DATA LABEL: Public

# ST JOHN'S HOSPITAL
# STAKEHOLDER GROUP MEETING

West Lothian Civic Centre
Howden South Road
Livingston
EH54 6FF

Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

1 May 2014

**DATE: WEDNESDAY 7 MAY 2014**
**TIME: 2.30 pm**

**VENUE: BOARDROOM 1, ST. JOHN'S HOSPITAL, HOWDEN**
**(and by video conference call from Waverley Gate)**

## Public Session

1. Apologies for Absence

2. Order of Business, including notice of urgent business

3. Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.

4. Confirm Draft Minute of Meeting of St John's Hospital Stakeholder Group held on Wednesday 09 April 2014 (herewith).

5. Hospital Activity Update with Year-on Year Comparisons (Out-patients)

   (a) Presentation by Mr Jim Crombie, Director of Scheduled Care, NHS Lothian.

6. Respiratory Medicine Update/Strategy Overview - Dr Donald Noble, Respiratory Consultant Physician.

7. Department of Laboratory Services Update - Jim Crombie

8. Key Quality Indicators Update - Report by Agnes Ritchie (herewith)

9. Paediatric Services Update - Jim Crombie

10. Stroke Care Delivery Update - Chris Stirling

11. Patients' Travelling Expenses Scheme Update - Jim Crombie

12. Hospital at Weekend Update - Report by Chris Stirling (herewith)

13. NHS Lothian Draft Strategic Plan 2014-2024 - Our Health, Our Care, Our Future - Note Update for Information (herewith)

14. Work Plan (herewith)

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NOTE **For further information please contact Elaine Dow on 01506 281594 or email elaine.dow@westlothian.gov.uk**

MINUTE of MEETING of the ST JOHN'S HOSPITAL STAKEHOLDER GROUP held within BOARDROOM 1, ST JOHN'S HOSPITAL on 9 APRIL 2014.

Present – Councillors John McGinty (Chair), Anne McMillan and Frank Toner and Maureen Anderson (Patient Representative) and by video link from Waverly Gate, Edinburgh – Alison Mitchell (Non-Executive Director of NHS Lothian Board).

Apologies – Agnes Ritchie, Chris Stirling and Professor John Iredale (NHS Lothian).

In attendance – Jim Crombie, Director of Scheduled Care, NHS Lothian, Jim Forrest, Director of West Lothian CHCP, Scott Prior, Laboratory ReNew Programme Manager and Mike Gray, Department of Laboratory Services.

1. ORDER OF BUSINESS

The Chair ruled that three reports be tabled to support the following items on the agenda:

Item 7: MRI Scanner Update

Item 8: Key Quality Indicators Update; and

Item 11: Transport Arrangements for Out-patient Appointments

2. DECLARATIONS OF INTEREST

Councillor Frank Toner declared a non-financial interest as a Non-Executive Director of Lothian Health Board and as Chair of the West Lothian Community Health and Care Partnership.

3. MINUTE

The Group confirmed the Minute of its meeting held on 12 March 2014 as being a correct record.

4. DEPARTMENT OF LABORATORY SERVICES UPDATE.

Mike Gray, Department of Laboratory Medicine, provided the Stakeholder Group with a presentation relating to the laboratories in the Lothian area. He advised that at the time of the presentation there were 19 laboratories across 4 sites in Lothian with a budget of over £30 million per annum.

The Group was advised that there were in the region of 14 million tests carried out each year, with the volume of tests increasing year on year. St John's Hospital (SJH) was the main processing site for 30 GP practices. It was noted that the service had 10 disciplines which included:

1. Haematology;

2. Biochemistry;

3. Blood Transfusion;
4. Microbiology;
5. Virology, Molecular Virology;
6. Clinical Genetics;
7. Molecular Genetics;
8. Cytogenetic;
9. Pathology, Molecular Pathology; and
10. Cytology.

Mr Gray went on to provide a breakdown of the Laboratory Medicine Strategy and the benefits and changes which had taken place at SJH. A breakdown was also given of the desired outcomes for the future of the laboratories at SJH and the effect of changes. Evidence was provided that turnaround could be managed following an incident in 2012 at St John's Hospital. However, the average turnaround time of tests carried out at the WGH was increased by an hour which was due to the increase in transportation time for samples to reach the WGH.

In conclusion, it was noted that the advantages of moving the work would mean more immediate access to specialist test repertoire in biochemistry and haematology at the WGH for GP work redirected from SJH, supporting future workforce planning and ensuring the best use of high throughput equipment.

A question and answer session then took place. Councillor McGinty asked what the proposals were for a consultation process to be carried out to share information with members of the public regarding the future proposals for the Department of Laboratory Medicine? It was agreed that feedback in relation to the proposals for consultation would be included on the agenda for the next meeting of the Stakeholder Group scheduled to be held on 7 May 2014.

Councillor McGinty also recommended that it would be useful to receive information in relation to the impact that moving this work would have on jobs within St John's Hospital. He also suggested that the presentation slides should include the advantages the changes would have on St John's Hospital in particular.

The Chair thanked Mr Gray and Mr Prior from the Department of Laboratories for attending the meeting.

<u>Decision</u>

- Noted the presentation by Mike Gray;
- Agreed that information regarding the consultation process be

included on the agenda for next meeting of the Stakeholder Group;

- Agreed that further details would be provided on the impact the proposed changes would have of jobs.

5. PAEDIATRIC SERVICES UPDATE

Jim Crombie provided the Stakeholder Group with an update in relation to the Paediatric Unit at St John's Hospital. He advised that the paediatric rota for April 2014 was fully populated and that work had commenced to secure the rota for May 2014.

Mr Crombie then advised that a six month recruitment programme was underway using a micro-site which would run in conjunction with standard recruitment advertising. The micro-site would be accessible from across the world with hyper-links available to key posts. Councillor Toner asked if it would be possible to provide details of how many hits the micro-site had received and also how many applications were received using the site. Mr Crombie agreed to provide an update to the next meeting of the Group.

The Chair thanked Mr Crombie for the update.

Decision

1. Noted the update in terms of the Paediatric rota;

2. Noted the update in terms of staff recruitment; and

3. Agreed that the item of business would remain on the agenda for the next meeting of the Stakeholder Group which would include an update on the use of the recruitment micro-site.

6. MRI SCANNER UPDATE

The Group considered a report (copies of which were tabled at the meeting) from Agnes Ritchie, Site Chief Nurse for St John's Hospital, which provided an update in relation to the MRI Scanner.

The report advised that work was underway and although the build project was two weeks behind schedule, it was hoped that the scanner would become fully operational at the beginning of September 2014. Staff were being appointed into posts and technical training was being carried out for radiographers on both the Western General Hospital and Royal Infirmary Edinburgh sites.

In May, a short term working group would be set up to look at patient pathways, standard operating procedures, protocols, safety, etc. to ensure that St John's Hospital was fully compliant with other centres within NHS Lothian in terms of MRI Scanner.

The Group agreed that an update in relation to the progress of the build

project and short term working group be provided to the meeting scheduled to be held in June 2014.

Decision

1. Noted the contents of the report; and

2. Agreed that an update would be provided to the June 2014 meeting of the Stakeholder Group.

7. KEY QUALITY INDICATORS UPDATE

The Group noted a report (copies of which had been tabled) by Agnes Ritchie which provided details of the monthly summary of process and outcome quality measures.

The Group recommended that the item of business be carried forward to the next meeting to allow Agnes to speak to her report and provide an explanation in relation to the information contained therein.

Decision

Agreed that the item of business be continued to the next meeting of the Group.

8. HOSPITAL ACTIVITY UPDATE WITH YEAR-ON YEAR COMPARISONS (OUT-PATIENTS)

Jim Crombie provided the Stakeholder Group with an update on the outpatient activity at St John's Hospital for 2013/2014 compared to the 2012/2013 activity. The year-end information was now available, however, he highlighted that the update was for information purposed only as a number of validation checks required to be carried out.

The Stakeholder Group agreed that a presentation would be provided by Mr Crombie at the next meeting of the Group on the year-end outpatient activity at St John's Hospital. It was also agreed that a report would be submitted to the June meeting of the Group providing details in relation to in-patient year end day care activity at St John's Hospital

Decision

- Noted the update on the outpatient activity at St John's Hospital;

- Agreed that a presentation would be carried out at the next meeting of the Group; and

- Agreed that a report would be included on the agenda for the June meeting of the Stakeholder Group on in-patient year end day care activity at St John's Hospital.

9. PRESSURES ON HAEMATOLOGY SERVICES UPDATE

Mr Crombie provided the Stakeholder Group with an update in relation to staffing levels within the Haematology Service at St John's Hospital. He reported that staffing levels remained stable, with colleagues from the Western General Hospital provided support when required.

The Stakeholder Group agreed that the item of business be removed from the agenda and would only need to be revisited should any problems arise.

Decision

1. Noted the update in relation to staffing levels; and

2. Agreed that the item of business be removed from the agenda.

10. STROKE CARE DELIVERY AND UPDATE ON TRANSPORT ARRANGEMENTS FOR OUT-PATIENT APPOINTMENTS

The Stakeholder Group agreed that the Stroke Care Delivery update would be carried forward to the next meeting of the Group to allow Mr Stirling to provide an update.

The Stakeholder Group considered the Financial Operating Procedures – Patients' Travelling Expenses Scheme (copies of which were tabled). Mr Crombie then reassured the Group that detailed financial operating procedures were available to support patients travelling to hospital. Leaflets were also available to provide patients with information relating to travelling expenses.

A question and answer session then took place. Maureen Anderson asked if processes were in place to ensure that patients who were attending St John's Hospital on a regular basis under a treatment pathway received information that they could claim for travelling costs if eligible? Mr Crombie agreed to check this out and report back to the next meeting of the Group.

Decision

- Noted the update in relation to patients' travelling expenses; and

- Agreed to provide an update to the next meeting of the Group on the information on claiming travelling expenses that was available to patients' attending the hospital on a regular basis under a treatment pathway.

11. HOSPITAL AT WEEKEND UPDATE

The Group noted the report (copies of which had been circulated) by Chris Stirling which provided an update in relation to the Hospital at

Weekend project. The model was driven by the need to support the existing medical workforce in the medical and head and neck ward areas during the weekend.

The Group agreed that the item of business be carried forward to be considered at the next meeting to allow Mr Stirling to speak to the report.

Decision

Agreed that the item of business be continued for consideration at the next meeting of the Stakeholder Group.

12. WORK PLAN

The Stakeholder Group considered the work plan (copies of which had been circulated).

Decision

Noted the contents of the work plan.

# St. John's Hospital Quality Dashboard – March 2014
## (dates for each data item stated in background charts)

This table shows a monthly summary of process and outcome quality measures. Trend graphs are shown on the pages following. The Committee should look for process measures to increase or remain stable and for outcome measures to decrease or remain stable. As many of the measures below are intended for improvement, it is important that background trend charts are also scrutinised as focussing on one data point (as below) may be misleading. Data below which has been updated since the last Quality Report is asterisked.

## QUALITY AMBITION

**PERSON-CENTRED - Outcome Measures**
Number of complaints *
Staff Absence Levels *

**SAFE – Outcome Measures**
Hospital Standardised Mortality Ratios
Unadjusted Mortality
Incidents with harm *
*C. Difficile* Numbers – Count *
*C. Difficile* Numbers – Rate *
*Staph. Aureus Bacteraemia* Numbers – Count *
*Staph. Aureus Bacteraemia* Numbers – Rate *
Number of Cardiac Arrests *
Rate of Cardiac Arrests *
Inpatient Falls with Harm *
Inpatient Pressure Ulcers Grade 2 or above *

**EFFECTIVE – Process Measures**
A&E 4 Hour Wait *
Admission to stroke unit on day or day after admission
Stroke Treatment Measure: CT Scan
Stroke Treatment Measure: Swallow Screen

**Additional Quality Measures**

Hospital Scorecard: January – March 2013 For St. John's Hospital

| **Indicator** | **SJH Rate (Per 1000 admissions)** | **Scottish Rate** |
|---|---|---|
| Standardised Surgical Readmission rate within 7 days | 17.90 | 20.92 |
| Standardised Surgical Readmission rate within 28 days | 35.18 | 39.92 |
| Standardised Medical Readmission rate within 7 days | 53.11 | 45.58 |
| Standardised Medical Readmission rate within 28 days | 126.24 | 104.19 |
| | **SJH** | **Scotland** |
| Average Surgical Length of Stay – Adjusted | 0.98 | 1.00 |
| Average Medical Length of Stay – Adjusted | 1.32 | 1.00 |

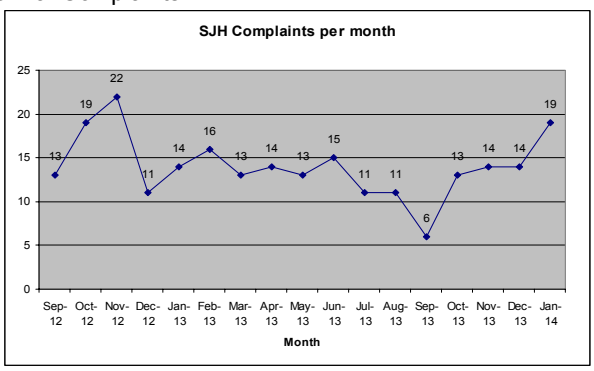
## Person-Centred

**"Mutually beneficial partnerships between patients, their families and those delivering healthcare services that respect individual needs and values and which demonstrate compassion, continuity, clear communication and shared decision-making."**

| Title: | Number of Complaints |
|---|---|
| Numerator: | Total number of complaints |
| Denominator: | |
| Goal: | Reduction in number of formal complaints |

**Outcome Measure**

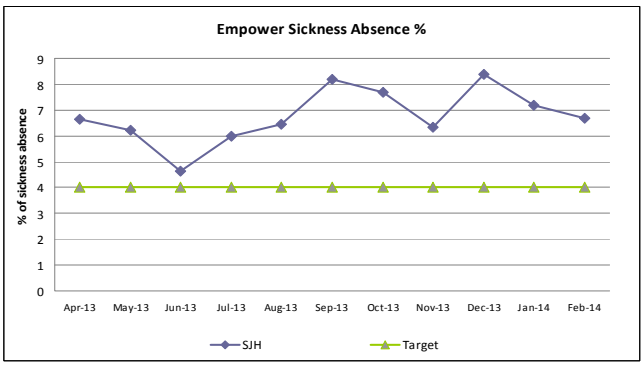
Formal Complaints




**Data Source: Datix Exec Lead: Alan Boyter**

| Title: | Staff Absence Levels for St. Johns |
|---|---|
| Numerator: | Total staff hours lost |
| Denominator: | Total staff hours available |
| Goal: | 4% or less |

**Outcome Measure**




**Data Source: Empower Exec Lead: Alan Boyter**

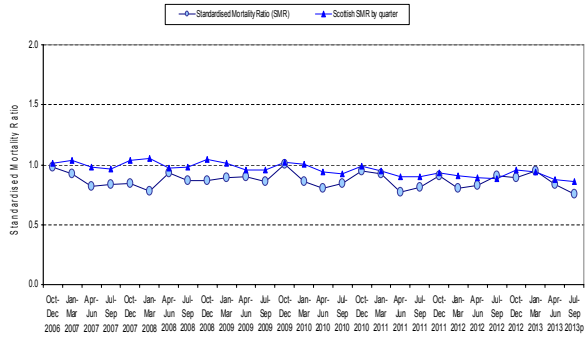
## Safe

**"There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times." Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, adverse event rate, key performance indicators for incident management and HAI indicators.**

| Title: | Hospital Standardised Mortality Ratio |
|---|---|
| Numerator: | Total number of in-hospital deaths and deaths within 30 days of discharge from hospital |
| Denominator: | Predicted total number of deaths |
| Goal: | 20% reduction against 2006/07 baseline by 2015. |

**Outcome Measure**

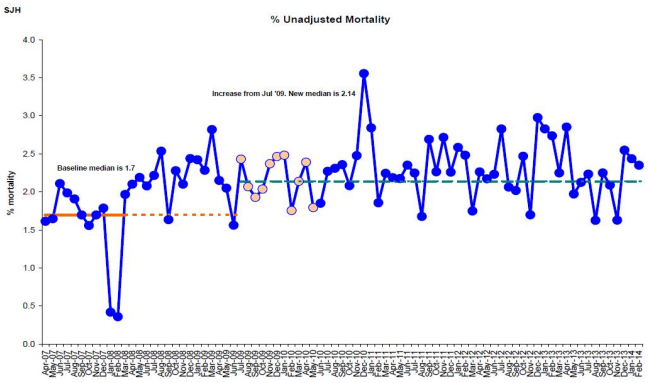
Quarterly Hospital Standardised Mortality Ratios in SJH, October 2006 – September 2013




**Data Source: ISD (Quarterly) Exec Lead: David Farquharson**

| Title: | Unadjusted Mortality for St. Johns |
|---|---|
| Numerator: | Number of deaths recorded for in patients each month |
| Denominator: | Live Discharges and Deaths (excluding Deaths in A&E) |

**Outcome Measure**

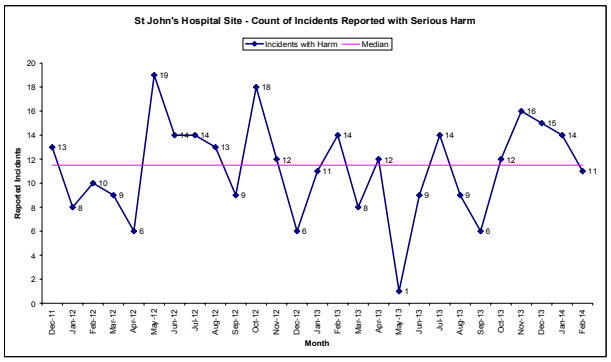



**Data Source: TRAK Exec Lead: David Farquharson**

## Safe (cont'd)

| Title: | Incidents with harm |
|---|---|
| Numerator: | Number of incidents associated with major harm/death reported per month |
| Goal: | There are specific goals for reductions in Falls & Pressure Ulcers. See separate graphs for progress against these. |

**Outcome Measure**

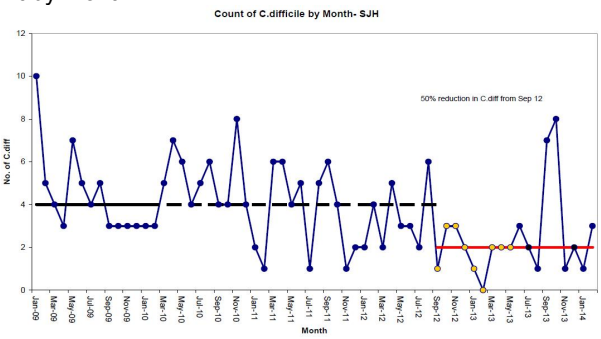



**Data Source: Datix Exec Lead: David Farquharson**

| Title: | C.Difficile associated disease against HEAT Target 2012-15 |
|---|---|
| Numerator: | Total number of patients over 15 with C.Difficile toxin positive stool sample (CDI) |
| Goal: | There is an NHS Lothian level target for March 2014 which will not be met. |

