BOARD MEETING

DATE: **WEDNESDAY 2 DECEMBER 2015**

TIME: **9:30 A.M. - 12:00 P.M.**

VENUE: **BOARDROOM, WAVERLEY GATE, 2-4 WATERLOO PLACE, EDINBURGH EH1 3EG**

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

AGENDA

Agenda Item		Lead Member	
	Welcome to Members of the Public and the Press		
	Apologies for Absence		
1.	**Items for Approval**		
1.1.	Minutes of the Previous Board Meeting held on 7 October 2015	**BH**	*
1.2.	Running Action Note	**BH**	*
1.3.	Board Development Sessions 2016	**BH**	*
1.4.	Committee Memberships and Terms of Reference	**BH**	*
1.5.	South East Scotland Research Ethics Committees - Annual Reports 2014 - 2015	**AKM**	*
1.6.	Integration Joint Boards' Strategic Plans and Acute Hospitals Plan-Update	**AMcM**	*
1.7.	Acute Hospitals Committee - Minutes of 1 September 2015	**KB**	*
1.8.	Healthcare Governance Committee - Minutes of 22 September 2015	**RW**	*
1.9.	Strategic Planning Committee - Minutes of 8 October 2015	**BH**	*
1.10.	West Lothian Integration Joint Board - Minutes of 20 October 2015	**FT**	*
2.	**Items for Discussion** (subject to review of the items for approval) *(9:35am - 12:00pm)*		
2.1.	2015 Annual Review Response Letter	**TD**	*
2.2.	Performance Management	**AMcM**	*
2.3.	Review of Medical Paediatric Inpatient Services	**JC**	*
2.4.	NHS Lothian Performance Delivery 2015/16	**AMcM**	*
2.5.	Refocussing Performance Reporting	**AMcM**	*
2.6.	Financial Position to October 2015 and Year End Forecast	**SG**	*
2.7.	Workforce Risk Assessment	**DF/AB/MJ**	*
2.8.	Quality Report	**DF/MJ**	*

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

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2.9.	Corporate Risk Register	**DF**	*
2.10.	Healthcare Associated Infection Strategy Improvement Plan and Performance Update	**MJ**	*
2.11.	Getting it Right for Every Child - Update & Scottish Government Progress Update	**AMcM**	*
2.12.	Integration and Governance of Children's Services in NHS Lothian	**AMcM**	*
2.13.	Integration and Children's Services in Midlothian	**AMcM**	*
3.	**Next Development Session:** 13 January 2016 at 9:30 a.m. in the Boardroom, Waverley Gate.		
4.	**Next Board Meeting:** Wednesday 3 February 2016 at 9:30 a.m. in the Boardroom, Waverley Gate.		
5.	Resolution to take items in closed session		
6.	Minutes of the Previous Private Meeting held on 7 October 2015	**BH**	®
7.	Matters Arising		
8.	Quality Improvement	**TD/AMcM**	**v**
9.	Financial Outlook 2016/17	**SG**	®
10.	Integration Joint Boards - 2016/17 Opening Budget Proposal	**SG**	®
11.	Any Other Competent Business		

Board Meetings in 2016	**Development Sessions in 2016**
	13 January 2016
3 February 2016	2 March 2016
6 April 2016	4 May 2016
22 June 2016	20 July 2016
3 August 2016	7 September 2016
5 October 2016	2 November 2016
7 December 2016	

DRAFT **1.1**

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 7 October 2015, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mr M Ash; Mrs K Blair; Dr M Bryce; Councillor D Grant; Councillor R Henderson; Mr M Hill; Ms C Hirst; Professor J Iredale; Mr P Johnston; Councillor C Johnstone; Mr A Joyce; Mrs J McDowell; Mrs A Meiklejohn; Mrs A Mitchell; Mr J Oates; Councillor F Toner and Mr G Walker.

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

In Attendance: Dr B Cook (for item 54); Dr S Edgar (for item 54); Dr N Maran (for item 54); Mr D Weir and Dr C Whitworth (for item 54).

Apologies for absence were received from, Mrs S Allan (Vice Chair) and Dr R Williams.

Declaration of Financial and Non-Financial Interest

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

44. Welcome and Introduction

44.1 The Chairman welcomed members of the public to the meeting. He also introduced Mr S Carmichael, Management Trainee to the meeting. It was also noted that Doctors Cook, Edgar, Maran and Whitworth would join the Board for the NHS Lothian Clinical Quality Approach debate.

45. Items for Approval

45.1 The Chairman reminded members that the agenda for the current meeting had been circulated previously to allow Board members to scrutinise the papers and advise whether any items should move from the approval to the discussion section of the agenda. The Chairman advised that Mrs Blair had pre-notified that although she was happy to go along with the recommendations in the consent agenda that she felt the Board should note with concern the position around the failure to meet so many HEAT targets. It was acknowledged that the Board would be discussing these

issues in other parts of the agenda. Mrs Blair felt that the HEAT position should not pass without any remark. This approach was approved.

45.2 The Chairman sought and received the approval of the Board to accept and agree the following recommendations contained in the previously circulated 'For Approval' papers without further discussion.

45.3 Minutes of the Board meeting held on 5 August 2015 - Approved.

45.4 Running Action Note - Approved.

45.5 Performance Management – The Board received the update on the existing performance against HEAT targets and other relevant standards subject to the caveat made by Mrs Blair at the beginning of the meeting.

45.6 Healthcare Associated Infection Update - The Board noted that NHS Lothian's staphylococcus aureus bacteraemia target was to achieve a rate of 0.24 per 1000 bed days (≤ 184 incidences) by March 2016 with a current rate of 0.33 and to note NHS Lothian's clostridium difficile infection target was to achieve a rate of 0.32 per 100 bed days (≤ 262 incidences by March 2016 with a current rate of 0.40).

45.7 NHS Lothian Performance Delivery - The Board agreed to note the risks against delivery of the LDP, particularly in relation to very high and high risk areas relating to delivery of LRP and performance as set out in section 4.1. The Board also noted that a quarter 1 review had taken place on 27 July 2015 in advance of the NHS Lothian annual review on 3 August 2015 to discuss performance and the financial position. The Board also noted a draft reporting template had been developed to support monitoring of the 2015/16 corporate objectives. The template would be piloted during 2015/16 to ensure processes were embedded to support monitoring of 2016/17 corporate objectives.

45.8 Audit and Risk Committee - Minutes of 7 September 2015 - Endorsed.

45.9 Finance and Resources Committee - Minutes of 9 September 2015 - Endorsed.

45.10 Healthcare Governance Committee - Minutes of 28 September 2015 - Endorsed.

45.11 Strategic Planning Committee - Minutes of 13 August 2015 - Endorsed.

45.12 East Lothian Integration Joint Board - Minutes of 1 July 2015 - Endorsed.

45.13 Edinburgh Integration Joint Board - Minutes of 17 July 2015 - Endorsed.

45.14 Midlothian Shadow Integration Joint Board - Minutes of 18 June 2015 - Endorsed.

45.15 West Lothian Shadow Integration Joint Board - Action Note of 2 June and 25 August 2015 - Endorsed.

46. Items for Discussion

46.1 Review of Medical Paediatric Inpatient Services

46.2 The Board were reminded of the detailed debate at the previous meeting around Inpatient Paediatric services at St John's hospital. The circulated Board paper reflected that debate. The Inpatient Paediatric Unit had reopened although this was predicated on the same rota process as previously in place when there had been a need to reduce the Inpatient service hours. The rota was covered for August, September and October. The Board were advised there had been 36 gaps in the rota which had been covered using locums. The current rota was safe although this had been achieved at a cost in respect of additional hours and the payments made to locums.

46.3 At the previous Board meeting it had been agreed to undertake an independent and comprehensive review of Lothian's Acute Paediatric Services to determine how a sustainable model of working could be secured to ensure safety, and quality of care, access, the best outcomes for patients and the best use of available public resources.

46.4 The Board noted that it was being proposed to use the Royal College of Paediatrics and Child Health (RCPCH) to carry out the review. It was reported that the RCPCH had significant experience in undertaking reviews of this nature and used a high level of clinical experience and engagement in the process. Informal discussions with the RCPCH had confirmed that they were keen to undertake the review and were supportive of significant engagement from St John's Hospital clinicians and engagement with other stakeholders.

46.5 It was proposed if the Board supported the proposal that contact would be made with the RCPCH who would undertake the review in November and December and report back early in the New Year. The circulated remit had been discussed with the RCPCH and they were content with the clarity it provided and were confident in their ability to deliver. The process had been supported by the Acute Hospitals Committee and the Healthcare Governance Committee and was therefore before the Board for endorsement.

46.6 Councillor Toner thanked staff for filling the gaps in the rota to keep the service open over October. He advised at the last St John's Stakeholder Group meeting a question had been raised about staffing and whether NHS Lothian were actively advertising and recruiting to the service. It was noted that the latest recruitment round had concluded during August and following interview a successful candidate had been identified but had accepted an offer of employment from elsewhere. An exercise was underway to look at the recruitment environment and if the leadership team felt there would be benefit in undertaking a further recruitment round then this would happen. However as reported to the Stakeholder Group no recruitment exercise was currently underway. The proposed review process might impact on the recruitment position and close links would be maintained with clinical teams.

46.7 Councillor Toner commented despite the current recruitment freeze and the review process he felt that recruitment attempts should continue and questioned whether if recruitment did not continue that there might be a requirement for further service closures in future. Mr Crombie in response stressed that there was absolutely no

recruitment freeze in place and that the position at the end of August represented the end of a 2 1/2 year recruitment process to attempt to support safer services.

46.8 Mr Johnson advised he had welcomed the opportunity to have discussed a number of issues off line with Mr Crombie. He commented he had consistently called for the review to be clinician led and welcomed the commitment to ensure clinicians would be involved with the RCPCH in terms of the remit for the review. He believed that it would be best practice for paediatric clinicians from St. John's and the Royal Hospital for Sick Children to be fully involved in all stages of the review and suggested that places be allocated to local clinicians. He felt those who knew the service best were best placed to help conduct the review and assist in re shaping services for the future. Mr Johnson advised he felt uncomfortable with the fact there was no mention of patient pathways or quality of care or of designing a service to meet the identified needs of the community. He felt these were essential and critical components of service redesign and should be clearly spelled out within the remit of the Review.

46.9 Mr Crombie in response provided examples of advance discussions with the RCPCH which covered the points raised about the engagement of the clinical team which consisted of professionals other than just doctors. He confirmed therefore that he was happy to ensure robust clinical engagement.

46.10 The point was made that the RCPCH review team would be able to produce significant assurance around patient pathway and quality aspects from their own experience and evidence sourced from elsewhere including the local healthcare system.

46.11 The question was raised about whether the RCPCH would have the capacity to complete the review by the end of the year. It was noted that the first phase of the review during November and December would be the interactive phase of the process. NHS Lothian would require to supply significant information to the team during this period. It was anticipated that a formal final report would be submitted by March/April 2016.

46.12 It was agreed that the remit would be amended to reflect the need for the proposal to provide a sustainable quality of care. The Board noted that the Acute Hospitals Committee and the Healthcare Governance Committee had discussed and endorsed the proposed review process. Progress with the implementation of the inpatient paediatrics review would be monitored by the Acute Hospitals Committee.

46.13 Councillor Toner moved a motion to make an amendment to add the following two recommendations to those contained in the paper:

- The Board gives its commitment that as a result of this review there will be no downgrade or removal of services at St John's.

- Invites the stakeholder members of Local Authorities to attend the Review Group.

46.14 The motion failed to secure a seconder and was therefore not carried and the Board agreed to the circulated recommendations to:

- Agree that the Royal College of Paediatrics and Child Health (RCPCH) shall be appointed to lead this review.

- Agree the proposed terms of reference for the review subject to inclusion of comments made at the meeting about inclusion of patient pathways and quality of care.

47. Winter Plan 2015/16

47.1 The Board were advised that the background to the production of the Winter Plan 2015/16 had been a keenness to establish oversight of winter through a multiagency stakeholder group. It was noted that not all aspects of the plan were deliverable solely by NHS Lothian and for that reason the characterisation of other stakeholders was represented on the front page of the plan.

47.2 It was noted a significant part of the work in the current year was to learn from issues and challenges experienced in the previous year and to mobilise options to mitigate these with details being provided of remedial action taken to date. The winter plan did not just represent the medical response and included input from nurses, allied health professionals and care teams. The plan also characterised additional elements as detailed in the table of contents.

47.3 The Board noted that the front door of the service was already under duress although individual hospital sites were showing a desire to work together to deliver the service. Mr Crombie commented this was a comprehensive plan which he commended to the Board.

47.4 The Board welcomed the quality of the winter plan. It was noted in the current year in terms of opening additional beds that this had been addressed through 2 avenues. The first was that the financial plan made provision for winter with the second aspect being the provision of bridging funding to NHS Lothian and the City of Edinburgh Council from the Scottish Government which had been included in the winter plan. The point was made in terms of the £6m plus spend and the related business cases whether goals and outcomes were being set that could be measureable on a dashboard basis. It was noted that this would be covered within the context of a further Board paper reporting pressure on the medical workforce which might have an impact on the ability to take on extra workload.

47.5 The Board were advised that a dashboard indicator exercise had been undertaken and where investments were made it would be made clear that this would need to produce a measureable outcome. It was reported that each Business Case had outcomes in place that would trigger an element in the dashboard which could be interrogated to check performance status. It was noted for instance that discharge earlier in the day performance was looked at twice daily with scheduled care and unscheduled care activity being monitored on a daily basis. The availability of data to forward project was becoming more elegant. There was also positive evidence available to demonstrate inter-site cooperation to alleviate pressure. In terms of new beds the availability of these was important with it being key that these were coordinated properly in order to ensure their efficient use.

47.6 In terms of communications with the public the suggestion was made that there would be benefit in working with areas like supermarkets and outlets for alcohol to highlight the benefits of good hand cleaning and washing as it was felt there was a need for these lessons to be refreshed. The point was made that sponsorship could

be sought to assist in communicating these important messages. Mr Crombie undertook to consider how best to progress this positive suggestion. It was noted work was underway around options to ensure people were aware of the types of support available to them. There would be an escalation of information over the next few months.

47.7 A concern was raised that the winter plan was predicated on significant primary care activity and delayed discharges working better than had been the case previously and an assurance was sought that this would be achievable. The Board were advised that reassurance had been received from local authorities and Community Health and Care Partnerships which had demonstrated that cross working across organisations was progressing. In support of this view the Board were advised that later on the agenda it would be reported that additional beds were opening in Gylemuir and that in Edinburgh it was planned to recruit an additional 66 domiciliary workers who would be available for work in December.

47.8 The Chairman commented that the points raised were important in terms of the governance needed around assurance in respect of the primary care role and the need to consider the reporting interface with Integration Joint Boards (IJBs). The point was made however that many Edinburgh GP practices were vulnerable. The point was made in terms of Board governance that the part that was missing from the winter plan was assurance around the impact of the plan and the articulation of aspects of primary care to track and support the winter plan.

47.9 The Board whilst welcoming the winter plan recognised that not all parts of it would be delivered. The point was made however that in terms of discharge of patients it would be important to ensure this happened at appropriate times in the day and that elderly patients should not be discharged late at night. The Board were advised that the system was now more informed about discharge profiles with data now showing the numbers and source of discharge. The standardisation of the morning hospital huddle process meant it was possible to tell which patients would be discharged before noon and the rest of the day. The Transport Hub was now coordinated as were notifications to pharmacy about the need for discharge medicines. The point was made when campuses were under duress late ward rounds tended to happen and this was where there was a risk of late discharges and this would be kept under review to stop the inappropriate discharge of patients.

47.10 The plea was made that whatever leadership structure was adopted in future it would be important to monitor data in real time and develop accurate forward facing data. It would also be important to react acutely when things were evidently not working. It was noted that the informatics team had been involved in the development of the winter plan. The point was made about the need to triangulate data about elderly patients being moved and to avoid boarding which caused harm to patients. It was agreed there was a need to support early discharge of people with less acute needs.

47.11 The Board agreed the recommendations in the circulated paper.

48. Person Centred Culture

48.1 The Board noted that the report continued the positive feedback on staff and services across all areas of activity. It demonstrated the ‘Tell us 10 Themes’ survey

was providing positive information at local levels which allowed wards and teams to react quickly. The current years submission to the Scottish Health Council on the patient participation standard had been on complaints and feedback with a positive response having been received.

48.2 The Board were reminded that the focus on complaints had been around the following areas with detailed updates on work under each theme provided to the Board: -

- Personnel issues in the centralised complaints team
- Prison complaints
- The overall process

48.3 It was noted that complaints performance around response rates was generally holding up in terms of final responses and 3 day acknowledgments. There had been a slight dip in performance as other operational issues were addressed around the impact of changes on staff and the introduction of the devolved Western General Hospital model.

48.4 The question was raised about the process for assessing the level of satisfaction on the content of responses and also whether problem areas could be identified by a cluster of complaints.

48.5 The Board were advised that the main way of judging satisfaction was when people returned for further clarification or comment on their original letter or by referrals to the Scottish Public Services Ombudsman (SPSO). The system was not yet sophisticated enough at seeking out this data although it was recognised that this was an area that needed to be developed.

48.6 In terms of cluster spotting although a sophisticated process was not in place it did occur at local level through Director level sign-off of complaints letters and by the complaints team identifying areas of common dissatisfaction. It was anticipated as more data became available on a site basis that by definition reporting could be undertaken in a more sophisticated way. The process in place in respect of serious incidents was also helpful as was datix.

48.7 It was reported that a proposal would come forward to establish a sub-committee of the Board to look at the substance and spread of complaints as well as at SPSO feedback. A key role of the committee would be to receive confirmation of closure of SPSO recommendations.

48.8 In terms of improvement and quality the point was made that assurance was needed that lessons were learned from complaint episodes and actions taken to reflect this. It was noted that there was a local learning focus around complaint incident debriefs. There was however an issue about how to translate this information to Board level.

48.9 The Board noted despite the progress made that resolving the complaints process would not be a quick fix with improvements likely to take time to become evident. As the process improved there was a likelihood that the number of complaints would increase. It was noted that good complaints managers had unique skills which included having emotional capacity with patients. The Board were advised that the focus was to now recruit to these posts by employing people who were registered nurses or had a clinical background. A work programme would be established on

how to train and support people once in post. The SPSO used the Samaritans to provide training for call handlers and this would be followed up. Ms Johnson and Ms Hirst would discuss issues around the staff selection process outwith the meeting.

48.10 The Board welcomed the focus on patient experience although it was suggested moving forward there was a need to do more about triaging and once this was established the reporting of the background to patient's complaints would be enhanced. It was recognised there would be a need to disaggregate data to take account of IJBs and alignment with Local Authorities. It was noted work was underway with Council colleagues.

48.11 The recommendations in the circulated paper were approved.

49. Acute Services Performance Update

49.1 The Board noted at the end of August 398 patients were waiting beyond the 12 week treatment time guarantee. 314 patients had been treated in-month beyond the guarantee. 6933 outpatients were waiting over 12 weeks which was an increase on July's position of 6087. Performance against the 31 day cancer standard in July had been 96.7% which exceeded the 95% expected standard. At 95.7% performance against the 62 day cancer standard had also exceeded the standard.

49.2 The published stroke care bundle performance data for July showed 52.3% against the local target of 70%. Performance in the previous week had reached 75%. Positive performance was reported against audiology standards, IVF and the 4 hour standard.

49.3 Mr Crombie advised in terms of outpatients that a decision had been made to switch off Medinet provision over the summer period which had resulted in a negative impact on outpatients performance. This had been exacerbated by a spike in additional capacity / referrals which had since been sustained. Work was underway to understand the drivers for this with a focus around 4 specialties. Analysis work was being undertaken around source and capacity. Discussions were being held with another Health Board in order to share intelligence. An analysis of GP practice referrals had shown a uniform position. The workstream would look to identify what type of activity was being referred and what the drivers were for this. The impact of national campaigns around bowl screening and persistent cough were also being considered.

49.4 The Board noted that an element of the Medinet capacity that had been switched off had been reinstated. However the overall demand shift was concerning and would have an impact on TTG (Treatment Time Guarantee) performance with there being a need to look at conversion rates. In terms of transparency a report would be made to the Finance and Resources Committee on the capacity model. It was hoped to have a view from the September data on why the demand pattern had continued. Mr Crombie commented it had been disappointing and concerning to see the deteriorating performance and assured the Board that the focus of teams was on how to mitigate this. It was hoped that additional data would be available for reporting at the December Board meeting.

49.5 The Chief Executive commented that a forensic analysis around DCAQ (demand capacity and activity queue) was critical. This would bring specificity to the position

and hopefully identify what was happening to demand which might be symptomatic of a growing population which was living longer. Once the reasons for the additional activity had been identified there would be a need to consider how to grow internal capacity to deal with this. The Board were advised that the phenomenon was not Lothian specific and was being replicated across Scotland. In the English NHS GPs has been incentivised to stop referrals into the acute sector. The Acute Hospitals Committee would look at DCAQ in more detail.

49.6 The Board received the update report on acute services performance.

50. Financial Position to August 2015

50.1 The Board were advised that there remained challenges in achieving financial balance at the year end. The position would be exacerbated if the current growth trend in outpatient appointments continued. There was potential for some additional central funding from the Scottish Government. It would be important to consider how best to manage the outpatient position within the context of the overall financial situation.

50.2 The month 5 financial position had shown a slight improvement partly as a consequence of turning of Medinet activity although this had resulted in an issue in meeting waiting time targets. The mid year review process would demonstrate how national waiting time performance would affect delivery of the year end financial position.

50.3 The Board were updated on trends in financial performance with particular emphasis on pay, nurse, staff bank and GP prescribing. A key determinant in achieving financial breakeven was the delivery of LRP (Local Reinvestment Plan). The recently received Deloitte's report identified opportunities for improvement and this would be discussed at the Finance and Resources Committee. It was noted there were opportunities for further efficiency although these would take time and would not necessarily deliver cash savings.

50.4 Progress against the year end forecast would be monitored on a monthly basis with it being key that the potential overspend of £14m was managed. Mrs Goldsmith advised she was not able to give complete assurance of breakeven at the year end although it still remained possible but was dependant upon delivery of management actions. A review of the balance sheet had been undertaken although this would result in all available flexibility being used up.

50.5 The Board were advised that a further round of directorate meetings were scheduled to ensure management actions were delivered. There was a need to focus on the workforce and managing the risk of not recruiting in some non essential areas.

50.6 The Board were advised that nationally a risk assessment was being taken forward of financial performance across Scotland including the need for contingency as some but not all Boards were not confident of delivering breakeven at the end of the financial year. Consideration was also being given to the impact of issues like the increase in employer National Insurance costs as well as the delegation of functions to IJBs which changed the risk profile for the Board.

50.7 It was reported that the CMT (Corporate Management Team) had considered a draft of the 2016/17 financial plan which would come to the Board to consider the distribution of uplift to ensure the proper risk profile across IJBs and the residual sum that the Health Board managed. A further update would be discussed at the November Board Development Session as well as at the Finance and Resources Committee.

50.8 The Board noted the update on the financial position and agreed and supported the recommendations contained in the circulated Board paper.

51. Workforce Risk Assessment

51.1 The Board noted that the circulated paper had a different focus based on comments made at the previous Board meeting. In particular the scope of the paper had been widened to consider workforce risk within the wider workforce.

51.2 It was reported in respect of National Medical Training that within Scotland only 48% of entrants to medical schools came from Scotland. More doctors completed foundation training than there was core / specialty places, however 34% in Scotland (41%) in Lothian chose not to immediately enter. It was reported up to 40% of doctors in CT2 (core medical training) training posts were choosing not to progress immediately to ST3 and were either not in UK training or were completing other higher specialty training such as clinical development fellows. In addition of the 19,977 doctors currently on the GMC register who graduated from Scottish medical schools 11,716 (59%) were working in Scotland and 8,261 (41%) were working elsewhere in the UK.

51.3 It was recognised that some medical specialties were more attractive than others and given changing demographics there was a need to try and encourage people to work in areas like Medicine of the Elderly. The Board received an update on recruitment in general Adult Psychiatry and Psychiatry in the Mother and Baby Unit at St John's Hospital.

51.4 The Board were advised in order to support primary care the best way would be to increase the number of available GP's. The fact that only 78% of GP training posts were filled was a concern.

51.5 It was noted that the GMC survey had demonstrated for Lothian that the quality of training experience was considered by 88% of trainees to be either excellent or good. Any issues raised around bullying and harassment were dealt with quickly.

51.6 Mrs Mitchell commented that she was confused by some of the figures particularly in respect of the over supply of medical graduates and the fact NHS Lothian was still unable to recruit to posts. It was noted that the GMC survey highlighted issues about workload and it was questioned what was being done about this and whether people did not apply for posts based on workload issues. The question was raised about what was happening locally to make people feel supported.

51.7 Dr Farquharson advised that the Clinical Development Fellow initiative went a long way to support out of hours services. The point was made that the number of trainees available was governed nationally and was out with the control of NHS Lothian. The areas where NHS Lothian did have control however were around

providing trainees with good consultant support and induction and it was felt through these provisions that trainees were indeed well supported.

51.8 It was noted that although Clinical Development Fellows were not accredited training posts that post holders obtained good experience that allowed them to proceed to develop other skills. It was reported that the outcomes of the GMC survey were addressed by Clinical Directors with performance being tracked and reported to the Healthcare Governance Committee to show where improvements had been made.

51.9 The Chief Executive commented that the intensity around the position would get worse. He felt there were 2 key levers. The first of these was the need for fewer out of hour's sites with bigger workforces and less intensive regulatory work on fewer sites. The second was around government debate in terms of recruiting more doctors and increasing the number of Scottish domiciled entrants into medical school.

51.10 Professor Iredale commented that the way forward was about fewer but bigger sites and bigger teams. In terms of Clinical Development Fellows he pointed out that by supporting services they made the experience more tolerable for others working in these areas. Lothian remained in the top 6 preferred places to train in the UK. The work of the Board for Academic Medicine and the Medical Schools Council was explained to the Board. Professor Iredale advised that the point about domiciliary status was complex and there was a need for a more aggressive approach to recruitment for the best benefit of patients and in making NHS Lothian a good place to work. In terms of GP recruitment the Board for Academic Medicines were currently considering issues and at the current moment in time people did not see it as an attractive career and were attracted by higher salaries in areas like Australasia.

51.11 The Board were advised in terms of Paediatrics that the medical workforce was dominated by one gender and this had an impact on maternity leave. Professor Iredale felt there would be benefit in exploring with the Government the appointment of 1.5 trainees to each consultant post. He advised that the Chief Executive had given evidence to the Greenaway Report the recommendations of which were around people in general medicine working as generalists rather than specialists. Professor Iredale felt it would be important that NHS Lothian ensured that the recommendations were rolled out for the best benefit of the Board.

51.12 The question was raised about whether there was a tension towards the move to super specialism and organisational requirements for more generalists and if so how would NHS Lothian manage this in policy terms. The Chief Executive advised the solution would be the implementation of the Greenway report. Future workforce planning would include Nursing and other professions like Healthcare Scientists to support doctors to do what only doctors could do.

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

52. Agenda Re-ordering

52.1 It was agreed to discuss the NHS Lothian Clinical Quality approach out of sequence to maximise the use of the time of the senior clinicians who would be making a presentation to the Board.

52.2 Mr Boyter left the meeting.

53. NHS Lothian Clinical Quality Approach

53.1 The Chairman welcomed Doctors Cook, Edgar, Maran and Whitworth to the meeting advising that they would be presenting on their perception of the benefits of the proposed clinical quality approach to future service delivery.

53.2 The Chief Executive opened discussion by advising that the development of the clinical quality approach represented a multi dimensional and complex process. He commented that the ethos of the proposed new way of working was in his opinion the only way forward to address the following concerns:

- Growth in demand outstripping growth in resources which was not sustainable
- The system finding it impossible to say no to new drugs and technologies despite concerns about affordability and effectiveness
- Finding it difficult to stop providing services with Homeopathy cited as an example
- Stopping providing services as they were currently configured across sites

53.3 The Chief Executive commented that the new approach detailed in the paper was principally around engaging with senior clinicians who largely determined the use of the majority of the systems resource. He felt there was a clear need to reach out to senior clinicians and seek their assistance in designing and delivering a new way of working. The process was also about reaching out externally to other strategic allies including in partnership with Intermountain Healthcare. It was hoped the process would help to influence resources at the level of microsystems at local level in order to seek out high cost / intensity / volume interventions and processes/ pathways. There was a need to work out the optimal process and use data to show deviation from the optimal position. There was also a need to drive inappropriate treatment and deviation out of the system as well as providing support to clinicians working at microsystems level in terms of time and capacity.

53.4 The Chief Executive advised that the outcomes of the new approach would be determined when work started although broadly for each pathway or specialty the aim would be to reduce:

- Unwarranted variation
- Unnecessary or inappropriate treatment
- Waste of resources
- Cost

53.5 The initial approach would be to target high cost/ intensity areas in order to maximise benefits including increasing quality and outcomes for patients at the lowest possible cost.

53.6 The Board were advised that they would receive a presentation from the senior clinicians present at the meeting which would demonstrate the work undertaken over the previous 6 months including the ongoing engagement with Intermountain Healthcare and the development of a Choosing Wisely Policy. It was noted that the Scottish Government had committed to part resource the project and the University sector had undertaken to support the process in kind as had a number of other agencies. It was noted that there were other partners that it might be desirable to engage with later in the process. The Chief Executive was of the belief that Endowment funding should be utilised to support the project and in that regard the Edinburgh and Lothian Health Foundation should be approached as a major funding source.

53.7 The Board received a detailed presentation from Doctors Cook, Edgar, Maran and Whitworth a copy of which was made available to Board members at the meeting.

53.8 The Chief Executive felt that the approach of using clinicians to drive out waste and inefficiency needed to be the organisational strategy moving forward if the system was to remain viable.

53.9 The Chairman reminded the Board that at this point the recommendation was to support the development and implementation of an NHS Lothian Quality Approach and the realignment of existing improvement support resources which would contribute to the delivery of the proposal.

53.10 The point was made that this was a very ambitious and significant proposal that changed the whole philosophical basis of the organisation. The proposal would need to have sufficient pace through the support of the Board with lessons being learned from elsewhere. Getting the process embedded through cultural change would be important.

53.11 Clinical leadership would be fundamental as doctors could influence other doctors. The interface between the Business Case and morality considerations would be important. Links were needed with Palliative Care. Compassion was already evident throughout the organisation.

53.12 It was felt that clinicians would get behind the proposals because they represented a different way of redesigning services and making efficiencies rather than the traditional salami slicing approach. It was felt this approach would secure better clinical engagement.

53.13 Concern was expressed about how the message would be marketed to stakeholders and staff. Care was also needed around the use of language. There was a need to build on what was already happening elsewhere. The real issue was about choosing wisely and stemming the drugs tide. How to engage with patients would be a huge challenge. It was questioned whether the proposal was ambitious enough and whether enough resource was being invested. Maintaining the momentum would be important and essential to this would be the need to be clear about the key messages.

53.14 There was some concern about recommendation 2.3 in the paper with it being noted that the Edinburgh and Lothian Health Foundation had asked for an Initial Agreement whereas there was support amongst a number of Board members for the

submission of several smaller Business Cases to a range of different partners rather than just the Foundation.

53.15 The point was made that this was not “the only show in town” and should be viewed as an essential part of the overall package. There was a need to make reference to GP and Community services. IJB Strategic plans were being developed and would dictate the use of 75% of NHS Lothian resources. Currently it was felt there was a dysfunction between community teams and the acute sector. There was a strong need to ensure IJB engagement.

53.16 The point was made if NHS Lothian was serious about shifting the balance of care there would be a need to invest in preventing and reducing health inequalities and therefore there was a need to proceed down the proposed route. It was questioned however whether what was being proposed would be palpable particularly in respect of denying people treatment that might be perceived as being life saving. It would be important to safeguard against this otherwise the direction of travel could be derailed.

53.17 It was suggested there was a need to carefully distinguish between cultural aspects and organisational change and innovation. There was also a need to be clear about what was basic management practice with the proposal only focussing on what was strictly innovative change. GP involvement would be crucial. The concept of multiple funding sources made sense and this should include the Foundation Trustees. There was a need to ensure visibility of funding sources over the 3 – 5 year period.

53.18 The point was made that there was a need to be clear about the motivation and drivers for progressing as well as who the proposal was intended to serve. There was a need to get the balance correct.

53.19 It was suggested the ambition of the plan might weaken the case for it. The proposal would represent a massive cultural and transformational change. It was questioned whether NHS Lothian could achieve this without significant resource and a “bite size chunk“ approach moving forward was proposed.

53.20 There was a need to consider how to sustain the proposal in terms of financial and other resources over the 3-5 year period given that the NHS Lothian financial position was sobering. It would be important not to set a challenge that could not be delivered upon. The focus should not be about building a centrally based flagship but about permeating the process down to grass root level from where change could be driven. The cultural change would be significant. The importance of having good and correct data to support change was emphasised. Again the point was made that several pilots would be the best approach moving forward. There would be a need to understand how to fund and sustain the process.

53.21 The Chairman concluded by suggesting from the debate that the following were the key issues that needed to be considered moving forward:

- Importance of momentum (battleship versus smaller pilots)
- Communications and public perception issues
- Ambition and cost levels

- Funding the Business Case with a desire to see Business Cases being submitted to areas other than the Foundation Trustees
- Primary Care and IJB engagement
- Use of appropriate language

53.22 The Board agreed subject to absorbing these comments into the development process to support the 3 recommendations contained in the Board paper.

54. Quality Report

54.1 The Board noted that a number of the issues in the quality report also featured in the consent part of the agenda i.e. Healthcare Associated Infection and also the Patient Experience. There were no concerns about HSMR (hospital standardised mortality ratio) data with none of the three acute adult hospitals being a statistical outlier. The Lothian performance on sepsis mortality reflected the positive work being done in the identification of deteriorating patients. It was noted that performance around C-difficile and Staphylococcus Aureus Bacteraemia were the main outstanding challenges from a patient safety perspective.

54.2 The Board noted the quality report.

55. Corporate Risk Register

55.1 The Board noted that the corporate risk register usually featured in the consent agenda and had been included for discussion as it was important that the Board were sighted on the following 3 new risks:-

- GP workforce sustainability
- Nursing workforce safe staffing levels
- Facilities fit for purpose

55.2 The Board noted the updated corporate risk register and the recommendations contained in the circulated report.

56. Transforming Older People's Services in Edinburgh

56.1 The Board were reminded that it had previously been agreed to bring a report to the October meeting of the Board on Older People's Services in Edinburgh. It was reported that the transformation plan developed to reshape Older People's Services in Edinburgh had been developed by the Edinburgh Integration Joint Board with support from the Scottish Government and had received bridging support in the current year of £2m to provide additional support in to the community.

56.2 The Board noted that the first step in the strategy was the investment in additional capacity to unblock re-ablement and the expansion of Gylemuir with further interim care beds which were now open. It was also planned to recruit in excess of 60 domiciliary workers to be in post by December. Further work was needed around recruitment as the current approach was not delivering the necessary numbers of staff needed.

56.3 It was noted that the prevention of early intervention agenda would also be used to support the programme and discussions were being held with the third sector to support this. Whole system capacity planning was also underway involving Health Improvement Scotland and would feed into IJB plans. In addition work was underway around commissioning services to support re-ablement.

56.4 The Board were advised that the funding from the Scottish Government was predicated on an improvement in performance being evident before Christmas and there was therefore a need to reduce delayed discharges and increase packages of care imminently. Locality managers had been appointed and the key area of focus for them would be to actively track patients in hospital and those in the community at risk of being admitted to hospital. The Board noted that an appropriate governance framework was in place.

56.5 The Board were assured that NHS Lothian, the Edinburgh IJB and the City of Edinburgh Council had endorsed the work and given their strong commitment to make the plans work.

56.6 The point was made that localities needed to be dynamic and promote care in their neighbourhoods without creating a new bureaucracy that would impede delivery. The intention was to empower people to deliver services through the devolution of power.

56.7 The Board were advised in terms of recruitment and retention of additional staff that the key issue was about retaining staff and this would be addressed in part by valuing people in terms of career development.

57. Date and Time of Next Meeting

57.1 The next meeting of the Board would be held between 9.30 – 12.30 on 2 December, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

58. Invoking Standing Order 4.8

58.1 The Chairman sought permission to invoke standing order 4.8 to allow a meeting of Lothian NHS Board to be held in private. The Board agreed to invoke standing order 4.8.

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LOTHIAN NHS BOARD MEETING

RUNNING ACTION NOTE

1.2

Action Required	Lead	Due Date	Action Taken	Outcome
Workforce Risk Assessment				
• Further consideration is needed in a future paper around overall developments, staffing, culture & values and their impact on individual areas including service redesign.	**AB**	Autumn 2014	*This work will be undertaken in the HR&OD Strategy which will come to the Board following consideration by the Staff Governance Committee.*	**In progress**
• The Medical Director and Director of Human Resources & Organisational Development would take away the points raised and come back with proposals about how scope the job offer to candidates to make the posts as attractive as possible.	**AB/DF**	TBC	*A paper on recruitment will be discussed at the Staff Governance Committee and then taken to the Board*	**In Progress**
Financial Position				
• Finances / LRP to be discussed at a future development session.	**SG**	Ongoing	*Further detailed review and discussion at F & R Committee and future Board Development Sessions.*	**In progress**
Integrating Children Services in Lothian (02/04/14)				
• Formal consultation on the proposals to be undertaken between May & July 2014.	**AMcM**	July 2014	*Paused whilst the review of the model of integration in Edinburgh is complete, but work has been done and we can go to consult quickly post decision re adult services.*	**Paper to March Special Board Session**
Integration Update (25/06/14)				
• Update report to future Board meetings.	**AMcM**	Ongoing		

Action Required	Lead	Due Date	Action Taken	Outcome
Revised Corporate Communications Strategy (25/06/14)				
• Arrange further discussion either at a development session or at a future Board meeting.	**AB**	Ongoing	*Paper to future Board meeting.*	
• Discuss investments and outcomes at the November Board Seminar.	**JC**	December 2014	*Full update report on Board agenda. Investments and outcomes that were discussed at the November Board Seminar.*	
Complaints Function (3/12/2014)				
• A review of the complaints functions was being undertaken to a tight timescale with the intention being to bring a paper to a future Board meeting to cover all of the complaints issues and to agree with the Board the level of granularity and frequency of future dedicated complaints papers to the full Board.	**AB**		*The complaints review is ongoing and on schedule. The report is due at the end of January 2015. progress has been reported to the Healthcare Governance Committee. Workshops have been organised for February. This work is on target for the April Board meeting.*	**In Progress**
Improving Older People's Care in Edinburgh - 2015/2017 (24/06/2015)				
• A definitive strategy and costed action plan to be developed by September and presented to the Board in October 2015.	**AMcM**	September 2015		**Paper to Board in October**
Delayed Discharges (05/08/2015)				
• Provide more detail on the lack of availability of care packages, particularly identifying if the problem was a recruitment or a budget issue	**AMcM**	Ongoing		
Workforce Risk Assessment(05/08/2015)				
• provide further details on practices that were facing workforce challenges and the work that was underway to support sustainability as well as information on other professions such as healthcare scientists and GP recruitment.	**DF**	September 2015	*Now addressed in the current report.*	

Action Required	Lead	Due Date	Action Taken	Outcome
Consent Agenda (05/08/2015)				
• Bring forward proposals for a review of the Consent Agenda process.	**BH**	September 2015	*Process of evaluation underway*	
Review of Medical Paediatric Inpatient Services (05/08/2015)				
	JC	Mid 2016	*Update reports to Board future meetings*	

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NHS LOTHIAN

1.3

Board Meeting
2 December 2015

Chairman

BOARD DEVELOPMENT SESSIONS 2016

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board agree the programme of Development Sessions for 2016.

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

2 Recommendations

2.1 Agree the provisional programme of Development Sessions for 2016 detailed in Appendix 1. The programme may be subject to variation by agreement with the Board during the year, dependent upon emerging issues throughout the year.

3 Discussion of Key Issues

3.1 The Programme of Development sessions requires to be agreed so that arrangements can be put in place for 2016.

3.2 The development sessions in the past have been used as briefing sessions or for advance discussions of issues which would subsequently be discussed at a public Board meeting. To date there has been relatively little focus on the "development" of the Board and how it functions. Future development sessions will therefore be topic specific with the topic acting as a focus on how the Board works. This will need some reflection and planning in advance of each development session with the topic lead and the Chair and Chief Executive.

3.3 The following two overarching questions should be explicitly addressed during the development sessions across each of the topics:

- What is the role of the NHS Board in relation to the topic and has it changed in the context of the functions delegated to the Integration Joint Boards?
- How can the new approach to our quality management system play a role in helping with this topic?

Douglas Weir
Corporate Services Manager
17 November 2015
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List of Appendices

Appendix 1: Draft Programme of Development Sessions for 2016

APPENDIX 1

2016 –Provisional Board Development Session Topics

13 January 09.30 -12.30	Financial Update	SG
2 March 09.30 – 12.30	Acute Strategy/Site master planning	AMcM
11 May 09.30 – 11.00 11.00 – 12.30	Paediatric Review Update Update on Children's Services Note date changed from 4 May	JC AMcM
20 July 09.30 – 11.00 11.00 -12.30	NHS Lothian Board Health and Safety Statutory Responsibilities/Accountabilities and Governance Requirements. Financial Update.	AB SG
7 September 09.30 – 11.00 11.00 -12.30	The Populations Health, Risks and Determinants of Health and Inequalities. Clinical Quality Improvement	AKM TD
2 November 09.30 – 12.30	Financial Update	SG

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NHS LOTHIAN

1.4

Board Meeting
2 December 2015

Chairman

SUMMARY PAPER - COMMITTEE MEMBERSHIPS AND TERMS OF REFERENCE

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

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

• To agree appointments to Board Committees	1.1
• To agree amended Terms of Reference for the Strategic Planning Committee	3

Peter Reith
Secretariat Manager
23 November 2015
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NHS LOTHIAN

Board Meeting
2 December 2015

Chairman

COMMITTEE MEMBERSHIPS AND TERMS OF REFERENCE

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the following appointments to Committees and amendments to the Terms of Reference of the Strategic Planning Committee.

- Finance & Resources Committee - Lynsay Williams from 1 February 2016 replacing Peter Johnston; Martin Hill to fill the vacancy left by Jeremy Brettell
- Staff Governance Committee - John Oates from 1 February 2016 replacing Alison Meiklejohn; Catherine Johnstone
- Audit & Risk Committee - Peter Murray from 1 February 2016 replacing Morag Bryce; Carolyn Hirst replacing Catherine Johnstone
- Healthcare Governance - Carolyn Hirst replacing Graeme Warner; John Oates
- Remuneration Committee - Lynsay Williams from 1 February 2016 replacing George Walker
- Strategic Planning Committee - Peter Murray from 1 February 2016; Martin Hill
- Acute Hospitals Committee - John Oates replacing Robert Wilson
- St John's Hospital Stakeholder Group - Lynsay Williams from 1 February 2016 replacing John Iredale
- Midlothian Integration Joint Board - John Oates from 1 February 2016 replacing Morag Bryce; Alison McCallum replacing Melanie Johnson
- West Lothian Integration Joint Board - Martin Hill replacing Alison Meiklejohn

1.2 Full Board Committee memberships are detailed in Appendix 1.

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

2 Recommendations

2.1 To agree the appointments to Committees listed in 1.1 above

2.2 To agree amended Terms of Reference for the Strategic Planning Committee (Appendix 2).

3 Discussion of Key Issues

3.1 The role, remit and membership of the Strategic Planning Committee was revised in March 2015 to take account of the establishment of four Integration Joint Boards (IJBs) in Lothian, as a result of the Public Bodies(Joint Working)(Scotland)Act 2014. This

recognised that the responsibility for strategic planning for a wide range of health services is now the responsibility of these new bodies, while NHS Lothian retains responsibility for planning for those acute hospital services, and other services which are not delegated through the four Integration Schemes. Lothian NHS Board approved the new Terms of Reference (TOR) at its meeting on 1 April 2015.

3.2 Further review has now taken place on the advice of the Head of Corporate Governance to:

1. Clearly specify the remit of the Committee in relation to integration functions separately from its remit for non-delegated functions
2. Set out the integration functions of IJBs, which include planning, directing and performance management
3. Set out the Committee's role to provide assurance that there are systems in place to provide the IJBs with information,
4. Set out the Committee's role to be assured that IJB directions are being complied with, and that NHS Lothian strategies and service change plans reflect the requirements of the four IJB strategic plans and directions, and are aligned to the delivery of the stated outcomes.
5. Set out the Committee's role in overseeing the development of the new Lothian Quality Management System as the central pillar of our organisational development strategy over the next 5 years.

3.3 These points are now reflected in sections 1.1-1.8 of the attached revised Terms of Reference (Appendix 1)

3.4 The Committee's remit with regard to those functions which are not delegated to IJBs is covered in sections 1.9-1.16 of the revised remit. This includes reference to monitoring the implementation of corporate objectives and Lothian NHS Board's performance in relation to the Local Delivery Plan and HEAT targets.

3.5 Specific reference is also made to overseeing the strategic plans developed by the Edinburgh Integrated Children's Services Board (section 1.10). The recently confirmed purpose and remit of this Partnership Board are attached for information (Appendix 2).

3.6 It is proposed to revise the membership to include two members from each Integration Joint Board, one from NHS Lothian and the other from the relevant local authority. One of the members will be a non-executive board member (who is not the local authority stakeholder representative on the Health Board), while the other will be one of the local authority councillor members (who may or may not be the local authority stakeholder representative on the Lothian NHS Board).

3.7 It is further proposed to restrict the number of executive members to the six officers listed (section 2.2). It is anticipated that other officers of the Board and of IJBs will continue to attend as appropriate to the agenda.

4 Key Risk

4.1 If appointments are not made to these Committees there may be problems in achieving a quorum.

5 Risk Register

5.1 There are no implications for NHS Lothian's Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 Not required as this is an administrative matter.

7 Involving People

7.1 The members and Committee Chairs involved have been consulted by the Chairman.

8 Resource Implications

8.1 There are no resource implications.

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30 November 2015
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List of Appendices

Appendix 1: Committee Memberships
Appendix 2 Strategic Planning Committee Revised Terms of Reference
Appendix 3: Edinburgh Integrated Children's Services Board Terms of Reference

APPENDIX 1

BOARD COMMITTEE MEMBERSHIPS

2015/16

Finance & Resources *(Quorum 3 non-Executives)*	**Staff Governance** *(Quorum 2 non-Executives)*	**Audit & Risk** *(Quorum 3 non-Executives)*	**Healthcare Governance** *(Quorum 3 non-Executives)*	**Remuneration** *(Quorum 3 non-Executives)*	**Strategic Planning** *(Quorum 3 non-Executives)*	**Acute Hospitals** *(Quorum 2 non-Executives)*
7 Non Executive 4 Executive	4 Non Executive 3 Executive	3-6 Non Executive	5 Non Executive	5 Non Executive	9 Non Executive	6 Non-Executive 2 Executive
George Walker (Chair) Peter Johnston (Vice Chair)(to 31/01/16) *Brian Houston* *John Iredale* Kay Blair Martin Hill Ricky Henderson Lynsay Williams (from 01/02/16) Tim Davison David Farquharson Susan Goldsmith Alex McMahon	*Alex Joyce (Chair)* *Brian Houston* Donald Grant Peter Johnston Catherine Johnstone Alison Mitchell John Oates (from 01/02/16) Alan Boyter David Farquharson Alex McMahon	Julie McDowell (Chair); Michael Ash Morag Bryce (to 31/01/16) Donald Grant Carolyn Hirst Alison Mitchell Peter Murray (from 01/02/16)	Morag Bryce (Chair)(to 31/01/16) Shulah Allan Carolyn Hirst *Alex Joyce* *Alison Meiklejohn* John Oates Frank Toner Richard Williams	*Brian Houston* (Chair) Michael Ash Alex Joyce Julie McDowell George Walker (to 31/01/16) Lynsay Williams (from 01/02/16)	*Brian Houston* (Chair) *Mike Ash* *Kay Blair* *Martin Hill* *John Iredale* Peter Johnston *Alex Joyce* *Alison Meiklejohn* Peter Murray (from 01/02/16) *George Walker*	Kay Blair (Chair) Alex Joyce Alison Meiklejohn Alison Mitchell George Walker John Oates David Farquharson Alex McMahon

Names in italics are ex-officio

30 November 2015

STRATEGIC PLANNING COMMITTEE
(Revised Terms of Reference December 2015)

1 Context

1.1 Integration of Health & Social Care

The NHS Board, through integration schemes, will delegate some of its functions to four Integration Joint Boards (IJB). Before the functions are delegated each IJB must prepare and approve the strategic plan for those functions ("integration functions") which will determine how those functions are to be carried out in the local authority area before 1 April 2016 ("the start day"). Consequently Lothian NHS Board is no longer responsible for preparing the strategic plan for those integration functions, and the terms of reference of the Strategic Planning Committee now reflects this.

A key objective is to ensure that each IJB has access to the information it requires in order to carry out all of its responsibilities for the integration functions. Members of IJBs will be members of this committee. The Committee must ensure that when any business is discussed, it is clear when it relates to integration functions, and when it does not. Within that if any business specifically relates to a particular IJB or IJBs, this should also be clear.

1.2 Lothian Quality Management

Lothian NHS Board has committed to the development and deployment of a total quality management approach to the delivery of healthcare. Based on principles of optimising patient outcomes through quality and cost optimisation, this system will be led by clinicians using trained and professionally supported teams and detailed data analytics. This will become the management approach to the development and ongoing operation of our healthcare system.

Strategy formulation, planning and performance management must be shaped to enable and drive this system.

2 Committee's Remit with Regard to "Integration Functions"

2.1 To be assured that each IJB is provided with such information as the IJB may reasonably require to:

- Prepare its Strategic Plan;
- Determine whether to issue a direction and;
- Determine what the content of any direction should be.
- Review its Strategic Plan
- Prepare its Performance Report

The above will include providing information in a manner that will allow the IJB to have regard to:

- The integration delivery principles
- The national health & wellbeing outcomes
- The needs of localities within each local authority area
- The effect that the IJB's strategic plan may have on services, facilities and resources that will be used by other IJBs in carrying out their strategic plans.

2.2 To be assured that the health board is co-operating with each local authority in relation to the efficient and effective use of resources (including in particular buildings, staff and equipment) in implementing the integration schemes.

2.3 To recommend to the Lothian NHS Board who should be the Board's nominee onto each of the IJBs' strategic planning groups.

2.4 To consider the consultation drafts of any IJB Strategic Plans, and prepare and submit the response to those drafts on behalf of Lothian NHS Board.

2.5 To be assured that the health board is complying with all of the directions of all IJBs, and that information is available to IJBs so that they may monitor the implementation of their respective strategic plans.

2.6 To lead on any situation whereby the health board considers that any IJB strategic plan is preventing the health board from carrying out any of its functions inappropriately, or in a way which complies with the integration delivery principles and contributes to the national health & wellbeing outcomes.

2.7 In the event that the health board proposes to take a decision that it considers might significantly affect the provision of a service relating to an integration function within a locality, to be assured that those affected are involved and consulted on the decision.

2.8 To be assured that all NHS Lothian strategies and service change plans reflect the requirements of the four IJB strategic plans and directions, and are aligned to the delivery of the outcomes set out therein.

<u>Committee's Remit with Regard to Functions that are not "Integration Functions"</u>

2.9 To oversee strategic planning for the health functions and services (that have not been delegated to IJBs) which are provided locally, regionally and nationally. The committee will prepare all strategies for approval by the NHS Board. This is subject to any provisions for major service change which require Ministerial approval.

2.10 As part of the above process, the committee shall consider:

- Any relevant regional (South-East and Tayside) plans.
- Any relevant national strategies, plans and directions
- The four Lothian Community Planning Partnerships Plans
- The Edinburgh Integrated Children's Services Plan
- Any other relevant plans developed through vehicles such as Children's Partnerships
- The content of any relevant and previously approved NHS Lothian strategies or plans
- The NHS Board's existing commitments to implement the directions of the four integration joint boards.

2.11 To consider and approve on behalf of the Board plans to change service models which will deliver the redesign, modernisation and integration of services required to implement approved Board strategies. This is subject to any provisions for major service change which require Ministerial approval.

2.12 To specifically seek assurance on the strategic fit (with Lothian and IJB strategic plans) of service changes which are essential components of the delivery of efficient and affordable capital and infrastructure investments prior to formal approval by Finance and Resources Committee.

2.13 To monitor the implementation of Lothian strategies.

2.14 To monitor the implementation of the Board's corporate objectives, informed by work undertaken by other committees for objectives that are directly relevant to their terms of reference.

2.15 To monitor the Board's performance against its Local Delivery Plan and HEAT targets, informed by work undertaken by other committees for performance matters that are directly relevant to their terms of reference.

3 Committee's Remit with Regard to Lothian Quality Management System

3.1 The Committee will require to consider the plans emerging from the development and deployment of the Lothian Quality Management System. It will then require to consider the development of strategic planning and management within NHS Lothian to reflect, enable and drive that system.

It is anticipated that these Terms of Reference will be further developed accordingly over the next 6 - 12 months.

4 Membership of the Committee

4.1 NHS Lothian Board wishes to operate an integrated system of governance with the four IJBs. To achieve this it is expected that this Committee will have representation from two members of each of the IJBs within its membership, one from NHS Lothian and the other from the relevant local authority. One of the members will be a non-executive Board member (who is not the local authority stakeholder representative on the Health Board), while the other will be one of the local authority councillor members of the IJB (who may or may not be the local authority stakeholder representative on the Health Board). Representation of the Acute Hospitals Committee through its Chair is equally important to promote strategic coherence and consistency across the whole system.

4.2 The Committee will comprise:

Non-Executive Board Members

- Committee Chair: Board Chairman
- Member from East Lothian IJB
- Member from City of Edinburgh IJB
- Member from Midlothian IJB
- Member from West Lothian IJB
- Chair – Acute Hospitals Committee
- Non-Executive - University of Edinburgh Stakeholder member
- Two other non-executive members of NHS Lothian Board

Executive Board Members:

- Chief Executive
- Medical Director
- Finance Director
- Director of Nursing and Allied Health Professionals
- Director, Public Health and Health Policy
- Director of Strategic Planning, Performance Reporting and Information

Additional IJB Members:

- East Lothian Councillor Member
- City of Edinburgh Councillor Member
- Midlothian Councillor Member
- West Lothian Councillor Member

All Lothian NHS Board members shall have the right of attendance and have access to papers.

Officers of the Board will be in attendance as appropriate to the agenda.

5 Frequency of Meetings

5.1 Meetings of the Committee shall normally be every two months.

6 Quorum

6.1 No business shall be transacted at a meeting of the Committee unless at least three non-executive members are present.

7 Reporting Arrangements

7.1 The Committee will report to the Board by means of submission of minutes and a summary from the chair of the Committee to the next available Board meeting. The NHS Lothian Secretariat will also routinely send the summary and the minutes to the IJBs' Secretaries and Chief Officers.

7.2 In the event that the Committee identifies an issue of direct and material relevance to an IJB, the committee chair will inform the IJB Chair and Chief Officer.

7.3 In addition to the above arrangements, each IJB will have a member on the committee, and that member will be in a position to directly report back to the IJB on the committee's activities. Each IJB will also be able to ask its own Chief Officer for further information on the carrying out of its integration functions. The committee shall respond to any further reasonable requests for information that any IJB may submit.

INTEGRATED CHILDREN'S SERVICES BOARD

Purpose and Remit

Background:

The **Integrated Children's Services Board** (ICSB) operates on a consensual basis, similar to the former Joint Board of Governance for adult services in Edinburgh. It builds on and supports the work of the successful Children's Partnership and Partnership Chief Officer Group and has oversight of all children's services within the city of Edinburgh in line with the Community Plan and Integrated Plan for Children and Young People.

(It should be noted that similar developments of integrated children's services in East, Mid and West Lothian will require to be addressed as they arise.)

Purpose

Through the development of appropriate management structures and reporting and monitoring processes, the ICSB ensures a holistic view of all children's services in Edinburgh from universal to specialist and acute services and including transition arrangements for young people moving into adult services.

The ICSB holds senior management within children's health, education and social work in Edinburgh accountable for the delivery of efficient and effective services, improved outcomes for children, young people and families in line with the requirements within the Children and Young People (Scotland) Act 2014.

The ICSB will promote effective and efficient co-production and joint commissioning processes to support service delivery where appropriate.

Remit

The work of the ICSB strengthens existing partnership working arrangements by:

- Maintaining clear oversight of the shared vision for children's services and delivery of the Integrated Plan for Children and Young People
- Ensuring a corporate approach across CEC and NHS Lothian to the delivery of children's health, social work and education services in Edinburgh
- Ensuring compliance with the statutory responsibilities within the Children and Young People (Scotland) Act and fulfilling the expectations of the Care Commission and Joint Inspectorate
- Developing a reporting framework to ensure the accountability of senior managers for their leadership of integrated service delivery across children's health, social work and education services
- Proposing and monitoring resource allocation - within the budgetary resources available to NHS Lothian and CEC - to meet joint service targets and statutory responsibilities in accordance with the Integrated Plan and to meet the requirements of the Children and Young People (Scotland) Act 2014

- Building on – and extending - the important interface with adult treatment and care services in terms of improving transition for young people into adult services and better supporting families

Membership:

Membership of the ICSB comprises:

City of Edinburgh Council:

- 3 x Elected Members
- Director of Children and Families
- Chief Social Work Officer

NHS Lothian:

- 3 x Non-Executive Members
- General Manager for Children's Services
- Child Health Commissioner
- 1x Staff Partnership representative

In attendance:

Voluntary Sector representative (through EVOC) (1)

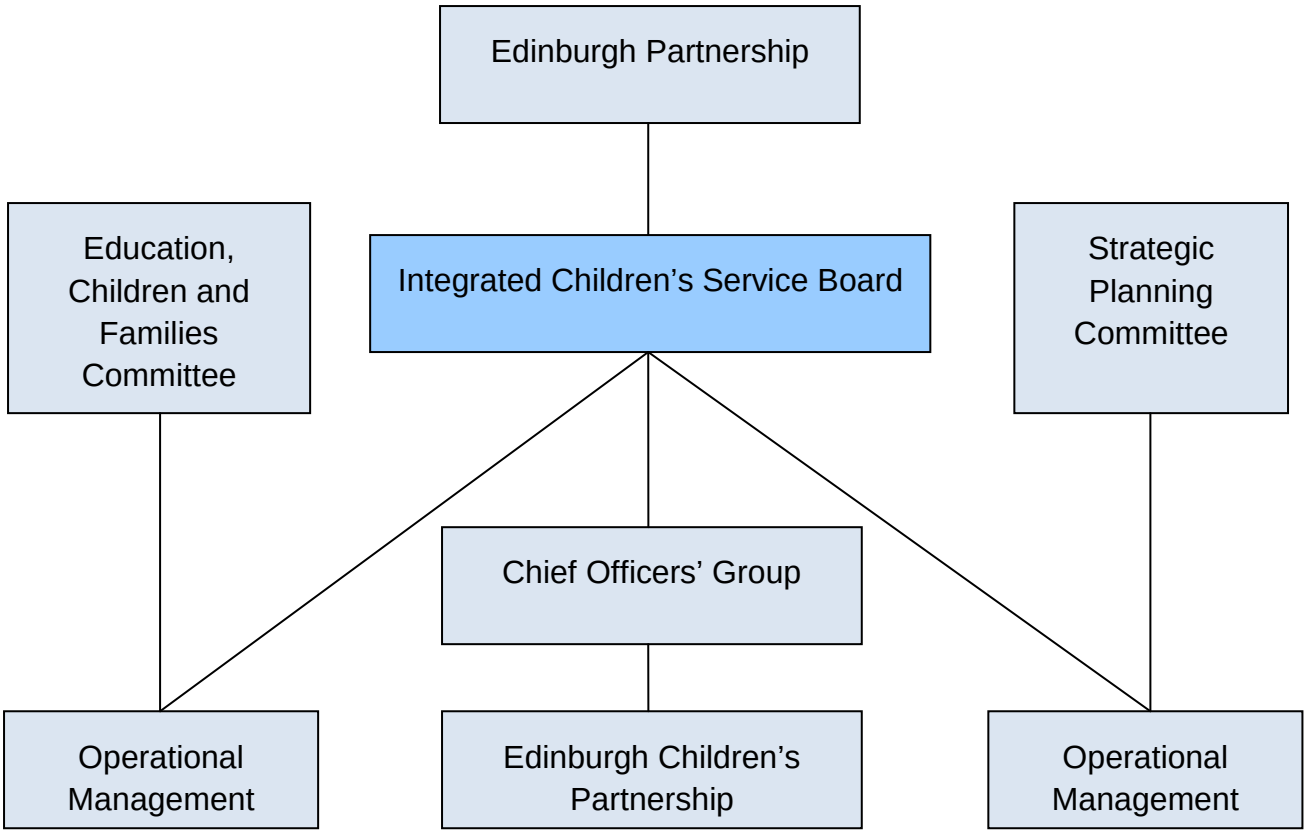
Police Scotland representative (1)

Lead Officers from NHS Lothian and CEC by agreement/as required

Meeting Structure:

- The Chair is agreed by the membership and will rotate annually between NHS Lothian and CEC
- Meetings will be held quarterly
- Secretariat functions will be jointly provided through CEC and NHS Lothian (NHS Lothian Year 1, CEC Year 2 etc)

Structural Relationships:



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NHS LOTHIAN

1.5

Board Meeting
2 December 2015

Director of Public Health & Health Policy

SUMMARY PAPER - SOUTH EAST SCOTLAND RESEARCH ETHICS COMMITTEES

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

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

• The purpose of the report is to recommend the Board accept the South East Scotland Research Ethics Committees annual reports for 2014-2015	1.1
• The UK Research Ethics Service requires NHS Research Ethics Committees to produce annual reports. These are generated by the UK Research Ethics Service database as a standard report and must be submitted to appointing authorities as set out in Governance Arrangements for Research Ethics Committees (A Harmonised Edition).	3.1
• There are minimal risks attached to the recommendation. There is a risk that NHS Research Ethics Committees become non-compliant, for example failing to act as prescribed by the UK Research Ethics Service Standard Operating Procedures. This risk is mitigated by ongoing internal Quality Control exercises and external audits	4.1
• Both South East Scotland Research Ethics Committees were audited and received full accreditation on 10/06/13. Similarly, the South East Scotland Research Ethics Service was last audited on 17/12/12 and retained its full accreditation.	4.2

Dr Alex Bailey
Scientific Officer
9 November 2015
alex.bailey@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
2 December 2015

Director of Public Health & Health Policy

SOUTH EAST SCOTLAND RESEARCH ETHICS COMMITTEES

1 Purpose of the Report

1.1 The purpose of the report is to recommend the Board accept the South East Scotland Research Ethics Committees annual reports for 2014-2015. It is a requirement for NHS Research Ethics Committees to submit standardised annual reports to their appointing authorities to demonstrate that Research Ethics Committees comply with the principles, requirements and standards set out in Governance Arrangements for Research Ethics Committees (A Harmonised Edition). Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 Approve the South East Scotland Research Ethics Committees reports for 2014-2015.

3 Discussion of Key Issues

3.1 The UK Research Ethics Service requires NHS Research Ethics Committees to produce annual reports. These are generated by the UK Research Ethics Service database as a standard report. The report incorporates the data that must be submitted to appointing authorities as set out in Governance Arrangements for Research Ethics Committees (A Harmonised Edition). The reports for South East Scotland Research Ethics Committee 01 and South East Scotland Research Ethics Committee 02 are attached as Appendix 1. These annual reports will also be sent to the UK Research Ethics Service and the Chief Scientist Office.

4 Key Risks

4.1 There are minimal risks attached to the recommendation. There is a risk that NHS Research Ethics Committees become non-compliant, for example failing to act as prescribed by the UK Research Ethics Service Standard Operating Procedures. This would expose the Board, as the appointing authority, to the risk of approving research whilst not adhering to the UK Research Ethics Service standards, of involving NHS patients in research that has not received adequate NHS ethical review and reputational risk.

4.2 This risk is mitigated by ongoing internal Quality Control exercises and external audits. The South East Scotland Research Ethics Committees undergo Quality Control checks twice a year. This involves following a nationally-prescribed Quality Control checklist that reviews a selection of research ethics applications, meetings, letters, membership and membership training, ensuring that they all comply with current UK Research Ethics Service standards. Quality Control checks are then assessed by the audit department of the UK Research Ethics Service. Any findings are incorporated into an Action Plan that the Research Ethics Committee implement and then review at

the next Quality Control Check. The UK Research Ethics Service conducts regular independent audits of both the Research Ethics Committees and the Research Ethics Service; passing the audit results in full accreditation. Both South East Scotland Research Ethics Committees were audited and received full accreditation on 10/06/13. Similarly, the South East Scotland Research Ethics Service was last audited on 17/12/12 and retained its full accreditation.

5 Risk Register

5.1 There is no requirement for risks to be added or removed from NHS Lothian's Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 Researchers must satisfy a Research Ethics Committee that the research they propose will be ethical and worthwhile, including considering the effects social inequalities may have on the research. For example, Research Ethics Committees ensure non-English speakers are not excluded from research studies by requiring researchers to incorporate the appropriate paperwork and/or translators into the research protocol. Where studies propose to use solely internet-based research materials, the Research Ethics Committee will require researchers to provide study materials suitable for those who do not have access to the internet. The Research Ethics Committees have seen an increase in the number of applications solely involving research on patient-identifiable data. The Research Ethics Committees have worked with NHS Lothian Research and Development, the Data Protection team and the Caldicott Guardian to ensure that researchers are aware of their duties and responsibilities when undertaking research on patient databases.

7 Involving People

7.1 The composition of NHS Research Ethics Committees is defined by the UK Research Ethics Service Standard Operating Procedures. These Standard Operating Procedures state that to ensure that Research Ethics Committees reflect the currency of public opinion, at least a third of Research Ethics Committees members must be lay members. Both of the South East Scotland Research Ethics Committees comply with this requirement. New members are recruited by open advertisement, as per the Nolan principles.

