS Lothian's place-based partnership work is led by four newly established Public Health Partnership and Place teams. These teams are developing work plans with partners in each partnership area. These plans will focus on health in all policies. A health in all policies approach involves working to ensure that all policy areas start to recognise their role in health, to value health and wellbeing, and contribute to enhancing population health. This means work with partners that prioritises reducing income inequality, housing inequality, educational inequality, child poverty an improving employability and other drivers of poor health. There is a developing evidence base to inform this work. Public Health representation on Community Planning Boards will be ensure consistency between strategic and local public health activity. The link to public health work plans will also ensure that the Board's Anchor Institution contribute to wider policy development such as Community Wealth Building.

Population Health Lothian Strategic Development Framework 5 year priorities

Population Health Priorities in the Lothian Strategic Development Framework
Now (Year Zero) • Life expectancy varies by 13 years and socioeconomic gradient in health • Social and economic factors have exacerbated health impacts of the pandemic and created backlog in healthcare, delayed presentation and treatment. • Wider public sector ongoing: expectation that NHS Lothian has leading role in community planning and other policy forums

	Priority 1: Population Health in the Health and Social Care System	*Priority 2: NHS Lothian as an Anchor Institution to reduce inequalities*	*Priority 3: Health in All Policies across Lothian partnerships*
Year 1 (2022-2023)	Establish Regional Health Protection function Implement Vaccination Transformation Programme Support cancer and non-cancer screening programmes in COVID-19 recovery Develop the healthcare public health work plan	Implement NHS Lothian Anchor Institution Programme Board: work plan focus on procurement, employability, income, capital development and disposals, sustainability and partnership Lothian hospitals income maximisation service established NHS Lothian is Living Wage Accredited Local Child Poverty Reports provide basis for wider anti-poverty approach in NHS Lothian	Establish public health led population health improvement approach in each Lothian partnership area jointly with community planning partnerships. Introduce core population health inequalities indicators into partnership discussions. Public Health Partnership work plans with clearly defined outcomes and measures established

	Priority 1: Population Health in the Health and Social Care System	*Priority 2: NHS Lothian as an Anchor Institution to reduce inequalities*	*Priority 3: Health in All Policies across Lothian partnerships*
Years 2/3	PH contribution to reducing inequalities through whole system working with particular emphasis on health intelligence (inequalities) and evidence informed interventions.	Principles established for use of NHS Lothian assets to contribute to reduction in inequalities Proposals for Astley Ainslie Hospital developed Clearly defined approach to population health co-ordinated internally with the Anchor Institution Programme Board.	Clarity about NHS Lothian's contribution to Community Wealth Building in each partnership area
Years 4/5		Anchor Institution Estates plans implemented	

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Children & Young People

Introduction

The early years of a child's life lay the foundations for physical, social, intellectual, and emotional development, linked to later life outcomes such as educational attainment, income, and where we live and work - all of which are drivers of health. A focus on the early years of life has been recognised as offering the best opportunity for preventing future health inequalities.(1)

The United Nations Convention on the Rights of the Child (UNCRC) defines a child as a person under 18 years of age (although children can be deemed competent in various areas before that age). The Children and Young People (Scotland) Act 2014 (Part 9) introduced a range of duties for Corporate Parents to provide support to care experienced children and young people up until their 26th birthday. Taking a life course approach to improving health and reducing health inequalities considers important life stages and transitions in child and family life where there are opportunities to support health and wellbeing and reduce inequalities, from preconception through early childhood, adolescence and transition to adulthood and work and family life.

There is a need to move from crisis management to prevention, early identification of need and early intervention through proportionate universalism, in the context of the wider determinants that influence health and future outcomes. Long-term, collaborative, and multifaceted efforts are required to tackle health inequalities, with a child-health in all policies approach.(2)

Inequalities and the impact of Covid-19

Health is closely linked to the conditions in which people are born, grow, live, work and age and inequities in power, money, and resources – known as the social determinants of health.(3) Health inequalities are the avoidable difference in people's health across the population and between specific population groups. These differences are socially determined by circumstances which are generally out-with an individual's control. Existing inequalities have been made worse by the Covid-19 pandemic.

The impact of factors such as deprivation, care experience, disability and other protected characteristics on daily lives can be considerable. The effects of poverty in childhood, including living in a low income family and in poor quality housing, can be felt into adulthood and can affect every part of a child's life – from economic and material disadvantage to impacting negatively on health and attainment. A collaborative approach is required across community planning partners, including children's services partnerships, and communities to develop services and effectively tackle the range of circumstances which contribute to poor health and health inequalities.

Covid-19 containment measures have widened inequalities in early years development and educational attainment.(1) Access to family support has been limited, particularly impacting families with children who have additional support needs. Children from more disadvantaged backgrounds tend to have less access to resources for home schooling, including digital access for online learning. Home learning environments may be less suitable for some children, who live in crowded homes affected by parental stress and poverty. Systematic reviews on the effects of school closures due to other disease outbreaks show that a loss of education is particularly harmful to the most vulnerable students, having a detrimental impact on welfare and causing nutritional problems in those eligible

for free school meals.(1) School closures can increase social isolation in young people, impacting on mental wellbeing at a time where there is limited access to mental health support and youth work services. For some, school closures may expose more children to violence at home. The pandemic has impacted employment prospects for young people aged 16-24 years, due to the availability of employment, apprenticeships, and other training programmes. This will impact health and wellbeing in the longer term. Child poverty rates are likely to rise.

There is a need to 'level-up' and improve life chances for those that are more disadvantaged, be that due to deprivation, adversity, care experience, disability, or ethnic group. Proportionate universalism is the provision of universal services at a scale and intensity proportionate to the level of need. It focuses on improving the health of the most disadvantaged groups as well as reducing the entire social gradient.(4)

The Royal College of Paediatrics and Child Health (RCPCH) State of Child Health Report (2020) presents three overarching priorities to improve the health, wellbeing, and life opportunities of children and young people. These are to reduce child health inequalities, prioritise public health prevention and early intervention, and build and strengthen local, cross-sector services to reflect local need.(5) The State of Child Health indicators show a widening gap between the health of children from the most and least deprived backgrounds.

A report by the Children and Young People's Special Interest Group in 2021 recognises that the pandemic has required high levels of resilience among all families. Some groups will have felt the impact of the pandemic more acutely than others, including children and families living in poverty before the pandemic or who are now living in poverty; children with additional needs and those with complex health conditions and disabilities; and families with adult distress through mental health needs, problematic alcohol and substance use, parental conflict, physical, emotional or sexual abuse. The report highlights that mitigating the disruption caused by the pandemic will require more than a resumption of services – it will require active recovery of missed opportunities and support to manage experiences of adversity and trauma from the direct and indirect effects of Covid-19.

Legislative and policy context

The National Performance Framework for Scotland sets out eleven national outcomes. One of these is that – *we grow up loved, safe and respected so that we realise our full potential*. The Framework highlights the importance of enhancing life chances through early years provision and supporting families when they need it. It commits to ensuring that children are involved in decisions that affect them and that their rights, dignity, and wellbeing are protected.(6)

The Children and Young People (Scotland) Act 2014 introduced significant changes that impact on the way children's services are delivered. The Act placed *Getting it Right for Every Child* (GIRFEC) on a statutory footing, underpinned by a common definition of wellbeing; that children are safe, healthy, achieving, nurtured, active, respected, responsible, and included. The principles of GIRFEC support child and family-centred care, and ensure that prevention, early intervention, tackling health inequalities and collaborative working are core aspects of service delivery. The Act places a

duty on local authorities and health boards to jointly prepare a Children's Services Plan every three years.

Part 9 of the Children and Young People (Scotland) Act ensures care experienced children and young people are a priority by creating the statutory basis for Corporate Parenting. It establishes a set of duties and responsibilities for relevant public bodies requiring them to intensify efforts to meet the needs of looked after children and care leavers, up to the age of their 26th birthday. This is further enhanced by The Promise which will drive forward the recommendations of the independent care review and the change in policy, practice and culture needed to maximise life chances for care experienced children and young people.

Child poverty can have a detrimental impact on health and wellbeing, educational attainment, and the future life chances of children, young people, and their families. The Child Poverty (Scotland) Act 2017 was introduced to drive and monitor action to reduce the number of children living in poverty in Scotland. Four statutory income targets were set for 2030, and four interim income targets for 2023. The Act places a duty on local authorities and health boards to jointly prepare an annual report on the activity they have taken, and will take, to reduce child poverty in their local area.

The United Nations Convention on the Rights of the Child (UNCRC) 1989 is an international human rights treaty that grants all children and young people a comprehensive set of rights. The UNCRC (Incorporation) (Scotland) Bill was introduced to parliament in September 2020 and means that children's rights will be legally protected in Scotland. Public bodies must take steps to respect, protect, and fulfil children's rights and ensure children and young people are involved and listened to in relation to decisions that affect them and their communities.

Adversity in childhood and the importance of relationships

Adverse childhood experiences are described as adverse events or traumas that occur in a child's life which result in a chronic stress response, and include all forms of abuse, neglect and household adversity such as domestic abuse, substance misuse or living in care.(7) Experiencing adversity in childhood has a detrimental, life-long impact on health, educational, and social outcomes. The risk of experiencing adversity is higher in areas of higher deprivation, and therefore they need to be understood in the context of poverty and inequality. Work to prevent and respond to adversity in childhood centres on the development of trusted relationships with individuals and families, and the delivery of trauma-responsive care. The National Trauma Training Programme aims to develop a trauma-informed and trauma-responsive workforce across Scotland, ensuring that care is delivered in a way that prevents further harm, builds resilience, and promotes recovery.(8)

LSDF:

Priorities for NHS Lothian and partners

Priority 1: Improving maternal health and tackling poverty

It is widely acknowledged that the health of the mother impacts on the health of the child long after infancy. Many interventions can improve mother and child health outcomes if delivered before pregnancy or early in pregnancy.(9) In line with GIRFEC principles, maximising health and wellbeing before, during and after pregnancy is important in improving child health outcomes and tackling inequalities. Maternal weight, mental wellbeing, stopping smoking and breastfeeding all improve the health of mothers and infants.(5) The foundations of health and wellbeing are laid down in these initial stages and providing support to parents and carers at this time is essential to ensuring children have the best start in life.

A Scotland where we flourish in our early years is a national public health priority for Scotland. This recognises that experiences in childhood, such as the impact of poverty, can have a significant impact on health outcomes throughout a person's life.(10) Action to prevent and mitigate the impact of child poverty in the early years is vital to improving the health, wellbeing, and life chances of future generations. It is vital that those working with women and families before, during and after pregnancy are fully trained and enabled to support financial wellbeing.

Areas of focus:

- *Preconception*
- *Best Start*
- *Financial wellbeing midwifery and health visiting services (links to Anchor work and LCPARs)*
- *Maternal weight*
- *Maternal smoking*
- *Maternal alcohol use and FASD*
- *Perinatal mental health*
- *Ensuring appropriate support for vulnerable pregnancies and implementing recommendations from the needs assessment of pregnant women with complex social factors*
- *Trauma- responsive care*

Priority 2: Infant and child health and wellbeing

Child health, development and wellbeing is supported from pre-birth to pre-school through GIRFEC principles and strengths-based approaches, the Universal Health Visiting Pathway, Family Nurse Partnership, early learning and childcare, and multiagency family support services. Early identification of developmental concerns (such as speech, language and communication skills or emotional and behavioural development) allows practitioners to target interventions and support transitions to early learning and school in those who need it most, to reduce inequalities in early years development and future educational outcomes.

Tackling poverty and the poverty-related attainment gap is crucial to supporting future health and wellbeing, and life chances. Action to address the cost of the school day, provision of high-quality early learning and childcare, and maximising resources to support learning through provision of free school meals and clothing grants, all support children and young people to learn.

Improving the mental health and wellbeing of children and young people should be seen within the context of wider social inequalities and the families and communities in which children live. Some young people are more likely to experience mental health problems, including but not limited to, children born into poverty, those who experience adversity in childhood, those who have a chronic health condition or learning disability, and those who are care experienced.(11) Good mental health support at an early age can protect and promote future mental wellbeing and resilience. Half of adult mental health problems start before the age of 14 and 75% start before the age of 24.(12)

Good mental health relies on a continuum of care. Prevention and early intervention start with early attachment and quality parent-child relationships, supported by evidence-based and accessible parenting programmes. Education and youth work services are core to supporting positive relationships and helping children to feel safe, resilient, confident, and ready to learn. The Royal College of Paediatrics and Child Health recommend that additional funding should be allocated to multidisciplinary youth services (healthcare, mental health services, youth workers and police) and targeted in the most deprived areas.(5) Youth work helps children and young people to develop their skills and confidence and plays an important role in enabling children and young people to reach their full potential, through the development of trusted relationships.

The Scottish Government's Mental Health Strategy 2017-2027 sets out a tiered approach to child and adolescent mental health services which emphasises the importance of well-equipped, multiagency universal and community-based services being the key building blocks of good mental health and wellbeing, with access to specialist care and treatment where required. Clear pathways need to be in place.(13)

Areas of focus:

- *Breastfeeding*
- *Solihull training, parenting programmes and wider family support*
- *Universal health visiting pathway and support for development outcomes*
- *Learning from child death reviews*
- *Child healthy weight*

LSDF:

- *Dental health*
- *Infant and child mental health and wellbeing – nurture, trauma-responsive practice, community mental health support, and specialist CAMHS*
- *Neurodevelopmental pathway*
- *Children and the environment – play, outdoor learning, active travel to school/nursery, new planning applications to consider children's needs*
- *Tackling poverty*

LSDF:

Priority 3: Adolescent health and wellbeing

Adolescence is a critical period which encompasses the transition between childhood and adulthood. In addition to that set out above, this is the stage of the life course when many of the factors contributing to lifelong wellbeing are (or are not) acquired and solidified.(14) Ross et al (2020) define adolescent wellbeing as having the support, confidence, and resources to thrive in contexts of secure and healthy relationships, realising their full potential and rights.(14)

Five domains of adolescent wellbeing are described.

- Good health (both physical and mental) and optimum nutrition
- Connectedness, positive values, and contribution to society
- Safety and a supportive environment
- Learning, competence, education, skills, and employability
- Agency and resilience

These domains are underpinning by gender, equity, and rights.(14)

Educational attainment influences life chances - employment opportunities and income in adulthood – factors which influence access to resources that determine future health and wellbeing. Children living in poverty have lower educational outcomes compared to those from affluent families, and these difference begin before children start school.(15) Parental income directly impacts educational outcomes due to the availability of resources for learning, the social and physical learning environment, and indirectly through its impact on parental mental health, stress, and the resultant quality of the parent-child relationship. Young people from the most deprived areas and those who are care experienced are less likely to be in a positive destination three months after leaving school.

Areas of focus:

- *Adolescent health and wellbeing service – inc. relationships, trauma-responsive practice, youth work approach, community mental health support, and specialist CAMHS*
- *Transition from paediatric to adult health services*
- *Positive destinations for all children and young people, including supported employment programmes*

LSDF:

Priority 4: The Promise: supporting care experienced children, young people, and families

An independent, root and branch review of Scotland's care system was commissioned by the First Minister in 2016. The Independent Care Review published its findings and recommendations in a set of reports in 2020, which cover the changes the Care Review recommended, plans for implementing changes, and the investment in services that was required.

The Promise identified a care system that is a complex web of legislation, policy and practice which does not reflect the needs of Scotland's children, makes 'cohesive operation impossible' and 'creates disconnects into which children, young adults and their families can fall'.

The Promise commits to creating a care system by 2030, in which:

- Children are listened to and meaningfully and appropriately involved in decision-making about their care.
- Families receive the support they need to stay together, including long term.
- Where living with their family is not possible, children must stay with their brothers and sisters where safe to do so and belong to a loving home.
- Children must be actively supported to develop relationships with people in the workforce and wider community, who in turn must be supported to listen and be compassionate in their decision-making and care.
- Children, families, and the workforce must be supported by a system that is there when it is needed. Help, support, and accountability must be ready and responsive when it is required.

Change Programme One (2021-2024) details the plan to implement the recommendations made in the Promise, across five priority areas:

- A good childhood
- Whole family support
- Supporting the workforce
- Planning
- Building capacity

These priority areas are underpinned by fundamentals principles: what matters to children and families, listening, poverty, children's rights, and language.

Community planning partners, including NHS Boards, are responsible for delivering changes across the five priority areas, working collaboratively to respond to the needs and aspirations of children and families in Scotland's care system.