**Outcome Measure**

Count by Month

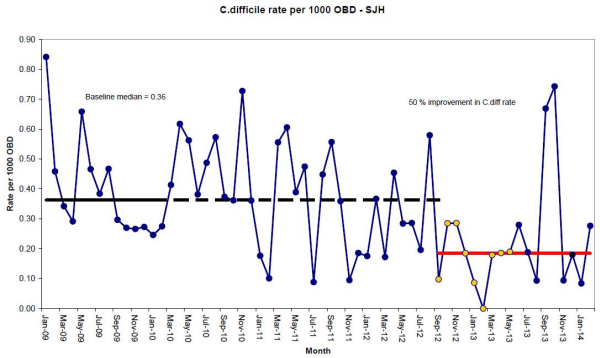



**Data Source: Infection Control Team Exec Lead: Melanie Johnson**

| Title: | C.Difficile associated disease against HEAT Target 2012-15 |
|---|---|
| Numerator: | Total number of patients over 15 with C.Difficile toxin positive stool sample (CDI) |
| Goal: | There is an NHS Lothian level target for March 2014 which will not be met. |

**Outcome Measure**

Rate

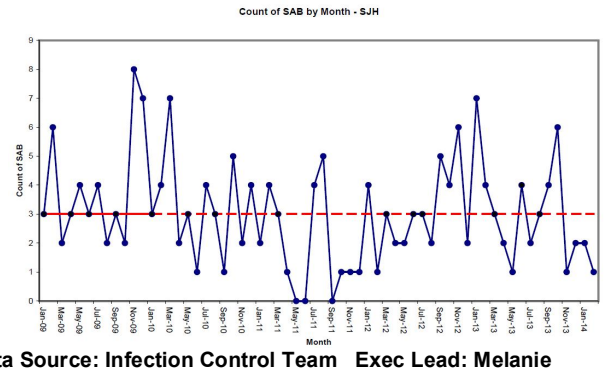



**Data Source: Infection Control Team Exec Lead: Melanie Johnson**

| Title: | Staph. aureus bacteraemias (SABs) against HEAT Target 2012-15 |
|---|---|
| Numerator: | The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections) |
| Goal: | There is an NHS Lothian level target for March 2014 which will not be met. |

**Outcome Measure**

Count by Month

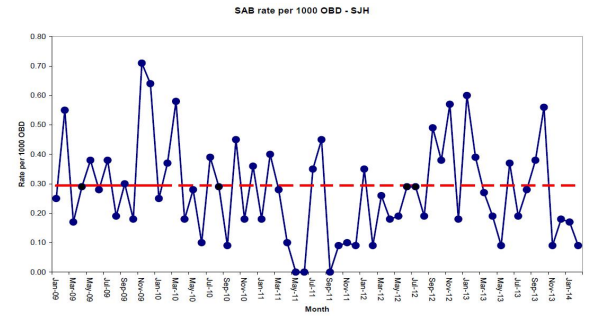



**Data Source: Infection Control Team Exec Lead: Melanie Johnson**

| Title: | Staph. aureus bacteraemias (SABs) against HEAT Target 2012-15 |
|---|---|
| Numerator: | The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections) |
| Goal: | There is an NHS Lothian level target for March 2014 which will not be met. |

**Outcome Measure**

Rate



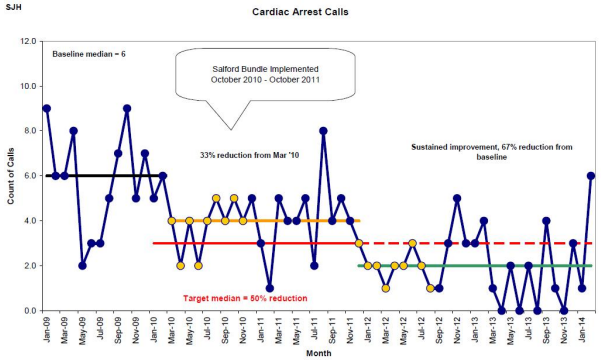

**Data Source: Infection Control Team Exec Lead: Melanie Johnson**

## Safe (cont'd)

| Title: | Number of Cardiac Arrests |
|---|---|
| Numerator: | Arrest – Number of 2222 calls which were for a cardiac arrest<br>Calls relating to staff, visitors, False Alarms, Cancelled Calls and Out of Hospital Arrests are excluded. |
| Goal: | 50% reduction in Cardiac Arrests with chest compressions from February 2013 baseline within 2 years at a Lothian level. |

**Outcome Measure**

Arrest Calls

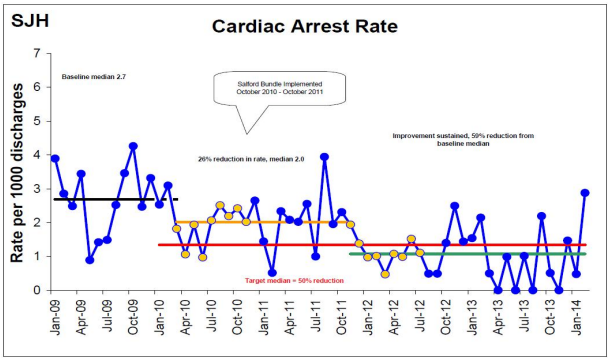



**Data Source: Local Audits (Resuscitation Officer Database)**
**Exec Lead: David Farquharson**

| Title: | Rate of Cardiac Arrests |
|---|---|
| Numerator: | Arrest – Rate of 2222 calls which were for a cardiac arrest. Calls relating to staff, visitors, False Alarms per 1000 discharges, Cancelled Calls and Out of Hospital Arrests are excluded. |
| Goal: | 50% reduction in Cardiac Arrests with chest compressions from February 2013 baseline within 2 years at a Lothian level. |

**Outcome Measure**

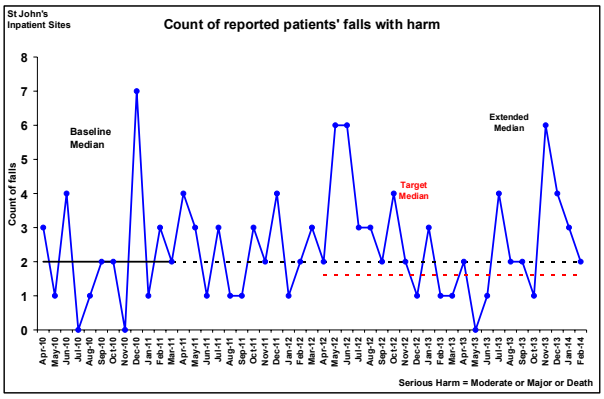
Arrest Rate




**Data Source: Local Audits (Resuscitation Officer Database)**
**Exec Lead: David Farquharson**

| Title: | Patient Falls with Harm |
|---|---|
| Numerator: | Number of falls reported with harm, moderate, major/ death. |
| Goal: | 20% reduction in inpatients falls and associated harm by March 2013 |

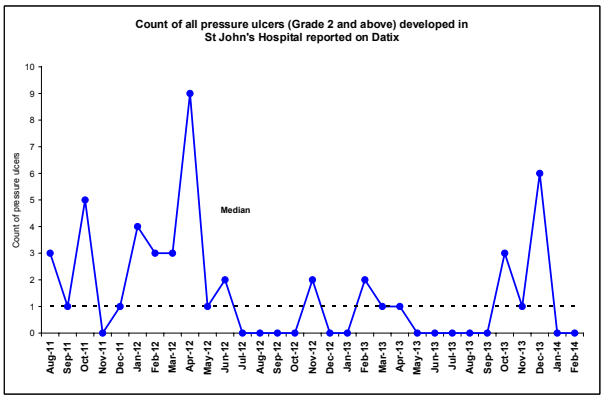
**Outcome Measure**




**Data Source: Datix Exec Lead: Melanie Johnson**

| Title: | Number of Pressure Ulcers per month |
|---|---|
| Numerator: | Number of Grade 2 or above pressure ulcers |
| Goal: | To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2014 (from one a day to none a day) |

**Outcome Measure**



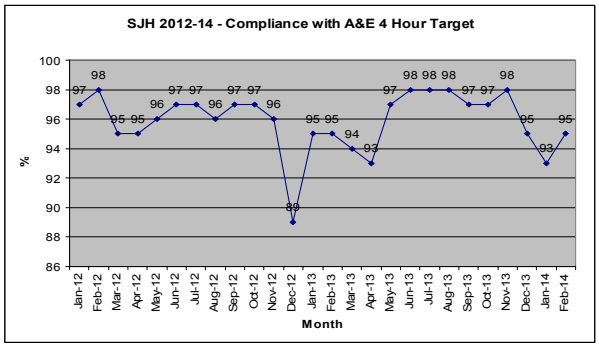

**Data Source: Datix Exec Lead: Melanie Johnson**

## Effective

**"The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated." Progress on this ambition is measured through clinical quality indicators, stroke care, medicine reconciliation and cost effective prescribing in primary care.**

| | |
|---|---|
| Title: | A&E 4 Hour Wait for St. Johns |
| Numerator: | Number of patients waiting less than 4 hours from arrival to admission |
| Denominator: | Number of patients attending |
| Goal: | 98% of patients waiting less than 4 hours from arrival to admission by March 2014 |

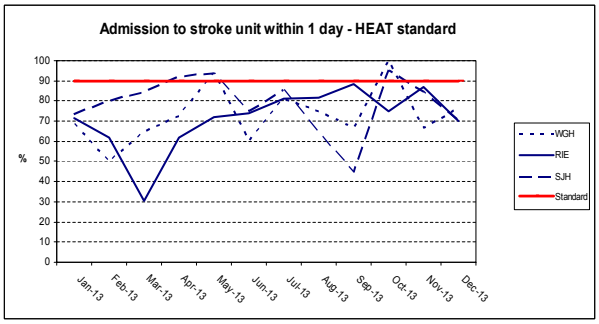
**Process Measure**




**Data Source: Patient Administration System (TRAK)**
**Exec Lead: Melanie Johnson**

| | |
|---|---|
| Title: | Admission to Stroke Unit within 1 day of admission |
| Numerator: | Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission |
| Denominator: | Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board |
| Goal: | By March 2013 90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission |

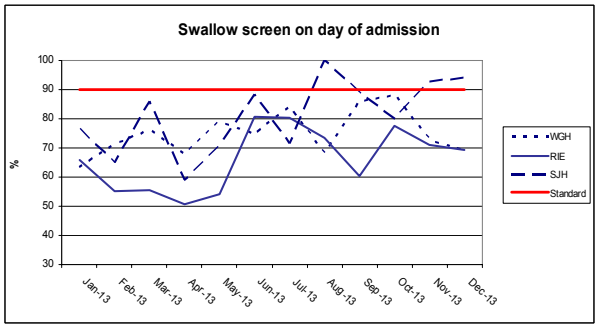
**Process Measure**




Note: 2013 data is not validated and should be treated as provisional
**Data Source: ISD Exec Lead: Melanie Johnson**

| | |
|---|---|
| Title: | Stroke Treatment Measures |
| Numerator: | Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission |
| Denominator: | Number of patients admitted with initial diagnosis of stroke |
| Goal: | 100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission |

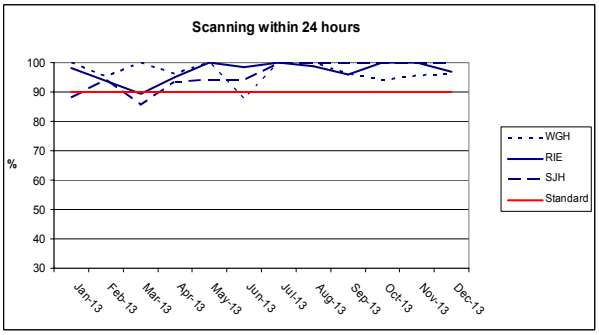
**Process Measure**




Note: 2013 data is not validated and should be treated as provisional
**Data Source: ISD Exec Lead: Melanie Johnson**

| | |
|---|---|
| Title: | Stroke Treatment Measures |
| Numerator: | Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival |
| Denominator: | Number of patients admitted with initial diagnosis of stroke |
| Goal: | 90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission |

**Process Measure**




Note: 2013 data is not validated and should be treated as provisional
**Data Source: ISD Exec Lead: Melanie Johnson**

**Item 12**

West Lothian Stakeholders Group 9th April 2014
Hospital at Weekend Update

Summary
Hospital at Weekend was launched at St Johns Hospital on 7th December 2013. The model was driven by the need to support the existing medical workforce in the medical and head and neck ward areas during the weekend.
The service has had a positive impact on:

- Allocation and distribution of weekend work
- Weekend discharge figures
- How the weekend 'feels' for the weekend medical and nursing team

Introduction
The team is made up of Senior Nurse Practitioners who have extended clinical and decision making skills. One practitioner acts as the coordinator and triages all calls from the ward areas, allocating the request to the most appropriate member of the team, be it a medic or a practitioner. Since February 2014, four Band 3 Clinical Support Workers (CSW) have also been employed to work with Hospital at Weekend and support the clinical workload.

Main findings
The average number of calls that the coordinator is taking each day from the ward areas at the weekend is 112. All of these calls would have traditionally gone to the junior doctor via a bleep. The triaging, prioritisation and allocation of these requests has allowed the medics to concentrate on tasks that only they can do, and has enabled them to feel supported. The nursing staff also feel more supported, noticing a more timely response to work requests over the weekend.
There is an upward trend on discharges over the weekend period compared to the same period twelve months ago. This increase in discharges as well as the improved workload at weekend has facilitated St Johns being better able to take additional bed bureau patients from Edinburgh to assist in overall unscheduled care flows across NHS Lothian on Mondays.

Outstanding Issues
Time is needed to develop the new role of the CSW in order to optimise their function within the team. This includes extended clinical skills training, as well as training with AHP's to support the physiotherapy and occupational therapy weekend service.
Improvement is needed in the way that the medical handover on a Friday evening is given to the weekend team. The current system (which is written on paper) is leading to repetition of work, with opportunities to improve the current system from a reliability and safety perspective. A TRAK handover similar to the one used for Hospital at Night is to be discussed at the TRAK board in April 2014. This will ensure that each request is attached to the patients EPR on TRAK providing clear information and instructions, and therefore helping patient safety.

The future
Funding has been given to extend Hospital at Weekend pilot for the next financial year (2014 / 2015). We will continue to evaluate the model and work with existing services to ensure that Hospital at Weekend continues to enhance and support weekend working at SJH.

Jane McNulty Lead Advanced Nurse Practitioner
Margot McCulloch Senior Nurse Practitioner
17th March 2014

# Our Health, Our Care, Our Future

## NHS Lothian Draft Strategic Plan 2014-2024

April, 2014

# Summary

## Policy Context

In 2011, the Scottish Government set out the strategic challenge for the NHS in Scotland, thus:-

**Our '2020 Vision'**

**Our vision is that by 2020** everyone is able to live longer healthier lives at home, or in a homely setting.

We will have a healthcare system where we have integrated health and social care, a focus on prevention, anticipation and supported self-management. When hospital treatment is required, and cannot be provided in a community setting, day case treatment will be the norm. Whatever the setting, care will be provided to the highest standards of quality and safety, with the person at the centre of all decisions. There will be a focus on ensuring that people get back into their home or community environment as soon as appropriate, with minimal risk of re-admission.

## Lothian Today

There have been many significant improvements in healthcare in NHS Lothian in recent times; mental health services are being transformed, following the development of community and intensive home treatment teams, reducing the need for hospitalisation; a Lothian wide service to support people with COPD and pulmonary rehabilitation is delivering benefits in patients' quality of life, in their ability to live more independently and in reducing admissions and re-admissions to hospital; there are improvements in sexual health services following redevelopment of the Chalmers Hospital; the Edinburgh Cardiac Centre has been designated as a national provider of trans-aortic transplant implementation; work with the Change Fund for Older People has seen significant investment into the community including joint community teams to support patients on discharge from hospital and additional carer support. In addition to the many improvements in particular services, more people are also being seen and treated more rapidly than ever before.

While acknowledging these and many other changes, NHS Lothian is nonetheless committed to continuous improvement across all of our services and we have identified, through this draft plan, key areas where further development is needed to achieve the 2020 vision. We also recognise that, against a background of rising quality aspirations, major demographic challenges and resource constraints, **delivering these changes will not be achieved without radical change, accelerating innovation and changing mindsets**:-

- Our current systems are not geared to deliver the outcomes that matter most to people with multiple conditions - coordination and continuity of care, accessible information and advice and good communication with, and between, staff at all times;

- General medical services (GP practices) and community services are already stretched and face increasing workload demands from a growing and ageing population, together with the consequences of the policy shift from hospital to home based care;
- Waiting times for some patients are still too long and fall outwith the Scottish Government's targets and guarantees;
- The number of people whose discharges from hospitals to residential care in Edinburgh are delayed, is increasing rather than decreasing;
- We lack the capacity to treat all NHS patients requiring hospital treatment within NHS Lothian facilities and remain dependent on other providers, including the private sector;
- Many of our buildings are old and not fit for purpose;
- Our costs and spending are higher than our anticipated income;
- Some of our systems of working are outmoded, stressed and struggling to cope with today's demands, let alone those of a larger and older population expected in the years ahead.

There is an increasing risk, unless we fundamentally change the ways we currently work and organise our services, that the quality of patient care will deteriorate and that we will fall short of meeting the needs and expectations of the people that we are here to serve.

**Lothian's Future**

Lothian population projections

The National Records of Scotland projections for 2010 to 2025 show a 15% increase in total Lothian population from 836,711 to 965,007 :-

| | **2010** | **2015** | **2020** | **2025** |
|---|---|---|---|---|
| East Lothian | 97,500 | 103,315 | 109,263 | 115,933 |
| Edinburgh | 486,120 | 517,222 | 543,785 | 568,200 |
| Midlothian | 81,140 | 83,412 | 85,553 | 87,649 |
| West Lothian | 172,080 | 179,912 | 186,735 | 193,354 |
| NHS Lothian | 836,711 | 883,732 | 925,207 | 965,007 |

## NHS Lothian's Vision for Services

Our vision is that services will be safe, effective and patient centred. We aim to deliver the right care, at the right time in the right place i.e. to be both caring and productive.

We will only achieve this by thinking and working differently and being more willing to innovate than we are currently.

| Current System | Future System |
|---|---|
| Geared towards acute / single condition | Designed around people with multiple conditions |
| Hospital - centred | Located in local communities and their assets |
| Doctor dependent | Multi-professional and team - based care |
| Episodic care | Continuous care and support when needed |
| Disjointed care | Coordinated and integrated health and care |
| Reactive care | Preventive and anticipatory care |
| Patient as passive recipient | Informed, empowered patients and clients |
| Self-care infrequent | Self-management / self-directed support |
| Carers undervalued | Carers are supported as full partners |
| Low tech | Technology enables choice and control |

## The Plan

This plan describes what NHS Lothian proposes to do over the coming decade to address these challenges and provide a high quality and sustainable healthcare system for the people of Lothian. The improvements and necessary changes will be delivered through new ways of working by our staff and independent contractors, as well as by working differently with our key partners through the four local authorities, the third sector and with patients and carers.