8 Resource Implications

8.1 There are no resource implications arising from this report or recommendations.

Dr Alex Bailey
Scientific Officer
10 November 2015
alex.bailey@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Annual reports for the South East Scotland Research Ethics Committees for 2014-2015

APPENDIX 1

Health Research Authority

National Research Ethics Service

South East Scotland REC 01

Annual Report

01 April 2014 - 31 March 2015

Part 1 – Committee Membership and Training

Name of REC:	South East Scotland REC 01
Type of REC:	Authorised
Type of Flag:	No flags
Chair:	Dr Janet Andrews
Vice-Chair:	Mr Chee-Wee Tan
Alternate Vice-Chair:	Dr Sara Smith
REC Manager:	Mrs Sandra Wyllie
Committee Address:	Waverley Gate 2 - 4 Waterloo Place Edinburgh EH1 3EG
Telephone:	0131 650 5679
Email:	sandra.wyllie@nhslothian.scot.nhs.uk

Chair's overview of the past year:

The composition of SESREC01 changed considerably at the start of this year, with some members moving to different committees and others standing down and I was delighted to be able to welcome 5 new expert members on to the committee. Sadly 2 of the lay members resigned during the course of the year, both had served on local RECs for many years and were thanked for their long service.

The newly configured committee has worked well and efficiently and I am grateful to everyone for their hard work and contributions. I would also like to thank Chee-Wee Tan who took up the role of vice-chair following the departure of the previous vice chair, for his support and hard work.

The total number of full applications reviewed by the committee was slightly down on the previous year, 47 compared to 55; and the proportionate review sub-committee looked at 14 applications compared with 17 the previous year. 83% of the full applications and 64% of the proportionate review applications were given a provisional opinion.

The average time to a final decision was 20 days for the full applications and all but one of the proportionate review applications were reviewed within 14 days. A sub-committee additionally reviewed 47 substantial amendments.

On behalf of the whole committee I would like to thank our Coordinator, Sandra Wyllie, and Scientific Officer, Dr Alex Bailey, whose commitment and hard work ensures the success and smooth running of SESREC 01.

South East Scotland REC 01 Membership

Name	Profession	Expert or Lay	Dates	
			Appointed	Left
Dr Janet Andrews	Retired Associate Specialist	Expert	31/03/2010	
Mrs Christine Beadle	Research Nurse	Expert	01/04/2014	
Dr Gail Corbett	GP Partner	Expert	01/04/2014	
Dr Kyle Gibson	CT2 Doctor (ACCS Anaesthetics)	Expert	01/04/2014	
Dr George Howat	Retired - Computing Services	Lay Plus	17/11/2009	
Dr Calum MacKellar	Director of Research	Lay Plus	01/04/2012	
Mrs Linda Morrow	Director of Community Stroke Services	Expert	02/06/2014	
Mr Andy Neustein	Retired	Lay Plus	31/03/2011	04/06/2014
Mrs Patricia Perry	Lecturer - Faculty of Health and Life Sciences.	Expert	01/10/2006	
Dr Derek Santos	Senior Lecturer - Faculty Of Health Sciences	Expert	31/05/2012	
Dr Lillian Schweizer	Retired Molecular Geneticist	Expert	01/04/2012	
Mrs Judy Scopes	Physiotherapy Manger	Expert	01/04/2011	
Dr Sandy Small	Consultant Clinical Physicist	Expert	01/05/2014	
Dr Sara Smith	Senior Lecturer- Dietetics	Expert	01/04/2011	
Dr Jill Stavert	Reader	Lay Plus	01/04/2011	
Mr Chee-Wee Tan	Lecturer in Physiotherapy	Expert	01/04/2012	
Mr Warwick Taylor	Retired	Lay Plus	01/04/2012	

South East Scotland REC 01: Deputy Members

Name	Profession	Status	Meeting date attended

South East Scotland REC 01: Co-opted Members

Name	Profession	Status	Meeting date attended

South East Scotland REC 01: Members' Declarations of Interest:

Name	Declaration of Interest	Date
Dr Janet Andrews	No declared interests	09/07/2014
Mrs Christine Beadle	Research nurse involved in various orthopaedic medical research studies.	28/04/2014
Dr Gail Corbett	None	28/04/2014
Dr Kyle Gibson	Involved in undertaking Medical Education and Intensive Care research in Edinburgh	28/04/2014
Dr George Howat	No declared interests	30/06/2014
Dr Calum MacKellar	Director of Scottish Council on Human Bioethics	16/07/2014
Mr Andy Neustein	No declared interests	18/07/2014
Mrs Patricia Perry	Lecturer of Edinburgh Napier University, School of Nursing, Midwifery and Social Care	30/06/2014
Dr Derek Santos	No declared interests	27/07/2014
Dr Lillian Schweizer	No declared interests	01/07/2014
Mrs Judy Scopes	No declared interests	09/07/2014
Dr Sandy Small	Support of research projects involving DEXA or Nuclear Medicine within NHS Lothian. I will act as the MPE for research projects which involve diagnostic or therapeutic Nuclear Medicine and as such may be involved in the establishment of diagnostic and therapeutic protocols. Any research project which requires involvement with ARSAC is likely to involve me in a capacity ensuring the most clinically effective use of radioactive materials.	12/05/2014
Dr Sara Smith	No declared interests	25/06/2014
Dr Jill Stavert	Director, Centre for Mental Health, Incapacity,Law Rights and Policy (Edinburgh Napier University)Director of Scottish Universities Law Institute Member of Public Policy Committee - Alzheimer Scotland Member of Faculty (Business School) Research Integrity Committee Leader of Law Research Group - Edinburgh Napier University Scottish Association for Mental Health	09/07/2014
Mr Chee-Wee Tan	Convener, Research Ethics Panel, Queen Margaret University.	18/01/2015

Meetings for Full Ethical Review 01 April 2014 - 31 March 2015:

Month	Date	Number of Members Present at Meeting
April	09/04/2014	10
May	07/05/2014	13
June	04/06/2014	11
July	09/07/2014	11
September	10/09/2014	12
October	08/10/2014	10
November	05/11/2014	12
December	03/12/2014	11
January	14/01/2015	8
February	11/02/2015	11
March	11/03/2015	10

11 full committee meetings were held during the reporting period.

Proportionate Review Sub-Committee Meetings held during 01 April 2014 - 31 March 2015:

Month	Date	Number of Members Present at Meeting
April	16/04/2014	3
May	09/05/2014	3
May	20/05/2014	3
June	18/06/2014	3
June	25/06/2014	3
August	13/08/2014	3
November	05/11/2014	5
November	14/11/2014	2
December	16/12/2014	3
December	19/12/2014	3
March	27/03/2015	3

11 proportionate review sub-committee meetings were held during the reporting period.

Sub-Committee Meetings held during 01 April 2014 - 31 March 2015:

Month	Date	Number of Members Present at Meeting
April	02/04/2014	2
April	23/04/2014	2
April	30/04/2014	2
May	07/05/2014	3
May	14/05/2014	2
May	29/05/2014	2
June	05/06/2014	2
June	18/06/2014	2
June	24/06/2014	2

July	08/07/2014	2
July	20/07/2014	2
July	22/07/2014	2
August	11/08/2014	2
August	13/08/2014	3
August	27/08/2014	2
September	17/09/2014	2
September	24/09/2014	2
October	29/10/2014	2
November	19/11/2014	2
November	26/11/2014	2
December	03/12/2014	2
December	10/12/2014	2
December	15/12/2014	2
December	30/12/2014	2
January	12/01/2015	2
February	06/02/2015	2
February	11/02/2015	2
February	24/02/2015	2
March	02/03/2015	2
March	19/03/2015	2

30 sub-committee meetings were held during the reporting period.

Details of inquorate meeting held: 01 April 2014 - 31 March 2015

Date	Reason	Action taken

Attendance of Members at full committee meetings: 01 April 2014 - 31 March 2015

Name	Number of Meetings Attended
Dr Janet Andrews	10
Mrs Christine Beadle	10
Dr Gail Corbett	7
Dr Kyle Gibson	6
Dr George Howat	10
Dr Calum MacKellar	5
Mrs Linda Morrow	7
Mr Andy Neustein	3
Mrs Patricia Perry	7
Dr Derek Santos	6
Dr Lillian Schweizer	4
Mrs Judy Scopes	6
Dr Sandy Small	10
Dr Sara Smith	7
Dr Jill Stavert	5
Mr Chee-Wee Tan	8
Mr Warwick Taylor	8

Attendance of Members at proportionate review sub-committee meetings: 01 April 2014 - 31 March 2015

Name	Number of Meetings Attended
Dr Janet Andrews	2
Mrs Christine Beadle	1
Dr Kyle Gibson	1
Dr Calum MacKellar	2
Joanne Mair	2
Mr Lindsay Murray	8
Dr Lillian Schweizer	1
Mrs Judy Scopes	4
Dr Sandy Small	1
Dr Sara Smith	2
Mr Chee-Wee Tan	1
Mr Warwick B Taylor	1
Dr Louisa Wilson	8

Attendance of Members at sub-committee meetings: 01 April 2014 - 31 March 2015

Name	Number of Meetings Attended
Dr Janet Andrews	26
Dr Gail Corbett	1
Dr Sara Smith	6
Dr Jill Stavert	1
Mr Chee-Wee Tan	29

Training 01 April 2014 - 31 March 2015

Name of Member	Date	Event(s) attended
Mrs Christine Beadle	20/06/2014	Induction
Mrs Christine Beadle	20/03/2015	Helping you to submit a successful NHS Research Ethics Application
Dr George Howat	10/09/2014	The Mental Health (Scotland) Bill
Dr George Howat	27/01/2015	UK BioBank Lecture
Dr George Howat	27/03/2015	Children and Young Persons and Mental Health
Mrs Linda Morrow	20/06/2014	Mandatory - Induction training
Mrs Linda Morrow	17/11/2014	NRS Conference
Mrs Linda Morrow	04/02/2015	Informed Consent
Mrs Patricia Perry	27/06/2014	General Comment Article 12 UN Convention on the Rights of Persons with Disabilities: Implications for Scotland
Dr Derek Santos	10/07/2014	Modern Research Governance
Mrs Judy Scopes	19/06/2014	Assessing the Consequences (benefits and harms) of Research: a Health Research Authority workshop
Dr Sandy Small	20/06/2014	Mandatory - Induction training
Mr Chee-Wee Tan	10/07/2014	Modern Research Governance
Mr Chee-Wee Tan	08/01/2015	Training for new REC Chairs

PART 2: REC WORKLOAD AND ACTIVITY DURING THE REPORTING PERIOD

Table 1: Applications assigned to a full committee meeting held within the reporting period:

Applications for full ethical review – Study Type	Number	%
Clinical Trial of Investigational Medicinal Product	0	0.00
Phase 1	0	0.00
Gene Therapy	0	0.00
Research Tissue Bank (including renewals)	0	0.00
Research Database (including renewals)	0	0.00
Others	47	100.00
Total Applications Reviewed	**47**	**100**

Table 2: Breakdown of full applications and other activity during reporting period

Number of applications made invalid by the REC Manager	0
Number of applications withdrawn prior to the meeting	2
Number of student applications reviewed	23
Number of paediatric applications reviewed	4
Number of device applications reviewed	3
Number of prisoner applications reviewed	2
Number of applications involving adults unable consent reviewed	0
Number of applications reviewed that are funded by the US DHHS	0
Number of qualitative applications reviewed	8

Table 3: Decisions given at meetings held within the reporting period

Decisions taken at meetings following review of applications	Number	%
Favourable Opinion with Standard Conditions	1	2.13
Favourable Opinion with Additional Conditions	3	6.38
Unfavourable Opinion	4	8.51
Provisional Opinion	39	82.98
Provisional Opinion Pending Consultation with Referee	0	0.00
Total	**47**	**100**
Number of studies sent back to full committee meeting for final opinion	1	

Table 4: **Summary of current status of applications reviewed during the reporting period**

Status of applications at date of generation of report	Number	%
Further Information Favourable Opinion with Standard Conditions	27	57.45
Further Information Favourable Opinion with Additional Conditions	11	23.40
Further Information Unfavourable Opinion	1	2.13
Favourable Opinion with Standard Conditions	1	2.13
Favourable Opinion with Additional Conditions	3	6.38
Unfavourable Opinion	4	8.51
Provisional Opinion	0	0.00
Provisional Opinion Pending Consultation with Referee	0	0.00
Further Information response not complete	0	0.00
No decision entered on system	0	0.00
Number of studies withdrawn after the meeting	0	0.00
Total	**47**	**100**

Table 5: **Applications assigned to a proportionate review sub-committee within the reporting period**

Total Applications Reviewed	**14**

Table 6: **Breakdown of PRS applications and other activity during reporting period:**

Number of applications made invalid by the REC Manager	5
Number of studies withdrawn prior to the meeting	3
Number of student applications reviewed	7
Number of paediatric applications reviewed	2
Number of device applications reviewed	0
Number of qualitative applications reviewed	2

Table 7: **Decisions given at proportionate review sub-committee meetings held within the reporting period**

Decisions taken at proportionate review sub-committee meetings	**Number**	**%**
Favourable Opinion with Standard Conditions	1	7.14
Favourable Opinion with Additional Conditions	2	14.29
No Opinion transfer to full committee for review	0	0.00
Provisional Opinion	9	64.29
Unfavourable Opinion	1	7.14
Total	**14**	**100**

Table 8: **Other Management Information for the reporting period:**

Average number of applications reviewed per full meeting	4.27
Number of applications for full ethical review	47
Number of applications for full ethical review over 60 days	0
Number of applications over 60 days as a % of total	0.00%
Number of applications for full ethical review over 40 days	0
Number of applications over 40 days as a % of total	0.00%
Number of days taken to final decision – average (mean)	20

Number of proportionate review applications for ethical review	13
Number of proportionate review applications for ethical review over 14 days	1
Number of proportionate review applications over 14 days as a % of total	7.69%

Number of SSAs (non-Phase 1) reviewed	1
Number of applications for SSA review over 25 days	0
Number of applications for SSA review over 25 days as % of all non- Phase 1 SSAs	0.00%

Number of SSAs (Phase 1) reviewed	0
Number of applications for SSA review over 14 days	0
Number of applications for SSA review over 14 days as % of all Phase 1 SSAs	0.00%

Number of substantial amendments reviewed	47
Number of substantial amendments over 35 days	0
Number of substantial amendments over 35 days as a % of total substantial amendments	0.00%
Number of substantial amendments over 28 days	0
Number of substantial amendments over 28 days as a % of total substantial amendments	0.00%

Number of modified amendments reviewed	2
Number of modified amendments over 14 days	1
Number of modified amendments over 14 days as a % of total modified amendments	50.00%

Number of minor amendments received	33
Number of substantial amendments received for information	0
Number of substantial amendments received for new sites/PIs	0
Number of annual progress reports received	37
Number of safety reports received	0
Number of Serious Adverse Events received	1
Number of final reports received	25

Table 9.1: **Breakdown of current status of all full applications reviewed within the reporting *period***

Further Information Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0059	Development of head cooling device for brain injury (Vs1)	16
14/SS/0080	SoFIA3: Sodium Fluoride Imaging of Abdominal Aortic Aneurysms	11
14/SS/0090	Childhood Epilepsy: A Qualitative Study of Children's Care Experiences	21
14/SS/0091	Mindfulness-Based Stress Reduction in Multiple Sclerosis	25
14/SS/0094	fMRI in fragile X premutation carriers	18
14/SS/1013	Cognitive change and Amyotrophic Lateral Sclerosis,(ALS)Staging	19
14/SS/1020	Optical Coherence Tomography To Detect Macrophages In Atheroma In Vivo	20
14/SS/1021	Cirrhosis screening in an alcohol support service in NE Edinburgh	23
14/SS/1047	Female intimate partner violence	19
14/SS/1049	18F-Fluoride Assessment of Aortic Bioprostheses Durability and Outcome	28
14/SS/1057	Emotional recognition and regulation in dissociative seizures	18
14/SS/1065	Emotion regulation patterns in posttraumatic stress disorder	23
14/SS/1067	Brief intervention for non-responders to bowel cancer screening	16
14/SS/1069	Care in the community for people living with advanced liver disease	15
14/SS/1081	The iSVD Study	19
14/SS/1082	Home bAsed VENtilation and quality of life: the HAVEN study	19
14/SS/1083	LRP vs RALP: a comparative study of outcomes and costs	19
14/SS/1093	An assessment of daylight PDT in the treatment of actinic keratoses	19
14/SS/1096	RAPID-CTCA	23
14/SS/1098	Exploring Resilience in People with Dementia: a Qualitative Study	20
15/SS/0014	Smoking cessation in pregnancy and social networks (SCIPS) V1.0	17
15/SS/0015	The Recovery Model for Patients within a High Secure Setting (Ver.1.)	16
15/SS/0022	Brain connections and cognition after epilepsy surgery Version 1	20
15/SS/0025	Self-stigma and making decisions about treatment	25
15/SS/0026	Vascular events In Surgery patIents cOhort evaluatioN (VISION)	24
15/SS/0029	KissPOS study	22
15/SS/0040	Tracking Endothelial cells in vascular injury	19

Further Information Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0061	Fear of falling in adults over 65 Version 1	23

14/SS/0076	Barriers in the Highlands	18
14/SS/0086	Opptimum Genetics	24
14/SS/1100	Women's decision-making regarding place of birth	22
15/SS/0009	MRI of the Pancreas in T1DM	17
15/SS/0010	Patients' Experiences of Hepatitis C and its Treatment v.1	19
15/SS/0013	Exploring the recovery process after experiencing interpersonal trauma	16
15/SS/0019	Feasibility of a software app for detecting inattention in delirium	25
15/SS/0021	Exploring the experiences of patients treated for anal cancer	25
15/SS/0037	Ultrasound Visual Biofeedback for Speech Sound Disorders in Children	24
15/SS/0041	Validation Study of the EMAS: A Brief Screening Tool for Motor Changes	24

Further Information Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1019	Hepatitis C treatment outcomes in prison versus community settings	20

Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1092	Dementia & Institutionalisation: Discharge from Hospital to Care Home	16

Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0057	Decision Navigation in diabetic foot ulcer patients: a pilot study	17
14/SS/0065	Subclinical peripheral neuropathy and effect on proprioception	15
15/SS/0035	Self-Compassion, Self Esteem and Chronic Pain Ver 0.5	20

Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0058	fMRI in fragile X premutation carriers	15
14/SS/1002	Time to Listen.	13
14/SS/1099	Greyzone Resistance and Flow with 3T MRI (GRAFT STUDY)	16
15/SS/0024	Bespoke vs Standard Instrumentation in TKR	19

Provisional Opinion		
REC Reference	**Title**	**Number of Days on Clock**

Provisional Opinion Pending Consultation with Referee		
REC Reference	**Title**	**Number of Days on Clock**

Further information response not complete		
REC Reference	**Title**	**Number of Days on Clock**

Withdrawn after the meeting		
REC Reference	**Title**	**Number of Days on Clock**

Table 9.2: **Breakdown of current status of all PRS applications reviewed within the reporting period**

Further Information Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0087	PR - Haemoglobin at birth and longterm outcome	8
14/SS/1014	PR - Experiences of the 27-30 month Child Health Surveillance Programme	12
14/SS/1015	PR - Laryngopharyngeal reflux.. assessment of a Cellular model	7
14/SS/1016	PR - DISH	8
14/SS/1038	PR - Bookstart Bump RCT	18
14/SS/1084	PR - Core clinical outcomes for glaucoma trials: patients' perspectives	14
14/SS/1085	PR - Learning from successful wards to improve patient safety.	14
14/SS/1112	PR - Ethnic variability in nerve conduction studies (Student Study) v.1	7

Further Information Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0083	Keele Aches and Pains Study	12

Further Information Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**

Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1039	PR - Development of a novel screen for leukaemogenic reintegration	7

Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0099	The urinary metabolic response to endurance exercise	3
15/SS/0063	Follow up CBT for anxiety and depression in adults with ID - V1	11

Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**
15/SS/0062	Better monitoring of Erythropoietin supported renal failure patients	8

Provisional Opinion		
REC Reference	**Title**	**Number of Days on Clock**

Further information response not complete		
REC Reference	**Title**	**Number of Days on Clock**

Withdrawn after the meeting		
REC Reference	**Title**	**Number of Days on Clock**

Table 10.1: **Breakdown of current status of all substantial amendments reviewed within the reporting period**

Favourable opinion				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
08/S1101/9/AM14	Beverages consumed by patients with alcohol-induced illnesses			5
08/S1101/9/AM14	Beverages consumed by patients with alcohol-induced illnesses		27/12/2014	5
09/S1101/54/AM07	Mild Stroke Study II		23/05/2014	10
11/SS/0006/AM01	Influence of a negative FOBt on response to symptoms		08/05/2014	7
12/SS/0108/AM03	Testing HPV activity in LBC samples using a novel biomarker set		12/09/2014	5
12/SS/0158/AM02	Multimodal brain imaging study in autism spectrum disorder - Version1		07/07/2014	1
12/SS/0186/AM01	Pro-inflammatory lung dendritic cells in severe RSV bronchiolitis		23/09/2014	0
12/SS/0234/AM01	Memory complaints in epilepsy:the role of mood and illness perceptions		14/04/2014	7
13/SS/0017/AM02	TST version 1		14/07/2014	2
13/SS/0017/AM03	TST version 1		09/01/2015	11
13/SS/0019/AM02	EAGLE		28/03/2014	3
13/SS/0054/AM01	MPFL Reconstruction VS Patellar Realignment for Patellar Instability		25/03/2014	8
13/SS/0095/AM03	Side Effects of Opioids Study (SEOS)		24/10/2014	3
13/SS/0099/AM03	Cognition & AEDs		04/11/2014	13
13/SS/0100/AM01	Elastic therapeutic taping and exercises for joint hypermobility pilot		08/09/2014	3
13/SS/0102/AM02	Fatigue in Patients with Glioma(Version 1.0)		04/02/2015	6
13/SS/0120/AM01	Demotivation in Dementia: development and validation of a new scale		23/05/2014	2
13/SS/0120/AM02	Demotivation in Dementia: development and validation of a new scale		14/11/2014	7
13/SS/0129/AM01	Epigenetics of Haematological disorders using B-CLL as a model		14/12/2014	7
13/SS/0176/AM01	Cortisol Pulsatility in Pregnancy (PIPa)		18/06/2014	3
13/SS/0176/AM02	Cortisol Pulsatility in Pregnancy (PIPa)		19/12/2014	4

13/SS/0179/AM02	Barriers and facilitators to physical activity in schizophrenia		06/06/2014	9
13/SS/0193/AM01	Preliminary testing of a novel device to detect epileptic seizures.		06/08/2014	6
13/SS/0206/AM01	COPD and respiratory rate monitoring (phase 2)		27/03/2014	6
13/SS/0231/AM01	Patient Concern in Brain Tumour Patients Version 1		18/07/2014	13
13/SS/0231/AM02	Patient Concern in Brain Tumour Patients Version 1		24/11/2014	2
13/SS/0234/AM01	PR - COQOL multi-centre surgical validation study		10/06/2014	7
13/SS/0239/AM01	CALCIVIS CARIES ACTIVITY IMAGING SYSTEM - POST APPROVAL STUDY		04/08/2014	1
13/SS/0248/AM02	Vitamin D and Colorectal Cancer Susceptibility Genetic Variants V1		11/08/2014	3
14/SS/0007/AM01	Barriers to recovery in people discharged from a medium-secure unit		21/04/2014	6
14/SS/0024/AM01	Intensive Communication Groups for people with Aphasia - a follow-up		28/05/2014	3
14/SS/0043/AM01	COPD and respiratory rate monitoring (phase 3)		11/11/2014	2
14/SS/0076/AM01	Barriers in the Highlands		04/06/2014	1
14/SS/0080/AM02	SoFIA3: Sodium Fluoride Imaging of Abdominal Aortic Aneurysms		01/07/2014	1
14/SS/0080/AM03	SoFIA3: Sodium Fluoride Imaging of Abdominal Aortic Aneurysms		03/02/2015	3
14/SS/0080/AM04	SoFIA3: Sodium Fluoride Imaging of Abdominal Aortic Aneurysms		17/03/2015	9
14/SS/0090/AM01	Childhood Epilepsy: A Qualitative Study of Children's Care Experiences		18/12/2014	16
14/SS/0091/AM05	Mindfulness-Based Stress Reduction in Multiple Sclerosis		23/02/2015	7
14/SS/1016/AM01	PR - DISH		06/11/2014	11
14/SS/1020/AM01	Optical Coherence Tomography To Detect Macrophages In Atheroma In Vivo		18/09/2014	2
14/SS/1021/AM02	Cirrhosis screening in an alcohol support service in NE Edinburgh		07/01/2015	1
14/SS/1021/AM03	Cirrhosis screening in an alcohol support service in NE Edinburgh		05/02/2015	10
14/SS/1049/AM01	18F-Fluoride Assessment of Aortic Bioprostheses Durability and Outcome		01/12/2014	4
14/SS/1067/AM01	Brief intervention for non-responders to bowel cancer screening		28/11/2014	10

14/SS/1096/AM02	RAPID-CTCA		11/02/2015	11

Unfavourable opinion				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
09/S1101/67/AM08	DREAM Study		27/11/2014	8
13/SS/0077/AM02	Barriers and facilitators to smoking cessation		29/04/2014	2
14/SS/0061/AM01	Fear of falling in adults over 65 Version 1		11/12/2014	11

Table 10.2: **Breakdown of current status of all modified amendments reviewed within the reporting period**

Favourable opinion timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
09/S1101/67/AM08/1	DREAM Study		18/12/2014	20
13/SS/0077/AM02/1	Barriers and facilitators to smoking cessation		12/05/2014	0

Unfavourable opinion timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**

Table 11: **Items exceeding timelines**

Full applications for ethical review over 60 day timeline		
REC Reference	**Title**	**Number of Days on Clock**

Proportionate review applications for ethical review over 14 day timeline		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1038	PR - Bookstart Bump RCT	18

SSAs (non Phase 1) over 25 day timeline		
REC Reference	**Title**	**Number of Days on Clock**

SSAs (Phase 1) over 14 day timeline		
REC Reference	**Title**	**Number of Days on Clock**

Substantial Amendments over 35 day timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**

Modified Amendments over 14 day timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
09/S1101/67/AM08/1	DREAM Study		18/12/2014	20

NHS
Health Research Authority

National Research Ethics Service

South East Scotland REC 02

Annual Report

01 April 2014 - 31 March 2015

Part 1 – Committee Membership and Training

Name of REC:	South East Scotland REC 02
Type of REC:	Authorised
Type of Flag:	None
Chair:	Mr Thomas Russell Ms Joanne Mair
Vice-Chair:	Professor Lindsay Sawyer
Alternate Vice-Chair:	Ms Joanne Mair Mr Lindsay Murray
REC Manager:	Ms Joyce Clearie
Committee Address:	2 - 4 Waterloo Place Edinburgh EH1 3EG
Telephone:	0131 650 5679
Email:	joyce.clearie@nhslothian.scot.nhs.uk

Chair's overview of the past year:

Over the past 12 months the work of the Committee has continued at a high standard. I would like to thank all the members of SESREC02 for their hard work throughout the year reviewing applications and for adapting to the new review template.

In total the Committee reviewed 42 applications, 38 amendments and 5 modified amendments.
The average review time for full applications was 16 days, with about a third of applications getting a final opinion at the meeting.

I have been ably assisted by Professor Lindsay Sawyer who is Vice-Chair and Lindsay Murray who is the Alternate Vice-Chair and who handles the proportionate reviews. I would like to offer a special thanks to them for their very valuable and prompt assistance.

As a new REC Chair I would like to extend my thank to the Committee, to Joyce Clearie, our Committee Coordinator, for all her efforts which were essential to the smooth running of the Committee and to Alex Bailey, for guiding through this new role.

South East Scotland REC 02 Membership

Name	Profession	Expert or Lay	Dates	
			Appointed	Left
Dr Balkishan Agrawal	General Practitioner	Expert	01/04/2010	
Mr William Farquhar	Retired	Lay Plus	01/04/2010	
Rev Denise Herbert	Priest	Lay	01/04/2012	
Mrs Alanah Kirby	Senior Lecturer	Expert	01/04/2014	
Dr Yann Maidment	General Dental Practitioner	Expert	01/04/2011	
Ms Joanne Mair	Research Facilitator	Lay Plus	01/04/2012	
Mr Lindsay Murray	Health & Safety Manager	Lay Plus	01/04/2014	
Mr Hugh Olson	Lawyer	Lay Plus	01/04/2012	
Dr Lynne Philip	General Practitioner	Expert	01/04/2011	
Mr Alec Richard	Researcher	Expert	01/04/2012	
Mr Thomas Russell	Retired Consultant Neurosurgeon	Expert	01/04/2008	15/07/2014
Professor Lindsay Sawyer	Professor Emeritus	Lay	01/04/2010	
Mrs Anne Tod	Retired	Lay Plus	01/04/2012	31/12/2014
Dr Hester Ward	Public Health Consultant	Expert	01/04/2011	
Mrs Louisa Wilson	Clinical Research Manager	Lay	01/04/2012	
Mrs Helen Wright	Pharmacy Assessor	Expert	01/04/2012	

South East Scotland REC 02: Deputy Members

Name	Profession	Status	Meeting date attended

South East Scotland REC 02: Co-opted Members

Name	Profession	Status	Meeting date attended

South East Scotland REC 02: Members' Declarations of Interest:

Name	Declaration of Interest	Date
Dr Balkishan Agrawal	No Declared interests	30/04/2014
Mr William Farquhar	Committee member Crossroads Care	30/04/2014
Rev Denise Herbert	None	23/04/2014
Mrs Alanah Kirby	No declared interests for 2014-2015 signed 25/6/2014	25/08/2014
Dr Yann Maidment	No Declared interests	01/04/2014
Ms Joanne Mair	Involved in Research with Univ of Edinburgh sometimes involves NHS Research Manager	02/05/2014
Mr Lindsay Murray	Member of Branch Council The Society of Biology (Scotland Branch)	23/04/2014
Mr Hugh Olson	No declared interests	23/04/2014
Dr Lynne Philip	No declared interests	01/04/2014
Mr Alec Richard	Annual Declaration 2014-2015 Edinburgh Napier University involvement declared in University Research Ethics Committee and Business School Faculty Research Ethics Committee	26/08/2014
Mr Thomas Russell	Member of MOD REC	01/04/2014
Professor Lindsay Sawyer	Pension may hold assets - likly to be involved in research. Occasional peer review for journals and grant agencies	30/04/2014
Dr Hester Ward	UNICEF and Friends of the Earth Scotland membership, and Scottish Health technologies Group, Member	30/07/2014
Mrs Louisa Wilson	No declared interests	27/05/2014
Mrs Helen Wright	No declared interests	23/04/2014
Mrs Helen Wright	No declared interests	19/01/2015

Meetings for Full Ethical Review 01 April 2014 - 31 March 2015:

Month	Date	Number of Members Present at Meeting
April	23/04/2014	11
May	21/05/2014	14
June	25/06/2014	9
July	30/07/2014	13
August	20/08/2014	9
September	24/09/2014	8
October	22/10/2014	13
November	19/11/2014	14
December	17/12/2014	10
February	25/02/2015	11
March	25/03/2015	10

11 full committee meetings were held during the reporting period.

Proportionate Review Sub-Committee Meetings held during 01 April 2014 - 31 March 2015:

Month	Date	Number of Members Present at Meeting
September	24/09/2014	3
October	07/10/2014	3
February	25/02/2015	3

3 proportionate review sub-committee meetings were held during the reporting period.

Sub-Committee Meetings held during 01 April 2014 - 31 March 2015:

Month	Date	Number of Members Present at Meeting
April	03/04/2014	2
April	17/04/2014	2
April	22/04/2014	2
May	01/05/2014	2
May	14/05/2014	2
May	20/05/2014	2
May	27/05/2014	2
June	18/06/2014	2
June	26/06/2014	2
July	14/07/2014	2
August	07/08/2014	2
August	08/08/2014	2
August	18/08/2014	3
September	04/09/2014	2
September	29/09/2014	3
October	07/10/2014	3
October	22/10/2014	3

November	05/11/2014	3
November	06/11/2014	3
November	12/11/2014	3
November	18/11/2014	3
November	25/11/2014	3
November	28/11/2014	2
December	03/12/2014	3
December	16/12/2014	3
December	22/12/2014	2
January	07/01/2015	2
January	13/01/2015	2
January	19/01/2015	2
January	23/01/2015	2
January	30/01/2015	2
February	10/02/2015	2
February	18/02/2015	2
February	25/02/2015	2
March	18/03/2015	2

35 sub-committee meetings were held during the reporting period.

Details of inquorate meeting held:01 April 2014 - 31 March 2015

Date	Reason	Action taken

Attendance of Members at full committee meetings: 01 April 2014 - 31 March 2015

Name	Number of Meetings Attended
Dr Balkishan Agrawal	10
Mr William Farquhar	10
Rev Denise Herbert	8
Mrs Alanah Kirby	8
Dr Yann Maidment	10
Ms Joanne Mair	7
Mr Lindsay Murray	11
Mr Hugh Olson	3
Dr Lynne Philip	11
Mr Alec Richard	7
Mr Thomas Russell	2
Professor Lindsay Sawyer	9
Mrs Anne Tod	5
Dr Hester Ward	8
Mrs Louisa Wilson	8
Mrs Helen Wright	5

Attendance of Members at proportionate review sub-committee meetings: 01 April 2014 - 31 March 2015

Name	Number of Meetings Attended
Ms Joanne Mair	2
Mr Lindsay Murray	3
Mrs Louisa Wilson	3
Mrs Helen Wright	1

Attendance of Members at sub-committee meetings: 01 April 2014 - 31 March 2015

Name	Number of Meetings Attended
Ms Joanne Mair	19
Mr Lindsay Murray	22
Mr Thomas Russell	7
Professor Lindsay Sawyer	33

Training 01 April 2014 - 31 March 2015

Name of Member	Date	Event(s) attended
Dr Balkishan Agrawal	20/06/2014	NRES INduction Training
Dr Balkishan Agrawal	26/03/2015	Ethics Update
Mr William Farquhar	26/03/2015	Ethics Update
Rev Denise Herbert	12/03/2015	Mason institue lecture - Baby Making
Mrs Alanah Kirby	08/09/2014	Helping you to submit a successful NHS Research Ethics Application
Mrs Alanah Kirby	16/09/2014	Handling Health related findings in research workshop
Mrs Alanah Kirby	26/03/2015	Ethics Update
Dr Yann Maidment	26/03/2015	Ethics Update
Mr Lindsay Murray	30/07/2014	SDL May to July 2014
Mr Lindsay Murray	18/08/2014	WTCRF seminar - Clincal R&D IN the Lothian's An introduction to ACCORD(Academic and Central Office)
Mr Lindsay Murray	20/08/2014	SDL
Mr Lindsay Murray	05/09/2014	Helping you submit a successful NHS research ethics application
Mr Lindsay Murray	24/09/2014	SDL August September
Mr Lindsay Murray	20/03/2015	Helping you to submit a successful NHS Research Ethics Application
Mr Lindsay Murray	26/03/2015	Ethics Update
Professor Lindsay Sawyer	26/03/2015	Ethics Update
Dr Hester Ward	26/03/2015	Ethics Update
Mrs Louisa Wilson	26/03/2015	Ethics Update

PART 2: REC WORKLOAD AND ACTIVITY DURING THE REPORTING PERIOD

Table 1: Applications assigned to a full committee meeting held within the reporting period:

Applications for full ethical review – Study Type	Number	%
Clinical Trial of Investigational Medicinal Product	0	0.00
Phase 1	0	0.00
Gene Therapy	0	0.00
Research Tissue Bank (including renewals)	0	0.00
Research Database (including renewals)	0	0.00
Others	42	100.00
Total Applications Reviewed	**42**	**100**

Table 2: Breakdown of full applications and other activity during reporting period

Number of applications made invalid by the REC Manager	0
Number of applications withdrawn prior to the meeting	4
Number of student applications reviewed	15
Number of paediatric applications reviewed	6
Number of device applications reviewed	10
Number of prisoner applications reviewed	0
Number of applications involving adults unable consent reviewed	0
Number of applications reviewed that are funded by the US DHHS	0
Number of qualitative applications reviewed	3

Table 3: Decisions given at meetings held within the reporting period

Decisions taken at meetings following review of applications	Number	%
Favourable Opinion with Standard Conditions	1	2.38
Favourable Opinion with Additional Conditions	9	21.43
Unfavourable Opinion	3	7.14
Provisional Opinion	29	69.05
Provisional Opinion Pending Consultation with Referee	0	0.00
Total	**42**	**100**
Number of studies sent back to full committee meeting for final opinion	0	

Table 4: **Summary of current status of applications reviewed during the reporting period**

Status of applications at date of generation of report	Number	%
Further Information Favourable Opinion with Standard Conditions	25	59.52
Further Information Favourable Opinion with Additional Conditions	3	7.14
Further Information Unfavourable Opinion	0	0.00
Favourable Opinion with Standard Conditions	1	2.38
Favourable Opinion with Additional Conditions	9	21.43
Unfavourable Opinion	3	7.14
Provisional Opinion	1	2.38
Provisional Opinion Pending Consultation with Referee	0	0.00
Further Information response not complete	0	0.00
No decision entered on system	0	0.00
Number of studies withdrawn after the meeting	0	0.00
Total	**42**	**100**

Table 5: **Applications assigned to a proportionate review sub-committee within the reporting period**

Total Applications Reviewed	**4**

Table 6: **Breakdown of PRS applications and other activity during reporting period:**

Number of applications made invalid by the REC Manager	0
Number of studies withdrawn prior to the meeting	0
Number of student applications reviewed	0
Number of paediatric applications reviewed	1
Number of device applications reviewed	0
Number of qualitative applications reviewed	0

Table 7: **Decisions given at proportionate review sub-committee meetings held within the reporting period**

Decisions taken at proportionate review sub-committee meetings	**Number**	**%**
Favourable Opinion with Standard Conditions	0	0.00
Favourable Opinion with Additional Conditions	3	75.00
No Opinion transfer to full committee for review	0	0.00
Provisional Opinion	1	25.00
Unfavourable Opinion	0	0.00
Total	**4**	**100**

Table 8: **Other Management Information for the reporting period:**

Average number of applications reviewed per full meeting	3.82
Number of applications for full ethical review	42
Number of applications for full ethical review over 60 days	0
Number of applications over 60 days as a % of total	0.00%
Number of applications for full ethical review over 40 days	0
Number of applications over 40 days as a % of total	0.00%
Number of days taken to final decision – average (mean)	16

Number of proportionate review applications for ethical review	4
Number of proportionate review applications for ethical review over 14 days	0
Number of proportionate review applications over 14 days as a % of total	0.00%

Number of SSAs (non-Phase 1) reviewed	2
Number of applications for SSA review over 25 days	0
Number of applications for SSA review over 25 days as % of all non- Phase 1 SSAs	0.00%

Number of SSAs (Phase 1) reviewed	0
Number of applications for SSA review over 14 days	0
Number of applications for SSA review over 14 days as % of all Phase 1 SSAs	0.00%

Number of substantial amendments reviewed	38
Number of substantial amendments over 35 days	0
Number of substantial amendments over 35 days as a % of total substantial amendments	0.00%
Number of substantial amendments over 28 days	0
Number of substantial amendments over 28 days as a % of total substantial amendments	0.00%

Number of modified amendments reviewed	5
Number of modified amendments over 14 days	0
Number of modified amendments over 14 days as a % of total modified amendments	0.00%

Number of minor amendments received	11
Number of substantial amendments received for information	0
Number of substantial amendments received for new sites/PIs	0
Number of annual progress reports received	35
Number of safety reports received	0
Number of Serious Adverse Events received	0
Number of final reports received	4

Table 9.1: **Breakdown of current status of all full applications reviewed within the reporting *period***

Further Information Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0066	The long term follow up of medically disordered offenders	10
14/SS/0068	TMS and Attentional Bias in Functional Motor Disorder.	11
14/SS/0069	OCT in hypertension & CKD	16
14/SS/0085	Exploring obese women's perception of risk during childbirth (vers 1)	10
14/SS/0093	A rehabiliation therapy for post-stroke fatigue	25
14/SS/0098	Clinical Investigation ReLEx hismile - version 1.2 dated 17/01/2014	13
14/SS/1010	MRI markers of neurobehavioural impairment in early onset epilepsy v1	16
14/SS/1025	SUPPORT-HF 2 study, v 1.0	17
14/SS/1028	CVLA Study - Capillary and Venous Lactate Agreement	15
14/SS/1030	Caring for a baby with drug withdrawal symptoms. Version One	16
14/SS/1031	STOPPIT-2	17
14/SS/1032	Preventing early unplanned hospital readmission after critical illness	18
14/SS/1040	Long-term outcome of non-operatively managed Scheuermann’s Kyphosis V1	19
14/SS/1041	Cardiac MR Phosphorous Spectroscopy in Breast Cancer Patients	19
14/SS/1062	eSMART Study	21
14/SS/1070	Good Lives Model: Piloting a tool to measure treatment fidelity.	18
14/SS/1089	Physical activity enhancing programme in patients with COPD	17
14/SS/1105	MBT Staff intervention in a low secure Forensic setting. Ver: 1.0	16
14/SS/1106	Brain development in neonates born to mothers prescribed methadone. V1	18
14/SS/1107	Executive functioning deficits in dementia and carer intervention: v1	16
14/SS/1110	Cardiac biOMarkers in Patients with Aortic StenosiS (COMPASS)	12
15/SS/0033	Self-compassion in adolescents experiencing emotional distress	17
15/SS/0055	Contrast Enhanced Magnetic Resonance Elastography in Renal Transplant	19
15/SS/0056	The Intensive Care Muscle Imaging ('I C Muscle') Study	14
15/SS/0057	GI CHARACTER	18

Further Information Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0092	Social-Emotional Processing & Depression: A Cross-Cultural Comparison	16
14/SS/1068	Lycra garments for children with cerebral palsy - version 3	20
15/SS/0058	Bespoke vs Standard Instrumentation in TKR	14

Further Information Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**

Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**
15/SS/0031	HIV anonymous seroprevalence survey in Lothian	10

Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1022	BMEA study: Electro-acupuncture (EA) and chronic pelvic pain (CPP)	15
14/SS/1050	MRI assessment for beta-blockers in portal hypertension	19
14/SS/1072	Psychological factors in acne: A focus on psychological trauma	16
14/SS/1073	Influence of physical impairment on language functions. Version 1.	14
14/SS/1088	LCDC Lung Cancer Discrete Choice Study	15
14/SS/1108	Calcaneal Fracture Study. Version 1	16
14/SS/1109	The Breast Surgery BetaScope and Specimen Analyser study, Version 1	14
15/SS/0028	Televent study	16
15/SS/0049	Pierre Robin Sequence	11

Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/0081	Clinical Investigation ReLEx hismile - version 1.2 dated 17/01/2014	16
14/SS/0088	Electro-acupuncture (EA) and chronic pelvic pain (CPP)	16
15/SS/0048	Emotion Regulation & Reactivity to Daily Stress in Young People	19

Provisional Opinion		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1090	Integrated informatics-imaging approaches to cardiovascular disease	n/a

Provisional Opinion Pending Consultation with Referee		
REC Reference	**Title**	**Number of Days on Clock**

Further information response not complete		
REC Reference	**Title**	**Number of Days on Clock**

Withdrawn after the meeting		
REC Reference	**Title**	**Number of Days on Clock**

Table 9.2: **Breakdown of current status of all PRS applications reviewed within the reporting period**

Further Information Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1071	An Investigation into the Mechanism of Inhalational Cough Challenge	8

Further Information Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**

Further Information Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**

Favourable Opinion with Standard Conditions		
REC Reference	**Title**	**Number of Days on Clock**

Favourable Opinion with Additional Conditions		
REC Reference	**Title**	**Number of Days on Clock**
14/SS/1058	Immunity to respiratory tract pathogens-version 1	8

14/SS/1059	The Acromegalic Arthropathy Study	8
15/SS/0036	ABIRISK MS	10

Unfavourable Opinion		
REC Reference	**Title**	**Number of Days on Clock**

Provisional Opinion		
REC Reference	**Title**	**Number of Days on Clock**

Further information response not complete		
REC Reference	**Title**	**Number of Days on Clock**

Withdrawn after the meeting		
REC Reference	**Title**	**Number of Days on Clock**

Table 10.1: **Breakdown of current status of all substantial amendments reviewed within the reporting period**

Favourable opinion				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
10/S1102/24/AM04	The role of fibrosis in aortic stenosis		18/03/2014	5
10/S1102/43/AM07	Scottish COmputed Tomography of the HEART (SCOT-HEART) Trial		07/04/2014	3
10/S1102/72/AM01	The Neurological Voice Project		24/11/2014	11
12/SS/0048/AM02	Investigating visual binding and acetylcholinesterase inhibitors		23/10/2014	1
12/SS/0055/AM04	Imagin'. Version 1		03/02/2014	10
12/SS/0151/AM03	Viking Health Study - Shetland		21/03/2014	11
12/SS/0151/AM04	Viking Health Study - Shetland		31/07/2014	2
12/SS/0183/AM02	Macrophages for Regenerative Medicine in Cirrhotics		28/01/2015	12
12/SS/0199/AM03	USPIO Assessment of Inflammation Post Acute Myocardial Infarct		11/08/2014	7
12/SS/0199/AM04	USPIO Assessment of Inflammation Post Acute Myocardial Infarct		14/10/2014	6
12/SS/0202/AM02	Double Loop Ureteral Stent Study - DUDLUIV1201EC		07/01/2014	16
12/SS/0205/AM02	Angiogenesis and Fibrosis following Myocardial Infarction		08/10/2014	1
13/SS/0062/AM02	FDG-PET/CT Imaging to assess lung inflammation in COPD patients.		06/03/2014	7
13/SS/0079/AM01	Hypertonic saline nasal irrigation for the common cold		06/10/2014	3
13/SS/0079/AM02	Hypertonic saline nasal irrigation for the common cold		17/02/2015	1
13/SS/0089/AM01	MR elastography and modelling in abdominal aortic aneurysm	1	10/11/2014	11
13/SS/0122/AM01	Outcome Measures for Amputees - A Repeatability Study		06/06/2014	19
13/SS/0135/AM08	CHE01 - Chronic Dysphagia Pilot Study		08/05/2014	4
13/SS/0143/AM01	Neurogenetics and epigenetics of preterm brain injury	1	23/09/2014	6
13/SS/0151/AM01	Sunlight and eczema		21/02/2014	1
13/SS/0155/AM01	Videoconference for Families/Children with Additional Support Needs	AMO1SA1	14/11/2014	3
13/SS/0195/AM01	ChILD-EU Database and Observational Study		19/05/2014	8
13/SS/0235/AM02	TOUCH Real-time Tissue Imaging Device Study		19/08/2014	3
13/SS/0242/AM01	The role of brown adipose tissue in humans		25/03/2014	28
13/SS/0242/AM02	The role of brown adipose tissue in humans		05/11/2014	1
14/SS/0085/AM01	Exploring obese women's perception of risk during childbirth		11/06/2014	7

	(vers 1)			
14/SS/0098/AM01	Clinical Investigation ReLEx hismile - version 1.2 dated 17/01/2014		12/12/2014	4
14/SS/1030/AM01	Caring for a baby with drug withdrawal symptoms. Version One		24/02/2015	0
14/SS/1032/AM01	Preventing early unplanned hospital readmission after critical illness		03/03/2015	8
14/SS/1062/AM01	eSMART Study		04/03/2015	12
14/SS/1072/AM01	Psychological factors in acne: A focus on psychological trauma		15/12/2014	2
14/SS/1110/AM01	Cardiac biOMarkers in Patients with Aortic StenosiS (COMPASS)			6
14/SS/1110/AM01	Cardiac biOMarkers in Patients with Aortic StenosiS (COMPASS)	1	27/01/2015	6

Unfavourable opinion				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
13/SS/0018/AM01	Social Cognition in mentally disordered offenders with schizophrenia.		05/11/2014	6
13/SS/0135/AM07	CHE01 - Chronic Dysphagia Pilot Study		19/03/2014	7
13/SS/0142/AM01	Interpersonal Psychotherapy for Depression with Female Offenders		04/12/2014	6
13/SS/0164/AM01	Patient Information Navigation Service Evaluation Study (MCS Scotland)		14/07/2014	7
13/SS/0195/AM03	ChILD-EU Database and Observational Study		15/12/2014	21
13/SS/0235/AM01	TOUCH Real-time Tissue Imaging Device Study		01/04/2014	14

Table 10.2: **Breakdown of current status of all modified amendments reviewed within the reporting period**

Favourable opinion timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
13/SS/0142/AM01/1	Interpersonal Psychotherapy for Depression with Female Offenders		15/01/2015	4

13/SS/0164/AM01/1	Patient Information Navigation Service Evaluation Study (MCS Scotland)		23/09/2014	12
13/SS/0195/AM03/1	ChILD-EU Database and Observational Study		26/01/2015	7
13/SS/0235/AM01/1	TOUCH Real-time Tissue Imaging Device Study		14/05/2014	5

Unfavourable opinion timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**
13/SS/0018/AM01/1	Social Cognition in mentally disordered offenders with schizophrenia.		26/11/2014	6

Table 11: **Items exceeding timelines**

Full applications for ethical review over 60 day timeline		
REC Reference	**Title**	**Number of Days on Clock**

Proportionate review applications for ethical review over 14 day timeline		
REC Reference	**Title**	**Number of Days on Clock**

SSAs (non Phase 1) over 25 day timeline		
REC Reference	**Title**	**Number of Days on Clock**

SSAs (Phase 1) over 14 day timeline		
REC Reference	**Title**	**Number of Days on Clock**

Substantial Amendments over 35 day timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**

Modified Amendments over 14 day timeline				
Amendment REC Reference	**Title**	**Version**	**Date**	**Number of Days on Clock**

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NHS LOTHIAN

1.6

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information/Executive Director Lead: REAS & Prison Healthcare

INTEGRATION JOINT BOARDS - STRATEGIC PLANS AND ACUTE HOSPITALS PLAN - UPDATE

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

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

• The four Lothian Integration Joint Boards (IJBs) are progressing their Strategic Commissioning Plans	3.1
• An Acute Hospital Plan is also in preparation, which will respond to IJB plans.	3.2
• The Strategic Planning Committee (SPC) will be considering the congruence of all 5 plans at a workshop on 10 December	3.3
• It is intended that the SPC considers all plans on behalf of the Board, including the financial plans, for "sign off" by March 2016 at latest.	3.4
• The Board is asked to agree to homologate the decisions of the SPC at its April 2016 meeting	3.4
• Tight timelines and financial allocation decisions may impact on current risks associated with these actions.	4

Libby Tait
Associate Director, Strategic Planning
12 November 2015
Libby.tait@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
2 December 2015

Performance Reporting & Information/Executive Director Lead: REAS & Prison Healthcare

INTEGRATION JOINT BOARDS STRATEGIC PLANS AND ACUTE HOSPITALS PLAN - UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the current progress and timelines for strategic plan development, and agree the process for formal consideration by NHS Lothian.

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

2 Recommendations

2.1 To note that the 4 Integration Joint Boards (IJBs) are working to finalise Strategic Commissioning Plans which will result in sets of 'directions' to NHS Lothian (and the respective local authorities) on the delivery of services over a 3 year period commencing 2016/2017.

2.2 To note that an Acute Hospitals Plan is also in development and will need to be informed by the IJB Plans.

2.3 To agree that the final plans and directions will be considered by the Strategic Planning Committee on behalf of the NHS Lothian Board

2.4 To confirm that the final plans with the Strategic Planning Committee's recommendations on implications for NHS Lothian are presented at the April Board for homologation.

3 Discussion of Key Issues

3.1 The four Integration Joint Boards in Lothian are progressing the development of their Strategic Commissioning Plans which will set out the priorities of the new public bodies for the period 2016-2019, and form the basis of the directions to NHS Lothian and the relevant local authority on the delivery of services delegated under the Integration Schemes. The current status of each is as follows:

3.1.1 Midlothian Partnership have completed formal consultation on their plan and will present the final plan to the Midlothian IJB on 10th December for approval.

3.1.2 Edinburgh Partnership have completed formal consultation on their plan and are developing more detailed action plans for consideration by the IJB informally during December. It is intended that the final version of the plan will be presented to the Edinburgh IJB on 11 March 2016.

3.1.3 East Lothian Partnership consulted on a version of their Strategic Plan earlier in 2015. A further draft of the plan will go to the East Lothian IJB on 26 November before a further period of public consultation until 23 January 2016. In reviewing the Strategic Plan the Partnership will take into account the feedback from the recent

Care Inspectorate Review of Older People's services in East Lothian. Following this second consultation the Plan will be brought to NHS Lothian for information before the final version is taken to the East Lothian IJB for ratification in February 2016.

3.1.4 West Lothian Partnership have developed their draft plan which is open for public consultation from 13 November till 31st December. It is intended to present the final plan to the West Lothian IJB for approval on 16 February.

3.1.5 Scottish Government regulations in relation to the Public Bodies(Joint Working) (Scotland)Act 2014 on integration of health and social care require NHS Boards to develop an Acute Hospitals Plan, to set out the strategic direction and plans for those services which are not delegated to the IJBs. The existing NHS Lothian Strategic Plan "Our Health, Our Care, Our Future" will now effectively be updated and replaced by the Acute Hospitals Plan, and the four IJB Strategic Plans as a suite of plans for health and care services across the area. An acute plan for NHS Lothian's hospital services is therefore currently being developed for consideration alongside the four IJB plans.

3.2 The Strategic Planning Committee of NHS Lothian is remitted to consider the IJB plans and other strategic plans on behalf of the Board. The Committee intends to consider all five plans and the "directions" which arise from these at a workshop meeting on 10th December. This session will include planning and finance leads from partnerships and will focus on key directions which impact on significant health service change and may involve more than one IJB as well as the Acute Hospital Division. This will allow the congruence between plans to be tested. Consideration will be given to the process for financial planning and budget setting for the IJBs and NHS Lothian, which should be fully aligned with plans for change.

3.3 It is recognised that the timelines are tight for completing all strategic plans and having sufficient clarity on the NHS budget position for 16/17 and beyond to allow supporting financial plans to be confirmed. The Strategic Planning Committee may require to hold an additional meeting in March (possibly the 17th) to allow formal "sign off" of the final position in relation to plans, directions and budgets. It is intended that the final position will be reported to NHS Lothian Board in April for homologation of the Planning Committee's decisions.

4 Key Risks

4.1 As stated above timelines are tight and there is a risk that it will not be possible to get plans and specifically the directions arising from them signed off by the 31st March. This would mean that the NHS and IJBs would go into 16/17 with uncertainty around direction and in turn funding arrangements.

4.2 There is a risk that the partners can't agree a process, principles or methodology for setting budgets and also managing current risk share arrangements across partnerships.

4.3 There is a risk that system performance may deteriorate as a result of these actions, particularly delayed discharge.

5 Risk Register

5.1 There are no new implications for NHS Lothian's risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 IJBs will have or intend to undertake impact assessments as part of finalising their strategic commissioning plans. The Acute Hospital's Plan will also be subject to an inequalities impact assessment.

7 Involving People

7.1 IJB are required to consult the local population and other stakeholders and have put in place a formal consultation process as part of developing their plans. The NHS Lothian Acute Hospital's Plan will reflect the IJB plans in relation to delegated hospital services and set aside budgets. Many aspects of the acute plan will already have been consulted on and communicated through the Our Health, Our Care, Our Future consultation. Any new proposals, and the detailed actions associated with existing acute proposals, will be the subject of appropriate public and stakeholder engagement as these are developed.

8 Resource Implications

8.1 The five plans together will set out the strategic direction of the whole NHS Lothian budget and each will therefore require to have an associated financial plan which delivers overall financial balance within NHS resources.

Libby Tait
Associate Director, Strategic Planning
12 November 2015
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ACUTE HOSPITALS COMMITTEE **1.7**

The draft minutes of the Acute Hospitals Committee held on 1 September 2015 are attached.

Key issues discussed included:

- Brief on Stroke Pathway Improvement Work - one process for all sites, new ways of working, support needed in terms of finance, data and resource. Key discussion around accountability, leadership, and what 'better' might look like and in what timeframe.
- Update on new restructuring and view from Western General on issues, challenges, progress and opportunities
- Inpatient Paediatrics Review across Lothian and the terms of reference
- Statement of Assurance Needs
- Acute Services Update, including discussion around waiting times, outpatients, endoscopy, winter planning, vascular services, review of obstetrics and gynaecology where Kay Blair is chairing the Obstetrics programme board
- Financial situation which remains challenging

Key issues on the horizon are:

- Financial challenges
- Delayed discharge
- Inpatient Paediatrics Review
- Implementation and effectiveness of new Acute Structure
- The results of the Deloitte Deep Dive exercise and better use of data and more effective pathways.

Kay Blair, Acute committee chair
8 Sept 2015

DRAFT

NHS LOTHIAN

ACUTE HOSPITALS COMMITTEE

Minutes of the Meeting of the Acute Hospitals Committee held at 2:00 pm on Monday, 1 September 2015 in the Meeting Room 5.4, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs K Blair (Chair); Dr D Farquharson; Mrs A Meiklejohn; Mrs A Mitchell and Mr G Walker.

In Attendance: Mrs S Ballard-Smith (Nurse Director – Acute Services); Ms J Brown (Associate Director, Human Resources); Mr A Bone (Finance); Mrs M Bryce (Chair, Healthcare Governance Committee); Dr B Cook (Medical Director); Mr J Crombie (Chief Officer); Mr T Davison (Chief Executive); Dr S Edgar (for item 28); Professor A McMahon (Director of Strategic Planning); Ms F Mitchell (for item 30) Mr C Stirling (Site Director, WGH) and Mr N Wilson (Unscheduled Care Manager).

Apologies for absence were received from Ms M Johnson and Mr A Joyce.

Declaration of Financial and Non-Financial Interest

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

26. Minutes of the Previous Meeting

26.1 The previously circulated minutes of the meeting held on 8 June 2015 were approved as a correct record subject to the following amendment:

Item 20.4 - It was noted that the position around endoscopy performance was disappointing. The Committee received assurance that actions to address issues had been identified and implemented and that full compliance would be achieved by the end of 2015.

27. Running Action Note

27.1 The Committee noted the previously circulated running action note and expressed concern about its content and progress. It was unclear who was responsible for ensuring the upkeep and progression of the running action note. In terms of governance, the note did not provide assurance that issues were being addressed and within agreed timescales. The Chair sought assurance that these concerns would be addressed and agreed to discuss this matter with Mr Crombie and Mr Reith out with the meeting. **KB/JC/PR**

27.2 Deloitte Deep Dive - Members noted that the Deloitte Deep Dive report would be deferred until the November meeting. **CM**

27.3 Delayed Discharges in Lothian - Members agreed it was somewhat over optimistic to expect reports to this committee from the Joint Directors in September but nevertheless sought assurance that issues were being addressed. Professor McMahon advised that following a meeting with Scottish Government colleagues he would be in a better position to provide the Committee with an update. He agreed to provide a brief electronic update in advance of the next meeting and a formal report to the November meeting. He anticipated that the report would focus heavily on the City of Edinburgh and action taken to build in recommendations from the Brian Slater report into plans for tackling Delayed Discharge across Lothian. The effect of continuing problems around delayed discharge on the acute sector were noted. The Committee wished to be kept informed of progress across Lothian. **AMcM**

27.4 Old People in Acute Care (Ombudsman Complaints) - Following the review of established cases Lynn McDonald had been charged with bringing forward a final plan that would address the 12 recommendations identified. The draft report was scheduled to go to the Acute Senior Management Team for approval before wider circulation. It was agreed that the final report would be brought forward to the November meeting for noting. **JC**

27.5 Statement of Assurance Needs - Members noted the previously circulated statement of assurance needs and the information it contained. It was agreed that Mr Wilson would ensure feedback was received from Mr Walker and that he would then discuss next steps with the Chair and Mrs Meiklejohn. **NW**

27.6 Waiting Times Governance - Mr Crombie advised that a further report was scheduled for November. Following the establishment of the Access Governance Committee, ownership had been transferred to Professor McMahon to maintain transparency in the governance process. **AMcM**

27.7 Sharing Good Practice - Mr Crombie advised the Committee of recent work with Procurement to improve the processes in theatre and how these lessons

could be shared with other theatres. It was agreed that the LRP Hub Team would produce a summarised bullet point report on work to date and identified good practice for the November meeting. **JC**

Dr Edgar entered the meeting.

28. Briefing on Stroke Pathway Improvement Work

28.1 Dr Edgar gave a brief verbal overview of the progress made to date with the stroke pathway improvement work. Dr Edgar noted real progress across Lothian following the second meeting of the collaborative team and changes to the project management processes. The main concern was the scope of the improvement work and understanding what was being asked of the collaborative. He reported that Professor Dennis had been charged with describing the process for stroke in NHS Lothian and how care could be build round that. He noted that the main challenges would be to ensure support from finance, good data and releasing time for staff to carry out the necessary work, whilst ensuring quality and consistency across the Western General Hospital, Royal Infirmary of Edinburgh and St. John's Hospital.

28.2 Members noted the complexity of the Multi-site piece of work that required clear pathways that would not disadvantage patients. Proposals to bypass accident and emergency and take stroke patients straight to a ward would require control measures for accessing beds to have a greater impact. It was anticipated that St. John's Hospital would do a double run to test the changes in a short period of time. Data from the double run would then be used to inform planning for changes across the three sites.

28.3 Dr Edgar advised the review remained in the early stages and it was important to support Professor Dennis as the review moved forward when considering with each Site Director how stroke services could be aligned across Lothian.

28.4 The debate focused on new ways of working, the need for one process for all sites, the necessity of key measures, what 'better' might look like and the need for overall management oversight. Questions were also raised about the need for effective leadership and ownership, the value of a structured plan and the need to do at least the same or hopefully "better" for less. The debate also focused on the need to identify service outcomes in addition to good processes, appropriate targets, good data and possible quick wins. Access to beds was critical.

28.5 Members expressed concerns in respect of the lack of a written report and the timeliness of the presentation. It was felt if the progress of the review was not sufficient to comment on, then the presentation should have been deferred to a later meeting. The Committee asked that, in future, those invited to present at the committee should be given a clear brief by the Executive Lead and should circulate a short but meaningful paper in advance to the committee to ensure good governance. Mr Crombie would take this forward. **JC**

28.6 In response to further questions, Dr Edgar informed the Committee about recent input from a consultancy firm and advised that Brent James would define the three measures of success as:

- How the process performs.
- Identify cost savings linked to the process.
- Service outcomes - patients and families.

28.7 The Committee agreed that a further, more detailed written update should be provided at an appropriate date. The update should focus on delivering "better' for less and how that could be achieved, clear leadership/ ownership, structured plans and appropriate timelines, how success will be measured and what indicators will be looked at.

28.8 It was noted that further similar work and approaches were planned for chemotherapy outpatients and Children and Adolescent Mental Health Services.

28.9 The Chair thanked Dr Edgar for his presentation and he left the meeting. The Chair and Mr Crombie agreed to discuss the brief for future presentations and bring forward the necessary update on the Stroke Pathway Improvement Work to a future meeting of the Acute Hospitals Committee. **JC/KB**

Ms F. Mitchell entered the meeting.

29. Western General Hospital; A View From The Bridge

29.1 The Committee noted that this was the first presentation addressing the new acute services management structure and focused on the Western General Hospital. *(Attached as Appendix 1 to these minutes.)*

29.2 Mr Stirling gave a detailed presentation on his role as the new Site Director of the Western General Hospital. He focused on the key challenges; progress made in the initial weeks of this role and how his knowledge and experience of other sites would benefit future relationships and improve joint working.

29.3 Mr Stirling noted the size of the Western General Hospital site and the impact of daily issues that impede the progress of actions tasked to the Site Directors.

He noted the challenges to restore buildings following flooding and the ongoing work to reduce the number of fire incidents and unnecessary call outs to the Fire Brigade.

29.4 Mr Stirling highlighted the structure post restructuring, and challenges such as the financial position, oncology drug and capacity pressures, bed flow, and DCN provision. Mr Stirling also highlighted current actions underway to address issues and the opportunities around the enhanced focus on quality and the IJB emergence and frailty model evolution.

29.5 The Chair thanked Mr Stirling for his informative presentation and asked if he could summarise what benefit the new structure had produced. He reported that the main benefit of the structure was a clear sense of ownership and clarity within the team.

29.6 There was some discussion on the importance of support and how resource for projects was obtained. Mr Stirling assured the Committee that, though it was challenging to identify the necessary support and although finding key individuals with the necessary skills for each project could be challenging, support from senior colleagues was strong.

29.7 Mr Stirling reported that it was a misconception that minor injuries at the Western General Hospital contributed to the issues within the hospital. In fact, the department was an exemplary service that could be utilised more if patients with those injuries could be directed away from the Accident and Emergency Department at the Royal Infirmary of Edinburgh. He reported that further areas of focus would be medical and assuring quality across the service.

29.8 The Committee discussed the cultural issues across the hospital sites and local issues associated with the Western General Hospital. Members agreed it was important to maintain staff morale and enthusiasm whilst sharing pressure within the team and across sites to sustain service levels. There was some discussion surrounding cycles of roles, identifying a ceiling volume for clinicians and the need for time for them to pursue academic interests.

Mr Stirling left the meeting.

29.9 The Chair reported that future meetings would feature presentations from each Site Director. Members agreed it would be useful to produce a formal brief for presentations. **JC**

30. Paediatric Review

30.1 The Committee received the short paper on the review of Lothian inpatient paediatric services.

30.2 The Committee discussed the proposed independent review by the Royal College of Paediatrics and Child Health and the timing implications for the release of the report and recommendations, given impending elections. Members felt that the scope of the review should produce viable recommendations across Lothian that provide a reliable, sustainable and affordable service, taking into account issues such as the current and reasonably projectable workforce levels without the continued use of Locum and agency staff, critical mass and patient forecasts concern, patient safety and good patient outcomes. It sought assurance that previous reviews and existing intelligence would be considered. It applauded the independence of the proposed review.