Areas of focus:

- *Advocacy*
- *Family support*
- *Peer and community support*
- *Service integration*
- *Trauma-responsive care*
- *Workforce support*
- *Data mapping, collection, and analysis*

LSDF:

Supporting data in development:

Data required to support each section, by deprivation where appropriate:

- Maternal – healthy weight, smoking in pregnancy, perinatal mental health, ?alcohol use
- Child poverty – income-based targets, financial wellbeing referrals midwifery/health visiting
- Breastfeeding attrition
- Developmental outcomes at 27 months – SLC, emotional and behavioural
- Child healthy weight and dental health
- Mental health and wellbeing – ScotPHO mean mental HWB score at S4?
- Educational attainment and positive destinations – CYPIC measures (deprivation/Care Experience)
- Acute paediatrics – ED attendances, involvement in medical specialities by deprivation (GI, diabetes, respiratory)

LSDF:

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LSDF CHILDREN, YOUNG PEOPLE, AND FAMILIES 1/3/5 PLAN

Area	1 year	3 year	5 year
Improving maternal health and tackling poverty	• Best Start continuity model expansion commences • Programme commenced through CYP Programme Board and link with Children's Partnership boards to ensure families are supported. This includes building on the current work and collecting baselines to measure improvement against maternal weight/smoking/alcohol use/ as well as financial wellbeing and complex social factors. • Deliver the recruitment plan for each of the Perinatal and Infant mental health specialist teams. Put an evaluation framework in place for new services. Plan and deliver agreed aspects of new services • Clear strategy and implementation plans for trauma- responsive care defined working with Children	• Continuity model implemented as the Neonatal regional model further expanded • Delivery of family support work programme through collaborative working across NHS services as well as local authority and 3rd sector partners • Implement learning from Perinatal and Infant mental health evaluation work to refine current services and inform any expansion e.g. Lothian-wide Infant Mental Health service • Work commences across all areas to ensure interventions and services are trauma-informed	• Outcomes for mothers and babies improved through increased continuity of care and centralisation of neonatal provision for the most acute babies • Families are supported in a way that demonstrably improves outcomes for mothers, babies and families. • Appropriate support for vulnerable pregnancies and recommendations implemented from the needs assessment of pregnant women with complex social factors

Area	1 year	3 year	5 year
	Partnership Boards • Baseline current preconception provision in preparation for national framework	• Implement recommendations in national preconception framework across all partnership areas	

Area	1 year	3 year	5 year
Infant and child health and wellbeing	• Continued monitoring of the delivery of the universal pathway and areas for improvement identified. This includes monitoring workforce requirements. • Child Death review process continues and learning informs change. • Scope with our partners Infant and child mental health and wellbeing services including tier 1 and 2 community services. • Review of neurodevelopmental pathways to identify areas for improvement and learning across all HSCP areas is completed • Work with Children's Partnerships to ensure planning applications consider children's needs • Continued work on the local Child Poverty Action Plans (LCPAP) • Maintain Baby Friendly accreditation in maternity, health visiting and family nursing and working towards accreditation in neonatology. • Rolling out Henry programme to educate family support staff to engage with families about nutrition as well as baselining and exploring practical support that can be offered to families through collaborating with 3rd sector and local authority partners.	• Tests of change underway to improve both coverage and developmental concerns identified • Tests of change underway based on the learning extracted from the now embedded child death review process • Implement learning from evaluation work to refine current services and inform any expansion e.g. Lothian-wide Infant Mental Health service • Neurodevelopmental service trialled and improvements underway, with expansion of capacity and waits for assessment reducing • Trial use of children's rights impact assessments when designing physical spaces through Children's partnerships • Maximise family income through the delivering of the LCPARs through consistent and effective health input into these plans, as well as NHS Lothian fulfilling its role as an Anchor Institution. • Centralised infant feeding service working towards UNICEF Gold standards for all of Lothian and identifying additional support for families living in areas of	• Universal pathway delivery coverage maximised, and services commissioned based on need using developmental concerns aggregated data resulting in improved outcomes for the most deprived families. • Reduction in child deaths due to changes made over previous years • Embedded infant mental health service to support families who may be at risk of poor infant mental health. • No long waits for neurodevelopmental assessment and post diagnostic support is in place for everyone who needs it • Children's environments – play, outdoor learning, active travel to school/nursery, are improved through proactive assessments at the design stage • A demonstrable reduction in families and children living in relative poverty. • Attain UNICEF Gold standards and meet Scottish Government targets for breastfeeding drop off in all SIMD categories in Lothian. This is in line with the SG aim of reducing the drop off in breastfeeding rates at 6-8 weeks by 10% by 2025

Area	1 year	3 year	5 year
Adolescent health and wellbeing	• Adolescent service scoping concluded and recommendations, business case developed if required and outcomes agreed to evaluate impact. Evaluate impact of youth work based support services embedded in acute services. • Transition workstream concludes scoping and recommendations shared • A proposal for expanding supported employment programmes to be worked up to enable positive destinations for all children and young people. This proposal can be based on the evaluated impact of the care experience Edinburgh employment programme	• Adolescent service implemented in phased approach. Includes defining adolescent components included in "adult" services • Work underway with adult services as well as local authority partners to streamline transitions into adult services. • Further expansion of employment programmes working with all 4 local authority areas, specifically targeting populations sharing protected characteristics	• Adolescent service implemented giving bespoke model of services delivery for this age group and in turn demonstrably improving outcomes. • Transitions from children to adult services are improved and the correct support is planned in advance with adult services and local authority partners with the young person involved in the process. • NHS Lothian proactively supports positive destinations through employment programmes for all areas of Lothian and targeting professions where there are particular workforce challenges.

Area	1 year	3 year	5 year
The Promise: supporting care experienced children, young people, and families	• The Corporate Parenting Programme Board established, and a NHS Lothian Corporate Parenting Strategy and "the Promise" implementation plan developed that then informs priorities in the 4 partnership plans. These plans will be informed by effective engagement with CYP who are care experienced and can provide feedback based on lived experiences.	• The Corporate Parenting Programme Board monitors the delivery of the new strategic plan as well as identifying improvement areas and working with partners and young people to improve service delivery and outcomes.	• NHS Lothian can demonstrably evidence improvement in outcomes for care experienced children and young people through the effective delivery of the NHS Lothian and 4 partnership strategic plans.

Mental Health, Illness and Wellbeing

Introduction

The Covid-19 pandemic has undoubtedly been a challenge for the mental health of everyone in Scotland. Human beings are social creatures, and being cut off from family and friends is not something that feels natural to us.

The pandemic has been a time of significant distress and sadness for many people. People have lost loved ones to Covid-19, many people have had Covid-19 themselves and others have cut themselves off from society to protect themselves against it.

The pandemic has shown us how much inequality there is in society. Unfair and systematic differences across occupation, gender, race and disability have been intensified.

It has shown us the best in humanity and the worst. At times we forgot about the whole in an effort to protect ourselves, other times we came together to help one another get through and to clap for our carers.

There has been both a deep sense of togetherness, but in contrast, isolation and loneliness. Certain groups will have found it more challenging than others – those who were shielding, new mothers and fathers, those with children with additional support needs, and people with caring responsibilities. It has felt at times like a never ending battle, we had to switch off the news to give ourselves a break from the endless negative press. We felt a rush of adrenaline at the start as we came together to 'fight', but as the energy wore off, it was clear that this was not a war.

Keeping mentally well is complicated because it looks different for each person, but the pandemic has given us some insights. Some have realised that the busy pace of life they had pre-pandemic was never good for their mental health in the first place. Others have realised that the social interaction from being in the office, shops, places of worship that they took for granted were a central part of what kept them mentally well.

As a society we understand a bit more about what keeps us mentally well – good sleep, exercise, not drinking too much alcohol, eating healthy food, social interaction, fun, laughter and time for rest. We are more aware of how common mental health conditions like anxiety and depression are and slowly we are becoming better at asking for help. These are all good things which help people to keep mentally well.

As more people ask for help, mental health services need to be in a position to respond.

Prior to the pandemic, our Psychological Therapies and Children and Adolescent Mental Health Services (CAMHS) were in a challenging position, with demand higher than the capacity we had to support people. The pandemic has increased these challenges, there are now more children and young people waiting than ever for CAMHS and the people who require support are more unwell. Despite this, we have managed to make improvements to the number of people waiting for adult psychological therapies. In order to meet the needs of people in Lothian, we have been making changes to services, using digital alternatives wherever possible/appropriate and recruiting to additional staff so that we can see more people.

In CAMHS, we have launched an Unscheduled Care service to meet the needs of people in urgent mental distress at home. We have recruited to over 100 new posts across psychology, nursing and allied health professionals, and this is beginning to make an impact on our waiting lists. We are also focussing on making our processes as efficient as possible through a number of improvement programmes, including a Digital Mental Health project to improve our digital infrastructure. The Children's section of this plan also describes how we will work with community partners to focus on improving mental health in children and young people.

We recognise that the answer is often not to invest more in NHS services. There needs to be support available in people's local communities to keep them mentally well. Additionally, we know that accessing the things that keep people mentally well is more challenging for those who experience deprivation.

The four IJBs across Lothian have been developing plans which focus on local services, prevention of mental illness, suicide prevention, addressing inequalities and enabling access to services without going through the NHS. These plans will be described in more detail in the refreshed IJB strategies due to be published in 2022.

The services delivered by NHS Lothian are largely focussed on supporting those with significant and chronic mental health conditions. These include schizophrenia, bi-polar disorder, personality disorder, post-natal depression, eating disorders, addictions and poor mental health relating to significant trauma. NHS Lothian also provides forensic mental health services which support people who have been charged with a crime which is related to their mental health condition.

The planning for the majority these services sits with the IJBs and the plans for each local area will be described in more detail in the IJB Strategies. However, this plan details the current plans in NHS Lothian to improve the specialist mental health services that it delivers, in some cases where services are delivered centrally, it makes more sense to agreeone plan for the whole of Lothian instead of four.

One of the major developments within NHS Lothian's mental health services is the re-development of the Royal Edinburgh Hospital (REH) Campus. Phase 1 was delivered in 2019 and provided a new facility for adult mental health, older people's mental health and our intensive psychiatric care unit. The next Phase is being planned in stages but aims to deliver a new building for people with mental health needs who also have an intellectual disability and a national unit for adolescents with an intellectual disability and mental health needs, and a building for adult mental health rehabilitation and low secure care – low secure care is not currently provided in Lothian, so this will be a significant improvement for those receiving care.

Our campus re-developments include a shift of resource from hospital based care to communities, so there is a reduction in hospital beds which will be enabled by an increased investment in homes and care in the community for people with long term mental health conditions and those with an intellectual disability.

Hospital based care is absolutely the right place of care for some people, and we work continuously to ensure that we deliver the highest quality care within our hospital settings. However, NHS Lothian and the four Lothian IJBs are committed to ensuring that we only provide hospital based care when there is no other alternative. This is why we will be continually reviewing whether or not we have the right number of inpatient mental health beds and if we can transfer any resource into the community.

A related challenge is in our mental health workforce, where we have an unprecedented number of staffing vacancies, particularly in registered mental health nursing. We are working to increase staffing numbers; however, our proposed bed reductions in the campus re-development are required to enable us to provide staff in the new facilities coming onto the REH site.

There have been a number of national reports and recommendations focussed on some of our specialist services.

We have expanded our perinatal community mental health team significantly over the last year to support women with mental health needs whilst pregnant and with a baby, we are also developing an Infant mental health service to support families who may be at risk of poor infant mental health.

Our eating disorders service has experienced a 30-40% increase in demand during the pandemic, and we need to do more work to understand why. Meantime, we are increasing investment in our psychology and dietetics services to meet the additional demand, and are launching a project to implement recent Scottish Government recommendations for eating disorder services.

Details Table

Ref	Area	1 year	3 year	5 year
1	**Psychological Therapies**	• Deliver the recruitment plan, maintain staffing levels, and achieve the increase in General Adult Mental Health Capacity remaining on or ahead of the waiting list reduction trajectory • Deliver the recruitment plan for additional specialist and supervisory roles and achieve the LDP standard in specialist PT services • Expand the use of the Lothian Psychological Therapies website and the delivery of digital therapies, including links to, and the use of, the proposed new Scottish Psychological and Wellbeing Digital Service	• Achieve and maintain the LDP standard across all Psychological Therapies services • Enhance earlier intervention through continually reviewing, re-defining and expanding the provision of psycho-social support at HSCP level supported by delivery of digital wellbeing modules and consultancy support from specialist psychology staff • Further integrate support services (social work, housing, employment), local psychologically informed care (primary care, matrix level 1 psychological interventions, interest groups, peer support) and specialist psychological therapies (groups, intensive therapy, consultancy support), including Third Sector roles as appropriate	• Enhanced programmes to raise psychological wellbeing and resilience as part of an integrated public health approach • Seamless pathways for Psychological intervention focused on early intervention and appropriate escalation (step up / down) supported by effective eHealth arrangements for administration and referral management and patient records • Review and refine the population-based needs assessment for evidence-based psychological therapies and negotiation of appropriate workforce investment to deliver a range of treatment at different levels of intensity, clear intervention criteria at all levels, and relevant outcomes standards and monitoring
2	**CAMHS**	• Implement the Choice and Partnership Approach	• Achieve and maintain the LDP standard across all	• Continue participation in the Children's Partnerships

Ref	Area	1 year	3 year	5 year
		(CAPA) across Tier 3 CAMHS Services in terms of the care principles, the care process, and the capacity planning and delivery approach • Deliver the recruitment plan for Tier 3 CAMHS, maintain staffing levels, and achieve the planned increase in Outpatients Capacity, remaining on or ahead of the waiting list reduction trajectory • Deliver the recruitment plan and with partners implement a Primary Care / Tier 2 service, including local retention and treatment of some cases currently referred to Tier 3 • With partners implement Single Point of Referral arrangements in all HSCP areas • Complete implementation of the CAMHS Unscheduled Care Service fully integrated with the broader range of Children's Services • Implement a Hub and Spoke model for delivering Eating Disorders Services, including expansion of specialist capacity • Enhance the delivery of Transition Planning, including,	CAMHS services • Fully embed and refine the use of CAPA within CAMHS, including effective operation with Single Points of Referral and full integration with Tier 2 local services and Tier 4 specialist services • Support the collective overall system of children's services including community capacity building through consultancy to schools, Third Sector organisation and other Children's Partnership participants and expansion of digitally delivered support and therapies • Deliver a new Neurodevelopmental Pathway fully integrated with Community Child Health, Paediatrics and wider Children's Partnership members ensuring support is provided at the appropriate level and meeting the LDP standard for waiting times for formal assessments	collectively working with parents and schools towards avoiding and reducing mental health problems and distress in children and enhanced home, school and community delivered programmes to raise psychological wellbeing and resilience as part of an integrated public health and education approach to the welfare of children • Increased local delivery of mental health services for children and families mediated through health, education and other professionals with consultancy support from CAMHS specialists and referral to Tier 3 only where necessary for the most significant / severe cases

Ref	Area	1 year	3 year	5 year
		where appropriate, retaining the care of patients up to age 25 within CAMHS • Expand the use of accredited digital therapies • Improve the administration and clinical support provided through Trak through redesign of functionality and additional training and support for staff	• Enhance recruitment, retention and career development for CAMHS staff through the development of new Nurse Consultant, Advanced Nurse Practitioner and Community Assistant Practitioner roles • Increase the CAMHS Psychiatry workforce as the available recruitment pool grows through additional trainee posts	

Ref	Area	1 year	3 year	5 year
3	**Mental Health Rehabilitation and Low Secure**	• Begin the commissioning exercise for long term care facilities based in the community to allow relocation of those patients currently in hospital who are no longer receiving intensive rehabilitation, but who do have significant longer term care and support needs • Submit the Initial Agreement to the Scottish Government and gain approval for a new facility at the Royal Edinburgh Hospital for 37 Mental Health Rehabilitation beds (reduction from the current 64 beds) and 23 new Low Secure beds	• Established alternative community places of care for those with significant long term mental health needs with patients having started / possibly completed moving out of the Royal Edinburgh Hospital • Outline Business case submitted to SG and approved for the new Rehabilitation and Low Secure accommodation	• New build accommodation for Mental Health Rehabilitation and Low Secure complete or almost complete • Use of existing Mental Health Rehabilitation beds still in use reduced to 37 in preparation for the move to the new facility • Low Secure care established and now delivered from within NHS Lothian with all patients, where appropriate, repatriated

Ref	Area	1 year	3 year	5 year
4	**Learning Disabilities**	• 21 discharges from existing inpatient Acute Learning Disabilities beds to community-based alternatives completed • Reduction achieved in the provision of inpatient Acute Learning Disabilities beds from 38 to 19 reflecting increased community provision and support for patients • Initial Agreement submitted to Scottish Government and approved for a new facility for 19 Learning Disability Inpatient beds	• Further 12 Learning Disabilities discharges to community care complete • Outline Business case submitted to Scottish Government and approved for the new facility	• New build facility for Learning Disabilities complete or almost complete
5	**National Intellectual Disability Adolescent Inpatient Unit (NIDAIPU)**	• Recruitment complete for the initial team to begin developing the service specification and associated physical infrastructure • National group established to review pathways and define arrangements for scope, use and patient flow through the national unit	• Refurbishment of existing facilities to provide a 2 beds facility completed, with commencement of the initial service • Outreach element of service developed to support local community teams across Scotland	• Expansion to 4 beds for the service complete or almost complete as part of the wider national expansion of Intellectual Disability services
6	**Prisons**	TBC	TBC	TBC

Ref	Area	1 year	3 year	5 year
7	**Perinatal and Infant Mental Health**	• Deliver the recruitment plan for each of the specialist teams. · Put an evaluation framework in place for new services. · Plan and deliver agreed aspects of new services e.g. delivery in commencement sites for infant mental health service.	• Implement learning from evaluation work to refine current services and inform any expansion e.g. Lothian-wide Infant Mental Health service.	• Achieve and maintain agreed service delivery and performance.
8	**MH Unscheduled Care**	• Clear and agreed route established and in use across NHS Lothian for responding to mental health calls to NHS 24, with agreement on the clinical decision maker role and processes for engagement of local unscheduled care services • Digital recording and support improved through customised updates to the TRAK system • Work undertaken in conjunction with Scottish Government to further develop national and local Mental Health Unscheduled Care plans	• Arrangements for rapid delivery of Brief Interventions in place across all unscheduled care services • Community Hubs bookable for local interventions by unscheduled care services available in each IJB area • Clear joined up strategy between NHS 24, NHS Lothian, the 4 IJBs and Police Scotland on an integrated common approach to mental health unscheduled care together with appropriate administration and system support	• Fewer frequent attenders through unscheduled care services achieved through enhanced distress local support services • Clear pathways and joined up working between all public sector and Third Sector agencies providing the various components of an integrated unscheduled mental health care system