We will put patient safety, quality and transparency truly at the heart of what we do. This will include full involvement in national programmes including the Scottish Patient Safety Programme, Person Centred care and Leading Better Care. We will undertake a programme of patient pathway redesign taking a whole system approach involving patients, staff and partners to transform our services around the needs of those who use them.

A wide range of propositions has been developed and will be debated and firmed up through consultation and engagement over the coming months; many of these are essential in order to deliver the 2020 Vision, including the following:-

- a radical shift away from a traditional, incremental approach to development based on services and specialties to a **patient-centred, whole-system, pathways approach**, focussing much more explicitly on the needs and experiences of people who use NHS Lothian's services;

- pursue the ten safety essentials and nine point of care priorities in the **Scottish Patient Safety Programme**, including infrastructure for building quality improvement capacity and capability, the strategic prioritisation of safety in acute care, the safe management of medicines and the prevention of falls

- improving services for the significant, and growing, number of people with multiple conditions, by developing and delivering Lothian's **multimorbidity action plan**, in concert with the national programme to deliver excellence through:-
  - care planning and consultations that help people have control over their conditions, care and support and to achieve their personal outcomes;
  - integrated care and support that builds on community assets and promotes independence, wellbeing and resilience;
  - whole system pathways that are designed around multimorbidity and to reduce health inequalities;
  - providing visible leadership and using research, innovation and improvement approaches to improve the quality of care for people with multimorbidity;

- ending 'silo working', through closer **interdependence and integration** of community and hospital based services and across the public sector, through the establishment of Health and Social Care Partnerships in 2015 for Edinburgh, West Lothian, Midlothian and East Lothian, in accordance with Government legislation;

- improving access to **primary care**, through an increase in the number and capacity of **general practices and community teams** to meet increased demand arising from the population growth, extended life expectancy and the consequent increase in multi-morbidities;

- develop primary care **premises**, wherever possible, as integral parts of multipurpose facilities providing health, social care, voluntary and other community-based services; develop a Lothian-wide approach to sharing and benchmarking of primary care **information** at general practice and partnership level;

- urgently reducing to a maximum of two weeks by April 2015 and eventually eliminating altogether **delays in patients' discharge** from hospitals;

- improving the care for older people by adapting and modernising the role of all current **continuing care** provision across Lothian to create a seamless spectrum of care from hospital based complex clinical care through to residential home care and care at home;

- improving arrangements for the residential **care of older people**, including assessment of the potential for the creation of a new 'care village' concept on the Royal Victoria Hospital and Liberton Hospital sites, replacing old and out of date hospital facilities with new purpose-built facilities, allowing social care to be provided in local communities, with NHS support provided on an in-reach basis, as required; this is in line with recent policy developments following reviews of residential care and the future of NHS inpatient continuing care;

- developing a new **East Lothian Community Hospital** and adapting the use of **Midlothian Community Hospital**, to provide 'step up' and 'step down' care for older people, to prevent inappropriate admission to acute hospitals in Edinburgh and to provide a wide range of community services for people closer to home;

- continuing to develop community **mental health services** to better support people at home, and to modernise acute mental health services by redeveloping the Royal Edinburgh Hospital**,** with phase one expected to be complete by 2016;

- delivering a wide range of improvements in **children's services**, including the construction of a replacement for the Royal Hospital for Sick Children on the Royal Infirmary of Edinburgh campus, with completion expected by 2017;

- creating a new, **Regional Cancer Centre**, fit for the 21st century, at the Western General Hospital, and integrating within a patient pathway designed to keep patients as close to home for treatment as possible;

- revising the model of **emergency care** at the Western General Hospital to improve the quality of service and the experience for patients and staff, and which is sustainable; to **review acute receiving and assessment capacity** at the Royal Infirmary of Edinburgh to meet the growing demand for more generalist services that can respond to the needs of older, frailer patients, often with multiple conditions and many with dementia;

- improving the **quality and sustainability of specialist hospital services**, through a new configuration of acute inpatient services at the Royal Infirmary of Edinburgh(RIE), Western General Hospital (WGH) and St John's Hospital, Livingston (SJH), including the development of a specialist clinical **neurosciences** centre at RIE, reviewing the model for **Dermatology** care, concentrating inpatient **orthopaedics and trauma** at RIE, **stroke** services at either the RIE or WGH and **ophthalmology** at RIE, WGH or SJH.

- improving patient services by widening the scope and scale of operative **procedures undertaken on a day case basis** and developing additional day surgery facilities at WGH and/or SJH;
- radically reviewing the future requirement for **outpatient services** and introducing more convenient, safe and innovative alternatives to routine outpatient attendance and follow-up;
- developing our human resources strategy to ensure a **capable, integrated and sustainable workforce**, within a healthy organisational culture which will support high quality health and social care;
- rebalancing investment between acute hospitals and primary and community services, as well as **urgent action on areas for disinvestment,** recognising the need to improve service quality while generating up to £40m cash-releasing savings each year;
- driving an innovative and radical approach to creating opportunities for **improving the value** of all (not just new) investment in facilities and services, identifying those which do not contribute to the health of the population, in order to free up the funds and capacity to deliver a higher quality, more modern and more sustainable health and care service in line with this plan.

This is a consultation document and, as such, it sets a 'direction of travel' for NHS Lothian in the years ahead. Firm commitments and priorities will not be determined without further detailed engagement with the public, with our staff, with GPs and other independent practitioners and with our many other partners.

It is essential that the plan supports innovative and modern clinical practice in ways that make it easier for clinical and other staff to provide the best care to patients. It is equally important that all clinicians and managers engage positively with the planning process and commit to supporting the outcome. This will only be achieved through facilitative management and effective clinical leadership which do more to break down the barriers to the best care and focus on developing new ways of working through integrating, not just health and social care, but primary, community and hospital care to deliver a seamless patient's journey.

A definitive strategic plan, which firms up the propositions and detail around the actions, timelines and implications for patients, staff and funding will not be presented to the Health Board for approval before the autumn of 2014, reflecting the outcome – and importance - of an extensive consultation and engagement process.

# 1. Outcomes to be achieved

**'Our Health, Our Future'**

In 2013, Lothian NHS Board approved a Strategic Clinical Framework which identified six aims to ensure we can deliver safe, effective and person-centred health and social care:

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

**'A Route Map to the 2020 Vision for Health and Social Care'**

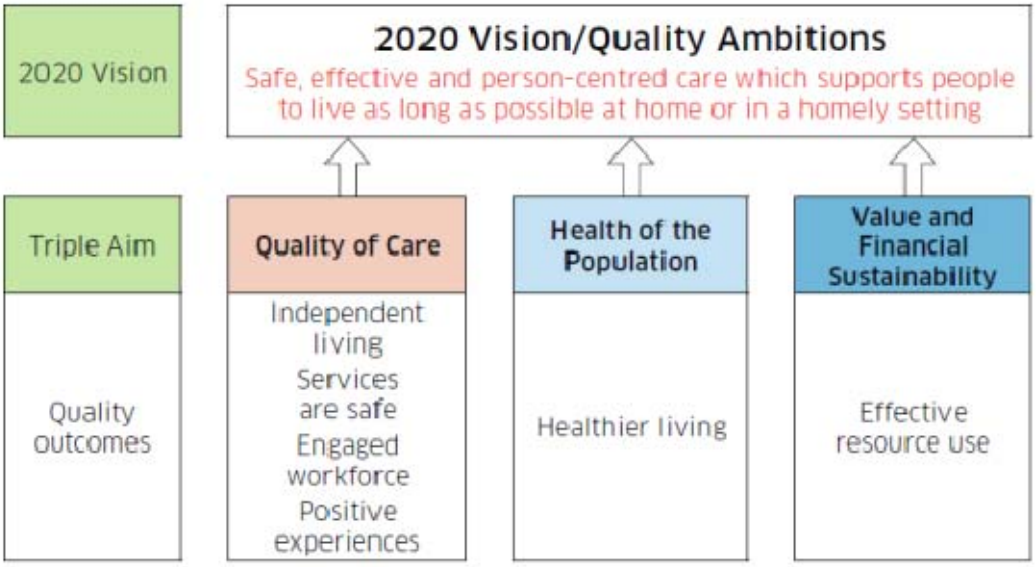
Also in 2013, the Scottish Government set out the triple aims for achieving the 2020 Vision and these have been used to structure this plan. They are:-

- Further **improving the quality of the care** we provide with a particular focus on:
- increasing the role of primary care
- integrating health and social care
- accelerating our programme to improve safety in all healthcare environments
- improving the way we deliver unscheduled and emergency care
- people-powered health and care services
- improving our approach to supporting and treating people who have multiple and chronic illnesses

- **Improving the health of the population** with a particular focus on:-
- early years
- reducing health inequalities
- preventative measures on alcohol, tobacco, dental health, physical activity and early detection of cancer

- **Securing the value and financial sustainability of the health and care services** we provide:-
- establish a vision for the health and social care workforce for 2020, and setting out a clear plan of actions which will have an immediate effect

- increase our investment in new innovations which both increase quality of care, and reduce costs and simultaneously provide growth in the Scottish economy
- increase efficiency and productivity through more effective use of unified approaches coupled with local solutions and decision making where appropriate



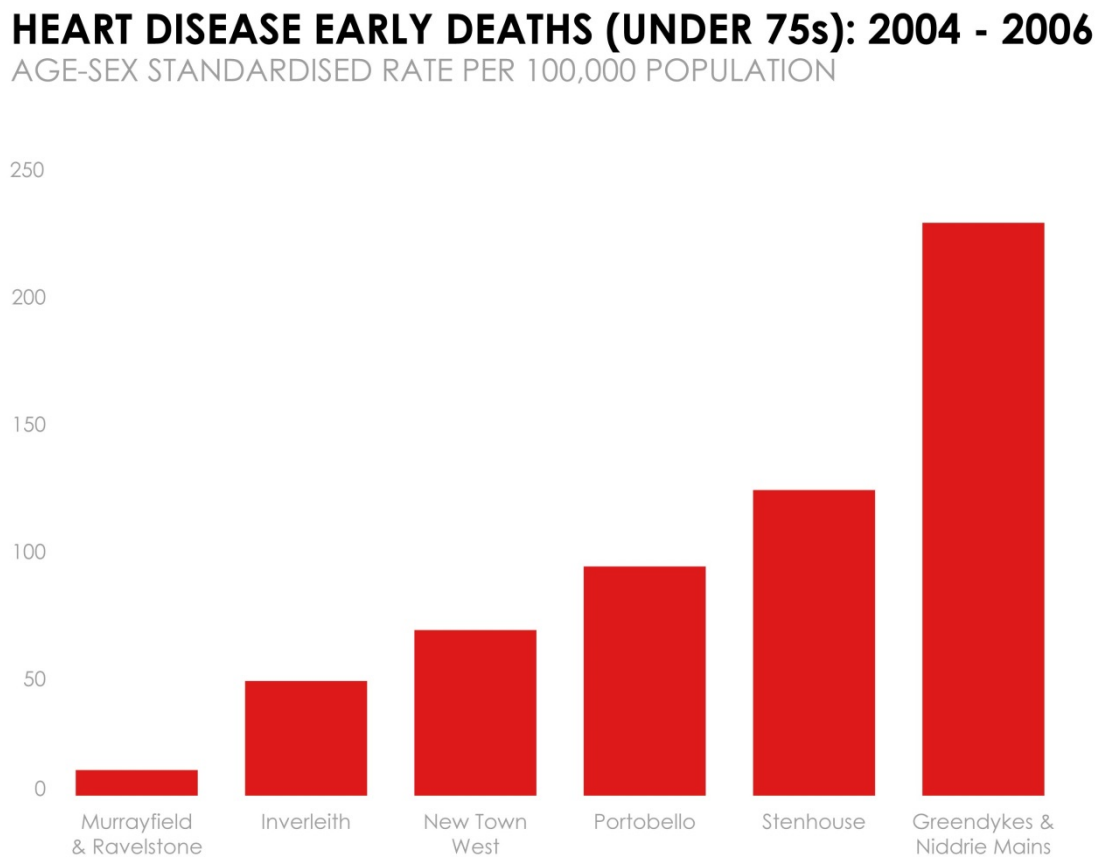

The NHS Lothian outcomes and measurement framework is being developed to ensure that we monitor progress against these aims and ambitions.

## 2. The Challenges

### Demography, Inequalities and Ill Health

Health services in Lothian have been designed or have evolved historically to serve much smaller numbers of people and a different age profile than is now predicted.

While the overall health of people is improving, the incidence and prevalence of some diseases is increasing; also, rates of health improvement are lower in poorer parts of our communities. While health is improving overall, with fewer deaths, for example, from coronary heart disease and stroke, there remains a significant difference in the rate of premature death from heart disease between the richest and the poorest sections of our community:-




Much of the attention of the NHS is spent on responding to the needs of people when they are unwell or unable to cope on their own. This will always be a major mission of the health and care services, but needs to be increasingly balanced by proactive interventions by people themselves, supported as necessary by health and care professionals, to avoid or delay the onset of illness. People also expect to be able to manage their own health conditions themselves to a greater degree than ever before and the health and care services must ensure that information and knowledge, along with specialist advice and equipment is made accessible to support people effectively in their own self-care.

In Scotland there are significant inequalities in health between people who are socially and economically well off, and those who are socially disadvantaged. In Lothian this means, for example, that **people living in the most affluent communities in Lothian can expect to live 21 years longer than people living in the most deprived communities**. People living in the most deprived communities also have poorer physical and mental health throughout their lives. However, health inequalities are not related to socio-economic status alone. People who are disadvantaged by race, disability, gender and other factors also have poorer health.

A common approach to tackling health inequalities is to target support and interventions to the geographical areas identified as being deprived, commonly the most deprived 15% of areas measured by the Scottish Index of Multiple Deprivation (SIMD). There are several

reasons why this approach cannot reduce health inequalities on its own, not least because many disadvantaged people do not live in these deprived areas – only about half of people who are income deprived live in the 15% most deprived areas by SIMD. So if an intervention is provided only to people living in targeted areas, other equally needy people will miss out.

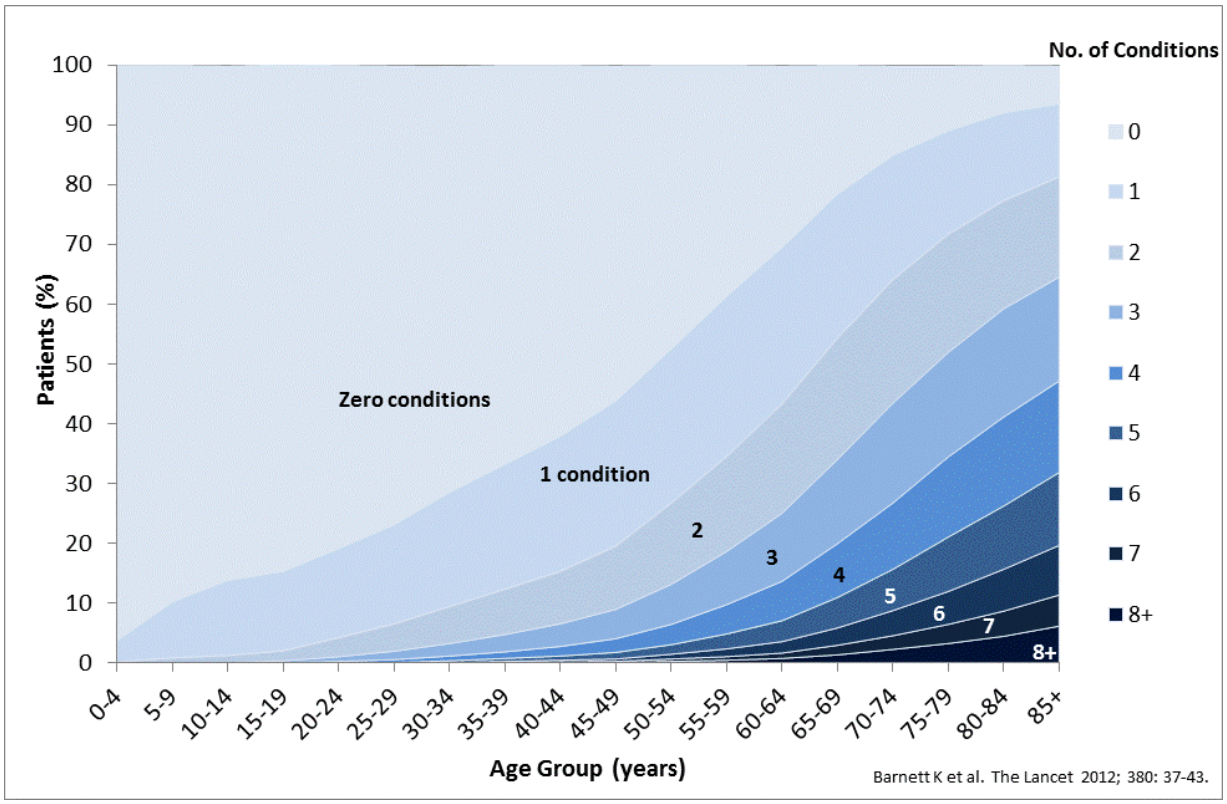
**Multimorbidity**

The risk of people suffering from a complex mix of long term conditions (multimorbidity) increases with age and lower socioeconomic status. **The overall prevalence of cancer is expected to rise by 8% every five years, and the prevalence of dementia to increase by up to 70% in the next twenty years.** New ways need to be found of tackling the causes of issues such as obesity, poor diet and limited physical activity, smoking and excessive consumption of alcohol, which are closely associated with long term conditions such as cardiovascular disease and diabetes.

We know that people living in deprived communities develop multimorbidity ten to fifteen years earlier than the least deprived. We also know that, while most over-65s have two or more conditions, and most 75+ have three or more conditions, multimorbidity is not just experienced by older people. There are more people in total aged under sixty-five with multimorbidity than over sixty-five.

New and innovative ways need to be found – and quickly - of reducing ill health and, following its onset, of treating and supporting people to be able to enjoy an acceptable quality of life.

***Average number of conditions, by age group***



**Health Service Demand**

The National Records of Scotland projections for 2010 to 2025 show a 15% increase in total Lothian population from 836,711 to 965,007. East Lothian's population increases by 19%, Edinburgh by 18%, West Lothian by 12% and Midlothian by 8% over this period. Overall, the Lothian population increases by 15%, or 128,296 people.

The over 65s represent 18.2% (up from 14.8% in 2010) of the total population in 2025 and account for 40% of the total increase of 128,296 between 2010 and 2025. It should be noted that the proportion of young people stays constant over the period.