30.3 Members noted the importance of user and stakeholder engagement during the review. Dr Farquharson assured the Committee that as part of the review colleagues from the Royal College of Paediatrics and Child Health would hold meetings across Lothian.

30.4 The Committee agreed that the Royal College of Paediatrics and Child Health was best placed to lead the review and noted the overview of how this would be provided, subject to inclusions of their comments on the scope and outcomes of the review.

30.5 Members agreed that the terms of reference would be circulated out with the meeting for comments and approval following their review at the Healthcare Governance Committee.

Ms F Mitchell and Mr Davison left the meeting.

31. Acute Services Update

31.1 The Committee received the overview on performance and progress within the Acute Services Division.

31.2 Mr Crombie highlighted that 6,087 outpatients were currently waiting over 12 weeks compared to June's position of 4,192; members noted their disappointment at the increase in numbers. Members noted that the increase was a result of increases in referrals to outpatient services across a wide range of specialties and reductions in external support and a focus on TTG. Work to bring the rates back online was on-going.

31.3 Mr Crombie noted that he was confident that Endoscopy would be on trajectory by the end of the year following receipt of additional resources.

Mrs Ballard-Smith left the meeting.

32. Divisional Financial Performance July 2015

32.1 Mr Bone gave a detailed overview of the report. He highlighted that the financial position at the end of July 2015 showed an overspend of £4m across all services, with implications for the achievement of a break even position at the year end; that the draft quarter one review forecast a £15.2m overspend.

32.2 Members agreed that they could not accept the third recommendation to 'Develop action plans by 24 August to support delivery of year-end financial balance' and requested that it was amended to 'The Committee is asked to note the development of action plans by 24 August 2015 to support the delivery of the year-end financial balance'.

32.3 The Committee agreed to accept the report subject to the amendment of the third bullet point.

33. NHS Lothian University Hospitals and Support Services - Update on Revised Management Arrangements

33.1 Mr Crombie advised that following the proposed restructure in September, improvements should be seen thereafter.

34. Quality of Papers and Debate

34.1 Members again emphasised the need for those invited to the Committee to be given good briefs and that in terms of governance written papers should be submitted in advance. Concerns around management of the papers were also stressed. It also agreed that the presentation on "the view from the bridge at the WGH" had provided insight and similar presentations from the RIE and SJH should be scheduled for the November and March meetings. In addition Mr Crombie and Dr Farquharson would identify a suitable clinical area to present at the next meeting.

JC/DF

35. Date of Next Meeting

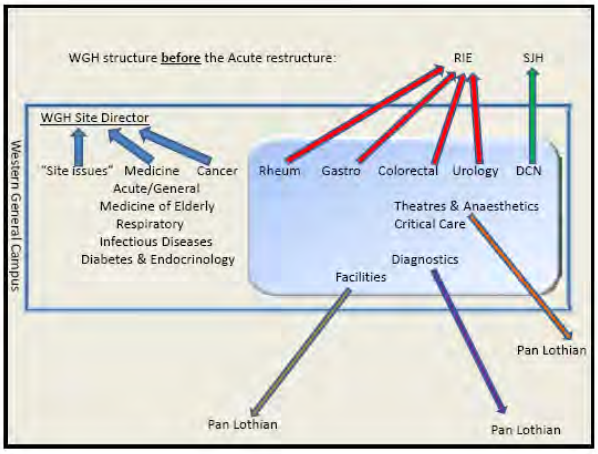
35.1 It was noted that the next meeting of the Committee would be held on Monday 30 November 2015 at 2:00 p.m. in Meeting Room 5.4 at Waverley Gate, 2-4 Waterloo Place, Edinburgh.

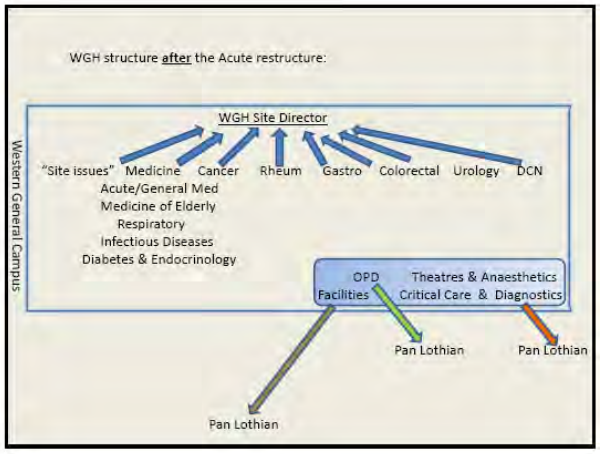
APPENDIX 1

"View from the bridge…"

Some WGH Dimensions

- Budget £151m
  - Pay 54%
  - Non pay 46%
  - Drugs budget 92% of non pay budget
- Workforce 2,115 wte
- 693 beds, 37 wards





Welcome to the WGH and the 4 Horsemen…

Floods

Fires

Plague

Pestilence

Just a few challenges…

Staff morale & engagement	Complaint & SAE backlog
Flow, boarding & bed configuration	Oncology drug & capacity pressures
TTG/OP & Cancer Access performance	Site infrastructure and building works
Finance position & LRP	Master-planning & LINAC replacement
DCN re-provision	HEI & OPAH compliance

Opportunities

- New management team
- New Partnership culture
- Brent James/Quality Academy
- Additional focus for quality
- IJB emergence / frailty model evolution
- Personal relationships with other sites

Examples of current actions

- Day of Care Audit *(2nd Sept)*
- Focus on discharge process, pre noon and discharge hub *(pre-winter by Site Team)*
- Establishing site infrastructure – quality/governance – *(end September – Associate Director of Nursing)*
- DCN reprovision work (96 weeks to go) (handover to site team 28 Aug for programme work)
- Masterplan focus on LINAC reprovision options (end Oct Cancer team)
- Oncology business case – ward 1 (end Sept Cancer team)
- TTG / OP / scopes focus (Dec/Mar trajectories – Surgical team)
- Improve the huddle process *(ongoing - Site Team)*
- Specialty discussions to improve safety / reduce boarding *(Site team and CD forum pre-winter)*
- RVH unfunded beds closed *(Site team – complete)*

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HEALTHCARE GOVERNANCE COMMITTEE **1.8**

The draft minutes of the meeting held on 22 September 2015 are attached.

1. Key issues discussed included:

1.1 Quality Improvement Team Annual Report

1.1.1 A comprehensive Quality Improvement Team update was well received and illuminated by two presentations from the Learning Disabilities QIT and the Medicine of the Elderly QIT. The impact of a robust quality improvement framework for care delivery was evident in both settings.

1.2 Person Centred Culture

1.2.1 This paper described the person centred culture programme and the changes being implemented to improve performance in the Complaints and feedback teams. While these far reaching changes would take some time to deliver improved performance, the Committee was reassured that remedial work would deliver improved performance in 2016.

1.3 Healthcare Associated Infection Improvement Plan

1.3.1 The Healthcare Associated Infection improvement plan was not discussed at this meeting due to the absence of the executive lead. This area remains a significant concern for the Healthcare Governance Committee and the recovery plan will be discussed at the meeting in November 2015.

1.4 Review of Paediatrics Services

1.4.1 The Committee was satisfied with the proposed review of paediatric services.

Dr Morag Bryce
Chair of the Healthcare Governance Committee
26 October 2015

DRAFT

NHS LOTHIAN

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 am on Tuesday 22 September 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr M. Bryce, Non-Executive Board Member (chair); Ms P. Eccles, Partnership Representative; Ms W. Fairgrieve, Partnership Representative; Mr A. Joyce, Employee Director, Non-Executive Board Member; Ms A. Meiklejohn, Chair of the Area Clinical Forum, Non-Executive Board Member; Mr A. Sharp, Patient and Public Representative; Cllr F. Toner, Non-Executive Board Member; Dr R. Williams, Non-Executive Board Member.

In Attendance: Ms J. Bennett, Clinical Governance Manager; Ms Marion Christie, Head of Health, West Lothian; Dr B. Cook, Medical Director, Acute Services; Mr J. Crombie, Chief Officer, University Hospitals Services; Dr D. Farquharson, Medical Director; Mr B. Houston, Board Chairman; Professor A. McCallum, Director of Public Health and Health Policy; Ms W. Morley, Medicine of the Elderly Consultant (item 29.1); Ms S. Morris, Community Learning Disability Nurse (item 29.1); Ms J. Morrison, Head of Patient Experience; Ms Caroline Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms B. Pillath, Committee Administrator; Dr T. Sanderson, Clinical Director, Learning Disability (item 29.1); Professor A. Timoney, Director of Pharmacy.

Apologies: Ms S. Allan, Non-Executive Board Member; Ms N. Gormley, Patient and Public Representative; Mr T. Davison, Chief Executive; Mr J. Forrest, West Lothian CHCP Manager; Ms C. Harris, Communications Manager; Ms M. Johnson, Director of Nursing; Professor A. McMahon, Director of Strategic Planning.

Chair's Welcome and Introductions

Dr Bryce welcomed members to the meeting and members introduced themselves.

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

24. Patient Story

24.1 A DVD was played in which a patient spoke about her experience of diagnosis and treatment of breast cancer. This DVD and others were recorded and would be used for staff education.

25. Committee Cumulative Action Note and Minutes from Previous Meeting (28 July 2015)

25.1 The updated cumulative action note had been previously circulated.

25.2 The minutes from the meeting held on 28 July 2015 were approved as a correct record subject to one amendment to item 19.1.1.

26. Matters Arising

26.1 Exception Reporting

26.1.1 Dr Bryce noted that some items coming to the Committee under Exception Reporting were important and felt that some consideration should be given and responses sent to authors of reports to show that their work was appreciated. She suggested that in future non-executive directors could be allocated exception reports and respond directly to the authors. This was agreed. Professor McCallum noted that feedback would be appreciated and advised that members of her team had reported to her about lack of feedback on their hard work to make improvements and raise issues. **MB**

27. Emerging Issues

27.1 Flood at Royal Victoria Hospital – Impact on Patient Care

27.1.1 Dr Farquharson advised that there had been a flood at the Royal Victoria Hospital in late August 2015 which had resulted in the evacuation of a ward to the Astley Ainslie Hospital. The evacuation went well due to the professional actions and decision making of all healthcare staff involved, including links with the Scottish Ambulance Service, and there were no adverse effects on the patients.

28. Corporate Risk Register

28.1 The updated risk register had been previously circulated. Dr Farquharson noted that the new risks identified at section 3.4 in the paper would be discussed at the Risk Management Steering Group Meeting.

29. Person Centred Culture

29.1 Quality Improvement Teams Annual Report – Primary and Secondary Care

29.1.1 Dr Sanderson and Ms Morris gave a presentation on the Learning Disability Service Quality Improvement Team. A paper had also been previously circulated. The composition of the QIT was clinical service development managers, representation from all relevant clinical professions and representation from all teams. The group initially focussed improvements on recommendation from national reviews, but now also considered ideas for improvement brought by clinicians, and used an action plan to capture this.

29.1.2 Ms Meiklejohn noted that a project on helping patients to understand information that clinicians gave them could be helpful in all services and any learning would be helpful in a wider context than just Learning Disabilities.

29.1.3 Members thanked Dr Sanderson and Ms Morris for a comprehensive and enlightening paper and presentation and commended the good work done.

29.1.4 Dr Morley gave a presentation on the Medicine of the Elderly Quality Improvement Team. Identification of possible improvements to be considered by the group was again based on project ideas from clinicians, a list of which was kept and considered at QIT meetings. Mr Houston suggested that the next step would be to identify needs using analytical diagnostic methodology to ensure all areas were covered. Ms Bennett noted that some of this was already done, for instance as part of Significant Adverse Event Reviews. It was suggested that analytical input for cost effectiveness of projects would also be beneficial and Professor McCallum advised that she would be putting Research and Development in touch with this and other QITs to help in this area. Dr Morley welcomed this.

29.1.5 Members thanked Dr Morley for her informative presentation and were encouraged by the work described.

29.1.6 The Quality Improvement Teams Annual Report had been previously circulated. Ms Bennett noted that it was important that the role of the QIT is improvement rather than providing assurance; providing assurance was done by service managers who would work to ensure that QITs had the resources and support to carry out improvements required. It was noted that QIT membership was integrated into clinicians' job plans, rather than separated. Training on quality improvement methodology was available and had been beneficial.

29.1.7 Mr Crombie noted that the report showed that good work was being done, but that there was still work required to ensure a link between senior management teams and quality improvement teams so that there was assurance, and so that problems identified by senior management teams could be solved using quality improvement and the QITs. The data on work done was voluminous and difficult to interpret overall. Dr Farquharson noted that the Clinical Quality Management approach being developed was a total approach which would link activity data from all areas with finance through clinical pathways. This could be discussed further once more had been done in this area.

29.2 <u>Person Centred Culture Programme</u>

29.2.1 A paper had been previously circulated. Ms Morrison noted that the name of the complaints team had been changed to the Patient Experience Team. Staffing problems were still being experienced with a sickness rate of 40% plus vacancies. A weekly 'huddle' had been introduced for communication amongst the team on high risk or urgent complaints and workload. Complaints numbers and data work now reviewed daily and a dashboard had been created to help categorised data by department.

29.2.2 The devolved complaints model was being piloted in the Western General Hospital, Royal Edinburgh Hospital and Associated Services, and in community facilities in the Edinburgh area. This would be evaluated and further role out considered.

29.2.3 Dr Bryce commended the work described in the report but noted that a lot more work was needed before a robust system would be in place. Key risks were resources and culture change. Ms Morrison agreed.

29.2.4 Mr Sharp asked how patient experience was captured; noting that he was regularly in hospital and had had surgery, but had never been asked to give feedback on his experience and some information leaflets available had been out of date. Ms Morrison advised that feedback could be given by writing to the team, or through the Tell Us 10 Things survey recently started but currently only used in inpatients services. Work needed to be done to ensure a more proactive and reliable approach. Ms Bennett noted that a separate Tel Us 10 Things survey was also being trialled in the Emergency Department with a slightly different question set, but that these were not yet being reliably given out. Cllr Toner noted that as there was no time or date on the survey, if they were not available at some times the results could be skewed. Ms Bennett agreed that time and day could be added to help analyse the results. Ms Christie noted that the survey was an opportunity to gather systematic feedback rather than waiting for ad hoc feedback from patients writing in.

29.2.5 Dr Williams was happy with the progress made. He noted that previously NHS Lothian had been an outlier in complaints not upheld but upheld by the Scottish Public Services Ombudsman. Ms Morrison advised that a Patient Experience Team Committee was being set up which would review these complaints systematically.

30. Safe Care

30.1 Improving Management of Significant Adverse Events

30.1.1 A paper had been previously circulated. Dr Farquharson noted that more reviews were now being closed than opened as the backlog was being cleared. Ms Bennett clarified that the paper showed adverse events with harm common categories; the categories for overall adverse events were different. For instance there were a large number of medication errors, but the majority of these did not result in harm.

30.2 Healthcare Associated Infection Improvement Plan

30.2.1 It was agreed that as Ms Johnson was not available at the meeting the Healthcare Associated Infection Improvement Plan would be discussed in full at the next meeting. **MJ**

30.3 Public Protection Update

30.3.1 A paper had been previously circulated. No issues were raised. Dr Bryce commented that the team was a good example of effective multi-agency working.

30.4 Review of Paediatrics Services

30.4.1 A paper proposing an external review of paediatrics services had been previously circulated. Mr Crombie advised that on 17 August 2015 the St John's Hospital Paediatric Inpatient service resumed 24 hour provision on the same model as prior to the change, whereby if the rota could not be covered alternative services would be considered. 28 gaps in the rota were covered by staff in September 2015, and 25 gaps will be covered in October 2015.

30.4.2 The paper proposed that an independent review of NHS Lothian Paediatric Services would be undertaken by the Royal College of Paediatrics; the proposed remit of the review was outlined; the review would include discussion with all stakeholders including the St John's Stakeholder Group, which had already been approached for suggestions of contacts, patient and carer groups, members of the public and the four local authorities. The review would be carried out before the end of 2015, so that recommendations could be reviewed early in 2016. Mr Crombie stated that this would be an opportunity to ensure that state of the art services were provided to children in Lothian. Professor McCallum stated that this was also part of a discussion about improving life chances for children and reducing socio-economic differences, and should be focussed on community services as well as hospital.

30.4.3 Dr Farquharson advised that the review team would be led by a consultant paediatrician from Poole, and other members would be a clinical director from Newcastle, a nurse practitioner from outwith Scotland and an experienced member of the Royal College of Paediatrics. The team had already started scoping for stakeholders to be engaged and were experienced in this aspect of review.

30.4.4 Cllr Toner raised a motion that the paper should include the additional recommendations that: 1) the Board give its commitment that there be no downgrade or removal of services at St John's Hospital as a result of this review; 2) that the stakeholder member of West Lothian Council be invited to attend the review group; 3) that stakeholders and the public would be fully engaged in the review at all stages. There was no seconder to support the motion and it was not upheld. The Committee agreed that to pre-empt the outcome of the review would negate its value and would be against the principles of independent review. Mr Houston also noted that this motion had been previously discussed and not upheld at the Board, when the framework of the review had been agreed. The Committee agreed that sufficient measures for stakeholder involvement in the review were already detailed in the paper and draft terms of reference.

30.4.5 The Committee supported the recommendations laid out in the paper and the draft terms of reference of the independent review by the Royal College of Paediatrics.

31. Effective Care

31.1 Quality Report

31.1.2 The report had been previously circulated. It was noted that the important issues in the report were covered on the workplan for the Committee.

31.1.3 A Hospital Standardised Mortality Ratio (HSMR) article recently published in the British Medical Journal had suggested a 10-15% increase in chance of death for patients admitted at the weekend as opposed to during the week. Dr Farquharson advised that this was using English data, and that there was no data on this in Scotland or in Lothian; in response to these concerns, this data would be collected in Lothian. The difference in chance of death was thought to be linked with senior clinician availability at weekends, but Dr Farquharson noted that the reality was much more complex, involving trained nurse numbers, community links and out of hours services.

32. Exception Reporting

32.1 General Medical Council National Training Survey

32.1.1 The survey had been previously circulated for information. Dr Farquharson noted that this was a good survey for triangulating pressure areas in the service, and advised that all but three of the cases reported in Lothian were already known about and were being worked on. The survey also stated that South East Scotland was considered to be in the top 5 UK areas for young doctors training.

32.2 Members noted the following previously circulated papers for information

32.2.1 Research Annual Report;
32.2.2 Scottish Intensive Care Society Audit Group Annual Report;
32.2.3 Lothian Viral Hepatitis Managed Care Network Annual Report;
32.2.4 Palliative Care Managed Care Network Annual Report;
32.2.5 East of Scotland Renal Transplant Service Annual Report;
32.2.6 Forensic Mental Health Services Report.

33. Other Minutes: Exception Reporting

Members noted the previously circulated minutes from the following meetings:

33.1 Area Drug and Therapeutics Committee, 14 August 2015;
33.2 Clinical Management Group, 9 June 2015, 14 July 2015;
33.3 Organ Donation Sub-Group, 13 August 2015;
33.4 Acute Hospitals Committee, 8 June 2015;
33.5 Health and Safety Committee, 28 April 2015, 28 July 2015;
33.6 Clinical Policy and Documentation Group, 3 June 2015.

34. Date of Next Meeting

34.1 The next meeting of the Healthcare Governance Committee would take place at **9.00am** on **Tuesday 24 November 2015** in **Meeting Room 7, Second Floor, Waverley Gate**.

34.2 Meetings in 2016 would take place on the following dates:
- 26 January 2016;
- 29 March 2016;
- 24 May 2016;
- 26 July 2016;
- 27 September 2016;
- 29 November 2016.

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STRATEGIC PLANNING COMMITTEE **1.9**

The draft minutes of the meeting held on 8 October 2015 are attached.

Key issues discussed included:

- An update on progress with the NHS Lothian Innovation Programme
- An update on progress with the Initial Agreement for the re-provision of Princess Alexandra Eye Pavilion
- A six month progress report on the work of the Out-patient transformation workstream.
- Progress with the appraisal of options for future provision of elective orthopaedic capacity.
- An update on national discussions on the development of Major Trauma Centres and the implications for the Royal Infirmary of Edinburgh.
- NHS Lothian Performance Delivery Reporting in 2015/16 and the interface with IJB performance reporting going forward.
- The East Lothian Integration Joint Board Draft Strategic Plan
- Revised terms of reference for the Strategic Planning Committee

Key issues on the horizon are:

- Consideration of all four IJB's strategic commissioning plans
- Consideration of "directions" to NHS Lothian arising from the IJB strategic commissioning plans
- Consideration of the development of the acute hospitals plan for Lothian

Brian Houston
Chair

Alex McMahon
Executive Lead

DRAFT

NHS LOTHIAN

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 9.30 am on Thursday 8 October 2015 in Meeting Room 7, Waverley Gate, Edinburgh EH1 3EG.

Present: Mr B Houston (Chair), Mr M Ash, Mrs A Meiklejohn and Mr G Walker.

In Attendance: Mr A Boyter, Mr C Briggs, Ms J Campbell (for item 42), Mr J Crombie, Mr G Cumming (for item 40), Mrs S Goldsmith, Ms C Harris, Professor A K McCallum, Professor A McMahon, Mrs L Tait and Mr D Weir.

Apologies for absence were received from Mrs J Anderson, Mrs K Blair, Mr T Davison, Dr D Farquharson, Professor J Iredale, Ms M Johnson, Ms C Lumsden and Mr D A Small.

36. Declaration of Financial and Non Financial Interest

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

37. Minutes of the Previous Meeting held on 13 August 2015

37.1 The Minutes of the previous meeting held on 13 August were approved as a correct record.

38. Matters Arising

38.1 St John's Hospital Master plan – It was noted that the master plan was being produced in conjunction with related work streams and would be brought back to the December meeting. **AMcM**

38.2 Learning Disabilities – East Lothian – Mr Ash advised at a meeting held the previous day it had been agreed that a contracting process would be undertaken and in the interim consideration would be given to extending the current contract. It was agreed that Professor McMahon and a team of IJB Chief Officers would progress with it being noted that each IJB would require to include proposals in their Strategic Plan. **AMcM**

38.3 Western General Hospital Master Planning Presentation – It was noted that a non-financial options appraisal regarding the expansion of linear accelerator capacity would be held on 23 October. There had been preparatory discussion with stakeholders from within NHSL and from across the SEAT region regarding the long-list of options. There had been some consideration of a possible "satellite" model, with the potential for capacity in other Board areas, but in discussion it was

noted how challenging this could be with the limited and highly specialist workforce required.

38.4 In terms of the Option Appraisal process it was noted that nationally there was a desire not to dismiss options too early and move away from a site based default. This would mean the process would commence with a long list of options not all of which would feature on the eventual short list.

39. Agenda Reordering

39.1 It was agreed to reorder the agenda to consider item11 "The NHS Lothian Innovation Programme" as the first topic followed by item 6 "Reprovision of the Princess Alexandra Eye Pavilion".

40. The NHS Lothian Innovation Programme

40.1 The Chairman welcomed Mr Cumming to the meeting advising that he would provide an update on progress with the NHS Lothian Innovation programme.

40.2 The Committee noted that the requirement to establish NHS Board Innovation Programmes had come from the Scottish Government and that interest in this area remained high. There had been recent investment of £70m backed up by a First Minister announcement. Progress to date had identified areas that were working well with it being noted there was a need to look at areas where change was not occurring as effectively as it might.

40.3 The point was made that moving forward the immediate focus should be on big opportunities and tackling wicked problems. It was noted that the outcome of a limited staff survey had suggested support for NHS Lothian to be innovative although it was noted that the culture needed to develop to support this aspiration. Other organisations were now contacting NHS Lothian seeking to work collaboratively. It was suggested there were significant innovative solutions around primary care, elective orthopaedics and data analytics especially if approached on a granular bottom up approach.

40.4 At a recent event with the City of Edinburgh Council and the Chamber of Commerce a number of companies had expressed an interest in working collaboratively with NHS Lothian in areas like digital technology. It was recognised that not all these approaches were solely about profit as some companies recognised the social values benefit of such engagement. Clinical engagement could not sit as part of a parallel process.

40.5 The Committee noted that work around Outpatients had been taken forward with a commercial partner and had culminated in a major conference which had included participation from industry. As a consequence consideration was being given on how best to engage with potential partners particularly in terms of technical time. It was felt that embedding the innovation process into the quality improvement process would allow progress to be made.

40.6 Mr Walker suggested that there was a danger of confusing service redesign with innovation. He commented that innovation was about thinking out of the box and that NHS Lothian should be seeking to engage with external companies as they were good at operating on that basis. External companies could help with the methodology of innovation as there was a danger that specific targeting could stifle the process. It would be important to avoid creating unnecessary infrastructure. It was anticipated that the innovation funnel referred to in the circulated paper would address these issues. The importance of not duplicating effort was stressed with it being noted that NHS Education Scotland was developing work around digital healthcare.

40.7 The Chairman commented that currently work was being undertaken in what was essentially a historical bureaucratic organisation and this had in large part driven the innovation approach to date to focus on behaviours and governance. He felt there was a need to move to a position of easy agile behaviours. He also felt that the key to success in future was through the quality improvement agenda which was about defining an entirely different organisation which would require a massive amount of time, energy and resource to develop.

40.8 It was noted that the Quality Academy and ongoing work with Intermountain would progress on a bottom up basis and would be driven and led by clinicians and not managers. The Chairman felt if traction could be obtained in these two areas then the question would be how to take what Mr Cumming had articulated as innovation to sit behind/underneath and alongside the quality improvement process to strengthen and empower the areas the organisation would want clinicians to lead on. There was also a need to think how best to engage with GPs given that they were small businesses.

40.9 The suggestion was made that innovation could effectively be a sub set of quality improvement with a focus on blue sky thinking. The sifting of ideas and testing of these would more appropriately sit within the Quality Academy and QI process rather than within the Strategic Planning Committee which encouraged a top down approach.

40.10 The Chairman agreed that there was a need to resolve the role of the Strategic Planning Committee in respect of the overview of innovation. Consideration needed to be given to the best mechanism for integrating innovation in the NHS in the widest sense whilst still pursuing the other business opportunities.

40.11 Professor McMahon and Mr Cumming would reflect on the comments made at the meeting and revisit where innovation would sit within the Boards governance structure in the context of wider business opportunities. An updated paper would be brought to a future meeting. **AMcM**

40.12 It was noted from the circulated paper that a number of initiatives had not been progressed as they had not been seen as a priority for the IT Department. It was questioned whether this was an appropriate response. The point was made that the biggest challenge for innovation was the development of digital technology. The IT department were working to capacity to support core business activities.

40.13 The Strategic Planning Committee agreed to support recommendation 2.1 in the paper and defer approval of recommendations 2.2 and 2.3 pending the progressing of the actions agreed at the meeting.

40.14 Mr Cumming left the meeting.

41. Re-provision of the Princess Alexandra Eye Pavilion

41.1 The Chairman welcomed Ms Campbell to the meeting advising that she would provide an update on work around the re-provisioning of the Princess Alexandra Eye Pavilion (PAEP).

41.2 The Committee noted that work around the Initial Agreement (IA) for the re-provisioning of the PAEP had been submitted to the Scottish Government following Finance and Resources Committee approval. The Scottish Government had subsequently requested that the IA be resubmitted using new draft criteria which had not yet been issued for formal implementation. Work was therefore underway with the Capital Investment Team to work through the process. It was noted that the IA had not been rejected although it had been requested in a different format.

41.3 It was reported that the Scottish Health Council were being engaged with to ensure engagement requirements were addressed through the re-provisioning process. The option of site disposal and Bio Quarter opportunities strengthened the need for appropriate guidance from the Scottish Health Council in terms of public and patient engagement.

41.4 The point was made that the new process felt similar to the former Outline Business Case model which had implications for resources as more input was needed at the early stages in the process.

41.5 It was noted although the scheme was caught between two processes the project team were keen to keep on schedule and were therefore focussed on avoiding delays. The Committee noted that there was a key role for the Communications Team in driving the process forward especially if guidance around public and patient engagement was inconclusive.

41.6 The suggestion was made that the new process might allow the Scottish Government to obtain a better sense of possible capital projects and whether they should be prioritised before they reached Business Case stage. In future there would be a need to be clear about capital priorities in Lothian given the new process and its resource implications.

41.7 Mr Walker commented that he did not feel that the Finance & Resources Committee needed to see the revised documentation as the principles had already been agreed.

41.8 The Strategic Planning Committee noted the progress being made in the PAEP re-provisioning exercise.

42. Outpatients

42.1 The Strategic Planning Committee received an update report on the Outpatient work stream which was now in month 6. The project had produced a matrix of data and details of who worked where in Outpatients. It was noted that there were 270,000 new Outpatient appointments per annum in Lothian with the corresponding number for NHS Scotland being 1.5 m. Lothian was therefore seeing a larger proportion of new appointments on a pro rata basis than the rest of Scotland. The Committee noted that 10% of new Outpatient appointments "did not attend". The key specialties for increased activity were ENT, Dermatology and Gastroenterology and a range of tools were being used to identify the reasons for the increased activity and to plot changes in referral patterns. GPs had stated that it would be helpful if they could telephone or e mail colleagues in the acute sector for referral advice. Further work was being undertaken to scope whether this would change referral patterns in a positive way. In addition a patient questionnaire had been developed to find out the reasons why patients were attending outpatient clinics and their expectations from the intervention.

42.2 The Committee noted that the point of the Outpatient exercise was to cost the workforce and ensure value for money to include the enhanced use of Allied Health Professionals (AHPs). It was noted moving to month 8 that high volume specialties would be the key area of focus. There was a need to look at redesigning the workforce to better meet the requirements of the service.

42.3 The point was made that during a Non Executive Board Member Patient Safety Programme visit it had emerged that GPs had good ideas about where better guidance could be provided and it would be useful to engage with them more proactively to identify areas they particularly wanted to discuss. It was noted that through a wider Stakeholder Group that engagement had resulted in lower back pain referrals.

42.4 It was agreed a further progress report would be submitted to the Committee in February 2016.

43. Future Provision of Elective Orthopaedic Capacity

43.1 The Committee received a report on the work that had been completed to date on considering the options for the future provision of elective orthopaedic services in line with the NHS Lothian Strategic Plan. It was noted that the outcome from the outline appraisal work had been completed with full stakeholder engagement and a more focussed and robust option appraisal would be completed by December 2015. The work stream would be considered in the context of the Royal Infirmary of Edinburgh (RIE) becoming a Major Trauma Centre, including the bringing on site of both the Royal Hospital for Sick Children and the Department of Clinical Neurosciences.

43.2 It was noted that the circulated paper addressed issues that needed to be considered through the Option Appraisal which would bring forward a preferred option for the way forward by December 2015. The potential availability of space at the Bio Quarter provided opportunities around the RIE site and clinical staff were fully engaged in these discussions

43.3 The suggestion was made that the greater centralisation of shoulder and ankle work was worth progressing. It was reported that National and Regional work was ongoing and that the planning focus had shifted to trauma centres. The Committee noted that work by Deloittes had looked at approaches for increasing throughput and efficiency for orthopaedics. It was suggested that steps to increase productivity and reduce private sector usage might be a way forward and needed to be part of the process accompanied by a proper evaluation criteria. It was noted that downstream there would be a need to plot theatre capacity at the RIE and match it to options. The outcomes of the Deloitte report pointed the system in a number of directions.

43.4 The Committee agreed the recommendations contained in the circulated report.

44. Major Trauma Centre Status

44.1 The Committee noted that the then Cabinet Secretary for Health and Well Being had announced in April 2014 that there would be a major trauma system in Scotland with 4 major trauma centres in Aberdeen, Dundee, Edinburgh and Glasgow. The announcement had indicated implementation would begin in 2016. The process of implementation had been remitted to a Major Trauma Oversight Group (MTOG) chaired by Professor McMahon with Dr Caesar attending as Clinical lead. Within SEAT (South East and Tayside Planning Group) a Regional Trauma Group was established with direct clinical and management stakeholder engagement from NHS Lothian, Borders, Fife, Forth Valley and Tayside.

44.2 A further Sub Group had been established and the work from this group had reinforced that Scotland should have one or at most two trauma centres. The initial announcement by the Cabinet Secretary had stated that the initiative would not incur additional cost although recent evidence had suggested significant costs would be incurred across Scotland. It was noted however that there had been no consistency in the way that individual centres had arrived at their castings. Mr Briggs provided the Committee with a detailed analysis of further clarity being sought around costings. It was noted that the proposed implementation date of 2016 would have both capital and workforce implications. It was noted that there was currently no national agreement about how the Major Trauma proposals would be funded.

44.3 The role of the Scottish Ambulance Service (SAS) was explained in detail in terms of the need for an effective casualty triaging protocol for where casualties would be transported to. The SAS had expressed concern about the potential impact on primary and secondary transport issues.

44.4 Mr Walker asked what provision, if any, had been made to ensure that appropriate cases were brought to Lothian by SAS, given the potential for significant activity shift as a result of this national initiative. It was explained that there had been significant work led by Lothian to ensure that all submissions worked to common assumptions and that one of these was to accommodate what was termed as “overtriage”. This referred to the reality that patients would be assessed conservatively by SAS, and with any doubt be brought to a major trauma centre. This had been estimated as being as much as 100% of the true major trauma

cases, so that 50 true major trauma cases would bring with them 50 cases which did not, post hoc, meet the criteria for major trauma. The Lothian submission included considerable provision for this overtriage.

44.5 The point was made if implementation were to happen in 2016 then consideration needed to be taken of other major initiatives coming on to the RIE site, specifically the potential for repatriation of orthopaedic activity and the impacts of moving the Royal Hospital for Sick Children and Department of Clinical Neuroscience onto the site, and that work was commencing to ensure that linkages and impacts were clear and understood. It was noted that there would be another meeting of MTOG before the next Strategic Planning Committee. Regardless of what model was adopted Edinburgh would be one of the major trauma centres and there would be a need to be aware of the financial implications around this. There would also be a need to maximise existing investment.

44.6 It was agreed further progress reports would be made to the December and February meetings of the Strategic Planning Committee and thereafter to the Finance and Resources Committee and the SEAT Group.

45. NHS Lothian Performance Delivery 2015/16

45.1 The Committee were reminded that they had agreed to take oversight of the Local Delivery Plan and Corporate Objectives. It would be important to reflect on the comments made by Mrs Blair at the Board meeting about the number of red performance areas. The Committee were advised that significant mitigating work was being undertaken around the performance areas requiring further focus although remedial action would not necessarily happen quickly.

45.2 Professor McMahon commented it would be important to highlight the wider strategy and reminded the Committee that the Annual Review had been both positive and challenging. NHS Lothian with the exception of Child Adolescent Mental Health Services (CAHMS) and Psychological Therapies was in the middle of the Scottish performance pack. It was felt to be important to reflect on this relative position. The Committee noted the appendix to the paper proposing an enhanced role for Board Committees in monitoring performance.

45.3 The point was made that there were a number of areas that NHS Lothian was not completely in control of in terms of performance delivery risks and amongst these were financial and delayed discharge issues.

45.4 The Committee agreed recommendations 2.1 - 2.3 in the circulated paper. Further discussion occurred in respect of the draft reporting template.

45.5 It was agreed in general that the proposed template was a necessary tool moving forward. The point was made that in future there would be a need for strong performance data that also met the needs of IJBs. This information should be reported back on a proactive basis and would also apply to the provision of financial information. The point was made that budgets for IJBs would need to be aligned to hospital activity as well as recognising the set aside component. There would be a need to concentrate on a few initial areas in the inaugural financial year. Mr Ash

advised he would welcome further discussion on this as any proposals would have to work for both sides of the spectrum.

45.6 It was noted that work was already underway with IJBs and the Acute Sector in respect of common performance issues. Dashboard data in future would need to be activity based. The suggestion was made that a future phase of work would be to look at population indicators and inequalities as part of the wider health inequalities agenda

45.7 Mr Walker suggested there would be benefit in each IJB having an identified lead performance contact. It was noted that the Edinburgh IJB would have a Performance Sub Committee and this would be an appropriate vehicle through which to initiate discussions. Mr Ash suggested there would be benefit in resurrecting meetings of IJB Chairs and Vice Chairs. The point was made that there was a need to reconsider how to deal with set aside budgets.

45.8 Professor McMahon advised these issues would be brought back to the next meeting and he would ensure all IJBs were aware of the proposed discussion. It was noted that Joint Directors and others had already been involved in related discussions. **AMcM**

46. East Lothian Integration Joint Board Draft Strategic Plan

46.1 Mr Ash commented that the discussion under the previous item had been helpful. He advised that the distributed paper had been consulted upon and would form the basis of a specific directions and financial document. The circulated paper set out 3 strategic intentions. Work had commenced on elements of the financial plan to include finances, adult wellbeing, health service care, hospital services and set aside budgets.

46.2 Mr Ash commented that over the course of the 3 years of the plan it would be important to show resource changes although these would probably not happen in the first year of the plan. He commented that once all of the IJB Strategic Plans were ready they should come back to the Strategic Planning Committee to check against the Strategic plan.

46.3 The Committee noted that the paper was an important document with a focus on year 1 albeit with indications for years 2 and 3. The document would be considered by the IJB Strategic Planning Committee in October with a draft plan being available before Christmas although there might be some slippage.

46.4 It was noted that a major challenge for East Lothian would be the significant growth in the over 75 and 80 year old population who would require acute care at the appropriate time. A key risk was that the 3 year plan signalled a reduction in beds and resources whereas beyond the 5 year period there was upward population trends that would need to be considered. It was suggested that the availability of the Integrated Care Fund for a 2 year period would be able to fund new services without denuding existing services.

46.5 The point was made that the growth in need and the rebalancing of services would be an increasingly difficult problem and would require data to become available as

early as possible to avoid unintended consequences. It was noted that indicative figures would be available before budgets were set. The suggestion was made that new models of care would be part of the journey and would include delivering care in the community or in step up facilities rather than acute provision.

46.6 Mr Walker agreed that cross discussion across IJBs would be important. It was noted that the Edinburgh process would conclude consultation later in the month. He commented in respect of the set aside budget that there would be difficulties around available finances and issues about slowing future growth. Concerns were expressed about the potentially destabilising effects of viring budgets from one area to another. Mr Ash suggested the issue would be about differential investment rather than reducing budgets as changing the relative balance affected investment outcomes. It was noted that the Edinburgh IJB would be holding a dedicated session on finance in December. Mr Walker commented that he worried about the set aside budget although he recognised for Edinburgh the largest immediate issue was around delayed discharges.

46.7 The point was made that addressing the needs of the most vulnerable was necessary but currently not sufficient. There was a need to look across the population to address gradients of ill health and identify where these could be slowed down. The Patient Experience and Anticipatory Care Team were looking at service provision for more vulnerable people. In the longer term there would be a need for a mechanism to "in reach" to hospitals from the community to ensure patients were treated in the most appropriate environment.

46.8 Mr Crombie advised he remained anxious and questioned what discussions were held at Council and IJB level in order to ensure activity and budgets were in line. He felt that IJBs should reduce the burden on the acute sector. Mr Crombie felt there was a need to scenario plan the use of resources and workforce to obtain the best available results.

46.9 Mr Ash commented there was an issue around encouraging more work to be do be done in primary care and the community as a result of the reconfiguration of beds/wards and also resources moving to primary care. He commented that he would welcome discussion at the next meeting around a range of issues and to agree a direction of travel moving forward.

46.10 It was agreed that the December and February meetings of the Strategic Planning Committee would focus on IJBs as a primary agenda item in order to map out future programmes. **AMcM**

47. West Lothian Integration Joint Board Draft Strategic Plan

47.1 It was noted that the first formal meeting of the West Lothian IJB had been held on 19 October with no formal feedback having been received. Professor McMahon would contact Mr Forrest and Cllr Toner and advise that more pace was needed. **AMcM**

48. Revised Terms of Reference

48.1 The proposed revised terms of reference were discussed in detail following which it was agreed that subject to small changes suggested at the meeting that they should be presented to the December Board meeting for approval. **AMcM**

49. Date and Time of Next Meeting

49.1 The next meeting of the Strategic Planning Committee would be held at 9.30 am on Thursday 10 December 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG.

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WEST LOTHIAN INTEGRATION JOINT BOARD

MEETING	KEY ISSUES	ACTION
West Lothian Integration Joint Board 20 October 2015	Standing Orders	Approved.
	IJB Membership	Noted prescribed members and agreed discretionary membership.
	Code of Conduct	Approved. Agreed appointment of a Standards Officer should be considered alongside the appointments of the Director and Finance Officer. Agreed in principle with SG proposed amendments to Regulations.
	West Lothian Integration Scheme	Noted approval and legal establishment of IJB.
	First Iteration for SPG Consultation and Comment	Noted. Agreed officers should progress with stakeholder consultation taking into account IJB comments.
	Strategic Planning Group Terms of Reference and Procedures	Approved.
	Budget and Finance	Noted.
	Workforce Development / OD Plan	Noted and agreed to support the key activities required for delivery of the plan.
	IJB Member Induction	Endorsed the proposed approach and that officers include visits / tours as part of the induction programme.
	Meeting Arrangements and Workplan	Noted and agreed.

MINUTE of MEETING of the WEST LOTHIAN INTEGRATION JOINT BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 20 OCTOBER 2015.

Present

Voting Members – Councillors Frank Toner (Chair), Alex Joyce, Danny Logue, Alison Meiklejohn, John McGinty, Anne McMillan.

Non-Voting Members – Elaine Duncan (Professional Advisor) Jane Houston (Staff Representative, NHS Lothian), Marie-Denise McKernan (Stakeholder Representative), Martin Murray (Staff Representative, West Lothian Council), Mairead Hughes (Professional Advisor).

Apologies – David Farquharson, Julie McDowell, James McCallum, Robin Strang.

In Attendance – Jim Forrest (Director), Rhona Anderson (CHCP Development, West Lothian Council), Alan Bell (Senior Manager, Communities and Information, West Lothian Council), Marion Christie (Head of Health Services), James Millar (Solicitor/Committee Services Manager, West Lothian Council), Patrick Welsh (Group Accountant, West Lothian Council), Carol Mitchell (Associate Director of Finance, NHS Lothian).

CHAIR'S OPENING REMARKS

The Chair welcomed those present to the first formal meeting of the IJB. He advised that apologies for absence from Voting Members would be dealt with at this stage in the meeting and later for Non-Voting Members. He advised that Non-Voting Members would be formally appointed later in the meeting and, thereafter, would be invited to take part in the meeting.

1. STANDING ORDERS - REPORT BY DIRECTOR

A report had been circulated by the Director providing draft Standing Orders for adoption and a suggested approach to minutes of Board meetings.

The Solicitor/Committee Services Manager recalled that a draft set of Standing Orders had previously been considered by the Shadow Board. A number of issues had been raised during discussion and it had been agreed that those issues would be considered and brought back for further discussion and decision by the Board. The draft Standing Orders now before the Board, and attached as Appendix 1 to the report, did not reflect any of the points raised by the Shadow Board. It was suggested that the present version be adopted with immediate effect, and reviewed in the spring of 2016, prior to the delegation of functions.

The Board was informed of two technical changes that had been made since the Shadow Board meeting on 25 August. In particular, it was noted that Standing Order 9.12 had been altered to match the current and

unsatisfactory regulations about withdrawing from a meeting after declaring an interest. The Scottish Government had yet to arrange for the amendment of the regulations.

Appendix 2 to the report contained a suggested approach to the preparation and wording of minutes. This approach had been recommended to the Shadow Board and it was now presented for consideration and for formal adoption.

The Director recommended that the Board:-

1. Adopt the draft Standing Orders, as contained in Appendix 1 to the report, to apply with immediate effect.

2. Agree that a further report should be brought to the Board prior to the delegation of functions to review the working of the Standing Orders and in relation to comments and suggestions made at meetings of the Shadow Board when the draft Standing Orders had been previously considered.

3. Agree the suggested approach to minutes of Board meetings, as contained in Appendix 2 to the report.

Questions raised by Board members were then dealt with by the Solicitor/Committee Services Manager.

During discussion, it was suggested that, in relation to Appendix 1, paragraph 9.1, the word “Chamber” be replaced with “Meeting Room”.

Decision

To approve the recommendations set out in the report; and

To amend the document at paragraph 9.1 to replace “Chamber” with “Meeting Room”.

2. IJB MEMBERSHIP

A report had been circulated by the Director concerning the prescribed and discretionary membership of the IJB.

The Board was informed that, under the Public Bodies (Joint Working) (Scotland) Act 2014 and associated regulations, the IJB was required to have two categories of membership:-

1. Voting – appointed by NHS Lothian and West Lothian Council.

2. Non-Voting – appointed in accordance with article 3 of the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014.

The Director recalled that, at its meeting of 2 June 2015, the Shadow IJB had noted the confirmation of the eight voting members and had agreed

that it would be appropriate for two staff members to be appointed in respect of both partner organisations engaged in the provision of the delegated services. The relevant West Lothian Council and NHS Lothian staff groups had been invited to fill these positions.

The Director also advised that, at its meeting of 25 August 2015, the Shadow IJB had agreed the process to recruit non-voting members and officers were actively seeking to full the remaining positions.

The IJB membership as it currently stood was appended to the report.

The IJB was asked to note the prescribed membership and agree the discretionary membership.

Decision

1. To note the prescribed members and agree the discretionary membership.

2. To note that officers were actively seeking to fill the vacant posts and that a further report would be brought to the next meeting of the IJB.

3. CODE OF CONDUCT

A report had been circulated by the Director seeking approval for the terms of the IJB Code of Conduct and for its submission to the Scottish Ministers for approval.

The Board was informed that a draft Code had been developed through the health board and the four councils in the health board area for use by each IJB. The proposed version was attached as Appendix 1 to the report and it almost entirely followed the draft but had been tidied up in relation to terminology and appearance.

The Solicitor/Committee Services Manager presented the report and explained the main features of the Code.

It was noted that, upon appointment, Board members would be provided with a form to complete to populate their Register for the first time. Regular reminders would be issued to ensure members kept their register up to date, but members had personal responsibility to declare any changes or additions as they occurred. The Register would be published and made available to the public through the internet and on request.

Initial advice would be made available to members as they were appointed, both in relation to populating their Registers and compliance at meetings. Ad hoc advice would be available on request to members in relation to the Register, and declarations and withdrawal from meetings.

Finally, the Board was informed that the Act required that the Board appoint a Standards Officer and that the Board should consider an appropriate process to secure that appointment.

It was recommended that the Board:-

1. Approve the draft Code of Conduct in Appendix 1 for submission to the Scottish Ministers for approval.

2. Agree that members should abide by the terms of the draft Code on an interim basis, pending its approval and formal adoption.

3. Note that procedures and forms were being prepared to assist members in completing and maintaining their Register of Interests and complying with the statutory obligations arising from their appointment to the Board.

4. Consider a process for the appointment of a Standards Officer for the IJB as required by the Act, to advise members and assist them in complying with the Act and their duties and to be the Board's point of contact for investigations and enforcement.

The IJB then heard advice by the Director that views had been invited on proposed amendments to the statutory regulations covering the conduct issue raised earlier in the meeting concerning withdrawing from a meeting. On this matter, the IJB was asked to agree in principle with the proposed amendments and to delegate to the Director to respond to the Scottish Government on the Board's behalf.

Decision

1. To approve the recommendations 1, 2 and 3 as set out in the report.

2. To agree that the process for the appointment of a Standards Officer for the IJB as required by the Act, to advise members and assist them in complying with the Act and their duties and to be the Board's point of contact for investigations and enforcement, should be considered alongside the appointments of the Director and Finance Officer.

3. To agree in principle with the proposed amendments to the regulations and that the Director should respond to the Scottish Government on the Board's behalf.

4. DECLARATIONS OF INTEREST

There were no declarations of interest made.

5. MINUTE

The Board approved the minute of meeting of the Shadow IJB held on 25 August 2015. The minute was then signed by the Chair.

6. WEST LOTHIAN INTEGRATION SCHEME

A report had been circulated by the Director informing the IJB of the approval of the West Lothian Integration Scheme and legal establishment of West Lothian Integration Joint Board.

The Director advised that, in accordance with the Public Bodies (Joint Working) (Scotland) Act 2014, West Lothian Council and NHS Lothian had prepared an integration scheme for West Lothian. The scheme had been approved on 16 June and the Order to establish the IJB was laid in the Scottish Parliament for 28 days. A copy of the scheme was attached as Appendix 1 to the report.

Appendix 2 to the report was a copy of correspondence from Scottish Government confirming that West Lothian IJB had become legally established from 21 September 2015.

The IJB was asked to note that West Lothian Integration scheme had been approved and that West Lothian IJB was legally established.

Decision

To note the terms of the report.

7. FIRST ITERATION FOR SPG CONSULTATION AND COMMENT

A report had been circulated by the Director providing an initial draft of the Strategic Plan for consideration prior to engaging in stakeholder consultation.

Under legislation, the IJB was required to establish a strategic planning group, which would be involved throughout the process of developing, consulting on and finalising a strategic plan.

The IJB was informed that the IJB would not assume responsibility for the planning, resourcing and operational delivery of all integrated services until such time as the strategic plan and associated locality arrangements had been prepared and considered fit for purpose by the Health Board and Local Authority.

Appendix 1 to the report provided a draft strategic plan. The Strategic Planning Group had considered the draft strategic plan at its meeting of 8 October 2015 and had been supportive of progressing to stakeholder consultation as detailed in Appendix 2 to the report.

In presenting the report, the Senior Manager Community Care Support and Services advised that budget figures within the plan had been updated and replacement pages 12 and 13 had been circulated to members prior to the meeting.

It was recommended that the IJB:-

1. note the requirement of the IJB to prepare a strategic plan.

2. note that the involvement of the Strategic Planning Group was integral to the preparation of the strategic plan.

3. consider the initial draft version of the strategic plan in Appendix 1 and agree to progress with stakeholder consultation on the draft strategic plan.

During discussion, the following suggestions were made by IJB members:-

- that the flowchart be amended (page 22 of the draft plan) to include the Care Governance Group,

- that officers should consider including commentary concerning resources within the plan,

- That officers should consider how to involve hard-to-reach groups in the consultation process.

Decision

1. To note the terms of the report

2. To agree that officers progress with stakeholder consultation on the draft strategic plan, taking into account the comments made by IJB members.

8. STRATEGIC PLANNING GROUP TERMS OF REFERENCE AND PROCEDURES

A report had been circulated by the Director seeking approval of the Terms of Reference for the Strategic Planning Group covering its role and remit, procedures, membership, meeting arrangements, and guidance on conduct.

The Director advised that Terms of Reference for the SPG in term of its role had been developed and had been approved in principle at the shadow IJB meeting on 2 June 2015. The Terms of Reference had since been added to, to include other matters relevant to the constitution and administration of the SPG, as described in the report, so that significant information was contained in one document for future reference purposes. All information was set out in Appendix for information.

The report went on to advice that a process for identifying the members required for the SPG had been approved in principle at the meeting of the shadow IJB on 2 June 2015.

Since that meeting, officers had been engaged in filling the required places on the SPOG and those identified so far had been invited to shadow meetings of the SPG leading up to it being established by the

Board on 20 October 2015. Details of the membership required and proposed for the SPG were included in Appendix 1. The individuals and representative who had been identified for consideration as SPG members were in Appendix 2 for formal appointment by the Board.

Appendix 3 set out dates identified for meetings of the SPG.

In relation SPG procedures, a set of procedural rules had been drafted and were contained in Appendix 1 for consideration and approval as part of the Terms of Reference. Some points to note in considering the draft procedures were highlighted in the report.

It was recommended that the IJB:-

1. approve the proposed Terms of Reference for the SPG in Appendix 1.

2. appoint members to the SPG as set out in Appendix 2.

3. note that the appointment of members to the places still vacant should be brought to future meetings of the Board.

4. agree the meeting arrangements for the SPG till June 20165.

5. note the draft Terms of Reference had been submitted to the SPG meeting on 8 October 2015 for information and that any feedback would be provided to members at the Board meeting.

During discussion, a number of suggestions were made concerning membership. In response to a suggestion that an Education representative be appointed to the SPG, the Director advised that there was scope for the Chair to invite others to attend on an ad hoc basis in relation to specific items. In addition, he advised that the scope of the IJB did not include Children's Services.

In response to a suggestion concerning representation from the Senior People's Forum, it was noted that officers would consider a process for locality representation and the Senior People's Forum would be included in the process.

Decision

To approve the terms of the report.

9. BUDGET AND FINANCE

A report had been circulated by the Director setting out the process and timescales for putting into place financial arrangements for the IJB and setting out the process for undertaking financial assurance on the resources to be delegated to the West Lothian IJB.

The Director advised that it was expected that functions and related budget resources would not be delegated to the IJB until the date the IJB

Strategic Plan came into effect which was anticipated to be on 1 April 2016.

As part of the project plan prepared for implementing health and social care integration for West Lothian, financial elements required had been identified and were being progressed via a structured project based approach. Table 1 within the report outlined the milestones within that plan, and provided progress updates for each milestone.

The report went on to provide detailed information concerning the appointment of a Chief Finance Officer, the creation of an IJB Audit Committee, and Financial Assurance.

It was recommend that the IJB:-

- note the implementation plan for delivering the financial arrangements for the West Lothian IJB and the work completed so far.

- note the financial assurance work undertaken to date and further work to be undertaken in advance of resources being delegated by the council and NHS Lothian to the IJB.

Decision

To note the terms of the report.

10. WORKFORCE DEVELOPMENT / OD PLAN

A report had been circulated outlining the progress in development of an Organisational Development and Workforce Plan to support the integration of the health and social care and achievement of the national health and well being outcomes.

The IJB was informed that the approach to integration was focused on person-centred planning and delivery ensuring that those who used services got the right care and support whatever their needs, at any point in their care journey. With a focus on improving people's lives and caring for the whole person, it was essential that partnership organisations made sure that those working in health and social care were equipped to make best use of their collective skills and resources to improve outcomes for individuals.

The report explained the purpose of the Organisational Development and Workforce Plan and attached a copy as Appendix 1 to the report.

The plan had been developed through the Organisational Development Board with membership from the management team and NHS Lothian and West Lothian Council organisational development and human resources teams. The plan embraced the staff governance standards and would be consulted on through the partnership fora.

The IJB was asked to note the contents of the report and support the key activities required for delivery of the organisational development and

workforce plan.

Decision

1. To note the terms of the report.

2. To agree to support the key activities required for delivery of the organisational development and workforce plan

11. IJB MEMBER INDUCTION

A report had been circulated by the Director informing the Board of the proposal for progressing induction for the IJB members.

The report advised that 10 appointed members of the IJB had attended an initial West Lothian induction event on 19 August 2015. To build on this event and progress the induction of IJB members further events were proposed to ensure that Board members had all the necessary information to meet their individual and collective needs.

The events proposed were:-

1. A repeat of the induction event provided in August taking on board feedback from participants and views from the shadow IJB. It would be open to all Board members but targeted at new members who hadn't previously attended.

2. An induction event to be available locally for elected members who had been unable to attend previous events to provide an overview and understanding of the role of West Lothian's IJB. This would be arranged by HR as part of the ongoing programme of Member development events.

3. Once all board members had attended the initial induction event a further development event was planned. The purpose of this would be to review any further induction needs as well as to facilitate the implementation of a Development Plans for the IJB.

The report went on to provide information on the IJB Development Plan which would pull together the themes and areas for improvement as well as detail actions required and monitoring process.

A range of resources had been produced nationally to facilitate the development of IJBs, and these were listed in the report. The report also contained a list of documents highlighting key themes for Boards to address as part of their development.

During discussion, the IJB heard a suggestion that officers consider including visits/tours as part of the Induction Programme.

Decision

1. To endorse the proposed approach and content of Board member

induction as outlined in the report.

2. To agree that officers consider including visits/tours as part of the Induction Programme.

12, MEETING ARRANGEMENTS AND WORKPLAN

A report had been circulated by the Director confirming the meeting arrangements and seeking approval for the maintenance of a workplan for the IJB.

The report recalled that, at its meeting of 2 June 2015, the shadow IJB had agreed proposed meeting arrangements for the shadow IJB and Board when formally established. These arrangements were outlined in Appendix 1 to the report for information.

It was proposed that in the interest of effective planning and evaluation, that the IJB maintained a workplan which would identify key areas for consideration and action. The purpose of the workplan would be to enable appropriate preparation and planning in advance of IJB reports and to monitor progress in these areas.

The IJB was asked to note the meeting arrangements and agree the maintenance of a workplan for the IJB.

Decision

1. To note the meeting arrangements; and

2. To agree the maintenance of a workplan for the IJB.

West Lothian Integration Joint Board
20 October 2015

ACTION NOTE

A meeting of the West Lothian Integration Joint Board was held on 20 October 2015. The items for action and the allocation of that action are listed below.

Please note officers have five working days from the date of the meeting to respond to any requests for information from Councillors. The officer responsible should send the information directly and simultaneously to all members of the committee or PDSP.

If you have any comments or questions, please contact Anne Higgins as soon as possible on 01506 281601 .

Item	Title	Decision	Action
001	Chair's Remarks	To note opening remarks by the Chair during which he welcomed those present to the meeting and advised that apologies for absence from Voting Members would be dealt with at this stage in the meeting and later for non-voting members. Apologies:- David Farquharson and Julie McDowell; Jane Kellock, Robin Strang and James McCallum	N/a
002	Standing Orders - Report by Director (herewith)	Agreed:- • To adopt the draft Standing Orders, as contained in Appendix 1 to the report, to apply with immediate effect. • That a further report would be brought to the Board prior to the delegation of functions to review the working of the Standing Orders and in relation to comments and suggestions made at meetings of the Shadow Board when the draft Standing Orders were previously considered. • To adopt the suggested approach to minutes of Board meetings, as contained in Appendix 2 to the report • That, in relation to Appendix 1, paragraph 9.1 an amendment be made to replace “Chamber” with “Meeting Room”. To note details of the unsatisfactory regulations about withdrawing from a meeting after declaring an interest and that the Scottish Government had yet to arrange for the amendment of the regulations.	Jim Forrest/ James Millar

003	Order of Business, including notice of urgent business	N/a	N/a

004	IJB Membership - Report by Director (herewith)	To note the report outlining the prescribed and discretionary membership of the IJB. To note that a process had been agreed by the shadow IJB for appointing Non-Voting Members. To appoint the non-voting members identified so far as shown in the appendix to the report To note that officers were actively seeking to fill the vacant posts and a further report would be brought to the next meeting.	Jim Forrest

005	Code of Conduct - Report by Director (herewith)	To approve recommendations by the Director as undernoted:- 1. That the draft Code of Conduct be approved for submission to the Scottish Ministers for approval. 2. That the members abide by the terms of the draft Code on an interim basis, pending its approval and formal adoption. 3. That members note that procedures and forms were being prepared to assist members in completing and maintaining their Register of Interests and complying with the statutory obligations arising from their appointment to the Board. **4.** That the process for the appointment of a Standards Officer for the IJB as required by the Act, to advise members and assist them in complying with the Act and their duties and to be the Board's point of contact for investigations and enforcement, should be considered alongside the appointments of the Director and Finance Officer. To note that views had been invited on proposed amendments to the Scottish Government's regulations on Integration Joint Board and Integration Joint Monitoring Committee Standing Orders and that it covered the issue raised at Agenda Item 2 concerning withdrawing from a meeting. To agree in principle with the proposed amendments and that the Director should respond to the Scottish Government on the Board's behalf.	Jim Forrest/ James Millar

006	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.	None	N/a

007	Confirm Draft Minute of Meeting of West Lothian Shadow Integration Joint Board held on Tuesday 25 August 2015.	Minute approved	N/a

008	West Lothian Integration Scheme - Report by Director (herewith)	To note the report informing the Board of the approval of the West Lothian Integration Scheme and legal establishment of West Lothian Integration Joint Board.	Jim Forrest

009	First Iteration for SPG Consultation and Comment - Report by Director (herewith)	To note the report providing an initial draft of the Strategic Plan for consideration prior to engaging in stakeholder consultation. To note advice by the Senior Manager Community Care Support & Services that budget figures had been updated and replacement pages 12 and 13 had been circulated to members prior to the meeting. To agree that the flowchart be amended (page 22) to include the Care Governance Group and that officers consider including commentary concerning resources within the Plan, and how to involve hard-to-reach groups in the consultation process.	Jim Forrest/ Alan Bell

010	Strategic Planning Group Terms of Reference and Procedures - Report by Director (herewith)	1. To approve the proposed Terms of Reference for the SPG in Appendix 1. 2. To appoint members to the SPG as set out in Appendix 2, together with the appointment of Mary-Denise McKernan in respect of carers of users of health and social care. 3. To note that the appointment of members to the places still vacant would be brought to future meetings of the Board. 4. To agree the meeting arrangements for the SPG till June 2016. **5.** To note that the draft Terms of Reference had been submitted to the SPG on 8 October 2015 for information and that there were no comments to pass on to the IJB. 6. To agree that Staff Representatives from WLC and NHS Lothian be invited to sit on the SPG. **7.** In response to a suggestion that an Education representative be appointed to the SPG, the Director advised that there was scope for the Chair to invite others to attend on an *ad hoc* basis in relation to specific items. In addition, he advised that the scope of the IJB did not include Children's Services. **8.** To note that officers would consider a process for locality representation and that the Senior People's Forum would be included in the process.	Jim Forrest/ James Millar

011	Budget and Finance - Report by Director (herewith)	To note the report setting out the process and timescales for putting into place financial arrangements for the IJB and setting out the process for undertaking financial assurance on the resources to the delegated to the West Lothian IJB.	Jim Forrest/ Patrick Welsh Carol Mitchell

012	Workforce Development / OD Plan - Report by Director (herewith)	To note the report on progress in development of an Organisation Development and Workforce Plan; and To agree to support the key activities required for delivery of the organisational development and workforce plan.	Jim Forrest/ Marion Christie/ Carol Bebbington

013	IJB Member Induction - Report by Director (herewith)	To endorse the proposed approach and content of Board member induction as outlined in the report. To agree that officers consider including visits/tours as part of the Induction Programme.	Jim Forrest/ Marion Christie/ Chris Kennan

014	Meeting Arrangements and Workplan - Report by Director (herewith)	To note the meeting arrangements; and To agree the maintenance of a workplan for the IJB.	Jim Forrest/ Rhona Anderson

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Cabinet Secretary for Health, Wellbeing and Sport
Shona Robison MSP

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The Scottish Government
Riaghaltas na h-Alba

LEGACY 2014

Mr Brian Houston
Chair
NHS Lothian
Waverley Gate
2-4 Waterloo Place
Edinburgh
EH1 3EG

12 November 2015

Dear Brian,

NHS LOTHIAN: 2015 ANNUAL REVIEW

1. This letter summarises the main points discussed and actions arising from the Annual Review and associated meetings at Waverley Gate, 2-4 Waterloo Place, Edinburgh, on 3 August 2015.

2. I would like to record my thanks to you and everyone who was involved in the preparations for the Annual Review Programme, and also to those who attended the various meetings. I found it a very informative day and I hope everyone who participated also found it worthwhile.

3. I began by meeting local staff from both the Area Clinical Forum and Area Partnership Forum and was grateful to them for taking the time out of their busy schedules to share their views with me. It is clear from our discussions that local relationships remain strong and that both Forums and the Board are well placed to address both outstanding challenges and those that lie ahead, in effective partnership.

Meeting with the Area Clinical Forum (ACF)

4. My discussion with the Area Clinical Forum was positive and interactive. I was reassured that NHS Lothian continues to actively support the Forum, with backfill arrangements in place to facilitate participation and a reinvigorated nursing group now in operation. I was please to hear that effective links to the senior management team are in place and that, in general, effective engagement and communication are appropriately prioritised. It was clear that the Forum has a determined focus on clinical quality and innovation to promote patient safety. Members of the Forum highlighted the importance of clinical engagement at a strategic level, including the development of the Clinical Change Cabinet, to empower clinicians to put ideas into action. Our discussions also covered the challenge of extending professional engagement structures to encompass social care, and how to manage the effective roll out of small scale tests of change to normal practice.

Meeting with the Area Partnership Forum (APF)

5. I had a lively and informative discussion with the Area Partnership Forum. The importance of staff engagement arrangements in the context of Health and Social Care Partnerships continued as a theme, recognising the particular challenges faced in Edinburgh city. In terms of long term sustainability, the key roles played by intermediate care facilities and initiatives to support and treat people safely at home were recognised by all parties. We also discussed the workforce implications of new models of capital investment as well as current developments in Agenda for Change structures.

Patient's Meeting

6. I very much value the opportunity to meet with patients and patients' groups and firmly believe that listening and responding to their feedback is a vital part of improving health services. I greatly appreciated the openness and willingness of the people present to share their experiences and noted the specific issues raised, including waiting times for Psychological Therapies and the impact on young carers of looking after family members with mental health issues. Concerns were also expressed about the personal wellbeing of carers who are providing long term care for people with learning difficulties. We went on to discuss the importance of ensuring people are discharged from hospital at the right time and with the appropriate support; local arrangements to facilitate involvement in the National Conversation; fair systems of payment for care and the need for staffing rotas to recognise the increasing acuity of inpatients in hospital. I would like to extend my sincere thanks to the patients who took the time to come and meet with me.

Annual Review Meetings – Format

7. Ministers have listened to feedback from members of the public at Annual Reviews in recent years who called for a more focussed public discussion of the key issues, ahead of the opportunity to ask questions. As such, Ministerial Reviews are now undertaken in two sessions – the first, in public, with the Minister setting the scene and context for the discussion before the Board Chair delivers a short presentation on key successes and challenges facing the local system. This is then followed by the opportunity for attendees to ask questions of the Minister and Health Board.

8. The second session is held in private between the Minister and the full Health Board. This is a more detailed discussion of local performance in delivering the six Quality Outcomes and offers Ministers the opportunity to reflect on the experience of the day whist also testing how Board Non-Executives are able to hold the Executive Team to account. This letter provides a detailed summary of the discussion and resulting action points.