Ref	Area	1 year	3 year	5 year
9	**Eating Disorders**	• Clear understanding of the demand for Eating Disorders services, including an understanding of any longer-term effects and impact of the Covid-19 pandemic • Plan developed for deployment of the additional funding provided by Scottish Government, which is likely to include increased staffing to enable the service to meet the 18 weeks standard • Project scoping and work underway to identify ways to make the service more sustainable and effective working in partnership with patients and the Third Sector	• Post pandemic demand stabilised and long-term need clarified • Further projects underway to ensure services are sustainable, integrated and effective, including earlier intervention and support for community partners • Increased understanding of the potential demand and services required to address 'binge eating disorder'	• Project improvements complete or ongoing • Service meeting 18 weeks standard
10	**Trauma Services**	• All urgent response services re-instated post pandemic • Scoping underway to identify any areas for further support for the service, including the role for Third Sector partners	• Agreement across Lothian around the role of Rivers and funding is sustainable • Recruitment to key offers such as Sea Change and Lightbulb is sustainable • To work across each HSCP to promote range of trauma informed psychological interventions within the evidence base for improved continuity and consistency of care	

Ref	Area	1 year	3 year	5 year
11	**Substance Use Services**	• Pan Lothian Substance Use Services group re-established • Plan in place for increasing the bed base for intensive rehabilitation if required and funded by Scottish Government in light of increased alcohol and drug related deaths	• Joint priorities identified across Lothian • Clear long-term direction of travel for substance misuse services supported by multi-sector planning • Decision made on where place-based services should be delivered	• Actions identified in joined multi-sector plans are complete • Achievement of earlier intervention based on a comprehensive multi-agency psycho-social support approach

Ref	Area	1 year	3 year	5 year
12	**Acute MH beds**	• Continue to maintain Mental Health Acute Bed occupancy at the Royal Edinburgh Hospital in the range 90 – 100%, including retaining the additional beds opened in 2019 to reduce occupancy levels and those in 2020 to manage Covid-19 isolation • Complete the review of Acute Care in Edinburgh in collaboration with Health Improvement Scotland including in scope community support for those with a history of inpatient admissions, MHAS and IHTT scope and capacity, the use of acute beds, and treatment and discharge scope and processes • Validate findings from the above review and their relevance in the other HSCP areas • Review discharge processes and implement improvements working alongside patients and carers	• Redesign and reconfigure acute care with a view to admission avoidance wherever appropriate and practical and in the best interests, and consistent with the wishes, of the patient • Implement any revisions to the required bed complement and put in place any associated requirements in terms of capacity in IHTTs, MHAS and other community resources • Implement a programme of intensified inpatient therapy with a view to reducing lengths of stay and achieving earlier discharge through closer integration with, and involvement of, community resources during the admission	• Continue to expand the boundaries of the support, from all community participants, that can be provided for patients at home and locally to maintain their mental health and avoid the occurrence of first episodes and relapses that require admission.

Ref	Area	1 year	3 year	5 year
13	**Older People's MH**	• Complete the Review of older people's mental health beds in Edinburgh City as part of the wider beds based review	• Reconfigured bed base reflecting the changes proposed in the bed based review	• The right number of older people's mental health beds in acute hospitals are in place and there is flow through the service with people receiving care in the least restrictive environment possible and there are greatly reduced numbers of delayed discharges
14	**Neuro-developmental Pathways**	• Review of neurodevelopmental pathways to identify areas for improvement and learning across all IJB areas is completed	• Improvements underway, with expansion of capacity and waits for neurodevelopmental assessment reducing	• No long waits for neurodevelopmental assessment and post diagnostic support is in place for everyone who needs it
15	**Veterans Services**	• To recruit psychological therapy staff to reduce waiting times and to provide a range of evidence based treatment • To consolidate links with 3rd sector providers, working with peer support workers to provide social based interventions and promotion of interventions to facilitate servicemen into paid employment	• To improve pathways of service provision into V1P, with improved clarity about providers for inpatient specialist care and outpatient care • To work with SG to identify recurrent funding for veterans specialist networks to stabilise person centred service delivery	• To maintain balanced and agile service with timely interventions, matched to each service person's level of need

Primary Care

What is Primary Care?

"Primary Care" is a very broad term which covers over 90% of citizen contacts with the NHS. Primary care covers a wide range of services, including;

- General Practice;
- Community Pharmacy;
- Community Optometrists (the first point of contact for any eye problems provided by high street opticians);
- General Dental Services;
- Public Dental Service;
- General practice out-of-hours services;
- Dental out-of-hours services;
- District nursing;
- Vaccination programmes e.g. for childhood immunisations, flu, and covid-19 etc;
- Community Treatment and Care Centres;
- Community Mental Health services;
- Pharmacotherapy services;
- Physiotherapy services.

Often "primary care" and general practice can be conflated. However, it is important to recognise how wide the provision of primary care services are across the 24/7 period.

Most of the time people use their own personal and community assets to manage their health and wellbeing. Primary care professionals, whether in general practice, dental practice, community pharmacy, optometry or urgent out-of-hours teams, enhance this by providing accessible health care and support to individuals and families in the community each and every day.

A good primary care system would be able to;

- Provide high-quality care for the population it serves;
- Prioritise those at highest risk;
- Support those with long-term conditions to self-manage these conditions as well as possible;
- Play a significant role in longer-term prevention of disease and harm.

How is Primary Care organised?

The organisation of Primary Care is complicated.

The statutory responsibility for the strategic planning and commissioning for Primary Care services lies with the four Lothian IJBs. General practices, optometrists, pharmacists, and dentists are independent contractors (with the exception of 8 GP practices within Edinburgh that are directly managed by Edinburgh HSCP and the Public Dental Service that provides General Dental Services and is directly managed by NHS Lothian) and provide services in line with nationally negotiated contracts. The contracts and administration of this work sits with NHS Lothian, which retains the statutory duty for provision.

HSCPs have the operational responsibility for the oversight of delivery of primary care services, and so employment of district nurses, some wider members of the general practice multi-disciplinary team and staff for out-of-hours general practice and dental services is by NHS Lothian.

LHCS accepts that this is complicated and therefore has a series of mechanisms in place which ensure safe and coherent management of the system. We are keen to ensure that we are more explicit in our strategic development and ensuring coherence and therefore are strengthening our current arrangements to take the work cited in here forward.

While Primary Care is delivered in neighbourhoods, villages, and towns, the contracts for general practice, optometry, community pharmacy, and dentistry are negotiated and agreed at a Scotland-wide level. So while the LSDF captures what LHCS sees as the correct direction of travel, this is subject to national policy developments and agreements, and the requirements this places on us.

What challenges does Primary Care face?

Primary Care faces a range of challenges in common with the rest of the LHCS, and specific challenges to different components.

General challenges

As noted throughout the LSDF, the population of the Lothians has grown by 12% over the last decade. The four local authority areas in Lothian are four of the five fastest-growing areas in Scotland. Funding for NHS Lothian, from which our Primary Care system is funded, remains behind where it should be according to the Scottish Government's funding mechanisms. This means there is less financial resource available for service provision. Some of this is offset by the high-efficiency of our general practice and pharmacy systems in effectively managing prescribing budgets, but the general challenge remains.

More broadly, the reductions in local authority funding over the last decade means that there is a social care provision crisis, and the impact of the covid pandemic on increasing waiting times for outpatient and elective care, means there is an increased pressure on our primary care system, most acutely felt in general practice, as patients seek support as their circumstances or conditions deteriorate.

While we have a growing population, this is not supported by a concomitant growth in staffing numbers. As noted elsewhere in this LSDF, demographic challenges mean that our working-age population is shrinking. The availability of general practitioners in particular has changed, and our system has therefore prioritised recruiting other healthcare professionals to expand the primary care workforce. It is therefore not unusual for citizens to now see a physiotherapist, a mental health worker, or a pharmacist as the first point of call. This change in model of general practice has impacted on other primary care services, for example the more pharmacists that support the general practice team the fewer available in community pharmacy as that workforce is also developed to meet demand.

The impact of the COVID-19 pandemic has been very significant. While our primary care systems have continued to provide high-quality care, the way in which we provide care has changed markedly, with a significant move away from in-person, first-come, first-served models of access, and, in general practice in particular, a shift to a model based on triaging of appointment requests, often digitally, and with contact being offered on the basis of need. This means that people needing to see a General Practice clinician in person will be seen in practice, but that those who can be supported over the phone or through digital communications are provided with a consultation in this way. This reduces the footfall through practices, provides more ways to access care often in a more convenient way, and the evidence we have is that there is a very significant section of the general population who prefer this approach.

General practice

There are 120 general practices across the Lothians with an average list size of 8,295 (excluding the Challenging Behaviour Practice). A decade ago there were 126 practices when the average list size was just over 7,000. An additional 110,000 people have been supported by general practice over the past 10 years. General practice in the Lothians remains high-quality with good outcomes in the

management of long-term conditions. Investments made by LHCS in expanding the workforce to deliver the national aims of the 2018 General Medical Services contract have reduced some of the pressure. However, the relentless increase in population growth does mean we have a significant challenge in keeping heads above water.

We do see a challenge for the next five years in ensuring that we have enough capacity across the general practice team to meet demand, including all members of the growing general practice multi-disciplinary team; administrators, practice managers, general practitioners, practice nurses, ANPs, pharmacists, AHPs and HCSWs.

We are also acutely aware that the quality of our general practice facilities is not always what we would want it to be. While we have invested heavily in new facilities and alterations and expansions to current buildings, many of our practices are, in Edinburgh in particular, in very old buildings that will need to be replaced over the next 15 years or so, with some needing alternative provision over the short-term. Our growing population also puts demands on additional space needed to house the additional members of the general practice multidisciplinary team, even with the move to provision of care remotely.

In addition, to support the move to providing services digitally and remotely, and with the pressures on space, we need to overcome some of the IT challenges to enable remote working to happen more easily. This is broader than just NHS Lothian eHealth with national changes to enable electronic prescribing to happen routinely.

General Practice Out-of-Hours Service

The Lothian GP Out-of-Hours service (LUCS) provides good access to urgent GP care when GP Practices are shut. This is provided across 5 bases in Lothian to provide care as close to home as possible for our citizens. Much like in-hours general practice, there are challenges to ensure sustainability of the workforce, particularly in attracting staff to work in the out of hours period.

Pharmacy

Pharmacy services have expanded considerably over the last decade and play a crucial role in supporting citizens in their own homes and communities.

We have community pharmacy services across Lothian with our 182 community pharmacies providing approximately one pharmacy per 5,000 population. In our more urban areas community pharmacies are frequently within a 20-minute walk of citizens homes and workplaces.

Achieving Excellence in Pharmaceutical Care is Scotland's strategy for Pharmaceutical Care in Scotland[3]. The launch and expansion of the core NHS Pharmacy First service demonstrates the role of community pharmacies as one of the first points of call for citizens to access healthcare advice and medicines. Other core services, universally available, include the Acute Medicines, Public Health,

[3] Achieving Excellence in Pharmaceutical Care - A Strategy for Scotland (www.gov.scot)

and Medication Care and Review Services. Community pharmacies also provide a wide range of enhanced services including services to care homes, care of people with substance misuse problems, palliative care network and increasingly, creating more vital capacity in flu and covid vaccination programmes.

The Lothian Community Pharmacy Pharmaceutical Care Services Plan 2021 outlines the recommendations to continue developing the role of community pharmacy through additional enhanced services (these are locally negotiated services and not part of the core provision of service and therefore not all pharmacies will provide enhanced services, and neither are they obliged to).

The challenges in pharmacy relate to how we can balance the further development of local services. Frequently we will see pharmacies who are innovative and keen to offer more to their local communities e.g. provision of Independent Prescribing Pharmacist clinics (Pharmacy First +), but where the local facilities are not flexible enough to allow this to happen, or where workforce challenges mean pharmacists need to focus on their core business and service.

Recently, workforce challenges have emerged in part due to the expansion of clinical pharmacy roles working in General Practice - the Pharmacotherapy Service. This service is a welcome addition to the multidisciplinary primary care team and delivers on several commitments to improving patient care made in Achieving Excellence in Pharmaceutical Care. There is opportunity to focus on making best use of skill mix, including the roles of Pharmacy Technicians and Pharmacy Support Workers, with plans to develop a new model of hub working within HSCPs, where pharmacotherapy tasks can be co-ordinated from a remote location. The pharmacy teams embedded in GP Practices can then focus on other direct patient care activities, optimising their skill set.

Optometry

Optometry is a stable and strong part of our healthcare economy, where national contracts facilitate a good balance of innovation and stability. There are 123 optometry practices (high street opticians) across Lothian. There are innovative developments within community optometry services to keep referrals for more complex conditions within the community network of optometry services therefore reducing referrals to secondary care services and providing care closer to home for our citizens.

Dental

Dental services have been significantly impacted by the nature of the COVID-19 pandemic. As COVID-19 is an airborne virus, one of the main methods of transfer is through aerosols generated by certain procedures and treatments, and this particularly includes dental treatment. Therefore, our estimate is that approximately 40% of the previous levels of activity are now being carried out in independent dental practices. This presents challenges to ensuring the dental health of the citizens of the Lothians, as well as raising significant questions as to the sustainability of the specialty. Not only will we have a growing backlog of treatment outstanding – which will continue to grow until we significantly mitigate the risks – we will struggle to attract people into the profession, especially with the closure of the Edinburgh Dental School several years ago.

We are fortunate in Lothian to have a secondary care oral health service to provide complex oral surgery. However, we want to ensure patient care is delivered in the community where appropriate.

Therefore we will develop an intermediate care model for oral surgery with a funding model that supports General Dental Practitioner provisioner in the community.

Before the pandemic a discussion began between the Scottish Dental Practices Committee of the British Dental Association and the Scottish Government about a revised model of care for NHS Dentistry, as the current system has been widely agreed to be no longer fit for purpose. We will be engaging with government colleagues about future reforms but as yet there is no timescale for any changes.

District nursing

Although district nursing services performed heroically – and in an unsung way – throughout the first waves of the pandemic, there are underlying pressures in demography in the profession. Firstly, although LHCS has stabilised the position over the last 5 years, there remains the challenges of how best to recruit people into the profession. This is made more difficult by the growing demand that there is for services, especially as we see the population age, with more health conditions requiring district nursing input.

What are we trying to achieve in Primary Care over the next five years?

We would want our Primary Care system to be able to deliver in the fashion we described at the start of this chapter;

- Provide high-quality care for the population it serves;
- Prioritise those at highest risk;
- Support those with long-term conditions to self-manage these conditions as well as possible;
- Play a significant role in longer-term prevention of disease and harm

In particular, we want to ensure that we can develop the concept of general practitioners as the "expert medical generalist" as outlined by the Scottish Government and be clear on how this is understood and applied in the Lothians.

There are some very specific markers that we would wish to monitor:

- That citizens are able to receive an urgent appointment, if clinically necessary, in a primary care setting, on the same day;
- That we want general practices to maintain open lists;
- That we support community pharmacies to grow and develop their capacity to deliver enhanced services such as vaccination services in addition to reliable delivery of core services;
- That citizens can access general practice services through digital access routes over the next 5 years;
- That patients get the best outcomes from their medicines, with access to regular review by an appropriate clinician;
- That patient access to vaccination services includes a range of local options, for example a mix of mass vaccination venues and more local community based sites, i.e. Community Pharmacies;
- That patients receive their care as close to home as possible and therefore variation in referral rates to secondary care across Lothian are reduced.

How are we going to deliver this?

The actions that we want to take going forward build on actions we have already taken to sustain and balance our system, but we need to accelerate some of these to ensure that we;

- Support development and spread of models that allow for asynchronous access and maximise multi-modal communications technologies e.g. phone, NearMe, e-consult, to develop a system which reflects modern citizen needs and expectations. We will move away from "the 8 o'clock lottery";

- Support general practice in continuing to develop triage systems to ensure that those with the greatest need are prioritised, and that patients are managed by the professional with the most appropriate skills for their needs;

- Bring forward cases to invest in technologies which support self-care and self-management of long-term conditions such as diabetes and hypertension;
- Continue to invest in new facilities for general practice provision, and wherever possible to build these alongside other public services. We will work within the City of Edinburgh to develop the “20-minute neighbourhood” approach, and in other areas to support “town and village centres”;
- Support the development of community pharmacy, optometry, and dentistry aligned with national contractual arrangements;
- Increase access to community pharmacy as the first port of call for managing self-limiting illnesses and supporting self-management of stable long-term conditions, in-hours and out of hours;
- Integrate pharmacists with advanced clinical skills and pharmacy technicians in GP practices to improve pharmaceutical care and contribute to the multidisciplinary team;
- Sustain access to GP and dental out-of-hours care as close to home as possible.