***Lothian population age projections, 2010-2025***

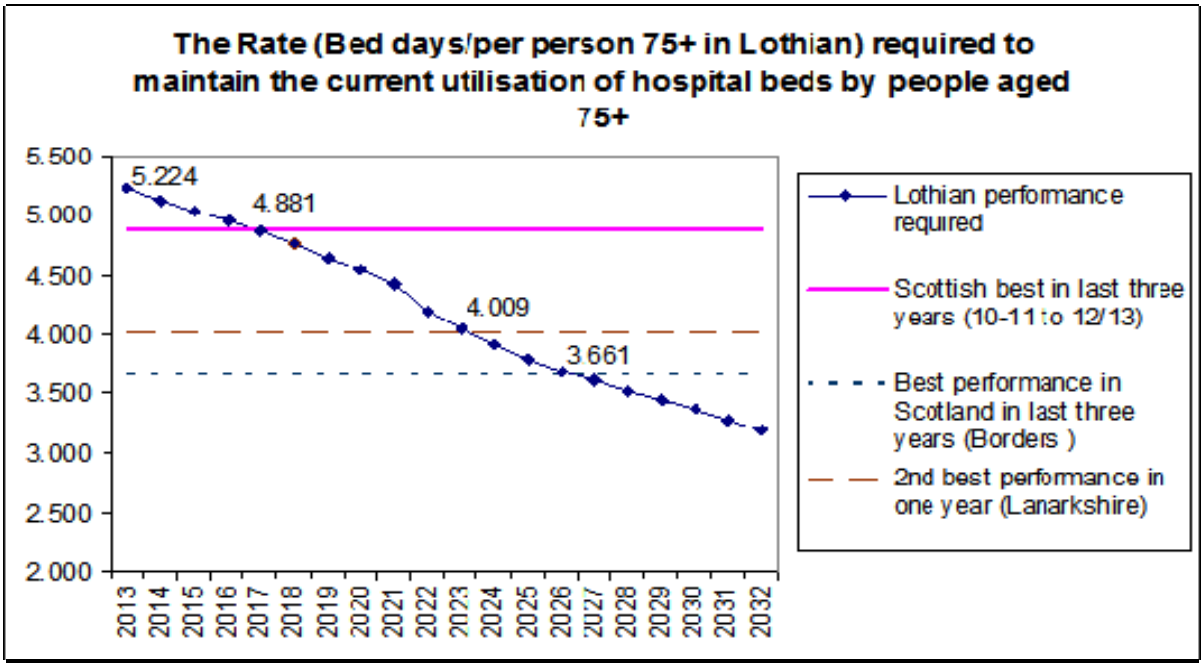
| | 2010 | 2015 | 2020 | 2025 | Scotland2025 |
|---|---|---|---|---|---|
| NHS Lothian | % | % | % | % | % |
| 0-15 | 16.9 | 16.7 | 17.0 | 16.7 | 17.3 |
| 16-64 | 68.3 | 67.4 | 66.2 | 65.2 | 61.4 |
| 65-74 | 7.8 | 8.6 | 9.0 | 9.2 | 10.8 |
| 75-84 | 5.1 | 5.2 | 5.3 | 6.2 | 10.3 |
| 85+ | 1.9 | 2.1 | 2.4 | 2.8 | |

Growth in the population and rising demand for services in recent years has not been matched by equivalent growth in the numbers of staff, largely due to improvements in efficient working and acceptance of more intensive working patterns. However, particular pressures on GP and practice staffing and on health visiting and district nursing need to be addressed early in the life of this plan, if the rising expectations on primary and community based services to support more patients and more complex conditions at home or in homely settings is to be realised.

As people get older they are also more likely to be admitted into hospital. In 2012/13 the rate of all emergency bed days for patients aged 75+ (per 1000 patients was 5,220. This is the equivalent of 5.22 bed days used by each person in Lothian aged 75+.

Some admissions are avoidable and there are many established services and pilots in place across Lothian to reduce the number of avoidable admission by increasing the capacity and effectiveness of community services to support people at home. These include care homes, home care and district nursing services which work alongside shorter term 'intermediate' services such as reablement, rehabilitation and step down services in hospitals and care homes. Activity in all of these services has grown or remained stable throughout 2013. There have however been particular issues in Edinburgh due to concerns about quality of care in care homes, which has resulted in a suspension of admissions to a number of larger care homes, approximately 15% of the capacity in Edinburgh. A number of actions are currently underway to mitigate the impact of this on the patient population, but more is required.

**The Rate of Emergency Admission Bed Days** for patients aged 75+ is decreasing in Lothian, but **is higher than the Scottish average**. To be able to cope with future demands within the current beds, the admission rate would need to reduce very significantly, as illustrated below***:-***

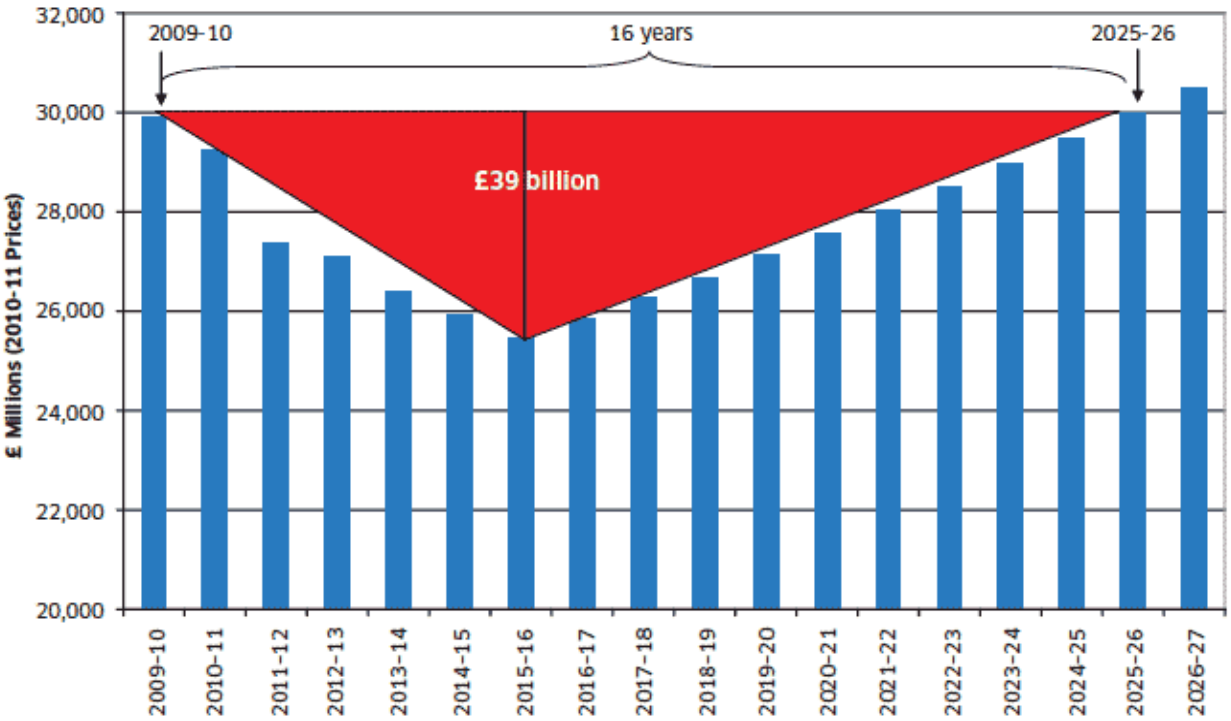



The definitive version of this plan will be informed by Scottish Government policy, both established and emerging, including the modernisation of the system of care for people who would traditionally have looked to either NHS continuing care or Local Authority or independent residential care provision for ongoing support, in pursuit of the long term policy goal to shift the balance of care from institutional settings to more homely settings in the community. Recent reports of the Residential Care Task Force and Continuing Healthcare Review offer a vision of care which has been translated by NHS Lothian into innovative propositions in this draft plan, including the creation of “care villages” on the Liberton and Royal Victoria hospital sites.

## Tighter Finances

The economic outlook for health, local government and the voluntary sector remains extremely tight and the global economic downturn means that real terms growth in public spending is not expected to return to the level of 2009/10 until 2025, so we have to deliver better health and healthcare while making best use of limited public resources.

***Projected Scottish public spending in real terms***




For NHS Lothian, **this means having to find cash releasing savings of around £40M in each of the next three years,** even before consideration of the investment required to deliver much of this plan. Restrictions in available growth funding and savings targets mean that the investment necessary to support more people appropriately at home or in homely, rather than hospital surroundings, will require a rebalancing of investment from hospital to primary and community services; action will also be required on areas for disinvestment - the elimination of tasks and actions that consume staff time and other resources without delivering benefit for patients, freeing up those resources to help deliver the priorities in this plan.

On current funding assumptions, **there is no capacity for discretionary investment until at least 2017**. Therefore, the only way to support the levels of investment required to deliver this plan is to generate funding by freeing up existing resources through much more efficient working, redesign and through disinvestment from services which are no longer appropriate or fit for a modern high quality health system in the 21st century. This is going to require renewed levels of commitment and effective leadership from clinicians and senior managers working even more closely together.

T**here is a duty on the Health Board and its partners to ensure that it public money is spent in ways which deliver the greatest health benefit and the highest quality of care to the population**. It would be irresponsible and not in the public's best interest to continue to spend on the things that we have always done, without maximising the benefits in terms of

healthcare. We will therefore review not only decisions about where to invest in new services, but also how we spend our money today on current premises, systems, medicines and practices to ensure that they are effective and adding value to the outcomes in this plan. Premises which are no longer fit for purpose will be declared surplus to requirements, subject to disposal and the gains from sale reinvested in the delivery of modern services and other changes set out in this plan.

It is important to ensure that any decisions about where to invest or disinvest public funds are taken in a properly considered way. Decisions on priorities and choices will therefore be determined through a transparent process of engagement which will require clinical leadership and will include weighing up of various dimensions of quality, consistent with NHS and Scottish Government policy as objectively as possible. The criteria will include equity, efficiency, effectiveness, safety, person-centredness and timeliness,

## 3. Developing Lothian's Health Services

### Developing Primary and Community Services

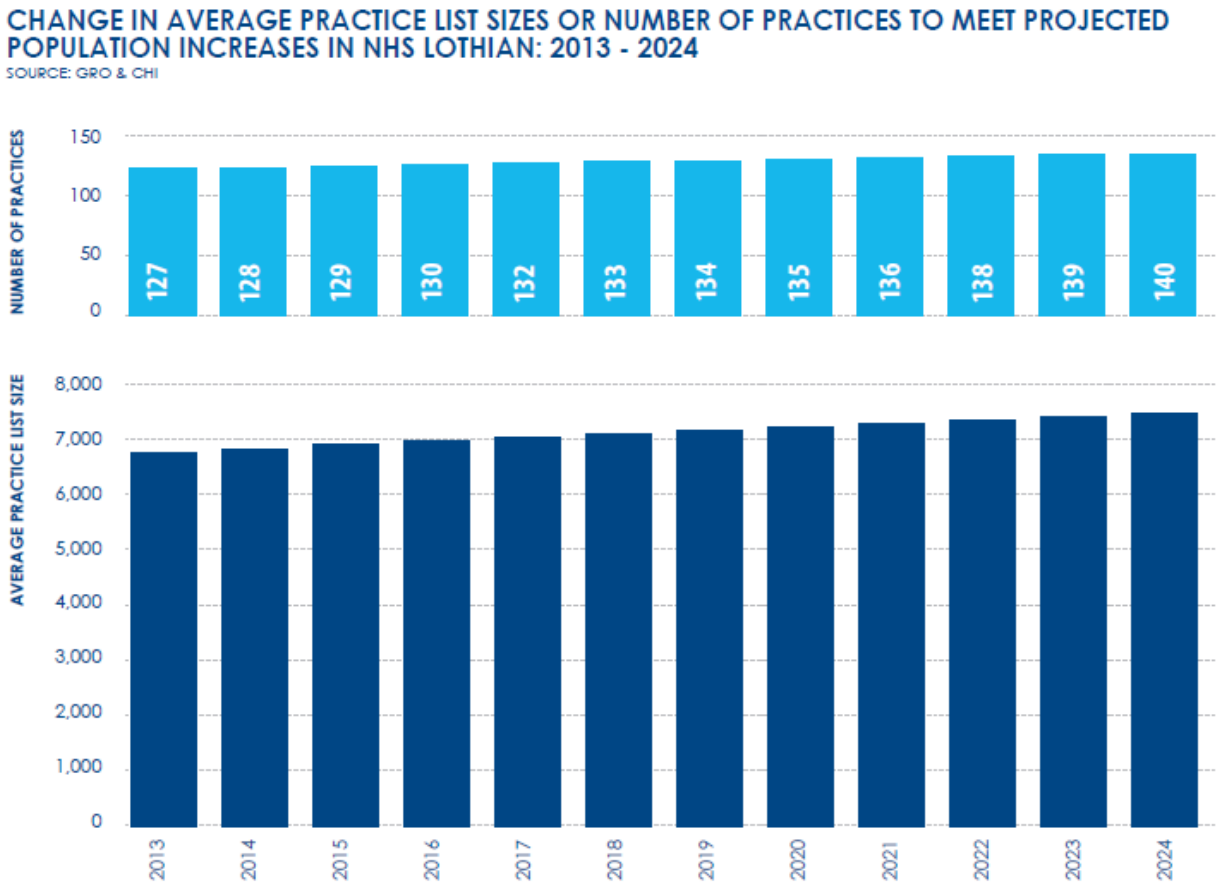
The overarching aims of Primary and Community Services are to be able to meet public expectations by ensuring timely consultation with an appropriate health care professional, involve the patient and carer in decision making about their healthcare choices, deliver access to safe and effective treatment, give clear and accessible information and experience an efficient, approachable and responsive service. **Primary Care and Community Services provide the first point of contact between an individual and a healthcare professional in more than 90% of contacts with health care services.**

Within primary care there are four practitioner services; medical, dental, pharmaceutical and optical. These practitioners are usually independent of the NHS and are contracted by local NHS Boards to provide their particular service. Contracts are negotiated on a national basis, however NHS Boards have some scope to negotiate local contracts or employ practitioners directly as salaried NHS employees.

Each year, there are over 5 million contacts with general medical practices, 1.5 million contacts with community services and 136,000 contacts with the Lothian Unscheduled Care Service (Out of Hours General Medical Service). There are 127 GP practices in Lothian (excluding the challenging behaviour GP practice) supported by a total of 1,601 general practitioners. The Primary Care and Community Services healthcare team consists of general medical practitioners, practice nurses, managers and reception staff working together with Health Visitors, District Nurses and Health Care Assistants, Community Midwives, Phlebotomists, Community Psychiatric Nurses and Allied Health Care Professionals.

In order to support the shift in the balance of care from secondary to primary and community care services at the same time as providing for the growth in numbers and the ageing in Lothian's population, and meet all the aspirations of a sustainable and high quality service (e.g. with patients waiting no longer than 48 hours for a non-urgent appointment to see a GP or practice nurse), we need to increase the capacity of our primary care and community services.

The rate of population growth and its impact on primary care is described in the diagram below:-




The propositions in this draft plan are designed to strengthen the capacity and capability of locally based teams in primary, community and social care. This will enable them to better support patients and to deliver the kind of anticipatory care and interventions which will maintain people at home and so avoid unnecessary emergency admission to an acute hospital, with all the inevitable stress and inconvenience that that entails. They also recognise the need for appropriate input to a residential sector focused on prevention and rehabilitation (step-up / step-down care) and a more specialised residential sector focused on delivering high quality 24-hour care for people with substantial care needs.

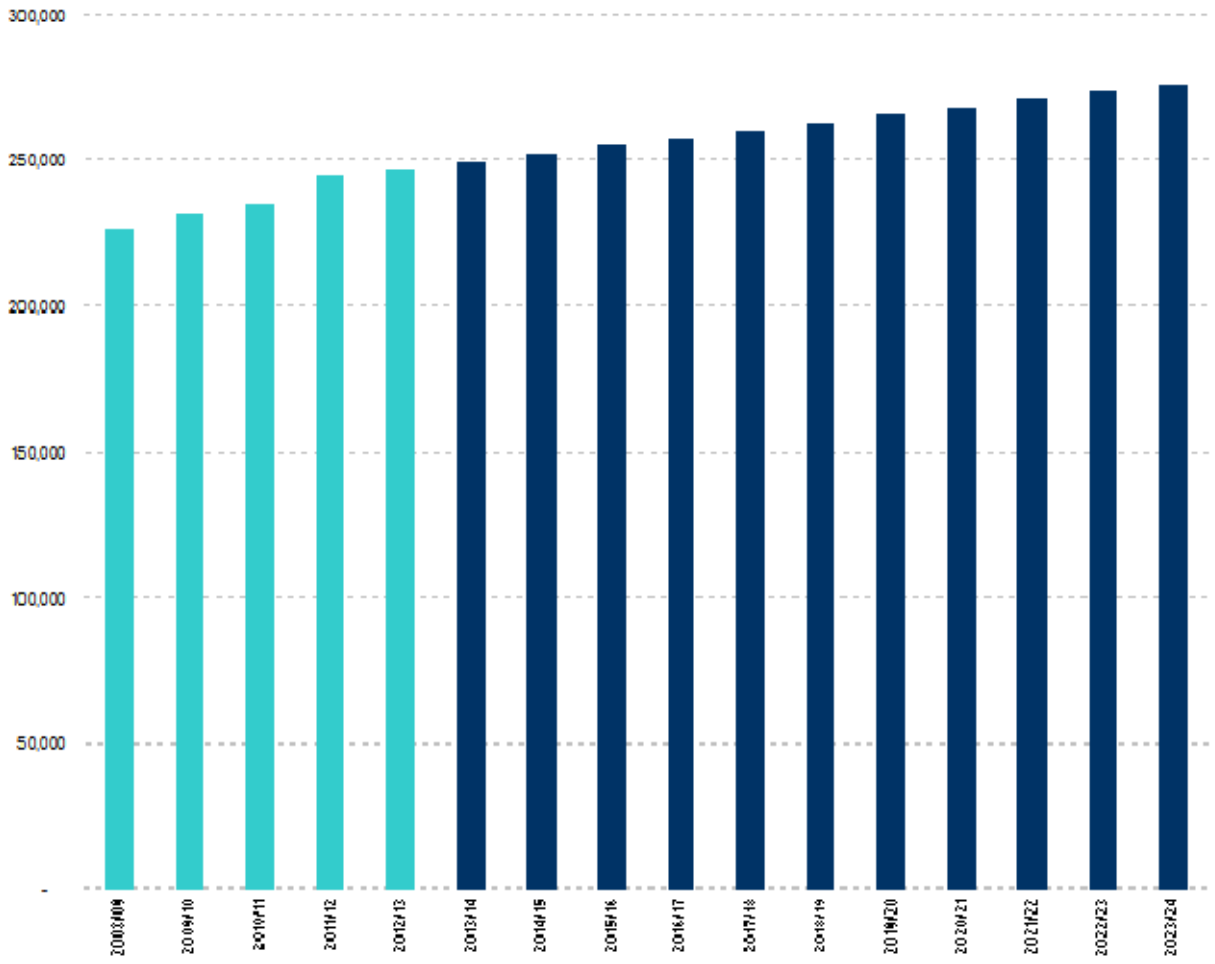
**Developing Acute Hospital Services**

Acute hospitals provide a focus for specialist secondary and tertiary care, bringing together highly specialised expertise, with specially designed equipment and premises operating 24