9. As in previous years, all Boards are expected to submit a written report to Ministers on their performance over the past year and their plans for the forthcoming year. I note that NHS Lothian's self-assessment paper gives a detailed account of the specific progress the Board has made in a number of areas and that it is available to members of the public on the NHS Lothian website. I have highlighted some of these key areas of challenge and success below.

Annual Review – Public Session

10. During your presentation, you provided a helpful summary of progress made against last year's Annual Review action points and I was pleased to hear you reiterate the Board's clear focus on proving care and treatment of the highest standard. You provided a helpful summary of progress with your Strategic Plan 'Our Health, Our Care, Our Future', with particular focus on 'Scott' and your services for Older People. You acknowledged the real challenge of responding to demographic demands and rising public expectations of health care and described the work going on across NHS Lothian to ensure services are in the best possible position to meet these challenges. In particular, I was interested to hear about the masterplanning being undertaken for all of your acute hospital sites and about the development and extension of partnerships with businesses and with key Third Sector partners with whom you are working to improve outcomes for individuals using your services.

11. Following the introductory presentations we took a number of questions from members of the public on a range of subjects including the difficulties of recruiting GPs and changing models of primary care; waiting times for chiropody services; the implementation of the Named Person policy; Paediatric services at St John's Hospital in Livingston; ensuring prompt access to medication for people with Parkinson's Disease who are admitted to hospital and the key role played by the local Ageing Well project in Stockbridge. I am grateful to you and the Board team for your efforts in this respect, and to the audience members for their attendance, enthusiasm and considered questions.

Annual Review – Private Session

Health Improvement and Reducing Inequalities

12. NHS Lothian is to be commended for a very strong performance in the delivery of alcohol brief interventions during the period 2008 to 2015, delivering179% of the target. On smoking cessation, however, performance was more disappointing. Between April 2014 and December 2015 the Board achieved 769 successful 12 week quits against a target of 1140 and I would encourage you to put into place appropriate actions to enable significant improvement going forward.

13. Over the last ten years, the number of deaths from stroke in Scotland has reduced by 41%. Building on this success, boards were asked to include in their Local Delivery Plans for 2014/15 their plans for implementing a 'bundle' of four activities to improve stroke care. NHS Lothian's trajectory was to deliver the appropriate aspects of the bundle to 65% of people admitted with stroke, which you have worked hard to achieve with performance rising from 51% in January rising to 62.4% in March 2015. The overall rate, however, was recorded as 56% for the period and I would appreciate it if you could work with my officials to ensure sustained and improved delivery of the bundle over the current year.

14. The Board has been more successful in increasing access to insulin pumps, having met and exceeded the Ministerial commitments of a tripling of the total number of users, including 25% of under 18s. I was also very pleased to hear of your progressive approach to Cardiac Rehabilitiation including a CR telehealth pilot and the Cardiac Support Service, using volunteers to reduce social isolation for patients with cardiac illness.

Clinical Governance, Patient Safety and Infection Control

15. Rigorous clinical governance and robust risk management are fundamental activities for any NHS Board, whilst the quality of care and patient safety are of paramount concern. I am aware that there has been a lot of time and effort invested in effectively tackling infection control. However, the Board was unable to achieve its the *Clostridium difficile (C.diff)* infection target or the *staphylococcus aureus bacteraemia* (SAB) infections target for delivery in March 2015. I understand you have requested support from Health Protection Scotland, who are currently undertaking a situational assessment on your behalf. Please keep my officials informed of the outcome of this exercise.

16. The Healthcare Environment Inspectorate (HEI) carried out four inspections during the period under consideration; in the Royal Infirmary of Edinburgh, Ellen's Glen House, Western General Hospital and St John's Hospital. Each inspection resulted in a number of requirements and recommendations, with action plans developed by the Board to respond to each of these. HEI will continue to monitor your progress in implementing these but I would find it of great benefit if you could keep me up to date on how your work is progressing.

17. I was happy to learn that under the NHSScotland National Cleaning Compliance Report for 2014/15, NHS Lothian showed Green compliance in both its domestic and estates services. Please pass on my thanks to staff for the hard work and determination they have shown to ensure that high standards have been maintained across the estate.

18. The Vale of Leven Hospital Inquiry resulted in 65 recommendations for action by health boards and the Implementation Group, set up in February 2015 and chaired by the Scottish Government's Chief Nursing Officer, Fiona McQueen, is in the process of producing a national action plan. Your self-assessment indicates that progress is being made in a number of vital areas including a review of antibiotic policy and ensuring consistent completion of medical documentation relating to *C diff* infection and antibiotic treatment. You have also signalled that you are undertaking audits of of patient nutrition care plans with feedback provided to support improvements in practice.

Improving Access, including Waiting Times Performance

19. NHS Lothian has continued to work hard to recover its waiting time position across all of its specialities. However, your progress to date has not been in line with your planned recovery trajectory, with the situation exacerbated by the increasing number of delayed discharges, which has impacted on available capacity for elective treatments. As a result, the Board has been unable to maintain compliance against the 18 week Referral to Treatment standard or the Treatment Time Guarantee for inpatients and daycases during the year. A new trajectory has now been received which, accompanied by significant additional investment is expected to deliver significant improvements by the end of the current calendar year. We expect you to now fully deliver against the plans agreed with the Access Support Team.

20. NHS Lothian has also experienced significant challenge in relation to access to diagnostic testing, with performance having deteriorated over the year 2014/15, and the position in relation to waits for outpatient appointments continues to be of particular concern. I am aware that you are looking at a number of initiatives including the development of a business case to support additional access to laparoscopic prostatectomy within other NHS Boards. The Board is also looking at measures to increase theatre capacity for colorectal cancer treatment. Please keep me informed of the outcomes of these initiatives.

21. I note NHS Lothian's overall performance against the 4-hour A&E target has shown improvement over the summer period. However, there remains significant variation in performance across the Board's sites. The National Unscheduled Care Team is working with the local team in NHS Lothian to help accelerate implementation of the new six essential actions approach to sustainably improving unscheduled care and ensuring best practice is installed throughout your hospital system and I look forward to seeing the positive effects of these developments.

22. I was also pleased to learn that the Board has sustained above average performance over the year against the 31-day cancer access standard. However, delivery of the 62-day cancer access standard has fallen below 95% for two of the last five reported quarters. Working with my officials, NHS Lothian has identified a range of performance challenges across a number of pathways. To recover performance, you have introduced specific actions such as reinstating weekly tracking meetings, undertaking pathway reviews, bolstering escalation policies and management control. These actions are now realising improvement gains and I would be grateful if you could keep my officials informed of your continuing progress.

23. For the quarter to the end of March 2015, 53.8% of patients waited less than 18 weeks from referral to treatment for specialist Child and Adolescent Mental Health Services (CAMHS), compared to the target of 90%. You have indicated that this shortfall was due primarily to recruitment and data transfer issues. You have advised that action taken to improve performance includes additional recruitment, development of a central booking hub and a review of referral pathways and you anticipate that the 90% target will be delivered shortly. Similarly, the Board did not meet the 90% target for access to Psychological Therapies within 18 weeks by the end of December 2014. I look forward to confirmation that work to speed up access to these key services has resulted in sustainable delivery of the 18 week target.

The Integration of Health and Social Care

24. Delayed discharge continues to be a significant challenge for NHS Lothian with 136,655 bed days lost to delayed discharge in 2014/15 and 126 patients delayed over 2 weeks at the September census point. I welcome the collaborative work the Board is taking with Local Authority partners and the Scottish Government to identify measures that will support and sustain improvement in this area and note that Healthcare Improvement Scotland has also been asked to prioritise the Edinburgh Health and Social Care Partnership for improvement and support. I am aware that a plan is being developed by the Board and the Edinburgh Health and Social Care Partnership which is scheduled to deliver improved performance and a new model of care over the Autumn of 2015. My officials will continue to stay in close contact with you as this work develops.

The Best Use of Resources, including Workforce Planning and Financial Management, as well as Service Redesign

25. Effective attendance management is critical - not only in terms of efficiency but also to ensure good support mechanisms are in place for staff. At 4.71% for the year to March 2015, NHS Lothian's sickness absence rate remained above the 4% standard but below the average rate for Scotland for the same time period. I recognise the efforts the Board is making to support its staff and would encourage you to continue your focus on minimising absences.

26. I am aware that NHS Lothian is progressing a number of initiatives as part of its staff governance action plan. Board actions going forward will include the roll out of e-Rostering during 2015/16 to assist in addressing staffing and workload issues; the roll out of iMatters to assist with gaining better intelligence around staff experience and the putting in place of local actions as outcomes from the recent staff survey.

27. It is vital that NHS Boards achieve both financial stability and best value for the considerable taxpayer investment made in the NHS. I am, therefore, pleased to note that despite a challenging year NHS Lothian met its financial targets for 2014/15, delivering a small surplus of £0.239m. The Board invested £50.8m in its capital programme during the year, and reached financial close on two major projects. Key developments during the year included £12.8m of enabling works around the Royal Hospital for Sick Children and the Department for Clinical Neurosciences, the modernisation and replacement of GP practices at £3.1m, upgrading of the special care baby unit at St John's Hospital totalling £1.2m, a new MRI scanner at St John's Hospital for £2.2m, a £2.4m radiotherapy replacement programme and works on the front door of the Western General Hospital which cost £3.2m.

28. I am aware of the financial pressures that the Board is facing in the current financial year, including increased prescribing costs, nursing workforce costs and the delivery of an ambitious programme of efficiency savings. Running alongside the investments required to maintain performance in key areas such as elective waiting times and unscheduled care, this is undoubtedly a difficult balance. Significant additional investment has been made available during the year to help Boards maintain this balance and I appreciate the efforts that NHS Lothian is making, with its partners, to use these resources creatively to deliver innovative solutions in the short and longer term.

29. Clearly, overall economic conditions mean that public sector budgets will continue to be tight whilst demand for health and care services will continue to grow. Nonetheless, you confirmed that the Board continues to actively monitor the achievement of all local efficiency programmes and, whilst the position is challenging, NHS Lothian remains fully committed to meeting its financial responsibilities in 2015/16 and beyond.

Conclusion

30. I would like to thank you and your team for hosting the Review and for responding so positively to the issues raised. It is clear that the Board is making significant progress in taking forward a challenging agenda on a number of fronts. However, our discussions have assured me that you are not complacent and you recognise that there remains much to do. I include a list of the main action points from the Review in the attached Annex A.

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ANNEX A

NHS LOTHIAN ANNUAL REVIEW 2015

MAIN ACTION POINTS

The Board must:

- Continue to deliver on its key responsibilities in terms of clinical governance, risk management, quality of care and patient safety, including an effective response to the findings of Healthcare Improvement Scotland inspections.
- Make sustained progress in achieving smoking cessation targets and delivering the stroke bundle to the relevant patients.
- Keep the Health and Social Care Directorates informed on progress towards achieving all access targets and standards, in particular the 4-hour A&E standard, Treatment Time Guarantees and Child and Adolescent Mental Health Services.
- Maintain focus on reducing staff absences.
- Work with partners to reduce the number of bed days lost to delayed discharge across Lothian in 2015/16.
- Continue to achieve financial in-year and recurring financial balance, and keep the Health and Social Care Directorates informed of progress in implementing the local efficiency savings programme.

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NHS LOTHIAN

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - PERFORMANCE MANAGEMENT

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

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

Key Points	**Paragraph**
Note the amendments made to the report as initial steps to meet the recommendations outlined in the 'Refocusing Performance Reporting' paper elsewhere on the agenda.	3.3
Four standards were met. Of the remaining 19, nine were on an improving trend with a further one was better than the national average.	Table 2, Page 4
Timescales for improvement are set out for Treatment Time Guarantee, Diagnostic Endoscopy and Outpatients.	2.3

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NHS LOTHIAN

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

PERFORMANCE MANAGEMENT

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the Board on the most recently available information on NHS Lothian performance against a range of measures, using data sourced from local and national systems. Any member wishing additional information should contact the lead director relevant to the standard in advance of the meeting.

2 Recommendations

2.1 Note the amendments made to the report in order to commence on the recommendations made elsewhere on the agenda, regarding the Refocusing of Performance Reporting;

2.2 Receive this update on the existing performance against HEAT targets and other relevant standards.

2.3 Note timescales for improvement set out for Diagnostic Endoscopy, Treatment Time Guarantee and Outpatients.

3 Discussion of Key Issues

3.1 The HEAT system sets out targets and measures on which the NHS Boards are monitored and the following table sets out NHS Lothian's current position against these, with a more detailed description of these being provided under item 4 of the paper.

3.2 Appropriate performance against delivery of targets is overseen by lead directors, committees and local management groups. This performance management paper provides an overview of the Board's position. With Board sub-committees now taking the lead for governance and assurance around the specified targets and standards, from the new-year board members will be able to explore in more depth where performance on a target is out-with the Board's explicit risk appetite.

3.3 Elsewhere on the Board's agenda, in the 'Refocusing Performance Reporting' paper, consideration will be given to proposals to move NHS Lothian towards best practice on performance reporting. Initial steps in this process have been incorporated into this paper, resulting in the amalgamation of this and the Acute Services paper. Links will also be made with the newly commissioned Information Board, and data quality improvement work being undertaken, as both numbers and narrative will be key in helping to drive quality.

3.4 Each standard is assessed as to whether it meets the target, and if not the trend in recent performance considered. Lothian's comparative position against overall Scottish performance is also set out. Positive assessments are graded green, those which are not red. The following table identifies where each standard sits following this assessment.

Table 1: RAG Count for Measures[1]

RAG Count	Measures	Notes
3 Reds	CAMHS (18 Weeks)	
	Cancer (62-day) (% treated)	
	Outpatients (12 weeks)	
	Referral to Treatment (18 Weeks)	
	Diagnostics (6 weeks)	
	Drug & Alcohol Waiting Times (3 weeks)	
2 Reds	Smoking Cessation (quits)	
	Carbon Emissions (tonnes)	
	Psychological Therapies (18 Weeks)	
	Delayed Discharge (over 2 weeks)	
	Reduction in Emergency Bed Days (rate per 1,000 population, aged 75+)	
	Healthcare Acquired Infection - CDI (rate per 1,000 bed days)	
	Healthcare Acquired Infection - SAB (rate per 1,000 bed days)	
	4-hour Unscheduled Care (% seen)	
	IPDC Treatment Time Guarantee (12 weeks)	
	Surveillance Endoscopy (past due date)	Only two Reds applicable
	Audiology (various)	
1 Red	Detecting Cancer Early (% diagnosed)	
1 Green	Stroke Bundles (% receiving)	Only one Green applicable
2 Greens	Early Access to Antenatal Care (% booked)	Only two Greens applicable
	Energy Efficiency (GJ)	
	Cancer (31-day) (% treated)	
	IVF (12 months)	

3.5 Table 2: Summary of Performance Position sets out compliance in more detail outlining whether the target is met, recent trend, and comparative position, and allowing assessment of variation from standards. Methodological complexity precludes further developments at this stage.

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[1] This table provides a tally of the number of 'Reds' or 'Greens' achieved per measure, to a maximum of two Greens (if a measure meets target, it can currently only achieve at most one other green, by comparison against national performance). 'Greens' and 'Reds' are otherwise achieved as a result of 'Status', 'Trend' and 'Published Status vs. National Position' – please see Table 2 (below) for details.

Table 2: Summary of Performance Position

Measure	Status[2]	Trend[3]	Published Status vs. National Position[4]	Target	Current	Lead Director
Smoking Cessation (quits)	Not Met	↑	Worse	1,765 (min)	1,104	AKM
Early Access to Antenatal Care (% booked)	Met		Better	80% (min)	89.0%	AMcM
Carbon Emissions (tonnes)	Not Met	↓	Better	26,266 (max)	27,755	AB
Energy Efficiency (GJ)	Met		Better	868,351 (max)	849,930	AB
CAMHS[5] (18 Weeks)	Not Met	↓	Worse	90% (min)	59%	JF
Psychological Therapies (18 Weeks)	Not Met	↑	Worse	90% (min)	47%	JF
Delayed Discharge (over 2 weeks)	Not Met	↑	Worse	0 (max)	117	JC/DF/RMG/EM/DS
Reduction in Emergency Bed Days (rate per 1,000 population, aged 75+)	Not Met	↑	Worse	4,709 (max)	4,978	JC/DF/RMG/EM/DS
Healthcare Acquired Infection - CDI (rate per 1,000 bed days)	Not Met	↑	Worse	0.32 (max) (262 max)	0.43 (207 YTD)	MJ
Healthcare Acquired Infection - SAB (rate per 1,000 bed days)	Not Met	↑	Worse	0.24 (max) (184 max)	0.30 (139 YTD)	MJ
4-hour Unscheduled Care (% seen)	Not Met	↑	Worse	95% (min)	94.4%	JC
Cancer (31-day) (% treated)	Met		Better	95% (min)	97.1%	JC
Cancer (62-day) (% treated)	Not Met	↓	Worse	95% (min)	89.3%	JC
Stroke Bundles (% receiving)	Met		Not Available	70% (min)	70.8%	JC
IPDC Treatment Time Guarantee (12 weeks)	Not Met	↑	Worse	0 (max)	277	JC
Outpatients (12 weeks)	Not Met	↓	Worse	95% (min)	86% (7,491)	JC
Referral to Treatment (18 Weeks)	Not Met	↓	Worse	90% (min)	84.9%	JC
Diagnostics (6 weeks)	Not Met	↓	Worse	0 (max)	2,398	JC
Surveillance Endoscopy (past due date)	Not Met	↓	Not Available	0 (max)	1911	JC
Audiology (various)	Not Met	↓	Not Available	0 (max)	17	JC
IVF (12 months)	Met		Equal	90% (min)	100%	JC
Drug & Alcohol Waiting Times (3 weeks)	Not Met	↓	Worse	90% (min)	83.4%	AMcM
Detecting Cancer Early (% diagnosed)	Not Met	↑	Better	29% (min)	26.2%	AKM

[2] ***Status*** – describes where Current meets or does not meet Target.
[3] ***Trend*** – '↑','↓', '-' describes Improvement or Deterioration for Current, against an average of the last two relevant reported data points where Status is 'Not Met'.
[4] ***Published Status vs. National Position*** – describes Lothian position against overall national position for rates (including %); or against NRAC share. To comply with Official Statistics' requirements this is based on published national position and thus will often relate to a different time period to the actual reported.
[5] ***Abbreviations*** – CAMHS - Child and Adolescent Mental Health; CDI- Clostridium difficile Infection; SAB Staphylococcus aureus Bacteraemia; IPDC – Inpatient and Day-case; IVF – In Vitro Fertilisation.

4 Detail on Areas of Performance

4.1 Smoking Cessation

Responsible Director: Director of Public Health and Health Policy

The latest data available from ISD on Smoking Cessation covers up to end of March 2015, and although the Board's performance shows a shortfall of 1,104 successful quits against a target of 1,765, it has improved its position at each quarter over the year.

4.2 Early Access to Antenatal Care

Responsible Director: Director of Strategic Planning, Performance Reporting & Information

The latest data available from ISD covers up to the end of March 2015. It shows that the Board's performance was 89.0%, for the most deprived quintile, compared to the minimum target of 80%. This is almost 7 percentage points better than the overall national position in the most recent publication.

Lothian's focus remains on action on those not being booked within 12 weeks.

4.3 Carbon Emissions and Energy Efficiency

Responsible Director: Director of Human Resources and Organisational Development

Over 2014/5, both energy standards were better than the overall nation position. However, whilst the reduction of energy was 2.12% better than the target of 868,351 GJ, at 849,930 GJ for 2014/5, the reduction of CO_2 is 5.67% worse than target at 27,755 tonnes of reported emissions, against a target of 26,266 tonnes.

In the short term the priority for NHS Lothian should be to complete the Carbon and Energy Fund Scotland (CEFS) project at St John's. This single project has enough energy and carbon savings for Lothian as a whole to achieve its HEAT targets for the following three years. Approval for this project now lies with Scottish Government whilst they confirm understanding of European Union rules on finances.

In the short to medium term the priority for Lothian should be to ensure low carbon design in its new build programme and in the energy infrastructure upgrade at the Western General.

In the long term Lothian must engage with national investment programmes to uplift the legacy of building stock with high energy demand.

4.4 Child and Adolescent Mental Health Services (CAMHs), and Psychological Therapies

Responsible Director: Joint Director, West Lothian

An action plan to progress improvement was recently discussed with the Health Minister for both areas. Supported by management consultants, Meridian Productivity, the services are currently seeking to improve the productivity,

efficiency and effectiveness of teams in Adult Inpatient and Community Mental Health and CAMHS.

This work involves developing and improving processes in a number of key areas, including improving the way community teams allocate and manage referrals; maximising the proportion of time spent providing direct care to patients by clinical staff; increasing focus on discharge planning from wards; and balancing staff rosters to improve efficiency of staffing resources.

The waiting times performance in CAMHS and Psychological Therapies is considered below.

Table 3: CAMHS Performance Trend

	Sep- 14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Percentage seen within 18 weeks*	69%	57%	52%	53%	51%	50%	62%	58%	57%	60%	71%	76%	59%
Revised Trajectory – June 2014	66%	69%	72%	75%									
Trajectory for seen within 18 weeks	88%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Total waiting at end of month	1724	1,680	1,678	1,784	1,651	1,699	1,704	1,687	1,709	1,708	1,737	1,737	1,668
Those waiting more than 18 weeks	623	526	492	494	428	446	445	478	472	509	639	694	680

There was a further increase in children and young people seen for a first treatment appointment in September (286, compared with 265 in August and 225 in July). More significantly, the number seen in September who had been waiting over 18 weeks represented a greater proportion of all children and young people treated compared to previous months. Whilst this is welcomed as it reduces the number of people waiting over 18 weeks, it does impact on our performance against the target which shows a drop in September to 59% of children and young people being seen within 18 weeks for first treatment. This is a significant reduction in our performance against the target in previous months of this quarter (August being 76%).

Table 4: Psychological Therapies Performance Trend

	Sep-14	**Oct-14**	**Nov-14**	**Dec-14**	**Jan-15**	**Feb-15**	**Mar-15**	**Apr-15**	**May-15**	**Jun-15**	**Jul-15**	**Aug-15**	**Sep-15**
Percentage seen within 18 weeks*	52%	40%	36%	36%	44%	34%	41%	39%	44%	40%	45%	46%	47%
Revised Trajectory for seen within 18 weeks	60%	62%	64%	64%									
Initial Trajectory for seen within 18 weeks	86%	88%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Total waiting at end of month	2,645	2,911	3,010	3,113	3,095	3,105	3,176	3,190	3,341	3,261	3,219	3,150	3,051
Those waiting more than 18 weeks	859	910	1,018	1,144	1,201	1,167	1,237	1,254	1,257	1,173	1,146	1,108	1,085

There was also an increase in the number of patients seen for a first psychological therapy treatment (312 in September compared to 266 in August, and 287 in July). The psychological therapies performance against the target remains stable - with 47% of people seen within 18 weeks in September, compared to 46% in August, and 45% in July – towards the 90% standard. However, it is important to note that the number of patients waiting beyond 18 weeks has continued to fall.

4.5 **Delayed Discharges**
Responsible Directors: Chief Officer and Joint Directors

November saw an improvement in the level and number of Delayed Discharges within our Hospitals, and a decrease of 6.5% compared to October—with reductions across three Integrated Joint Boards. In terms of those whose discharge is delayed over two, and four weeks, the issue remains one principally focused in Edinburgh where albeit an improvement this month, home care packages continue to be the single biggest reason for delay.

Table 5: Breakdown in Lothian Hospitals at census point

	May	June	July	Aug	Sep	Oct	Nov
All Delays Recorded	421	403	403	382	392	394	364
All ISD Reportable Delays	238	238	248	237	253	258	257
ISD Delays excluding X codes	178	177	188	180	199	201	188
Those over 2 weeks	105	99	104	108	126	122	117
Those over 4 weeks	70	63	69	75	73	77	75

Table 6: ISD Delays excluding X Codes by Local Authority at census point

	Reportable Delays			Reportable Delays >2 weeks			Reportable Delays >4 weeks		
	Sept	Oct	Nov	Sept	Oct	Nov	Sept	Oct	Nov
Edinburgh	157	148	145	103	101	100	63	64	63
East Lothian	16	32	20	9	16	9	4	9	7
Midlothian	10	7	6	6	0	1	1	0	1
West Lothian	12	7	13	6	1	3	3	0	1
All (inc other)	199	201	188	126	122	117	73	77	75

4.6 **Reduction in Emergency Bed Days**
Responsible Directors: Chief Officer and Joint Directors

The latest data provided by ISD on rate of occupied bed days per 1,000 population (aged 75+) covers up to end of March 2015. The Board's performance is 4,978 against a target of 4,709 - this is 5.7% worse than target, despite improving on previous quarters.

Lothian overall, and three of the four local authorities, has a higher rate of bed use than Scotland as a whole. West Lothian's rate is less than that elsewhere in the Board area.

4.7 **Clostridium difficile Infection (CDI) and Staphylococcus aureus Bacteraemia (SAB)**
Responsible Director: Executive Director: Nursing and Allied Health Professionals

The Board's approach on Healthcare Acquired Infection is covered elsewhere on the agenda.

In October both measures are below the standard sought for this year with Clostridium difficile Infection at a current rate of 0.43 per 1,000 bed days, and Staphylococcus aureus Bacteraemia at 0.30, per 1,000 bed days.

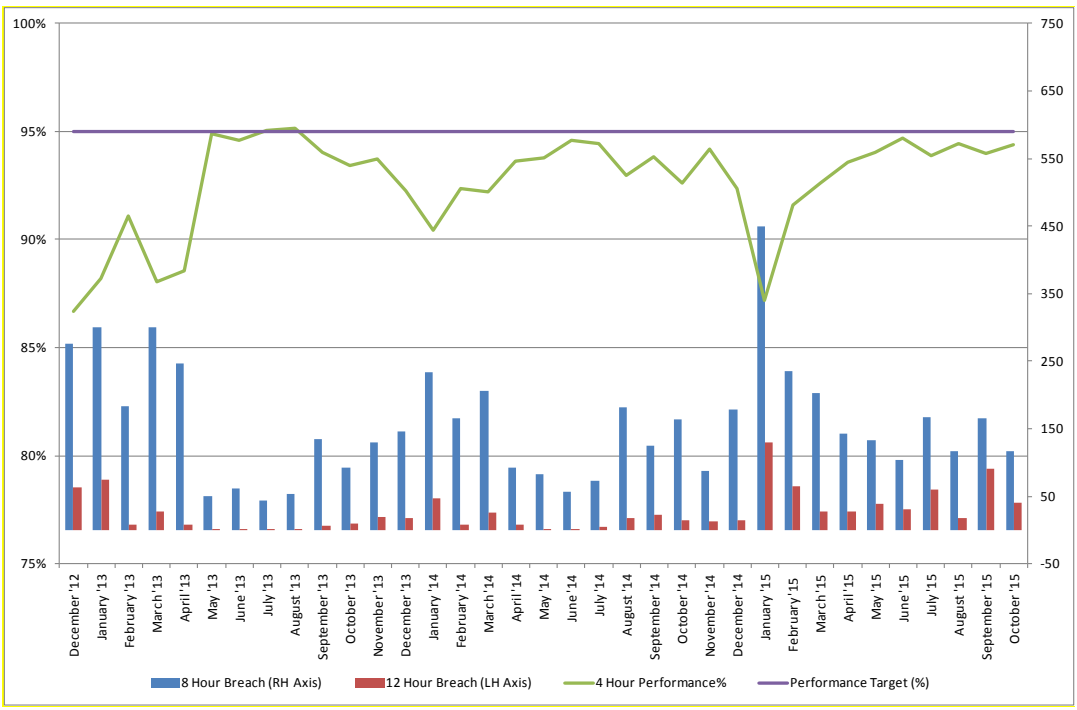
Although both measures are below the overall standard in Scotland, recent movement is towards compliance.

4.8 **4-Hour Unscheduled Care**
Responsible Director: Chief Officer

NHS Lothian's overall performance against the 4-hour standard in October was 94.37%, marginally below the national standard and an improvement on recent months with the number of patients beyond 8- and 12-hours reducing from previous months to 117, and 41 respectively.

The Royal Infirmary and Royal Hospital for Sick Children were above the standard expected (at 95.48%, and 98.58%) whilst St John's and the Western were below (at 94.67%, and 86.46% respectively). Board members will be aware that the configuration at the Western General is different from most hospitals covered by the 4-hour standard as it does not have an A&E department and thus the areas under consideration comprise the assessment area, where the breaches arise, and the minor injuries unit.

Figure 1: Trend in A&E performance



Winter Planning

To ensure robust planning arrangements for Winter 2015-16, a Winter Planning Board, chaired by the Chief Officer for University Hospital Services, has been established, and is meeting monthly over the period. Membership is multi-disciplinary with representation across a number of key health service stakeholders.

The Winter Planning Board has overseen the delivery of a robust winter plan for Lothian. Lothian's Winter Plan has been approved by NHS Lothian Board and formally submitted to the Scottish Government.

A total of £6.4 million is being invested for Winter 2015-16. Part of this will support an additional 46 acute beds being made available over the winter period. Further workforce capacity will also be supported covering a range of staff groups including medical, nursing, AHPs, Imaging, and Facilities (porters/ domestics).

4.9 Cancer - 31- and 62-day Performance

Responsible Director: Chief Officer

Performance over recent months is set out by tumour site in the two tables below. Overall in September provisional information suggests that Lothian met the 31-day but not the 62-day standard. As the following tables indicate, this is largely, although not uniquely, attributable to issues in urology and colorectal pathways.

Table 7: 31-Day Performance

Cancer Type	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
	Percentage that started treatment within 31 days											
All Cancer types	**98.2%**	**95.3%**	**97.4%**	**93.3%**	**94.1%**	**96.2%**	**97.2%**	**96.2%**	**95.8%**	**96.7%**	**96.3%**	**97.1%**
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%	100.0%	100.0%
Cervical (screened excluded)	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened only)	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	n/a	0.0%
Colorectal (screened excluded)	96.9%	96.4%	96.3%	86.4%	94.4%	96.0%	95.2%	88.9%	100.0%	96.2%	90.6%	100.0%
Colorectal (screened only)	100.0%	100.0%	87.5%	75.0%	80.0%	100.0%	100.0%	100.0%	75.0%	100.0%	50.0%	88.9%
Head & Neck	100.0%	92.3%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	93.3%	100.0%
Lung	100.0%	98.4%	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	100.0%	100.0%	100.0%	98.3%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Melanoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurological - Brain and CNS	n/a	n/a	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	85.7%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper GI	100.0%	100.0%	100.0%	95.8%	100.0%	95.8%	95.2%	100.0%	95.2%	100.0%	100.0%	100.0%
Urological	90.4%	84.6%	90.7%	75.9%	73.1%	82.4%	89.5%	85.5%	84.6%	85.5%	92.9%	90.3%

Table 8: 62-Day Performance

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15
Cancer Type	**Percentage that started treatment within 62 days**											
All Cancer types	**96.8%**	**92.9%**	**96.5%**	**94.5%**	**93.1%**	**95.6%**	**96.1%**	**93.4%**	**92.3%**	**95.7%**	**93.4%**	**89.3%**
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened excluded)	100.0%	100.0%	50.0%	66.7%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened only)	n/a	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%	n/a	0.0%
Colorectal (screened excluded)	81.3%	93.8%	93.3%	78.6%	85.7%	87.5%	91.7%	100.0%	84.2%	93.8%	85.7%	90.9%
Colorectal (screened only)	100.0%	100.0%	71.4%	100.0%	66.7%	100.0%	100.0%	100.0%	71.4%	100.0%	50.0%	75.0%
Head & Neck	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	87.5%	66.7%	100.0%	75.0%
Lung	100.0%	100.0%	100.0%	100.0%	94.4%	94.1%	93.3%	93.3%	100.0%	100.0%	100.0%	78.9%
Lymphoma	80.0%	71.4%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	71.4%	100.0%	80.0%	85.7%
Melanoma	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%	0.0%	100.0%
Neurological - Brain and CNS	n/a	n/a	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	50.0%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	50.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper GI	100.0%	91.7%	100.0%	100.0%	90.9%	100.0%	100.0%	83.3%	83.3%	92.9%	100.0%	86.7%
Urological	95.2%	87.5%	94.4%	87.0%	80.0%	82.6%	85.2%	78.6%	92.3%	73.7%	85.2%	77.8%

A group has been established, chaired by the Site Director at the WGH, to look at actions to support sustainable improvement in performance. The group involves a number of clinicians as well as administrative staff involved in the process of tracking patients against their cancer pathway. The group is focusing on a range of areas including training and support for the Cancer Tracker roles, reviews of the escalation pathways for tumour groups and, in collaboration with SCAN, some reviews of cancer pathways. Urology and Colorectal will be priority areas and this work will be undertaken in the first half of 2016 once SCAN facilitation support is made available. Pressure in urology performance is also noted to be, in part, due to pressures on the laparoscopic prostatectomy service - due to increased demand, and also to the recent reduction in the number of operators available. Discussions are ongoing across the region about the long-term direction of this service in regard to the benefits of moving from laparoscopic to robotic prostatectomy.

4.10 **Stroke**

Responsible Director: Chief Officer

Lothian's performance has improved since May with the target being achieved in September. Results are set out in the table below with performance also being presented for each element in the bundle. The composite bundle measure assesses the proportion of patients with an initial diagnosis of stroke, receiving four key elements of care.

The stroke bundle target to be met by March 2016 has been set at 70%, with a stretch target of 75% at RIE. Both service managers and the Board agreed that this trajectory will challenge the current performance, and drive improvement and consistency.

Access to the stroke unit has improved with the combined integrated stroke unit now in place at RIE. Since mid-July there have been 44 beds at RIE, and from August the majority of the beds have been used for stroke patients, improving compliance towards accessing the unit. Despite the longer length of stays associated with an integrated stroke unit, the team at RIE are managing to maintain the flow to create capacity to support admissions.

Table 9: Stroke Bundle Performance

	May	June	July	August	September	**Target**
Stroke Bundle Performance	59.8%	56.4%	50.0%	63.2%	70.8%	**70%**
1. Access to stroke unit by date after admission		66.3%	47.8%	69.8%	75.0%	**85%**
2. Imaging undertaken within 24-hours		95.7%	97.8%	94.7%	97.8%	**90%**
3. Swallow screen on the day of admission		83.0%	81.5%	85.3%	93.3%	**90%**
4. Aspirin by the day following admission		90.3%	87.0%	93.1%	96.4%	**95%**

The unit has adopted a local boarding plan whereby two beds are identified daily, for patients that can be safely boarded when the need arises, to create an available bed for a stroke patient presenting at the front door. In August there were 14 patients failing to access the stroke unit, compared to 23 in July. Better compliance of the phone sweep at RIE has contributed to the improved bundle performance.

The named stroke bundle nurse role at St John's and Western General front door is continuing and their input is ensuring that stroke care is initiated from the onset of admission. Stroke outliers at the Western are now included in the daily 11am ward huddles, and identified for early transfers in the unit. Additional medical cover has been in place during September at St John's, and together with REACT involvement, they were able to facilitate quicker discharges. However with recent medical sick leave the unit is under-covered again. There is no dedicated outreach team at St John's, and the senior nurses in the unit continue to provide stroke outreach and link with the stroke bundle nurse at the front door.

Compliance with swallow screening is now improving and the number of bundle fails due only to the swallow screen is decreasing each month. It is expected that this will further improve as Train the Trainer sessions took place in September – attended by senior front door nurses from across Lothian. Swallow screen training sessions will be included in the induction for the recent divisional-wide recruitment drive in Lothian. This will increase the awareness and skills for all newly recruited nurses for this procedure. An increase in the number of "phone sweeps" to the front doors, to raise awareness of the swallow screen to newly admitted patients, will continue to improve performance.

4.11 **Inpatients and Day-cases (Treatment Time Guarantee)**
Responsible Director: Chief Officer

The table (Table 10) following outlines the number of patients waiting beyond the waiting time standard at month end. At the end of October 277 patients who had waited more than 12 weeks remained on the waiting list, with 293 being treated in the month beyond the guarantee (Table 11). These are the lowest level of breaches since the effective introduction of treatment time guarantee almost 3 years ago. The Scottish Government has been informed that this trend will continue with minimal numbers exceeding the guarantee by the end of 2015. However some subspecialties and areas, such as Urology, Plastic Surgery specifically delayed breast reconstructions, Oral and Maxillofacial Surgery, and Scoliosis are anticipated to remain challenging into the new year.

Table 10: Treatment Time Guarantee Patients waiting beyond standard at month end

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Urology	109	68	63	108	97	137	123	92	104	133	143	116
Plastic Surgery	184	196	256	215	145	114	106	89	86	95	79	55
Orthopaedic Surgery	64	49	89	107	53	88	86	60	55	62	40	32
Maxillofacial	35	30	41	52	42	42	46	34	31	30	33	30
General Surgery	39	18	14	27	22	48	39	18	29	21	15	18
Ear Nose and Throat	49	62	90	102	46	39	38	33	13	28	19	13
Others	18	24	39	38	21	32	38	23	29	29	16	13
Total	498	447	592	649	426	500	476	349	347	398	345	277

Table 11: Treatment Time Guarantee Patients seen beyond 12 weeks

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
TTG Seen	448	397	427	406	564	692	476	463	389	314	314	368	293

Figures on list size and unavailability are shown in the following table (Table 12). The use of unavailability and choice codes in Lothian remains low.

Table 12: List Size and Unavailability

Inpatients

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Total List Size (TTG)	9832	9961	9600	9481	9140	8941	8692	8642	8421	8599	8826	8820
Available	8733	8784	8714	8576	8174	7911	7644	7453	7264	7543	7907	8070
Unavailable	1099	1177	886	905	966	1030	1048	1189	1157	1056	919	750
Percentage Unavailable	11%	12%	9%	10%	11%	12%	12%	14%	14%	12%	10%	9%
non-TTG	328	513	715	691	631	564	574	551	606	572	620	1069

4.12 Outpatients

Responsible Director: Chief Officer

Across NHS Lothian 7,491 outpatients were waiting over 12 weeks at the end of October (the trend is shown in Table 13 below.) The rise over the recent period has been stemmed in the latest month. The Board has been experiencing difficulties in common with others across Scotland.

Discussions with the Scottish Government have outlined the additional steps to be taken in order that the numbers over 12 weeks fall to 4,000 by March. This would effectively address the rise in numbers waiting over 12 weeks since the spring although would not meet the national standard expected of no more than 5% of patients on the outpatient waiting list exceeding 12 weeks. Currently that level sits at 14%.

Table 13: Trend in Outpatients over 12 weeks – Key Specialties

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Trauma And Orthopaedic Surgery	408	459	647	775	517	515	665	558	912	1291	1623	1847
Gastroenterology	263	198	210	252	323	477	671	902	1208	1334	1360	1375
General Surgery (Excl Vascular)	352	288	506	596	342	454	583	632	854	1036	1141	1197
Ear, Nose & Throat (ENT)	292	295	272	269	320	431	504	541	872	1093	1040	681
Urology	339	358	378	339	315	398	438	321	606	648	542	525
Gynaecology	98	112	341	284	97	256	266	216	283	379	446	583
Ophthalmology	288	285	335	481	296	336	378	326	475	395	412	335
Vascular Surgery	6	6	49	65	23	21	23	21	28	93	182	281
Community Child Health	24	66	115	144	122	137	111	92	87	109	104	82
Neurology	380	455	355	261	113	124	125	72	100	107	82	59
Others	252	150	183	155	214	318	497	511	662	448	496	526
Total over 12 Weeks	2702	2672	3391	3621	2682	3467	4261	4192	6087	6933	7428	7491

Table 14: List Size and Unavailability

Outpatients

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Total List Size	43,004	42,639	41,721	42,861	43,694	46,547	48,672	50,243	53,046	52,040	50,788	50,850
Available	42,085	41,527	41,000	41,987	42,878	45,843	47,951	49,004	51,930	50,867	49,746	50,011
Unavailable	919	1112	721	694	816	704	721	1239	1116	1173	1042	839
Percentage Unavailable	2%	3%	2%	2%	2%	2%	1%	2%	2%	2%	2%	2%

4.13 18 Weeks Referral to Treatment Standard

Responsible Director: Chief Officer

October's figure was not available at the time of writing. During September performance on 18 weeks RTT has remained below the 90% standard at 84.9%. This is a slight reduction from prior months and remains below Scotland's overall position.

Table 15: Trend in 18 Week Performance and Measurement

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Patient Journeys within 18 weeks (%)	86.1	87.3	85.9	86.3	85.1	85.6	88.0	86.1	87.0	85.9	87.3	85.2	84.9
Number of patient journeys within 18 weeks	13415	13877	13042	11811	12044	11838	13626	12446	12417	13795	13297	12631	13820
Number of patient journeys over 18 weeks	2163	2014	2137	1873	2103	1996	1861	2001	1849	2265	1941	2201	2449
Patient journeys that could be fully measured (%)	86.3	85.9	86.0	83.4	85.5	85.6	85.8	85.1	85.7	86.0	84.8	84.9	86.7

4.14 Diagnostics

Responsible Director: Chief Officer

The tables below show the breakdown on waits by diagnostic test in October to 2,306 over 6 weeks in endoscopy. In radiology, there were 92 patients waiting over 6 weeks at the end of the month.

Steps have been taken to increase capacity for endoscopy with sessions secured in the independent sector and internally. The service has informed the Scottish Government that by the end of December the number of patients exceeding 6 weeks will be 400, which, if achieved, will better any position in the year to date.

Table 16: Numbers over 6 week standard for Key Diagnostic Tests (Endoscopy)

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Colonoscopy	42	47	49	25	151	100	51	285	303	421	654	674	680	639
Upper Endo	29	41	72	36	261	288	367	654	761	841	978	846	778	850
Flexi Sig	39	19	17	13	99	115	87	262	284	294	310	278	235	246
Flexi Cysto	485	603	602	514	495	288	237	247	224	296	410	470	487	571
Total	595	710	740	588	1,006	791	742	1,448	1,572	1,852	2,352	2,268	2,180	2,306

Table 17: Numbers over 6 week standard for Key Diagnostic Tests (Radiology)

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
CT	0	0	0	0	0	2	3	15	8	6	12	9	9	3
MRI	0	1	0	1	1	0	2	108	123	106	60	38	111	77
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Ultrasound	1	7	21	67	90	40	15	23	13	30	4	5	10	12
Total	1	8	21	68	91	42	20	146	144	142	76	52	130	92

4.15 Surveillance Endoscopy

Responsible Director: Chief Officer

The number of patients waiting beyond their planned review date is outlined in Table 18. Surveillance scopes patients are being offered appointments at the Regional Endoscopy Unit within NHS Fife.

Table 18: Surveillance and Review Patients overdue appointment

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Colonoscopy	96	191	301	447	487	570	614	621	611	627	686	741	869
Upper Endo	71	99	125	206	279	299	320	326	307	340	369	404	436
Flexi Sig	17	18	35	58	80	99	109	119	126	135	155	165	153
Flexi Cysto	334	324	282	263	259	285	196	164	200	235	290	327	342
Other	59	34	62	105	93	98	93	104	100	105	98	106	111
Total	577	666	805	1079	1198	1351	1332	1334	1344	1442	1598	1743	1911

4.16 Audiology

Responsible Director: Chief Officer

An overall 18 week standard applies to audiology patients and such journeys are included with the 18 week figures covered earlier in the paper (please see 4.13). In addition to this pathway standard, audiology services are expected to also meet stage of treatment targets for assessment and both treatment and hearing aid fitting.

These standards are set locally within an overall 18 week timeframe. Adult services elected to adopt 9 week standards for both elements, while paediatric services selected timeframes of 12 and 6 weeks. Small numbers of patients exceeding these standards in both areas are shown in Tables 19 & 20 below for September. Unfortunately at the time of writing, no update is available for October.

Table 19: Adult Audiology – Performance against Standard

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Patients waiting for audiology assessment (first contact)													
Number waiting 9 weeks and over	0	0	0	111	174	5	0	1	0	0	0	1	1
Total number waiting	1608	1464	1662	1939	1710	1683	1810	1756	1161	908	1247	1180	1175
Patients waiting for fitting of hearing aid													
Number waiting 9 weeks and over	1	0	26	215	177	2	0	1	0	2	1	0	2
Total number waiting	995	1007	1024	978	886	789	616	736	796	748	723	761	791
Patients waiting for other treatment (excl. hearing aids)													
Number waiting 9 weeks and over	4	0	8	15	27	6	0	1	0	0	0	0	0
Total number waiting	67	84	116	121	115	117	90	119	137	146	126	142	145

Table 20: Paediatric Audiology – Performance against Standard

	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15
Patients waiting for audiology assessment (first contact)													
Number waiting 12 weeks and over	0	0	0	0	0	0	0	0	0	0	0	0	0
Total number waiting	101	168	238	189	161	229	362	429	435	343	289	180	145
Patients waiting for fitting (excl. hearing aids)													
Number waiting 6 weeks and over	0	0	1	0	17	29	22	16	0	23	11	15	16
Total number waiting	8	7	38	47	50	71	69	56	38	27	60	67	62

4.17 **IVF**

Responsible Director: Chief Officer

90% of those receiving IVF treatment are expected to do so within 12 months from March 2015.

NHS Lothian is currently meeting this standard and using its capacity to assist the reduction of IVF waiting times elsewhere in Scotland.

Publication of this provisional information has now commenced nationally. The numbers waiting at month end are outlined below. These exclude those patients waiting to be seen on behalf of other centres.

Table 21: IVF Waiting List

	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15	Sep-15	Oct-15
Numbers Waiting	242	196	192	192	190	194	178	191	202	194	195	217	215
Numbers over 12 Months	2	3	2	0	0	0	0	0	0	0	0	0	0

4.18 **Drug & Alcohol Waiting Times**
Responsible Director: Director of Strategic Planning, Performance Reporting & Information

Current Board performance against the HEAT 2015/16 minimum target of 90% of people who need help with their drug or alcohol problem waiting no longer than 3 weeks from referral received, to appropriate drug or alcohol treatment that supports their recovery, is over 83%, as at the end of June 2015. Data recording issues (including data accuracy, consistency of monitoring, and reporting arrangements) up-to February 2015, have affected performance reporting. The recording issues relating to data accuracy and consistency of monitoring have been resolved, and difficulties associated with reporting arrangements were remedied for data submission from July 2015.

Edinburgh Community Health Partnership (CHP) has not achieved 90% since the end of June 2014, whereas of the three other CHPs (Midlothian, East Lothian and West Lothian), only West Lothian has missed achieving 90% for Quarter 1 2015 (April – June).

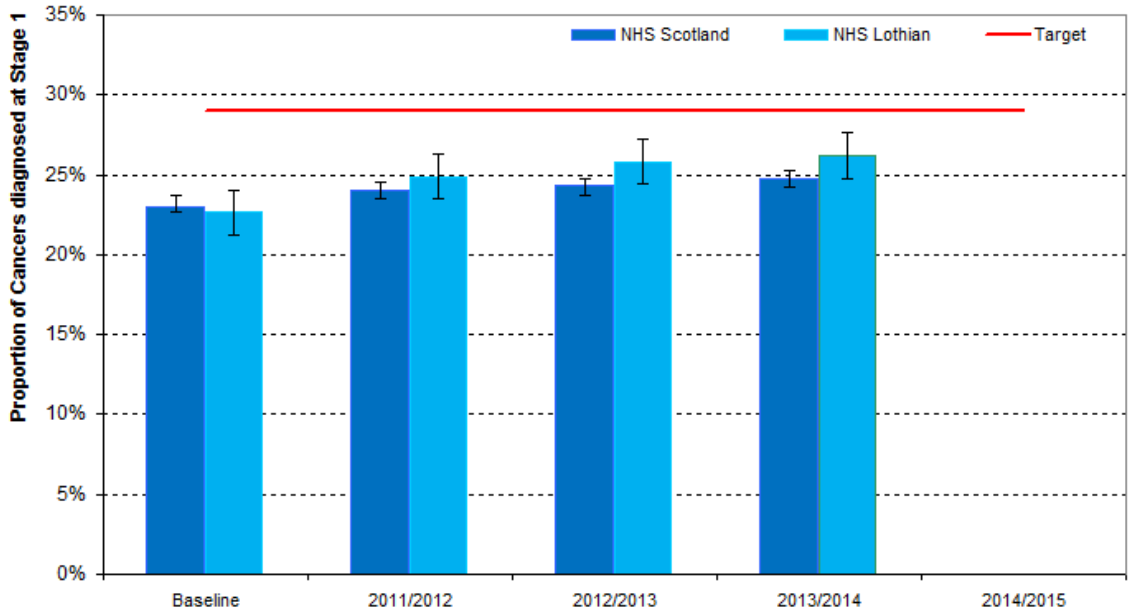
Pan-Lothian work is also being undertaken to improve performance. This includes improvements in data accuracy and consistency, reviewing responses to referrals approaching the 3 week threshold; maximising staff capacity, revising the model of assessment and care, improving capacity, activity levels and productivity of services in Edinburgh, potentially with support from Meridian; and improving capacity, activity levels and productivity of contracted services in primary care and the third sector.

4.19 **Detecting Cancer Early**
Responsible Director: Director of Public Health and Health Policy

This HEAT target is based on increasing the combined proportion of Breast, Bowel and Lung cancers diagnosed at stage 1. A national target of 29% of breast, lung, and bowel cancers combined, diagnosed at stage 1 of disease, is to be reached by the end of 2015.

Figure 2 below provides a performance update for this Programme. This is based on the latest national ISD published data, which relate to the two-year period 2013 & 2014 combined. Current performance is shown for both NHS Scotland overall (1st bar in each year shown), and for NHS Lothian (second bar in each year shown).

Figure 2: Current Performance for NHS Scotland and NHS Lothian



Since the DCE programme's baseline position (years 2010 & 2011 combined) NHS Lothian's performance has moved from 22.6% (Scotland: 23.0%) to 26.2% (Scotland: 24.7%).

NHS Lothian has the highest relative percentage change of all NHS Boards, at 15.9%. This compares to the all Scotland performance improvement, which shows a relative 6.5% increase in the percentage of people diagnosed at stage 1 for breast, colorectal and lung cancer (combined).

5 Risk Register

5.1 Responsible Directors have been asked to ensure that any risks associated with their targets have been clearly identified within the risk register. Risks are escalated to the corporate risk register as appropriate i.e. delayed discharges.

6 Impact on Inequality, Including Health Inequalities

7 As a report on progress, this paper does not require impact assessment in its own right. The HEAT performance framework has been subjected to impact assessment, with programmes assessed individually for impact on health inequalities in the wider population since April 2010 rather than overall.

8 Involving People

9 This paper does not propose any strategy / policy or service change.

10 Resource Implications

10.1 There are no resource implications relating directly to the provision of this report. Financial implications are reported as appropriately to the Board, SMT and other committees.

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NHS LOTHIAN

2.3

Board Meeting
2 December 2015

Chief Officer

UPDATE - REVIEW OF MEDCIAL PAEDIATRIC INPATIENT SERVICES

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress with the planned Royal College of Paediatrics and Child Health (RCPCH) review of acute Medical Paediatric services across the whole of NHS Lothian and the proposed Stakeholder Engagement plan.

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

2 Recommendations

2.1 Note that the RCPCH Review Team visit will take place over three days, from 18 - 20 January 2016

2.2 Consider and approve the proposed Stakeholder Engagement Plan attached at Appendix 1

3 Discussion of Key Issues

3.1 At its meeting on 7 October 2015, the NHS Lothian Board formally agreed to appoint the RCPCH to lead a Review of acute Medical Paediatric services across NHS Lothian and agreed the Terms of Reference for this Review.

3.2 This Pan-Lothian Review will involve an initial intensive 3 day visit to NHS Lothian to meet the clinical teams, see at first hand the services at the Royal Hospital for Sick Children, St John's Hospital and the Simpsons Centre at the Royal Infirmary of Edinburgh and meet with service user representatives and other stakeholders.

3.3 The visit is now scheduled to take place from Monday 18th to Wednesday 20th January 2016 and the clinical teams have been advised. There will be a need for further visits after this which will be arranged as required but will include focus group activity in February and potentially March.

3.3.1 Following discussion with NHS Lothian representatives about the importance of a comprehensive approach to clinician, service user and wider stakeholder involvement, the RCPCH has drawn up a Stakeholder Engagement Plan (Appendix 1) This Plan sets out the range of methods the RCPCH propose to use to seek the views of parents, families, staff and those who represent them, including face to face meetings and an online questionnaire.

3.4 The proposed timetable for this is also set out in Appendix 1 and the Engagement Plan will start with the launch of the online user, staff and stakeholder representative survey in December 2015.

3.5 The final Report from the RCPCH is expected to go to the May 2016 NHS Lothian Board Members Workshop meeting and then on to the June Board meeting.

4 Key Risks

4.1 The risks associated with the staffing situation at St John's Hospital will remain until implementation of the Review's recommendations and this includes the risk that the Children's Ward there may have to be closed at short notice for out of hours periods, for clinical safety reasons.

5 Risk Register

5.1 The risks associated with the fragile staffing situation at St John's Hospital and the potential risk to other related services, are on the Board's Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1.1 A Health Inequalities impact assessment and Equality and Diversity impact assessment will be undertaken as part of the review design and again once the Review is completed.

7 Involving People

7.1 This paper and Appendix 1 set out the proposed engagement process during the Review period. In addition to the stakeholders outlined in Appendix 1, we will also engage with colleagues in primary care including GPs and NHS Lothian Unscheduled Care Services, and with the Edinburgh Integrated Children's Services Board.

8 Resource Implications

8.1 There are no new or significant resource implications arising from this paper.

Jim Crombie
Chief Officer
University Hospitals and Support Services
1 December 2015

List of Appendices

Appendix 1: RCPCH Stakeholder Engagement Plan

Background

Following long-standing recruitment difficulties, and the six-week closure of overnight beds at St John's Hospital in Livingston during July-August 2015, NHS Lothian invited the RCPCH to carry out a review of paediatric services across NHS Lothian.

It is important to again emphasise that this review will look at St John's and the Royal Hospital for Sick Children which is moving into brand new accommodation next year. This move provides the opportunity for an external view of the whole service to identify the best model for long-term provision of paediatric care for the people of Lothian.

The review will consider:

- the optimal configuration of safe, sustainable, high-quality inpatient medical paediatric services to provide for Lothian's population build on research based effective and recognised clinical pathways
- how associated services such as outpatient clinics, urgent and emergency care, medical assessment, and day surgery could be provided as close to people's homes as possible
- how the medical paediatric and nursing workforce can be best used across the sites to ensure service sustainability
- outcome measures to provide transparent evidence of the effectiveness of service distribution[1]

The Review team comprises clinical and lay members and is visiting the area w/c 18 January 2016. They are also being provided with a range of background material from the Health Board and hospitals involved.

Involvement of those who use the services

The Review team is aware of the strength of public feeling around the review and possible reconfiguration of services. Whilst this Review is not a formal public consultation, it is crucial that alongside the practical factors listed above, the Review team understands the direct experiences and expectations of those who have recently used, or are currently using the services. This will be done in a number of ways:

a) Consideration of user views already available. This is a 'desktop' exercise reviewing the patient feedback already collected by the units and NHS Lothian about the services, and also public views submitted and expressed about the review to date.

b) Surveying of parents, families, staff and those who represent them, of their opinions about the services, particularly those who have used them within the last 18 months. This will be managed directly by the RCPCH through an online questionnaire to maintain confidentiality and enable people to communicate openly their views, hopes and fears.

c) Face to face meetings with service user representatives and stakeholders (see stakeholder engagement plan below) during the visit in January 2016.

Other stakeholder engagement activities the College has undertaken in similar reviews, which could be considered for this review include:

a) **Webinar** – an interactive online seminar allowing the review team to provide information on the background, aims and process of the review, and to answer stakeholder questions.

b) **Focus group** -set up by the client themselves against specific criteria which provide the

review team with a fresh and direct perspective on the current arrangement of services, views of those who use them, and the attitude to change. Criteria and guidance for setting up focus groups could be provided if this method was agreed.

However further discussion between NHS Lothian and RCPCH would need to take place before any of these methods could be agreed.

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[1] All four objectives should be with clear reference to RCPCH's published standards within its Facing the Future work stream.

Stakeholder engagement plan

Issues about the reconfiguration have featured heavily over the past year(s) in the public and political domain, with a range of media stories, communications, letters and presentations explaining or challenging the changes available on the internet and directly from NHS Lothian. The evaluation was requested in the
public domain so there will be a high degree of scrutiny to the RCPCH's process and findings. In order to
mitigate challenge in future months and years it is important that all those who consider themselves to be stakeholders are provided with an opportunity to share their views with the team and thus contribute to the evaluation.

A range of individuals and groups will be identified and involved during the course of the work to ensure full engagement and transparency of the final report. Approaches will be either be made directly by the Review team as part of the project, or facilitated by NHS Lothian representatives. Wherever possible these contacts will be face to face, but where this is not feasible email and telephone contact will be used and a survey can capture the views of those we may otherwise be unable to reach.

Notes will be kept of all substantive meetings and communications in order that an evidence trail is available, and information provided will be cross-checked for accuracy wherever possible. We would not usually attribute information in the report to specific individuals and would endeavour to maintain the confidentiality of our sources with a view to open publication of the report once accepted by the Client.

The following table sets out an example stakeholder analysis and summary of the type of engagement that we will conduct during the course of the review. We will draw up a more detailed database of contacts and communication plan to ensure that all receive consistent timely information about the review and feel as engaged as they wish or need to be.

Stakeholder	Purpose of engagement	Approach
NHS Lothian management	Strategic and policy issues	Meetings during visit
Local MPs, MSPs and councillors	Constituent concerns, explaining issues around sustainability.	Correspondence, meeting/call if requested, request to promote survey
Voluntary and parent groups (e.g. BLISS)	Open explanation about review and hearing their views / concerns	Promote survey and offer to meet representatives during visit.
Campaigning group		
Users, parents & public from across Lothian	Opportunity to provide views, maybe something not anticipated. Helps messaging	Survey link through media and units
Deanery / training providers	Alignment of recommendations with future of training scheme, availability of trainees, and requirements to maintain high quality training	Correspondence and meeting

Neonatal network, PIC network, specialised transport	Activity and impact of possible models	Correspondence and meeting if needed
Ambulance provider	Current issues around access and emergency transfers	Correspondence and meeting
Staff at St John's hospital	Structure and delivery of service, hopes and fears, feasibility of new models	Meeting/interviews whilst on site, plus survey opportunity
Staff at The Royal Hospital for Sick Children		
Print and broadcast Media	Maintain calm, promote survey, ensure that messages are agreed open and consistent.	Mainly handled by NHS Lothian with RCPCH input. Need to keep them onside and briefed
Social Media	Promote review and survey Pick up early warnings to be dealt with in meetings/ communications.	Promote on own sites/feeds. Monitor external sites/feeds. Usually policy of not responding unless factually inaccurate.

Engagement timescale

A suggested timeline for the review work is as follows:

October	Initial meeting of Review lead with NHS Lothian and representatives and senior staff from the units.
November	Set up of the review team and confirmation of visit date. Some responsive information provided to politicians and media
December	Formal launch of user and staff survey and communications initiatives. Preparation of timetable for visit. Gathering of relevant data and information.
January	First analysis of survey results, and follow up where indicated. 18-20th Main review team visit. Post-visit correspondence and dealing with issues. Seeking additional information
February	Survey closes. Continue drafting the report, checking facts and models. Possible additional visit or further meetings to test models.
March –May	Drafting report. Fact checking. Report through internal QA at RCPCH. Report shared with NHS Lothian. Visit to discuss models and implementation plan.

Engagement with the media will be managed through or with the agreement of NHS Lothian and with the involvement and oversight of the client and RCPCH leads. RCPCH has a professional communications team who will work in synergy with the Trust where this is helpful.

The survey will be based on models used previously and provides the opportunity for all stakeholders to contribute. Our experience shows that this mechanism works best if conducted directly and publicly by RCPCH through a range of media and provides a useful 'catch-all' for any comments, complaints, queries, etc. Staff are also local users of the service so sometimes complete with both perspectives. We will stress that this is not the forum for complaints, and that these should be directed to the Health Board, but will monitor submissions and respond swiftly if any submissions raise clinical concerns.

Engagement with politicians will recognise the political tension with the forthcoming election but will focus on the sustainability of the service, compliance with standards, and issues raised by constituents. Consistent messages will be given throughout and no opinions will be provided or confirmed until the report is complete.
It is important to consider the position of maternity services. We are making the assumption that there will be no change to maternity provision, but we will need to ensure there are consistent messages.

Further details

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NHS LOTHIAN

2.4

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - NHS LOTHIAN PEFORMANCE DELIVERY

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

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

• To provide an update on 2015-16 Local Delivery Plan approved by NHS Lothian Board on 1 April 2015	1.1
• An update associated with the Local Delivery Plan is outlined in Appendix 1	1.2
• Note progress made with the integration agenda, children's agenda, and developing plans for primary care and house of care	1.3
• Progress associated with LDP standards (previously HEAT targets) particularly in relation to delayed discharge, CAMHS and psychological therapies and unscheduled care performance is not as we would want and is reported to the Board via separate performance reports.	1.4
• Key risks associated with delivery of the LDP and Corporate Objectives are predicated on NHS Lothian's ability to deliver local reinvestment plan assumptions.	4.1

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20 November 2015
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NHS LOTHIAN

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

NHS LOTHIAN PERFORMANCE DELIVERY 2015/16

1 Purpose of the Report

1.1 The purpose of this report is to provide a progress update associated with the delivery of the 2015-16 Local Delivery Plan (LDP) actions. The 2015-16 Corporate Objectives are aligned to the LDP. The LDP and Corporate Objectives were approved by NHS Lothian Board on 1 April 2015.

1.2 Appendix 1 sets out the agreed actions in the LDP and the progress that has been made against these in year. Progress has been reported through use of narrative as many of the targets that need to be achieved are reported to the Board, Corporate Management Team and other committees of the Board on a regular basis for example in the performance and finance reports; waiting times report; HAI and Quality reports. Therefore this paper does not report a red, amber or green status report.

1.3 Much progress has been made in the year to date to progress the integration agenda; the children's agenda as well as developing our plans for primary care and house of care. We are also progressing our thinking and developing a business case to drive the quality improvement agenda which will support service and pathways redesign which in turn will drive safety and quality and efficiency and productivity.

1.4 It is important to note however that progress in relation to a number of the LDP targets and standards, particularly the 2 week delayed discharge target; delivery of the target for CAMHS and psychological therapies and unscheduled care performance are not as we would want and these are reported under cover of separate reports but do require to be highlighted.

1.5 The Board and Corporate Management Team have been appraised of its financial position in year and actions to address this but this alongside workforce planning are key elements of the LDP for this year.

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

2 Recommendations

2.1 To seek Board members comment or questions relating to progress against the priorities outlined in the LDP report (appendix 1)

2.2 The Board notes the risks against delivery of the LDP, particularly in relation to very high and high risk areas relating to delivery of LRP and performance as set out in section 4.1

2.3 That the Board also notes that a Quarter 1 review took place on the 27th July 2015 in advance of the NHS Lothian Annual Review on the 3rd August 2015 to discuss performance and the financial position.

2.4 The Board notes a draft reporting template has been developed to support monitoring of the 2015-16 Corporate Objectives. The template will be piloted during 2015-16 to ensure processes are embedded to support monitoring of 2016-17 Corporate Objectives (appendix 2).

3 Discussion of Key Issues

3.1 The Scottish Government have outlined six improvement priorities for focus within the 2015-16 LDP relating to:

- Health inequalities and prevention
- Antenatal and early years
- Person Centred Care
- Safe Care
- Primary Care
- Integration

The 2015-16 Corporate Objectives have also been structured to mirror the six key strategic improvement priorities set out in the LDP.

3.2 The LDP also outlines how NHS Lothian will support delivery of:

- LDP Standards (previously HEAT standards and targets)
- Financial Planning
- Workforce
- Community Planning

3.4 In addition to this report, NHS Lothian Board and Committees also receive regular reports associated with financial plans, workforce plans, performance, integration and children's services.

3.5 An update on delivery of the 2015-16 LDP is outlined in Appendix 1.

4 Key Risks

4.1 The key risks associated with delivery of the LDP and Corporate Objectives are predicated on NHS Lothian's ability to delivery local investment plans assumptions and have been identified as:

- Very High Risk – Bed reductions, income assumptions, deficit in social care investment
- High Risk – Local reinvestment programme/financial balance, delivery of scheduled care treatment time guarantees, unscheduled care, Edinburgh and East Lothian delayed discharge position, changes to Individual Patient Treatment Review process, introduction of parental and adoption leave, Hepatitis C Drugs cost, SGHD Allocations, Capital Programme and Equal Pay
- Medium Risk – Pay(Terms and Conditions), prescribing, rebates and property sales

5 Risk Register

5.1 Responsible Directors have been asked to ensure risks associated with targets and plans are clearly identified on the Risk Register and risks are escalated to the Corporate Risk Register as appropriate i.e. finance, delayed discharges.

6 Impact on Inequality, Including Health Inequalities

6.1 All approved strategies and plans that support delivery of the LDP will have been subject to Equality and Diversity Impact Assessment.

7 Involving People

7.1 NHS Lothian's LDP and Corporate Objectives are aligned to Our Health, Our Care, Our Future: NHS Lothian Strategic Plan 2014 -2024 which was subject to a public consultation in 2014. On-going strategic and service change developments will also be subject to public and staff engagement.

8 Resource Implications

8.1 NHS Lothian faces challenges in the delivery of the financial plan associated with the 2015-16 LDP and has been subject to detailed discussion at NHS Lothian Board meetings and Board Development Sessions during 2015.