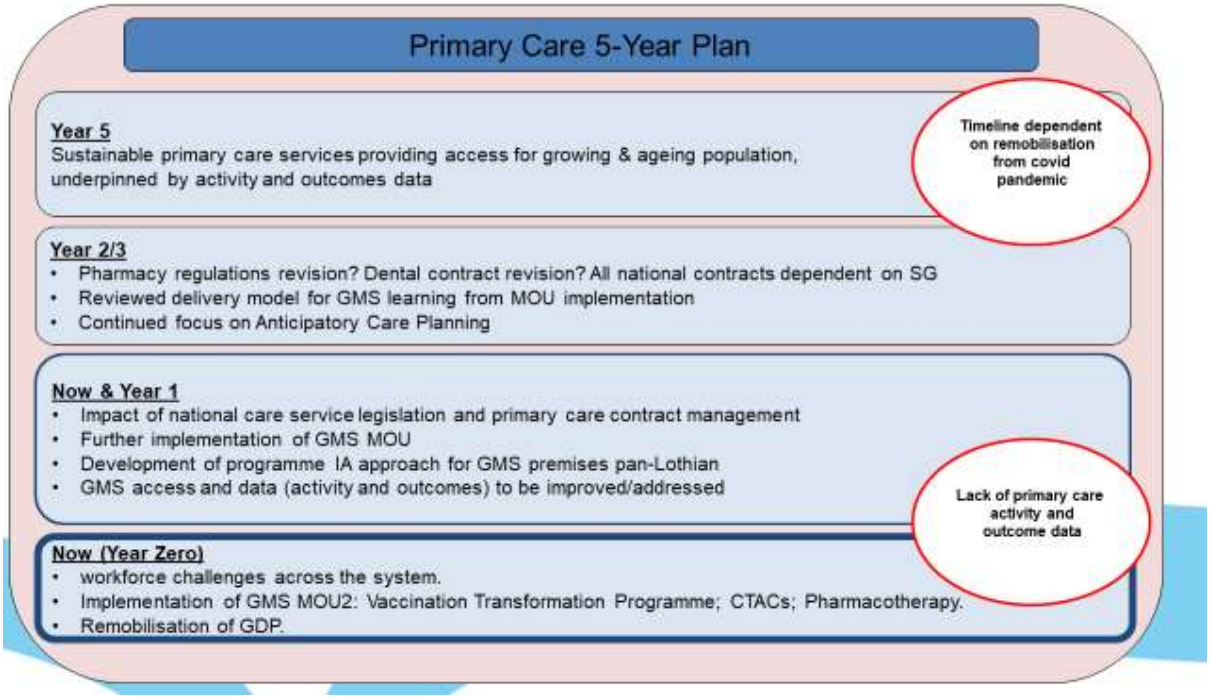
We believe that working more and more closely with other public services at the neighbourhood or village level is key to ensuring that citizens are supported in the most appropriate way. We are very conscious that, in Edinburgh in particular, we have significant challenges with some of our primary care facilities, and we have been investing in these over the last decade. Where there is opportunity with future developments we will look to increasingly house public services in shared buildings with shared facilities.

Our actions year by year

In year one we will seek to;

- Support general practice in stabilising its position, by building on the implementation of the Vaccination Transformation Programme, CTACs, and Pharmacotherapy priorities of the general medical services contract, and evaluate the impact of the improvement plans on general practice capacity;
- Develop the strategic programme investment appraisal for general practice to agree across LHCS and at government level the investment needed to ensure appropriate access to general practice and the premises to support that;
- Work with general dental practices to expand activity from the baseline of 40% of pre-pandemic activity;
- Encourage and support community pharmacies to support vaccination programmes;
- Continue to develop public messaging about access to community pharmacy as a first line of contact for minor illness and self care advice;
- Work to keep all our current general practice out-of-hours bases open, and ensure good access to the dental out-of-hours service
- Develop the primary care data sets to better present activity and outcomes data

In year two we will build on the actions described above and influence national contracts revision working with government colleagues. Many of the future year's actions will be dependent on the national direction and the remobilisation from the covid pandemic.



How are GP Practices working?

NHS Lothian

GP practices are open

Since the pandemic, health services must operate differently to protect everyone. It's important to maintain safe infection control and minimise unnecessary physical contact where possible. This means there are now more ways for you to access care.

What has changed?

All appointments are being triaged. This helps keep you safe and makes sure that those who need to be seen in person are prioritise. We will see everyone in person who needs to be seen.

What is triage?

You will be assessed to decide who needs:

- to be seen in person
- a phone consultation
- a video consultation
- help from a community pharmacy.

Why do receptionists ask questions?

GP reception staff are a vital part of the health care team and are there to triage enquires.

You don't have to tell them anything that makes you uncomfortable, however they can help you get the most appropriate appointment as quickly as possible. All the information they handle is treated confidentially.

I wanted to see my GP, so why am I seeing someone else?

Many GP practices include nurses, advanced nurse practitioners (who can diagnose and treat health conditions), occupational therapists, pharmacists, physiotherapists and link workers.

By utilising the skills of everyone at practice we can ensure you seen as quickly as possible by the right person.

What about emergencies

Always dial 999 in a life-threatening emergency.

If you need help with minor injuries or urgent care when your GP practice is closed dial NHS 24 on 111.

Where else can I get help?

Visit **www.nhsinform.scot** for advice on common symptoms and a list of local services or speak to your pharmacist first for advice on minor illnesses.

Call 111:

- for minor injuries
- for urgent mental health advice and guidance
- if you're too ill to wait for your GP or dentist to open.

Please be patient

Our health services are under enormous pressure, but we are open and here if needed. Please work together with us to make sure you get the right care, in the right place, at the right time by the appropriate health professional for your needs.

Right Care Right Place

Unscheduled Care

Introduction

The provision of high-quality unscheduled care is at the core of NHS provision and is at the heart of the integration agenda. NHS Lothian provides a broad range of unscheduled care services, ranging from GP in-hour services, through GP out-of-hours, district nursing, minor injuries, medical receiving, surgical receiving and emergency departments, up to the provision of major trauma care for the South-East of Scotland.

The complexity does not stop at the organisational boundaries of NHS Lothian. The provision of social care services, both preventative and reactive in the form of home care, residential and nursing care, and a range of other services, requires considerable operational input from our local authority partners.

In 2019, the Pan-Lothian Unscheduled Care Programme was established to take a whole system approach to developing a sustainable model for the delivery of unscheduled care services. The aim is to provide timely access to care in the right place, at the right time, avoiding delays anywhere in the whole system.

Policy Context

In 2015, the Scottish Government set out its framework ***6 Essential Actions*** (6EAs) to improve unscheduled care and support the delivery of the 4-hour Emergency Access Standard. The 6EAs programme aims to ensure 95% of patients attending Emergency Departments are either admitted, transferred, or discharged within 4 hours. The focus of the programme is to deliver improvements across the whole system and in 2021, in response to Covid-19, a revised 6EAs was developed. The revised programme ***6EA: Building Capacity for Recovery*** aims to reduce unplanned attendance at Emergency Departments through three national programmes:

- ***Redesign Urgent Care Programme (Phase 1 and 2):*** Redesigning the Urgent Care pathway for patients seeking urgent non-emergency medical assistance. The overall aim of the programme is to reduce attendances at Emergency Departments by 15% to 20% ensuring faster access for those who do require to attend.

- ***Interface Care Programme:*** The overall aim of the Interface Care programme is to deliver high quality care for defined patient groups, which safely provides an alternative to hospital admission or leads to early front door discharge, reduces length of stay and occupied bed days to improve system capacity. The specific target population for Interface Care are those patients currently presenting with Acute Care Sensitive Conditions (ACSC Codes), with a length of stay between 0 -14 days. The overall SG aim is to achieve a 20% reduction in length of stay for the target population.

- ***Optimising Flow Programme:*** Improving discharge processes through the Discharge without Delay Programme. The Discharge without Delay programme aims to reduce delay in every patient journey by:
  - Prioritising planning and reducing the risk of inadvertently causing delay using a 'pathways-based planning' approach to support morning/daylight discharge
  - Whole-system planning and preparation for discharge

- Adopting 'home first' as an ethos, 'discharging to assess' as a default

The overall focus of the Scottish Government strategy for urgent and unscheduled care is on optimising safe and effective patient care whilst enabling local teams to develop appropriate alternatives to Emergency Departments.

Impact of Covid-19

The Covid19 pandemic impacted Accident and Emergency (A&E) attendances throughout 2020 - 21. During the months of national lockdown attendances were lower than predicted. This was largely due to the public messaging of staying at home and social distancing. A&E attendance has now returned to pre-pandemic levels and there are challenges in delivering a sustained performance >90% against the 4-hour Emergency Access Standard. Our overall performance has been influenced by a range factors including, but not limited to:

- workforce challenges throughout the acute and HSCP system secondary to staff shielding or self-isolating.
- patient acuity. Patients have presumed the system is overwhelmed and have therefore tolerated symptoms for longer and have presented later than normal via GP/Flow Centre /Self-Presentation
- the volume of Emergency Department (ED) attendances as restrictions have eased compounded by patients having difficulty accessing care within other parts of the system.
- bed pressures due to an increase in the number of delayed discharges.

Delayed discharges have been a challenge within Lothian and the result impacting on patients, both those who are delayed in hospital and the corresponding impact on those waiting to access hospital. The key reasons for delays are predominantly patient delays related to care required to live in their own home and nursing/residential home placements. The demand for community care has increased as COVID restrictions have eased, whilst capacity continues to be limited by the workforce availability. Drivers for increasing demand include people being de-conditioned (i.e. frailer, less confident) following periods of lockdown, family/unpaid carers who have cared for people during the pandemic returning to work following furlough. Capacity issues are due to reductions in staff availability across the sector with both our internal and external provision seeing as much as a 30% reduction in capacity. This is part due to EU nationals returning home, people moving to jobs in other parts of the economy, and fatigue and absence related to COVID-19 and the pressures of the pandemic on the workforce. Delays and community capacity are inextricably linked, with delays rising through the reductions in capacity and providers being unable to provide care at home.

Prior to the outbreak of Covid-19 there was agreement across the five organisations known as the Lothian Health and Care System that a collaborative approach would be taken to delivering unscheduled care. There is agreement and commitment to take a whole health and social care system approach to delivering the Lothian Home First principles which insures we provide quality care as close to home as possible. It is acknowledged that our hospitals provide high quality

specialist clinical care when required. However, staying in hospital leads to de-conditioning, falls, delirium and through this often prevents people from ever returning home. The Lothian Home First approach promotes independent living and reducing unwarranted harm caused by long hospital stays. The Lothian Home First principles underpin the strategic priorities within this document.

The Home First Approach advocates:

- Best pathway available: ensuring care is delivered as close to home as possible.
- What matters to you? – asking what matters ensures the care is delivered based on what is most important to the person receiving care.
- Assessment of health and care needs: determined by appropriate professional at appropriate time. Ideally, any assessment of long-term needs will be carried out in the individual's own home surrounded by their belongings in a familiar environment.
- Embrace Realistic medicine: balancing investigations and treatments and supporting shared decisions.
- Stay in hospital: when clinical needs can only be met in hospital, and the person should return home or to a homely setting at the earliest opportunity.
- Discharges and transfers of care are planned and coordinated early on, with clear expectations as soon as someone is admitted to hospital.
- Life-changing decisions about long term care: will not be made in times of acute crisis. These decisions should be part of Anticipatory Care Planning (ACP). ACP is based around thinking ahead conversations and allows opportunities to plan care that is right for that individual, making it more likely that individuals will receive the care they wish at times of crisis.

The strategic priorities outlined within this document are underpinned by a Home First approach with personalised care at the heart of ensuring our high-quality Unscheduled Care Services.

Unscheduled Care Strategic Priorities

The provision of timely access to care in the right place, avoiding delays anywhere in the system continues to be a strategic priority for NHS Lothian and the Lothian Health and Social Care Partnerships.

Strategic Priority: Whole system approach to reducing attendances, admissions, and occupied bed days to an acute hospital.

Redesign of Urgent Care: Phase 1

(Public Access – Reducing self-presenter attendances to Emergency Departments)

Our system is consistent in its belief that people should only come to a hospital if they absolutely have to and should not stay in hospital any longer than absolutely necessary. We will therefore continue to develop the approach to redesign urgent care we introduced during the pandemic.

The first phase of the **Redesign of Urgent Care** programme went live on 1st December 2020 for patients aged 16 years and over. This phase aimed to reduce and smooth self-presenter attendance demand at acute hospital front doors, to minimise overcrowding and protect public, patients and staff. Work continues to optimise this pathway.

Getting the Right Care in the Right Place

The way we access services changed and to help navigate our citizens to the right care in the right place we will develop a Lothian policy to support Signposting/Redirection at our entry points. We will actively support implementation of consistent approaches to **signposting/ redirection** to ensure patients receive the **right care**, in the **right place**.

Interface Care

(Professional access – increasing referrals to alternatives to ED attendance, reducing admissions and occupied bed days)

The second phase of the **Redesign of Urgent Care** programme is focusing on improving professional referral pathways and this will be explicitly linked to the development of new models of care that provide an alternative to admission to an acute hospital. Existing professional pathways will requirement enhancement and in some instances the development of new pathways will be required utilising both the Flow Navigation Centre and Single Point of Contact services within the community. We will continue to enhance our professional-to-professional pathways to improve access to early diagnosis, assessment, and monitoring to reduce potentially preventable admissions. Some aspects of phase 2 have been progressed alongside the phase 1 work, with each HSCP building on their existing community services to provide easy access for GPs to safely keep patients at home.

For example, WLHSCP community Single Point of Contact (SPoC) will enable GP and SAS referrals through a real time SPoC to access a range of community services as alternatives to admission. This real time SPoC will further enhance our approach to supporting people to stay at home or in a homely setting, with maximum independence for as long as possible and only come to hospital if they have to.

At present there are five key workstreams with technology as a sixth enabling workstream looking at enhancing our professional-to-professional pathways:

- **Community Pharmacy** - integrating community pharmacy into urgent care with an emphasis on self-care.
- **Primary Care** - enhancing referral pathways for patients requiring urgent care by building upon clinician-to-clinician communications.
- **Mental Health** – utilising existing mental health services and enhancing their pathways for unscheduled mental health presentations.
- **Scottish Ambulance Service** – focussing on delivering care closer to home for people requiring urgent care.
- **Musculoskeletal** - providing Physiotherapy resource in the assessment of acute and urgent medical needs to enhance the patient journey.

The effects on hospital admissions, particularly for our frail elderly population, are well known, which is why admission to hospital should only occur when the required level of clinical care cannot be provided at home. Alternatives to hospital admission remain our priority and we will continue to enhance and develop new models of care closer to home. This will require increased infrastructure in services such as Same Day Emergency Care, Care at Home, Hospital at Home and Single Point of Access in the Community.

We will enhance our enabling services to provide a range of interface care and will deliver this as part of the Scottish Government's National Interface Care Programme. The National Interface Care Programme focusses on safely reducing admission rates or shortening lengths of stay to improve patient experience and minimise hospital related complications. The Scottish Government definition for interface care is:

> *the delivery of high-quality care for defined groups of patients, that safely provides an alternative to avoid hospital admission or leads to early front door discharge and reduces length of stay. 'Interface Care' will provide care for the complete patient journey, from point of contact to conclusion of need, optimising staff and patient experience.*

We will use data to identify which conditions or symptom-based pathways would benefit from interface care delivery models. We will take a phased approach and implement alternative models to traditional hospital admission, over the next 3 years, with an initial focus on:

- **Same Day Emergency Care (SDEC) -** the provision of care for patients who may have otherwise been admitted to hospital for assessment and treatment. Under the SDEC care model patients with specific conditions can be assessed, diagnosed and treated without admission to a ward, and if clinically safe to do so, can be discharged home the same day. This delivery model benefits

both the patient and healthcare system by reducing waiting times and avoiding admissions where possible by ensuring patients receive the right care, at the right time, in the right place.

- The acute front doors throughout NHS Lothian are under immense pressure. An SDEC service is currently operational in the Western General Hospital and has assisted in decompressing pressures on the acute front doors. The next phase is the expansion of the SDEC service to a Pan Lothian model. A Pan Lothian SDEC model will aim to minimise and remove delays in the patient pathway, allowing services to process emergency patients within the same or next day by scheduling attendance as an alternative to unplanned ED attendance and onward hospital admission.

- **Hospital at Home** –provides a level of acute hospital care in an individual's own home that is equivalent to that provided within a hospital. It is an important part of the Lothian system supporting people to stay at home that reduces the potential harms of extended hospital stays, particularly for the frail elderly. It supports hospital sites by preventing admission, improves flow and reduces occupancy. The Lothian Hospital at Home services are well established but there are areas for improvement highlighted by all services, such as increasing referrals from GPs and other services, measuring unmet need and standardising opening hours.

- We are undertaking a review of the four Hospital at Home services across Lothian. The aim is to determine how best to scale-up current Hospital at Home provision to:

    - measure the true service need and the required capacity and consider how this can be sustainably delivered with a consistent and skilled workforce;
    - identify opportunities to standardise the Hospital at Home offer, referral criteria and work collaboratively across the four services (including workforce) and consider how best to work with other community-based services;
    - establish evaluation methods through an agreed core data set across the four services incorporating qualitative feedback; and
    - identify future delivery models that supports care at home and prevention of hospital admission.

- **OPAT and Respiratory – Accelerated Interface Care** Working with Scottish Government on OPAT and Respiratory services which have been identified for rapid 30, 60, 90 days accelerated increased capacity. We are in the process of scoping demand to identify optimal service expansion based on data. We will develop proposals for expansion of these services in conjunction with proposals around increasing capacity of Hospital @ Home.

- **Hot Clinics** – are intended to prevent hospital admission for patients presenting with acute problems. For example, a Respiratory Hot Clinic is available within RIE that aims to treat patients with acute respiratory problems and preventing a hospital admission. We aim to scale up and spread this model to other sites and other conditions.