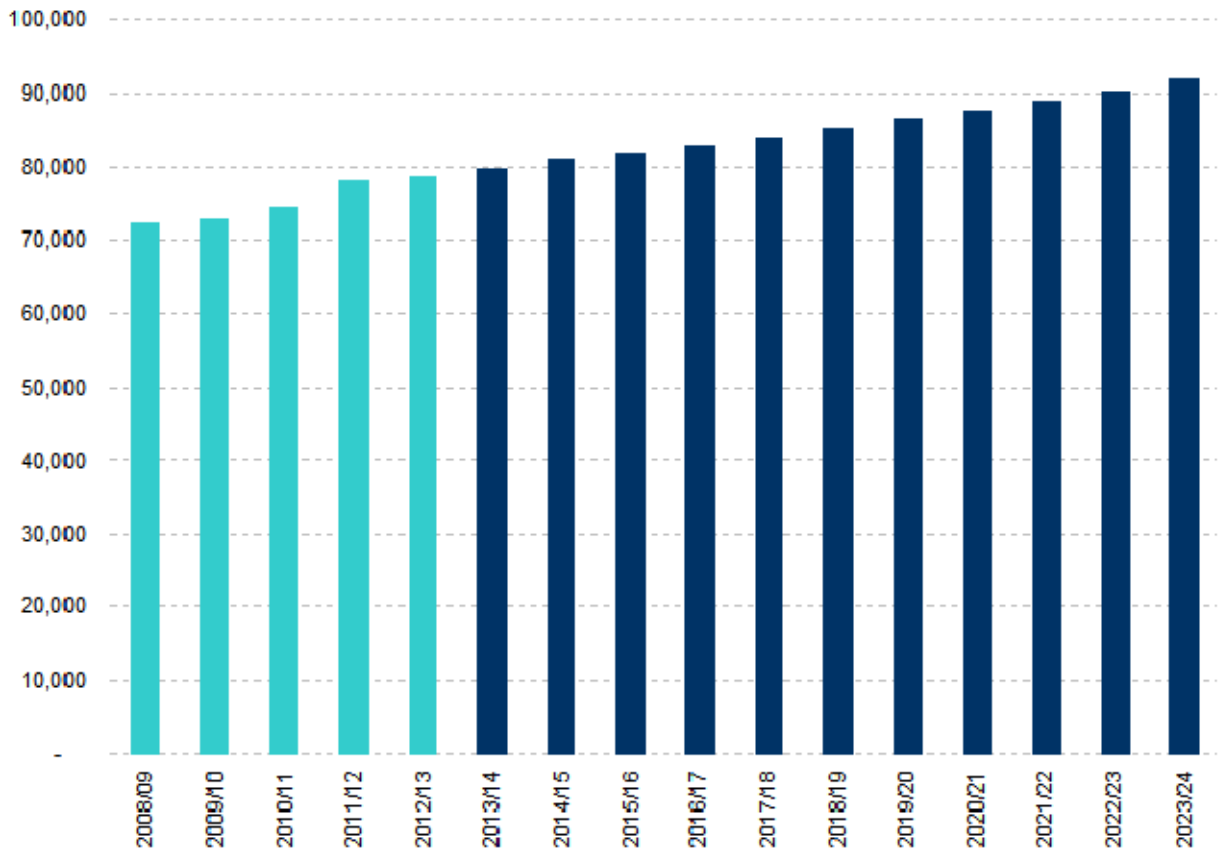
hours a day, 7 days a week, assessing, diagnosing and treating patients. Their main role is focused around the clinical assessment and interventions required to return people to a state of health where they can return home, or to a more homely setting, as soon as possible and without unnecessary delay. Same-day treatment, without the need for an overnight stay in hospital, is the norm for an increasing number of conditions and planned procedures and should always be preferable, where it is safe to do so. Where the specialist, secondary or tertiary care services uniquely available within an acute hospital are not required, patients should not have to go there and more appropriate assessment, treatment and care arrangements should be provided at home or in the community.

So far as hospital services in Lothian are concerned, we see almost 1 million outpatients, carry out around 100,000 planned surgical interventions and more than 240,000 people attend our accident and emergency departments every year. NHS Lothian hospitals admitted more than 100,000 inpatients last year. The following graphs show the projected activity changes based on population growth, assuming that care delivery follows current trends and remains unchanged:-

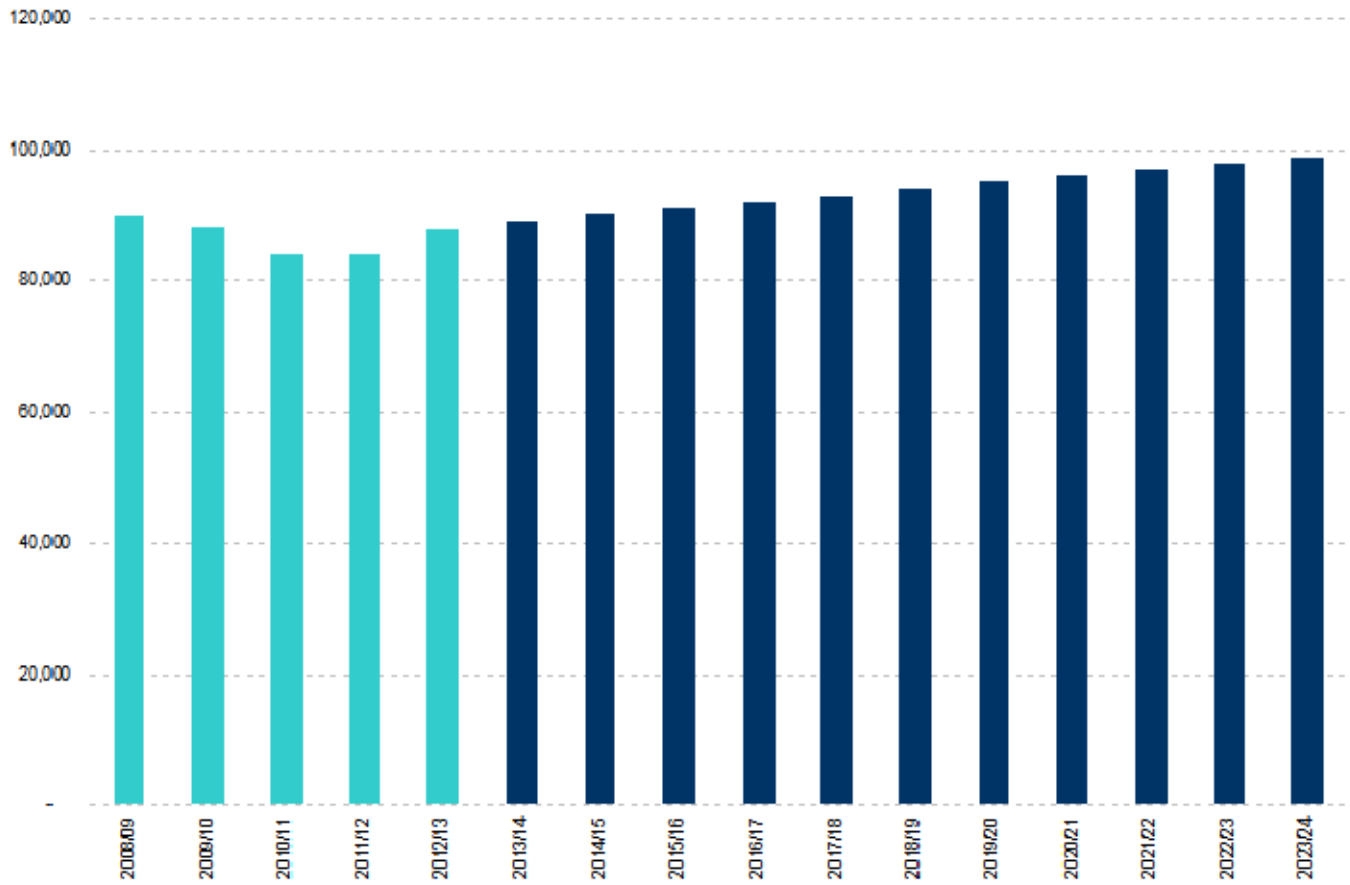
***Projections for A&E attendances, based on population changes***



***Projections for Unplanned Inpatient Admissions, based on population changes***



***Projections for Planned Inpatient and Day Case Admissions, based on population changes***




Increasingly, acute hospitals are not simply responding to the acute health needs of patients, but are providing an essential element of specialist support to frail, older people with a complex range of conditions on a continuous basis as part of an integrated pathway of care. These arrangements need to be further strengthened by hospital-based physicians and other specialists working more closely with GP and community based clinicians and care professionals to provide expertise and support to patients with increasingly complex conditions living at home or in care homes in the community. This will involve hospital based clinicians working more on an ‘outreach’ basis to patients at home, and GPs and other community based clinicians working on an ‘in-reach’ basis to inform appropriate care in hospital when this is unavoidable.

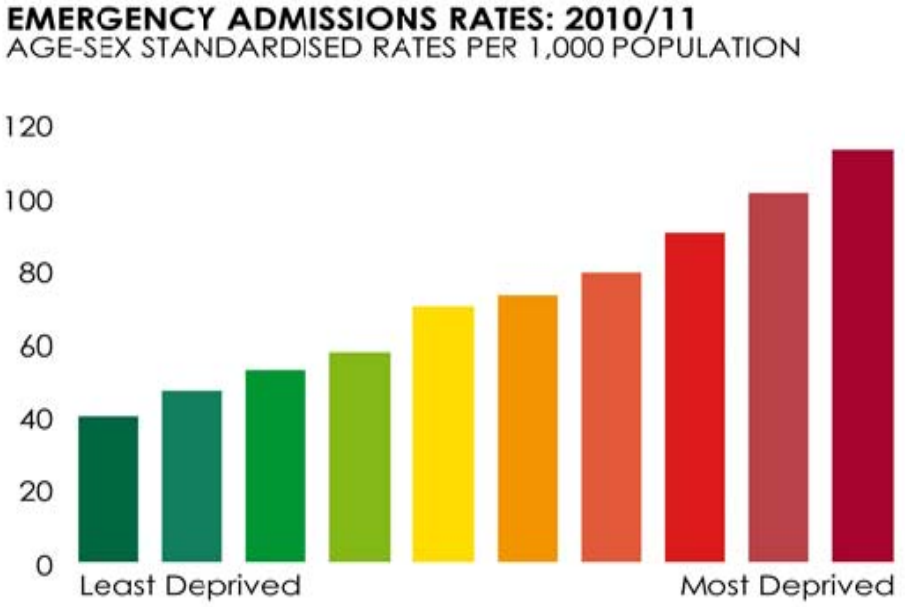
Although we remain fully committed to shifting the balance of care from acute hospital to care at home or in the community where this is appropriate, we also need to deliver the right capacity in the hospital system which is able to efficiently meet the acute needs of the population and to better respond to the growing demands of an ageing population.

**Unscheduled care**

Key elements of our strategic approach to Unscheduled Care include:-

- Providing alternatives to emergency care in hospitals;
- Improving emergency care access and treatment across all main hospitals;
- Enhancing joint working with primary, community and social care and other agencies to improve patient pathways of care;
- Reducing delayed discharges;

There is also considerable disparity between emergency hospital admission rates of people living in the poorest and the wealthiest areas of Lothian:-




In the short term, there is a real issue about frail older people with complex care needs being accommodated as inpatients in acute hospitals, having been admitted to hospital as emergencies, sometimes because of the lack of more appropriate arrangements, or remaining in hospital following assessment and treatment, when no longer clinically necessary, but again due to a lack of community support to allow them to return home. While the acute hospital is often seen as a 'place of safety' for frail patients in need of urgent care, particularly out of hours, alternative arrangements which are more appropriate and which would allow patients to remain at home, or at least to stay in more homely surroundings with appropriate healthcare support determined by a properly designed pathway of care, are being developed, but too slowly.

While delays in patients being discharged from hospitals are reducing across Scotland, the position in Lothian is not improving as rapidly. This plan addresses particular challenges due to lack of community care capacity in the City of Edinburgh and East Lothian. Successful

collaboration with local authority partners to improve our performance on this will make a significant impact on improving both the lives of patients and on the more efficient use of hospital resources.

Currently the unscheduled care system in NHS Lothian is not meeting the demand being placed on it, particularly in its accident and emergency departments and its minor injury units and is not helped by the unique, hybrid arrangements for acute receiving which have developed in recent years at The Western General Hospital. This means that too many people are waiting longer than they should i.e. longer than current targets, before being seen, treated, transferred or discharged.

The current situation, characterised by pressures on services and failure to deliver best care, is far from ideal and can also compromise the ability of staff to deliver high quality care.

**Scheduled care**

Many people continue to wait too long for their hospital appointment, and there are disparate arrangements across the specialties for additional operating and outpatient capacity, both within NHS Lothian hospitals and across the wider NHS and private sector. This is being urgently addressed, with immediate but sustainable actions to deliver reductions in waiting times that are acceptable to patients and that meet and better national targets.

Key elements of our strategic approach to scheduled care include:-

- Improve capacity for patients to be admitted on a day case basis and for inpatient theatre provision
- Deliver benchmarked performance to reduce unnecessary reliance on inpatient beds
- Reduce unnecessary reliance on out of hours junior doctors
- Patients admitted on the day of surgery, as the norm
- Enhanced recovery, as norm
- Extended working day/extended working week

Careful attention needs to be given to issues affecting the quality and efficiency of patient services, especially given that specialist, acute hospital services are relatively scarce and extremely expensive. Increasing demand on the current pattern and organisation of acute hospital services generates unacceptable waiting times and delays; without radical change and targeted investment in ‘upstream’ anticipatory, primary and social care, demographic and other pressures will create unsustainable demand well before the expiry of this plan. Radical action will therefore be required to deliver the Scottish Government’s 2020 vision.

Such radical actions need to include consideration of:-

- more flexible working e.g. evenings and weekends, to make best use of staffing and facilities and meet patient needs for planned outpatient and elective treatment or care;
- the current state and fitness for purpose of our buildings and estate to improve patient and staff safety and to reduce the incidence of healthcare associated infections;

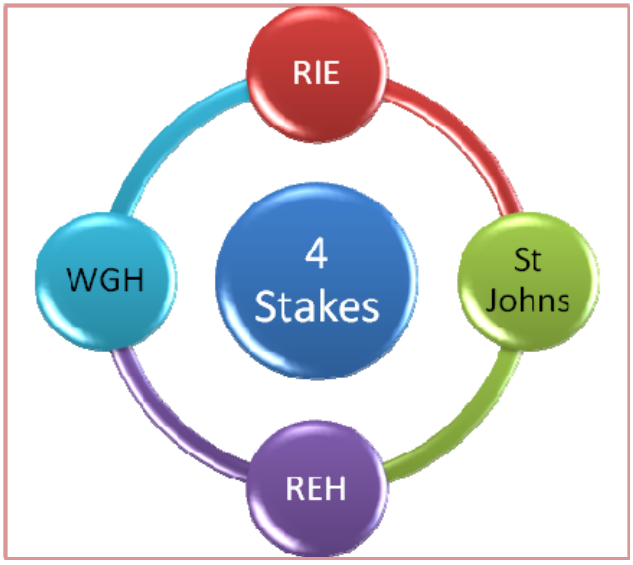
- how services can best be organised on each of our acute hospital sites to improve service quality and sustainability to meet current and future demand, taking account of patient needs and efficient use of resources.

**The Estate**

NHS Lothian has too many buildings and more than it needs to provide a modern and effective health service for the population. A number of these are underused, unoccupied or in the wrong place. In reducing the overall number, we will ensure that the buildings retained are fit for purpose and, along with any new developments, meet future demand and are suitable for the delivery of high quality healthcare in the 21st century. This needs to include the modernisation of supporting infrastructure.

Work is underway to review in detail the demand and capacity of every hospital specialty, in light of population and any known technological changes during the period of this plan. In addition to considering the best contemporary models of patient care, capacity constraints on the RIE site and the age and condition profile of buildings on the WGH and other sites are being taken into account in determining the best location for patient services in any reconfiguration. These have been mapped to site plans according to current and proposed specialty configurations.

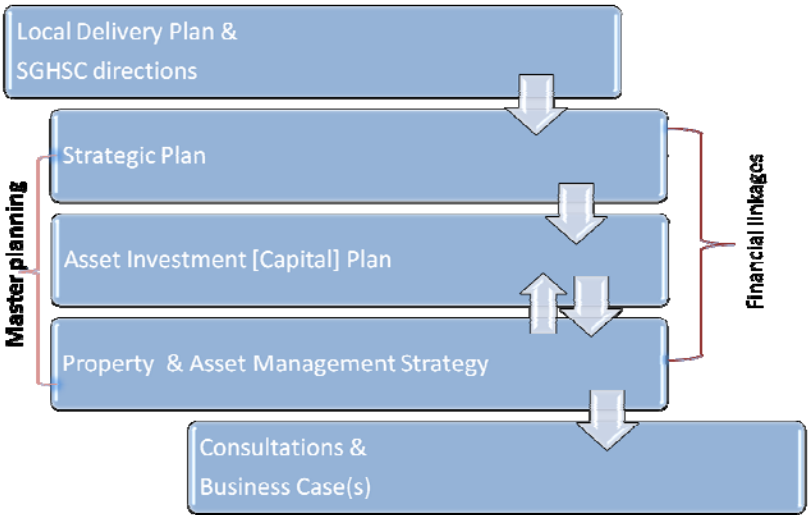
We have identified a number of our property assets as “stakes in the ground” and our masterplanning work is initially concentrated on these four sites:
Royal Infirmary of Edinburgh – the re-provision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences being part of the Edinburgh BioQuarter are future reference points;
St John’s Hospital in Livingston;
Western General Hospital – a re-provision of the Regional Cancer Centre is a major development requirement;
Royal Edinburgh Hospital Campus – the phased redevelopment is already being planned.