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List of Appendices

Appendix 1: 2015-16 Local Delivery Plan Progress Report

Improvement Priority	LDP Milestones	Progress Update
Health Inequalities and Prevention	<u>Health Inequalities Strategy</u> Increase in targeted community benefits as new projects specified (Nov 2015) Training Developed for Different Staff Groups (Dec 2015) Complete Pilot of Integrated Impact Assessment and identify impact assessment leads in each area (April 2015)	• Integration Joint Boards Strategic Plans should include actions to address health inequalities through the Needs Assessment within the four Lothian health and social care partnerships. An outline of all four draft strategic plans have been will be presented to the Board's Strategic Planning Committee on 10 December 2015 and NHS Lothian Board in April 2016. • A health inequalities strategy implementation group has been established and meets quarterly to monitor implementation of actions. • A draft Health Inequalities Aide Memoire has been developed to inform scrutiny of papers and proposals presented to NHS Lothian Board / Committees to help assess if proposals are likely to increase / reduce health inequalities
	<u>Health Promoting Hospital Services (HPHS)</u> Development of HPHS Priorities Action Plan	• A draft HPHS reporting template was issued to NHS Boards in October 2015 which outlines both existing and a number of new reporting areas. The Director of Public Health is meeting with colleagues to discuss the revised reporting template and will propose a way forward to support the existing work and to address the new reporting areas. • The Scottish Government HPHS Annual Reporting Template will be disseminated to NHS Boards in December 2015 with requirements for completion and submission by 30 April 2016.
	<u>Tobacco</u> Smoke free grounds by 1 April 2015	• NHS Lothian grounds became smoke free on 1 April 2015.
Antenatal and Early Years	Health Visitor Population	• Challenges remain in recruitment and retention of Health Visitors (HV) to support delivery of a named person associated with the Children and Young People (Scotland) Act 2014. An additional 61 WTE Health Visitors are required to meet the named person legislation based on national SIMD quintiles by 2018. • The current gap in HV workforce across Lothian is 27 WTE (18%) with a further 9.3 WTE resignations expected to be enacted by the end of December 2015. • The greatest proportion and impact relates to an establishment gap of 58% within

Antenatal and Early Years	Health Visitor Population	Midlothian. A short life working group has been established to take forward an action plan to manage Lothian wide health visitor pressures. • There were plans to train 26 HV during 2015-16 , however 2 WTE Specialist Practitioner Supervisors (SPS) have taken up HV lecturer posts which has resulted in the need to reduce SPS to HV student ratio and will necessitate a reduction in the January 2016 cohort of students from 10 to 7 students, therefore 23 HV will be trained in 2015-16. • The issues outlined above will result in NHS Lothian not having trained sufficient HV by 2016 and do not expect to be at full HV capacity until 2018-19 at the earliest. • A paper providing an update on implementation of Getting It Right For Every Child (GIFREC) will be presented to NHS Lothian Board on 2 December 2015.
	Implementation of NHS Lothian Children and Young People's Strategy	• Good progress is being made and progress reports will be submitted to the Strategic Planning Committee and Corporate Management Team.
	Family Nurse Partnership - 4th team in place by July 2015	• A fourth Family Nurse Partnership Team is now in place and will begin to recruit clients from 1 August 2015. This is a hybrid team with six nurse supporting Lothian and two nurses support in the Borders. • Due to pressure associated with client numbers, there will be a slight delay in rolling out the service to East Lothian which will begin in late 2015 / early 2016.
	NHS Lothian Maternity Services Strategy 2016 – 2021	• Work is underway to develop an NHS Lothian Maternity Services Strategy 2016- 2021. It is expected a first draft will be taken to the Strategic Planning Committee in March 2016.

Person Centred Care	Tell Us Ten Thing –Local Patient Experience Survey Programme	• A patient experience survey (183 returns) undertaken in all wards at the Royal Infirmary of Edinburgh in March 2015 indicates out of a possible maximum weighted score of 10, responses to 8 of the 10 questions asked scored over 8. The highest scores related to 'treated with kindness and compassion' by the staff looking after you (score 9.48) and 'staff did everything they could to help control your pain' (score 9.13). The results below 8 related to patients being bothered by noise at night from the hospital staff (score 6.66) and happy with the food / meals I received (score 7.25) • In order to realise the aim of 90% of patients using our services have a positive experience of care and get the outcomes they expect, a Patient Experience Quality Improvement Plan has been developed, key aspects to the plan include: - NHS Lothian organisational culture and leadership improves patent, family and staff experience - Direct care delivery is reliable and is delivered in acute collaboration and partnership with patients and staff including the physical environment - Staff are engaged with the organisation to deliver services centred on the needs of people including the physical environment - Staff are open when dealing with people raising concerns or complaint - That there is an infrastructure in place to support system change underpinned by measurement
	Feedback and Complaints	• A draft Annual Feedback and Complaints Report 2014-15 has been produced which outlines improvements undertaken to consult with the public about planned changes in NHS Lothian to ensure a conscious effort is made to keep the person as the centre of all that NHS Lothian does. The draft plan was submitted to the Scottish Government and Scottish Health Council on 30 June 2015 for review and feedback has been sought from members of the public. The report was presented to the Healthcare Governance Committee in July 2015. • Following the external review of the complaint process undertaken earlier this year by Dorothy Armstrong – Listening and Learning from Complaints and Complaints, this report was fully supported by NHS Lothian Board in January 2015 and supports a devolved approach to complaints and feedback. The current Customer Relations and Feedback Team are going through organisational change, the Head of Patient Experience has been appointed and we are working with colleagues in HR and Partnership to support the staff to establish the Patient Experience Team.

Person Centred Care	Feedback and Complaints	• The Patient Experience Team will have two main functions – complaints and feedback and the proactive approach to patient experience through the use of patient stories and surveys. The complaints and feedback devolved approach is being tested in 3 areas: the Western General Hospital, Royal Edinburgh and Associated Services and Edinburgh CHP. This is going well and we are now looking for others to be part of phased 2 which we are planning will be begin in October 2015. The learning and reflections from the 3 tests areas will be incorporated into phase 2. • The Healthcare Governance Committee has received progress reports at the January, March, May and July meetings and there was a presentation given by the Executive Nurse Director at the private session on the 24 June 2015 at the NHS Lothian Board.
	Lothian House of Care	• NHS Lothian continues to lead the House of Care Collaboration in partnership with the Thistle Foundation to support implementation of the approach to deliver more person centered integrated care. Strategically, links have been established with the Choosing Wisely Clinical Change Forum initiative, and with the Edinburgh and Midlothian Health and Social Care Partnerships Strategic Plans. The RCGP has endorsed the approach in its blueprint for General Practice. • The first phase (2015-16) of the House of Care collaboration is focusing on working with 11 GP practices in areas of relative deprivation, and the cardiac rehabilitation service. The second phase of the work (2016-17) will seek to identify and support more partners other than GP practices and NHS services and explore the House of Care approach for people who have a higher proportion of social rather than healthcare needs. Initial funding of £70,000 was received in 2014-15 from the Scottish Government to support House of Care earlier adopter sites. This has since been supplemented by a further £70,000 from the British Heart Foundation. • A cross-sectoral multi-disciplinary Learning Advisory and Resource Group has been established to identify a menu of training options for the health and care workforce to support collaborative care and support planning. This will supplement the training delivered by the Year of Care Partnership as part of the British Heart Foundation support. A measurement and evaluation framework has been developed. Two third sector led groups, Collective Voice and Supported Self Management network, have been formed to support and enable people living with long term conditions.

Safe Care	Scottish Patient Safety Programme and Quality Improvement	• NHS Lothian remains committed to the Scottish Patient Safety Programme. Priorities for action during 2015-16 include spread and sustainability set within a Quality Improvement infrastructure. An annual report associated with the Scottish Patient Safety Programme will be available towards the end of 2015. • A policy relating to 'Choosing Wisely' is being developed to understand the risks of over diagnosis and over treatment, acknowledge the wishes and goals of patients and to recognise the limits of treatments when considering harm, costs and the potential outcomes which might be achieved. • An NHS Lothian Quality Improvement Academy is also in the process of being developed aligned with the work undertaken to date regarding the establishment of the Clinical Change Cabinet and the 'Choosing Wisely' work outline above. A paper outlining NHS Lothian's Clinical Quality Approach was discussed at the meeting of NHS Lothian Board in October 2015.
	Hospital Associated Infections	• Delivery of LDP standards associated with healthcare associated infections (CDifficile and MRSA / MSSA) continues to be challenging. A review of environmental cleaning and standards will be undertaken in 2015-16 with the aim of reducing CDifficile. • A Healthcare Associated Infection Strategy Improvement Plan and performance update will be presented to NHS Lothian Board on 2 December 2015
Primary Care	Take forward work to support the priority areas outlined within the Strategic Plan	• In October 2015, primary care representatives from the Edinburgh partnership visited NHS Forth Valley who are developing a 'toolbox' of options to support general practice with the use of other professions such as pharmacists, Advanced Nurse Practitioners, mental health nurses and NHS 24 to support triage and redirection of patients to community pharmacy with a view to considering these new ways of working in Lothian. • A primary and secondary care interface workshop took place 12 November 2015 where workshops focused on discussion and outcomes relating to outpatient working, prescribing, organising test and 'virtual' clinics and discharge planning and arrangements. A Lothian wide primary and secondary care interface group will be established to support the implementation of the recommendations from the workshop and provide a forum to support ongoing primary and secondary care interface working. • The Scottish Government have designated £6m to support development of primary care digital services focusing on work streams relating to digital online appointment booking / repeat prescriptions, improvements in practice management and administration, digital innovation and national patient portal development. The NHS Lothian Primary Care IT

		Operations Board have been tasked to develop proposals for submission in November 2015.
Integration	Establishment of Health and Social Care Partnerships and Integration Joint Boards	• The Integration Joint Boards have drafted their Strategic Commissioning Plans, which are currently being consulted upon. The NHS Lothian Strategic Planning Committee meeting on 10 December 2015 will focus on reviewing the position in respect of the four IJB strategic plans. Aligned with this discussion will be a review of the position in relation to financial planning and budget setting for the IJB's and NHS Lothian. • In preparation for discussion at the Strategic Planning Committee, IJB Chief Officers have been asked to prepare a list of the Directions which need to be set within their strategic plan. Directions that impact on more than one IJB will be worked through at a workshop session, to consider principles to be applied. The four Lothian Health and Social Care Partnerships Strategic Plans will be discussed at the NHS Lothian Board meeting in April 2016. • The four Lothian Health and Social Care Partnerships Strategic Plans will be presented at the NHS Lothian Board meeting in April 2016 for homologation.
	Support for the Care of Older People	• The four Lothian Integrated Joint Boards have been asked to build this work into their Strategic Commissioning Plans • A costed programme for the work that needs to be taken forward in Edinburgh is being developed and was submitted for consideration by NHS Lothian Board and the Integrated Joint Boards in October 2015. This plan alongside the development of the Edinburgh Strategic Plan will need to fundamentally transform the performance in Edinburgh in relation to people delayed in hospital or 'boarding'.
LDP Standards	Monitoring and Reporting Performance	• Delivering for Patients, an appendix to Our Health, Our Care, Our Future: NHS Lothian Strategic Plan 2014 - 2024 outlines NHS Lothian's commitment to meet and sustain treatment time guarantees and outpatient standards. Implementation of Delivering for Patients is supported through a Programme and Priority Leadership Group to ensure delivery of the national waiting times standards in Lothian. This group oversees the progress of the Clinical Management Teams reviewing and managing performance and to ensure associated risks are managed. • NHS Lothian continues to be challenged in the delivery of the LDP Standards (previously HEAT targets), regular performance reports are submitted to the Corporate Management Team and NHS Lothian Board. The Board should note that progress is

		not cited within this update, the most up to date performance position will be presented to NHS Lothian Board on 2 December 2015. NHS Lothian Board meeting through the standard Board reports on elective and unscheduled care waiting times; the performance paper and Quality and HAI papers.
Financial Planning	Deliver Financial Balance	• A separate paper outlining the Financial Position to October 2015 will be presented for discussion at the NHS Lothian Board meeting on 2 December 2015.
Workforce	Reduction in Workforce Expenditure	• A Human Resources and Organisational Development Strategy June 2015 – August 2018 was approved by NHS Lothian Board in June 2015. The 5 priorities for action outlined in the strategy relate to Healthy Organisation Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Managers • The Learning and Development Strategy Steering Group is currently reviewing and refreshing an action plan to support implementation of the 5 key priorities for action outlined above. The action plan will be presented to the Staff Governance Committee in April 2016. • A review of the corporate administration function has been undertaken, consultation and feedback to those involved in the review is currently being undertaken along with suggested new ways of working. Proposals for skill mix changes will be considered through the workforce organisational change process and Workforce Organisational Change Group.
	Effective Leadership and Management	• A Clinical Change Cabinet which brings together clinicians from across NHS Lothian has been established to support development of the new strategic direction around organisational culture and behaviours. The Cabinet will focus on how we work together to improve quality while using the resources to create sustainability. • Work is underway to establish regular meetings of the Clinical Change Forum and the Quality Improvement Academy.
Community Planning Partnerships	Continue to work with partner organisations to support engagement in community planning	• A NHS Lothian Board Director and Non Executive Director have been appointed to each of the four CPP's • The Edinburgh Community Plan was taken to the April 2015 NHS Lothian Board meeting. The other three plans are expected to be taken to Board or Committees as appropriate. • NHS Lothian and the four community planning partnerships have been actively

		engaged in the development of the legislation around the Community Empowerment • Key relationships between the CPP's and the development of the four IJB's strategic commissioning plans will be important during this initial year. • The Edinburgh Joint Board of Governance for Children's Services has been established.

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NHS LOTHIAN

2.5

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - REFOCUSING PERFORMANCE REPORTING

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

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

Performance reporting is to be refocused in line with best practice elsewhere – and to reflect organisational needs.	1.1
Separate performance and quality reports and associated papers (e.g. HAI) to the Board, CMT and Acute SMT are replaced with a single report based around the six dimensions of quality.	2.1.1
Board reporting will emphasise narrative to highlight responses required by members and mitigating actions that will be undertaken to improve performance .	2.1.2
That comparative performance against peers is considered in various degrees throughout the performance reporting framework.	2.1.5 & 4.2.4
That measures are reported using 'RAG' status against pre-defined criteria.	4.2.1
That data used will be of the highest quality possible.	4.7
That this approach will align with the Information Plan.	4.8
Phase 1 development work spans from calendar year quarter 1 2016, to quarter 1 2017 inclusive, though work will begin immediately. Ongoing, development will be iterative.	Appendix 1

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NHS LOTHIAN

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

REFOCUSING PERFORMANCE REPORTING

1 Purpose of the Report

1.1 The purpose of this report is to advise the Board that the Corporate Management Team have approved the following steps to refocus the reporting of performance in line with best practice elsewhere, and to reflect the needs of the organisation.

2 Recommendations

The Corporate Management Team has recommended that:

2.1 NHS Lothian refocuses arrangements for reporting of the organisation's performance against key measures, underpinned by the following principles:

1. The separate performance and quality reports and associated papers (e.g. HAI) to Board, CMT and Acute SMT are replaced by a single report based around the six dimensions of quality;
2. The Board version of the report will focus on narrative from Lead Directors, to highlight responses required from the Board as well as actions that will be taken to mitigate areas of concern. The CMT, Acute SMT and further committee reporting will balance figures and narrative to ensure appropriate governance;
3. That areas of variance are explored through a standard approach, completed by the Lead Director or on their behalf;
4. That comparative performance against peers is considered within the reports;
5. That consideration be given, on a rotating basis, by all committees as relevant, to detailed scrutiny of all areas covered in the report to identify further quality improvement opportunities;
6. Following the establishment of a corporate level report that "roll-up/roll-down" functionality for these measures, using dashboard technology, be developed to allow identification of improvement opportunities by, and within, management units;
7. The new reporting framework will be aligned with the shift towards Board Committee's taking a lead role for the monitoring and governance of targets and standards as appropriate from first quarter 16/17.

2.2 It is anticipated that corporate level reports to CMT and Board meetings would be in place for the first quarter of 2016/7. Current reporting arrangements would remain in place until the new arrangements are implemented.

3 Background

3.1 Currently a summary of the organisation's performance against key metrics is provided to the Corporate Management Team and the Board at its formal meetings, with the metrics being considered being drawn predominantly from national HEAT standards and trajectories, agreed with the Scottish Government, within the Local Delivery Plan. Separate reports are provided to these meetings, as well as to some other committees covering quality, finance and performance within acute services.

3.2 The current approach is inconsistent with that advocated by Audit Scotland, Health Improvement Scotland and NHS England which emphasise the importance of considering aspects of performance 'in the round' alongside financial and quality considerations. Furthermore the potential for increased scrutiny of improvement actions, and lessons from comparative performance elsewhere has been highlighted.

4 Progress to Date and Next Steps

4.1 Analytical Services have consulted with colleagues from a variety of teams including Strategic Planning, Acute Services, Integrated Joint Boards, Quality and Finance where the need for change has been accepted. Additionally examples of good practice cited by Audit Scotland have been considered as well as those in place in British Columbia Ministry of Health, Intermountain Healthcare, Mayo and Salford. In Scotland mechanisms in place in NHS Greater Glasgow and Clyde, Golden Jubilee and NHS Tayside have been examined and a visit has been undertaken to Greater Glasgow to discuss with them the lessons learned from implementing their approach.

4.2 On the basis of the progress to date the following principles have been identified.

1. A single reporting template for Quality and Performance should be established – dispensing with the separate reporting arrangements currently in place. This will include metrics aligned on a 'best fit' basis under the Scottish Government's 6 Quality themes (Safe, Timely, Effective, Efficient, Equitable, Person-Centred), supporting the 2020 Vision. 'RAG' status for each of these metrics will be provided, against pre-defined criteria. This template will provide committee members with a high level overview of performance;
2. More detailed exception reporting will be included and will be provided by the relevant service area in an agreed format to aid understanding. This will include standardised charts clarifying the nature of any variance;
3. Consideration should be given to an in-depth examination of key areas on a rotating basis, even where performance is reported as acceptable, to fulfil the expectation that "boards and leadership of provider and commissioning

organisations [should]... confidently and competently us[e]... data and other intelligence for the forensic pursuit of quality improvement"[1];

4. Detailed consideration of the Board's performance against peers, drawing on national reports. The Board will receive high level commentary summarising the Board's performance in relation to other NHS Boards and more detailed benchmarking information will be provided to the CMT and Acute SMT.
5. Following the establishment of reporting at a corporate level, that data should be made available on a "roll up/roll down" basis throughout Lothian's management hierarchy, and within IJBs and other services, to support further detailed analysis through use of dashboards, and pursuit of improvement by individual management teams.

4.3 It is envisaged that the new template will be in place for the first quarter of 2016/7 with current reporting arrangements remaining in place to that point, and with the development of dashboards and provision of "roll-up/roll-down" thereafter. A more detailed timescale is provided in Appendix 1.

4.4 Consideration has been given to the potential to incorporate financial reporting within the performance paper. This will be explored further; however, the initial view is that the performance paper should provide a limited overview of finance performance, signposting readers to the separate financial overview.

4.5 Consideration will also be given to the Strategic Planning paper on Performance Delivery 2015/16, considered at October's CMT meeting.

4.6 It is likely that various aspects of the integrated Quality and Performance report will need to be signed off by a number of committees – namely the Acute Services Committee, the Healthcare Governance Committee and Integrated Joint Boards - depending on the role and responsibilities each committee has in terms of performance governance. This will be taken into consideration throughout the re-design process.

4.7 In conjunction with the development of a new reporting process a separate work-stream will be established to focus on data quality which will ensure that the information that is being reported is of as high a quality as possible. Narrative from Lead Directors should aid clarity of meaning where data quality is at issue. Work on improving data quality will be ongoing.

4.8 The performance reporting process will align with the development of the new Information Plan for NHS Lothian.

5 Risk Register

5.1 Risks against elements covered in the performance reports should be identified, where relevant, by the responsible director.

[1] Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report. Professor Sir Bruce Keogh KBE, July 2013.

6 Impact on Inequality, Including Health Inequalities

6.1 An impact assessment will be carried out during the development and selection of metrics for reporting, in order to ensure that both process and measures under consideration reflect NHS Lothian's responsibilities in relation to inequalities.

7 Involving People

7.1 Throughout development of the new reporting process, the project team will be consulting with internal stakeholders in areas of Finance, Quality, Performance and Acute Services.

8 Resource Implications

8.1 The change in the reporting approach, and establishment and maintenance of performance dashboards does involve significant updates to the arrangements currently in place. Given that the emphasis on the use of data is core to the philosophy informing the organisation's QI approach, discussion with the Director of Strategic Planning, Performance Reporting and Information has led to this work being viewed as central for those involved in this approach. There is therefore no additional resource requirement above that.

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List of Appendices

Appendix 1: Timescales

APPENDIX 1

Timescales

Provisional timelines are outlined below and subject to reassessment. Following phase 2, development will be iterative going forward.

Phase 1	Jan-Mar 2016	Review, streamline, amalgamate and agree indicators (including previous omissions) across NHSL and committees in line with the 6 quality themes, possibly with a pilot in one area. Identify further measures to potentially be incorporated subsequently, depending on data availability. Formulate approach to providing narrative and source relevant, timely data.
	Apr-June 2016	Implement new reporting process for committee cycles & gather feedback for development.
	Jul 2016–Mar 2017	Create a beta version of a dashboard, ensuring suitable data architecture is in place to support “roll-up/roll-down”.
Phase 2	Apr-Jun 2017	Expand coverage of dashboard to beyond aspects implemented in phase 1.

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NHS LOTHIAN

2.6

Board Meeting
2 December 2015

Director of Finance

FINANCIAL POSITION TO OCTOBER 2015 AND YEAR END FORECAST

1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with an overview of the financial position for the 7 months to October and an update on the year end forecast.

1.2 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 Members of the Board are asked to:

- **Note** that the cumulative financial position at period 7 shows an overspend of £7.8m across all services, with an in-month overspend of £597k in October;
- **Note** the in month position has benefited from the release corporately of reserves and non recurring benefits totalling £3,216k, a higher proportion of those identified at Mid Year Review than planned;
- **Consider** the risks around delivery of breakeven;
- **Support** the implementation of actions by the Board to support the delivery of a breakeven position;

3 Discussion of Key Issues

3.1 At period 7 of this financial year, NHS Lothian overspent by £597k, bringing the year to date position to £7,781k overspend against the Revenue Resource Limit. This position includes £6,463k of unachieved efficiency savings as well as the release of reserves flexibility of £8,403k reflecting a pro-rata share of total available reserves identified following the Quarter 1 review.

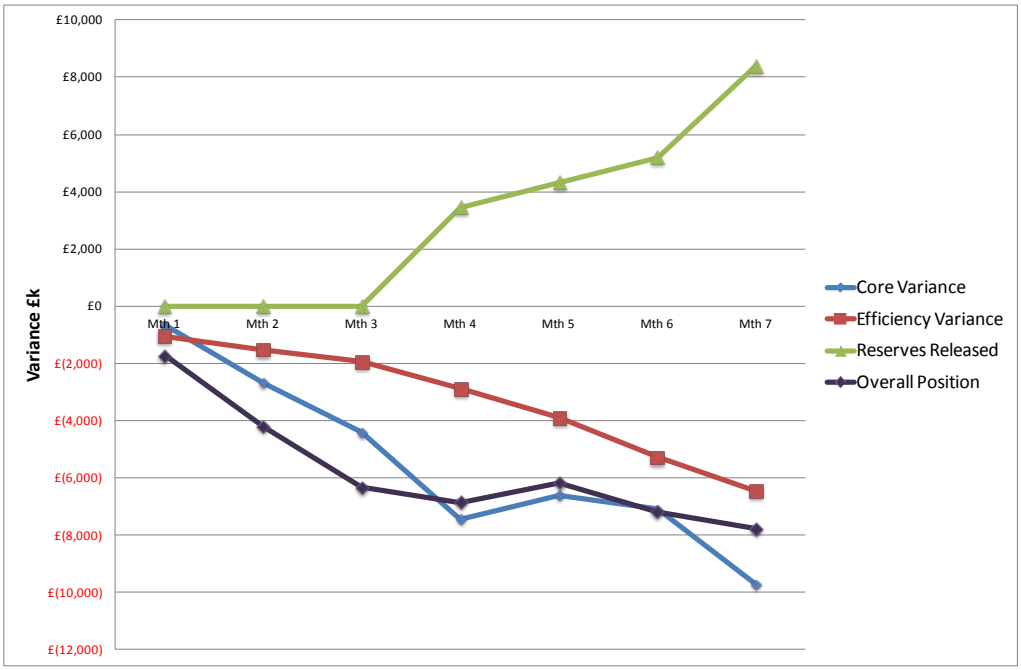
3.2 Table 1 shows a summary of the monthly trend and year to date position. A detailed analysis by expenditure type and business unit is shown in Appendix 1 and by operational unit in Appendix 2.

Table 1: Financial Position to 31 October 2015

	Mth 1 £000's	Mth 2 £000's	Mth 3 £000's	Mth 4 £000's	Mth 5 £000's	Mth 6 £000's	Mth 7 £000's	YTD £000's
Pay	(1,468)	(89)	(266)	(823)	571	144	(64)	**(1,995)**
Non Pay (including GP Prescribing)	846	(1,754)	(1,800)	(3,008)	55	(916)	(2,334)	**(8,911)**
Income	(48)	(169)	351	800	204	273	(225)	**1,186**
Efficiency Savings	(1,044)	(475)	(414)	(949)	(1,008)	(1,384)	(1,190)	**(6,463)**
Operational Position	**(1,714)**	**(2,487)**	**(2,130)**	**(3,980)**	**(178)**	**(1,882)**	**(3,813)**	**(16,184)**
Reserves Flexibility	0	0	0	3,458	865	864	3,216	**8,403**
Total Financial Position	**(1,714)**	**(2,487)**	**(2,130)**	**(522)**	**687**	**(1,018)**	**(597)**	**(7,781)**

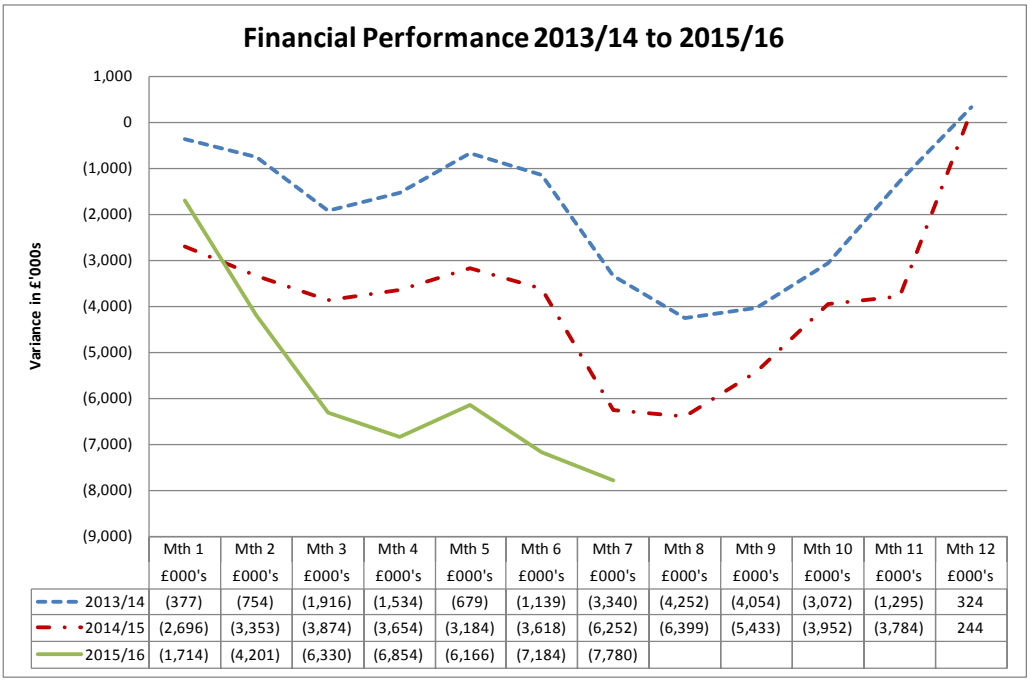
3.3 Table 2 below demonstrates the cumulative variances on the core position, efficiency savings and the level of reserves flexibility over the year which clearly shows a deteriorating position despite increasing levels of reserves released.

Table 2: Cumulative Run Rate



3.4 Table 3 below shows the cumulative overall position for the year compared to the last 2 financial years.

Table 3: Cumulative Run Rate Comparison



	Mth 1 £000's	Mth 2 £000's	Mth 3 £000's	Mth 4 £000's	Mth 5 £000's	Mth 6 £000's	Mth 7 £000's	Mth 8 £000's	Mth 9 £000's	Mth 10 £000's	Mth 11 £000's	Mth 12 £000's
2013/14	(377)	(754)	(1,916)	(1,534)	(679)	(1,139)	(3,340)	(4,252)	(4,054)	(3,072)	(1,295)	324
2014/15	(2,696)	(3,353)	(3,874)	(3,654)	(3,184)	(3,618)	(6,252)	(6,399)	(5,433)	(3,952)	(3,784)	244
2015/16	(1,714)	(4,201)	(6,330)	(6,854)	(6,166)	(7,184)	(7,780)					

3.5 NHS Lothian is currently failing to deliver financial balance against its core budget, with some of the risks highlighted within the 15/16 financial plan materialising. In addition, cost pressures which were expected to be managed as part of the financial planning process continue to overspend.

3.6 The main areas reflecting ongoing pressure against budget are as follows:-

- **GP Prescribing** is reporting an overspend to date of **£5.5m.** The latest data shows an increase in average prices specifically around respiratory items combined with volume increases which were higher than estimated. This latest information on price has caused a further detrimental impact on the predicted year-end forecast.

- The pay overspend is driven predominantly by Nursing costs, reporting an adverse variance to date of **£3.6m.** The main areas of overspend continue to be within Edinburgh CHP and Acute Services.

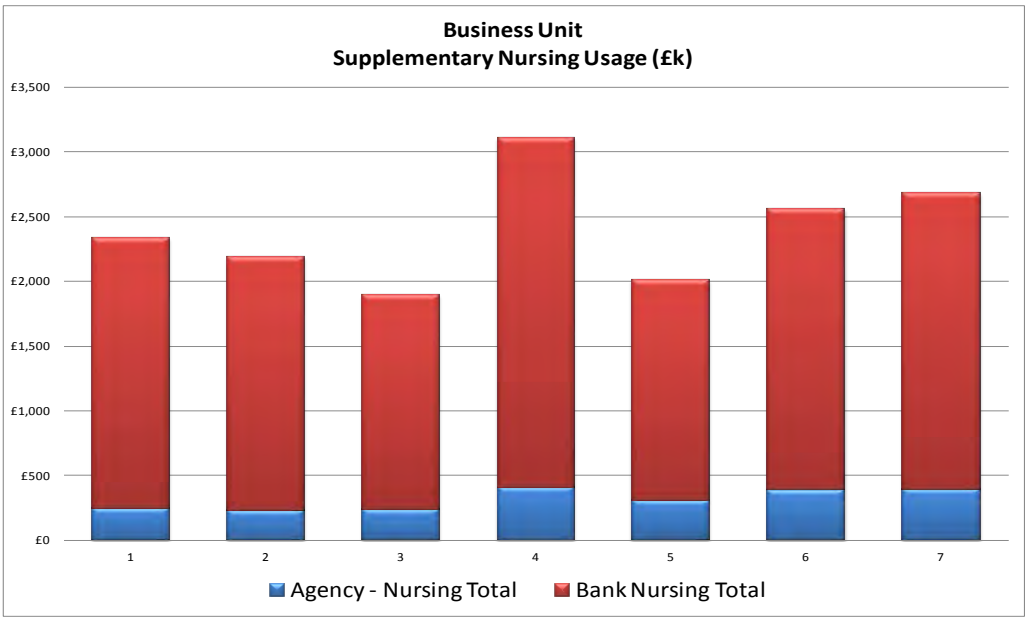
- Acute services are reporting a **£2.4m** pressure in **Nursing** to date, a deterioration of £300k in the month:

    - Continued use of supplementary staffing in theatres to cover vacancies and core sessions continue to cause an overspend. Additional staff have been recruited to fill these vacancies and are being trained accordingly with a view to disengaging from supplementary staff from January.
    - Occupancy levels remain high in Critical Care requiring nursing resource beyond budgeted levels.
    - Opening of additional beds within Surgical and Cancer areas continues to cause a net pressure of approximately £40k per month for the Western General Site. Work is ongoing with the Scottish Government to improve flow and increase discharges to ensure less reliance of flexible beds. High levels of sickness absence and the use of overtime and supplementary staff to cover vacancies adds to the nursing pressures at the site.
    - Directorates had proposed recovery plans that involved a significant reduction in the use of supplementary staffing in order to recover the overall forecast position. With pressures remaining in the system, these plans continue to be having little impact.

- Within Edinburgh CHP the continued use of supplementary staffing in Rehab, Older People and REAS services is driving the £1.2m overspend on the nursing budget, a deterioration of £174k in the month. Analysis of the issues include acuity, 1:1 observations and sickness levels. Month 7 is reporting supplementary staffing usage above the trend position which suggests little progress in achieving a short term solution to this pressure.

- The reduction in Nursing supplementary staffing was a key component in a number of recovery plans, unfortunately this month sees a further increase in supplementary staffing usage. Table 4 below shows the supplementary staffing level trend for Clinical Business Units. The peak in month 4 is in relation to a charging amendment relating to the previous 3 months.

Table 4: Supplementary Staffing Usage



- Whilst pay expenditure in month 7 overall is showing a small overspend, non pay costs continue to run at levels significantly higher than budget available, with an overspend year to date of £3.4m, reflecting a better than trend movement of £225k in the month**.** Acute Services is reporting a £3m pressure with Edinburgh CHP reporting a £751k overspend to date. The main drivers across these business units is medical supplies (£2.4m) and acute medicines (£1.1m) and Equipment Costs (£1m). Recovery plans are in place following the Q1 review to bring the monthly spend back into balance through closer review and monitoring of high cost activity and use of high cost drugs, However, this is again not currently being evidenced by the actual expenditure position.

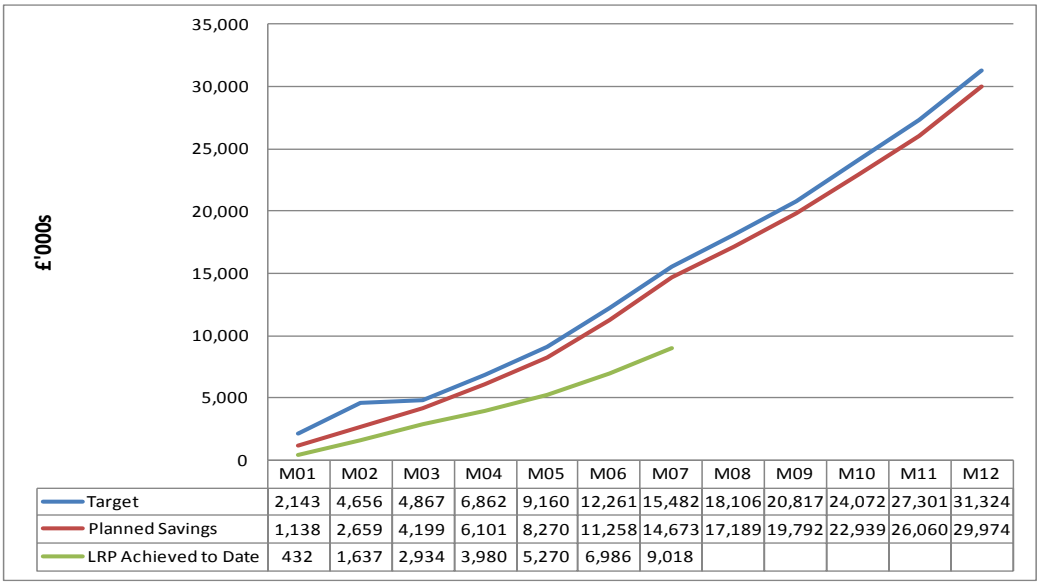
Efficiency and Productivity

3.7 Of the £29.3m plans identified for the year, £14.7m were targeted to be achieved by the end of month 7. With only £9m being achieved, a shortfall against plans of £5.7m is reported. A further £786k slippage gap arises from a pro-rata shortfall against the total target required, bringing the total year to date efficiency slippage to £6.5m. Of this, £4.3m relates to the Acute Services and £1.7m Edinburgh CHP efficiency programmes. Appendix 3 out sets the efficiency savings achieved to date in further detail.

3.8 To achieve this current year end forecast a further £9m of savings above trend will be required to be delivered in the last five months of the year.

3.9 Failure to make efficiency savings to the required £31.3m value presents the health board with a major challenge to deliver breakeven; therefore a significant focus is required to ensure both delivery of the agreed plans and the development of additional schemes to ensure the target is delivered in full both in-year and on a recurrent basis. Table 5 shows the widening gap between required and actual delivery.

Table 5: Trajectory of Efficiencies at Month 7



	M01	M02	M03	M04	M05	M06	M07	M08	M09	M10	M11	M12
Target	2,143	4,656	4,867	6,862	9,160	12,261	15,482	18,106	20,817	24,072	27,301	31,324
Planned Savings	1,138	2,659	4,199	6,101	8,270	11,258	14,673	17,189	19,792	22,939	26,060	29,974
LRP Achieved to Date	432	1,637	2,934	3,980	5,270	6,986	9,018					

4 Year end forecast - Mid Year Review and Update at Period 7

4.1 NHS Lothian has a statutory requirement to breakeven and following the first quarter of the financial year a detailed year-end forecast was undertaken to establish the projected year end outturn based on current information, and agreed actions required to ensure delivery of breakeven. A further review at mid year reflected a small deterioration on the quarter 1 position, however, the forecast update following review of the month 7 position shows a more significant adverse movement at year-end.

4.2 The Period 7 in-month operational overspend of £3,813k does raise concerns on the ability to deliver year-end financial balance. When comparing the anticipated Month 7 position to the Mid Year Review forecast a movement of £2,754k against trajectory is shown. This reflects the significant operational deterioration in the month. A breakdown by Business unit is shown in Table 6 below.

Table 6 – Period 7 comparison of operational position to MYR projections

	MYR - FORECAST VARIANCE	M6 YTD VARIANCE	ANTICIPATED M7 VARIANCE	ACTUAL M7 VARIANCE	MOVEMENT FROM ANTICIPATED M7 VARIANCE
University Hosp Support Serv	(11,431)	(5,737)	(949)	(2,242)	**(1,293)**
East Lothian Chp	(74)	(632)	93	(137)	**(230)**
Edinburgh Chp	(5,824)	(4,435)	(232)	(1,211)	**(980)**
Midlothian Chp	0	(142)	24	(52)	**(76)**
West Lothian Chp	(280)	(612)	55	(211)	**(266)**
Facilities And Consort	1	449	(75)	(230)	**(155)**
Corporate Services	391	137	42	42	**0**
Inc + Assoc Hlthcare Purchases	(4,230)	(2,213)	(336)	(130)	**206**
Strategic Services	1,819	(93)	319	358	**39**
Grand Total	**(19,628)**	**(13,277)**	**(1,058)**	**(3,813)**	**(2,754)**

4.3 The year end forecast has been reviewed based on the Month 7 position and a further deterioration in the outturn operational position of £2m is now forecast.

4.4 Table 7 provides a breakdown of the year-end forecast, comparing the projection at Quarter 1 (an underspend of £286k) with the latest forecast position at period 7, which shows an estimated overspend of £1,760k, and therefore a failure to achieve year-end balance. The latest forecast is based on a series of assumptions, some with significant risk involved.

Table 7: Movements in Year End Forecast

	Quarter 1 Forecast	Month 7 Updated Forecast	Mvt Qtr 1 to Mth 7 Forecast
	£k	£k	£k
University Hosp Support Serv	(10,981)	**(13,420)**	(2,439)
East Lothian Chp	(0)	**(177)**	(177)
Edinburgh Chp	(5,583)	**(7,371)**	(1,788)
Midlothian Chp	0	**(228)**	(228)
West Lothian Chp	(132)	**(412)**	(280)
Facilities And Consort	(109)	**1**	110
Corporate Services	463	**358**	(105)
Inc + Assoc Hlthcare Purchases	(4,498)	**(4,880)**	(382)
Strategic Services	1,819	**1,819**	0
Operational Position	**(19,022)**	**(24,310)**	**(5,288)**
Further Anticipated Commitments	(5,000)	**(3,300)**	1,700
Reserves & N/R Flexibility	23,308	**25,815**	2,507
Other Options net of FP funding shortfall	1,000	**35**	(965)
Grand Total	**286**	**(1,760)**	**(2,046)**

4.5 In addition to the management actions set out at Quarter 1, a number of additional benefits have been identified and assumed in the year end forecast including: the reduction of balance sheet provisions and accruals; the removal of anticipated costs for voluntary severance; and some other higher risk assumptions.

4.6 Other high risk assumptions include the potential to utilise additional Primary Care funding due but not yet received to support pre-existing financial plan commitments; the realisation of financial plan funding that is not currently assumed; and receipts from the sale of properties.

4.7 The delivery of all the management actions and high risk assumptions does not evidence achievement of financial balance, so further recovery actions will be require to be implemented.

4.8 In order to support the delivery of a year-end breakeven position, further remedial actions are required. UHSS and Edinburgh CHP have both been tasked with identifying actions to return to their original quarter 1 year forecast. It is recognised that the identified actions may impact on the delivery of additional Board targets.

4.9 Further additional recovery actions are identified below:-

- Review of winter priorities and uncommitted resources, while looking to achieve full use of all existing, available funded capacity for winter purposes.
- Delivery of savings from revised contracts with private sector during the last 3 months of the year.
- Review of any uncommitted capacity funding.

- Stringent management of discretionary spend.
- Review plans in relation to Hepatitis C treatment targets
- Review SMC new drug plans.
- Rigorous agency spend controls to be introduced.

4.10 These recovery actions will be risk assessed to ensure the financial benefit gained is not offset by other factors.

4.11 Dialogue with the Scottish Government is also ongoing as to the Boards ability to breakeven and the assumptions currently being made, including outstanding funding.

5 Risks and Assumptions

5.1 At this stage, elements of the Financial Plan funding still require to be confirmed. There is £20m assumed Scottish Government allocations included within the annual budget which has not yet been received or confirmed. Just over £4m remains an elevated risk, including assumptions around the delivery of capital to revenue resource which is dependent on asset sales.

5.2 In addition, the ability for the board to deliver against other operational targets, including waiting times and delayed discharges as well as the unknown impact of winter may yet impact adversely on the outturn position.

5.3 The risks in relation to the agreed financial plan were originally set out with some risks now materialising and contributing to the current projected overspend. A detailed list of these risks was considered at Finance and Resources Committee in August. In addition there are now further risks associated with the full delivery of Business Unit financial recovery plans and this has been highlighted earlier in this paper. An updated risk schedule is shown in Appendix 4 in this paper.

6 Risk Register

6.1 The Risk register will be considered and any changes will be made based on the outcome of this review.

7 Health and Other Inequalities

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

8 Involving People

8.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

9 Resource Implications

9.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report at this stage.

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24 November 2015
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Appendix 1: NHS Lothian Income & Expenditure Summary 31 Oct 2015
Appendix 2: NHS Lothian Summary by Operational Unit to 31 Oct 2015
Appendix 3: NHS Lothian Efficiency & Productivity Summary at 31 Oct 2015
Appendix 4: Risk Schedule 2015/16

APPENDIX 1

NHS Lothian Income & Expenditure Summary to October 2015

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)	Period Variance (£k)
Medical & Dental	235,988	137,716	137,266	449	76
Nursing	377,653	219,838	223,527	(3,688)	(576)
Administrative Services	82,269	47,021	47,019	2	144
Allied Health Professionals	60,930	35,547	34,505	1,042	172
Health Science Services	36,554	21,384	20,919	465	130
Management	9,884	5,859	5,488	371	44
Support Services	51,144	29,883	30,690	(807)	(147)
Medical & Dental Support	6,212	3,626	3,523	103	20
Other Therapeutic	24,435	14,411	14,282	129	28
Personal & Social Care	2,984	1,695	1,589	106	27
Other Pay	(3,982)	(4,421)	(4,249)	(172)	16
Emergency Services	28	21	16	5	1
Pay	**884,099**	**512,580**	**514,575**	**(1,995)**	**(64)**
Drugs	116,308	66,812	67,943	(1,131)	(110)
Medical Supplies	84,334	50,103	52,546	(2,443)	(499)
Maintenance Costs	5,651	3,291	3,839	(547)	5
Property Costs	39,004	21,192	19,919	1,274	71
Equipment Costs	26,076	17,716	18,783	(1,067)	(380)
Transport Costs	10,119	6,055	6,330	(275)	30
Administration Costs	145,386	43,367	41,593	1,775	753
Ancillary Costs	14,851	8,654	8,622	32	(90)
Other	12,977	(8,055)	(8,211)	156	219
Service Agreement Patient Serv	88,217	61,236	62,393	(1,157)	(224)
Non-Pay	**542,922**	**270,371**	**273,755**	**(3,384)**	**(225)**
Premises	0	0	0	0	0
Other Payments/Reimbursements	0	0	0	(0)	0
Gps Other Payments	0	0	0	0	0
Gms2 Expenditure	113,690	65,221	65,262	(41)	(815)
Ncl Expenditure	3	1	(46)	48	12
Other Primary Care Expenditure	0	0	74	(74)	(11)
Pharmaceuticals	133,590	79,916	85,425	(5,509)	(1,304)
Primary Care	**247,283**	**145,138**	**150,716**	**(5,577)**	**(2,117)**
Fhs Non Discret Allocation	(2,177)	(1,487)	(1,487)	(0)	9
Bad Debts	0	0	23	(23)	(14)
Other	**(2,177)**	**(1,487)**	**(1,464)**	**(23)**	**(4)**
Income	**(1,722,835)**	**(159,208)**	**(160,447)**	**1,238**	**(225)**
Capital Charges	**0**	**0**	**0**	**0**	**0**
Revenue Resource Limit	**0**	**(24)**	**(45)**	**21**	**13**
Extraordinary Items	**0**	**0**	**0**	**0**	**0**
CORE POSITION	**(50,709)**	**767,370**	**777,089**	**(9,719)**	**(2,623)**
Savings Target Non-Pay	(6,463)	(6,463)	0	(6,463)	(1,190)
Additional Reserves Flexibility	8,403	8,403	0	8,403	3,216
TOTAL	**(58,800)**	**769,310**	**777,089**	**(7,780)**	**(597)**

NB. The above table relates to Core Services only. There is £58,800m of Non Core Budget not shown above that balances the Annual Budget to zero.

NHS Lothian Summary by Operational Unit to October 2015

APPENDIX 2

Description	University Hosp Support Serv (£k)	Edinburgh Chp (£k)	East Lothian Chp (£k)	Midlothian Chp (£k)	West Lothian Chp (£k)	Corporate Services (£k)	Facilities And Consort (£k)	Strategic Services (£k)	Inc + Assoc Hlthcare Purchases (£k)	Reserves (£k)	Total (£k)
Annual Budget	**646,949**	**307,253**	**86,612**	**53,233**	**120,686**	**89,446**	**137,842**	**8,228**	**(1,569,771)**	**60,722**	**(58,800)**
Medical & Dental	572	333	(207)	53	(229)	173	(13)	(233)	0	(0)	**449**
Nursing	(2,416)	(1,247)	368	172	(265)	(258)	(16)	(28)	0	0	**(3,688)**
Administrative Services	274	73	(13)	(57)	(135)	(10)	(89)	(40)	0	0	**2**
Allied Health Professionals	(148)	184	11	228	86	(133)	0	(2)	0	816	**1,042**
Health Science Services	230	177	8	(12)	63	14	0	(16)	0	0	**465**
Management	130	158	(0)	36	2	90	(53)	8	0	0	**371**
Support Services	(192)	53	(23)	0	(28)	57	(673)	(1)	0	0	**(807)**
Medical & Dental Support	(34)	(1)	0	0	89	48	0	0	0	0	**103**
Other Therapeutic	45	25	28	(8)	(172)	218	0	(6)	0	0	**129**
Personal & Social Care	(23)	(17)	17	0	0	129	(1)	0	0	0	**106**
Other Pay	(109)	(27)	(7)	0	0	(9)	(20)	0	0	0	**(172)**
Emergency Services	0	0	0	0	5	(0)	(0)	0	0	0	**5**
Pay	**(1,671)**	**(288)**	**183**	**412**	**(583)**	**320**	**(865)**	**(319)**	**0**	**815**	**(1,995)**
Drugs	(1,126)	36	(20)	(25)	(83)	127	(1)	(247)	0	209	**(1,131)**
Medical Supplies	(1,520)	(661)	(78)	(58)	(80)	40	(51)	(35)	0	0	**(2,443)**
Maintenance Costs	(333)	(88)	(21)	23	(34)	(78)	(10)	(6)	0	0	**(547)**
Property Costs	(20)	12	(23)	(11)	33	14	1,277	(8)	0	0	**1,274**
Equipment Costs	(733)	(67)	(163)	(35)	49	61	(37)	(128)	(14)	0	**(1,067)**
Transport Costs	(116)	(12)	(27)	15	67	(68)	(133)	10	(10)	0	**(275)**
Administration Costs	880	175	413	50	137	(409)	64	467	(1)	(0)	**1,775**
Ancillary Costs	91	2	14	23	8	(17)	(88)	(1)	0	0	**32**
Other	15	(1)	0	0	14	136	(7)	0	0	0	**156**
Service Agreement Patient Serv	(90)	(147)	167	0	(39)	353	0	819	(2,220)	0	**(1,157)**
Non-Pay	**(2,953)**	**(751)**	**262**	**(17)**	**71**	**158**	**1,013**	**869**	**(2,245)**	**209**	**(3,384)**
Premises	0	0	0	0	0	0	0	0	0	0	**0**
Other Payments/Reimbursemen	(0)	0	0	0	0	0	0	0	0	0	**(0)**
Gps Other Payments	0	0	0	0	0	0	0	0	0	0	**0**
Gms2 Expenditure	(7)	196	(370)	(28)	170	(2)	(1)	0	0	0	**(41)**
Ncl Expenditure	47	(0)	1	0	0	(1)	0	0	0	0	**48**
Other Primary Care Expenditure	(74)	0	0	0	0	0	0	0	0	0	**(74)**
Pharmaceuticals	(1)	(2,865)	(749)	(616)	(1,278)	0	0	0	0	0	**(5,509)**
Primary Care	**(36)**	**(2,668)**	**(1,117)**	**(644)**	**(1,108)**	**(3)**	**(1)**	**0**	**0**	**0**	**(5,577)**
Fhs Non Discret Allocation	0	0	0	0	(2)	1	0	0	0	0	**(0)**
Bad Debts	(24)	(0)	0	0	(1)	(0)	(0)	2	0	0	**(23)**
Other	**(24)**	**0**	**0**	**0**	**(3)**	**1**	**(0)**	**2**	**0**	**0**	**(23)**
Income	1,050	(171)	(14)	16	267	(62)	310	(60)	(98)	0	**1,238**
Income	**1,050**	**(171)**	**(14)**	**16**	**267**	**(62)**	**310**	**(60)**	**(98)**	**0**	**1,238**
Capital Charges	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Revenue Resource Limit	**0**	**0**	**0**	**0**	**0**	**21**	**0**	**0**	**0**	**0**	**21**
Extraordinary Items	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
CORE POSITION	**(3,634)**	**(3,879)**	**(686)**	**(233)**	**(1,355)**	**437**	**457**	**492**	**(2,342)**	**1,024**	**(9,719)**
Savings Target Non-Pay	(4,344)	(1,767)	(83)	38	531	(258)	(238)	(343)	0	0	**(6,463)**
Additional Reserves Flexibility	0	0	0	0	0	0	0	0	0	8,403	**8,403**
TOTAL	**(7,979)**	**(5,646)**	**(769)**	**(194)**	**(823)**	**178**	**219**	**150**	**(2,342)**	**9,427**	**(7,780)**

NB. The above table relates to Core Services only. There is £58.800m of Non Core Budget not shown above that balances the Annual budget to Zero.

APPENDIX 3

NHS Lothian Efficiency and Productivity Summary as at Month 7 2015/16

Business Unit	Total Recurring Target	Current Year Plans	Gap on In Year Plans	Current Month Position					Year to Date Position				
				October					April - October				
				Plans Phased to Date	Actual Delivery	Slippage on Plan	Gap Phased to Date	Total Slippage	Plans Phased to Date	Actual Delivery	Slippage on Plan	Gap Phased to Date	Total Slippage
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
East Lothian Chp	465	1,203	(738)	163	24	140	(123)	17	558	59	500	(430)	69
Midlothian Chp	447	744	(297)	106	39	68	(49)	18	283	160	123	(173)	(50)
Edinburgh Chp	4,658	3,784	874	270	76	194	136	330	2,089	880	1,209	510	1,719
West Lothian Chp	377	1,342	(964)	192	108	85	(164)	(79)	595	588	8	(563)	(555)
Prescribing	1,298	3,325	(2,027)	470	0	470	(338)	132	1,670	390	1,279	(1,183)	97
Acute Hospital Services	15,846	11,820	4,025	852	725	127	432	559	5,670	3,674	1,996	2,348	4,344
Facilities & Consort	3,208	3,242	(34)	916	785	131	(6)	125	2,048	1,791	258	(20)	238
Total Business Units	**26,298**	**25,460**	**838**	**2,969**	**1,755**	**1,214**	**(112)**	**1,102**	**12,913**	**7,540**	**5,373**	**489**	**5,862**
Corporate Services & Strategic Programmes													
eHealth	1,355	912	443	58	61	(3)	74	71	355	237	118	259	376
Finance	408	1,411	(1,003)	118	27	91	(167)	(77)	240	258	(18)	(585)	(603)
Human Resources & Communications	593	678	(85)	61	40	20	(14)	6	409	287	122	(49)	73
Medical Director	121	122	(1)	10	10	0	(0)	(0)	71	71	0	(1)	(1)
Nursing	226	227	(1)	20	19	1	(0)	1	126	132	(6)	(0)	(7)
Pharmacy	1,012	390	622	(19)	28	(47)	104	56	227	196	31	363	394
Planning	178	150	28	11	11	0	5	5	85	75	9	16	25
Public Health	498	501	(3)	32	32	(0)	(1)	(1)	175	173	2	(2)	(0)
Strategic Programmes	552	124	428	(5)	0	(5)	71	67	93	0	93	250	343
Strategic - Other	82	0	82	(7)	48	(55)	14	(41)	(0)	48	(48)	48	0
Total Corporate Depts & Strategic Programmes	**5,024**	**4,514**	**510**	**279**	**277**	**2**	**85**	**87**	**1,781**	**1,477**	**303**	**297**	**601**
Total	**31,323**	**29,974**	**1,348**	**3,248**	**2,032**	**1,217**	**(27)**	**1,190**	**14,694**	**9,018**	**5,676**	**786**	**6,463**

NHS Lothian 15/16 Risks and Assumptions updated as at Month 7 APPENDIX 4

Key Assumptions / Risks	Risk rating	Impact	Month 7 Review Update
Efficiency Savings	High	Delivery of recurring savings to the value required to meet the known gap between anticipated income and planned activities.	A savings target of £31.3m has been set to cover the gap in the plan and additional carry forward savings target. As part of the financial planning cycle savings schemes of £29m were proposed. The latest forecast predicts a shortfall of £7.5m
Scheduled Care	High	There requires to be continued management of the financial exposure on elective capacity pressures. The risk is that additional investment in capacity will not deliver the required volume to meet the DFP Strategy.	Risk remains that delivery of TTG and WT standards within agreed timescales will impact on financial performance. Variation in demand and availability of core capacity will affect performance against trajectory; Management within budget will limit service ability to access variable capacity (private sector, WLI). Additional Risk that failure to deliver required savings may impact on resources available to support delivery of TTG, etc. The resources available to support TTG and WT are based on delivery of efficiency savings. This will be at risk if the efficiency targets are not met.
Unscheduled Care	High	Continued management of the financial exposure on unscheduled care capacity pressures	Actions were taken to close unfunded beds in USC or identify alternative funding sources, however, additional capacity continues to be an issue on the acute sites and costs are being incurred on flexible bed usage.
Delayed Discharge	High	Need to manage the volume of delayed discharges and the cost of new initiatives that will be required to deliver the required reductions.	The overall delayed discharge performance is not improving and continues to cause significant issues with flow across the acute sites. Lack of sufficient community capacity continues to be an obstacle.
Parental and Adoption Leave	High	The implementation of paid parental leave until the child is 14 years has been modelled with various scenarios. No additional funding has been assumed in the Financial Plan.	With limited information on the take up of Parental Leave it is difficult to ascertain at this stage any additional costs that have impacted on the pay position, however this may be a reason for the continued high use of supplementary staffing. There is nothing specifically built into the forecast to the year-end on additional cost.
Rates Rebates and Property Sales	High/ Medium	The ongoing rateable value appeal of the GMS properties could generate substantial backdated rebates. An initial £5m was been assumed as part of the non recurring support available for 2015/16.	Rebate has been received and the amount available corporately for non recurring support for 2015/16 is confirmed as £3m. Risk is now low.
Prescribing	Medium	A sustained level of short supply has been included in the financial plan along with growth and price increases, however there is the potential for increases to be greater than projected.	Prescribing forecast is now £7.6m overspent. This assumes full delivery of £4m efficiency target. Projects are identified to reach the target although only £1m has been delivered at month 7. The 15/16 outturn is based on 3.4% growth on 14/15 spend. In 2015/16 volume growth has been relatively low but prices have not fallen to a level that would match available budget. Volume prediction is a 2% growth with prices at 1.4% Recovery plan projects developed in 15/16 around Scriptswitch and Scottish Therapeutics utility will now see benefits in 16/17. Lothian expenditure growth is consistent with peers and there is differentially higher population growth in Lothian.

Key Assumptions / Risks	Risk rating	Impact	Month 7 Review Update
Changes to the IPTR process	High	It has been assumed that these costs will be offset by national savings in the drug tariff along with any further costs incurred in year.	Risk Remains over receipts from New Medicine Fund although substantial allocation has been received. IPTRs will be monitored separately and not treated under blanket allocation. As more Drugs reach approval by SMC, IPTR spending is expected to be less than in 14/15 and still assumed to be fully funded. The risk is also in wider NMF issues and risk remains HIGH
Hep C Drugs	High	The usage of the new range of Hep C Drugs is greater than the costed projection.	There has been progress on delivering better prices for Hep C drugs but risks remain due to higher target treatment levels being introduced and this spend needs to be monitored. The move to community delivery took up pace in June and gives more confidence that LRP will be delivered. The Advanced Clinical Pharmacist is working through the savings generated from the change in practice, and anticipating being able to book savings for November in line with plans but depends on the level of resource available from the SMC reserve. Risk is now Medium.
Changes to pay T&Cs, specifically the implementation of transitional points under AFC and ongoing discussions with Consort on the full implementation of the Two Tier Working Agreement	Medium	The financial consequence has not be included in the financial plan and will need to be monitored as the year progresses.	Unison and Cofely have now agreed a timescale for payment of the backdated basic pay and unsocial hours elements, the cost of which is approximately £2.7m to be paid in Dec. There remains a further £1.4m under negotiation for full implementation of TTW. This can be funded from the Pay Terms and Conditions reserve but will reduce the level of support available to achieve financial balance in year.
SGHD Allocations	High	Availability of SGHD funding for previously separately funded programmes and initiatives.	Financial balance has been predicated on the assumption of a number of allocations and funding streams. An assessment has been made of non delivery of some of the assumed funding and has been factored into the year end forecast.
Capital Programme	High	NHSiL has an ambitious capital programme which requires significant resources in addition to those available to deliver against the plan. The revenue consequences of the programme are a significant pressure to the organisation	A prioritisation process was approved by CMT, enabling LCIG to reduce the in-year over commitment to a manageable level. NHS Lothian continues to see support for costs relating to schemes in governance over its delegated limit. An ongoing risk exists for those schemes for which there is no funding, including the level of investment in medical equipment, backlog maintenance, eHealth and acute / primary care service redesign.
Equal Pay	High	Discussions are continuing with CLO and Audit Scotland with regards to the treatment of this potential financial exposure.	Assumption at present is that the Scottish Government will cover any costs. Current projections are that the costs will be lower than originally anticipated.
Winter Beds	High	The risk remains whether sufficient additional resources are available to meet the pressures from anticipated winter demand	Winter plans have been agreed and costed, with funding ready to go into services. Recruitment in most cases has been completed. Where agreed funding was at a level lower than original plan, the services have redrafted their plans to allow for the reduced funding levels, however, following the month 7 forecast, a further review of Winter priorities is being reviewed. Risk remains in relation to the actual impact winter will have on activity, flow and services.

NHS LOTHIAN

2.7

Board Meeting
2 December 2015

Medical Director/Director of Human Resources and Organisational Development/Nurse Director

SUMMARY PAPER - WORKFORCE RISK ASSESSMENT

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

• There is a relatively low level of vacancies as percentage of the total consultant workforce 47.8wte (4.6%) for the year to date, whilst there are 21.7wte (16%) within staff grade and associated specialists. There are however a number of specialties where it is not possible to fill posts despite repeated attempts to do sol. • During April to August a total of 84.7wte of posts were advertised for recruitment, 49% were fully filled, with 14wte of posts only partially filled by 7wte, providing a combined fill rate of 57%. Of the 43% that were unfilled 23.9wte (28% of total) received no applicants, with the reminder receiving applicants that were either not suitable or who withdrew prior to commencement.	3.2.1 3.2.2
• Recruitment to a permanent Consultant post based at Roodlands at the end of September was unsuccessful, however a locum consultant has been appointed. An interview is planned for January 2016 for a MoE consultant post covering the RIE & Roodlands and recruitment will commence shortly on recruitment of a specialty doctor to provide cover for wards and ELSIE service. • Trainees will be removed from Roodlands at the weekend from the end of January, which will better meet training and supervision needs and support out of hours services at the RIE at the weekend.	3.2.3
• Recruitment measures in the Perinatal Mental Health Service have attracted applications with interviews scheduled for the end of November.	3.2.4
• Interim arrangements remain in place to sustain the Regional Eating Disorder Unit until current consultant recruitment is complete.	3.2.4
• The Scottish Government has announced an intention to increase GP Training places from 300 to 400 across Scotland. This will however be challenging given current difficulties in filling GP training posts.	3.3
• The Healthcare Sciences(HCS) Forum is leading the development of a workforce plan for healthcare sciences to support the implementation of the National HCS Action Plan and NHS Lothian clinical strategy.	3.4
• Health visiting services with Midlothian are experiencing a very high number of vacancies due to a high level of retirals. A detailed action plan is in place to sustain services whilst a recruitment campaign is developed.	3.5.1

Nick McAlister
Head of Workforce Planning
13 November 2015

NHS LOTHIAN
Board Meeting

2 December 2015

Medical Director/Director of Human Resources and Organisational Development/Nurse Director

WORKFORCE RISK ASSESSMENT

1 Purpose of the Report

The purpose of this report is to update the Board on the actions currently underway to ameliorate risks to service sustainability within specialties where high levels of risk have been identified. The scope of the paper has been widened to consider workforce risk within the wider workforce.

2 Recommendations

2.1 Acknowledge the challenges that remain with the recruitment of trained doctors and the potential financial impact this can have in relation to workforce alternatives.

2.2 Acknowledge the positive work that is underway in East Lothian to develop a more outward community focused integrated service and note the appointment of a locum consultant to provide cover for Roodlands until January 2016 when interviews will take place for a permanent consultant post.

2.3 Note the removal of trainees from Roodlands at the weekend from the end of January, which will better meet training and supervision needs whilst enhancing weekday service contribution and supporting out of hours services at the RIE at the weekend.

2.4 Acknowledge the success of the recruitment measures in the Perinatal Mental Health Service, which has attracted applications with interviews scheduled for the end of November. Recruitment to two consultant posts within old age psychiatry has however once more been unsuccessful.

2.5 Note the aims of the national delivery plan for healthcare science and the work of the Lothian Healthcare Science Forum to develop a workforce plan to support workforce sustainability across the branches within healthcare science. Further detail will be provided in subsequent papers of current pressure areas and the actions underway to support sustainability.

2.6 Note the emerging demographic pressures within nursing and the national process to plan student nurse intakes to ensure adequate supply in the coming years.

2.7 Acknowledge that these demographic pressures are already causing substantial challenges for the retention and recruitment of health visitors within Midlothian in particular where it has been necessary to put contingency measures in place to ensure workforce and service sustainability.

3 Discussion of Key Issues

3.1 Background

Since April 2013 a paper has been brought to the board to provide members with an understanding of where NHS Lothian faces pressures within the medical workforce. Many of the pressures that NHS Lothian faces are national and in some cases UK-wide.

In the October the paper was revised to provide an increased focus on appraising members of the performance of our recruitment processes and highlighting the financial impact associated with measures required to support service sustainability.

3.2 Progress in addressing key medical workforce risks

3.2.1 NHS Lothian Medical Workforce Establishment

As with other job families there is an overall medical workforce baseline budget establishment, the following table details how this is distributed across the medical workforce.

Row Labels	2015/16 Establishment	YTD WTE Average	Month 6 WTE in-post
Dental Career			
Clincal Director Dental	1.62	1.20	1.2
Consultant Dentist	15.55	14.76	16.65
Dentist	49.53	46.71	44.81
SAS	4.5	3.88	4.03
Dental Career Total	**71.2**	**66.55**	**66.69**
Dental trainee			
Dental trainee	0	1.68	1
Dental trainee Total	**0**	**1.68**	**1**
Medic Career			
Associate Specialist	52.15	63.63	63.15
Consultant	963.13	918.15	927.81
GP	6.15	12.71	16.77
Other	60.79	57.48	56.67
SAS	134.85	113.13	112.24
Medic Career Total	**1217.07**	**1165.10**	**1176.64**
Medic Trainee			
Trainee	1055.53	960.96	1014.95
Other Registrar	2	0.00	
Locum - House Officer	5	0.00	
Medic Trainee Total	**1062.53**	**960.96**	**1014.95**
Grand Total	**2350.8**	**2194.28**	**2259.28**

These establishments represent the baseline funded staffing budgets within each service area. It is clear that in a number of instances as has been detailed within previous board papers there remain areas where it is not possible to recruit.