- **Community Single Point of Contact** providing timely access to urgent requirements to prevent unnecessary acute hospital attendance and admissions. This can be delivered through a range of community services. For example, Integrated community teams to support rapid access to short- and long-term interventions, Care at Home Teams and Community Hospitals.

As we progress implementation of the above models, we will use our data to identify further areas for developing and delivering services that support people to stay at home or in a homely setting, with maximum independence for as long as possible and only come to hospital if required.

Strategic Priority: Whole system approach to Optimising Patient Flow

Discharge without Delay (DwD)

(Reducing occupied bed days)

Optimising patient flow and providing timely access to care in the right place at the right time, **avoiding delays** anywhere in the system continues to be a strategic priority for NHS Lothian. Good discharge planning is an essential element of patient flow. Hospital discharge is a complex and at times a challenging process for all involved, particularly for patients and their carers. We must acknowledge that delays do occur and endeavour to ensure effective discharge planning is in place across our system to shorten lengths of stay, reduce delays and hospital readmissions and improve patient experience and outcomes.

A pan-Lothian approach will be undertaken to deliver DwD. A core implementation group has been established and will develop an implementation plan based on completion of the DwD self-assessment. Next steps include:

- Undertake a self-assessment of discharges processes to identify areas for improvement through a scoring mechanism and develop an action plan for implementation to review.
- HSCP and Acute teams will develop their improvement implementation plans.
- DwD Implementation Group will drive implementation and monitoring of improvement plans through process and outcome data review.

A revised pan-Lothian **Discharge and Transfer Policy** is being developed and a collaborative approach to implementation is fundamental to the success of this. Taking into consideration how large and complex our system is, with multiple HSCPs and acute sites, our aim is to improve consistency in discharge planning and move to a planned date of discharge model, recognising that it will be appropriate to consider local processes/protocols for delivering this across our HSCPs. This variation reflects the differing demographic and geographic features and delivery models in place across our system. Delayed discharge is a whole system problem and it is important that the patient pathway is managed seamlessly by all key stakeholders, providing consistent positive outcomes for our residents across the Lothian system. We will develop and implement processes that support:

- whole system planning with good communication between professionals with the patient, family and carers;
- all parties working towards an agreed Planned Date of Discharge; and
- discharge to assess as default position.

In taking a whole system approach to optimising patient flow we will aim to deliver care as close to home as possible, support alternatives to admission, and ensure patients are **Discharged without Delay.**

1, 3 and 5 year Plan

Focus	1 year	3 year	5 year
Redesign of Urgent Care: • **Phase 1 Public Access** • **Signposting and Redirection** • **Review of Frequent Attenders**	• **Phase 1** – continue to optimise 111 pathway and reduce self-presenters at A&E. • Develop and support implementation of an NHS Lothian Signposting and Redirection Policy • Continue to support the implementation of the Scheduling Minor Injuries. • Conclude and evaluation Phase 1 • Conclude review of *Frequent Attenders* and make recommendations for future delivery models.	• Focus on enhancing technology as a key enabling workstream. For example, increase opportunities for virtual consultations • Continue to monitor performance against KPIs and test, develop and implement changes to continually improve our processes.	• 95% of patients attending Emergency Departments are either admitted, transferred, or discharged within 4 hours

Focus	1 year	3 year	5 year
• **Interface Care:** • **RUC Phase 2 Professional Access** • **SDEC** • **Hospital at Home** • **Hot Clinics** •	• RUC Phase 2 (Professional Access) – Support the development of further Professional to Professional referral pathways. Monitor and evaluate the impact of new / enhanced pathways. • Implement plans to expand SDEC service to a Pan Lothian model. • Review existing Hospital at Home Models against current national recommendations. Develop and implement action plan to meet national recommendations. • In collaboration with HIS conduct economic evaluation of Hospital at Home, whilst building capacity and capability of NHL staff in economic evaluation methodology. • Scale up Respiratory Hot clinics to other sites. • Identify potential focus for other clinical Hot Clinics • Identify options to create community-based capacity; specifically focussing on early intervention, urgent care, and prevention of admission.	• Continue to enhance the five key workstreams within RUC, building on the findings of the impact assessment. • Develop, test, and implement Hot Clinics for a range of clinical conditions. • Scale-up Hospital at Home services to meet population growth. • Scoping new service areas applicable for Hospital at Home delivery model. • Conduct impact and economic evaluation of new models, eg SDEC, Hot Clinics. • Support delivery models for community-based interventions.	• Reduce occupancy of acute sites. • Increased proportion Lothian citizens spend the last six months of life at home or in a community setting. • Hospital @ Home Services expanded • A range of Hot Clinics available to prevent hospital admissions.

Focus	1 year	3 year	5 year
Optimising Patient Flow: • **Planned Date of Discharge** • **Discharge without Delay**	• Develop a Lothian Planned Date of Discharge operating model with clear roles and responsibilities across acute and community teams. • Support culture and behavioural change to discharge planning processes through the development of an operating model. Agreeing an overarching set of principles, consistent approach and coordinated implementation to enable and support tests of change. • Promote standardisation to add value, supporting local variation where that value is key to the delivery of patient care, and encourage parallel working with all stakeholders. • Agree outcomes and timelines to improve the discharge experience for patients, increased numbers with a planned date of discharge plan, pre 12 noon discharge and reduced readmissions.	• Continue to support implementation of a Pan-Lothian approach to Discharge without Delay. • Enable open discussions and awareness of pilot processes, share good practice, and bring together a common Lothian approach ensuring the safe facilitation and effective discharge for patients who experience inpatient care in an acute or community hospital setting within Lothian. • Consider capacity and resourcing implications within acute and community teams to support enhanced discharge processes.	• Reduction in Delayed Discharges • Enhanced patient discharge experience with all discharges discussed with patients, their carers, and their families. • Increased numbers with a planned date of discharge plan and pre 12 noon discharge and reduced readmissions.

Scheduled Care

The Recovery of our Elective Services

Introduction and Background

Scheduled Care (also known as elective or planned care) covers out-patient, diagnostics, and in-patient and day-case services. As this is planned in advance, it is not normally considered an emergency. It may, however, be urgent and NHS Lothian manages referrals and treatments in line with their level of urgency and clinical priority.

Prior to the Covid-19 pandemic, the length of time and the number of people waiting for planned appointments or treatment was improving, with ongoing implementation of the Board's response to the Scottish Government Waiting Times Improvement Plan (2018).

NHS Lothian's plan included several initiatives to reduce demand, optimise utilisation of capacity, deliver additional internal activity and supplement with activity delivered by external providers. This was whilst also planning ambitious projects to address growing demand and longstanding capacity gaps in a sustainable way: through projects such as a new treatment centre for planned surgery on St John's Hospital campus, a new Eye Pavilion in Edinburgh, and a new Edinburgh Cancer Centre for the East Region on the Western General Hospital campus.

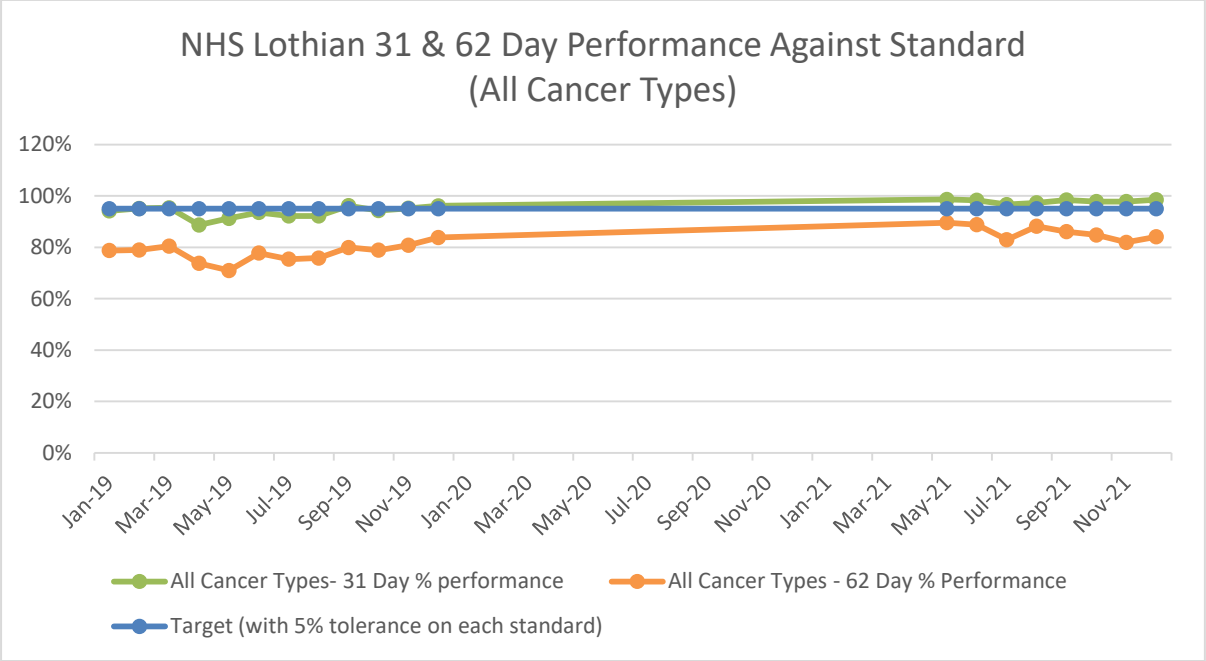
The impact of responding to the Covid-19 pandemic saw cessation of the majority of elective activity in wave 1, and as the pandemic continues we have seen ongoing reduction in scheduled care services, particularly in in-patient and day case activity. This is due to workforce pressures, (vacancies, absences and the redeployment of staff to unplanned activity), rising bed pressures due to high acute site occupancy, and increasing numbers of delayed discharges.

The Impact of Covid-19 & Current Challenges across Scheduled Care

As a direct consequence of the current Covid-19 pandemic, more people in Lothian are waiting longer for the care they need, impacting on quality of life, social and economic well-being, and consequently their physical and mental health. The number of people waiting for treatment in acute care has increased by over 50% (October 2021 vs February 2020), with waiting times increasing substantially for our less urgent referrals and treatments. These increased waits and impacts, in turn increase pressure on community services across health & social care.

Referrals to scheduled care have returned to pre-covid-19 levels. However, the proportion of urgent referrals received, including numbers of people referred with an urgent suspicion of cancer, has exceeded pre-Covid-19 volumes. Particularly in Dermatology, Gastroenterology, Gynaecology, and Respiratory Medicine, the number of people referred with an urgent suspicion of cancer is now significantly above previous levels. Whilst the 31 day cancer waiting time standard (from decision to treat to first treatment) has been met throughout the pandemic, the 62 day standard (from urgent suspicion of cancer (USC) referral to first treatment) remains challenged across a number of tumour groups in NHS Lothian, and across NHS Scotland, as shown in Figure 1. Since the onset of the pandemic, theatres have been operating below pre-Covid levels. Activity (not including additional External Provision activity) was 60% of 2019 activity levels in January 2022.

Figure 1: NHS Lothian 31 & 62 Day Performance



Outpatient services have achieved comparable levels of activity to 2019; with activity at 105% of 2019 activity levels in January 2022 (not including additional External Provision activity). Out-patient services are delivering activity through a combination of face to face and virtual appointments.

The limited capacity we have is directed to support our most clinically urgent patients, which impacts on our ability to provide timely scheduled care to our less clinically urgent patients. Clinical urgency is based on the published criteria developed by the Federation of Surgical Specialty Associations. COVID-19 documents - FSSA. A National Clinical Prioritisation Short Life Working Group (CPSLWG) was established, under the authority of the NHS Chief Executive of Scotland and with the support of the Chief Medical Officer, to provide national oversight of the Clinical Prioritisation process and the principles and guidance required to support the NHS in a secondary surge of COVID-19, and the subsequent recovery phase. The framework has been used in NHS Lothian from early in the pandemic, with a revision in February 2021 to replace the previous scheduled care priorities of Urgent and Routine with additional stratification as follows:

- Priority 2 (P2) Urgent Suspicion of Cancer (USoC; should be scheduled within 4 weeks);
- P2 Urgent (should be scheduled within 4 weeks);
- P3 (should be scheduled within 12 weeks), P4 (may be safely scheduled after 12 weeks).

P1 (emergency workload required within 24 or 72 hrs) are not included as scheduled care.

Implementation of clinical prioritisation has nonetheless led to specific challenges for certain specialties such as orthopaedics, where the majority of people waiting are categorised as P3 and P4. The shape of the Orthopaedic waiting list is shown in Figure 2 on the following page.

Figure 2: Shape of the Orthopaedic Waiting List 21 January 2022

Waiting list by priority - waiting by length of wait category

	0-4 weeks	5-12 weeks	13-26 weeks	27-52 weeks	53-78 weeks	79-104 weeks	>104
P2 USoC	1	0	0	0	0	0	0
P2 Urgent	22	11	7	8	6	1	0
P3	52	153	187	181	131	52	4
P4	175	766	997	1,422	814	116	26
Total	250	930	1,191	1,611	951	169	30

Source: TRAK

For these specialties, routine surgery may be less urgent from a medical perspective but people waiting significantly longer for surgery can result in a deterioration of their condition, a poorer quality of life for longer, higher risk of chronic pain, disability, depression and economic hardship.

Whilst we continue to work towards recovery we will also optimise opportunities to prevent and minimise deterioration e.g. through increased rehabilitation offered through Allied Health Profession (AHP) services and a developing multimodal pre-habilitation programme that involves exercise, nutritional advice, emotional support, and a behavioural change approach to help negate the negative effects of increasing waiting times for treatment and improve outcomes following treatment.

Delivering solutions that separate and protect high volumes of routine elective care in the face of competing pressure on resource from unscheduled, and higher clinical priority elective demand will be critical to recovery and future sustainability. It is known that prior to the Covid-19 pandemic, we had a recurrent capacity deficit in scheduled care, which was a key driver for the board's case for a new facility on the SJH campus for planned surgery, a new Eye Pavilion in Edinburgh and a new cancer centre at the WGH. There is now a significant and growing backlog of patients waiting to be seen.

NHS Lothian relied on waiting list initiatives, independent sector activity and an allocation from Golden Jubilee National Hospital (GJNH) to help meet previous levels of demand. There is currently limited availability across markets within Scotland to secure the quantities of external activity required to address the growing backlog of people waiting, and the recurrent capacity gap. The external market have themselves been impacted by Covid-19 and are experiencing an increasing demand and backlog of private patients waiting for treatment as well as similar workforce challenges. This presents a further risk to the stability of NHS Lothian's workforce, with growing competition for what is currently a finite workforce in Scotland.

We know demand for planned care will continue to increase based on changing demographics. Lothian's population is ageing more quickly than the rest of Scotland. In 2028 it is projected that there will be almost 10,000 fewer people aged under 30, and 40,000 more people aged 60 and above. Whilst the Lothian Health and Care System encourage the growing population of Lothian to take control of their own health we must also ensure people using healthcare services and their families feel empowered to discuss their treatment fully with healthcare professionals, including the

possibility that a suggested treatment might come with side effects – or even negative outcomes. NHS Lothian actively supports a Realistic Medicine approach, including:

- Active Clinical Referral Triage (ACRT)
- Introducing 'opt in' approaches for patients referred for arthroplasty
- Encouraging the use of 'BRAN' Choosing Wisely questions in clinical consultations, to promote shared decision-making
    - What are the **Benefits**?
    - What are the **Risks**?
    - What are the **Alternatives**?
    - What if I do **Nothing**?

Realistic Medicine may also mean seeking to shift our collective focus from clinical interventions at the end of life, to reimagining a better death. One in three people in Scottish hospitals is likely to be in the last year of life, and 16% in the last three months of life. (Clarke et al, 2014). We recognise the view expressed in the Report of the Lancet Commission on the Value of Death (2022) that the role of health care in care of the dying has become unbalanced: 'interventions at end of life are often excessive, exclude contributions from families and friends, increase suffering and consume resources that could otherwise be used to meet other needs'. Conversations about death and dying can be difficult. We want to work with our partners and our communities to support people in Lothian to talk about their wishes for care to the end of life, so that those wishes can be understood and respected, and to enable people to die well.

There are specific workforce pressures in scheduled care, within theatre nursing, radiology and endoscopy as well as widespread vacancies across nursing. For medical staff there are vacancies both in Consultant and Trainee level and there is also a growing shortage of anaesthetists within most health boards. Over the next 5 to 10 years, within the consultant workforce alone, a significant number of employees are expected to retire, in the region of 25% of the overall consultant workforce. In parallel, the supply of future consultants is not strong nationally, with for example over 40% of Orthopaedic trainees completing training choosing not to work in Scotland. The impact of the pandemic on training opportunities is significant for those on craft specialties (surgical and anaesthetic specialties), with a number of trainees requiring prolongation of their training to meet critical experience levels, particularly in those specialties where elective activity has been significantly reduced e.g. elective Orthopaedics, plastic surgery, ENT as well as Anaesthetics. These emerging challenges will only add to the shortages already experienced.

In light of the workforce challenge, addressing a growing backlog of care while continuing to meet the ongoing urgent or unplanned health and care needs of the population is a significant challenge faced by NHS Lothian, and all Health Boards across the country. The baseline from which we are planning to move forward is unstable/ deteriorating. Over the next 5 years Scheduled Care in NHS Lothian will focus on a number of key priority areas, described in the following section.