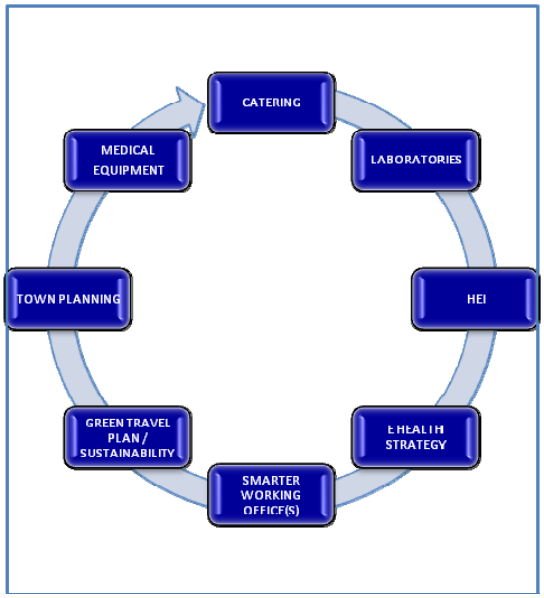

At this stage, NHS Lothian has developed the site masterplans as an in house technical assessment of the physical site assets looking at the condition of the buildings and infrastructure. The potential to develop accommodation on each site, through demolitions and extensions has been identified.

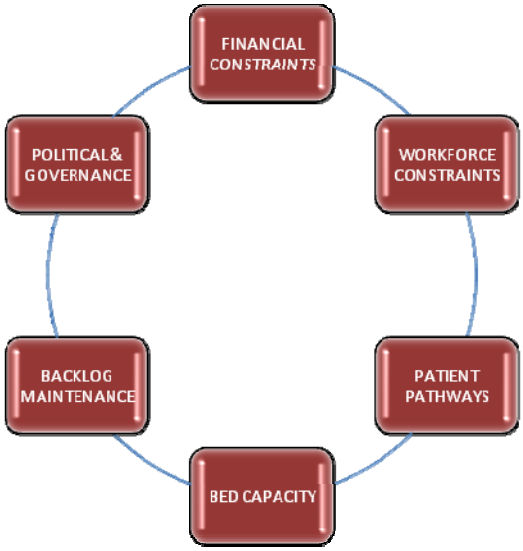
This will support consideration of options for future development or reprovision of services and inform individual business cases.

Only the masterplan for the Royal Edinburgh Hospital Campus has been submitted for Town Planning consent at this point. This application supports the Business Case for the initial phase of Mental Health reprovision on the Campus in fit for purpose accommodation, linked to a longer term redevelopment of the whole site.




There are a number of underlying requirements and developments that influence site specific masterplans:




A number of supporting plans are also under development to provide a similar framework or address the future planning developments including the integration requirements for Health and Social Care. These include:

- Lauriston Campus which consists of the Lauriston Building, Chalmers Centre, and the Princess Alexandria Eye Pavilion
- Royal Victoria Hospital site which has the opportunity for an innovative mix of health and social care facilities

- East Lothian Community Hospital which includes the related hospital provisions in East Lothian
- Liberton Hospital where the adjoining land is subject to redevelopment proposals as the Scottish National Blood Transfusion Service relocates to a new facility in 2017.
- Primary care premises requirements are being reviewed, across NHS Lothian, to establish priorities for future investment and support to this part of the wider healthcare estate.

As part of the financial planning for the next five years, we are assessing the capital plan implications of the masterplans in line with future programmes of investment to address backlog maintenance and anticipated service demands. As such the masterplans are seen as a longer term framework, within which individual service projects can be developed.

## 4. Planning Approach

### Transforming our services - Putting patients at the centre of our plans

For a long time, and in common with much of the rest of the UK, we have planned the way we deliver health services separately in different parts of our system (primary care, acute care, NHS, local councils). We have also tended to plan around buildings, or around individual services.

What is proposed here is **a radical shift away from this 'traditional' approach to a patient-centred, whole-system approach,** focussing much more explicitly on the needs of people who use NHS Lothian's services.

This plan is predicated on the need for radical redesign to deliver sustainable improvements in health and care services in Lothian. A central tenet of service redesign is to focus on the patients' journey and experience, to help identify where service improvements are necessary and to involve a wide range of service users and providers in analysing and redesigning patient pathways.

Using intelligence and evidence, we have identified representative patients with varying degrees of care needs: we have called these patients Callum, Hannah, Scott and Sophie. These patients are not representative of all NHS Lothian patients, but are examples to illustrate pathways of care and to help us understand a range of typical patients' care needs, how their care needs are currently being met and to agree how these can be met more effectively and efficiently in radically different ways. This is being conducted through a designed and managed process of engagement during 2014 and will inform large and significant parts of the final plan.

Some urgent redesign work is currently ongoing and will continue, in order to meet the most pressing and immediate challenges that we face. However, alongside that, a number of new work streams will be initiated with the aim of redesigning healthcare across whole pathways. These need to use innovative methods which will lead to rapid cycle change and review.

**Who are Callum, Hannah, Scott and Sophie?**

We have identified four names to represent four groups of patients. These groups have been chosen because their current use of health services suggests that those services could be provided in a better way and because these patients' pathways impact upon the majority of healthcare that is currently delivered across NHS Lothian.

The four groups are represented by Callum, Hannah, Scott and Sophie. Their current pattern of use of health services has been summarised in a risk prediction tool called SPARRA (Scottish Patients at Risk of Readmission and Admission). The tool predicts the risk of emergency admission in the following year for each patient in Scotland. It looks at previous use of health services by analysing activity such as number of drugs prescribed by GPs, A&E attendances, hospital admissions and out-patient appointments.

**Callum**

Callum represents an adult patient between 16 to 55 years of age. The group he represents is likely to have mental health problems such as anxiety or depression, a history of alcohol and drug misuse and typically presents frequently to A&E.

Approximately 41,000 or 5% of people in Lothian are in this patient group. They account for 11% of the adult patients who experience at least one emergency admission each year.

As well as being frequent A&E attenders, patients in this group are likely to make use of primary care, community mental health services, specialist drug and alcohol services and a range of local authority and voluntary sector services. Patients represented by Callum are also more likely to be involved with the criminal justice system.

**Hannah**

Hannah represents an adult patient aged between 16 and 74. The group she represents is likely to have one or more long term conditions such as diabetes, COPD and heart failure.

Approximately 440,000 or 49% of people in Lothian are in this patient group and they account for 56% of the adult patients who experience at least one emergency admission each year.

Depending on the number and type of long term conditions each patient has, and how long they have had the conditions, these patients are likely to make use of primary care and specialist community care services, attend A&E, be admitted as an emergency and receive a range of local authority and voluntary sector services.

**Scott**

Scott represents an adult patient aged over 74. The group he represents is likely to be frail and may have a range of long term conditions or may not have any specific diagnosis.

Approximately 59,000 or 7% of people in Lothian are in this patient group and they account for 33% of the adult patients who experience at least one emergency admission each year.

Patients in this group are likely to make use of primary care and specialist community care services, attend A&E, be admitted as an emergency and receive a range of local authority and voluntary sector services.

**Sophie**

Sophie represents a child patient aged under 16. The group she represents may have at least one long term condition.

Approximately 103,000 or 11% of people in Lothian are in this patient group.

Patients in this group are likely to make use of primary care and specialist community care services, attend A&E, be admitted as an emergency and receive a range of local authority and voluntary sector services.

**What happens now and how could we give Callum, Hannah, Scott and Sophie better care?**

The first step in the redesign process will be for the '*Hannah'* work stream to map the care that Hannah receives. We will do this using data, the experience of people like Hannah who use our services and the experience of those who provide care and treatment for people like Hannah. The same will take place for the '*Callum'*, '*Scott'* and '*Sophie'* work streams.

Having identified what currently happens, we will work with patients, carers, staff, GPs, social care and 3rd sector colleagues to come up with a better way of doing things, in line with our aims and ambitions. Once we have agreed a better way of doing things, we will decide how best to deliver this in terms of services, buildings, staff, IT and the other infrastructure needed.

This is expected to lead to quite different working patterns and arrangements for clinical and other staff e.g. making the expertise currently located exclusively in hospitals more accessible to people in their own homes, or providing some services available at different times of the day or week, as we better match our services to patients' needs.

# 5. The Draft Plan

Many of the propositions in the final version of NHS Lothian's Strategic Plan will be informed by the radical redesign of patient pathways described above, as well as by the wider consultation and engagement process throughout 2014 with the people of Lothian, with staff and with those organisations in the public, private and third sectors with an interest in the work of NHS Lothian. **This plan must, therefore, be regarded as a dynamic document, rather than a definitive answer to all of the challenges and opportunities of the coming decade.**

However, we need to be clear about the direction of travel and this section expands on the main strategic areas for action that NHS Lothian intends to pursue during the plan period, in order to deliver the outcomes listed in section 1 above. Some propositions are reasonably clear and firm, while others are less clear and will require further debate and investigation and, in some case, detailed option appraisal to firm up. The propositions are not yet listed in order of priority, although indicative timescales will be shown on the final plan.

It is intended that the Strategic Plan will be finalised in the Autumn of 2014, in order to set a context for consultation on the four Integration Plans and to inform the development of each of the Health and Social Care Partnership Board's Strategic commissioning Plans, later in 2014 and into 2015.

Under each of the three aims, are listed short term **ST** (years 1-3) and longer term **LT** (years 4-10) actions. A detailed schedule is being developed to include estimates of headline resource implications, in terms of staffing, capital and buildings, revenue funding and enabling technologies.

## 5.1 Improving the Quality of Care

### *Developing Person-centred Primary and Community Services*

#### *Propositions*

**5.1.1** To **engage people** in making decisions about their care taking into account their preferences, values and coping skills, to improve quality and reduce 'waste' associated with unattended appointments, unused medication or unnecessary investigations **ST**

**5.1.2** To develop Lothian's **multimorbidity action plan**, alongside the national programme to deliver excellence through:-

- care planning and consultations that help people have control over their conditions, care and support and to achieve their personal outcomes;
- integrated care and support that builds on community assets and promotes independence, wellbeing and resilience;
- whole system pathways that are designed around multimorbidity and to reduce health inequalities;

- providing visible leadership and using research, innovation and improvement approaches to improve the quality of care for people with multimorbidity. **ST/LT**

**5.1.3** To develop the business case during 2014 to enhance the community-based model of services for people requiring **palliative care**, maximising the time spent in people's preferred place of care, minimising emergency admissions where these can be avoided, and supporting choice of place of death where this can be realistically achieved; all in accordance with the NHS Lothian Palliative Care Strategy and proposed 3-year redesign/delivery programme **ST**

**5.1.4** To transform the role of primary care through active participation in the Scottish Government's **Primary Care Modernisation** Programme 2013-2020, aimed at better integrating primary and secondary care as well as health, social and other community care; develop a more outcomes-focused GP contract linked to opportunities for an expanded role of other healthcare professionals and assets within local communities **LT**

**5.1.5** To deliver on the new GP contract 2014/15, including the new QOF '**Quality and Safety** Domain' relating to integration liaison, review of access, continuous quality improvement and anticipatory care plans **ST**

**5.1.6** To fully explore the potential of the GP contract enhanced service model to better support integrated pathways of care, including extending the scope of **anticipatory care** to cover frail older patients living in their own homes, ensuring that a lead practice is identified for all Care Homes and that there is a consistent approach to **polypharmacy** medication reviews in conjunction with community pharmacists.**ST**

**5.1.7** To review General Practitioner numbers and workforce support, locations and suitability of premises used by **GP practices;** consider additional requirements in the light of population and demographic changes as well as the growing need to support older people with complex needs living at home with chronic disease and complex multi morbidity; the resource shift required to support the transformation of primary care will be assessed as work progresses across a number of work streams such as the redesign of pathways of care, provision of local 'step up' and 'step down' beds, expansion of primary care premises and development of primary care and community care workforce plans. **ST/LT**

**5.1.8** To review **GP practice premises** requirements, recognising that 38 practices (some 30%) have been identified as requiring premises solutions to meet current capacity, compliance or quality issues and to address the future population growth **ST/LT**

**5.1.9** To develop specific propositions to support the **shift in the balance of care** and workload from hospitals to primary care across a range of services including near-patient testing, enhanced diabetes services, community speciality nursing and the consequences of outpatient review; improve the sharing and rapid transfer of **information** between primary and secondary care services to better coordinate care. **ST**

**5.1.10** To accelerate the development of services for people at risk and suffering from **diabetes**, which impairs the quality and length of people's lives as well as accounting for a very significant and fast-growing proportion of healthcare costs **ST**

**5.1.11** In light of significant growth in the numbers of people who will have **dementia**, develop the role of dementia link workers, complete patient registration and support skills training for acute and other staff to better manage pathways of care for people with dementia **ST**

**5.1.12** To develop a strategy (including e-strategy) and fully integrated pathways of care for patients with **neurological conditions**, head injury, sensory impairment, epilepsy, Huntington's and other rare conditions requiring physical and complex care **ST/LT**

**5.1.13** To improve **dental and oral health** and strengthen dental services, through increasing registration for those aged up to 2 years, improving access to specialist dental services by integrating and aligning the public dental service with the Edinburgh Dental Institute, continuing to deliver Scottish Government funded prevention programmes and raise awareness of signs and symptoms of oral cancer particularly amongst younger people, ensuring access to specialist services for oral cancer **ST/LT**

**5.1.14** To implement the recommendations in "Prescription for Excellence" published in 2013 which outlines a vision and action plan for the delivery of **pharmacy services** across Scotland to support people living in the community, receiving care at home, living in care homes and those receiving hospital / specialist hospital care at home; establish a framework for joint working and information sharing between primary and secondary care pharmacists and other members of the multidisciplinary team. **ST/LT**

**5.1.15** To recognise **optometry services** as the first point of contact for individuals who are experiencing eye problems; to implement legislative and pathway changes which support improved joint working and a shift in the balance of care, through e.g. independent prescribing rights for optometrists and optometrist direct referral to hospital ophthalmology services.**ST/LT**

**5.1.16** To improve care and reduce acute hospital emergency admissions and readmissions by rapidly developing suitable alternatives delivered in the community. By the end of 2014, we will have robust models of integrated care and demand management within the Health and Social Care Partnerships' Strategic Commissioning Plans, including integrated assessment and rehabilitation **services for frail older people** (e.g. REACT/COMPASS/ELSIE/MIDcare). **ST**

**5.1.17** To urgently reduce to a maximum of two weeks by April 2015 and eventually eliminate altogether **delays in patients' discharge** from hospitals; through joint modelling, develop a mix of care home and home support packages to facilitate rapid discharge whenever clinically appropriate; explore innovative models of care home and homecare commissioning to address particular market conditions in Edinburgh; expand provision of community-based reablement capacity, step up/step down beds in care homes, a Discharge Hub on each hospital site and increase challenging behaviour capacity in care homes **ST**

**5.1.18** To improve the care for older people by adapting and modernising the role and functioning of NHS Lothian **inpatient continuing care** so that NHS beds are focused on the care of people with the most complex needs, in line with Scottish Government guidance; to review the future role for all current continuing care provision across Lothian to create a seamless spectrum of care from Hospital Based Complex Clinical Care through to residential home care and care at home **ST**

**5.1.19** To develop the concept of a **'care village' on the Royal Victoria Hospital and Liberton Hospital sites**, remodelling or replacing old and out of date hospital facilities with new purpose-designed residential care facilities for older people, including those with a range of complex conditions, strengthening social care provision in local communities, with NHS support provided on an in-reach basis; this could involve replacing existing NHS continuing care hospital systems and buildings with a range of sheltered housing and residential care home facilities for ongoing care and support, able to respond to changing needs. **ST/LT**

**5.1.20** To continue to develop community **mental health** services to better support people at home, and to modernise acute mental health services by redeveloping the Royal Edinburgh Hospital, with phase one expected to be complete by 2016, in accordance with the joint strategy "A Sense of Belonging" **ST/LT**

**5.1.21** To improve the quality and best ways of delivering care in the future, develop jointly with local authority partners, a community and residential support service for **people with learning disability**, autism spectrum disorder and challenging behaviour; to shift to integrated models of community rehabilitation, enabling residential provision to be modernised and inpatient capacity reduced and including a 12 space development for those with the most complex and challenging care needs in the community **LT**

**5.1.22** To **develop a new East Lothian Community Hospital,** replacing Roodlands and Herdmanflat Hospitals, with modern accommodation and capacity to treat more East Lothian residents locally, including the repatriation of some services currently provided elsewhere, and to provide 'step up' and 'step down' care for older people, to prevent inappropriate admission to and facilitate earlier discharge from acute hospitals in Edinburgh **ST/LT**

**5.1.23** To adapt the use of **Midlothian Community Hospital** to maximise its potential to meet the health care needs of the Midlothian population. This will include the provision of 'step up' and 'step down' care for older people, to prevent inappropriate admission to acute hospitals in Edinburgh and facilitate early discharge. This redesign will entail the repatriation of some services to East Lothian **ST/LT**

**5.1.24** To review the operation and design of the **Lothian Unscheduled Care Service** (LUCS) in the face of increasing numbers of patients with complex needs being seen out of hours, the increase in direct access to out of hours primary care advice through our professional to professional telephone line, (a 25% increase since 2010/11) and the additional demands out of hours, over and above the normal core work e.g. public health **ST**

## *Developing Person-centred Hospital Services*

### Propositions - Unscheduled care

**5.1.25** To urgently develop an integrated care pathway, including a new model of **ambulatory care** as well as **rapid assessment** beds and **diagnostics** availability designed to avoid delays in patient flow so that more than 80% of patients can be discharged home, or to specialist rehabilitation/step down facility off-site within 48-hours **ST**

**5.1.26** To urgently explore the considerable potential to improve patient outcomes in **stroke services**, including options to concentrate inpatient stroke provision at either RIE or WGH and at SJH. **ST**

**5.1.27** To review the model of emergency care at the **Western General Hospital** with arrangements for medical receiving which improve care, improves the experience of patients and staff and which is sustainable; to similarly review provision for surgical admission of patients to WGH-based surgical and cancer specialties; to work with senior clinical and managerial staff at the hospital, general practitioners and social work partners to look closely at the model of care offered by the hospital and to redesign the way in which patients are received, assessed, admitted and discharged **ST**

**5.1.28** To **expand acute receiving and assessment capacity** at the Royal Infirmary of Edinburgh to meet the growing demand for more generalist services that can respond to the needs of older, frailer patients, often with multiple conditions and many with dementia; **ST**

**5.1.29** To explore opportunities to improve hospital throughput and avoid inappropriate 'boarding-out' of patients, by various means including **extending specialist capacity to seven day working**, to facilitate more rapid and appropriate assessment and discharge, including conversion of patients presenting for unscheduled, out of hours care to scheduled, in hours care. **ST**

**5.1.30** To realise the quality and clinical safety benefits of re-locating **the Royal Hospital for Sick Children** to purpose-built accommodation on the RIE site, co-located with adult specialist services, with direct links between maternity and paediatrics supporting mothers and new born babies; and of the transfer of the department of **clinical neurosciences** to RIE linking with major A&E trauma unit and other key trauma specialties.**ST/LT**