Within the training grade workforce where a post cannot be filled Boards are able to use the unspent salaries to pay for alternative staffing to cover rota gaps. This may represent posts such as Clinical Development Fellows which are not established posts, they are however employed to provide cover for a range of areas and reduce reliance on short term forms of supplementary staffing. This funding is also used for short term supplementary staffing to cover gaps in rotas or posts where it is not possible to fill on a substantive basis. Where trainee posts are filled as part of the annual recruitment process on a less than full-time basis the unspent funding remains with NES and may be used to fund new specialty training posts at a national level. This however potentially leaves a funding pressure for Boards to pick up.

3.2.2 Vacancies under recruitment

As highlighted in the previous section NHS Lothian seeks to recruit to vacancies when they arise and where it is not possible alternatives are used to sustain services. The following table details trained doctor recruitment in the period April 2015 to the end of October 2015 where the recruitment process has concluded detailing both whole time equivalent and specialty.

Speciality	Fully Filled	Partial - 1 of 2	Partial - 1 of 3	Partial - 2 of 3	Partial - 2 of 4	No applicants	Applicants by not filled	Candidate Withdrew	Grand Total
Acute Medicine						2.0		1.0	3.0
Acute Medicine & Stroke Medicine	2.0								2.0
Anaesthesia					4.0	2.0			6.0
Anaesthetics	1.0								1.0
CAMHS	1.7								1.7
Cardiothoracic Surgeon	2.0								2.0
Community Child Health							1.0		1.0
Dental	1.1								1.1
Dental (Paediatric)	0.9								0.9
Dermatology	1.0								1.0
Forensic Psychiatry	0.8								0.8
General Adult Psychiatry	2.0					1.0			3.0
General and Upper GI Surgery x 2		4.0							4.0
General Medicine	1.0							1.0	2.0
GP	1.4								1.4
GP Performers list						0.0			0.0
GP with Special Interest in Diabetes						0.5			0.5
Haematology	1.0								1.0
Histopathology						1.0			1.0
IPCU Psychiatry	0.5								0.5
Medicine of the Elderly	0.6		3.0			5.0			8.6
Medicine of the Elderly & Stroke x 2 posts						1.0			1.0
Mgt GP	0.1								0.1
Microbiology	1.0								1.0
MOE & Stroke	0.4								0.4
Neuroradiology	1.0								1.0
Obs and Gynae	2.0			3.0					5.0
OHS Sessions						0.0			0.0
Old Age Psych						2.0			2.0
Old Age Psychiatry	1.0					2.0			3.0
Oncology	1.0								1.0
Ophthalmology (DMO)						1.0			1.0
Ophthalmology (Glaucoma)	1.0								1.0
Ophthalmology (Paediatric)	1.0								1.0
Oral Medicine						1.0			1.0
Paedatric A&E	1.0								1.0
Paediatric Anaesthesia							1.0		1.0
Paediatric Intensive Care						1.0			1.0
Perinatal Psychiatry						1.4			1.4
Plastic Surgery	1.0								1.0
Psychiatry LD	2.6					1.0			3.6
Public Dental (Special Care)	0.9								0.9
Public Health	1.0						0.4		1.4
Radiologist	2.0								2.0
Radiology/Breast Screening	0.8								0.8
Rehab Psychiatry						2.0			2.0
Rheumatology	1.0								1.0
Salaried GP	0.6								0.6
Salaried GP with Special Interest in Addictions	1.0								1.0
Thoracic Surgeon	1.0								1.0
Transplant	2.0								2.0
Transplantation / Renal Medicine							1.0		1.0
Vascular surgery	1.0								1.0
Grand Total	41.4	4.0	3.0	3.0	4.0	23.9	3.4	2.0	84.7

During April to August a total of 84.7wte of posts were advertised for recruitment, 49% were fully filled, with 14wte of posts only partially filled by 7wte, providing a combined fill rate of 57%. Of the 43% that were unfilled 23.9wte (28% of total) received no applicants, with the reminder receiving applicants that were either not suitable or who withdrew prior to commencement.

Where posts are not filled areas may seek to recommence recruitment immediately or delay recruitment until there are likely to be individuals completing their specialty training and therefore eligible to apply for a consultant post.

Supplementary Staffing Expenditure

One of the key means for filling gaps is through utilising staff bank and agency alternatives. The following table details expenditure on both elements between April 15 and October 15.

	Agency	Bank	Total
Acute Divisional Management	248,020	858,121	**1,106,141**
Diagnostics, A+T, Crit Care	25,279	478,307	**503,586**
E/L Chp - Community Services	71,647	480	**72,127**
East Lothian Non Partnership		2,152	**2,152**
Ed.Chp - Hosted Services	5,980	40,631	**46,611**
Edinburgh Chp - Core Services	7,519	2,228	**9,747**
Facilities Management	12,881		**12,881**
M/L Chp - Community Services	507	(808)	**(301)**
Pharmacy	5,906		**5,906**
Medical Directors Office		1,307	**1,307**
Nursing		3,531	**3,531**
Reas	154,272	161,308	**315,579**
Reas Hosted Services	(5,052)		**(5,052)**
Royal Infirmary Edinburgh Site	114,005	118,123	**232,128**
St Johns Hospital Site	489,022	52,597	**541,619**
W/L Chp - Community	542,674	3,469	**546,143**
Western General Hospital Site	297,930	44,634	**342,565**
Wl.Chp - Hosted Services	270	21,722	**21,993**
Women + Children Services	92,960	390,964	**483,924**
Grand Total	**2,063,821**	**2,178,765**	**4,242,586**

There are also other forms of supplementary staffing that are used including waiting list initiative payments where NHS Lothian staff are paid for undertaking additional activity over and above their contracted hours to help meet and sustain treatment time guarantees and reduce reliance on the external capacity. Expenditure in April to October 15 is detailed in the following table.

Row Labels	April to October waiting list payments
Anaesthetics & Theatres	4,821
Children	88,092
Critical Care	1,179
Director Of Nursing	364,908
Edin Dental Ins Lauriston	3,366
Imaging - Radiology	129,066
Junior Medical	158
Laboratories	9,906
Ophthalmology	38,432
Rie Medicine	9,446
Rie Surgery	77,353
Sjh Medicine	6,252
Sjh Surgery	298,643
Wgh Medicine	117,339
Wgh Surgery	245,407
Women	65,688
Grand Total	**1,460,055**

As part of the clinical quality initiative services will be supported to review their service models in areas of high pressure and expenditure. This pathway work will be supported by the Clinical Quality Management Leads supported by appropriate expertise from the Quality Program support team and reporting within the new corporate management structure.

3.2.3 Roodlands Hospital

East Lothian continue to develop a more outward community focused integrated service with an expanding hospital at home service, active hospital to home and discharge to assess models as well as developing care home support team and step down care facilities. Roodlands Hospital is an integral part of this service providing care for those East Lothian residents who need this as well as step up care for those in the Hospital at Home Service(ELSIE). There are already very positive signs that this model is delivering real benefits with more assessment and treatment for East Lothian residents closer to home. Plans for the new East Lothian Community Hospital are in development, which will also provide more opportunities to achieve the Scottish Government National 2020 Vision. The current Roodlands Hospital staffing model is currently under review to enhance weekday medical staffing with greater supervision and training and refocus weekend staffing to a Nurse Practitioner led service with remote Consultant support.

Recruitment to a permanent Consultant post at the end of September was unsuccessful, however a locum consultant has been appointed and will cover ward 1a and 1b, provide clinical supervision and support care home working. They will also provide input into South Edinburgh Integrated Older peoples service and contribute to out of hours work for RIE/Liberton/Roodlands. An interview is planned for January 2016 for a MoE consultant post covering the RIE and Roodlands and recruitment will commence shortly on recruitment of a specialty doctor to provide cover for wards and also the ELSIE service.

Currently trainees provide out of hours cover until 11pm on weekdays with remote consultant support and HaN thereafter. At weekends they work until 9.30pm with support from a locum consultant on both days. However workload is low at the weekend and training and supervision needs could be better serviced by enhancing weekday service contribution and supporting out of hours services at the RIE at the weekend. This proposal has been supported by the South East Region Post Graduate Dean and from the end of January 2016 trainees will be removed from weekend working at Roodlands.

A plan is being developed to ensure a sustainable weekend staffing plan which will include a communications strategy to ensure stakeholders are aware of the changes.

It will be important going forward that the medical staffing model is integrated with the RIE and Liberton. The current medical staffing model of 2 wte consultants and 1 wte staff grade when fully populated is sufficient to meet the current needs of the site and ELSIE however further review and discussion will be required to define the model of care for the New East Lothian Community Hospital and associated staffing model.

3.2.4 Psychiatry

Recent board papers provided detail on the increasing difficulties that are being faced in filling consultant posts across Scotland and also the very poor fill rates in higher specialty training programmes. It also set out where NHS Lothian is facing difficulty in filling posts and the following section provided an update on the current situation within each area.

Old age psychiatry – Recent recruitment to 2 full time consultant posts was unsuccessful in attracting any applications. This follows on from a previous attempt to fill these posts in September which was also unsuccessful in attracting any applications.

Rehabilitation Psychiatry – As with old age psychiatry recent recruitment has been unsuccessful. This now represents the third time recruitment has been unsuccessful in attracting any applications.

Perinatal Psychiatry Mother and Baby Unit - As detailed in the previous Board paper the service has been unsuccessful in recruiting to vacant consultant posts which have subsequently been reviewed to attract as many interested and suitably qualified applicants as possible through a multifaceted recruitment campaign. The vacancy has now closed and has successfully attracted candidates with interviews due to take place at the end of November the outcome of which will be reported in the next Board paper.

Regional Eating Disorder Unit – As detailed in the previous Board paper recruitment is underway for a full time consultant posts to fill a key gap within the unit and support the implementation of the recommendations review of the service undertaken the Royal College of Psychiatrists. This post has recently closed and any applications received are currently being short listed. Interim arrangements detailed in the previous board paper remain in place.

3.3 General Practice

The October board paper provided detail around the challenges that General Practice is facing in recruiting at both a national level in terms of trainees and also at a local level within practices. The paper also detailed the investments that NHS Lothian is making to support practices that are currently experiencing difficulties.

It also detailed proposals that are being taken forward to develop a:

- Local GP Returner scheme
- Primary Care Clinical Development Fellows
- Locum pool of recently retired GPs
- Practice Emergency Care fund

These proposals will take time to be developed to implementation stage and as such there is no update since the October Board meeting. They are however being taken

forward urgently and further updates will be provided as and when significant progress is made.

The SGHD is running the Primary Care Workforce Survey 2015 between August and the end of October. This will ask all GP practices and OOH services to complete a survey looking at the workforce profile of both GPs and practices nurses including demography, retirals and vacancies. This will provide the Scottish Government with intelligence with which to develop the New GP Contract and also plan GP training programmes.

The First Minister has recently announced that the SG intends to increase GP training numbers from 300 to 400. Further work is also underway nationally to understand the push and pull factors for individuals considering entering GP training and what can be done to widen and enhance GP careers. Achieving this level of expansion will however be a substantial challenge given the current inability to fill existing training posts.

3.4 Healthcare science

The healthcare science(HCS) workforce provides a diverse range of essential specialist clinical support services a number of which include small workforces and associated challenges with succession planning. Appendix 1 details the different specialism's with the HCS workforce.

The healthcare science workforce is the fourth largest clinical group in NHSScotland, with approximately 6000 scientists, practitioners and technologists working across acute and primary care settings. It is hugely diverse, comprising more than 50 disciplines. Collectively, they undertake over 60 million laboratory tests (at a cost of £61 million) and 730 000 clinical physiological measurements per year, and have responsibility for the management of medical equipment with a replacement value in excess of £940 million (Scottish Government, 2014). Their work underpins 80% of all clinical diagnoses. Among many other services, this workforce provides:

- leading-edge technological services, such as positron emission tomography and magnetic resonance imaging
- advanced laboratory diagnostics
- innovative genomic services that have the potential to change how health care science is delivered in the future
- patient-facing aspects of physiological and physical sciences, including the diagnosis and treatment of hearing disorders, the optimal programming of pacemakers, provision of rehabilitation and assistive technology, and the management of medical equipment in hospitals and community.

Given the diverse nature of this workforce ensuring adequate workforce supply and succession planning can be complex, with long lead in times for training and recruitment very challenging where gaps do arise.

The challenges associated with sustaining these workforces have been recognised nationally in the Driving Improvements, Delivering Results NHS Scotland Healthcare Science Delivery plan 2015 – 2020.

Improvement programme	Deliverables	Full implementation by end of:
Streamlining health technology management	**Deliverable 1** NHS board healthcare science leads will work with stakeholders to deliver a high-quality, sustainable, coherent and whole systems approach to the management of health technology.	2020
Point-of-care testing	**Deliverable 2** NHS board healthcare science leads will work with medical directors and clinical teams to develop a local implementation plan that ensures clinical governance and effective roll-out of point-of-care testing.	2020
Demand optimisation	**Deliverable 3** NHS board healthcare science leads will work with stakeholders to develop local improvement plans to reduce unnecessary testing across primary and secondary care. This will free-up capacity to address rising demand and deliver testing that positively affects the patient pathway, supports primary care preventive measures and reduces hospital referrals and admissions.	2019
Developing sustainable services	**Deliverable 4** NHS board healthcare science leads will work with stakeholders to explore new and developing healthcare science roles that support areas of service pressure and have the potential to free-up medical capacity, with the initial focus on histopathology services.	2019
A new integrated model for clinical Physiology services	**Deliverable 5** NHS board healthcare science leads will work with stakeholders to develop a sustainable integrated service model to enhance clinical physiology service delivery and quality.	2020

Each element of the delivery programme is heavily dependent on the HCS workforce and consequently the Scottish Government (SG) will provide support for implementation by the National Healthcare Science Officer and the three national healthcare science leads, who will work collaboratively with NHS board healthcare science leads and the healthcare science workforce. A local healthcare science lead is also in the process of being appointed to take a lead on local implementation of the action plan. The post holder will report directly to the Medical Director who is the professional lead for healthcare science. This post will also help ensure that the HCS workforce in considered and involved in service planning as part of the process as changes in service can impact on capacity both directly and indirectly.

Despite the considerable size of the overall HCS workforce it remains one of the most ‘hidden’ areas to the general public and as a consequence it can be challenging to market careers to school leavers and graduates. Within the services the HCS workforce has in the past not been highly visible and as a consequence has in some instances been an afterthought when looking at service change.

In recognition of this the Lothian Healthcare Science Forum has supported the development of promotion materials providing information about the careers and roles within HCS for use with schools. There is also a quick reference guide and Intranet site

under development to provide a quick reference guide to HCS services, which helps to provide availability across the service and enhances branding and visibility.

The National HCS Action Plan and local Clinical Strategy will both drive an increase in demand for the HCS workforce either in terms of numbers and/or skill sets. There are however significant pressures within the various specialism's with a number facing recruitment and retentions issues associated with an ageing workforce.

Work will shortly be commencing on the development of a workforce plan for Healthcare Science which will:

- Look at workforce structures within and across Life sciences, Physical sciences and Physical & engineering sciences.
- Facilitate a workforce 'conveyor belt' from band 2 to band 9
- Look at succession planning – including external recruitment and local development
- Optimise skills and competences within other areas of the workforce
- Review the stage at which specialisation occurs
- Create a career structure for generalists as well as specialists
- Develop leadership skills
- Optimise learning underpinning generic science and specialist science learning through a combination of academic and on-the-job learning.

Work has already commenced on the development of a modern apprenticeship scheme to develop new routes into the workforce. Future board papers will look at specific areas are facing challenges that are/may potentially impact on service provision and provide detail on the development of the workforce plan for HCS.

3.5 Nursing workforce

In March 2015 19% of the total of NHS Lothian workforce were aged over 55 years old compared to 14.6% in March 2009. The age grouping with the largest percentage has also shifted from 17% in 45-49 years old in 2009 to 17.88% in 50-54 years old in 2015. Within registered nursing the ageing of the workforce is already pronounced, between March 2009 and March 2015 the proportion of staff aged over 50 has increased from 21.4% to 31.2% an increase of nearly 10% in 6 years. Changes to pensions will see the retiral age gradually increase to 68 years old. Within this age grouping a significant number of staff hold special class/mental health officer status and as such can retire at 55 without any actuarial reduction being applied to their pension. This means that potentially those staff within the 45-49 age category and those above may consider retiral; this equates to 47% of the registered nursing workforce.

It may be in practice there are a range of factors that influence individual decision making and not all staff will hold special class/mental health officer status however this remains a key area of uncertainty and risk for health boards.

Student nursing intakes are planned and commissioned nationally by the Scottish Government in conjunction with Professional Bodies and are in part informed by the NHS Boards annual workforce demand projections process. Board demand projections are combined with a national level assessment of workforce supply to provide an estimated level at which to set intakes to ensure workforce sustainability.

The national assessment of supply has been based upon historical trends in retirals, new joiner and rejoiner rates. However it is becoming increasingly clear that this is no longer

sufficient as this does not adequately factor in the ageing of the workforce outlined above and there is a significant risk that there is a disproportionate number of retirals in a relatively short period of time. The national student nursing intake group are currently developing proposed intakes for 2016 which will in turn be considered by the Cabinet secretaries for Health and Education. There is recognition that the planning process in 2016 for 2017 intakes need to more fully take into account the demographic factors in more detail.

3.5.1 Health Visiting Capacity

As mentioned in previous Board papers the Health Visiting (HV) workforce requires to considerably increase across Scotland the to ensure compliance with the Named Person and Child Statutory Planning Service legislation from August 2016.

The Scottish Government have agreed to fund an additional 500 HVs in Scotland by 2018 to support the required workforce expansion. NHS Lothian share will be in the region of an additional 61 fully funded posts this being based on an anticipated 13% share of the national resource. Funding allocation will be recurring and allocated incrementally during 2015-18.

The issues regarding reduced supply and capacity within the Health Visiting workforce across Scotland are well recognised. In Lothian we have carefully risk managed this dilemma and trained additional HVs during 2013-14 and 2014-15, and had hoped to increase to 26 trainees in 2015/16. Loss of Specialist Practice Supervisors has however reduced this to 23 trainees. We have also introduced significant staff nurse skill mix in response to service development and redesign and in mitigation of the growing number of HV vacancies. This ensures the needs of our families are being met and the role of the HV staff nurse is now well embedded within HV teams. However changes in the HV pathway recently issued by the SGHD indicate that an all Health Visitor model will prevail.

There are however clearly significant risks associated with the ageing of the workforce, with: 54% of Band 6 HVs aged over 50 years of age (72.3 WTE). Most HVs have retained NHS ‘special status’ and therefore could potentially retire at 55. This, together with the growth in the populations through increasing housing and incoming families in parts of the Lothians and recognition of the caseload complexity has increased the HV requirement. It was highlighted to the Board in May 2015 that the additionality required to meet this shortfall in the HV workforce is a further £1.3m to train a further 53 new HVs (over and above the 61 funded by SGHD).

The impact of this is currently being experienced within Midlothian where there has been a higher than anticipated number of retirements and resignations over recent months and significant increases in the number of families within the area with two major housing developments attracting families. Modelling the known changes in the workforce that are scheduled to happen between now and December would indicate that the end position would be a gap of c76% in Midlothian, 23% across NHS Lothian. Staff have however not yet left and a short life group involving representatives from all H&SCP and HV services in Edinburgh is taking forward an action plan to manage the pressures in the HV system through a corporate approach, to resolve the issues before they actually happen. The comprehensive action plan put in place aims to maintain safe and effective services to clients across Midlothian and to consider an equity across all areas in Lothian, whilst also supporting the workforce in areas of particular difficulty. The action plan includes supporting the existing HV workforce, utilising the skills and experience of other NHS clinical staff and Local Authority early years staff, deferring internal movement of staff from Midlothian to other parts of Lothian and initiating a national recruitment campaign. Meetings have been held with all HV staff across each part of Lothian to enlist their support to manage the current situation corporately and to learn from them their thoughts

and ideas on how to support the workforce and other potential solutions to support the service.

4 Risk Register

4.1 The NHS Lothian risk register contains a 'Medical Workforce Sustainability' risk and a 'Nurse Workforce – Safe Staffing Levels', which relate the risk that workforce supply pressures in conjunction with activity pressures will impact on service sustainability and/or NHS Lothian's ability to achieve its corporate objectives. The multi-factorial risk assessments that have been carried out will be reviewed and updated where necessary on a 6 monthly basis or where there are significant changes. The controls around the HV workforce have been strengthened however the risk to service delivery remains high.

5 Impact on Inequality, Including Health Inequalities

The introduction of the medical workforce risk assessment process has been subject to a rapid impact assessment for which a report has been prepared.

6 Involving People

Before any changes in service provision across any site in NHS Lothian are made, there would need to be engagement and consultation with appropriate audiences with the guidance of the Scottish Health Council.

7 Resource Implications

7.1 There are potential resource implications, which are identified as part of the planning process within specialties to reduce the level of workforce risk. These will be progressed through the appropriate local management structures to secure necessary support.

Nick McAlister
Head of Workforce Planning
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13 November 2015

List of Appendices

Appendix 1: Different Specialism's with the Healthcare Science Workforce

Healthcare Science Professions

Life Sciences

Blood Sciences
Cell Sciences (Microbiology)
Cell Sciences (Pathology)
Cell Sciences (Reproductive Sciences)
Gene Sciences (Clinical Genetics)
Gene Sciences (Regional Genetics Service)
Gene Sciences (Regional Molecular Pathology Service)

Physiological Sciences

Audiology
Audiology (Paediatric)
Cardiac Physiology
Clinical Perfusion
Diabetic Retinopathy Screening
Gastrointestinal Physiology
Neurophysiology
Paediatric Respiratory & Cardiac Physiology
Respiratory Physiology
Sleep Physiology
Vascular Science

Physical Sciences

Biomechanics - SMART
Clinical Engineering and Non-Ionising Radiation Physics (CENIR)
Electronic Assistive Technology - SMART
Imaging Physics
Maxillofacial Prosthetics and Technology
Medical Equipment Management
Medical Photography
Nuclear Medicine Physics
Radiation Protection
Radiotherapy Physics
Rehabilitation Engineering - SMART

Return to first page

NHS LOTHIAN

Board Meeting
2 December 2015

2.8

Medical Director

SUMMARY PAPER - QUALITY REPORT

This paper summarise the key points in the full paper.

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

	Para
• The data presented as part of the Hospital Scorecard (January-March 2015), would indicate that NHS Lothian is an outlier for Readmissions, however, it is not statistically significant. The trend data, however, provided by ISD would suggest it is normal cause variation which is illustrated by previous quarters data not showing NHS Lothian as an outlier.	3.1.1
• There is now regular reporting of patient experience across the three acute inpatient sites on patient experience and as such the patient experience outcome measure has now been included in the Quality Report (Chart 1). The person-centred culture paper on the Board agenda and highlights that this data is still in a developmental stage, with respect to establishing a reliable process that offers all patients the opportunity to complete the patient experience questionnaire, Tell us Ten Things (TTT).	3.1.2
• The HSMR publication in August 2015 is for the period January to March 2015 and shows none of the three acute adult hospitals are below 1.	3.1.3
• The number of formal complaints remains fairly stable. Chart 2 shows an improvement in responses to complaints in 20 days in NHS Lothian with 3-day response rate remaining a challenge.	3.1.4
• Staff absence levels (chart 6) are over 4% (4.8) which has been above 4% for a number of months across NHS Lothian.	3.1.5 & chart 6
• The HEAT target for reduction in *C.Difficile* is not being achieved (chart 11). Healthcare Associated Infection is a separate agenda item and paper.	3.1.6 & chart 11
• Achieving the stroke standards for admission to unit within 1 day remains a challenge, however there has been improvement in swallow screen on day of admission (Chart 19). A stroke review is taking place which is due to report to HCG in early 2016.	3.1.7

Jo Bennett
Associate Director for Quality Improvement & Safety
10 November 2015
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NHS LOTHIAN

Board Meeting
2 December 2015

Medical Director/Nurse Director

QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for November 2015, to provide assurance on the quality of care NHS Lothian provides.

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

2 Recommendations

2.1 Review the quality dashboard and exception reporting to inform assurance requirements, (context and technical appendix are set out in Appendix 1).

3 Discussion of Key Issues

3.1 Exception Reporting – Quality Dashboard

3.1.1 The data presented as part of the Hospital Scorecard (January-March 2015), would indicate that NHS Lothian is an outlier for Readmissions, however, it is not statistically significant. The trend data, however, provided by ISD would suggest it is normal cause variation which is illustrated by previous quarters data not showing NHS Lothian as an outlier.

3.1.2 There is now regular reporting of patient experience across the three acute inpatient sites and as such the patient experience outcome measure has now been included in the Quality Report (Chart 1). The person-centred culture paper on this agenda highlights that this data is still in a developmental stage, with respect to establishing a reliable process that offers all patients the opportunity to complete the patient experience questionnaire, Tell us Ten Things (TTT).

3.1.3 Since December 2009, Information Services Division (ISD) has produced quarterly hospital standardised mortality ratios (HSMR) for all Scottish hospitals participating in the Scottish Patient Safety Programme (SPSP). The aim of the Scottish Patient Safety Programme is to reduce hospital mortality by 20% by December 2015 compared to the baseline of 2007.

The HSMR is based on all acute inpatient and day case patients admitted to all specialties (medical and surgical). The calculation takes account of patients who died within 30 days from admission; that is, it includes deaths that occurred in the community (out of hospital deaths) as well as those occurring in-hospital. It excludes deaths that occur more than 30 days after admission whether in hospital or not.

Hospital Standardised Mortality Ratio (HSMR) = Observed Deaths / Predicted Deaths. The prediction is based on data from SMR01 returns. The purpose is to adjust observed mortality for the underlying risk of death at the time of admission (Charts 7-9).

Key Points:

- The current values and change from baseline are in Table 1 below
- None of the three acute adult hospitals is a statistical outlier for upper limits. All three sites, however, are outliers for lower control limits, as set out in funnel charts in Appendix 2.

Table 1

	HSMR Oct-Dec 2007	**HSMR Apr-June 2015**	**Change from baseline**
Scotland	1.03	0.86	-15.7%
RIE	0.89	0.68	-19.4%
St John's	0.84	0.83	-8.7%
WGH	0.84	0.62	-11.7%

3.1.4 The number of formal complaints remains fairly stable (Chart 4). Chart 2 shows an improvement in responses to complaints in 20 days in NHS Lothian. Achieving a sustained response rate at 3 days remains a challenge (Chart 3).

3.1.5 Staff absence levels (Chart 6) are over 4% (*4.8%)* which has been above 4% for a number of months with significant variation across NHS Lothian.

3.1.6 The HEAT target for reduction in *C.Difficile* is not being achieved (see Chart 11). There has, however, been improvement in Staph. aureus bacteraemias (Chart 12). A separate paper on the prevention and management of HAI is on this committee agenda.

3.1.7 Achieving the stroke standards for admission to unit within 1 day remains a challenge, however there has been improvement in swallow screen on day of admission (Chart 19). A stroke review is taking place which is due to report to HCG in early 2016.

Quality Dashboard – November 2015 (dates for each data item stated in background charts)

This table shows a monthly summary of process and outcome quality measures. Trend charts 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.
If you have an electronic version of this report, links to each measure chart have been embedded in the headings below.

QUALITY AMBITION

PERSON-CENTRED - Process Measures
20-day Complaints Response Rate *
3-day Complaints Response Rate *
Delayed Discharges and Average Length of Stay *

PERSON-CENTRED - Outcome Measures
Patient Experience *
Number of Complaints *
Staff Absence Levels *
Staff Experience

SAFE – Outcome Measures
Hospital Standardised Mortality Ratios for RIE, WGH & St. John's *
Incidents with harm *
C. Difficile Numbers *
Staph. Aureus Bacteraemia Numbers *
Number of Cardiac Arrests *
Rate of Cardiac Arrests *
Inpatient Falls with Harm *

EFFECTIVE – Process Measures
A&E 4 Hour Wait *
Cancer Waits 62 Days from Diagnosis to Treatment *
Admission to stroke unit on day or day after admission *
Stroke Treatment Measure: CT Scan *
Stroke Treatment Measure: Swallow Screen *

Additional Quality Measures

Hospital Scorecard: January to March 2015 *

Indicator	Lothian Rate (Per 1000 admissions)	Scottish Rate
Standardised Surgical Readmission rate within 7 days	22.01	20.85
Standardised Surgical Readmission rate within 28 days	42.70	39.58
Standardised Medical Readmission rate within 7 days	55.36	52.30
Standardised Medical Readmission rate within 28 days	122.79	113.61
	Lothian	**Scotland**
Average Surgical Length of Stay – Adjusted	0.92	1.00
Average Medical Length of Stay – Adjusted	1.06	1.00

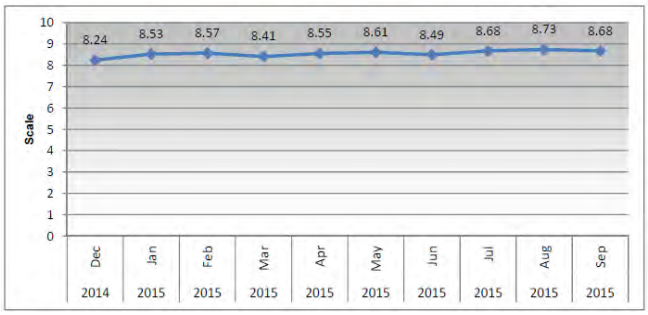
Person-Centred

"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:	Tell us ten things (TTT) Inpatient Survey Question 10 (Chart 1)
Numerator:	Average of Inpatient responses (out of 10) to Question 10 : Overall experience
Goal:	9.5 (out of 10)

Outcome Measure

Average score out of 10 for this question overall

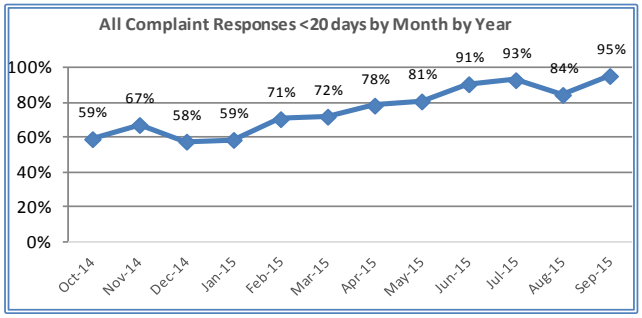


Data Source: TTT Database Exec Lead: Melanie Johnson

Title:	20-day Complaints Response Rate (Chart 2)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	85% of complaints responded to within 20 days

Process Measure

20-Day Response Target across NHS Lothian

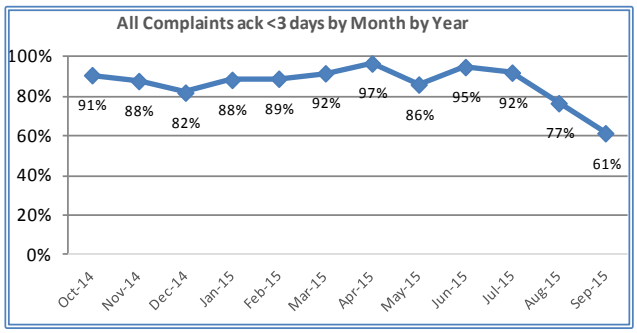


Data Source: Datix Exec Lead: Melanie Johnson

Title:	3-day Complaints Response Rate (Chart 3)
Numerator:	Number of complaints responded to within 3 days
Denominator:	Number of complaints
Goal:	100% formal acknowledgement within 3 working days

Process Measure

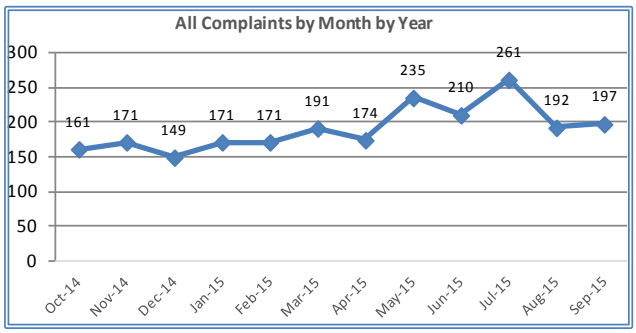
3-Day Response Target across NHS Lothian



Data Source: Datix Exec Lead: Melanie Johnson

Title:	Number of Complaints (Chart 4)
Numerator:	Total number of complaints
Goal:	Reduction in number of formal complaints

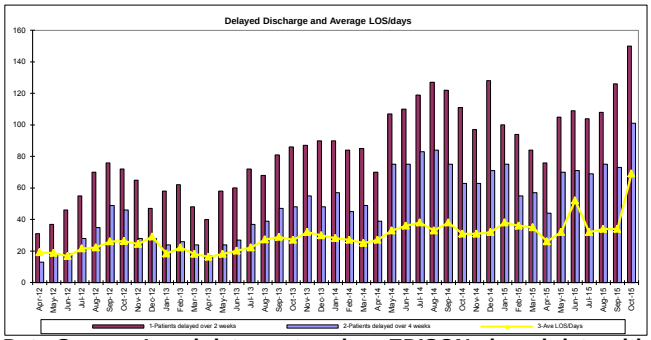
Outcome Measure



Data Source: Datix Exec Lead: Melanie Johnson

Title:	Delayed Discharges & Average Length of Stay (Chart 5)
Goal:	No patient waiting longer than 2 weeks for discharge

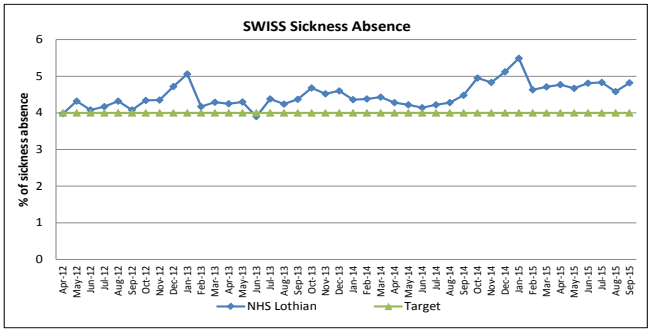
Process Measure



Data Source: Local data captured on EDISON shared data with Health & Social Care Exec Lead: Jim Crombie

Title:	Staff Absence Levels (Chart 6)
Numerator:	Total staff hours lost
Denominator:	Total staff hours available
Goal:	4% or less

Outcome Measure



Data Source: Scottish Workforce Information Strategic Systems (SWISS) Exec Lead: Alan Boyter

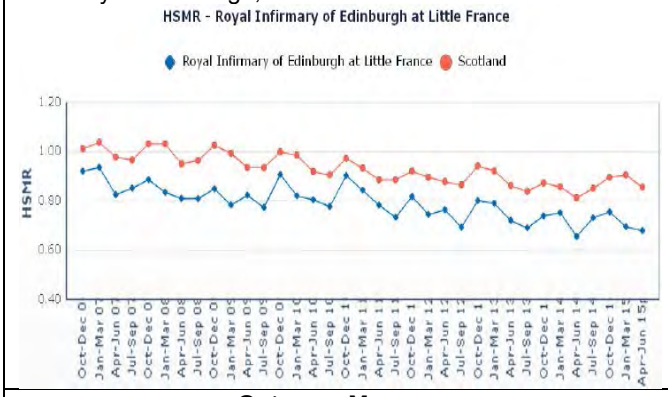
Safe

"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, HAI indicators, arrest calls, falls with harm and pressure ulcers.

Title:	Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Charts 7-9)
Numerator:	Total number of in-hospital deaths and deaths within 30 days of discharge from hospital
Denominator:	Predicted total number of deaths
Goal:	20% reduction against 2006/07 baseline by December 2015

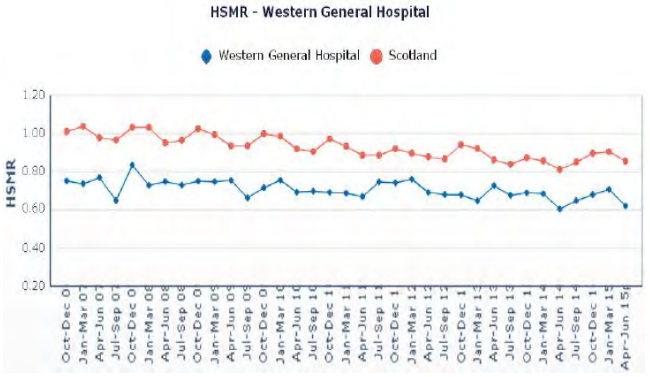
Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – June 2015



Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – June 2015



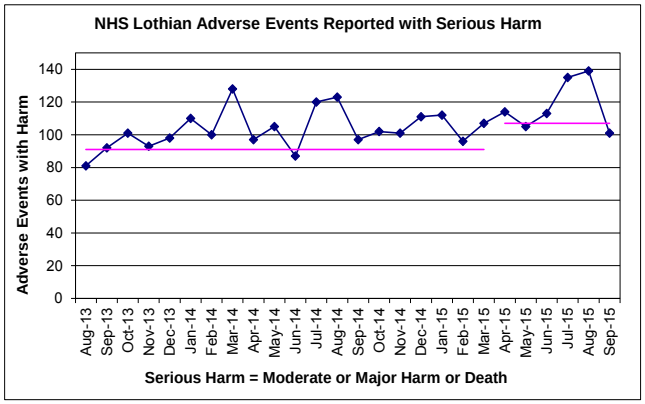
Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in St John's Hospital, October 2006 – June 2015

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

Title:	Adverse Events with harm (Chart 10)
Numerator:	Number of adverse events associated with serious harm reported per month in NHS Lothian
Goal:	There are specific goals for reductions in Falls

Outcome Measure

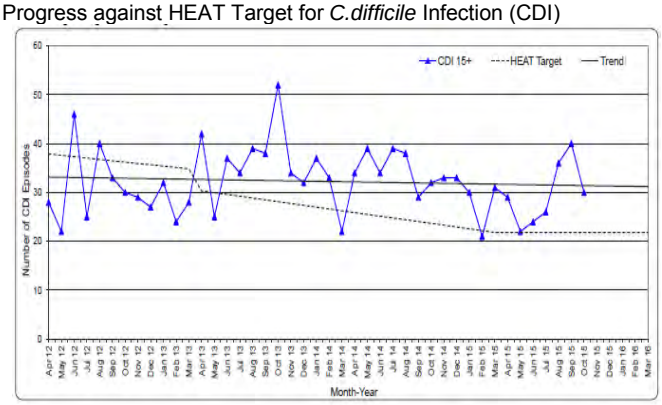


Data Source: Datix Exec Lead: David Farquharson

Title:	C. difficile associated disease against HEAT Target 2012-13 (Chart 11)
Numerator:	Total number of patients aged 15 and over with C.difficile toxin positive stool sample (CDI)
Goal:	NHS Lothian is to achieve a rate of 0.32 per 1000 bed days (<262 incidences) by March 2016

Outcome Measure

Progress against HEAT Target for *C.difficile* Infection (CDI)



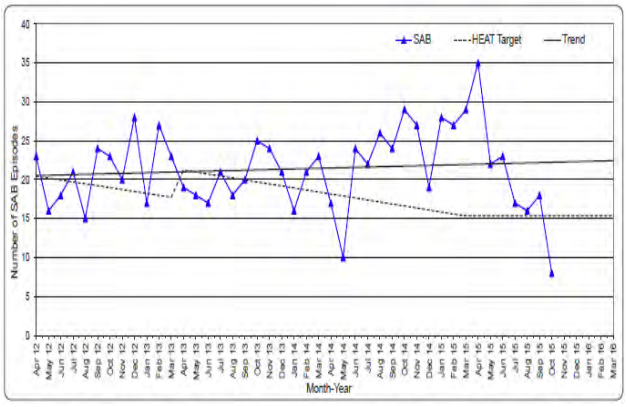
Data Source: Infection Control Team Exec Lead: Melanie Johnson

Safe (cont'd)

Title:	Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Chart 12)
Numerator:	The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)
Goal:	NHS Lothian is to achieve a rate of 0.24 per 1000 bed days (<184 incidences) by March 2016

Outcome Measure

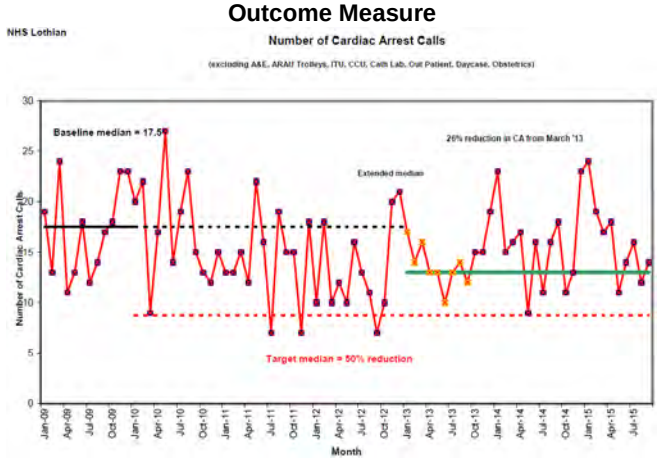
Progress against HEAT Target for *S.aureus* Bacteraemia



Data Source: Infection Control Team
Exec Lead: Melanie Johnson

Title:	Number of Cardiac Arrests (Acute Wards) (Chart 13)
Numerator:	Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

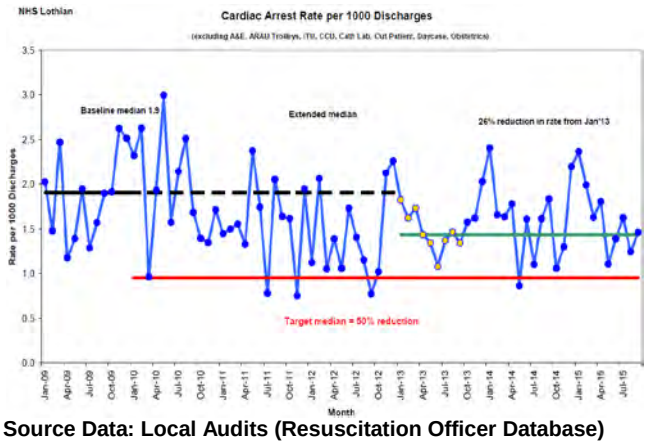
Outcome Measure



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

Title:	Rate of Cardiac Arrests (Acute Wards) (Chart 14)
Numerator:	Arrest – Rate of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

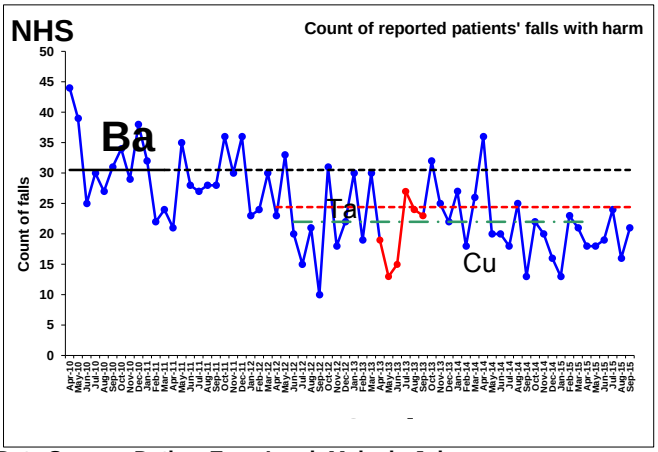
Outcome Measure



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

Title:	Patient Falls with Harm (Chart 15)
Numerator:	Number of falls reported resulting in moderate or major harm or death (define moderate/ major). Data for NHS Lothian inpatient sites
Goal:	20% reduction in inpatients falls and associated harm by December 2015

Outcome Measure



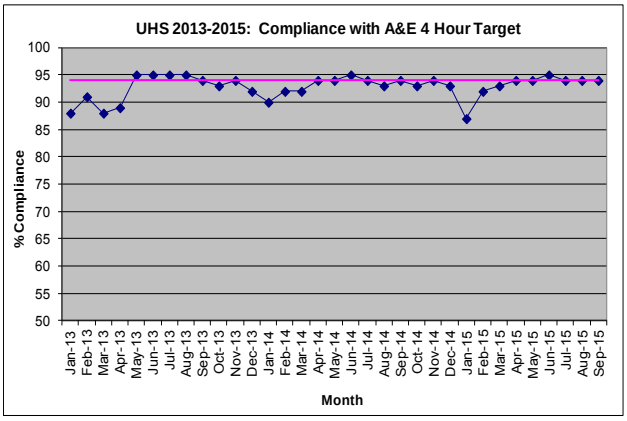
Data Source: Datix Exec Lead: Melanie Johnson

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 and stroke care.

Title:	A&E 4 Hour Wait (Chart 16)
Numerator:	Number of patients waiting less than 4 hours from arrival to admission or discharge
Denominator:	Number of patients attending
Goal:	98% of patients waiting less than 4 hours from arrival to admission by March 2015

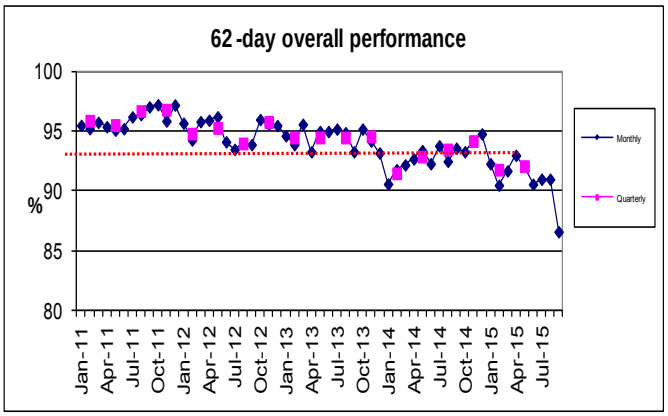
Process Measure



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

Title:	Cancer Waits 62 Days from Referral to Treatment (Chart 17)
Numerator:	Number of patients waiting 62 days to treatment. Please note the scale
Denominator:	Number of cancer patients
Goal:	95% of patients from diagnosis to treatment wait no longer than 62 days

Process Measure

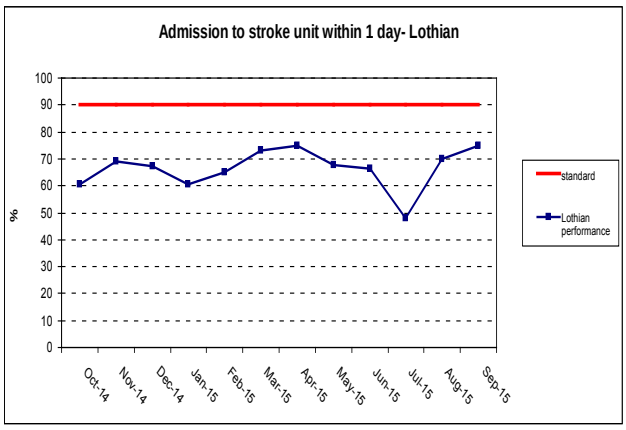


Data Source: SGHD Management Information
Exec Lead: Jim Crombie

Title:	Admission to Stroke Unit within 1 day of admission (Chart 18)
Numerator:	Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
Goal:	90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

Process Measure

Note: 2015 data is not validated and should be treated as provisional

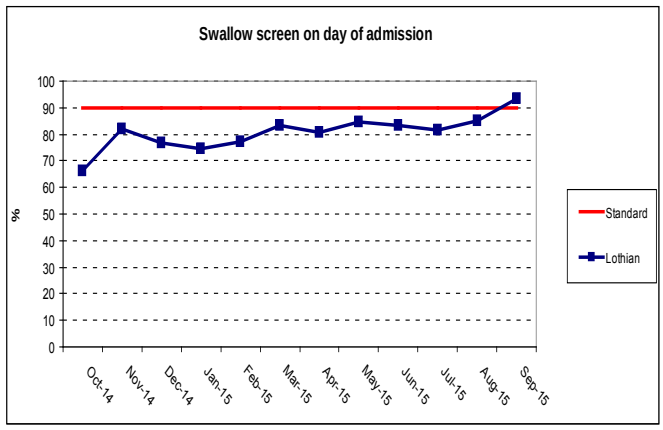


Data Source: ISD Exec Lead: Jim Crombie

Title:	Stroke Treatment Measures (Chart 19)
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: 2015 data is not validated and should be treated as provisional



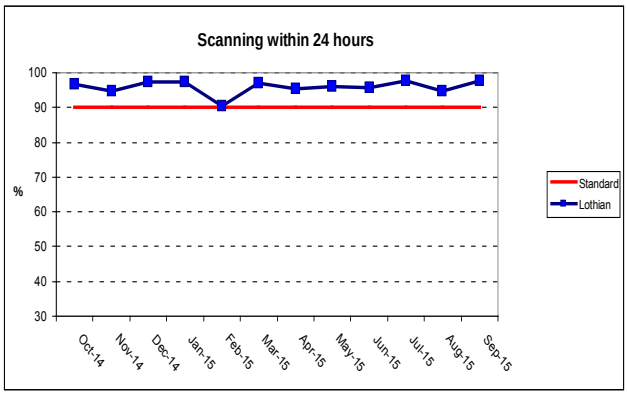
Data Source: ISD Exec Lead: Jim Crombie

Effective (cont'd)

Title:	Stroke Treatment Measures (Chart 20)
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: 2015 data is not validated and should be treated as provisional



Data Source: ISD Exec Lead: Jim Crombie

4 Key Risks

4.1 Achieving the HAI HEAT target, complaints response times, stroke targets, delayed discharge target and cancer target.

4.2 This dashboard has been developed to ensure a range of measures that can be considered easily, all of which impact on the patient experience and outcome of care. These measures, however, do not reflect all aspects of care and need to be supplemented with condition-specific data, both qualitative and quantitative.

4.3 Failure to comply with national standards with potential impact on patient experience and outcomes of care, and external inspections.

5 Risk Register

5.1 Achieving HAI targets is also on the Corporate Risk Register (Risk 1076) and its risk grading has been increased to reflect that NHS Lothian is outwith HAI trajectory. Access to Acute Stroke Unit is on the University Hospital Services Risk Register – Medicine and Associated Services (Risk 2444). Compliance with stroke standards is captured in Unscheduled Care on the Corporate Risk Register. Complaints Management is also captured on the Corporate Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.

6.2 This paper combines elements of the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010) and the Scottish Patient Safety Programme (assessed in May 2009).

6.3 The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

7 Involving People

7.1 No service change.

8 Resource Implications

8.1 Work is ongoing to automate the production of this Dashboard, which is complex, as it uses data from a number of sources. This is within the Clinical Governance Workplan.

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10 November 2015
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List of Appendices

Appendix 1: Supporting Context and Technical Appendix
Appendix 2: HSMR Funnel Charts (April-June 2015)

APPENDIX 1

Context and Technical Appendix

Quality Report Development

The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland's quality ambitions and across levels 1 to 3.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian's Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

Hospital Standardised Mortality Ratio (HSMR)

HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level 'warnings' for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

S.aureus Bacteraemia (SAB) rate

New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.

***C.difficile* Infection (CDI) rate**
New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

Incidents associated with harm
Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.

Surgical readmissions within 7 days
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Surgical re-admissions within 28 days
As for 7 day readmissions.

Medical Re-admissions Within 7 Days
This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.
The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Medical Re-admissions Within 28 Days
As for 7 day readmissions.

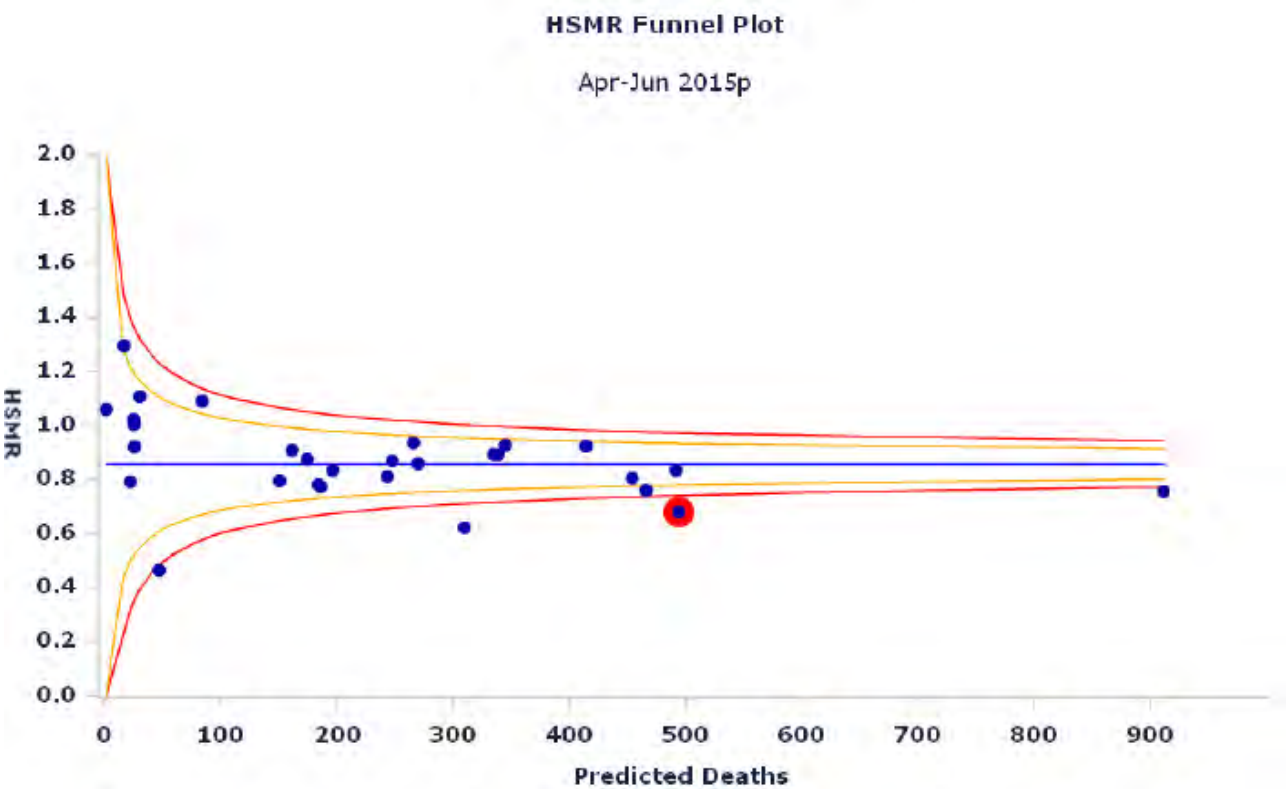
Average Length of Surgical Stay (Adjusted)
Ratio of 'observed' length of stay over 'expected' length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

Average Length of Medical Stay (Adjusted)
Ratio of observed length of stay over expected length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

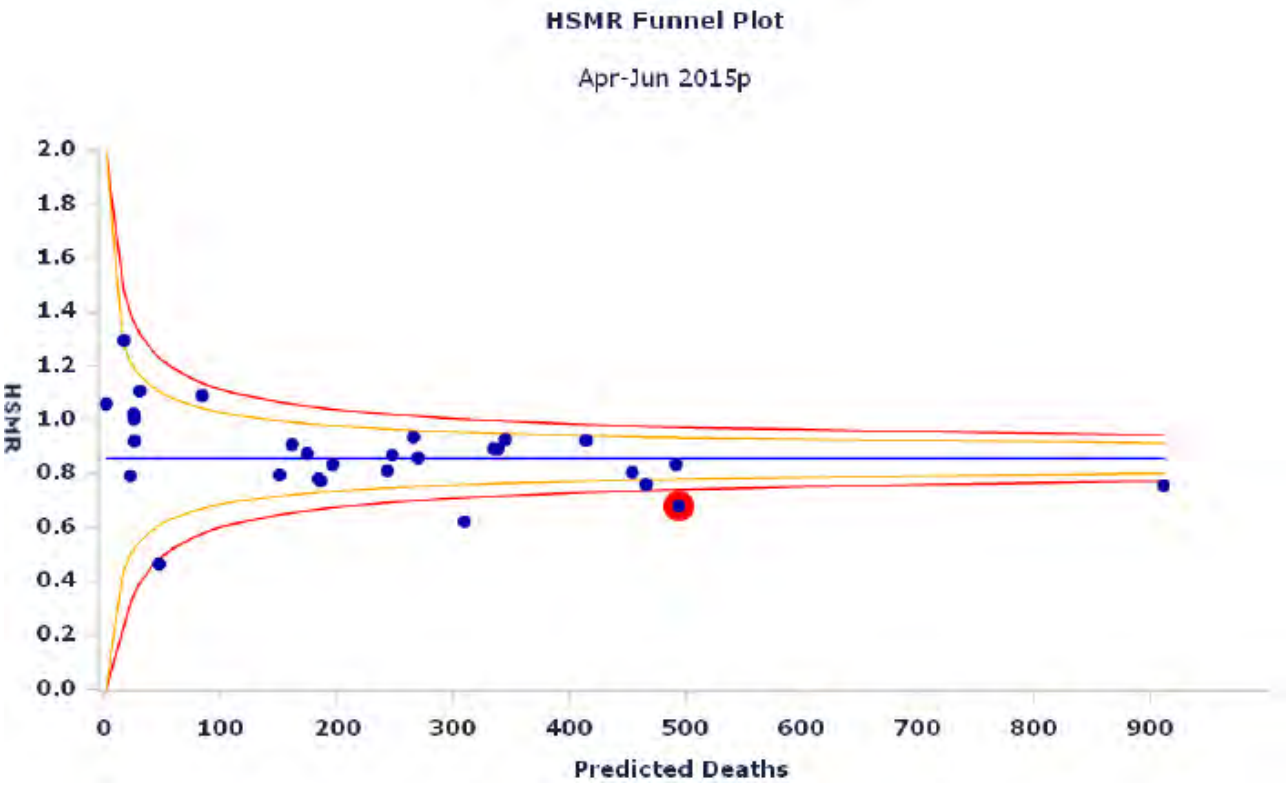
* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations.

APPENDIX 2

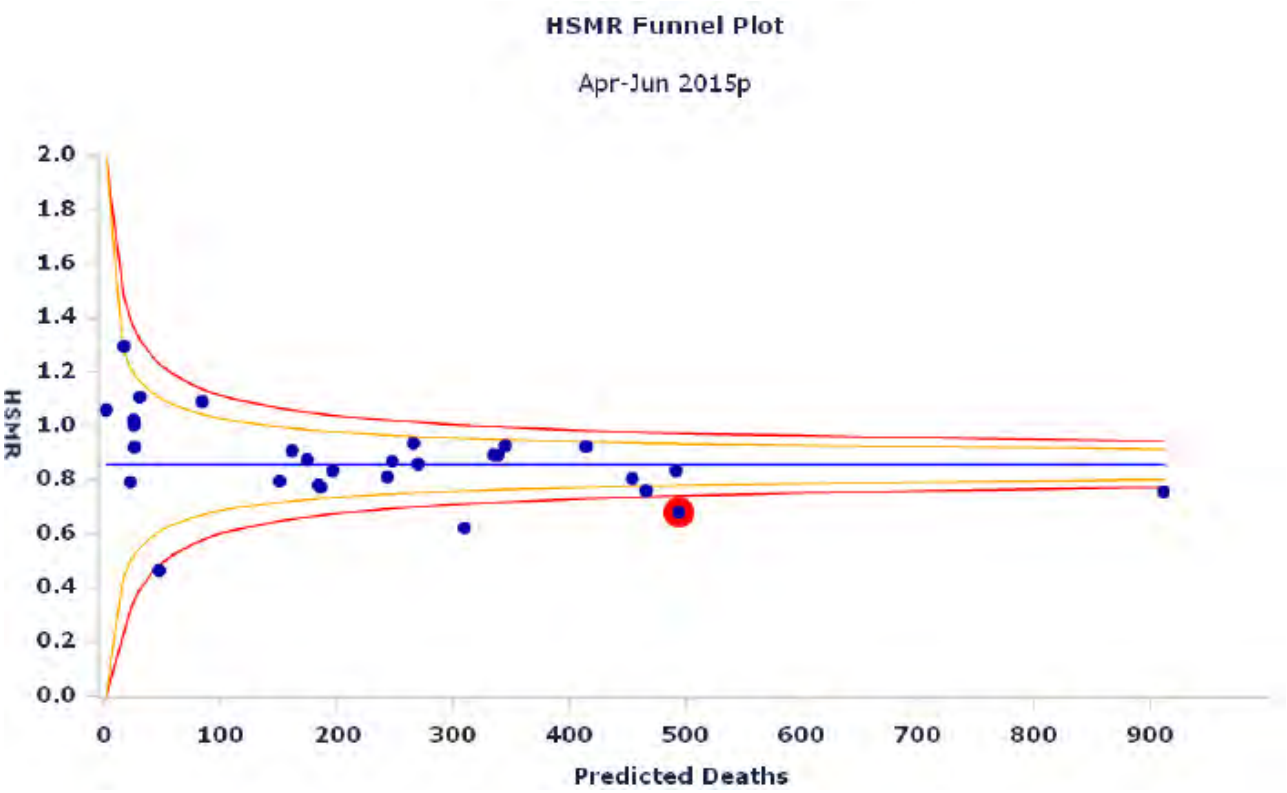
HSMR at RIE, Apr-June 2015– Funnel Plot



HSMR at SJH, Apr-June 2015– Funnel Plot



HSMR at WGH, Apr-June 2015– Funnel Plot



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NHS LOTHIAN

2.9

Board Meeting
2 December 2015

Medical Director

SUMMARY PAPER - CORPORATE RISK REGISTER

This paper summarise the key points in the full paper.

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

	Para
• The top 4 risks at Very High 20 are:- o Healthcare Associated Infection o Achieving the 4-Hour Emergency Care standard o Achieving the Delayed Discharge targets at 2 and 4 weeks o The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	3.2.1
• Table 1 sets out a Quarter 2 update of the NHS Lothian Corporate Risk Register.	3.2.2
• One risk is proposed for inclusion on the Corporate Risk Register - Road Traffic Management.	3.4
• NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 2/2.2), patient experience (Corporate Objective 2/2.1) and improving the way we deliver unscheduled care (Corporate Objective 2/2.4). NHS Lothian is also out with risk appetite for health population (Corporate Objective 1) and Financial Planning (Corporate Objective 3/3.1), where a medium appetite has been set. The Board may wish to examine the management actions to address areas which are outwith appetite to inform assurance requirements as set out in management reports submitted to the Board	3.5

Jo Bennett
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10 November 2015
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NHS LOTHIAN

Board Meeting
2 December 2015

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to set out NHS Lothian's Corporate Risk Register for assurance.

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

2 Recommendations

2.1 Use the updated NHS Lothian Corporate Risk Register; highlights of which are contained in section 3.2 and set out in detail in Appendix 1 to inform assurance requirements

2.2 Reflect on the current position that NHS Lothian remains outwith its Risk Appetite on corporate objectives where low and medium risk appetite has been set, with the exception of Scheduled care

2.3 Approve Road Traffic Management, for inclusion onto the NHS Lothian Corporate Risk Register as set out in paragraph 3.4 and detailed in Appendix 2.

3 Discussion of Key Issues

3.1 As part of our systematic review process, the risk registers are updated on Datix on a quarterly basis at a corporate and an operational level. Risks are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used, is based on the same risk scoring matrix, remains unchanged.

3.2 This report sets out the Quarter 2 position. Table 1 below provides a summary of the corporate risks and movement in risk grading over last 4 quarters. Three additional risks were approved at the October 2015 Board for entry onto the Corporate Risk Register. These were: General Practice Workforce Sustainability, Nursing Workforce-Safe Staffing Levels and Facilities Fit for Purpose. Appendix 1 provides additional details of each individual risk on the Corporate Risk Register with recent 2015 updates. When a risk's adequacy of control is inadequate or uncertain, the rationale is stated on the individual risk.

3.2.1 There are 10 risks in total; the top 4 risks at Very High 20 are:-

- Healthcare Associated Infection *

- Achieving the 4-Hour Emergency Care standard
- Achieving the Delayed Discharge targets at 2 and 4 weeks *
- The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge *.

* Outwith risk appetite as illustrated in Table 2 below.

3.2.2 If you have an electronic version of this report, links to each risk in Appendix 1 have been embedded in the below table (please click on individual Datix risk number in the table).

Table 1

Datix ID	Risk Title	Initial Risk Level	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015
1076	Healthcare Associated Infection (Standing item on Board Agenda)	High 12	High 16	⇧ Very High 20	Very High 20	Very High 20
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. (Standing item on Board Agenda)	High 12	High 12	⇧ Very High 20	Very High 20	Very High 20
3203	Achieving the 4 hour emergency target	High 10	High 10	⇧ Very High 20	Very High 20	Very High 20
3726	Achieving the Delayed Discharge targets at 2 and 4 weeks (split into two separate risks)	Very High 20	-	Very High 20	Very High 20	Very High 20
3829	GP Workforce Sustainability (new risk – October 2015)	-	-	-	-	Very High 20
3480	Patient Safety - Delivery of 4 SPSP Work streams. (Safety Measures in Quality Report.) (Standing item on Board agenda.)	High 16	High 16	High 16	High 16	High 16
3211	Achievement of National Waiting Times Targets (Standing Board Agenda item under Performance Report)	High 12	High 12	⇧ High 16	High 16	High 16
3454	Patient Experience – Management of Complaints and Feedback. (Complaints reporting and Person-Centred Culture Programme reported to Board)	High 12	High 12	⇧ High 16	High 16	High 16
3527	Medical Workforce Sustainability	High 16	High 16	High 16	High 16	High 16
3189	Facilities Fit for Purpose (accepted back on the Corporate Risk Register October 2015 following review)	High 15	High 16	Removed from Corporate Risk Register for review	-	High 16
3455	Health & Safety – Management of Violence & Aggression. (Reported at H&S Committee, via Staff Governance	Medium 9	High 15	High 15	High 15	High 15

Datix ID	Risk Title	Initial Risk Level	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015	Jul-Sep 2015
	Committee Minutes)					
3828	Nursing Workforce – Safe Staffing Levels (new risk – October 2015)	-	-	-	-	High 12
3567	Health & Social Care Integration	High 16	High 16	⇩ Medium 9	Risk Closed 26/06/15	

3.3 The risks concerning the development of NHS Lothian Integration Schemes have been closed as they have now been approved. Service risks related to integration are being examined to inform NHS Lothian risk reporting at a local and corporate level and are due for further discussion at the January 2016 Risk Management Steering Group.