The Recovery of our Elective Services: Key Priority Areas over the next 5 years

To respond to the challenges set out in the above section we need to focus on actions that close the gap between demand and capacity in a sustainable way. This will include models to support individuals to self-manage their condition, new technologies to reduce demand and optimise current capacity, and programmes to deliver an expansion of our current capacity. Scheduled care services will focus on 4 key priority areas in the face of multifaceted resource challenges:

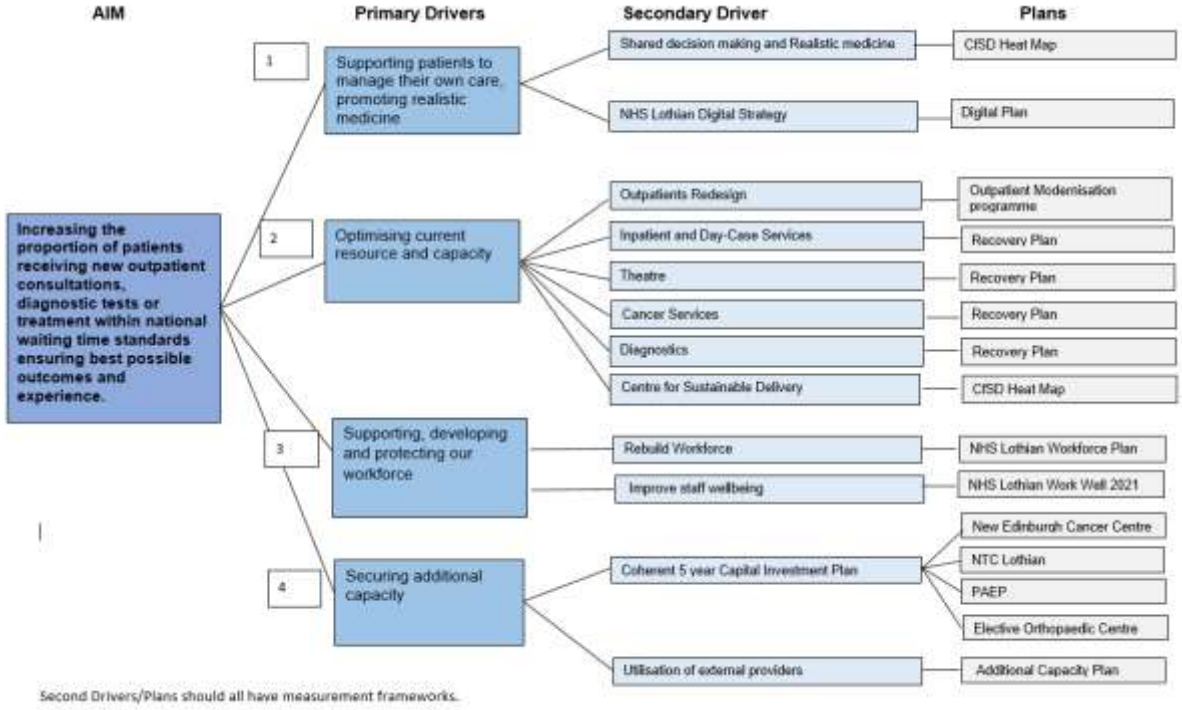
1. **Active promotion of Realistic Medicine -** Supporting our population to take ownership of their own health and the ways in which they engage with scheduled care services, promoting shared decision making and realistic medicine in all aspects of care including end of life. A critical factor will be how we maximise use of digital tools to in support of this.

2. **Optimising current resource & capacity** - Using our finite resources efficiently and effectively, with continued prioritisation of care towards the most clinically urgent whilst working to reduce the length of wait for people living in Lothian who require less urgent treatment. This will require a Quality Management Approach with a focus on value, innovation, co-production and sustainability to ensure we achieve, within the resources available to us, high quality, person-centred experience and outcomes for our residents.

3. **Supporting, developing and protecting our Workforce** – Building a healthful culture that develops and supports our workforce - now and for the future. To deliver this there will be a redesign of models of care, and skill mix, education and skills needs analysis. There will be active talent management and succession planning in addition to recruitment and retention initiatives.

4. **Securing additional capacity -** A coherent Capital investment programme - Progressing ambitious capital projects to address longstanding capacity gaps in planned care whilst utilising external capacity in the interim.

Figure 3: Scheduled Care Recovery Driver Diagram



Priority 3: Active promotion of Realistic Medicine - Supporting our population to take ownership of their own health and the ways in which they engage with scheduled care services, promoting shared decision making and realistic medicine in all aspects of care including end of life. A critical factor will be how we maximise use of digital tools in support of this.

Services will continue to manage referrals and treatments in line with their level of urgency and clinical priority. Health interactions will support shared decision making and realistic medicine in all aspects of care including end of life with an aim to deliver person centred outcomes.

Through active clinical referral triage we will embed the principles of "right person, right time, right place", ensuring we fully utilise all members of our multidisciplinary team. At minimum this will be from point of referral but our ambition is to work with primary care, community, and secondary care referrers to further develop pathways and optimise use of and effect of RefHelp. Thereby we will ensure no one is on a waiting list to see a consultant when an alternative option such as a different health care profession may offer a more appropriate intervention.

Clinicians and Services will embed principles of reducing unwarranted variation and embracing innovation. Examples of areas to focus on, and improve our efficiency and effectiveness can be accessed by use of the Atlas of Variation or BADS. We will continue to use data to inform teams where changes to established practices or clinical guidelines are warranted to improve outcomes and patient experience. We will aim to develop capacity to capture patient experience as a key outcome of scheduled care activity.

The Covid-19 response has demonstrated what can be delivered when a 'digital first' approach is taken and this has changed public and professional expectations about what effective health

services could look and feel like. A 'Digital First' approach has obvious benefits in reducing travel time and burden for patients, it reduces the footfall into clinical premises freeing capacity for alternative use, and feedback from some patients indicates it is their preferred approach for many.

With a significant proportion of health resources dedicated to the ongoing monitoring of people through return out-patient appointments, remote health monitoring offers a viable and accessible option for people to remotely record and share their symptoms and clinical readings reducing the frequency of appointments. This, in turn, also reduces the footfall to clinical premises, reduces travel, and may release more time for the assessment and treatment of new patients waiting. We will continue to explore new tools to support delivery of a remote health monitoring where evidence supports their value such as Asynchronous Appointments. We will look at the role of monitoring clinics established in response to the pandemic, to see whether they continue to deliver value for patients and clinical services, or whether their function is better moved to sites closer to the patients home e.g. Community Treatment and Care services. (CTAC).

Moreover, accessing and informing people of appointments and results, monitoring outcomes, seeking information, delivering advice and support must become a less resource consuming process and deliver safe, reliable exchange of accessible information between our population and staff. It must be designed to meet the needs of those patients who struggle with accessing our services because of health literacy, deprivation or other reasons. It is NHS Lothian's aim to deliver all services in one accessible and usable digital format as part of NHS Lothian's developing Digital Strategy (2022-2027).

When people need to be seen by a healthcare professional face to face, they will be, and that is why appointments that are agreed (whether virtual or face to face) should not needlessly go to waste. An increasing number of people who do not attend appointments negatively impact the ability of some services to meet ongoing demand. The way we manage our services can also lead to last minute cancelations which result in a poor patient experience. Unforeseen events happen but we must share in our commitment to reduce and wherever possible eliminate waste of what is a finite resource.

It is critical everyone feels able to ask 'BRAN' questions of their healthcare professional when they have suggested a test, treatment or procedure, and all decisions about a person's care should be made jointly between the individual and their healthcare team. These meaningful discussions should focus on treatment options, benefits, and risks. This is realistic medicine. The CfSD will play a vital role in supporting our continued efforts to embed realistic medicine across our services.

Scheduled care services will continue to promote use of the BRAN questions below with both clinical staff and our population. People in Lothian are encouraged to ask healthcare professionals the BRAN questions:

- What are the **B**enefits?
- What are the **R**isks?
- What are the **A**lternatives?
- What if I do **N**othing?

Clinicians in NHS Lothian have been encouraged to embed the principles of person-centred care and shared decision making in their consultations with patients, in the consent process, and in their communication of options with patients. We actively encourage clinicians to write to patients directly, to recap on discussions of options. We will work with the residents of Lothian to identify how we can further support shared decision making at each and every contact with a health professional, to continue to improve health literacy and empower shared decision making.

Realistic Medicine may also mean seeking to shift our collective focus from clinical interventions at the end of life, to reimagining a better death. One in three people in Scottish hospitals is likely to be in the last year of life, and 16% in the last three months of life. (Clarke et al, 2014). We recognise the view expressed in the Report of the Lancet Commission on the Value of Death (2022) that the role of health care in care of the dying has become unbalanced: 'interventions at end of life are often excessive, exclude contributions from families and friends, increase suffering and consume resources that could otherwise be used to meet other needs'. Conversations about death and dying can be difficult. We want to work with our partners and our communities to support people in Lothian to talk about their wishes for care to the end of life, so that those wishes can be understood and respected, and to enable people to die well.

Areas of focus:

- *Prioritisation of resources aligned with Clinical Prioritisation*
- *Continued promotion of BRAN with clinicians and people*
- *Implementation of Effective Quality Interventions* ***Pathways (EQuIP)***
- *Digital First' for health contact including more remote health monitoring to release capacity for more new contacts e.g. Digital Dermatology - Accessibility and equity will continue to be important including digital exclusion*
- *Interactions will support shared decision making and realistic medicine in all aspects of care including end of life with an aim to deliver person centred outcomes - serving as a way of supporting people to take control of their health*
- *Promoting patient empowerment and patient-centred surgical services and promoting patient initiated follow up or review*
- *Improving access to devices with multiple uses for our workforce*
- *Seamless communication exchange between people and clinical staff*
- *Health and wellbeing information and promotion to improve health literacy and empower shared decision making in all aspects of care including end of life.*
- *Patient centred anticipatory care planning*

Priority 2: Optimising current resource & capacity - Using our finite resources efficiently and effectively, with continued prioritisation of care towards the most clinically urgent whilst working to reduce the length of wait for people living in Lothian who require less urgent treatment. This will require a Quality Management Approach with a focus on value, innovation, co-production and sustainability to ensure we achieve, within the resources available to us, high quality, person-centred experience and outcomes for our residents.

The new national Centre for Sustainable Delivery (CFSD) will play a vital role in supporting our efforts to remobilise, recover and redesign towards a better health care system. By working in collaboration with the CfSD, NHS Lothian aims to implement best practice aligned with the Boards priorities and that of the Scottish Government. Benchmarking our performance against other boards in Scotland will be key to driving and sustaining delivery in these areas. To build on the significant progress and developments that have already been made through redesign and transformation, a significant programme of work is being planned across multiple areas and services in Lothian to radically improve the support available to our population through better use of existing resources, the rapid rollout of new techniques, innovation, and safe and efficient care pathways. Recent examples include implementation of Cytosponge in endoscopy, utilisation of data to identify optimal colonoscopy surveillance frequencies, enhanced recovery after surgery (ERAS) and qFit pathway redesign. However we recognise there is scope to improve in areas such as utilisation of Day surgery.

Using improvement methodology to lean surgical pathways will also reduce waste and improve value. Avoiding unnecessary procedures but also other types of waste such as unnecessary single-use items in surgery will contribute to the organisations sustainability agenda. The NHS is responsible for more than a third of all public sector carbon emissions, operating theatres contribute to this by consuming six times the energy of other clinical areas. Whilst raising awareness we will promote low-carbon alternative products and processes in surgery, including reusable instruments, maintenance, repair, and recycling.

NHS Lothian's Out-patient Redesign Programme is a comprehensive plan across all specialties that will support delivery of key elements of CfSD best practice. This programme will support people to manage their own conditions through patient initiated follow up, improve our communications with people accessing our services through text reminders, reduce lost capacity by supporting patients to actively book and keep their appointments and optimise the use of technology to reduce the need to travel to hospital.
A theatre optimisation programme focussing on the effective and efficient prioritisation of available theatre capacity aligning with the clinical prioritisation of need across scheduled care services, is already underway. This work-stream will develop plans to meet the needs of scheduled care as we move forward ensuring optimal planning, scheduling and utilisation of available theatre resources, benchmarking achievements with Health Boards in Scotland and comparative Health Trusts across the UK.

It will be our focus in 22/23 to develop a Cancer Plan 22/27 aligned with the principles of this framework and our board wide objective to improve the cancer journey.

Diagnostic services are critical to the effective and timely delivery of scheduled care (urgent, urgent suspicion of cancer and routine). The expansion of both the diagnostic workforce and equipment will be essential if diagnostic services are to meet the dual challenge of addressing immediate waiting list pressures whilst modernising services to achieve a sustainable future.

We understand people are waiting longer than is optimal and we know for some people circumstances will change and conditions may deteriorate or improve during this wait. Patient

preferences may change. We will embed a process of reviewing and communicating with those waiting to ensure we better understand their needs and how best we can support and this needs to be a whole system Lothian Health & Care System response. We will review the urgency of need regularly to ensure we continue to prioritise people assessed as most urgently requiring care.

Whilst we continue to work towards reducing waiting times we will optimise opportunities to prevent and minimise deterioration e.g. through increased rehabilitation offered through Allied Health Profession (AHP) services and a developing multimodal prehabilitation programme that involves exercise, nutritional advice, emotional support, and a behavioural change approach, to help negate the negative effects of increasing waiting times for treatment and improve outcomes following treatment.

Underpinning this priority is our desire to improve patient outcomes and experience by involving those living in Lothian to develop optimal services, processes and environments that are person centred.

Areas of focus:

- *Matching capacity to demand*
- *Innovative alternatives to current practice e.g. Cytosponge in endoscopy, Ophthalmology Diagnostic Lanes*
- *One Stop clinics to reduce visits and optimise pathways e.g. Flexible Cystoscopy*
- *Patient experience and outcomes*
- *Quality improvement*
- *Delivery of NHS Lothian Outpatient Redesign Programme*
- *Theatre optimisation programme*
- *Expanding and modernising diagnostic capacity*
- *Developing a Cancer Plan 2022/27*
- *Optimising peri-operative care e.g. expansion of enhanced recovery pathways, reducing length of stay and planning for improved recovery after surgery and improved outcomes,*
- *Keeping in touch and reviewing our prehabilitation*
- *Maximise utilisation of our resources by using improvement methodology to reduce waste and cost. Ensuring lean surgical pathways, including identifying and avoiding unnecessary procedures or unused single-use items in surgery.*
- *Promoting low-carbon alternative products and processes in surgery, including reusable instruments, maintenance, repair, recycling and raising awareness.*

Priority 3: Supporting, developing and protecting our Workforce – Building a healthful culture that develops and supports our workforce - now and for the future. To deliver this there will be a redesign of models of care, and skill mix, education and skills needs analysis. There will be active talent management and succession planning in addition to recruitment and retention initiatives

Re-building the workforce in the timescales required to support the recovery of scheduled care will be extremely challenging and NHS Lothian's workforce plan (2022-2025) requires workforce

pipelines that support recruitment to new and existing roles. An inpatient skill mix project is underway to support the redesign of care models to support every job family and role to work to the top of their scope of practice and ensure the most effective delivery of patient care. With insufficient lead in time to train more anaesthetists and surgeons, consideration of alternative professional roles, particularly at advanced practice level within nursing and AHPs, will be key, in addition to utilising the relatively new roles within Medical Associate Professions (Anaesthesia Associates and Physician Associates) which are embedding across the UK.

With the planned opening of our National Treatment Centre in spring 2027 and in recognition of existing gaps, the recruitment and retention of a skilled workforce and accelerated training is key to our scheduled care recovery programme.

NHS Lothian Work Well 2021-23 provides a clear plan to continuously improve staff wellbeing: and a framework to measure impact and progress across NHS Lothian. Using this strategy as a template to develop local plans, scheduled care services will continue to take steps to make work a healthier and happier place to be.

Areas of focus:

- *Staff health and wellbeing - Work Well 2021-2023 local plans in Scheduled Care*
- *Embed recommendations and outputs from the inpatient skill mix project to support the redesign of care models*
- *Development and implementation of Action Plans for key areas of challenge e.g. sonography workforce, theatre nursing etc.*
- *Increase education, training and development opportunities to our existing workforce and work with colleges and universities to support and expedite training and education.*
- *Promote access routes for Health Care Support Workforce (HCSW) locally and work with NHS Academy to understand national plans for attracting and inducting new health and social care staff from a variety of different routes*
- *Improve retention of those who train to join our workforce by improving their experience and building relationships with our students and trainees.*
- *Consider innovative responses to retain staff beyond retiral.*
- *Recruit to our vacancies and start to build capacity for the future - with International recruitment already underway to fill current vacancies but also to address future demand.*
- *Progress new roles such as: Advanced Practiced AHPs, Medical associate Professionals (MAPs) such as Anaesthetic Associates, Physician Associates, and surgical care practitioner (SCP) roles.*

Priority 4: Securing additional capacity - A coherent Capital investment programme - Progressing ambitious capital projects to address longstanding capacity gaps in planned care whilst utilising external capacity in the interim.

Whilst we work to build new capacity which we can better protect from the pressures of unplanned and emergency care (such as the NTC Lothian), we will continue to utilise capacity available to us such as the national treatment centre at GJNH, and the regional endoscopy unit in Fife. We will

continue to explore and implement models of care in partnership with the independent sector to maximise all available capacity for our residents.