**5.1.31** To implement the Lothian High Demand Service, an innovative service model, which aims to bring **individualised patient-centred care** to the 1,500 to 2,000 patients at highest risk of emergency hospital admission; to work with each patient to draw up their own, personal anticipatory care plan to ensure that all of the patient's care needs are met in a way that is coordinated, consistent and effective **ST**

***Propositions - Scheduled Care***

**5.1.32** To pursue the ten safety essentials and nine point of care priorities in the Scottish **Patient Safety** Programme, including the two strategic priorities in acute care, i.e. infrastructure for building quality improvement capacity and capability and the strategic prioritisation of safety; two major areas for further attention are the safe management of medicines and the prevention of patient falls **ST/LT**

**5.1.33** To continue to develop **demand and capacity models** for all key specialties to deliver sustainable compliance with Government waiting time targets, including orthopaedics, ophthalmology, rheumatology, urology and general surgery **ST**

**5.1.34** To review **efficiency and productivity** of current arrangements, including pathways, booking processes, job planning and opportunities for skills substitution, in the light of relevant benchmarking with a view to achieving upper quartile system performance **ST/LT**

**5.1.35** To develop a **new configuration** of general acute inpatient hospital services at the Royal Infirmary of Edinburgh, Western General Hospital and St John's Hospital, Livingston, concentrating inpatient orthopaedics and trauma at RIE, and ophthalmology within the Lauriston Building .**ST**

**5.1.36** To increase **day surgery** capacity on WGH and/or SJH site, redirecting elective day cases from RIE site and providing dedicated **multi-specialty day case centres** supporting efficient and effective use of specialist surgical staff and facilities; planned procedures should be carried out on a day-case basis wherever possible, with the aim of upper quartile performance as the minimum.**ST**

**5.1.37** To change the model of delivery for **outpatient services** to ensure that the maximum clinical benefit is derived from direct patient contact time, for example one stop clinics, more complex procedures on an out-patient basis; avoid unnecessary out-patient attendances by using innovative alternatives to hospital attendance which ensure patient centred access to specialist assessment and follow-up care where necessary.**ST/LT**

**5.1.38** To radically review options for the provision of modern **facilities for outpatient** assessment, consultation and treatment, which will include the acute hospital sites (RIE, WGH and St John's) and the Lauriston Building for ambulatory care provision. **ST**

**5.1.39** To keep under review the capacity for delivery of **maternity care** across the facilities at RIE and St John's, recognising the need to have flexibility to increase capacity and utilization as the birth rate fluctuates **ST/LT**

**5.1.40** To implement the NHS Lothian **laboratories** strategy, as an essential diagnostic resource for both primary and specialist hospital care, delivering more efficient diagnostic facilities, investing in automation, workforce redesign and capital infrastructure in blood sciences, genetics and molecular sciences.**LT**

**5.1.41** To maximise systems, such as the patient reminder service, to significantly reduce **'did not attends'** and so improve clinic resource utilisation **ST**

## 5.2 Improving Health and Tackling Inequality

### Propositions

**5.2.1** To promote the value and importance of **patients' experience** in reviewing and designing services **ST**

**5.2.2** To develop and implement the NHS Lothian **Health Inequalities Strategy** detailing the role of NHS Lothian to reduce and mitigate health inequalities. This will include both delivery of appropriately targeted clinical services, and the wider impact, for example relating to procurement, HR policies and NHS Lothian as an advocate for wider actions by partners **ST/LT**

**5.2.3** To implement the NHS Lothian strategy for **children and young people** 2013 – 2020, "Improving the Health and Wellbeing of Lothian's Children and Young People"; Implement the requirements from the Children's Bill that NHS Boards provide a named person for every child from zero to 5 years, requiring the recruitment of additional Health Visitors and School Nurses; drive the work generated by the Lothian strategy and the Bill through utilisation of the Early Years Change Fund and the Early Years Collaborative to ensure that we and our partners achieve the local and national ambition for every child to have the best start in life **ST/LT**

**5.2.4** To work with **community planning** partners and through the Single Outcome Agreements to realise the Christie Commission's vision of harnessing wider community resources; develop plans and policies that address the underlying causes of health inequalities. This may include actions to reduce poverty and income inequality, ensure high quality education and lifelong learning, and provide employment opportunities and employability support **ST**

**5.2.5** To ensure **health improvement initiatives** such as the early years collaborative, healthy eating, physical activity and weight management are implemented to standards of best practice, and are appropriately targeted and tailored to meet the needs of the most vulnerable populations as well as achieving a population impact. **ST**

**5.2.6** To explore and develop combined **telehealth and telecare** solutions such as 'Living it Up' to support people living in their own homes or in care homes in assisted living for independence; continue development and implement the 'patient portal' enabling patients to access information and their own health records, email clinicians and review their clinical results.**ST**

**5.2.7** To ensure engagement of and effective **working with the third sector** through integrated patient pathways and as partners in Health and Social Care Partnerships, at all points in the patients' pathway and spanning all sectors and programmes of care **ST**

**5.2.8** To **assist patients to manage their own health** condition by developing an integrated service model for people with chronic obstructive pulmonary disease (**COPD**), thereby improving the quality and sustainability of care and reducing the numbers of patients requiring admission to hospital. **ST**

### 5.3 Securing Value and Financial Sustainability

**Propositions**

**5.3.1** To develop and implement a system wide **capacity planning and bed modelling** approach which ensures the health and care system can regularly identify, for each Health and Care partnership, the capacity needed in terms of specialist hospital beds, community based step down care, care home and care at home capacity to meet the needs of local populations **ST**

**5.3.2** To develop Lothian's inpatient services within a new configuration in order to achieve **gains in both quality of patient services and efficiency of provision**; this includes specialties which require a 'critical mass' of patients to deliver the best quality of care and should therefore be concentrated on a single NHS Lothian hospital site. Changes may be subject to further option appraisal, including services to be provided on a pan-Lothian, single site basis, including reviewing the model for **Dermatology** care, specialist **laboratory** functions at WGH and RIE, with the blood sciences training school at SJH. **ST/LT**

**5.3.3** To develop the business case for a new **Regional Cancer Centre**, to be sited at the Western General Hospital, in accordance with NHS Lothian's agreed strategy; review patient pathways designed to strengthen early detection, radiotherapy and primary and community support; ensure sustainable arrangements for complex pelvic cancer surgery through multi-specialty team working **ST**

**5.3.4** To replace the **ophthalmology** service currently provided in the Princess Alexandra Eye Pavilion, a building which is no longer fit for purpose, following growth in demand for eye care and the need to improve the quality of experience; appraise options for the provision of a modern ambulatory and day case facility on RIE, Lauriston Campus, SJH or WGH site, with the proposed timescales being developed during 2014. **ST/LT**

**5.3.5** To maintain a one site model for **Orthopaedic inpatients and trauma** at the RIE, whilst repatriating independent sector capacity **ST**

**5.3**.6 Develop and implement our **catering strategy** in line with proposed service changes, while ensuring delivery of good quality services meeting patient food and nutrition standards **ST**

## 6. Making it Happen: Delivering the Changes

This section describes the key enabling actions which need to be put in place to deliver the propositions in section 5 and achieve the outcomes in section 1 above.

Measures of successful achievement, or key performance indicators, will be identified for each of the propositions and the final action plan during consultation, so that there is transparency of the improvements sought. Active management of the Plan implementation and routine monitoring of progress will be incorporated into NHS Lothian's measurement framework and 'balanced scorecard' approach to performance management.

**Leadership**

In committing to the vision of a better future set out in this plan, NHS Lothian needs to provide the resources, including the leadership and management capability to deliver it. This is not a simple task and will involve working closely with partners on a reallocation of current resources – budgets, professional and supporting staff and managers, and capital assets – to be working differently throughout the life of the plan.

It is essential that the plan supports innovative and modern clinical practice in ways that make it easier for clinical and other staff to provide the best care to patients. It is equally important that all clinicians engage positively with the planning process and commit to supporting the outcome. This will only be achieved through strong and effective clinical leadership.

**A different relationship with patients and the public**.

Patients and the public expect to be treated with respect and dignity and giving people a voice and demonstrating responsiveness are essential to improving care. What being involved means can vary – from being made to feel welcome, to being able to share anxieties, to weighing the pros and cons of treatments.

Surveys by the Picker institute, Europe show that the UK has a more paternalistic approach than other countries; we have comparatively good levels of doctor-patient relationship and provider continuity, but low scores for choice, involvement and information.

The following list represents what patients want from their relationship with the NHS:-

- Relational aspects of care – found in individual consultations and in team working.
- Continuity of care, smooth transitions which require planning and co- ordination
- Fast access, effective treatment, respect for their preferences, support for self-care and the involvement of family and carers.
- Patients want organisations not to argue and to be consistent. They expect professionals to work together as a 'team around the patient'.
- They want obvious inefficiencies to be addressed – not least in making the best use of their own time.
- Knowledge of the patient /service user/carer as a person.
- Knowledge of their relevant conditions and all options to treat manage and support, including support services available elsewhere.

Addressing these issues will be key challenges in our patient pathway transformation programme.

**Person Centred Health and Care Programme**

The national Person Centred Health and Care Programme (PCHC) was launched by the Scottish Government in November 2012 with the aim of developing health and care services that are centred on the people who use our services. This programme builds on the work that NHS Lothian has done to date and gives us a further emphasis on how we use the experiences of patients, families and carers to improve our care and services.

In addition to the national improvement programme, we will also consider other sources of patient feedback and information such as patient stories. We will use a range of approaches to ensure that the patient's voice and their experiences are used to drive improvements so that care and services are provided safely, effectively and in a person centred way.

It is proposed that a series of workshops are held starting in 2014, including our staff and people from communities and organisations across Lothian to inform our ongoing involving people activity and the requirements for the emerging integrated partnerships. In the meantime, we will continue to involve people using effective, meaningful and outcome focused methods in service improvement, development and redesign of health services, strategies and policies.

**Integrating Health and Social Care Systems**

Health, social care and other public services across Scotland have been working increasingly closely for many years, including in Lothian, but this has not been sufficient to deliver the seamlessness and efficiency required for high quality care for everyone. Further significant changes will therefore be made during the early years of this plan when NHS Lothian will work with its four local authority partners and the people of Lothian to establish four new Health and Social Care Partnerships, covering the communities of Edinburgh, East Lothian, Midlothian and West Lothian. Each of the four new Health and Social Care Partnership areas in Lothian will be developing methods of involving people to reflect local variations in the Community Planning Partnerships and Health and Social Care Partnerships.

Aligned to the development of this plan will be the development of four integration plans describing how NHS Lothian will work with its four Council partners. These integration plans will be consulted on within a timeframe consistent with the Scottish Government’s legislative programme during 2014, with a view to the new Partnerships becoming operational in 2015.

These changes are expected to fully integrate services with the prime purpose of delivering improvements in patient care. They will also affect the governance, leadership and management arrangements, all of which are essential for successful delivery of this plan. It will therefore be a priority for NHS Lothian and its partners, not only to avoid structural concerns of integration becoming a diversion or a hindrance to change, but rather to ensure that the process of integration is designed and enacted in ways which most effectively deliver the necessary changes at a pan Lothian, partnership, locality and neighbourhood level.

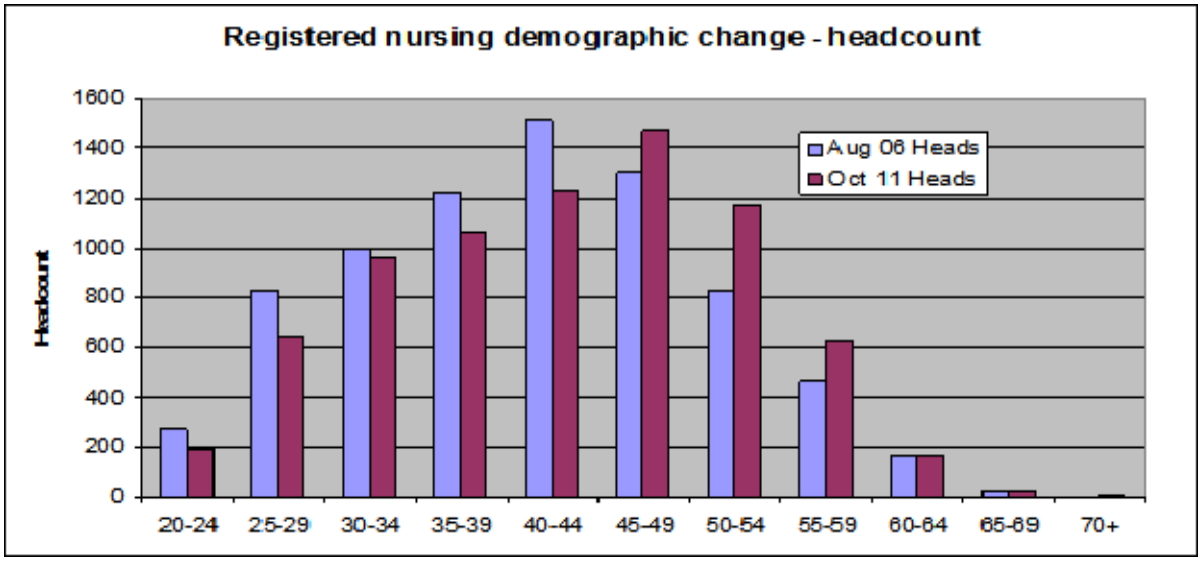
Integration, therefore, is not simply an important contextual matter, but is an essential enabler, generating a new dynamic and creating exciting opportunities for NHS Lothian and its partners to work differently - and more efficiently - to realise the ambitions of this plan.

**Workforce**

The imperative in this plan is to deliver the best quality of patient care and to do this safely, for an ageing population, recognising financial resources and recruitment challenges, particularly for doctors. Whilst acknowledging the high quality of care our staff is delivering in the vast majority of cases, there are occasions when care falls short of the standards or the quality of experience that we should all expect at every stage of the patient journey, e.g. in meeting waiting time targets, or in timeously enabling hospital patients to return home.

The shape of our workforce is changing and there are exciting opportunities to develop and use the skills of many staff groups and professional disciplines differently and more effectively. Where we are unable to recruit the doctors' skills needed in specialist areas of care, e.g. in emergency medicine, paediatrics and in smaller surgical specialities, these may be concentrated, to ensure that services remain at the highest quality and are safe.

The demographic change in the population as a whole is also reflected within the NHS Lothian workforce, e.g. between 2006 and 2011 the proportion of registered nurses aged more than 50 years old has increased from 19% to 27%:-




We need to balance the positive aim to provide family friendly working conditions for staff with the need to extend the working hours of our services. Extended days and 7 day working already apply in many areas, but extending the availability of other important staff groups who support diagnosis, treatment, rehabilitation and care at home will be required to ensure we can provide services when needed and make best use of our resources.

We also need to improve workforce efficiency and productivity whilst improving quality. The development of new and innovative roles is required, to enable services to be provided to a growing population at a lower unit cost and to a higher standard.

We will review the quantitative and qualitative information used for both management and governance at all levels of the organisation and ensure that the knowledge and skills to make use of these are developed.

For the benefits to be realised in full, greater attention also needs to be paid to the 10 patient safety essentials (CEL19(2013)), particularly to standards of practice and care and to the identification and elimination of variation which compromises the quality of outcome for the patient. This means that leaders and managers must apply a consistent approach to performance monitoring and a firm but supportive and developmental response to the identification of areas for improvement. It is important to distinguish between the range and scope of services, which may differ across communities and neighbourhoods according to their needs, and the quality standards to which these services are provided, which must aim to consistently reflect best practice and should not vary.

This will be achieved through embedding the NHS Scotland and NHS Lothian values of quality, dignity and respect, care and compassion, openness, honesty, responsibility and teamwork in all that it does. Living these values and behaving in ways consistent with them at all times are essential to achieve the engaged workforce and organisational culture we need to respond to the changes and challenges we face.

**Organisational Development**

Our vision is to have a healthy organisational culture, a sustainable and capable workforce. Working in an integrated manner with our partners, we will demonstrate effective leadership and management of our people, conducted in a manner that improves staff experience and lets us demonstrate that we have put our values into action. The cornerstone of employee relations in NHS Scotland is to work in partnership with the trades unions/professional organisations.

The human resource strategy will be delivered through five priorities for action:-

**Healthy Organisational Culture**: by developing and sustaining a healthy organisational culture we will create the conditions for high quality health and social care:-

- Incorporate behavioural competencies (which reflect our values) within recruitment, development and appraisal processes
- We will take action to ensure that staff are clear about the values and behaviours expected of them
- Engage and involve staff in decisions that affect them
- Develop a strategy for tackling the health and wellbeing issues associated with an ageing workforce.

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

- Ensure that appraisers and those being appraised understand the purpose of development reviews/appraisals, their individual and mutual responsibility for ensuring it is meaningful and that conversations review whether behaviours, decisions and actions reflect our shared values.
- Improve the confidence, capability and capacity of everyone involved in leading and practicing quality improvement
- Work collaboratively with other Health Boards to develop training programmes for small occupational groups e.g. Oncology, Medical Physics, and Perfusionists.

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

- Ensure Consultant job plans match service demand and support 24/7 delivery; Consider extending the use of job plans to other staff who manage caseloads (e.g. Nurse Consultants)
- Review the need for 24/7 staffing by clinical area and develop staffing models that match service demands
- Continue to develop medium to long term sustainable plans to address medical staffing pressures
- Consider and explore further developments in regional rationalisation for clinical and non – clinical areas to optimise opportunities for workforce availability and development.
- Expand and develop the Band 1-4 workforce in clinical areas creating roles that are both patient centred and provide a career structure, working with the Colleges of Education to have job ready employees
- Maximise opportunities for youth employment and socially responsible recruitment through academies, placement schemes and recruitment campaigns, working with voluntary and other public sector partners.

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

- Plan to build local leaderships and management capacity and capability as part of our workforce plan to deliver the 2020 vision
- Ensure that line managers at all levels are clear about their people management responsibilities and are held to account for how they carry out these responsibilities
- Ensure that the approach to ongoing leadership and management development supports Everyone Matters: 2020 Workforce Vision and Quality Ambitions and reflects the leadership and management policy statement
- Develop and implement a Leadership Framework.

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

- Develop a joint workforce/organisational plan that aims to have a fully integrated workforce by 2020 for each Health and Social Care Partnership
- Explore and maximise opportunities for shared services across NHS Scotland and with other public sector partners.

**Better use of Information**

The NHS has been slow to develop whole-system information systems and to adopt the technologies which, in many cases already exist and are necessary to inform service improvements. This is due in part to the costs involved, even though the proportion of total budgets spent on new technologies by other industries tend to be much higher. It is also due, in part, to the fragmented nature of services which this plan intends to address through service integration and the pathway approach to patient service delivery. Clinical informatics and a more modern approach to the capture, analysis, sharing and use of routine clinical and other data will therefore be essential in redesigning treatment and co-ordinating care. However, much can be achieved in the meantime by more focussed and accurate use of existing IT systems, but only through universal clinical engagement, flexibility, and commitment to work through the issues.