3.4 The Board is asked to consider Road Traffic Management for inclusion onto NHS Lothian's Corporate Risk Register, as this risk cannot be managed at executive level and requires discussion and decision at Board level and is set out below (see Appendix 2 for risk detail).

3.4.1 Road Traffic Management

This risk was removed from the Corporate Risk Register in June 2015 for review at divisional level. The conclusion of the review was that this risk could not be fully managed at divisional or executive level and requires consideration by the Board for inclusion onto the Corporate Risk Register. The risk is described as:-

'There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites.'

There have been recent allocations of circa £1m this financial year to implement improvements in traffic management. However, these will not be in place until the next financial year. There are also designs being developed which takes cognisance of the master planning exercises on the larger acute sites and funding will be sought. The Board is asked to consider until it has adequate design solutions in all large inpatient sites, the risk of pedestrian vehicle conflict and also vehicle to vehicle conflict which could result in injury or fatality and therefore it should remain on the Board's Corporate Risk Register.

3.5 Risk Appetite Reporting Framework

NHS Lothian's Risk Appetite Statement is:-

"NHS Lothian operates within a low overall risk appetite range. The Board's lowest risk appetite relates to patient and staff safety, experience and delivery of effective care. The Board tolerates a marginally higher risk appetite towards delivery of corporate objectives including clinical strategies, finance and health improvement."

Table 2

	Current Status	Current Position	Data Report
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.2 Deliver Safe Care) **Low Risk Appetite**			
• Scotland target to reduce acute hospital mortality by 20% (Scotland-14.4%) with a tolerance of 15-20% by Dec 2015 [1]	Green	15.7%	Quality Report (charts 7-9)
• Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015	Green	99.7%	Patient Safety Programme Annual Report (July)
• Achieve 184 or fewer SAB by March 2016 with a tolerance of 95% against target. n=193 to 184	Red	290 (as at Sept 2015)	Quality Report (chart 12) HAI report on Board Agenda
• Achieve 262 or fewer C.Diff by March 2016 with a tolerance of 95% against target. n=275 to 262	Red	357 (as at Sept 2015)	Quality Report (chart 11) HAI report on Board Agenda
• Reduce falls with harm by 20% with a tolerance of 15-20% by Dec 2015	Green	20%	Quality Report (chart 15)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.1 Deliver Person-centred Care) **Low Risk Appetite**			
• Patients would rate out of 10 their care experience as 9.5, with a tolerance of 9	Red	8.7	Quality Report (chart 1) Tell us Ten Things (TTT) Patient Questionnaire Person-centred Report
• 90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%	Tbc	Tbc	To be collected
• Staff absence below 4% with a 5% tolerance (4-4.2%)	Red	4.8%	Quality Report (chart 6)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.4 Scheduled Care & Waiting Times) **Low Risk Appetite**			
• 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Green	85%	Scheduled Care Report
• 95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%	Green	95.7%	Quality Report (chart 17) Performance Report
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.3 Appropriate Unscheduled Care) **Low Risk Appetite**			
• 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%	Green	94%	Quality Report (chart 16) Performance

[1] This is a Scotland-wide target which NHS Lothian will contribute to.

	Current Status	Current Position	Data Report
			Report
• No of patients will wait no more than 14 days to be discharged by April 2015 with a tolerance of 13 to 14 days	Red	150	Quality Report (chart 5) Performance Report
• No of patients will wait no more than 28 days to be discharged from hospital by April 2015 with a tolerance of 26-28 days	Red	101	Quality Report (chart 5) Performance Report for management actions
• 90% of all stroke patients to be admitted to stroke unit on day of admission following a stroke with a tolerance of 85-90%	Red	75%	Quality Report (chart 18) Performance Report for management actions
Corporate Objective 1 – Protect & Improve the Health of the Population. **Medium Risk Appetite**			
• Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas, with a 10% tolerance (36-40%)	Green	37.5%	Performance Report on Board Agenda
• At least 77% of women in each SIMD percentile will be booked for antenatal care by 12th week of gestation, with a 10% tolerance (69.3-77%)	Green	85.4%	Performance Report
Corporate Objective 3 – Secure Value & Financial Sustainability (LDP 2015-16 – 3.1 Financial Planning) **Medium Risk Appetite**			
• In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%	Red	£1,012k overspend at period 6 (inc. unachieved LRP), equating to 1.0%	Period 6 Finance Report (Sept 2015)
• For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%	Red	£7,180k overspend for the year-to-date (inc. unachieved LRP) equating to 1.1%	Period 6 Finance Report

3.5.1 The above reporting would suggest NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 2/2.2), patient experience (Corporate Objective 2/2.1) and improving the way we deliver unscheduled care (Corporate Objective 2/2.4). NHS Lothian is also out with risk appetite for health population (Corporate Objective 1) and Financial Planning (Corporate Objective 3/3.1), where a medium appetite has been set. The Board may wish to examine the management actions to address areas which are outwith appetite to inform assurance requirements as set out in management reports submitted to the Board.

4 Key Risks

4.1 The risk register process fails to identify, control or escalate risks that could have a significant impact on NHS Lothian

5 Risk Register

5.1 Not applicable.

6 Impact on Health Inequalities

6.1 The findings of the Equality Diversity Impact Assessment are that although the production of the Corporate Risk Register updates, do not have any direct impact on health inequalities, each of the component risk areas within the document contain elements of the processes established to deliver NHS Lothian's corporate objectives in this area.

7 Resource Implications

7.1 The resource implications are directly related to the actions required against each risk.

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10 November 2015
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List of Appendices

Appendix 1: Summary of Corporate Risk Register
Appendix 2: Proposed Road Traffic Management risk for inclusion on Corporate Risk Register

APPENDIX 1

Summary of Corporate Risk Register

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
1076	2: Improve the quality and safety of health care	Healthcare Associated Infection	Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital, increased mortality and morbidity and further treatment requirements.	Leadership and Governance: UHS and CHP Infection Prevention and Control Committees are well established and report to board through LICAC. In addition to LICAC and local committees, Infection Prevention and Control routinely report at a senior management level to CMG/Healthcare Governance and bi-monthly board papers. NHS Lothian has an Infection Prevention & Control team in place. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid & East and West Lothian) established with responsibility for both acute and community settings within their remits. Education: • There is a HAI Education Strategy which defines the training and education requirements for staff of all disciplines across the organisation. • HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro. IPCT provide support for NES Cleanliness Champions Programme accessible to all staff to increase an understanding of Infection Prevention and Control Precautions. • IPCNs work collaboratively with clinical and non clinical services to communicate risk, support improvement and escalate concerns as appropriate. A Problem Assessment Group (PAG) or Incident Management Teams (IMT) is convened to investigate and manage any significant event or outbreak. These teams are supported by the wider multi-disciplinary team and any external stakeholders as appropriate. The Communications Team provide support to manage public release of information as required. • The Infection Prevention and Control Service provides a single point of contact duty nurse 7 days per week between 0830-1600hrs facilitating access to Infection Prevention and Control advice for clinical teams. Surveillance: • IT systems are in place to allow IPCNs to monitor incidence, trends and patterns of HAI within their clinical remits. Weekly and Monthly reports with progress made against HEAT Targets are shared with clinical teams and senior management and are widely available on the Intranet. • Surveillance Policy and Procedure is in place.	Risk Reviewed: Sep 2015 The Infection Control Doctor role has been taken on by Dr Donald Inverarity Consultant Microbiologist. Dr Inverarity will provide support to the service and the medical strategic leadership going forward. The professional meeting has also met since last review and should return to regular meetings as previously There are no other notable changes at this review point Risk Grade/Rating remains Very High/20	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 4	Melanie Johnson	Fiona Cameron	Healthcare Governance Committee

1076	2: Improve the quality and safety of health care	Healthcare Associated Infection		Controls Continued: • Enhanced investigation and surveillance is carried out of all SAB and CDI incidences. An SBAR Report is provided to clinical and senior management teams where 2 or more cases are identified within the same clinical area within a defined timescale. • NHS Lothian complies with all mandatory surveillance reporting requirements outlined within HDL 2006 (38). Antimicrobial Stewardship: • The Antimicrobial Management Team are responsible for the review and development of the Antimicrobial Prescribing Guidelines. They also provide oversight of antimicrobial use and compliance with guidelines and report findings to clinical teams to help drive improvement. Summary Reports are also provided to Clinical Management Team. Policies and Guideline: • NHS Lothian has adopted the National Infection Prevention and Control Manual and has an ongoing programme of 2 yearly policy and development review. • Audit results are posted through the patient safety programme QIDs system, allowing clinical areas to directly enter data onto database and obtain reports to monitor own trends and patterns. • Improvement plan in place monitored through HCG. Decontamination: • There is a Decontamination Strategy Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment. Procurement of Equipment • NHS Lothian's Procurement Strategy in support of the Efficiency and Productivity Programme and the Medical Devices Committee oversee the purchase of procurement and the supply of equipment and medical devices with input from the IPCT.		Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 4	Melanie Johnson	Fiona Cameron	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3600	3: Secure Value & Financial Sustainability	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target. On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years. The December 2014 Finance Board paper updated the Board on the current financial challenge. If the Board and management fail to systematically and robustly respond to this challenge now it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.	The Board has already established a financial governance framework and systems of financial control. NHS Lothian is currently reliant on non-recurring efficiency savings. A detailed Action Plan, attached to this risk, is in place and is regularly reviewed by the Senior Finance Team. Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years, combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested.	Risk Reviewed: October 2015 Finance reports since the July review reinforce the previous trends. A new approach to financial planning by business unit which will clarify accountability has been agreed by the September Finance & Resources Committee. This is currently being implemented. Quarterly financial recovery review meetings continue to take place. Mid year review meetings are scheduled in November. Risk grading/rating remains Very High/20.	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Susan Goldsmith	Craig Marriott	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3203	2: Improve the quality and safety of health care	Unscheduled Care: 4 hour Performance	There is a risk that patients are not seen in a timely manner who require emergency care as required by the Emergency Care standard of 95% resulting in sub optimal care experience and outcome.	A range of governance controls are in place for Unscheduled Care notably: - Bi monthly NHS Lothian Board oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area. -The bi-monthly Acute Hospitals Committee as well as formal SMT meetings. Both are chaired by the Director for Unscheduled Care. - The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis. - Monthly SMG and SMT meetings in place for acute services in Lothian - Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, StJ). - NHS Lothian's Winter Planning Project Board responsible for ensuring sustainable performance throughout the winter period A number of performance metrics are considered and reviewed, including: - 4 hour Emergency Care Standard and performance against trajectory - 8 and 12 hour breaches - Attendance and admissions - Delayed Discharge (see Corporate Risk ID 3726) - Boarding of Patients - Winter Planning - Length of Stay (LOS) - Cancellation of Elective Procedures - Finance Adherence to national guidance/ recommendations Plethora of work now focussed around the Scottish Government's *6 Essential Actions* initiative to support achievement of 95% target for 4 hour performance.	Risk Reviewed: October 2015 Risk Grade/Rating remains Very High/20 Following Risk being reviewed in March 2015 A&R Committee, agreement reached in developing separate controls/ plans for achieving goals for 4 hour performance and Delayed Discharge Work is being developed in line with the Scottish Governments 6 Essential Actions initiative. Following launch in May, Boards now involved in taking forward set of actions (per site) to support a step change in performance. Priority interventions will focus on: • Clinical Leadership • Escalation procedures • Site safety and flow huddles • Workforce capacity • Basic Building blocks models • Proactive discharge • Flow through ED/ Acute Receiving • Smooth admission/ discharge profiling The above has been absorbed as part of approach to winter planning, led by the Winter Planning Board. The Winter Plan has been developed and approved by NHS Lothian Board ahead of formal submission to Scottish Govt. Ongoing activity include • Winter Readiness plans in place for each site • Plans will have a focus on discharge capacity as well as bed capacity • Clear measures in terms of escalation procedures • Counter any demand as a result of the extended 4 day break during the festive period. • Dealing with DD will be imperative to ensuring sustainable performance throughout the winter period. • Agreed data set to assist with developing a wider capacity plan across all health & social care areas The Winter Planning Board to meet monthly through to April 2016.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jim Crombie	Neil Wilson	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3726	2: Improve the quality and safety of health care	Unscheduled Care: Delayed Discharge	There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	A range of governance controls are in place for Unscheduled Care notably: NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area. The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a fortnightly basis The bi-monthly Acute Hospitals Committee as well as formal SMT and SMG meetings. Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON NHS Lothian's Winter Planning Project Board NOW responsible for ensuring sustainable performance throughout the winter period NHS Lothian strategy to improve unscheduled care performance and delayed discharge is being delivered under the umbrella of the Scottish Government's *6 Essential Actions* initiative.	Risk Reviewed: October 2015 Risk Grade/Rating remains Very High/20 Action to help tackle DD across NHS Lothian include: • Criteria led discharge pilots • Downstream hospitals to have admission and discharge quotas similar to main acute sites. • Enhanced cover for Day Bed suite to protect elective capacity • Re-balancing of weekend health delays from RIE to all sites • Any boarding to reflect those patients with an EDD of < 24 hours • Extending Hospital to Home capacity • Additional capacity to support weekend discharge (diagnostic, pharmacy, AHPs, transport etc) • Every ward to evidence a Friday morning board ward round • Twice weekly delayed discharge ward round • Joint Venture with CEC to create additional bed capacity –Gylemuir • Discharge Hubs in the Royal Infirmary of Edinburgh, the Western General Hospital and St John's Hospital • Orthopaedic Pathway Review Inaugural Winter Planning Board meeting held on 1st July 2015 and will meet monthly through to April 2016. Actions include: • The need for robust site winter readiness plans by Nov 2015 • Plans to have a focus on discharge capacity & bed capacity • Clear measures in terms of escalation procedures • Counter any demand as a result of the extended 4 day break during the festive period. • Dealing with DD will be imperative to ensuring sustainable performance throughout the winter period. • Agreed data set to assist with developing a wider capacity plan that covers all health and social care areas Lothian's Winter Plan developed and approved by NHS Lothian Board ahead of formal submission to Scottish Govt	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jim Crombie	Neil Wilson	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3829	2: Improve the quality and safety of health care	GP Workforce Sustainability	There is a risk that the Board will be unable to meets its duty to provide access to primary medical services for its population due to increasing population combined with difficulties in recruiting and retaining general practitioners, staffing, premises and IT difficulties. This may affect: - ability of practices to accept new patients (restricted lists); - patients not being able to register with the practice of their choice; - ability to successfully fill practice vacancies; - ability to cover planned or unplanned absence from practice; - ability to safely cover care homes; and difficulties in one practice may impact on neighbouring practices/populations, occur at short notice with the result that practices are unable to provide services in their current form to existing patients.	1. PCCO maintain a list of restrictions to identify potential and actual pressures on the system – this is shared with HSCPs and taken to PCJMG monthly. 2. Position with closure of lists set out in regulatory framework. 3. Ability to assign patients through PSD. 4. HSCP development of risk register for general practice. 5. "Buddy practices" through business continuity arrangements. 6. PCJMG review the position monthly with practices experiencing most difficulties. 7. Primary Care propositions in strategic plan – updates reported to Board and Strategic Planning Committee. 8. Primary Care IT Operational Board now established.	October 2015 – New Risk Risk Grade/Rating: Very high 20 As at 04/08/15 – general medical practitioners are mostly independent contractors and business continuity is not explicit in the contract. Proposals are being put forward through the strategic plan for additional support, eg an emergency measures package, clinical development fellows, local enhancement of the National Returner Programme, locum pools of recently retired practitioners, LEGUP/IPA, 2c.	Inadequate; control is not designed to properly manage the risk and further controls and measures are required.	Very High 20	High 16	David Farquharson	David Small	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3480	2: Improve the quality and safety of health care	Delivery of SPSP Work Programme	There is a risk that NHS Lothian does not reliably implement the 4 workstreams of the Patient Safety Programme leading to potential patient harm	• The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to patient safety. • Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical adverse event reporting and response. • The Patient Safety Programme reports to relevant governance committees of the Board setting out compliance with process and outcome safety indicators and includes external monitoring. • Adverse Event Management Policy and Procedure. • Quality of care which includes patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit & Risk Committee and HCG Committee when appropriate. • Patient safety walkrounds to gain an understanding of safety culture and work taking place at service level. Also now in general practice. • Quality Assurance Mechanism proposed to validate self reporting of patient safety data • Quarterly visit by HIS to discuss progress actions and monthly submission of data • Adverse Event Improvement Plan in place monitored via HCG • Site Based Quarterly Reports including Patient Safety Data (QIDS) sent monthly. •Single System medicines reconciliation group.	Risk Reviewed October 2015: • Improvements can be demonstrated but compliance with 10 Essentials is variable and priorities work at testing phase. Outcomes have shown improvements but not achieved all SPSP goals. • External review HIS. Meeting trajectory on core measures and outcome measures with exception of managing of deteriorating patients. Proposal being developed to improve the management of deteriorating patients through the Acute Clinical Management Group.. Risk grade/rating to remain High/16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Dr David Farquharson	Jo Bennett	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3211	2: Improve the quality and safety of health care	Achievement of National Waiting Times Targets	There is a risk of: Lack of management of national waiting times targets for a number of reasons due to lack of core capacity or appropriate use of what is available Overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money. Lack of robust management process and staff capability to deliver consistent management of waiting lists. Risk of adverse publicity relating to failure to meet waiting times targets.	Monthly Access Performance and Government Group meeting chaired by Director of Planning, Performance Reporting and Information oversees this area. These are supplemented by weekly scheduled reviews between this Director and Directors of Operations. It considers: • Performance against trajectory across a range of measures (including waiting time standards) • Finance • Governance position, in terms of adherence to national guidance and local access policy/SOPs This meeting reports to the Acute Services Committee with a comprehensive overview on governance arrangements provided in September 2014. Papers on CAMHS and psychological therapies presented to the Board in April 2015 outlining difficulties in delivering standards of 18 weeks coming into force in December. Further investments were approved.	Risk Reviewed: October 2015 No change. Risk Grade/Rating remains High/16	Satisfactory; controls adequately designed to manage risk and working as intended	High 16	Low 1	Jim Crombie	Andrew Jackson	NHS Lothian Board

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3454	2: Improve the quality and safety of health care	Management of Complaints and Feedback	There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times. This includes the management and learning from complaints.	• NHS Lothian Board approved in full the Listening and Learning form Feedback and Complaints report (Jan 2015) that agreed to a devolved approach to complaints and feedback. • The Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical adverse event reporting and response. • The Quality Improvement Strategy (2011-14) set out a range of improvement programmes to improve patient experience and outcome of care. • The National Person Centred Health & Care Programme has been concluded and work is being undertaken nationally to embed patient experience into the existing quality improvement programmes. • Tell us Ten Things questionnaire was reviewed in November 2014 and aligned to the "5 Must dos". Patient experience data feedback to the service on a monthly basis at service and site level to inform improvement planning. • Regular reports on Complaints management through Datix Dashboards and reports. • Delivering Better Care commitments have been agreed and plans are now in place to deliver on the required actions from the HIS Older People's review and the updated vulnerable Patient's Quality Improvement Framework. This activity is reported to the Board through the Executive lead. These plans are informed by inspection reports. produced by Healthcare Improvement Scotland, local audit and regular checks i.e. PQI, mock OPAH ,frailty bundle audit and via the Clinical manager ward assurance checklists. The tools in use have been adapted and updated to reflect the person centred agenda. • HIS Older People in Acute Care had their initial Board Assessment day on 16th April 2014, an unannounced inspection is awaited. There has been intense work on each of the Adult Acute Sites to raise the profile of OPAH and each site has a nominated lead. The new Older peoples Standards were published in June ; Board will be notified when they will be assessed against these new standards. The PQI tool is being amended and currently in the test phase. • Quality of care is subject to Internal Audits and compliance with audit recommendations reported via Audit & Risk Committee and Healthcare Governance Committee. • The Delivering Better Care established on 2012 as a resource for staff (primarily nursing) but where appropriate, other disciplines continue to deliver support to clinical areas on the key ambitions of harm reduction work is now on going to streamline programmes of work for 2015/16 working more closely with Clinical Governance and using improvement methodology. • As part of the improving care to vulnerable patient's support manual with detailed information inclusive of a rapid patient essential care check sheet was implemented within acute and community In patient facilities during 2013 and has recently been reviewed and the e-version on all PC's has been updated. • March 2015 the Vulnerable People Manual was refreshed and updated, there is ongoing work on the web page. Rationale for Adequacy of Controls is a developing process that is not at present stable.	Risk Reviewed: October 2015 • Organisational change processes have dissolved the Customer Relations & Feedback Team and the new Patient Experience Team has been established. The Head of Patient Experience was appointed in June 2015 and some appointments have been made to the new team. As of Oct 2015 there are 9WTE currently advertised. This team brings together complaints and feedback with patient experience and provide enhanced reporting arrangements to the committees and Board. • Throughout 2015 there have been regular reports to the Healthcare Governance Committee that brings together complaints performance and patient experience reports • In June complaints and feedback reports have been sent to the operational management teams to identify those complaints that are over 50days • Continue to test devolved complaints management system at WGH, REAS ECHP, ATCC. • Meeting the SPSP core process and outcome measures (HIS external assessment Sep 15) related to harm reduction, supported by data available to the service at ward and site including inpatients. • Work ongoing to implement standardised nursing clinical documentation and care planning supported by educational events. Risk Grade/Rating remains High/16	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Medium 6	Melanie Johnson	Jeannette Morrison	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3527	3: Secure value and financial sustainability	Medical Workforce Sustainability	There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.	•In response to a request from the SEAT Planning Board, a medical workforce risk assessment tool has been developed and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. •For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group. This group will co-ordinate actions across Boards within SEAT and feed into the national medical workforce planning processes co-ordinated by NES/SG. •A report is taken to each Board meeting updating the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. The main challenges have been in Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Radiology and Medicine for the Elderly. •For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. •A Medical Workforce Group has being established who are looking at medical workforce issues in Ophthalmology and Radiology. The group will also be looking at the Greenway Report on 'Shape of Training' and how this framework should support changes to the medical staffing model.	Reviewed October 2015 – no change since last update There has been successful recruitment to a numbers of anaesthetic posts at the RIE, WGH and STJ which has significantly improved capacity. Within Medicine for the Elderly there has been some improvement in consultant recruitment at the WGH and RIE. There remain however significant problems at Roodlands with only 1 of 4 posts filled on a substantive basis. There is reliance on ad-hoc staffing measures to remain open to admissions. There have been occasions where there has been a short term closure to admissions as a result. Vacancies have been reviewed to make more attractive and are under recruitment. There are difficulties in filling consultant psychiatrist posts within the Peri-natal Mental Health Unit and Regional Eating Disorder Unit at St John's hospital and as a consequence short term contingency arrangements have been put in place to ensure sustainability. Further recruitment is underway. The on-going difficulties in sustaining paediatric out of hours services at St John's hospital have resulted in the closure of the unit for a six week period in July/aug 2015 A review is underway looking at areas of high expenditure on locums, waiting list payments and private sector with a view to identifying areas where more sustainable solutions can be developed. Of the 14 International Medical Training Fellowships approved by the Scottish Government 12 have been advertised, with 5 appointments being made. There have been significant difficulties in recruitment for GP practices. Whilst most practices are independent providers there is a risk for the board as where the workforce is no longer sustainable then the Board requires to take over the practice to avoid closure. Risk Grade/Rating remains as High/16.	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Dr David Farquharson	Nick McAlister	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3189	3. Secure Value of Financial Sustainability	Facilities Fit for Purpose	Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk.	•The reported backlog maintenance as at 1st May 2015 and reported in the Property Asset Management Strategy (PAMS) 2015 is now £67.4m which includes a 13% uplift for inflation which has been applied nationally. The PAMS describes the action which will be taken to reduce the figure, which includes estate rationalisation, capital investment and Re-provision projects.. •The financial plan for 2015/16 has allowed for a further £3m BLM allocation for 2015/16, thereafter the allocation has been reduced to £2.5m. Programmes of works are being confirmed for the next three financial years. •The capital plan for 2015/16 has a number of capital projects which will improve the physical condition of the estate and reduce backlog maintenance. •The programme of works will continue to address high and significant risks. The programme continues into the financial year 2015/116. The allocation for this financial £3m has been committed. •A procurement and implementation strategy was approved in early November 2012, which described how this funding would safely expended. •An update of the PAMS each year will log the affect upon the backlog maintenance and compliance figure. - Regular updates are provided to the Capital Steering Group and Capital Investment Group •A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance. •A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years.	October 2015 – Agreed by Board to include on Corporate Risk Register Reviewed by A&R Committee June 2015 and it was agreed to reinstate this risk back on the risk register. Programme of works for 2015/16 has been prepared against an allocation of £3m. A review of the current risks and re-categorisation of the risks dependent on use of property is currently ongoing and as a result of this process and investment in the estate the total of high and significant works has fallen from 78% (of total blm) to 73%. The disposal programme for 2015 has reduced the BLM with the sale of Rosslynlee and Longstone clinic to date. Two other properties are due to be sold this financial year. Further properties have now declared surplus in line with the property rationalisation programme of works. Risk Grade/Rating remains High 16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 4	Alan Boyter	George Curley	Finance & Resources Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3455	2: Improve the quality and safety of health care	Management of Violence & Aggression	There is a risk of Corporate Prosecution by HSE under the Corporate Homicide Act or the H&S at Work Act Section 2, 3 and 33 or any relevant H&S regulations If the risk from violence and aggression adverse events are not adequately controlled. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being.	•Closed loop Health & safety management system in place. •Robust H&S Committee structure. •Violence & Aggression related policies and procedures in place (attached document). •Competent specialist V&A and H&S advice in place. Robust Occupational Health Services. Learning lessons through adverse event investigation. • The Interim Director of Occupational Health & Safety delivers an annual report to the NHSL H&S Committee with specific actions related to controlling violence & aggression risk within these reports. ROSPA QSA Audit complete and action plan in place. NHS Lothian Health and Safety Strategic Plan endorsed. Specific actions related to controlling violence & aggression risk are contained within these reports.	*Risk Reviewed: September 2015*: The status will be assessed further to the imminent Internal Audit regarding H&S Governance which commences in October 2015. The audit will have a particular focus on the control of V&A risks. Risk Grade/Rating remains High/15	Adequate but partially effective; control is properly designed but not being implemented properly	High 15	Medium 6	Alan Boyter	Ian Wilson	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3828	2.2 Deliver Safe Care	Nurse Workforce – Safe Staffing Levels	There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and / or inability to recruit. Risks occur across the nursing and midwifery workforce where additional capacity is opened to facilitate delivery of other corporate targets (e.g HEAT target 4 hour wait) or where patients have a greater level of acuity than the funded establishment is based upon. Service sustainability risks are high within theatres and anaesthetics, critical care and in health visiting owing to lower levels of workforce supply. Risks arise from the high use of supplementary staffing to counteract shortfalls. The impact of any of these situations potentially compromise the safety of the patient care delivered with consequent impact on length of stay, patient experience and long term	A Nursing and Midwifery Workforce Group has been long established to co-ordinate actions across the organisation. Nationally accredited tools to measure the nursing and midwifery workload by speciality are used on at least an annual basis. The findings from the tools are triangulated with the professional judgement, quality measures and with the local context. The findings from these exercises are used to inform local workforce plans to minimise risk and where appropriate escalated as priorities for additional funding via the financial planning process. eRostering and SafeCare are being rolled out to all nursing and midwifery wards, community teams and departments to provide real time information for local decision making around the deployment of the available staffing. Escalation procedures are in place to review the use of external agency suppliers. Datix reports are escalated on a weekly basis for all adverse events with staffing issues identified as a major or contributory factor. In response to a request from SEAT Workforce Board a regional approach is being adopted to the Health Visiting workforce recruitment, training and deployment of staff.	October 2015: New Risk Risk Grade/Rating: High 12	The control is adequately designed to manage the risk, but it is not being implemented properly	High 12	Low 2	Melanie Johnson	Fiona Ireland	

APPENDIX 2

Proposed risk for inclusion on Corporate Risk Register – Road Traffic Management

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3328	1:Improving the Quality and Safety of Healthcare	Roadways / Traffic Management	There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites	• Traffic surveys have been conducted across all hospital sites, and action plans have been prepared. Higher risks have been prioritised and actions taken where funding has permitted. • Actions include: o segregation of vehicle and pedestrian traffic where possible; o risk assessing and controlling reversing manoeuvres for drivers and vehicles under NHSL control o creation of protected walk ways where possible; o development and use of one way systems where possible o use of barriers and entry systems to control traffic where possible o drop-off areas and disabled spaces; o additional parking attendants. • Interim measures have been put in place to prevent illegal and inappropriate parking including temporary barriers and bollards. • RIE Site Campus Group has been put in place to co-ordinate the re-provision of DCN & RHSC, including impact on activity on traffic management. Action plans have been revisited on a number of hospital sites and has resulted in additional high risk works being undertaken • Banks man arrangements in place on high volume high risk delivery areas, • Risk assessments and procedures are being developed and reviewed all areas where risk has been identified – a more robust risk assessment process has been developed • NHSL fleet vehicles fitted with reversing cameras and audible alarms. • Traffic Management training in place along with regular refreshers. • Work Place Transport policy available and reviewed within agreed time scales. • Escalation process in place should congestion become an issue • Site traffic management groups to review all sites established. • Action plans developed from the above groups and implemented monitored and reviewed by Traffic Management Review Groups • Capital proposals to introduce engineered solutions for in-patient sites. • High Risk Capital proposals funded. • Reviews regularly carried out as to effectiveness of plans and operational procedures • Site walk rounds in place conducted by site stakeholders • Improved monitoring systems in place – formally recorded • Known areas of people v vehicle conflict segregation measures put in place to avoid risk of injury due to contact where reasonable and practicable to do so Rationale for Adequacy of Controls: There are ongoing issues with traffic management and potential for pedestrians to stray into Facilities type areas. Proposals have been prepared and costed for each site. These will have to be approved before works can commence. The plans have been provided to capital to incorporate into master plans and this is reflected in the Adequacy of Controls Local TM Groups will continue to apply simple and low cost actions and repairs/improvements where approvals and budgets allow.	Removed from corporate risk register June 2015.– Risk Reviewed. October 2015 and agreement to reinstate on register. The Pan Lothian TM Plan is being updated monthly and tabled quarterly at each Heads of Service Meeting. This details the risks, controls and further actions required at each site. Applications have been submitted to extend the TRO at the REH and introduce a TRO at the AAH. Designs are ongoing to align with master planning on the larger acute sites, and also to align with emerging large capital investments. A recent allocation of £700k to undertake works on 5 sites, anticipate completion Spring 2016. A draft monitoring tool has been developed to ensure the TM Groups are carrying out formal and effective monitoring, findings will be discussed at each TMG and issues escalated to the Pan Lothian Plan as required. A review of all TM Risk Assessments in currently underway using an improved process and linked in to the monitoring activities (above) and will be reviewed at each TMG as they are updated Risk grade/rating remains unchanged - High/12	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 12	Medium 8	Alan Boyter	George Curley	Staff Governance Committee

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NHS LOTHIAN

2.10

Board Meeting
2 December 2015

Executive Nurse Director

SUMMARY PAPER - HEALTHCARE ASSOCIATED INFECTION STRATEGY IMPROVEMENT PLAN AND PERFORMANCE UPDATE

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

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

• Progress against Health Efficiency Access Treatment Targets	3.1
• *Staphylococcus aureus* Bacteraemia: NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days (≤184 incidences) by March 2016 with a current rate of 0.30.	3.2
• *Clostridium difficile* Infection: NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days (≤262 incidences by March 2016 with a current rate of 0.43.	3.3
• Mandatory Surgical Site Infections**:** during July to August 2015 there were 760 procedures performed and 5 Surgical Site Infections detected with a rate of 0.7%.	3.4
• *Escherichia coli* Bacteraemia: there was a delay in establishing surveillance process in NHS Lothian, this has now been resolved. Mandatory surveillance will commence on 1 April 2016.	3.5
• Infection Control Doctor: Dr Inverarity has taken up the role of Infection Control Doctor.	3.6
• Meticillin Resistant *Staphylococcus aureus* Screening Programme: for quarter 2 of 2015 NHS Lothian indicated an overall Clinical Risk Assessment compliance of 64% and compliance with swabbing 79%.	3.7
• Antibiotic Prescribing Guidelines: results for September 2015 show that in the 20 patient cases reviewed on medical and surgical wards at the 3 acute sites all prescribed doses were administered and the indication for antibiotic treatment was documented in 90 to 100% cases.	3.8
• Decontamination: Building of the new Royal Infirmary centralised Endoscopy Decontamination Unit is complete and the equipment is being installed in November.	3.9
• Healthcare Environment Inspectorate: the update on the 2 partially met requirements following the Western General Hospital inspection on 26-27 may 2015 was returned to the Inspectorate on 29 September 2015	3.10
• Healthcare Environmental Inspectorate: Vale of Leven Update: NHS Lothian's update on the Vale of Leven Recommendations was returned to SGHD in July 2015. 32 are now fully implemented (↑18); 27 mostly implemented (↓6); and 5 partially implemented (↓12).	3.11

Fiona Cameron
Head of Infection Prevention and Control Services
10 November 2015
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NHS LOTHIAN

Board Meeting
2 Decemberr 2015

Executive Nurse Director

HEALTHCARE ASSOCIATED INFECTION STRATEGY IMPROVEMENT PLAN AND PERFORMANCE UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection (HAI) across NHS Lothian. Any member wishing additional information should contact the Executive Nurse Director in advance of the meeting.

1.2 The data reporting is in the new monthly report format as agreed with Clinical Management Group and Clinical Governance combining infection control and antimicrobial data and patient safety data (HAI Appendix 1).

2 Recommendations

2.1 The Board is recommended to:

- acknowledge receipt of the Healthcare Associated Infection Reporting Template for October 2015. (Appendix 2)
- note NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days (≤184 incidences) by March 2016 with a current rate of 0.30, which equates to 139 incidences. Multidisciplinary effort is required if progress towards target is to be sustained.
- note NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days (≤262 incidences by March 2016 with a current rate of 0.43, which equates to 207 incidences. NHS Lothian is currently off trajectory therefore a pan Lothian multidisciplinary effort is essential if target is to be achieved.
- approve Healthcare Associate Infection Standards Strategy and Improvement Matrix (HAI Appendix 3 and 4)

3 Discussion of Key Issues

3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets March 2016

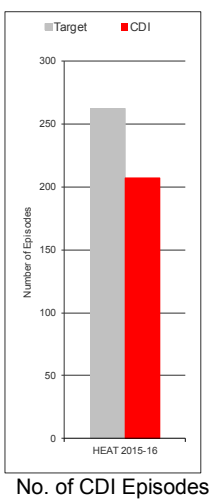

Figure 1: No. of CDI Episodes 2015-16

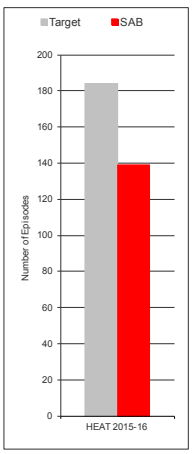

Figure 2: No. of SAB Episodes 2015-16

3.2 *Staphylococcus aureus* Bacteraemia: NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days (≤184 incidences) by March 2016 with a current rate of 0.30 (Appendix 1, figure 3.1b). This is a decrease of 13 incidences compared to the same period in 2014.

There were 8 episodes of *Staphylococcus aureus* Bacteraemia in October 2015 (1 Meticillin Resistant *Staphylococcus aureus*, 7 Meticillin Sensitive *Staphylococcus aureus*), compared to 18 in September 2015 (2 Meticillin Resistant *Staphylococcus aureus*, 16 Meticillin Sensitive *Staphylococcus aureus*). Incidence rates in NHS Lothian continue to show natural variation. Appendix 1, figure 2.1 shows between June 2014 and April 2015 NHS Lothian has seen an upward shift in the numbers reported. In the last 6 months this shift is beginning to show signs of reversal. There was an outlying data point in October 2015 where the data was below the lower control limit.

Target Date	Target	Actual
Year Ending 31/3/2013	213	255
Year Ending 31/3/2014	219	243
Year Ending 31/3/2015	184	282
Year Ending 31/3/2016	184	139*

* Cumulative to date

Key Messages:

- Skin and soft tissue infections account for approximately 22%, vascular access devices account for approximately 15% and persons who inject drugs account for approximately 14% of NHS Lothian's *Staphylococcus aureus* Bacteraemia.
- Peripheral venous catheter related *Staphylococcus aureus* Bacteraemia is being treated as severe adverse event utilising DATIX incident reporting system. This is trialled for a three moth period with the possibility of extending this process to all vascular access device related *Staphylococcus aureus* Bacteraemia.
- One Year fixed term Education Facilitator and Quality Improvement Facilitator posts commenced from October 2015. Part of these roles will be to support review of procedures and practice in line with NHS Lothian Local Delivery Plan, and develop a 90 day improvement cycle in relation to Peripheral venous catheter/line management related *Staphylococcus aureus* Bacteraemia.

3.3 *Clostridium difficile* Infection: NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days (≤262 incidences) by March 2016 with a current rate of 0.43. (Appendix 1, figure 3.1a). This is a decrease of 38 incidences compared to the same period in 2014.

There were 30 episodes of *Clostridium difficile* Infection in patients aged 15 or over in October 2015, compared to 40 in September 2015. Incidence rates in NHS Lothian for age 15-64 continue to show natural variation. Appendix 1, figure 1.1 shows the incidence rate in NHS Lothian for age group 15-64 years indicates the process is showing random variation, however there are a few significant data points which are out with the warning limit. Appendix 1, figure 1.2 shows Incidence rates in NHS Lothian for age 65 years showing a shift in process, six or more data points in a run below the mean. However this shift has not been sustained.

Target Date	Target	Actual
Year Ending 31/3/2013	418	364
Year Ending 31/3/2014	313	425
Year Ending 31/3/2015	262	393
Year Ending 31/3/2016	262	207*

* Cumulative to date

Key Messages:

- NHS Lothian engaged with Health Protection Scotland to review *Clostridium difficile* infection data and to identify targets for focused work. There were no issues with ongoing transmission in NHS Lothian. There were a few recommendations:
    - NHS Lothian to review trends in stool sampling rates.
    - NHS Lothian to review community prescribing to help identify any variation among practices, and possible targets for educational interventions.
    - NHS Lothian to review hospital prescribing audits, including surveillance of high-risk antimicrobials, and feed back to prescribers.
    - NHS Lothian to improve documentation of diarrhoea to improve reporting during validation stage of *Clostridium difficile* Infection quarterly reporting.
    - NHS Lothian to carry out a review of proton pump inhibitor use to identify if further need for interventions.

- Infection Prevention and Control team are currently developing an overarching plan to target interventions to achieve HEAT target.

3.4 Mandatory Surgical Infection (SSI's): during July to August 2015 there were 760 procedures performed and 5 Surgical Site Infections detected with a rate of 0.7%. The Surgical Site Infection rate for caesarean section (inpatient and post discharge) surveillance for NHS Lothian is marginally up this quarter from 0.8% to 1.0%. Four were post-discharge infections and one was an inpatient infection and all were classified as superficial infections. There were no infections reported for hip Arthroplasty or repair of neck of femur for July or August 2015.

3.5 *Escherichia coli* Bacteraemia: implementation phase of the data collection for the National Surveillance commenced 1 September 2015. There was a delay in establishing this process in NHS Lothian as Infection Prevention and Control had restricted access to Microbiology information system, this has now been resolved. Local testing of the process to start in December 2015 and mandatory surveillance will commence on 1 April 2016.

3.6 Infection Control Doctor: Dr Inverarity has taken up the role of Infection Control Doctor. His job plan has 3 programmed activities allocated for the duties associated with the role.

3.7 Meticillin Resistant *Staphylococcus aureus* Screening Programme: the most recent report (quarter 2), from Health Protection Scotland key performance indicator system for NHS Lothian shows Meticillin Resistant *Staphylococcus aureus* Clinical Risk Assessment compliance of 64% and compliance with swabbing is 79%. Wards and departments are encouraged where possible to monitor local

compliance with the screening programme and ensure compliance is improved and sustained. A proposal is in development to set out a method for Infection prevention and control risk assessments to be embedded in TRAK.

3.8 Antibiotic Prescribing Indicators: revised prescribing indicators were implemented from July 2015. The results for September 2015 show that in the 20 patient cases reviewed on medical and surgical wards at the Royal Infirmary of Edinburgh, Western General Hospital and St Johns Hospital all prescribed doses were administered and the indication for antibiotic treatment was documented in 90 to 100% cases. However, treatment was compliant with the antibiotic prescribing policy in 60 to 95% of cases and duration/review date was documented in 25 to 80% of cases.

3.9 Decontamination: decontamination is overseen by the Decontamination Project Board. This group has responsibility for taking forward major projects to allow NHS Lothian to meet and maintain compliance with current extant decontamination standards and guidance.

Key Messages:

- Building of the new Royal Infirmary centralised Endoscopy Decontamination Unit is complete and the equipment is being installed in November.
- The new centralised Endoscopy Decontamination Unit at the Western General Hospital is progressing well with an estimated date for installation of the new equipment in the new year.
- The new Endoscopy Decontamination Unit being built in the new East Lothian Community Hospital is being reviewed to ensure alignment with SHPN 13 part 3 and future capacity.
- A specification for a NHS Lothian Tracking and Traceability system has been developed. A business case is now required for LCIG and this will be presented at the November meeting.
- A review of the Podiatry facility at Slateford Medical Centre will take place in November with a view to upgrading to bring in line with SHPN 13 part 2.
- Procurement of the additional instruments required for the post-1997 cohort (in relation to the NICE Guidance (IPG196) 2006) and adenotonsillar surgical procedures as per Chief Medical Officer letter (SGHD/CMO(2015)2) is being progressed.

3.10 Healthcare Environment Inspectorate: the update on the 2 partially met requirements following the Western General Hospital inspection on 26-27 may 2015 was returned to the Inspectorate on 29 September 2015.

3.11 Vale of Leven Update: NHS Lothian's update on the Vale of Leven Recommendations was returned to SGHD in July 2015. 32 are now fully implemented (↑18); 27 mostly implemented (↓6); and 5 partially implemented (↓12). The HAI Strategy and Improvement Plan will continue to support NHS Lothian's progress against the recommendations. The SGHD have established two working groups to take forward the Vale of Leven actions and further information and guidance is awaited on the expectations of SGHD for the Board's continued delivery against the recommendations.

4 Key Risks

4.1 The key risks associated with the recommendations are:

- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Factors influencing exceedance of the Health Efficiency Access Treatment Target for *Clostridium difficile* Infection are actively being investigated. Compliance with antimicrobial prescribing guidelines continues to be promoted.
- Based on current data for both *Clostridium difficile* Infection and Staphylococcus *aureus* Bacteraemia NHS Lothian is currently reporting amber for progress against the Health Efficiency Access Treatment Target.
- Potential risk of decrease in Meticillin Resistant *Staphylococcus aureus* screening compliance with the loss of dedicated resources.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register 1076 is currently graded high due to reported incidences of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection impacting on negative trend to achieving Health Efficiency Access Treatment Target. The risk register covers Norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Inequality, Including Health Inequalities

6.1 Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. Accordingly, changes made are reducing the burden of Healthcare Associated Infection.

7 Involving People

7.1 Patient public representatives are actively involved during the Healthcare Environment Inspectorate inspections, with one member sitting on the Healthcare Environment Inspectorate Steering Group. Other patient public representatives sit on the Infection Control Committees for Acute and Community and Lothian Infection Control Advisory Committee.

8 Resource Implications

8.1 Infection Prevention and Control is an invest to save service. The excess cost of each episode of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection is variable, depending on increased length of stay and additional treatment requirements.

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10 November 2015
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List of Appendices

Appendix 1: Clinical Management Group Monthly Infection Report November 2015
Appendix 2: Healthcare Associated Infection Reporting Template for October 2015
Appendix 3: Healthcare Associate Infection Standards Strategy and Improvement Matrix
Appendix 4: Healthcare Associate Infection Improvement Matrix

APPENDIX 1

NHS Lothian Monthly Infection and Antimicrobial Report - November 2015

Date produced: 9th November 2015

This report is in development. The intial focus for development has been the acute sites.
A more comprehensive report is available quarterly. Brief commentary is provided alongside each figure.

Note that for data on infections, infections are attributed to the clinical area from which the sample was sent.

Contacts

Infections data janathan.danial@nhslothian.scot.nhs.uk

Antimicrobial data barbara.moore@nhslothian.scot.nhs.uk

Primary Data sources

Prescribing data: Ascribe (to June 2014); JAC (from June 2014)

Activity data: TRAK oracle

Infections data: Apex labs system

Please see individual sheets for other data sources

Abbreviations

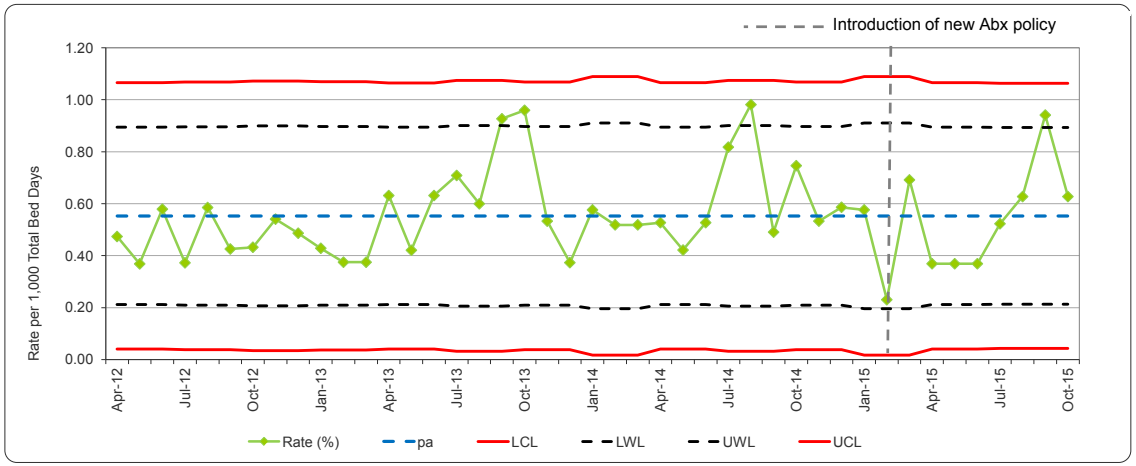
DDD - Defined Daily Dose
The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults.

OBD - Midnight Occupied Bed Days

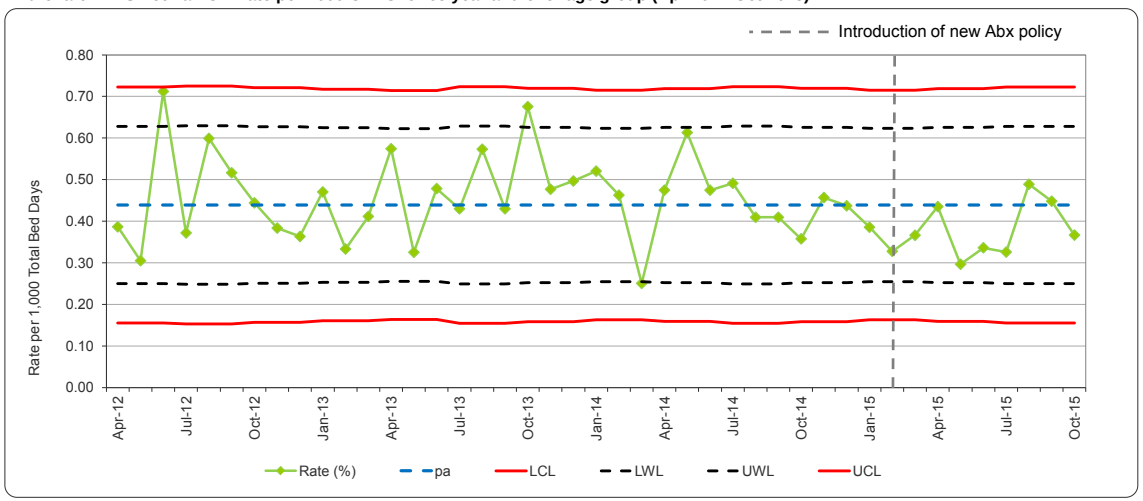
CDI - Clostridium difficile infection

For SPC charts: pa - process average, **LCL** - lower control limit, **LWL** - lower warning limit, **UWL** - upper warning limit, **UCL** - upper control limit

1.1 u-chart - NHS Lothian CDI rate per 1,000 bed days for15-64 year age group (Apr 2012-Oct 2015)



1.2 u-chart - NHS Lothian CDI rate per 1000 OBDs for 65 year and over age group (Apr 2012-Oct 2015)

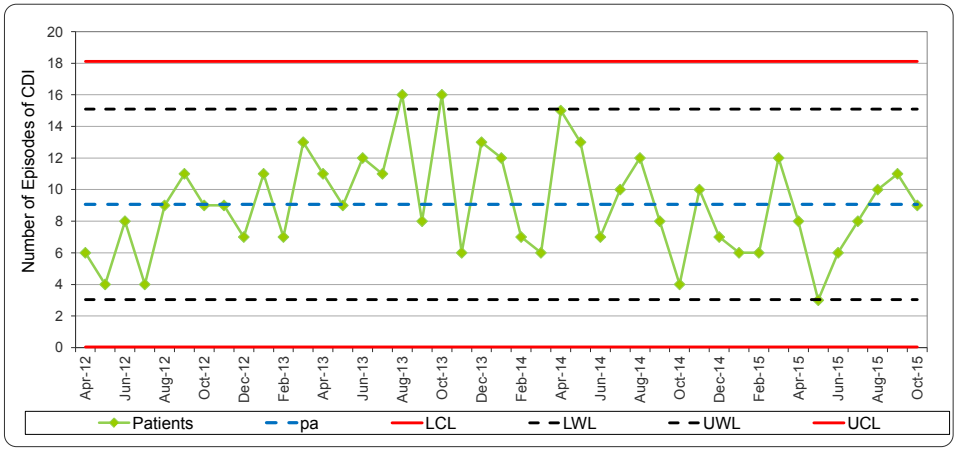


Source: IPCT
All data

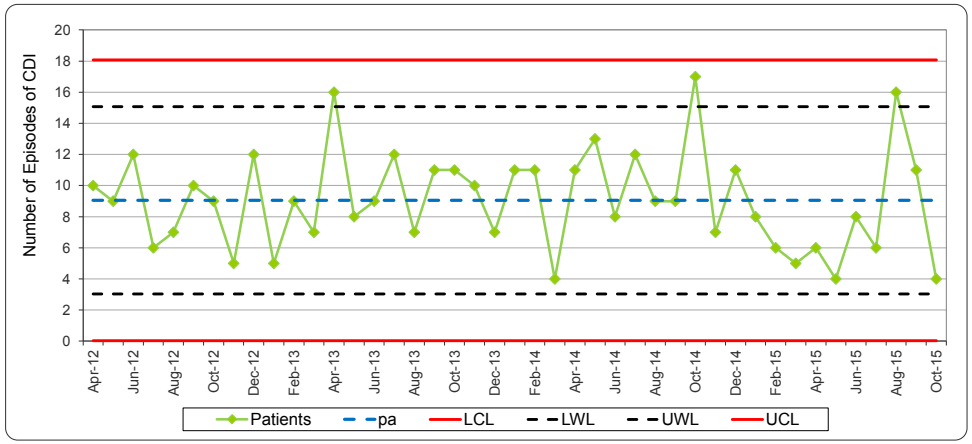
Figure 1.1 shows the incidence rate in NHS Lothian for age group 15-64 years indicates the process is showing random variation, however there are a few significant data points which are out with the warning limit.

Figure 1.2 shows incidence rates in NHS Lothian for age 65 years and over showing a shift in process, six or more data points in a run below the mean. However this shift has not been sustained.

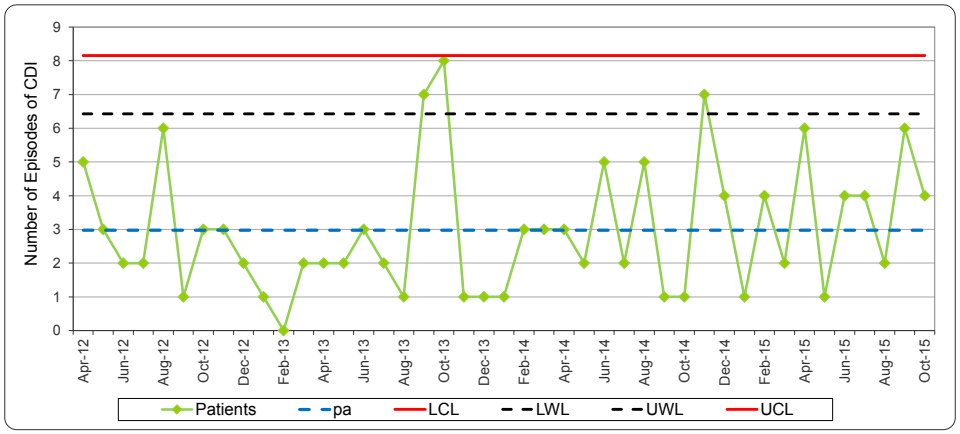
1.3 c-chart of number of episodes of CDI per month in RIE in pts aged 15+ (Apr 2012-Oct 2015)



1.4 c-chart of number of episodes of CDI per month in WGH in pts aged 15+ (Apr 2012-Oct 2015)



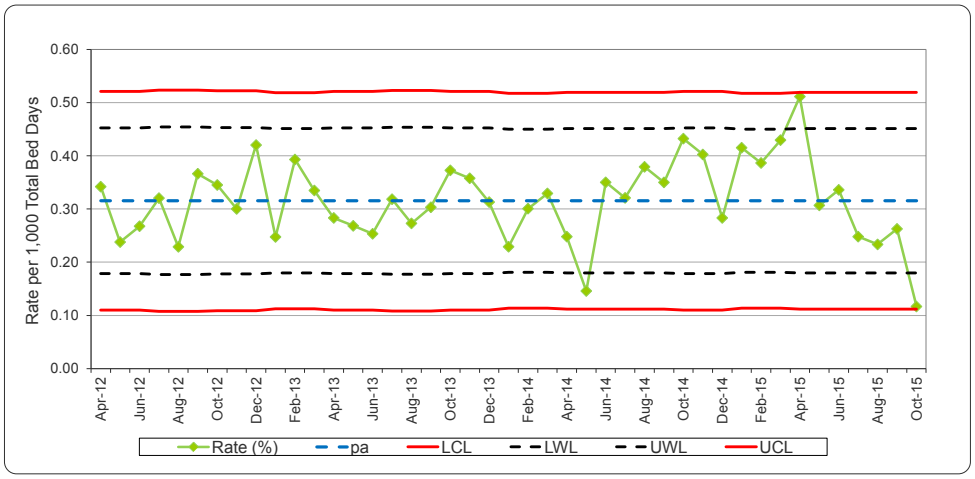
1.5 c-chart of number of episodes of CDI per month in SJH in pts aged 15+ (Apr 2012-Oct 2015)



Source: IPCT
All data

Incidences for RIE, WGH and SJH indicate the process is showing random

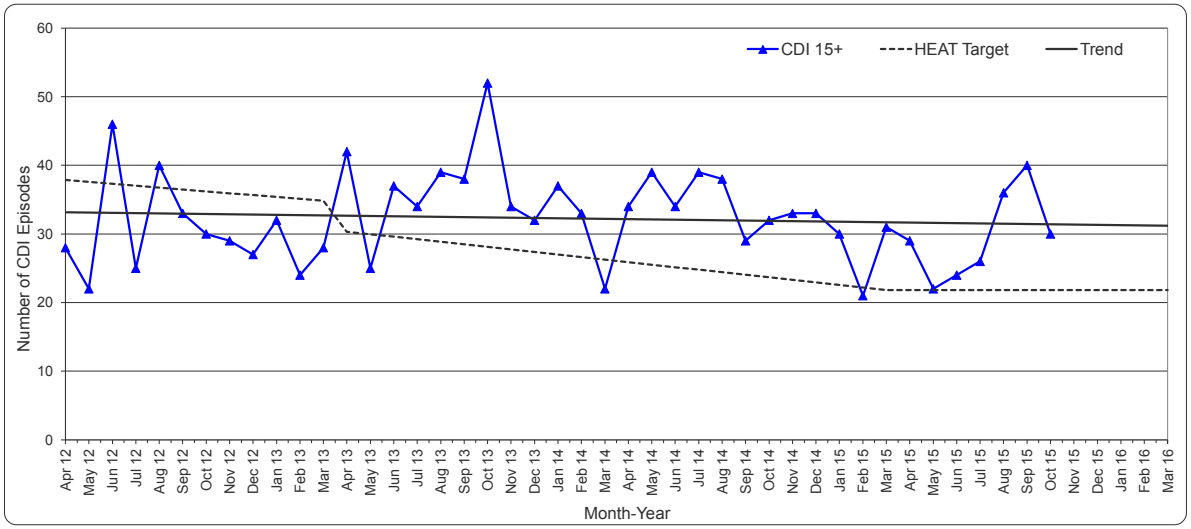
2.1 u-chart - NHS Lothian *Staphylococcus aureus* Bacteraemia rate per 1000 OBDs (Apr 2012-Oct 2015)



Source: IPCT
All data

Figure 2.1 shows between June 2014 and April 2015 NHS Lothian has seen an upward shift in the numbers reported, however this shift has not been sustained. In the last 6 months this shift is beginning to show signs of reversal. There was an outlying data point in October 2015 where the data was below the lower control limit.

3.1a CDI Progress against HEAT target - NHS Lothian

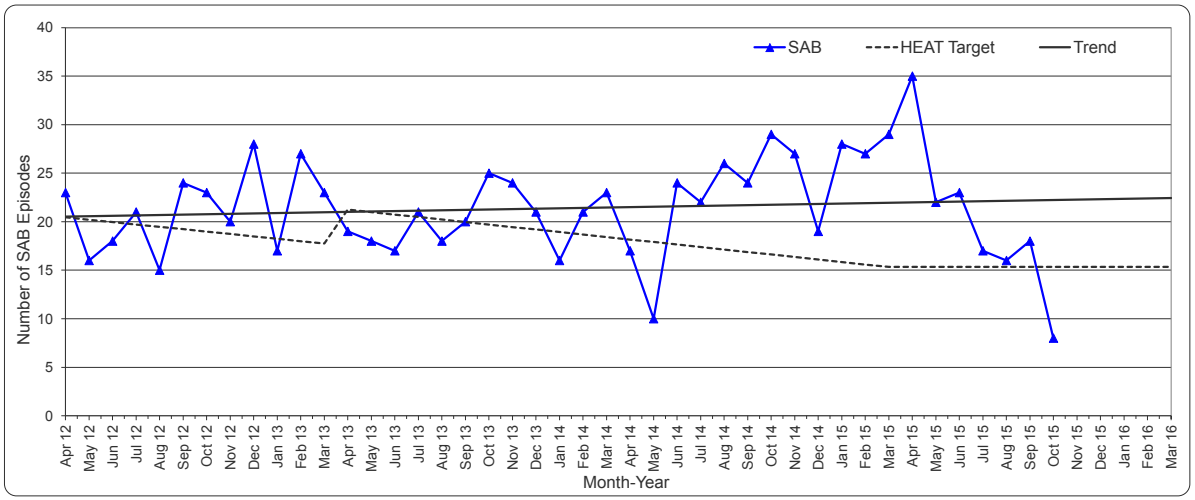


Source: IPCT
All data

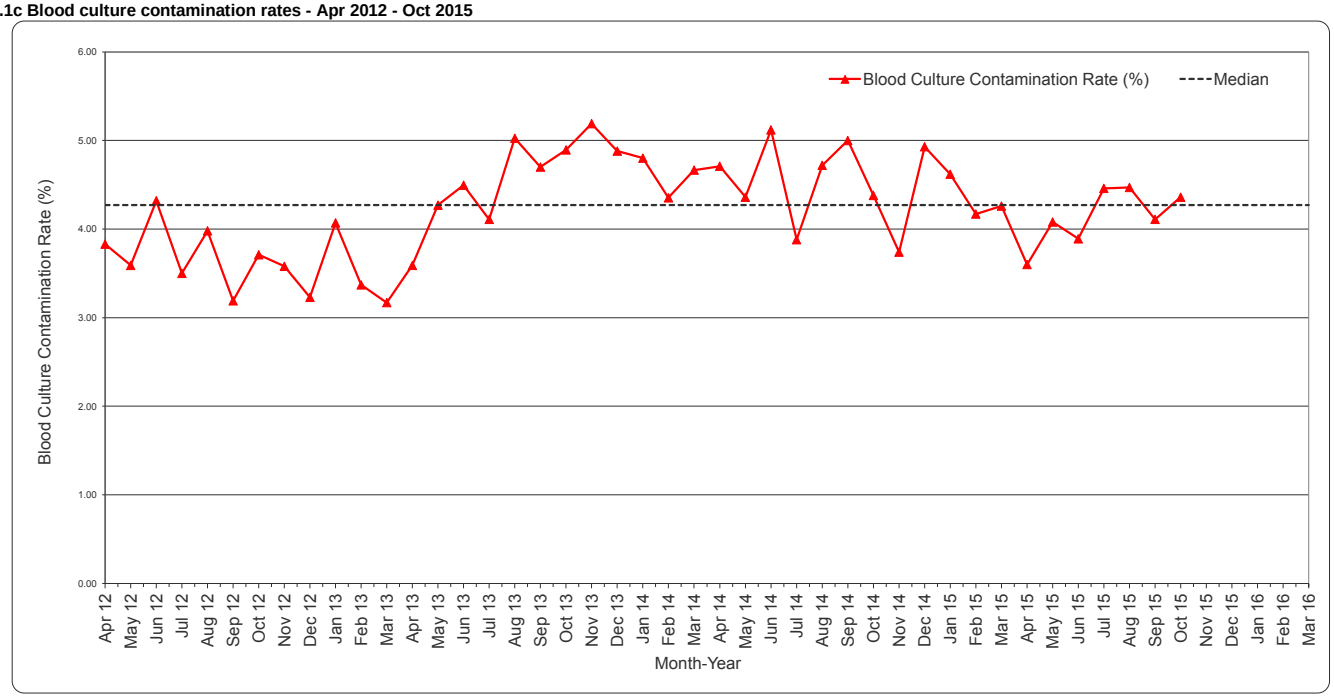
NHS Lothian's *Clostridium difficile* Infection Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 total occupied bed days (<262 incidences) by March 2016 in patients aged 15 and over, with a current rate of 0.43 (207 incidences). NHS Lothian not achieving the HEAT target for *Clostridium difficile* Infection. Seasonal variation has been observed in previous years for the period July to October and the reasons for this are not yet fully understood. Continuing to see this trend this year.

NHS Lothian's *Staphylococcus aureus* Bacteraemia Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days (<184 incidences) by March 2016 with a current rate of 0.30 (139 incidences). NHS Lothian not achieving the HEAT target for *Staphylococcus aureus* Bacteraemia.

3.1b SABs progress against HEAT target - NHS Lothian



3.1c Blood culture contamination rates - Apr 2012 - Oct 2015



Source: IPCT
All data
No change in rate over last year.

Notes:

During October 2015 there were 3,490 sets of blood cultures taken in NHS Lothian. Of these, 152 (4.36%) of the blood culture was considered to be contaminated.
During the previous 12-month period, there were a total of 44,433 blood cultures collected of which 1,880 (4.23%) were considered to be contaminants.

3.2 Ward closures

No up to date aggregate data are currently available.

3.3 Number of wards that have exceeded CDI trigger levels (Nov 2014 to Oct 2015)

LocationDescription	2014-11	2014-12	2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	2015-09	2015-10	Grand Total
RIE Ward 107	2	1	2	0	0	1	0	1	2	0	0	0	9
RIE Ward 206	2	2	0	0	0	2	2	0	1	0	0	0	9
WGH ARAU Beds	0	1	1	1	0	2	0	1	0	2	0	0	8
RIE Ward 207	2	0	0	1	0	1	0	1	1	0	1	0	7
SJH Ward 9	1	1	0	0	0	0	0	3	0	0	1	1	7
RIE Ward 105	2	1	0	0	1	0	0	0	1	0	0	1	6
SJH Medical Assessment Unit	0	1	0	2	0	1	0	0	0	0	1	1	6
SJH Ward 8	1	1	0	1	0	2	0	0	0	0	1	0	6
WGH Ward 8	1	0	1	0	0	0	1	0	2	0	0	1	6
AAH Charles Bell Pavilion 1	1	1	2	0	1	0	0	0	0	0	0	0	5
RIE Ward 208	0	0	1	0	2	0	0	0	1	0	1	0	5
GP: University Health Service	0	0	1	0	0	0	1	0	2	0	0	0	4
RIE Ward 104	1	1	0	0	0	0	0	0	0	2	0	0	4
RIE Ward 118 ITU	0	0	0	1	3	0	0	0	0	0	0	0	4
RIE Ward 206 Transplant	0	0	0	0	0	0	0	1	0	2	0	1	4
WGH Ward 52	0	0	0	0	1	0	0	2	0	1	0	0	4
GP: St Triduana's Medical Practice	1	0	0	0	0	0	0	0	0	0	0	2	3
WGH ARAU Bed Area 2	0	0	0	0	0	0	0	0	0	3	0	0	3
WGH Ward 25	0	0	0	1	0	0	0	0	0	0	2	0	3
WGH Ward 53	0	1	0	0	0	0	0	0	0	2	0	0	3
GP: Linlithgow Group Medical Practice	0	0	0	0	0	0	0	0	0	0	0	2	2
RIE Combined Assessment Area 6	0	0	0	0	2	0	0	0	0	0	0	0	2
RIE Ward 117 HDU	0	0	0	0	0	0	0	0	0	0	0	2	2
RIE Ward 210 Gynae Inpatient	0	0	0	0	0	0	0	0	0	0	2	0	2

Source: IPCT
All data
These represent clinical areas where there have been > 2 CDI in the given time period - the highlighting illustrating how many CDIs there have been in the given time period.