Key to the future sustainability of planned care in Lothian, is a programme of capital investment to deliver 4 key projects:

1. The establishment of a new National Treatment Centre (NTC) in Lothian on St John's Hospital Campus (formerly known as the Short Stay Elective Centre),
2. The Redesign & Reprovision of Princess Alexandria Eye Pavilion in Edinburgh on the bioQuarter
3. The Redesign and Reprovision of the Edinburgh Cancer Centre at the WGH in North Edinburgh
4. Dedicated Elective Orthopaedic Capacity

The NTC Lothian is a key priority for the Board and will provide new and additional capacity to deliver c17000 surgical procedures per annum, based on the current in scope case mix by Spring 2027. With 11 operating theatres, a 100% single room capacity and an imaging centre, the NTC Lothian will provide much needed ring-fenced capacity to protect significant volumes of scheduled care. The design of the facility will deliver flexibility to accommodate future changes to the clinical model and critically enable elective work to continue regardless of Covid-19 (or any future epidemic/pandemic situation) in a protected facility, assuming the availability of workforce. A key foundational pillar of the NTC Lothian will be delivery of an optimal operating model in relation to theatre throughput, pre-habilitation including enhanced recovery after surgery, reduced length of stay, patient initiated review/ patient initiated follow up and efficient flows through the facility without delay. The facility will improve standards of patient privacy and dignity, patient safety, efficiency and be at the forefront of surgical care.

NHS Lothian is also embarking on a programme of eye care service modernisation and transformation. A principal aspect of this is the Business Case for a replacement eye hospital which will not only improve the environment for patients and staff but delivers the opportunity to revisit and improve pathways and models of care. Traditional workforce roles in eye care and undergoing significant change across the country with a move towards extended roles across community and hospital optometry, orthoptics, nursing and constantly evolving developments in digital diagnostic equipment. The redesign and Reprovision of eye services in Lothian will provide fit for purpose accommodation additional capacity and improved technology to meet forecast growth in eye care.

The re-provision of cancer services in a new Edinburgh Cancer Centre for the South East Region will enable services to meet all applicable technical and clinical standards as well as respond to a rapidly increasing demand for cancer services by delivering a transformed model of care. Achieving the vision of transformed and improved cancer services and pathways for adult patients from across the South East Region will:

- Streamline patient pathways and maximise efficiencies based on a patient focused, holistic approach;
- Offer a range of specialist cancer therapies to patients in the South-East Region;
- Provide facilities to deliver safe and effective, high quality clinical care, designed to optimise efficiencies and new technologies;

- Provide Care Closer to Home where clinically appropriate and financially viable;
- Make opportunities available to ensure recruitment and retention of specialist staff; including teaching, training, research and academic opportunities;
- Provide equitable access to the most innovative therapies, optimise resource utilisation and patient outcomes by integrating Cancer Research with core services across the South East Region.

NHS Lothian will build the case for dedicated elective capacity for Orthopaedics. This dedicated capacity will enable separation and protection of high volumes of routine, elective orthopaedic care, from the competing pressure of unscheduled care and higher clinical priority elective demand.

Essential to the sustainable delivery of all surgical care in Lothian is also a new multi-site model for Hospital Sterilisation and Decontamination Units, to ensure resilience for what is a critical support service. We will work with the national group to align with the direction for national resilience across Scotland.

A number of additional projects will also support scheduled care recovery:

- Expansion of diagnostic services (including at SJH with a 2nd CT for the site)
- Delivery of an ambulatory care suite for Gynaecology at SJH, allowing us to transfer day case activity to an ambulatory setting, improving the patient experience and releasing theatre capacity for activity that requires a theatre and day-case setting.
- Improvements to the fabric and condition of Critical Care at the WGH and SJH.

Areas of focus across these projects:

- *Technology & innovation throughout*
- *Optimised patient pathways and*
- *Value & Sustainability - improving access and reducing visits and unnecessary travel,*
- *Supporting new service models through 'Technology Supported' building design*
- *Workforce planning*

Scheduled Care Grid

The table below plots known aims and objectives across a 5 year period (2022-2027):

Ref	Priority	1 year	3 year	5 year
1	**Active promotion of Realistic Medicine -**A critical factor will be how we maximise use of digital tools to in support of this.	• Prioritisation of clinical resources aligned with clinical need. • Promotion of 'Digital First' unless face to face examination is required. • Embed BRAN questions during all clinical contacts. • Promoting patient empowerment and patient-centred surgical services, and promoting patient initiated follow up or review. • Reducing the number of people who do not attend scheduled appointments. • Embed active clinical referral triage - Develop and identify suitable alternatives to treatment. • Stakeholder consultation throughout • End of Life & Anticipatory Care Planning	• Improving access to devices with multiple uses for our workforce. • Seamless communication exchange between residents and clinical staff. • Accessible Health and wellbeing information. • Implementation of EquiP Pathways complete. • End of Life & Anticipatory Care Planning	

Ref	Priority	1 year	3 year	5 year
2	**Optimising current resource & capacity** - Using our finite resources efficiently and effectively, with continued prioritisation of care towards the most clinically urgent whilst working to reduce the length of wait for people living in Lothian who require less urgent treatment.	• Prioritisation of clinical resources aligned with clinical need. • Continuation of NHS Lothian's Out-patient redesign programme. • Implementation of best practice in collaboration with CfSD e.g. enhanced recovery. • Theatre Optimisation • Using improvement methodology to lean surgical pathways will also reduce waste and improve value. • Develop a Cancer Plan 22/27 • Keeping in touch and review current prehabilitation offer.	• Diagnostic expansion and modernisation • Develop Prehabilitiation programme	

Ref	Priority	1 year	3 year	5 year
3	**Supporting, developing and protecting our Workforce** – Building a healthful culture that develops and supports our workforce - now and for the future.	• Develop and deliver a recruitment plan, including ongoing international recruitment to address key areas of challenge e.g. sonography workforce, theatre nursing etc. • Deliver the recruitment plan for additional specialist and supervisory roles. • Increase education, training and development opportunities to our existing workforce. • Promote access routes for Health Care Support Workforce (HCSW) locally and work with NHS Academy to understand national plans for attracting and inducting new health and social care staff from a variety of different routes. • NHS Work Well Framework and Local Plans • Phased implementation of NTC Workforce Plan e.g. appoint General Manager	• Maintain and improve staffing levels. • Respond imaginatively to retain staff beyond retiral. • Work with colleges and universities to support and expedite training and education. • Test, change and explore new opportunities such as: Anaesthesia Associates Physician Associates (formerly Physician Assistants), surgical care practitioner (SCP) roles. • Retain those who train to join our workforce by improving their experience and building relationships with our students and trainees. • Phased implementation of NTC Workforce Plan	• Maintain and improve staffing levels. • Delivery of NTC Workforce Plan

Ref	Priority	1 year	3 year	5 year
4	**Securing additional capacity -** A coherent Capital investment programme - Progressing ambitious capital projects to address longstanding capacity gaps in planned care whilst utilising external capacity in the interim.	• Continue to explore and implement models of care in partnership with the independent sector to maximise all available capacity for our residents. • NTC - Progress exemplar design with stakeholders & Reengage with PSCP for NTC, Lothian, May 2022. • Development of NTC Full Business Case and progress design development. • Reengage with PSCP for PAEP early 22/23 & progress design development. • Development of PAEP Full Business Case • Complete delivery of 2nd CT at SJH • Complete delivery of Gynae Ambulatory Care Unit at SJH complete. • Build the initial case for Elective Orthopaedic capacity	• Continue to explore and implement models of care in partnership with the independent sector to maximise all available capacity for our residents. • NTC Full Business Case Approved Autumn 2024. • Construction begins on NTC 2025. • PAEP Full Business Case Approved. • Construction begins on new PAEP. • HSDU Outline Business Case Approved. • HSDU Full Business Case in Development • Additional Imaging requirements confirmed. • Improved critical care facilities at SJH (isolation facilities). • Submission of Cancer Centre Full Business Case to SG. • Build the case for Elective Orthopaedic capacity -OBC	• Completion of 1 or more HSDU premises. • Services commence at NTC Lothian 2026/27. • Services commence at PAEP 2027. • Delivery of Edinburgh Cancer Centre 2027 • Elective Orthopaedic FBC •

Parameters

About this chapter

This chapter seeks to describe the potential future contexts within which we will need to work to deliver our future strategic intentions, in relation to our parameters: Finance, workforce, digital and environmental sustainability. The purpose of this work is to build our shared awareness of what the future might look like for the Lothian Health & Care System, and, and the decisions we may need to make as we move forward to use our resources to best affect.

This section is closely linked to our current position and next steps in these areas, as set out in the section: *Where are we now?*

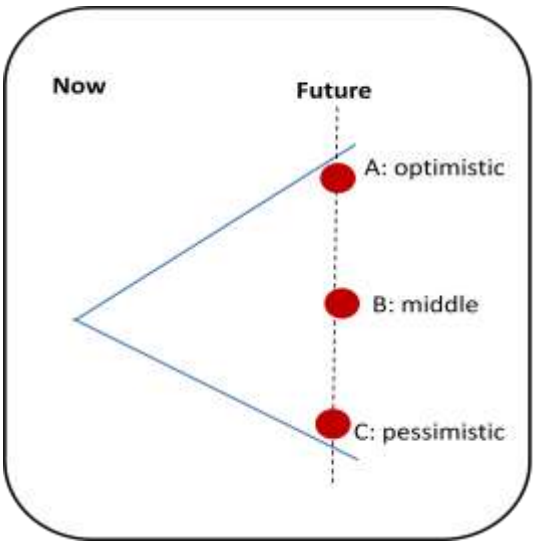
Planning in an uncertain environment

Scenario planning, or the use of "strategy cones", is a method for planning within an uncertain environment.

Traditionally, planning looks to the past and uses trends to predict the future. This traditional approach has limitations during periods of change and ambiguity. Scenario planning instead considers alternative future situations with differing contextual environments, and considers the implications of these alternative futures, to generate new insights.

Scenario planning is particularly pertinent at this time, as the environment associated with the pandemic continues to remain ambiguous and unclear. Periods of relative certainty over the last year have been punctuated by events that change the environment – for example the rise of Covid-19 variants which change infection rates and hospital admissions. While we can be relatively certain about the next twelve months, that certainty diminishes as we look beyond the next twelve months to the next five years, as demonstrated in figure 1 below, which is based on Amy Webb's Futurist's Framework for Strategic Planning[4].

Figure 1: Strategy cone



[4] Webb, Amy: *How to do Strategic Planning Like a Futurist*. Harvard Business Review. July 2019.

The following table seeks to describe what the future might look like within the context of each of our parameters, from an optimistic, realistic and pessimistic perspective.

	Optimistic	Realistic	Pessimistic
Capital Finance	• Through detailed service engagement, Board agrees a capital plan which implements the strategy • Plan is ambitious and transformational with sustainability, service delivery and reducing inequality central to decision making • There is a framework in place with the Scottish Government to support Board priorities and subsequent delivery • SG and Board Governance / Assurance requirements are clear, consistent and transparent. There are the resources and support for projects to ensure robust appraisal of options and delivery of value for money • We have the financial and wider resources to enable us to take forward priority projects • There is an understanding from Government on the challenges of maintaining our existing estate, and	• The Board agrees a strategy, and a number of high level priority capital projects to deliver this, which exceeds the likely available resource • Priority projects are recognised through the National Investment Board, and funded although with some restrictions on funding • Some additional revenue impact from strategic developments, to be managed through the financial plan • Some non-Acute projects may be put through a revenue funding route • Board works with NHS Scotland Assure to develop assurance requirements in parallel with progressing projects • Sustainability considered as service delivery / funding allows	• The vast majority of greatly reduced capital funding is restricted or ring-fenced for government priorities, restricting NHS Lothian's ability to spend to its own strategic priorities unless these are perfectly aligned • In this environment, the Board cannot agree a plan to deliver the strategy • Cost inflation in construction (through market factors and assurance requirements) continues to grow restricting the amount of strategic change that can be supported • Focus is therefore on maintenance, but without sufficient funding / resources to safely maintain • Internal resources are stretched to a point where priorities cannot move forward as desired • Ongoing survey work around existing assets reveals an increased and increasing risk to the organisation

	Optimistic	Realistic	Pessimistic
	funding to support this • Services recognise they are part of a transparent and consistent process around allocation of resource, and the process supports the need to evidence the need for 'more' • Multi-year capital budgets support forward planning • Additional revenue impact is limited / mitigated		without the increased financial and staffing resource to respond • Increasing reliance on revenue funding capital routes • One year capital budgets continue
Revenue Finance	• Through Programme Recovery Boards, services develop and approve 3 – 5 year financial plans (based on service planning rather than desktop financial planning) to deliver strategy. Support services adopt consistent process • Consolidated into Board wide Medium Term Financial Framework, supporting decision making around use of limited resources (finance, workforce, capacity etc) • MTFF builds in agreed performance benchmarks to understand efficiency of services and opportunities to improve performance without	• Progress through Recovery Boards on developing and reporting service capacity planning beyond current year • Some high level interpretation of financial implications of service planning against key priorities, with inconsistencies in approach to be ironed out • Specific allocations made recurring to support service change in delivery of key priorities, but non-recurring or poorly timed allocations remain • Development of existing efficiency metrics to support benchmarking of	• Limited service level planning beyond current year, so difficult to assess financial implications or opportunities to consider options for using resources efficiently • Investment decisions considered in silos against incremental investment proposals, and not as part of a consistent, transparent decision making framework • No engagement in efficiency programme and focus solely on incremental requests for additionality. No monitoring or reporting of service efficiency against agreed metrics

	Optimistic	Realistic	Pessimistic
	additional resources. Opportunities are then resourced to work through and embed improvements • MTFF drives consistent, transparent approach for investment decision making, based on assessment of risk and value for money • Systems of control universally implemented and monitored to assure grip and control over expenditure • Move away from one year budgets to recurring funding to support investments to deliver strategic priorities within Medium Term Financial Framework • Recognition of existing recurring deficit within any future Government funding against performance improvements • Highly trained and skilled finance function working towards objectives jointly agreed with services.	services, with some new measures agreed. Efficiency measures approved and monitored through financial planning process, with some limited exploration of opportunities to generate efficiencies • New allocations allow some element of support for existing pressures, but recurring deficit remains • Grip and control monitored but systems of control not consistently implemented	• SG funding released in non recurring tranches, against unclear deliverables and with contradictory outcomes • Funding released with an expectation that will deliver more, rather than addressing existing deficits • Insufficient finance resources (wte, skills) to deliver against objectives. Inconsistency within finance, and between finance and service, on objectives • No adherence to grip and control process over expenditure.

	Optimistic	Realistic	Pessimistic
Workforce Supply	• Entry level supply increases to meet demand, due to reduction in other sector opportunities and increased positive profile of the NHS and career progression pathways	• Entry level supply does not fully meet demand without significant concerted attraction and recruitment drives	• Entry level supply cannot meet demand due to actual workforce availability, attraction and competition in the market, those attracted are not sustained in employment
Workforce Wellbeing	• Stabilisation in sickness absence at 4.33%, supported by staff wellbeing and psychological support interventions	• Increase in sickness absence from 4.33% to 5.16% based on predicted 20% increase in Covid related mental health, psychological issues	• Increase in sickness absence in excess of 20% due to Covid related mental health, psychological issues (30% increase = 5.63%) (40% increase = 6.06%)
Digital	• Digital development plans are well considered, and can be resourced both in terms of financial investment and Digital Department capacity.		• Unexpected developments are required, for which there is insufficient funding and resource to effectively manage, alongside business as usual.