**eHealth**

eHealth needs to be central to the delivery of the care journey from planning, delivery, and evaluation across primary care, hospital care, and preventative service. eHealth is crucial to the delivery of safe, efficient, effective, quality and patient-centred care as outlined in the NHS

Scotland Healthcare Quality Strategy and supported by the six eHealth strategic aims outlined in the associated eHealth Strategy

Key eHealth actions will be establishing service delivery in a paper-light environment, and where possible paper-free by providing systems and access mechanisms to electronic information, which are "digital by default" This includes scanning of existing paper documents and ensuring that these are an integral part of the wider patient record, with future transactions being electronic. The provision of hand held and mobile technology to create and access patient information is also key, ensuring that information is "virtually" available at the point of care, and also where patients or staff are remote from NHS premises.

This includes fully integrated and secure patient and staff access to the necessary information and video/voice services for care planning and delivery. This supports virtual as well as face to face communication, enabling services to be delivered in the location of choice and a more mobile workforce - including communication with patients at home and staff working from home or other care settings. The use of ‘portaling’ technologies ensures that information that requires to be securely shared across organisational boundaries is available, making the services seamless to the patient. This includes interoperable messaging within NHS Scotland healthcare and for communication with other agencies, including social services, education, police and voluntary sector, and an accompanying real time access to service management information for service planning and monitoring.

**Propositions - Delivering the Changes**

**6.1** To establish **Health and Social Care Partnerships** for Edinburgh, West Lothian, Midlothian and East Lothian, working with the local authorities, local communities and other stakeholders, in shadow form during 2014 and operational by April 2015; review the remaining **governance** arrangements within NHS Lothian in the light of the establishment of Partnerships. **ST**

**6.2** That the four Lothian Health and Social Care Partnerships develop **Strategic Commissioning Plans** supported by a number of Joint Commissioning Plans such as those for older people, mental health, learning disability, addiction and criminal justice services, in ways which ensure local ownership and support from the Primary Care Contractor Organisation. **ST**

**6.3** To implement NHS Lothian’s 2013 **values**, through local engagement events with managers and staff across each of our main management units and sites including the four Community Health and Care Partnerships, the major hospital sites, the scheduled care directorates and corporate services, by:-

- extensive use in internal and external communications
- embedding in HR processes including recruitment and induction
- incorporation in staff and management competencies, behavioural training, development and appraisal
- to be the cornerstone of our organisational development plan **ST/LT**

**6.4** To strengthen **leadership and management** and systems of governance to reflect the priorities in this plan and the need to deliver **continuous improvement,** better use of information systems and a balanced scorecard in the performance of NHS Lothian services **ST/LT**

**6.5** To create dynamic, new fora for clinical engagement across the hospital and community interface; to promote initiatives to develop medical and other **clinical leadership** arrangements that facilitate the engagement of frontline staff and that position clinicians as leaders delivering change **ST**

**6.6** To modernise and train the workforce, reflecting efficient and innovative use of knowledge and skills and challenging outmoded systems of working; to develop and publish a **workforce plan ST/LT**

**6.7** To develop new models of working with staff groups and partnership support which allow utilisation of our hospital facilities such as operating theatres and out-patient departments for scheduled care over extended (three session) days and **7 days** per week to maximise capacity and productivity **ST**

**6.8** To make optimum use of **managed clinical networks** and other organisations to engage clinical and other service providers with citizens and to focus attention of services on patient-centred priorities and pathway redesign **ST/LT**

**6.9** To make full use of **new technologies** e.g. wireless communications, telehealth/telecare and other digital systems such as paperless processes to enable service modernisation and efficiency improvements; **make better use of existing IT systems** and further develop clinical informatics and other ways that NHS Lothian will achieve NHS Scotland's six strategic eHealth aims (set out in the eHealth Strategy 2011-2017) **ST** :-

- Efficient working practices
- Assisting patients to manage own health
- Support people with long term conditions
- Providing information and tools for staff to effectively improve quality
- Medicines safety
- Real time management information

**6.10** To drive forward the **innovation** agenda; the priorities of the programme board will be to develop a culture of innovation across the whole organisation and to implement the agreed action plan, in particular addressing:-

- the demands that will be placed upon healthcare services, as the result of the over 75 population doubling in number over the next 20 years.
- The need to reduce the levels of hospital admissions.
- Reducing the number of clinic based outpatient appointments.
- Reducing the cost base by up to 5% each year. **ST**

## 7. Managing the Finances

The principal aim of this plan is to continue to improve the quality, accessibility and effectiveness of healthcare services for the people of Lothian and the real driver of change is the prospect of improving health and health services. However, the challenging financial context makes the pursuit of efficiency and excellence all the more imperative, so that NHS Lothian is also able to demonstrate maximum value for the public purse.

We are projecting a £400m total efficiency challenge over the next 10 years. This is based on the assumption that we will need to continue to deliver a minimum of a 3% cash efficiency target each year. The ever rising demands on our health budget over the next decade are increases in the population, demography, quality improvements, increases in the cost of providing care and developments in medical technology. Although there are projected increases in healthcare funding, these are not at the same level as the last decade and are not expected to be sufficient to cover the increased costs of demand from an expanding ageing population. The organisational challenge will therefore need to focus on better understanding and maximising the value and benefit from the 100% of expenditure rather than focusing on the annual 3% efficiency challenge.

Future investment and disinvestment decisions will be the outcome of strategic service choices. These decisions will be based in part on changing health care needs, wants and desires, but also on changes in the unit costs of providing care relative to inflation in the economy as a whole and the capacity of our health system to generate productivity gains. It is recognised that improvements in productivity should enable improved value from the level of funding that is deemed affordable. However it is likely that a gap will open up between the resources available and the demands over the next decade.

This plan highlights an ambitious programme of change for NHS Lothian. To support delivery of such a change programme it is important that efficiency and innovation are recognised as core building blocks for a sustainable financial future. Our focus will be on reducing waste and inefficiency and driving through productivity improvements, although these principles alone will not be sufficient to bridge the £400m NHS Lothian efficiency challenge.

The financial challenges are not confined to NHS Lothian, but are also being faced by local authority partners. To address the financial challenge it is important that NHS Lothian together with our local authority partners, through the Health and Social Care Partnerships, embrace the opportunity to modernise our service and strive to make them more cost effective and resilient in the process.

Patient safety and quality will be at the heart of the measures taken to address the £400m challenge. Some of the tools that we will seek to employ will include:

- Benchmarking our services against national and international comparators, constantly striving for improvement.

- Seeking out and reducing unnecessary variation in clinical practice and quality outcomes.
- Utilising any major change agenda as an opportunity to improve our service provision and cost effectiveness. e.g. integration, capital investments, service strategies.
- Encouraging the public to take greater ownership for their health care needs and assist in reducing avoidable demand.

The radical transformation of our services to meet service and financial challenges can only be delivered through rigorous engagement with all of our stakeholders - staff, patients and partner organisations. This open conversation needs to recognise the combination of a tightened financial settlement, an ever increasing demand for healthcare and rising expectations of standards and quality. Our current model is not sustainable within the current service configuration.

**Property and Asset Management Investment Programme**

To develop a programme which aligns with and supports this strategy, masterplans have been commissioned for all major sites. Each of these masterplans is at a different stage of development and the draft five year programme captures the agreed and emerging priorities.

The draft programme for 2014/15 onwards is summarised in the table below. This shows a potential over commitment for next financial year and a significant over commitment thereafter. Ensuring a balanced position is achieved will require a combination of prioritisation of unapproved projects via the masterplanning process, reviewing the timing of unapproved projects, exploration of potential funding routes with SGHSCD, Scottish Futures Trust (SFT) and council partners and detailed consideration of the revenue consequences of capital build aspirations that support the strategy.

*Summary Five Year Property and Asset Management Investment Programme*

| | 2014/15 | 2015/16 | 2016/17 | 2017/18 | 2018/19 |
|---|---|---|---|---|---|
| | £m | £m | £m | £m | £m |
| *Specifically funded schemes* | | | | | |
| Investments (agreed & proposed) | 25.301 | 16.403 | 65.830 | 115.882 | 130.358 |
| Funding agreed | -25.301 | -14.503 | -24.537 | -25.140 | -6.849 |
| **Specific funding gap** | **0.000** | **1.900** | **41.293** | **90.742** | **123.509** |
| *Schemes funded via formula* | | | | | |
| Proposed investments | 39.098 | 36.809 | 37.024 | 23.714 | 23.377 |
| Assumed Formula Funding | -29.007 | -28.988 | -26.988 | -25.988 | -25.988 |
| **Formula Funding Gap** | **10.091** | **7.821** | **10.036** | **-2.274** | **-2.611** |
| | | | | | |
| Total planned net capital expenditure | 64.399 | 53.212 | 102.854 | 139.596 | 153.735 |
| Total assumed funding | -54.308 | -43.491 | -51.525 | -51.128 | -32.837 |
| **Over/(under) commitment** | **10.091** | **9.721** | **51.329** | **88.468** | **120.898** |

The table shows a formula funding gap of up to £10m for the next two years. This is considered to be manageable. The large funding gap in the years 2016 – 2019 is due to large capital schemes that have not yet received approval from the SGHSCD, and which therefore do not have specific funding agreed. This five year plan has been submitted to the SGHSCD as part of the draft LDP for 2014/15 – 2018/19

## 8. Next Steps - Engagement Process

It is intended that the Strategic Plan will be finalised in the Autumn of 2014, in order to set a context for consultation on the four Integration Plans and to inform the development of each of the Health and Social Care Partnership's Strategic commissioning Plans, later in 2014 and into 2015.

To achieve that, the following outline timetable is proposed:-

2 April 2014 –Lothian NHS Board approved this document as the basis for further consultation and engagement and as a framework for completion of a definitive Strategic Plan.

April – May 2014 - "Our Health, Our Care, Our Future" is published on NHS Lothian website and distributed widely for comments and feedback.

May, June, July, August 2014 – meetings with patients groups, staff, independent contractors, partnerships, local authorities, Scottish Government and other stakeholders to analyse patent pathways, consider options and develop specific proposals, including workforce, capital and other resource implications.

September 2014 – feedback from the consultation will be incorporated into the plan.

October 2014 –Lothian NHS Board receive a refined and more definitive Strategic Plan for approval

Detailed consultation and meaningful engagement with an extensive range of affected stakeholders will be necessary to convert the list of propositions into a prioritised set of deliverable commitments. There will also be a specific programme of engagement to analyse and redesign patient pathways to take forward the work outlined in section 4 above.

However, in addition, a number of general questions have been posed in order to facilitate and focus the dialogue with staff, partners and the public and the aggregated responses reflected in the submission to the Board in October 2014. Details have been specified in the Communications Plan as to how respondents may submit their comments (e.g. electronic, paper, telephone) and confirmation that they are content for their comments to be published where appropriate.

## Consultation Questions

**Q1. Does this plan address the most important issues?**

**Q2. Have we missed anything that is really significant? If so, what is it?**

**Q3. Do the propositions in the Summary, taken together, reflect the right priorities?**

**Q4. Are the criteria for making decisions the right ones?**

**Q5. Which of the criteria do you think are the most important?**

**Q6. Is there anything else you would like to tell us before finalising our Strategic Plan?**

**Decision-making criteria**

| | Dimensions of Quality | Strategic Aims and Principles | Criteria to base decisions about service change | % Weighting |
|---|---|---|---|---|
| | **Essential Baseline Criteria which must be met for all Proposals before further prioritisation** | | **Meets National objectives**<br>• The service change go towards meeting identified national priorities and targets<br>**Meets Local objectives**<br>• The service change go towards meeting identified local priorities and targets<br>**Meets Legislative requirements**<br>• The service change meets current legislative requirements | **N/A** |
| **1** | **Equitable**<br>*Equity* is the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically, or geographically. | Prioritise prevention, reduce inequalities and promote longer healthier lives for all<br><br>Focus on prevention and early intervention to help people keep well and anticipate care needs | **Equity**<br>• Implementation of this service change will reduce inequalities.<br>• For example, does it :<br>• Address the inverse care law?<br>• Address socioeconomic gradient in risk of harm?<br>• Uphold the principle of proportionate universalism?<br>**Access**<br>• The service change will be fully accessible<br>• The service change addresses the gradient in access, engagement, treatment and retention<br><br>**Prevention**<br>• The service change will prevent ill-health or improve health resilience status | |
| **2** | **Efficient**<br>(Cost Effectiveness) no better outcome can be achieved through alternative use of the available | Put in place robust systems to deliver the best model of integrated care for our population – across primary, secondary and social care<br><br>Consider the continued use of active treatments which have not been shown to extend the length of life or improve quality of | **Affordable and sustainable**<br>• Are the set-up, training costs and running costs affordable and sustainable?<br>• Will this service change release cash through efficiencies?<br>• Will this service change demonstrate productivity gain?<br>• What is the likelihood of long-term survival of the service change? | |

| | Dimensions of Quality | Strategic Aims and Principles | Criteria to base decisions about service change | % Weighting |
|---|---|---|---|---|
| | resources | life. Make sure we stop procedures and treatments which add no clinical value.<br><br>Maximise the opportunities for use of new technologies to support health and healthcare.<br><br>Identify services that are not sustainable in longer term and proactively plan a new way of delivering care. Provide a healthy built environment and reduce spend on property and buildings as hospital stays reduce to release money for direct patient services. Deliver services with the appropriate mix of staff skills, ensuring viable clinical staff rotas. | **Ease of implementation**<br>• Is the service change easy to implement? Is there local 'buy-in'?<br>**Acceptability to partner agencies**<br>• Has the potential impact (positive or negative) on other NHS and non-NHS agencies been reviewed and addressed?<br>• Is there evidence that partner agencies will support the service change?<br>**Staff availability**<br>• Is trained, skilled staff available from the current workforce? | |
| **3** | **Effective** (Clinical Effectiveness) Does the intervention deliver its intended outcomes | Ensure that care is evidence-based, incorporates best practice and fosters innovation, and achieves seamless and sustainable care pathways for Patients<br><br>Take a whole system approach to planning and managing integrated pathways of care working with partner agencies in local authorities and voluntary sector. | **Magnitude of benefit**<br>• Is there a quantifiable health gain from this service change?<br>• Is there evidence of benefit compared to current practice?<br>**Duration of Benefit**<br>• Will the health gains be sustainable?<br>**Personal networks**<br>• Will the service change help service users to form relationships? This could be through employment, education, community groups or social support and social action?<br>**Population impact**<br>• Are there likely to be other external benefits to the population such as improvements to public safety, reduced levels of crime and disruptive behaviour?<br>**Social capital**<br>• Does the service change encourage community and social cohesion? | |

| | Dimensions of Quality | Strategic Aims and Principles | Criteria to base decisions about service change | % Weighting |
|---|---|---|---|---|
| | | | **Appropriate**<br>• Is the service change fit for purpose?<br>• Is it culturally appropriate and are the physical resources of high quality and up-to-date?<br>**Recognised standards**<br>• Does the service change meet recognised standards? | |
| **4** | **Safe**<br><br>Reduced level of harm (morbidity and mortality) | Design our healthcare systems to reliably and efficiently deliver the right care at the right time in the most appropriate setting | **Safety**<br>• Is the service change safe for both service users and staff?<br>• Is it more or less safe than the current service?<br>**Risks**<br>• Have the risks been reviewed and addressed appropriately? | |
| **5** | **Person-centred**<br>Engaging patients and carers as co-designers and co-deliverers | Involve patients and carers as equal partners, enabling individuals to manage their own health and wellbeing and that of their families | **Patient/carer experience**<br>• Will the service change improve the patient/carer experience?<br>• Is the service change person-centred?<br>• Does it offer a pleasant, comfortable, caring environment in which patients are treated with respect?<br>**Service user acceptance**<br>• Will the service change be acceptable to the service user?<br>**Public and political acceptance**<br>• Will the service change be acceptable to the public and politicians? | |

| | Dimensions of Quality | Strategic Aims and Principles | Criteria to base decisions about service change | % Weighting |
|---|---|---|---|---|
| 6 | **Timely** | Use the resources we have – skilled people, technology, buildings and<br><br>equipment - efficiently and effectively | **HR/staff impact**<br><br>• Will the service change improve the quality of the working environment for staff?<br>• Will there be high morale and support and opportunities for career development?<br>**Waiting time**<br><br>• Will the service change reduce waiting times? Will individuals be assessed and receive the intervention within an acceptable timeframe? | |
| | | | **Should add to 100%** | |

## Supporting Documents (available via weblink)

### Context

1. Lothian's changing population and trends in disease incidence and prevalence
2. Health Inequalities Strategy

### Programme Strategies

3. Strategy for Primary and Community Care
4. Children and Young People's Strategy 2014-2020
5. Mental Health Strategy
6. Learning Disability Strategy
7. Cancer Strategy
8. Action Plan for Unscheduled Care Services
9. Delivering for Patients - Plan for Scheduled Care Services

### Resource Strategies

10. Workforce Plan
11. Finance Plan 2014/15-2018/19; Property and Asset Management Investment Programme 14/15-2018/19;

### Planning and Delivery Processes

12. Integration of Health and Social Care
13. Communications, Consultation and Engagement Plan
14. Key Outcomes and Measurement Framework
15. Involving People framework 2014-16
16. Decision Criteria
17. Integrated Pathways of Care

West Lothian Council

NHS Lothian

# ST JOHN'S HOSPITAL STAKEHOLDER GROUP

## Work Plan as at 7 May 2014

| | SUBJECT | OFFICER | MEETING DATE |
|---|---|---|---|
| 1 | Hospital Activity Report including year-on-year comparisons (Out-patients) and Presentation by Jim Crombie | Jim Crombie | 7 May 2014 |
| 2 | Department of Laboratory Services Update | Jim Crombie | 7 May 2014 |
| 3 | Key Quality Indicators | Agnes Ritchie | Quarterly update – next report 7 May 2014 |
| 4 | Paediatric Services Update | Jim Crombie | Standing item |
| 5 | Stroke Care Delivery | Chris Stirling | 7 May 2014 |
| 6 | Patients' Travelling Expenses Scheme Update | Jim Crombie | 7 May 2014 |
| 7 | Update on Hospital Working at Weekends | Chris Stirling | 7 May 2014 |
| 8 | Respiratory Medicine Update/ Respiratory Medicine Strategy Overview | Chris Stirling | 7 May 2014 |
| 9 | Hospital Activity Report including year-on-year comparisons (In-patient day care service) | Jim Crombie | 4 June 2014 |
| 10 | A&E Staffing Resources | Jim Crombie | 4 June 2014 |
| 11 | MRI Scanner Update | Agnes Ritchie | Quarterly update – next report 4 June 2014 |
| 12 | Nuclear Medicine Update | Jim Crombie | 4 June 2014 |
| 13 | Strategic Plan Update | Jim Crombie/Libby Tait | Update to future meeting |