Glossary of Terms

4EAS	**The 4 hour Emergency Access Standard** 4EAS is an LDP standard, which states that 95% of patients should wait no longer than four hours from arrival to admission, discharge or transfer for A&E treatment. https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/accident-and-emergency-waiting-times/
6EAs	**Six Essential Actions** The six essential actions are actions intended to improve unscheduled care. https://www.gov.scot/publications/improving-unscheduled-care-six-essential-actions/
ACRT	**Active Clinical Referral Triage** Under ACRT, all referrals to secondary care services are triaged by a senior clinical decision maker to evidence-based, locally agreed pathways after reviewing all the appropriate electronic patient records. Patients are offered one a range of options, including a virtual appointment, clinical information to support them to opt-in, investigations, addition to a waiting for a procedure or, if clinically required, a face to face attendance. *(Definition provided by NES)* https://learn.nes.nhs.scot/28430/scottish-government-health-and-social-care-resources/modernising-patient-pathways-programme/mppp-improvement-programmes/active-clinical-referral-triage-acrt
AHP	**Allied Health Professional** AHP is an umbrella term for a range of professions and includes registered Health and Care Professions Council (HCPC) practitioners and support staff. AHPs are a diverse group of professionals supporting people of all ages to live healthy, active and independent lives. AHPs apply their expertise to diagnose, treat and rehabilitate people of all ages across health, education and social care. *(Definition provided by the Scottish Government)* A list of Allied Health Professions is provided on the SG website: https://www.gov.scot/publications/allied-health-professionals-list/

Anchor Institution	The term anchor institution refers to a large, typically non-profit, public sector organisations whose long-term sustainability is tied to the wellbeing of the populations they serve. Anchors get their name because they are unlikely to relocate, given their connection to the local population, and have a significant influence on the health and wellbeing of communities. *(Definition provided by the Health Foundation)* https://www.health.org.uk/news-and-comment/charts-and-infographics/the-nhs-as-an-anchor-institution
ANP	**Advanced Nurse Practitioner** Advanced Nurse Practitioners are educated at Masters Level in clinical practice and have been assessed as competent in practice using their expert clinical knowledge and skills. They have the freedom and authority to act, making autonomous decisions in the assessment, diagnosis and treatment of patients. *(Definition provided by the Royal College of Nursing)* https://www.rcn.org.uk/professional-development/advanced-practice-standards
Asynchronous appointments	Asynchronous means **'not happening or done at the same time or speed'** (Cambridge Dictionary, 2021). The concept of asynchronous consulting is the sharing of health and wellbeing information where there is no 'real-time' interaction between the person and the practitioner. Asynchronous consultations offer people more choice and flexibility to access health and social care support by completing an online questionnaire or a form, or uploading photos which are then reviewed, assessed and responded to by a practitioner in an agreed timescale. *(Definition provided by NES)* https://learn.nes.nhs.scot/49383/remote-consulting/asynchronous-consulting
BRAN	The BRAN questions are a tool to support health service users to make informed choices about their health and care. We encourage patients to ask: • What are the **BENEFITS**? • What are the **RISKS**? • What are the **ALTERNATIVES**? • What if I did **NOTHING**? https://www.nhsinform.scot/care-support-and-rights/nhs-services/using-the-nhs/realistic-medicine

CAMHS	**Child and Adolescent Mental Health Services** These services work with children and young people (from age 5 to their 18th birthday), and their parents or carers. NHS Lothian CAMHS provides specialist assessment/intervention as part of a tiered system https://services.nhslothian.scot/camhs/Pages/default.aspx
CAPA	**Choice And Partnership Approach** The CAPA model is a system for delivering CAMHS services, with the aim of improving the efficiency of services.
CfSD	**Centre for Sustainable Delivery** The national Centre for Sustainable Delivery supports Scotland's efforts to remobilise, recover and redesign (3Rs) towards a better health care system. Building on significant progress and developments that have already been made through redesign and transformation, the Centre will support the rapid rollout of new techniques, innovation, and safe, fast and efficient care pathways for Scotland's patients. The Centre will also offer customised assistance across NHSScotland to help tackle a variety of challenges in health and care. https://www.nhsgoldenjubilee.co.uk/cfsd
CTACs	**Community Treatment And Care services** CTACs were introduced in the 2018 General Medical Services (GMS) Contract. Community treatment and care services include many non-GP services that patients may need, including (but not limited to): • management of minor injuries and dressings • phlebotomy • ear syringing • suture removal • chronic disease monitoring and related data collection CTACs are commissioned by Health & Social Care Partnerships and delivered in collaboration with NHS Boards. It is expected that services will be available for use by both primary and secondary care services. https://www.gov.scot/publications/gms-contract-scotland/

DwD	**Discharge Without Delay** Discharge Without Delay is a Scottish Government improvement programme, to improve pathways through hospital settings, reducing inpatient length of stay and building bed capacity. Working with patients, families and/or carers, it will ensure patients are treated in their home where appropriate. *(Definition provided by the Scottish Government)* https://www.gov.scot/news/delivering-the-right-care-in-the-right-setting/
FBC	**Full Business Case** The Full Business Case is a key stage in the Scottish Capital Investment Manual (SCIM) lifecycle. The **Full Business Case** stage will set out the agreed commercial arrangements for the project whilst also confirming that it remains value for money, is affordable, and that the organisation is ready to proceed towards implementation of that option. It will be developed within the final procurement phase of the project and record the detailed assessment and/or negotiations with potential service providers / suppliers prior to the formal signing of contracts. *(Definition provided by the Scottish Capital Investment Manual)* https://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm
GDP	**General Dental Practitioner**
GIRFEC	**Getting It Right For Every Child** Getting it right for every child (GIRFEC) supports families by making sure children and young people can receive the right help, at the right time, from the right people. The aim is to help them to grow up feeling loved, safe and respected so that they can realise their full potential. *(Definition provided by the Scottish Government)* https://www.gov.scot/policies/girfec/
GMS	**General Medical Services** General Medical Services are services provided by General Practices.
Health Debt	**Health debt** is the accumulated impact of changes during the pandemic that will have long-term negative effects on health. This may include changes in health behaviour, including delaying seeking treatment for ill health.
Health Inequalities	**Health inequalities** are the unjust and avoidable differences in people's health across the population and between specific population groups. *Definition provided by Public Health Scotland* http://www.healthscotland.scot/health-inequalities/what-are-health-inequalities

HSCP	**Health & Social Care Partnership** Health & Social Care Partnerships are responsible adult social care, adult primary health care and unscheduled adult hospital care. Some are also responsible for children's services, homelessness and criminal justice social work. There are 31 Health & Social Care Partnerships in Scotland, including four in the Lothians. https://hscscotland.scot/hscps/
HSCW	**Health Care Support Worker** Healthcare support workers assist nurses, therapists, midwives, hospital doctors and other healthcare professionals to deliver high-quality person-centred care. https://www.careers.nhs.scot/careers/explore-our-careers/clinical-healthcare-support-workers/
HSDU	**Hospital Sterilisation and Disinfection Unit** The Unit provides a comprehensive decontamination and sterilisation service for all reusable surgical instrumentation and medical devices across NHS Lothian
IHTT	**Intensive Home Treatment Team** The **Intensive Home Treatment Team** offers a service for individuals who are experiencing mental health crisis which requires an urgent mental health assessment
IJB	**Integration Joint Board** Integration Joint Boards are responsible for the strategic planning of the health and social care functions delegated to the IJB, and for ensuring the delivery of those functions through the directions issued by the IJB. There are four Integration Joint Boards in the Lothians. https://www.gov.scot/publications/roles-responsibilities-membership-integration-joint-board/
iMatter	*A staff experience continuous improvement tool* designed with staff in NHS Scotland to help individuals, teams and Health Boards understand and improve staff experience. https://www.staffgovernance.scot.nhs.uk/monitoring-employee-experience/imatter/

LACAS	**Lothian Accreditation & Care Assurance Standards** The NHS Lothian Accreditation and Care Assurance Standards provide a framework to give Organisational and Service User Assurance that Quality Person Centred Care is being delivered consistently across all NHS Lothian services.
LDP	**Local Delivery Plan** Local Delivery Plan standards are a set of priorities agreed between the Scottish Government and Health Boards
LHCS	**Lothian Health & Care System** The Lothian Health & Care system comprises the five bodies responsible for planning, commissioning and delivering health and care services in the Lothians.
LUCS	**Lothian Unscheduled Care Service** Lothian Unscheduled Care Service (LUCS) provides out of hours general medical services to the population of Lothian and temporary residents.
MH	**Mental Health**
MHAS	**Mental Health Assessment Service** MHAS provides same day emergency mental health assessments. The service accepts referrals from GPs, NHS 24, Accident and Emergency departments and the police, and is based at the Royal Edinburgh Hospital.
MOU	**Memorandum of Understanding** The Memorandum of Understanding is associated with the General Medical Services (GMS) contract. It sets out the principles by which primary care redesign will be delivered.
MTFF	**Medium Term Financial Framework** The Medium Term Financial Framework will be a live document that describes the financial implications of achieving the organisation's operational performance targets.
Multimorbidity	**Multimorbidity** is the presence of two or more long-term health conditions. *(Definition provided by NICE)* https://cks.nice.org.uk/topics/multimorbidity/

National Care Service	The establishment of a **National Care Service** in Scotland has been proposed by the Scottish Government, to address some of the challenges across social care, highlighted before and during the pandemic. *(Definition provided by the Scottish Goverment)* https://www.gov.scot/publications/national-care-service-scotland-consultation/
National Outcomes	The **National Outcomes** are set out in Scotland's National Performance Framework. The outcomes reflect the values and aspirations of the people of Scotland; are aligned with the United Nations Sustainable Development Goals, and; help to track progress in reducing inequality. *(Definition provided by the Scottish Government)* https://nationalperformance.gov.scot/national-outcomes
NearMe	**Near Me** is a video consulting service that enables people to attend appointments from home or wherever is convenient. https://www.nearme.scot/
NTC	**National Treatment Centre** (Formerly Short Stay Elective Centre – SSEC) To tackle Covid-19 related treatment backlogs, and put the NHS on a sustainable path for the future, the Scottish Government proposes to create a network of National Treatment Centres (NTCs) for planned elective procedures and diagnostic care. *(Definition provided by the Scottish Government)* https://www.gov.scot/publications/nhs-recovery-plan/pages/6/
OBC	**Outline Business Case** An Outline Business Case is a key stage in the Scottish Capital Investment Manual (SCIM) life cycle. An Outline Business Case will identify the preferred option for implementing the strategic / service solution confirmed at Initial Agreement stage. It will demonstrate that the preferred option will deliver the necessary service change, optimise value for money, and be affordable. It will also set out the supporting commercial and management arrangements to be put in place to successfully implement that option. *(Definition provided by the Scottish Capital Investment Manual)* https://www.pcpd.scot.nhs.uk/Capital/scimpilot.htm
OPAT	**Outpatient Parenteral Antibiotic Therapy**

PAEP	**Princess Alexandra Eye Pavilion** The Princess Alexandra Eye Pavilion (PAEP) provides specialist care for the treatment and management of diseases and conditions affecting the eye and eyesight.
PC	**Primary Care** Primary care is the first point of contact with the NHS. This includes contact with community based services provided by general practitioners (GPs), community nurses, dentists, dental nurses, optometrists, dispensing opticians, pharmacists and pharmacy technicians. It can also be with allied health professionals such as physiotherapists and occupational therapists, midwives and pharmacists. *(Definition provided by the Scottish Government)* https://www.gov.scot/policies/primary-care-services/
PDD	**Planned Date of Discharge** The date a patient is expected to be clinically ready for discharge or transfer which health and social care teams will use when making arrangements to help the patient leave their current healthcare setting
PFB	**Patient Focused Booking** Patient Focused Booking requires a patient to make contact with the booking office to arrange a suitable appointment over the telephone. On receipt of a referral, a letter is sent to the patient, inviting them to call to book an appointment.
Population Health	**Population Health** Population health is an approach that aims to improve physical and mental health outcomes, promote wellbeing and reduce health inequalities across an entire population *(Definition provided by the King's Fund)* https://www.kingsfund.org.uk/publications/vision-population-health

Prevention	**Prevention** is focussed on measures we can take to avoid poor or worsening health. Prevention can improve population health by: • Preventing health problems developing in the first place (primary prevention) • Stopping health problems from getting worse (secondary prevention) • Reducing the impact of disease on people's health and wellbeing (tertiary prevention). *(Definition provided by Pubic Health Scotland)* http://www.healthscotland.scot/publications/economics-of-prevention
Private Sector	**Private sector** organisations comprise organisations owned privately by individuals or shareholders, and run primarily to generate a profit.
Programme for Government	The **Programme for Government** is published every year at the beginning of September and sets out the actions the Scottish Government intend to take in the coming year and beyond. It includes the legislative programme for the next parliamentary year to drive forward change across all levels of society. *(Definition provided by the Scottish Government)* https://www.gov.scot/programme-for-government/
PSCP	**Principle Supply Chain Partner**
Public Sector	**Public sector** organisations comprise the portion of the economy composed of all levels of government and government-controlled enterprises. Public sector organisations include Local Authorities, Fire and Health services.
Public Square	Any venue where the public can gather to share or learn views and opinions. The public square can include opportunities to gather either in person or virtually.
Realistic Medicine	One of the main aims of Realistic Medicine is for people using healthcare services and their families to feel empowered to discuss their treatment fully with healthcare professionals, including the possibility that a suggested treatment might come with side effects – or even negative outcomes. Everyone should feel able to ask their healthcare professional why they've suggested a test, treatment or procedure, and all decisions about a person's care should be made jointly between the individual and their healthcare team. *(Definition provided by the Scottish Government)* https://www.realisticmedicine.scot/

REH	**Royal Edinburgh Hospital** The Royal Edinburgh Hospital provides acute psychiatric and mental health services, including treatment for learning disabilities and dementia. Its specialist services include centres for the treatment of eating disorders, alcohol problems and young people's mental health.
RIE	**Royal Infirmary of Edinburgh** The Royal Infirmary of Edinburgh is a major acute teaching hospital located on the Edinburgh BioQuarter. With a 24-hour accident and emergency department, it provides a full range of acute medical and surgical services for patients from across Lothian and specialist services for people from across the south east of Scotland and beyond.
RSA	**Royal Society of Arts, Manufactures and Commerce** https://www.thersa.org/
RUC	**Redesign of Urgent Care** The redesign of urgent care is a new approach to support people to access care in the right place at the right time. This has changed the way, for example, that people access Accident & Emergency department for non-life-threatening conditions
SC	**Scheduled Care**
SDEC	**Same Day Emergency Care** Same-day emergency care (SDEC) allows specialists to care for patients within the same day of arrival as an alternative to hospital admission.
SG	**Scottish Government**
SJH	**St John's Hospital** St John's Hospital is a modern teaching hospital that provides a comprehensive and expanding range of services for the people of Lothian and beyond. The hospital, based at Howden in Livingston, has a 24-hour Accident and Emergency department and a range of specialist services including burns treatment and plastic surgery.
SLWG	**Short Life Working Group**
Third Sector	The **third sector**, includes charities, social enterprises and voluntary groups. The third sector delivers essential services, helps to improve people's wellbeing and contributes to economic growth. It plays a vital role in supporting communities at a local level *(Definition provided by the Scottish Government)*

TTG	**Treatment Time Guarantee** The treatment time guarantee places a legal requirement on health boards that once planned inpatient and day case treatment has been agreed with the patient the patient must receive that treatment within 12 weeks https://www.gov.scot/publications/nhsscotland-performance-against-ldp-standards/pages/treatment-time-guarantee/
UNCRC	**United Nations Convention on the Rights of the Child** The UNCRC is the most complete statement of children's rights ever produced and is the most widely-ratified international human rights treaty in history. *(Definition provided by Unicef)* https://www.unicef.org.uk/what-we-do/un-convention-child-rights/
USC	**Unscheduled Care**
USoC	**Urgent, Suspicion of Cancer**
WGH	**Western General Hospital** The Western General Hospital provides a comprehensive range of general and specialist services to the people of Edinburgh, Lothian and beyond. The hospital has circa 570 beds (including day beds) and is home to the regional centre for cancer, the Regional Infectious Diseases Unit, and a Minor Injuries Clinic.

Lothian Strategic Development Framework: Engagement Process

The Lothian Strategic Development Framework (LSDF) seeks to determine how the Lothian Health & Care System can achieve its strategic objectives, considering:

- The challenges presented and/or exacerbated by Covid
- The opportunities/innovations brought about during the pandemic response

As outlined in this document, it is anticipated that the Lothian Health & Care System will need to plan and deliver services differently in future, and that some of our previous commitments will remain. The organisation may also need to make some difficult choices with regard to priorities as a result of constraints.

It is important that we don't do what we think is right without seeking the views of the people we work for. Engaging our communities in this work will help us to understand what is important to people who live in Lothian, and help to inform the choices we make.

Purpose

During April and May 2022, we intend to undertake a period of engagement with the public. The purpose of this activity is to:

- Explain the issues and challenges facing the Lothian Health & Care System
- Outline the work undertaken so far to engage stakeholders in developing our thinking
- Outline what we have heard from the public to date
- Explain our thinking, and the direction of travel that we think the Lothian Health & Care System should take
- Seek feedback from the public on our proposed direction, identify any potential problem areas, and seek to understand how these might be resolved
- Seek to build support for the proposed direction
- Establish a basis for ongoing and continuous engagement in the LSDF

This phase follows engagement work to date across the LHCS, including:

- Engagement with service users, carers, the public and staff in specific programmes of work referenced within the LSDF, including IJB strategic plan development, business case development and clinical change programmes
- Engagement with senior leaders from across the Lothian Health & Care System, to apply the RSA Future Change Framework to help shape our strategic direction going forward through a series of workshops facilitated by the RSA
- The establishment of an NHS Lothian Citizen Reference Group, facilitated by the RSA, to
- Ongoing engagement with NHS Lothian staff, IJB Strategic Planning Groups and Integration Joint Boards as our thinking about the LSDF has developed

Expectations

It is our expectation that this period of engagement activity will:

- Build a shared understanding of the challenges that we face
- Support those who live and work in the Lothians to provide feedback on our proposed direction of travel, as set out in the LSDF
- Identify potential problem areas in our proposals, and seek to understand how those problems might be resolved

Anticipated Outcomes

Lothian residents are able to influence the future strategic direction of the Lothian Health & Care System, informed by relevant data and information

Lothian residents are supportive of the finalised direction of travel within the LSDF

The Lothian Health & Care System has confidence that our future direction is cognisant of the priorities of our communities, and focussed on delivering the outcomes they value.

A basis for ongoing and continuous engagement is established, to support the development of LSDF implementation plans.

Engagement Period

This initial period of engagement will take place over eight weeks from April 6th – May 31st 2022. Responses and feedback will be reviewed on a weekly basis during this period, with a final collated summary of responses and associated recommendations submitted to the NHS Lothian Board in June 2022.

Engagement Prompts

We have agreed a series of prompts, to support our citizens to provide feedback on the draft LSDF:

- Do you feel the LSDF addresses the issues that are most important? If not, why not?
- Have we missed anything really significant in the LSDF? If so, what?
- What, if any, or the proposals set out in the LSDF worry or concern you?
- What would you suggest that the Lothian Health & Care System could do to alleviate your concerns?
- Is there anything else you would like to tell us before we finalise our strategy?

You can submit your views on the draft LSDF by email: loth.lsdf@nhslothian.scot.nhs.uk