4.1 Monthly medication error Datix reports - all NHS Lothian sites

	Financial year 2014/15					2015/16						
	Nov	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Number of medication error reports	215	213	221	190	273	262	270	203	230	211	219	233
Number related to gentamicin	0	1	0	2	6	6	3	3	2	2	5	5
% related to gentamicin	-	0.5%	-	1.1%	2.2%	2.3%	1.1%	1.5%	0.9%	0.9%	2.3%	2.1%

Source: Datix, All data
The antimicrobial policy changed in Feb 2015. Following an apparent decline in medication Datix reports in February, the number of medication error Datix reports increased in March, April and May in NHS Lothian, driven by the increase in the RIE and WGH (see below). Please use the gentamicin figures for the most recent month with caution and see the notes below .

4.2 Monthly medication error Datix reports - Royal Infirmary of Edinburgh

	Financial year 2014/15					2015/16						
	Nov	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**
Number of medication error reports	55	51	54	43	66	83	68	44	64	63	55	56
Number related to gentamicin	0	1	0	1	2	3	1	2	0	0	2	1
% related to gentamicin	-	2.0%	-	2.3%	3.0%	3.6%	1.5%	4.5%	-	-	3.6%	1.8%

Chart 4.1 NHS Lothian Medication error Datix reports

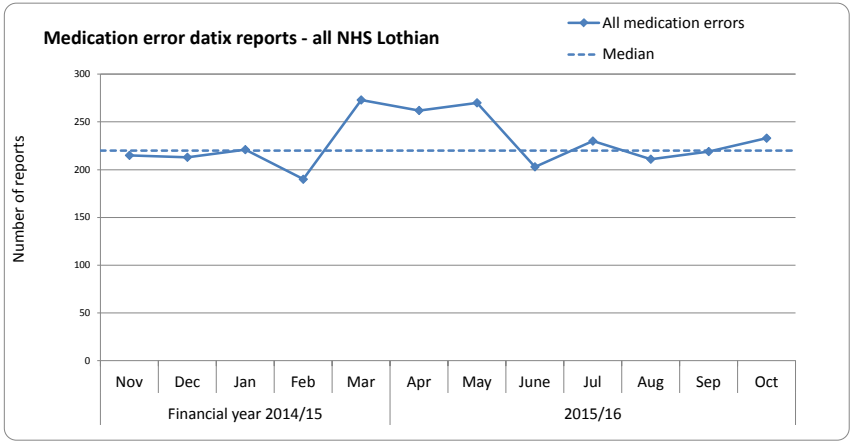
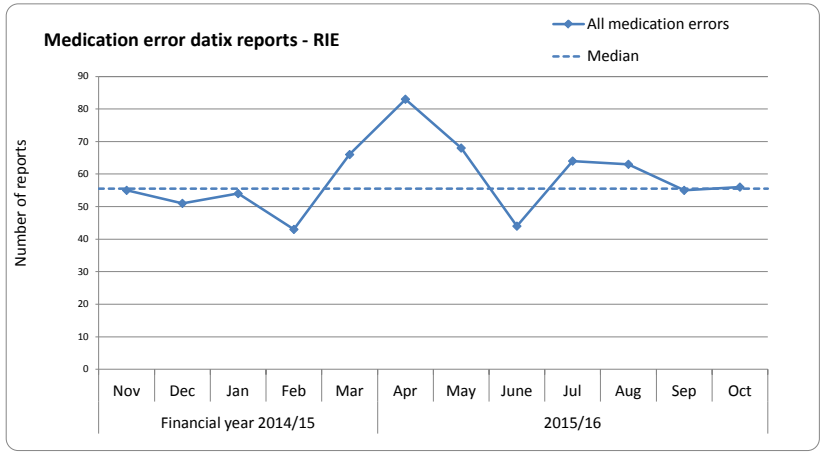


Chart 4.2 RIE Medication error Datix reports



4.3 Monthly medication error Datix reports - Western General Hospital

	Financial year 2014/15					2015/16						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Number of medication error reports	57	59	63	49	82	49	77	54	51	56	64	61
Number related to gentamicin	0	0	0	0	3	2	1	1	0	1	2	4
% related to gentamicin	-	-	-	-	3.7%	4.1%	1.3%	1.9%	-	1.8%	3.1%	6.6%

Source: Datix, All data
The antimicrobial policy changed in Feb 2015. Following an apparent decline in medication Datix reports in February, the number of medication error Datix reports increased considerably in March and May in WGH, but only a small percentage have been attributed to gentamicin. Figures for SJH have remained relatively stable. Please use the gentamicin figures for the most recent month with caution

4.4 Monthly medication error Datix reports - St John's Hospital

	Financial year 2014/15					2015/16						
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct
Number of medication error reports	16	22	23	20	20	17	22	16	14	18	10	18
Number related to gentamicin	0	0	0	0	1	0	0	0	2	0	1	0
% related to gentamicin	-	-	-	-	5.0%	-	-	-	14.3%	-	10.0%	-

Chart 4.3 WGH Monthly medication error Datix reports

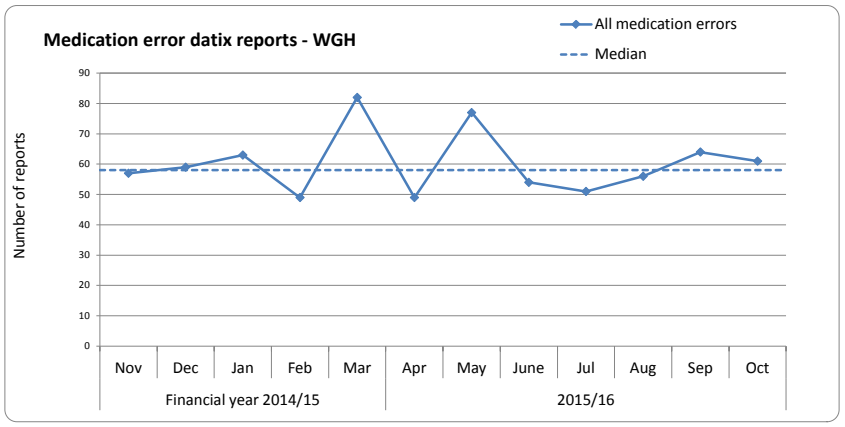
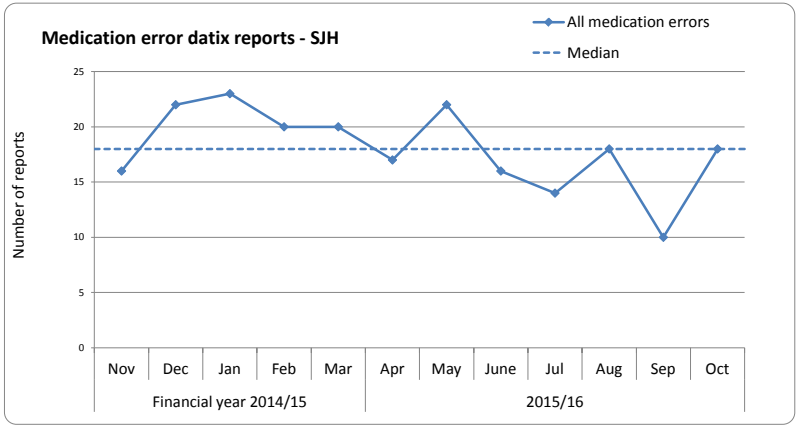


Chart 4.4 SJH Monthly medication error Datix reports



Adverse events - medication adverse events in and number related to gentamicin

Source: DATIX; data extracted 06/11/2015
Notes:
1: Data as at 06/11/2015.
2: Adverse events are recorded in 'real-time', therefore the total number of medication error reports for October (to date) are assumed to be accurate. However, it is not mandatory to record the drug involved when initally recording a medication adverse event and this is often only added to the database once the adverse event has been investigated.
For this reason, please use the gentamicin adverse events figures for October with caution.

NHS LOTHIAN

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
MRSA	4	1	3	1	2	6	1	3	2	1	2	1
MSSA	23	18	25	26	27	29	21	20	15	15	16	7
Total	27	19	28	27	29	35	22	23	17	16	18	8

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	10	11	10	4	12	7	7	7	10	12	18	12
Age 65 plus	23	22	20	17	19	22	15	17	16	24	22	18
Total	33	33	30	21	31	29	22	24	26	36	40	30

Hand Hygiene Monitoring Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
AHP	94.86	95.49	95.30	95.75	96.54	94.42	98.12	94.31	96.24	96.02	96.44	-
Ancillary	91.58	93.19	89.40	92.36	92.52	89.22	90.30	94.98	94.29	90.48	93.72	-
Medical	93.45	90.91	94.08	92.85	93.64	93.57	94.23	92.21	92.92	92.50	90.72	-
Nurse	98.19	98.09	98.54	98.59	98.26	98.43	98.75	98.25	97.52	97.78	97.79	-
Board Total	96.37	95.97	96.67	96.68	96.82	96.40	97.24	96.43	96.28	96.10	96.00	-

Cleaning Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	95.70	95.10	94.95	95.40	94.55	94.25	95.55	95.25	95.50	95.45	97.40	95.60

Estates Monitoring Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	97.20	97.10	96.65	96.60	94.75	95.85	96.40	96.15	95.70	95.35	94.90	94.85

ROYAL INFIRMARY OF EDINBURGH

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
MRSA	2	0	2	0	0	4	1	0	1	0	1	0
MSSA	13	11	14	15	16	11	10	9	10	7	7	3
Total	15	11	16	15	16	15	11	9	11	7	8	3

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	2	2	1	0	5	2	1	2	3	2	5	3
Age 65 plus	8	5	5	6	7	6	2	4	5	8	6	6
Total	10	7	6	6	12	8	3	6	8	10	11	9

Cleaning Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	96.63	96.72	96.27	96.55	96.62	96.92	96.61	96.53	97.26	97.12	96.52	96.96

Estates Monitoring Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	97.98	96.10	95.45	95.47	95.99	96.45	95.87	95.94	97.24	94.42	95.23	96.86

WESTERN GENERAL HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
MRSA	1	1	0	1	2	1	0	0	0	1	1	0
MSSA	6	6	2	7	6	12	7	7	4	8	6	4
Total	7	7	2	8	8	13	7	7	4	9	7	4

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	2	2	4	3	3	3	2	3	1	7	4	2
Age 65 plus	5	9	4	3	2	3	2	5	5	9	7	2
Total	7	11	8	6	5	6	4	8	6	16	11	4

Cleaning Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	94.02	93.55	92.89	93.42	93.22	94.53	94.65	94.17	94.01	94.02	93.74	93.94

Estates Monitoring Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	97.75	97.73	98.17	97.83	96.50	95.36	96.07	95.33	94.84	94.87	93.24	92.55

ST JOHNS HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
MRSA	0	0	0	0	0	0	0	3	1	0	0	0
MSSA	1	1	6	2	3	3	3	4	0	0	1	0
Total	1	1	6	2	3	3	3	7	1	0	1	0

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	2	1	0	1	0	0	0	0	2	1	2	0
Age 65 plus	5	3	1	3	2	6	1	4	2	1	4	4
Total	7	4	1	4	2	6	1	4	4	2	6	4

Cleaning Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	95.38	95.02	95.76	95.92	94.51	94.52	95.79	94.75	94.92	95.65	95.14	95.65

Estates Monitoring Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	95.63	95.43	95.53	95.01	94.97	95.97	95.45	95.16	93.97	94.56	94.24	94.73

LIBERTON HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
MRSA	0	0	0	0	0	1	0	0	0	0	0	1
MSSA	0	0	0	0	1	0	0	0	0	0	0	0
Total	0	0	0	0	1	1	0	0	0	0	0	1

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Age 65 plus	0	0	1	1	1	1	0	0	0	1	1	0
Total	0	0	1	1	1	1	0	0	0	1	1	0

Cleaning Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	97.02	96.71	96.87	96.77	96.23	96.96	97.87	96.63	97.39	97.92	96.41	97.77

Estates Monitoring Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	97.43	98.11	98.04	97.99	98.61	97.37	97.52	97.84	97.73	98.06	98.40	97.49

ROYAL HOSPITAL FOR SICK CHILDREN

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
MRSA	0	0	0	0	0	0	0	0	0	0	0	0
MSSA	3	0	3	2	1	3	1	0	0	0	2	0
Total	3	0	3	2	1	3	1	0	0	0	2	0

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	0	0	0	0	0	0	1	1	0	0	0	1
Age 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	1	1	0	0	0	1

Cleaning Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	95.13	95.83	94.11	94.47	91.83	92.61	94.22	93.47	94.11	94.90	93.93	94.42

Estates Monitoring Compliance (%)

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Board Total	98.29	99.00	96.61	97.91	95.15	95.82	97.77	95.83	93.99	95.73	93.27	93.54

COMMUNITY HOSPITALS

Community Hospitals include the following hospitals and care facilities

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

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
MRSA	1	0	1	0	0	0	0	0	0	0	0	0
MSSA	0	0	0	0	0	0	0	0	1	0	0	0
Total	1	0	1	0	0	0	0	0	1	0	0	0

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	1	2	2	0	1	0	0	0	0	0	0	0
Age 65 plus	0	2	0	1	0	0	1	1	0	0	0	1
Total	1	4	2	1	1	0	1	1	0	0	0	1

OUT OF HOSPITAL INFECTIONS

Clostridium difficile Infection **Monthly Case Numbers**

	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015	Sep 2015	Oct 2015
Age 15-64	3	4	3	0	3	2	3	1	3	2	7	6
Age 65 plus	5	3	9	3	6	6	8	3	4	5	4	5
Total	8	7	12	3	9	8	11	4	7	7	11	11

HAI STANDARDS STRATEGY

2015-2017

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Contents

Overview:

NHS Lothian recognises that the effective prevention and control of healthcare associated infection is essential to patient and staff safety and to the overall performance of the organisation. The strategic approach to healthcare associated infection as reflected in this document is fundamental to the delivery of the Board's objectives in relation to patient safety, clinical governance and performance. Effective prevention and control systems and the development of a committed approach to learning will ensure that NHS Lothian continues to develop and improve the safety and quality of patient care.

The Matrix is based on Health Improvement Scotland HAI Standards (2015) which require NHS Scotland Health Boards to "*demonstrate the implementation of evidence based infection prevention and control measures*".

This strategy is directed at all staff (including Contractors). It describes in detail the roles and responsibilities allocated to different staff groups (from Ward to Board) in relation to HAI Standards. Evidence of implementation and improvement will provide the Board with assurance that infection prevention and control is being constantly monitored and reviewed to ensure best practice for patient and staff safety.

All staff are expected to understand the importance of infection prevention and control procedures, particularly the value of hand hygiene and the application of Standard Infection Control Precautions (SICPs). It is not acceptable for members of staff or students to plead 'ignorance' of their responsibility for Infection Prevention and Control. All staff have an implicit responsibility to ensure that they comply with infection prevention and control and take the necessary actions to prevent the spread of infections as failure to follow guidance may put the staff member, their colleagues or patients at risk.

Whilst the Board has the strategic responsibility for ensuring infection prevention and control issues are addressed, it is the Infection Prevention and Control Team who provide the routine operational support to staff. But it is important to emphasise that Infection Prevention and Control is "**everyone's responsibility**"

	HAI Standard	Rationale
1.	NHS Lothian to demonstrate leadership and commitment to infection prevention and control to ensure a culture of continuous quality improvement throughout the organisation.	Robust leadership in infection prevention and control is essential for effective decision-making, efficient use of resources and ensuring the provision of high quality safe, effective, person-centred care**.**
2.	Education on Infection Prevention and Control is provided and accessible to all healthcare teams to enable them to minimise risks that exist in care settings.	To minimise the infection risk associated with healthcare, all staff are provided with the necessary knowledge and skills in infection prevention and control too confidently and competently demonstrate behaviours integral to safe, effective and person-centred care.
3.	NHS Lothian has effective communication systems and processes in place to enable continuity of care and infection prevention and control throughout the patient's journey.	Patients are vulnerable to infection s and some present an infection risk to other patients, visitors and staff. As a single patient journey can involve staff in multiple care settings, effective care provider communications are vital in infection prevention and control, and safe, effective and person-centred care. Wherever possible, patients and their representatives must be assured of, and involved in, communications regarding their care
4.	NHS Lothian has a Surveillance system in place to ensure rapid response to Healthcare Associated Infections	HAI Surveillance is the ongoing and systematic collection, analysis and interpretation of data, relating to HAI, which is used to reduce the risk of infection and improve patient outcomes.
5.	NHS Lothian demonstrates effective antimicrobial stewardship.	Antimicrobial stewardship, in the form of a co-ordinated programme, has been shown to reduce inappropriate antimicrobial use, improve patient outcomes and reduce adverse consequences of antimicrobial use including antimicrobial resistance, toxicity and unnecessary costs.
6.	NHS Lothian demonstrates implementation of evidence based infection prevention and control measures.	The minimum standard of infection prevention and control to be practiced by all staff, in all care settings, for all care procedures is the application of standard infection control precautions, as detailed in chapter one of the National Infection Prevention and Control Manual. SICPs are the most effective means to prevent cross-transmission and cross-infection with micro-organisms in care settings.
7.	Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters.	Invasive devices present a significant infection risk to patients. These risks can be minimised by: • Avoidance of device use where possible • Following evidence-based procedures for insertion and maintenance • Removing the device as soon as there is a clinical indication to do so
8.	The Environment and equipment (including reusable medical devices used) are clean, maintained and safe for use. Infection risks associated with the built environment are minimised.	Effective decontamination is critical in the provision of a safe, clean environment and equipment. The built environment must be designed, planned, constructed, refurbished and maintained to minimise the risks of infection. The standards covers the decontamination, management and maintenance of: • Reusable communal patient care equipment • Reusable medical devices • The built environment
9.	All equipment acquired (this being equipment that is procured, loaned, donated, in-house manufactured, or for use within a trial or research) for the care environment is safe for use.	The infection risk to patients is minimised by having an acquisition process in place that ensures all equipment (including reusable medical devices) is safe for its intended use. Safety refers to minimise the risk of transmission of infection.

Principles of the Strategy:

The following principles underpin the strategy:

- That infection prevention and control will be embedded in the core processes and systems of the Board, including guidelines and procedures, operational policies, education and training the business planning cycle, and business case development.
- That infection prevention and control will be integrated and converge with business planning, performance management and corporate governance.
- Infection prevention and control will be actively managed and positive assurance sought
- That infection prevention and control is the responsibility of all staff within their own sphere of work
- That high-risk infection prevention and control areas and activities will attract focus and attention.
- That there will be learning from root cause analysis, data review, incidents, claims, complaints and national reports and explicit roll-out of identified improvements.

There is a significant amount of national guidance available to NHS Board to ensure they have sufficient effective systems and processes in place to assure patients and staff that the healthcare provided is of a quality that safeguards patients in both hospital and community care. These include

- Revised HAI Standards issued 2 February 2015
- Health Protection Scotland: Standard Infection Control Precautions (SICPs)
- HAI SCRIBE (Healthcare Associated Infection. System for Controlling Risk In the Built Environment)
- Vale of Leven Enquiry Report

Within NHS Lothian there are national and local policies/strategies in place which can be found on the intranet page.

- Infection Control Manual and associated Standard Operating Procedures
- HAI Education Strategy
- HAI Patient Information Leaflets
- Non Compliance with Hand Hygiene Policy.

Key Forums for the Management and Accountability of Infection Prevention and Control:

Infection Prevention & Control Committees (IPCC)
Within NHS Lothian each of the acute hospitals has an operational Infection Prevention and Control Committee chaired by Site Director meeting monthly. The site based committees report to Pan Lothian IPCC chaired by the HAI Executive Lead which meets every 3 months.

There is Community Health Partnership IPCC chaired by Clinical Director for Edinburgh CHP which meets every 3 months.

It is the responsibility of each site based IPCC to develop local actions plans based on the HAI Standards Strategy and Improvement Matrix including named responsible staff members for delivery and time frames for achievement.

Pan Lothian IPCC and CHP ICC report to Lothian Infection Control Advisory Committee.

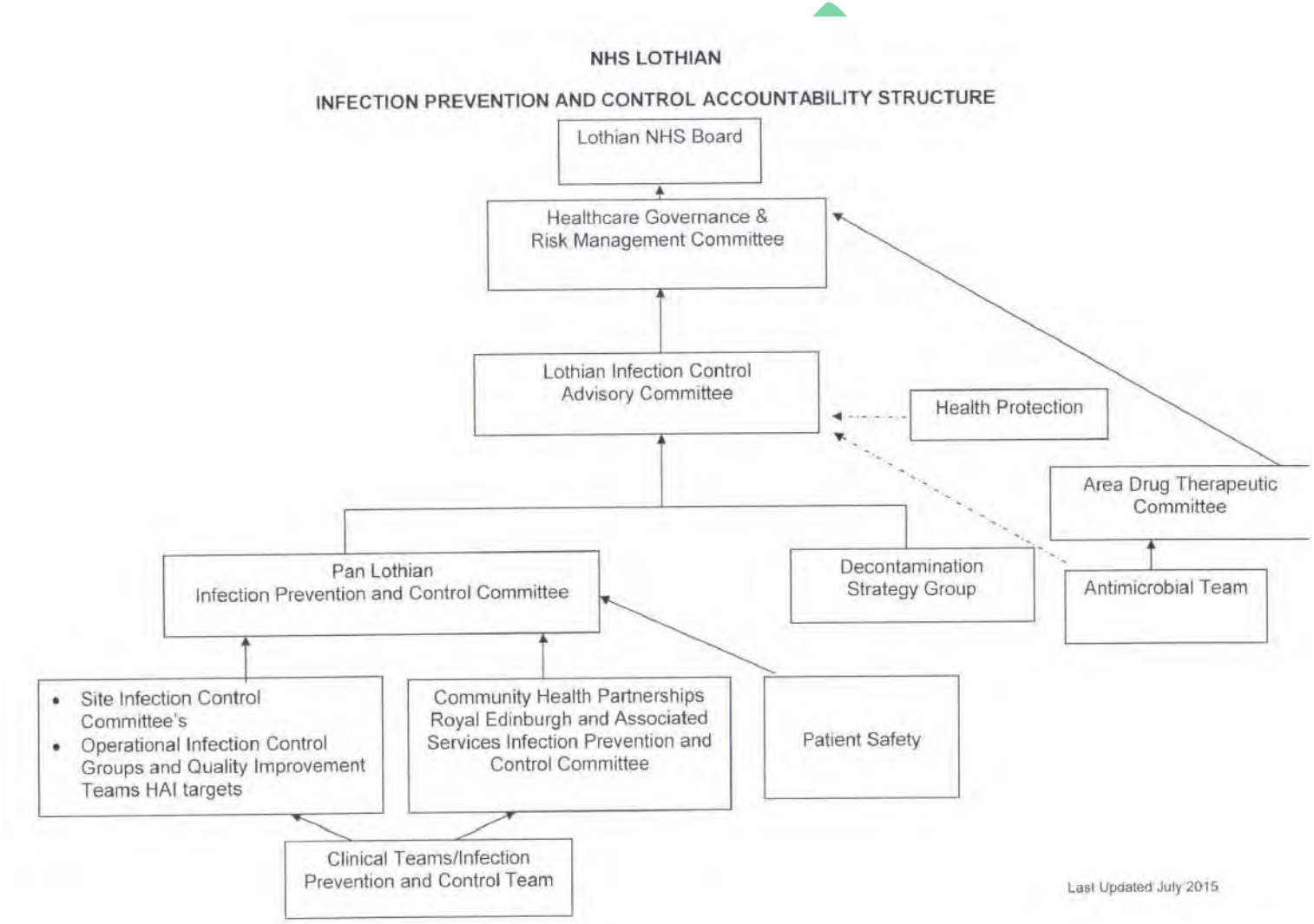
The IPCCs are the main forum for discussion concerning changes to policy or practice relating to infection prevention and control. The committees have a multi-disciplinary membership which includes representation from senior management and all directorates. The committees are responsible for:

- The ratification of NHS Lothian's policies and guidelines relating to infection prevention and control, ensuring appropriate consultation has taken place, that policy documents have been impact assessed and that they are endorsed by NHS Lothian Board where appropriate.
- Oversight of surveillance of infection control and antimicrobial prescribing in NHS Lothian.
- Reviewing IMT Debrief Notes to ensure that lessons learned are applied across the whole organisation.
- Oversight of performance of NHS Lothian against national standards relating to infection prevention and control.
- Endorsement of the annual infection prevention and control work programme and reports.

Lothian Infection Control Advisory Committee
Chaired by the Director of Public Health, the Lothian Infection Control Advisory Committee oversees the prevention and control of infection across NHS Lothian incorporating:

- Infection Prevention and Control
- Health Protection Team
- Emergency Planning
- Clinical Governance
- Domestic Services
- Environmental Health

Figure below shows NHS Lothian's Infection Prevention and Control Accountability and Structure



Standard 1 Leadership Roles and Responsibilities:

It is recognised that effective healthcare associated infection prevention and control requires commitment and active involvement of all employees. It is therefore vital that the infection prevention and control process is communicated and embedded throughout the organisation from the Executive Team including Board Members to Clinical Teams on the ward. Appendix 1 outlines the Infection Prevention and Control Roles and Responsibilities Matrix.

Chief Executive and NHS Lothian Board designates responsibility for the prevention and control of infection as a core part of the Board's clinical Governance. The Board have designated specific responsibility relating to Healthcare Associated Infections to the HAI Executive Lead who is a member of the Board. The Chief Executive has appointed a Head of Service for Infection Prevention and Control who reports directly to the HAI Executive Lead.

HAI Executive Lead has designated specific responsibility relating to the control of healthcare associated infections within NHS Lothian. The HAI Executive Lead is responsible for the Board approved Infection Prevention and Control Programme. The HAI Executive Lead chairs the UHS Infection Control Committee.

Nurse Director/Associate Nurse Directors have delegated responsibility to ensure the further development and implementation at operational level of the Infection Prevention and Control Improvement Matrix.

Medical Director has delegated responsibility to support the implementation and further development of the infection prevention and control strategy.

Head of Education and Employment responsible for ensuring the Board has an HAI Education Strategy identifying the level and type of training required based on the Skills for Health Occupational Standards (January 2012). The Strategy is available within HR Online within the Intranet and outlines the HAI training requirement for staff with:

- Non direct patient contact – such as medical secretaries, hospital administration staff, van drivers
- Direct Patient Care, Non Clinical Contact – such as ward clerks, clinic reception staff, non-patient porters laboratory staff, pharmacist and social workers
- Direct Patient Care, Clinical Contact – such as registered and non registered practitioners, under and post graduate students and portering staff who have direct patient contact.
- Frontline Healthcare Associated Infection Control Specialists, Link Trainers who require advanced knowledge in all aspects of healthcare associated infections, direct clinical contact and those with no direct patient care.

Department of Clinical Governance will support the senior managers/ward staff in the delivery of effective healthcare associated infection prevention and control practice, education and audits through the QID system. These include:

- The Quarterly Standard Infection Control Precautions

- VAP Bundle
- PVC Bundle
- CVC Insertion and Maintenance Bundles
- Point of Care Priorities which includes Sepsis, Surgical Site Infections and CAUTI.

Site/Service Managers within NHS Lothian include Site Director, Associate Nurse Directors, Associate Medical Directors, General Managers and Clinical Service Manager, who have been designated by the Board to be responsible for their specific site/service, e.g. Royal Infirmary of Edinburgh, St John's Hospital etc. Site/Service Managers are responsible for ensuring there is effective infection prevention and control processes and policies are implemented within their remit area which includes:

- Dissemination of the strategy details, development of local action/delivery plan and allocation of responsibilities for implementation to site/service managers and staff
- In conjunction with Lead or Geographical Lead Infection prevention and control nurse and Lead Infection Control Doctor, identify directorate/site specific infection control issues that might not have been addressed explicitly within the Strategy
- Ensuring that infection prevention and control is incorporated into the directorate/site decision making, service planning, performance management, project management, maintenance and refurbishment, and other related processes.
- Monitoring site infection rates and compliance audits for example Standard Infection Control Precaution (SICP) Audits, MRSA National Screening results and Patient Safety Bundles.
- Ensuring that infection prevention and control is included as a core item on all management team briefings/meetings.
- In the event of an incident, ensuring appropriate investigation is carried out and participating in Incident Management Team Meetings if required.
- Reporting via performance and clinical practice and standards reviews on the directorate/site infection prevention and control management performance in addition to new and emerging risks, major changes of priority on existing risks and key actions.
- Ensuring, where necessary, healthcare associated infections prevention and control risks are reported on the Risk Register.
- In accordance with Vale of Leven requirement carry out week Senior Managers Walk round for their site/remit with an Infection Prevention and Control Nurse

Clinical Nurse Managers in addition to contributing to the responsibilities outlined above, Clinical Nurse Managers will have responsibility for:

- Leading and driving a culture of cleanliness in clinical areas.
- Ensuring implementation of NHS Lothian's Infection Prevention and Control Manual, Policies and Procedures.
- Identifying healthcare associated infections prevention and control training needs to ensure that staff and volunteers are able to work safely and comply with NHS Lothian's policies and procedures, including mandatory training requirements.
- Monitoring standards of cleanliness in clinical areas.
- Promoting infection prevention and control awareness responsibilities amongst employees, service users, contractors and partners.

- In conjunction with Infection Prevention and Control Team leading root cause analysis and where required promote learning and practice improvement.
- Ensuring effective ward management by Charge Nurses which includes implementation of infection prevention and control policies, the provision of high standards of essential patient care and the maintenance of a safe and clean and patient friendly environment.
- Attending the relevant Infection Prevention and Control Committees to role.

Antimicrobial Management Team (AMT) to support the prudent prescribing of antimicrobials across both primary and secondary care within NHS Lothian. The key members of the AMT comprise a Lead Clinician, Chairperson, Microbiologist, and Antimicrobial Pharmacist, Head of Service for Infection Prevention and Control and Data Analyst. The aim of the AMT is to:

- Reduce antimicrobial resistance
- Promote prudent antimicrobial prescribing
- Develop a strategic approach to systematic identification and containment of future resistant organisms

Medical Microbiologist/Virologists are accountable to the Medical Director and provide clinical leadership on all matters relating to infection prevention and control. The Microbiologists and Virologists provide a 24 hour Duty Service 7 days a week and are the "Out of Hours" contact for provision of infection prevention and control advice. In addition, they advise on surveillance and clinical policies development and provide access to specialist infection prevention and control advice and support to both acute and community settings. The Microbiologists/Virologists depending on the incident may chair the Problem Assessment Groups or Incident Management Team.

Head of Service for Infection Prevention and Control is accountable to the HAI Executive Lead and has overall responsibility for the management of processes and risk assessment relating to infection prevention and control. The Head of Infection Prevention and Control Services is responsible for working closely with Scottish Government Health Department, Health Improvement Scotland, Health Protection Scotland and other agencies on improving practice.

In particular the Head of Service for Infection Prevention and Control is responsible for:

- Providing managerial support to the infection prevention and control team
- Co-ordinating the prevention and control of infection throughout NHS Lothian wide
- Delivering the Board approved Infection Prevention and Control Programme
- Challenging non compliance with local and national protocols and guidance relating to prevention and control of infection, decontamination, antimicrobial prescribing and cleaning
- Producing an annual report on the state of HAI, decontamination and cleaning in NHS Lothian

Lead Infection Control Doctor

Although not directly mentioned in the HAI Standards, the ICD provides an essential role providing leadership to senior medical staff in the development and implementation of IPC policies, guidelines and practice. This will entail pro-active engagement with medical teams to ensure infection control requirements meet the needs of clinical teams and national standards as well as addressing areas of improvement.

Lead Infection Prevention and Control Nurse will provide specialist knowledge and advice on all matters pertaining to infection prevention and control and is responsible for:

- All areas of infection prevention and control in relation to production, review and implementation of local policies, protocols and guidelines with input from other appropriate clinical and non clinical staff
- Leading the Infection Prevention and Control Audit Programme
- Developing and maintaining partnership working with other infection control specialists, partner organisations and patient

Infection Prevention and Control Team is responsible for the surveillance and monitoring of infection within NHS Lothian. Providing operational advice and support to all staff on infection prevention and control matters. The team comprises of Head of Service, Lead Infection Prevention and Control Nurse, Geographical Lead Infection Prevention and Control Nurses, Infection Control Doctor, HAI SCRIBE Lead Infection Prevention and Control Nurse, Infection Prevention and Control Nurses, Clinical Scientists, Cleanliness Champions Programme Facilitator, HAI Quality Improvement Facilitator and Administration Team.

Responsibilities relating to Specific Groups of Staff:

All staff have a responsibility to ensure patient safety through the implementation of the best possible infection prevention and control practice. As an employee of NHS Lothian everyone has a responsibility for and a role to play in managing infection prevention and control which includes:

- Being aware of NHS Lothian's infection prevention and control policies and procedures
- Adhering to infection prevention and control as required within their role
- Alerting managers to any infection control risks or environmental deficits within the service area that requires urgent attention.
- Participation in annual mandatory infection prevention and control training either via Leanrpro or Toolbox talks
- Maintaining a clean and safe environment.
-

Non compliance with infection prevention and control policies by any staff member may general disciplinary action

Consultants: Consultant staff have a responsibility to ensure they abide by the Board's infection prevention and control protocols and procedures and to act as a positive role model for junior doctors and other staff of hand hygiene and all other infection prevention and control issue including the application of standard infection control precautions. Infection prevention and control performance should be included as a measure in appraisals of all junior doctors within their teams. Failure to abide by NHS Lothian's infection prevention and control procedures may result in disciplinary action taken against the practitioner.

Locums/Agency Staff: Any Locum or Agency Staff must be made aware on commencement of their duties where to access information on infection prevention and control procedures and how to contact the Infection Prevention and Control Duty Nurse for advice. Their daily supervisor must ensure they understand the Board's commitment to preventing and controlling infection, and to have the necessary skills to comply with the infection prevention and control requirements placed upon them. Failure to abide by NHS Lothian's infection prevention and control policies and procedures may result in termination of the temporary contract.

Unit Operational/Locality/Area Operational Managers: are to provide a positive role model to the rest of the staff and to spearhead infection prevention and control initiatives jointly with the Infection Prevention and Control Team. They advise on how strategic decisions on infection control issues can be implemented and drive such implementation forward through the role of the Senior Charge Nurses and Service Leads.

Senior Charge Nurses/Ward Managers: Senior Charge Nurses are responsible for ensuring that the following Standard Infection Control Precautions (SICPs) are complied with:

- Patient Placement
- Hand Hygiene
- Respiratory Hygiene (Cough etiquette)
- Personal Protective Equipment
- Re-useable Patient Care Equipment
- Control of the Environment
- Management of Linen
- Management of Blood and Body Fluids
- Waste Disposal
- Occupational Exposure Management

These standard precautions should be embedded into practice and become routine, safe practice by all staff for which they have day-to-day responsibility. This can best be achieved by being a good role model, and through being accessible and visible on a daily basis. Performance of the above standard precautions should become core to all nurse appraisals with onward referral for further training where skills are found to be lacking.

Further infection prevention and control issues for which senior nurses are responsible for include:

- Appropriate use of indwelling devices
- Managing and recording accidents and incidents
- Good communication with other healthcare workers, patients and visitors
- Training and education

Senior Charge Nurses must also ensure that access to the online infection prevention and control manual and associated policies and standard operating procedures/guidelines is available in all work areas and that all staff know how to obtain infection control advice at all times via IPCN Duty Nurse during core hours, their allocated infection prevention and control nurse or contacting Duty Microbiologist/Virologist Out of Hours.

Nurses (all Grades): All nurses have a day-to-day responsibility to ensuring that the SICPs listed above are maintained to the best of their ability. They have the responsibility to prevent and reduce the spread of infection by the use of good infection control practices.

Any nurse who feels they do not have the necessary skills to achieve the high standards expected of them should approach their line manager for advice. Line Managers must ensure that nursing staff are released to attend infection prevention and control courses.

Nursing staff may be asked to participate in the 10 Standard Infection Prevention and Control Audits which are to be carried out with 20 observations/questions asked per clinical area on a quarterly basis with the results logged by the deadline within the Quality Improvement Data System (QIDS) that is utilised within NHS Lothian.

All Nurses should know how to access the online infection prevention and control manual and associated policies and standard operating procedures/guidelines and know how to obtain infection control advice at all times via IPCN Duty Nurse during core hours, their allocated infection prevention and control nurse or contacting Duty Microbiologist/Virologist Out of Hours if further advice is necessary.

Compliance with infection prevention and control practices should be incorporated into the appraisal process. Failure to abide by NHS Lothian's infection prevention and control policies and procedures may result in disciplinary action taken against the nurse.

Allied Health Professionals: e.g. therapists technicians will come into contact with patients in a variety of ways; i.e. direct or indirect physical contact.

All AHPs have a day-to-day responsibility for ensuring that the SICPs listed above are maintained to the best of their ability. They have the responsibility to prevent and reduce the spread of infection by the use of good infection prevention and control practices. Any AHP who feels they do not have the necessary skills to achieve the high standards expected of them should approach their line manager for advice. Line Managers must ensure that AHPs are released to attend courses where infection prevention and control training has been identified as a need.

All AHPs should know how to access the online infection prevention and control manual and associated policies and standard operating procedures/guidelines and know how to obtain infection control advice at all times via IPCN Duty Nurse if further advice is necessary.

Domestic Staff: Are employed to maintain a clean environment and hold joint responsibility with care staff for achieving this. All Domestic staff must have clear roles and responsibilities which are known throughout the work area. Schedules of cleaning should be displayed, reviewed and maintained. Problems should be immediately reported to the line manager to ensure prompt remedy.

All other staff including Healthcare Assistants/Support Workers/Portering Staff/Estates Staff: All staff have to attend induction sessions where information will be provided on the importance of infection prevention and control relevant to the role that they carry out. Further training is available as part of the infection prevention and control education programme. They must ensure that they are familiar with the relevant infection prevention and control procedures for their role, and where they feel they do not have the necessary skills to deal with infection prevention and control issues, they should seek advice from their line manager. Failure to abide by NHS Lothian's infection prevention and control policies and procedures may result in disciplinary action taken against the member of staff.

Estates Team have the responsibility to ensure that they comply with infection prevention and control policies such as Healthcare Associated Infection System for Control in the Built Environment (HAISCRIBE) to ensure that all new builds and refurbishments carried out in clinical areas comply with required national standards.

Contracted Staff: All contracted staff must abide by this policy and the associated guidelines. Those employing contracted staff have a responsibility to ensure they are aware of the requirements of the organisation, before work is commenced. NHS Lothian reserves the right to review and cancel the contract of any contractor who is non-compliant with their infection control responsibilities under this policy.

APPENDIX 1 – IMPROVEMENT PLAN - ROLES AND RESPONSIBILITIES MATRIX

HAI Standard 1: NHS Lothian to demonstrate leadership and commitment to infection prevention and control to ensure a culture of continuous quality improvement throughout the organisation.

Rationale: Robust leadership in infection prevention and control is essential for effective decision-making, efficient use of resources and ensuring the provision of high quality safe, effective, person-centred care**.**

	Operational Management					Infection Prevention and Control Team					
Leadership in the Prevention and Control Of Infection	**All Staff**	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist/ Virologist**
	All staff to be aware of their role in maintaining a safe care environment ensure compliance with SICPs and TBPs at all times Be prepared to challenge and/or escalate as appropriate practice where breaches	Ensure compliance is monitored and use local data to assess and improve the quality of care. Ensure, reporting structure, guidance, training and education to facilitate the delivery of effective infection prevention and control standards.	Monitor compliance ensuring action plans developed and implemented Support SCN in escalation as appropriate through reporting structure, Ensure compliance with training and education to facilitate the delivery of effective infection prevention and control.	Ensure have a working knowledge, appropriate to role in the organisation of the IPC Policies and procedures as well as national and local priorities that impact on care within NHS Lothian. Support in the provision of resources and equipment as appropriate	Ensure have a working knowledge, appropriate to role in the organisation of the IPC Policies and procedures as well as national and local priorities that impact on care within NHS Lothian. Support in the provision of resources and equipment as appropriate	Ensure that HAI issues are addressed by Board Management Ensure there is strategic, operational and quality assurance systems in place with Clinical Governance	Ensure there is an infection prevention and control accountability framework. Ensure that data from variety of sources is utilised to support learning and continuous improvement in infection prevention and control	Responsible for ensuring the infection prevention and control team have the necessary expertise and leadership skills to support the organisation. Ensure risk assessments are undertaken to ensure continuity of safe patient care	Provide support through provision of resources, suitable environment, reporting structure, guidance, training and education and data that facilitate the delivery of effective infection prevention and control.	ICD will provide expert advice in liaison with infection specialties on the clinical management of patients with infection to the Infection Prevention and Control Nurses as well as other nursing and medical colleagues.	Provide patient centred clinical reviews of patients with infections (in conjunction with clinical team caring for patient), liaising with other relevant infection specialists. Interpretation of diagnostic laboratory tests and arranging further relevant specialist testing of samples and advising on diagnosis and treatment of infected patients.

HAI Standard 2: Education on Infection Prevention and Control is provided and accessible to all healthcare teams to enable them to minimise risks that exist in care settings.

Rationale: To minimise the infection risk associated with healthcare, all staff are provided with the necessary knowledge and skills in infection prevention and control too confidently and competently demonstrate behaviours integral to safe, effective and person-centred care.

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist/ Virologist**
Education to support the prevention and control Of infection	Undertake mandatory and appropriate infection prevention and control training relevant to role. (See HAI Education Strategy) Able to demonstrate knowledge and competence in the delivery of care, and act as role models in the promotion of infection prevention and control.	Ensure mandatory training in PDPs and monitor compliance at appraisal. Ensure local induction includes IPC information / training appropriate to department and role. Responsible for identifying issues relating to infection prevention and control at point of care.	Monitor compliance with mandatory training taking action when evidence of non or poor compliance Support the Senior Charge Nurse to identify additional IPC training appropriate to role/dept utilising HAI education strategy	Ensure staff are enabled to undertake mandatory and additional training appropriate to role/dept.	Ensure staff are enabled to undertake mandatory and additional training appropriate to role/dept.	Promote the contribution of HAI education in professional training programmes. Ensure progress is reviewed by the ICC	Ensure infection prevention and control education is included in HAI work programme	Develop and deliver educational material for the IPCT and clinical teams. Support the HoS and Education Department in development and review of HAI Education Strategy Act in role as HAI Education Lead for IPC ensuring IPC Staff develop and maintain knowledge and skills	Deliver Educational material to clinical teams Undertake relevant qualifications and maintain own knowledge and skills	Provide specialist Medical Microbiologist expertise to the development of educational programmes. Teaching medical students, nursing staff and post graduate doctors in aspects of infection control. Providing advice regarding infection management, antibiotic stewardship/ management and infection control management.	Provide specialist Medical Microbiologist expertise to the development of educational programmes. Teaching medical students, nursing staff and post graduate doctors in aspects of infection control. Providing advice regarding infection management, antibiotic stewardship/ management and infection control management.

Standard 3: NHS Lothian has effective communication systems and processes in place to enable continuity of care and infection prevention and control throughout the patient's journey.

Rationale: Patients are vulnerable to infection s and some present an infection risk to other patients, visitors and staff. As a single patient journey can involve staff in multiple care settings, effective care provider communications are vital in infection prevention and control, and safe, effective and person-centred care. Wherever possible, patients and their representatives must be assured of, and involved in, communications regarding their care.

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist/ Virologist**
Communication between organisations and with the Patient or their representative	Provide HAI information to patients relevant to their care. Ensure risk assessments are completed and advice documented.	Ensure HAI information leaflets are available to patients and stocked appropriately.	Ensure HAI information is available to patients.	Seek assurance that patient information systems are in place.	Undertake IPC walk rounds and review patient records in accordance with VoL requirements and take action when non compliance is identified.	Promote the culture of openness around HAI information. Ensure progress is reviewed by the ICC. Describe organisational accountability and support for effective communi-cation systems and processes.	Ensure that gaps in information materials are addressed. Ensure that patient public reps. are involved in the planning and development of measures to prevent and reduce HAI.	Support the development of patient information leaflets and advice on methods of accessing these.	Develop patient information leaflets.	During incidents provide briefing to Communications Department. Explaining infectious disease pathogenesis, transmission risks and possible outcomes to clinical teams managing infected patients. Communicate with external stakeholders such as Reference laboratories or Health Protection Scotland etc.	Provide specialist IPC/Medical Microbiology advice to the development of patient information materials Microbiologists/ Virologists may be required to communicate directly with patients as part of their clinical care pathway. Explaining infectious disease pathogenesis, transmission risks and possible outcomes to clinical teams managing infected patients. Communicate with external stakeholders such as Reference laboratories or HPS etc

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist/ Virologist**
Provision of Infection Control Advice	Ensure familiar with SICPs and TBPs. Demonstrate good practice to trainees, new staff or direct reports. Share advice provided by the IPCT with colleagues. Seek specialist IPC advice when issues cannot be resolved within own knowledge	Ensure all staff are aware how to access Infection Control Manual, and demonstrate knowledge of SICPs and TBPs. Include IPC advice in ward safety briefings. Escalate for specialist advice as appropriate	Provide support for implementation of IPC advice where there are conflicting priorities e.g. limited isolation facilities Seek advice when issues cannot be resolved within own knowledge. Include IPC advice in ward safety briefings/ team meetings. Monitor compliance with SICPs and TPBs	Provide support to SCN and CNM in the challenges of competing pressures in the implementation of advice e.g. patient placement, closures and limited single rooms. Seek advice when issues cannot be resolved within own knowledge. Include IPC advice in ward safety briefings/ team meetings	Supports the service delivery manage competing priorities e.g. patient placement, waiting times versus IPC closures	Ensure that appropriate HAI advice is available to NHS Lothian	Provide an efficient and effective IPC advisory service.	Provide general and specialist infection prevention and control advice to staff.	Provide general and specialist infection prevention and control advice to staff.	During incidents provide briefing to Communications Department. Explaining infectious disease pathogenesis, transmission risks and possible outcomes to clinical teams managing infected patients. Communicate with external stakeholders such as Reference laboratories or Health Protection Scotland etc.	Explaining infectious disease pathogenesis, transmission risks and possible outcomes to clinical teams managing infected patients on a daily basis. Communicate with external stakeholders such as Reference laboratories or HPS etc

HAI Standard 4: NHS Lothian has a Surveillance system in place to ensure rapid response to Healthcare Associated Infections.

Rationale: HAI Surveillance is the ongoing and systematic collection, analysis and interpretation of data, relating to HAI, which is used to reduce the risk of infection and improve patient outcomes.

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist/ Virologist**
HAI Surveillance	Participate in data collection/ submission. Contribute to the investigations in to acquisition and source. Take corrective action as appropriate	Implement local & national surveillance as required. Ensure compliance with audit programme Review audits and develop action plan for improvement as appropriate	Review action plan and escalate unresolved issues	Review action plan and escalate unresolved issues to risk register	Check that action has been taken to address issues on risk register.	Ensure review of the audit programme by the ICC. Promote the culture that infection prevention and control is everyone's business	Develop quality assurance systems. Supply adequate specialist support. Ensure there is a robust HAI audit programme.	Ensure quality assurance of data collection is carried out by IPCNs	Support audit methodology design. Quality Assure data collection	In conjunction with multi disciplinary Team develop, maintain and support the implementation of national strategies for the prevention, surveillance and control of infection – a part of which is to ensure resilience in the event of (re-) emerging pathogens.	Support ICD provide specialist expertise relating to HAI Surveillance.

HAI Standard 5: NHS Lothian demonstrates effective antimicrobial stewardship.

Rationale: Antimicrobial stewardship, in the form of a co-ordinated programme, has been shown to reduce inappropriate antimicrobial use, improve patient outcomes and reduce adverse consequences of antimicrobial use including antimicrobial resistance, toxicity and unnecessary costs.

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist / Virologist**
Antimicrobial Stewardship	Comply with current antimicrobial policy/ guidelines Demonstrate awareness of antimicrobial guidelines relevant to their role and responsibility.	Comply with current antimicrobial policy /guidelines. Ensure that current antimicrobial guidelines are appropriately displayed.	Comply with current antimicrobial policy /guidelines. Ensure that current antimicrobial guidelines are available for clinical team.	Ensure that current antimicrobial guidelines are available for clinical team.	Ensure that current antimicrobial guidelines are available for clinical team.	Describe the organisations accountability and support for antimicrobial stewardship.	In conjunction with the Antimicrobial Management Team demonstrate that guidelines reviews are completed every two years.	Ensure IPCNs have a baseline knowledge of empiric prescribing	Ensure ABX data is included as appropriate in patient monitoring and escalate as appropriate to Microbiologist /Virologist where issues identified during investigations and monitoring of patient care	Support the Antimicrobial Management Team providing expertise on resistance trends and patterns informing the advice, guidance and policies produced by AMT.	Monitor resistance trends and patterns adjusting advice and guidance as appropriate

HAI Standard 6: NHS Lothian demonstrates implementation of evidence based infection prevention and control measures.

Rationale: The minimum standard of infection prevention and control to be practiced by all staff, in all care settings, for all care procedures is the application of standard infection control precautions, as detailed in chapter one of the National Infection Prevention and Control Manual. SICPs are the most effective means to prevent cross-transmission and cross-infection with micro-organisms in care settings.

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist / Virologist**
Infection Prevention and Control Policies and Procedures	Implement policies, protocols and procedures and seek guidance from line manager where required. Ensure compliance with SICPs and TBPs and be prepared to challenge or escalate breaches as appropriate	Implement current guidance e.g. SICPs and monitor compliance through observation and audit. Receive monitoring information on compliance e.g. CDI ward round feedback and take actions to address gaps	Demonstrate clinical leadership towards implementation. Receive monitoring information on compliance e.g. CDI ward round feedback, review QiDS results and support improvement plans	Review monitoring information and ensure compliance and improvement or sustained practice addressing gaps with relevant manager	Seek assurance that policies are implemented and compliance maintained and quality assured.	Ensure review of policies and their sign off as Chair of the ICC.	Ensure policy development is included in HAI work programme with appropriate multi-disciplinary team involved e.g. public health, Occupational Health, Infectious Disease Physicians, and relevant clinical representation	Co-ordinate policy development and review. Provide tailored advice supporting the development of policies and ensure they are reviewed to maintain consistency and currency.	Provide tailored advice for implementation	Provide specialist IPC/ Medical Microbiology expertise to support policy development and provide clinical leadership towards implementation	Provide specialist IPC/ Medical Microbiology expertise to support policy development and provide clinical leadership towards implementation

HAI Standard 7: Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters.

Rationale: Invasive devices present a significant infection risk to patients. These risks can be minimised by:

- Avoidance of device use where possible
- Following evidence-based procedures for insertion and maintenance
- Removing the device as soon as there is a clinical indication to do so

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist/ Virologist**
Insertion and Maintenance of invasive Devices	Follow key practice recommendation on how and when invasive devices are to be used, maintained, monitored and removed, documenting within patients records, Demonstrating knowledge of associated risks Challenge colleagues who do not follow best practice on the use of invasive devices.	Demonstrate knowledge of risks associated risks with invasive devices and seek to minimise use. Ensure patients, or their representative involved in the decision making process and where appropriate the care and monitoring of device use. Monitor compliance with insertion and maintenance bundles	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues. Monitor/ Audit documentation relating to invasive devices within patients notes escalating any gaps in information required.	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues. In conjunction with Associate Medical Directors ensure staff those working with IV access devices such as CVC and PVCs are appropriately trained and competence tested for both insertion, maintenance and handling.	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues.	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues.	Ensuring that appropriate senior managers are aware of any increased incidents/ trends for infections relating to invasive devices	Provide reports on the surveillance of infections relating to invasive devices.	In the event of an infection caused by invasive device follow IPCT SOP which involves investigation, root cause analysis and development of SBAR Monitor/Audit documentation relating to invasive devices within patients notes escalating any gaps in information required.	Provide specialist IPC/ Medical Microbiology Advice to all staff. Review patients for IV oral Switch ABX therapies as appropriate in conjunction with Antimicrobial Pharmacists and Infectious Diseases Physicians	Provide specialist IPC/ Medical Microbiology Advice to all staff. Review patients for IV oral Switch ABX therapies as appropriate in conjunction with Antimicrobial Pharmacists and Infectious Diseases Physicians

HAI Standard 8: The Environment and equipment (including reusable medical devices used) are clean, maintained and safe for use. Infection risks associated with the built environment are minimised.

Rationale: Effective decontamination is critical in the provision of a safe, clean environment and equipment. The built environment must be designed, planned, constructed, refurbished and maintained to minimise the risks of infection. The standards covers the decontamination, management and maintenance of:

- Reusable communal patient care equipment
- Reusable medical devices
- The built environment

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist / Virologist**
Decontamination	Ensure all near patient equipment is effectively decontaminated between use Carrying out cleaning duties and responsibilities as required and documented as appropriate	Review local cleaning schedules for near patient equipment and mechanism for documentation completion Ensure SICP audits for re-usable patient Care equipment and control of environment completed and action plan developed to address deficits.	Review audit results and monitor progress against action plans Quality assure equipment and control of the environment results being reported	Review monitoring information and ensure compliance with audit standard ensuring improvement	Review site monitoring information and take action (from environmental audits) when non compliance is identified	Ensure progress is reviewed by the Infection Control Committee	Ensure monitoring systems are developed and reviewed	Ensure quality assurance of data from wards is collected.	Provide advice for implementation Quality assure data collection	Provide specialist medical microbiology advice on interpretation of laboratory results, decontamination methodology and quality assurance of methodologies. Providing specialist knowledge of prions and how they impact on decontamina-tion	Support ICD provide specialist advice.

HAI Standard 9: All equipment acquired (this being equipment that is procured, loaned, donated, in-house manufactured, or for use within a trial or research) for the care environment is safe for use.

Rationale: The infection risk to patients is minimised by having an acquisition process in place that ensures all equipment (including reusable medical devices) is safe for its intended use. Safety refers to minimise the risk of transmission of infection.

	Operational Management					Infection Prevention and Control Team					
	All Staff	**Senior Charge Nurses**	**Clinical Nurse Manager/ Departmental Lead**	**Associate Nurse Directors**	**Site Directors**	**HAI Executive Lead**	**Head of Infection Prevention and Control Services**	**Lead Infection Prevention and Control Nurse**	**Infection Prevention and Control Nurse**	**Infection Control Doctor**	**Medical Microbiologist/ Virologist**
Acquisition of Equipment	Contact local Infection Prevention and Control Nurse when considering purchase of any non-standard equipment (including reusable medical devices). Utilising DATIX Escalate any issues with current patient equipment	Prior to purchasing any non-standard equipment ensure Infection Prevention and Control Team have reviewed and approved choice	Prior to purchasing any non-standard equipment ensure Infection Prevention and Control Team have reviewed and approved choice. Review all incidences recorded within DATIX associated to near misses with equipment.	Ensure that staff comply with policies and procedures for the acquisition of equipment. Review all incidences recorded within DATIX associated to near misses with equipment.	Ensure that staff comply with policies and procedures for the acquisition of equipment. Review all incidences recorded within DATIX associated to near misses with equipment.	Ensure that staff comply with policies and procedures for the acquisition of equipment.	Support members of the Infection Prevention and Control Team to represent NHS Lothian on National CAP Panels for new equipment	Support Procurement in development of Procurement Policy. Support members of the Infection Prevention and Control Team to represent NHS Lothian on National CAP Panels for new equipment	Provide advice to local teams wishing to purchase new equipment not already agreed on national procurement list. Provide expert advice at CAP Panels reviewing new equipment for "Fit For Purpose" taking into consideration infection prevention and control requirements	Provide specialist medical microbiology advice as and when required.	Provide specialist medical microbiology advice as and when required.

NHS LOTHIAN

Healthcare Governance Committee
22 September 2015

Nurse Director

NHS LOTHIAN INFECTION PREVENTION & CONTROL IMPROVEMENT PLAN

1 Purpose of the Report

1.1 The purpose of this report is to set out NHS Lothian's Infection Prevention and Control Improvement Plan to provide assurance on the management of infection prevention and control.

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

2 Recommendations

The Health Care Governance Committee is recommended to:

2.1 Review the improvement plan to inform assurance requirements

2.2 Approve the plan and associated actions set out in this paper.

3 Discussion of Key Issues

3.1 Background

Healthcare associated infection is a national political and clinical priority. It is a recognised cause of a significant number of avoidable patient harms. Such infections are not only of clinical significance and concern, but also attract substantial financial costs (approx £186million per annum).

Globally, the World Health Organisation has identified antimicrobial resistance as one of the most significant public health threats currently facing clinicians and governments. The continuing emergence of resistant organisms coupled with the lack of new antimicrobial treatments is resulting in limited treatment options for commonly occurring infections, with an associated risk of increased mortality due to unresolved infection.

Although our patients can be challenged by a number of infections caused by 'alert organisms' (not all of which are acquired as a result of healthcare) mandatory reporting and performance measurement is focused on reduction of *Clostridium difficile* infection (CDI) and *Staphylococcus aureus* bacteraemia (SAB)which includes both antibiotic resistant and sensitive strains (MRSA and MSSA respectively). These data are used as a proxy measure for all infection rates and

there is commonality in the interventions and control measures required to prevent, limit or manage disease.

A number of high profile incidents and outbreaks have shaped and informed the current HAI agenda. Following an independent public enquiry into the circumstances leading an outbreak of Clostridium Difficile at the Vale of Leven Hospital in 2007-2008, NHS Boards were required to provide a detailed action plan in response to the 75 recommendations made in the final report. Of these, 65 recommendations were specifically for NHS Board action.

The majority of these recommendations have since been reflected in the Healthcare Improvement Scotland (HIS) Healthcare Associated Infection Standards (2015). NHS Lothian is obliged to provide assurance of compliance with the 2015 HAI Standards.

This can broadly be summarised as the need:

- To demonstrate effective leadership across the organisation which promotes a culture of continuous quality improvement in relation to infection prevention and control
- To provide appropriate education and training to staff
- To demonstrate effective risk communication systems and processes between organisations and with the patient or their representative.
- To provide a robust surveillance system which generates data to support quality improvement
- To demonstrate effective antimicrobial stewardship
- To demonstrate compliance with key policies including Standard Infection Control Precautions (SICPs) and Transmission Based Precautions (TBPs)
- To demonstrate compliance with systems and processes relating to the insertion, care and maintenance of invasive devices
- To demonstrate that the environment and equipment is clean, safe and ready for use through effective decontamination and acquisition of equipment

The board's performance against these standards is subject to external scrutiny and public reporting by the Healthcare Environment Inspectorate (HEI).
Some key elements of infection prevention and control (IPC) activity are also mandated as core elements of wider improvement programmes, including the Scottish Patient Safety Programme. These include:

- Hand hygiene
- Reduction of surgical site infection
- CAUTI
- Sepsis bundles
- Ventilator acquired pneumonia
- Reduction of Peripheral Vascular access Device related *Staphylococcus aureus* Bacteraemia (SAB)

The scope and range of improvement required to deliver a reduction in the number of preventable infections is significant, and requires input from a range of clinical stakeholders and subject matter experts.

3.2 Current Position

3.2.1 Standard Infection Control Precautions (SIPS)

A key component of HAI improvement is securing reliable implementation of SICPs and TBPs.

SICPs should be the foundation of all clinical practice, and encompass 10 elements ranging from hand hygiene and use of personal protective equipment, to waste and linen management. TBPs are the additional precautions required in response to a suspected or known infection to further minimise risk of spread.

All boards are required to monitor compliance with SICPs and provide assurance of this as part of self assessment against the HIS HAI standards and as part of external scrutiny by the Healthcare Environment Inspectorate (HEI).

NHS Lothian has already adopted the National Infection Prevention and Control Manual, and supporting staff to implement this through ongoing engagement and education. Compliance with SICPs is monitored by quarterly audits which are reported into the Quality Improvement Data System (QIDS). National SICPs monitoring tools were adopted at the start of Q3 2015 (July-Sept), and so limited compliance data is currently available. Baseline audits were completed for the majority of clinical areas in Q1 and Q2; however these data should be interpreted with some caution due to the limited number of recorded observations achieved for some wards and departments. Overall, the results do indicate that further improvement in relation to SICPs is required. This position is also reflected in recent HEI inspection reports.

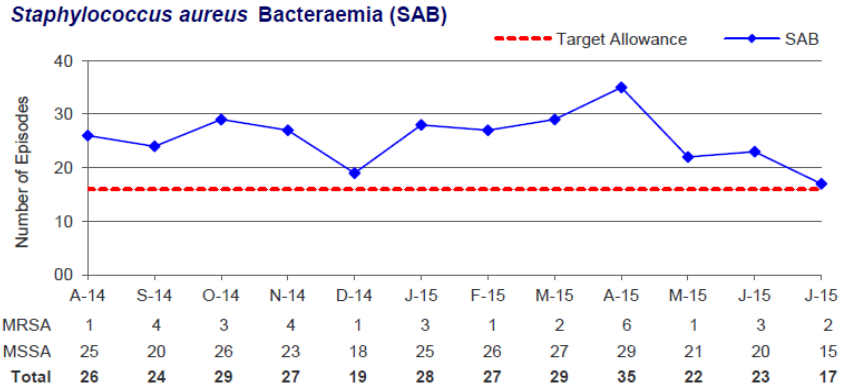
3.2.2 Staphylococcus aureus bacteraemia (SAB)

HEAT targets for reduction of *Clostridium difficile* infection and *Staphylococcus aureus* bacteraemia are set by the Scottish Government HAI policy unit, and are recalculated on an annual basis.

The current HEAT target for SAB is to achieve a rate of 0.24 per 1000 AOBD by March 2016. This equates to no more than 184 cases in 2015/16.

As of July 2015, the board has a rate of 0.37 per 1000 AOBD, and is not on track to meet this target as illustrated in Figure 1. There is an increasing trend in the overall incidence of SAB although this remains within the upper and lower control limits and as such is not statistically significant as illustrated in Figure 2.

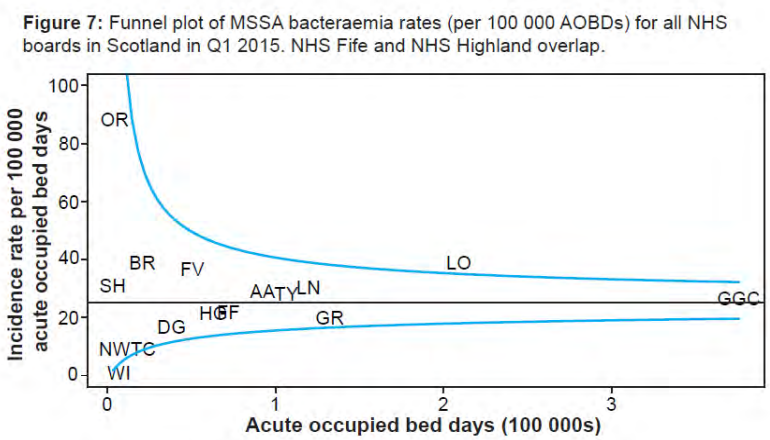
Figure 1



Overall, there was no annual increase or decrease (comparing the year-ending March 2014 with the year-ending March 2015) in MRSA, MSSA or SAB overall Scottish rates.

However, NHS Lothian is considered an outlier for MSSA SAB at present.

Figure 2



Enhanced surveillance has demonstrated that the majority of SAB in NHS Lothian are associated with skin and soft tissue injury (SSTI). The causes of these infections are complex and multi-factorial, and the ability to secure improvement in relation to all SSTI infections may be limited. An example would be where SSTI is identified in a patient who is a known IV drug user, and relates to their injecting practice and other lifestyle factors.

A significant number of SAB are associated with invasive devices which includes PVC. These SAB's are largely viewed as preventable if best practice is followed in relation to patient assessment, insertion and maintenance of devices.
Although PVC insertion and maintenance bundles are widely used, it has been highlighted from internal review and external scrutiny that reliable documentation is still a challenge. In addition, concern has been raised about observed practice in relation to disconnection of IV giving sets (breaching a closed system) and the reliability of capping giving sets and cleaning PVC hubs prior to reconnection.

Key interventions and improvements which will influence SAB are:

- Management of invasive devices – reliable compliance with PVC insertion and maintenance bundles
- Reducing blood culture contamination rates
- Education and training – particularly improving practice in relation IV line management (disconnection)
- Reliable compliance with SICPs

To assist with this improvement, it is proposed to:

- Report all PVC related SAB into DATIX as a serious adverse event. This will prompt a clinical review to enhance learning and focus clinical teams to make the required improvements
- Use fixed term Education Facilitator and Quality Improvement Facilitator posts from October 2015 to support review of procedures and practice, and develop a 90 day improvement cycle in relation to invasive devices, related SAB based on dates of highest incidence.

Below also sets out a range of actions which will also contribute to the reduction of SABS which are reduction in surgical site infections and catheter related infections.

3.2.3 Surgical Site Infection

NHS Lothian complies with mandatory surgical site surveillance of Caesarean sections (until 10 days post procedure) and Hip arthroplasty procedures.

The IPCT investigate and review each SSI identified. An SBAR is sent to the appropriate clinical team to confirm the SSI within two working days of the SSI being identified. When required, a case review and increased incidence SBAR will be completed. Monthly and quarterly reports are distributed to the clinical areas and the IPCT will discuss any actions required.

- To the end of Q1 2015 (Jan- March) SSI rates for caesarean section (inpatient and Post discharge surveillance (PDS) to day 10) are below the National average of 1.2% at 1.0 %. SSI rates for caesarean section (inpatient and Post discharge surveillance (PDS) to day 10) are below the National average of 1.2% at 1.0 %
- SSI rates for Hip arthroplasty are below the published national rates for Scotland at 0.5% with one infection in Q1.
- SSI rates for Repair of Neck of Femur fracture are in line with the published national rates for Scotland at 0.9% with one infection Q1.

Table 1

Category of procedure	Surveillance Type	Number of procedures	SSIs	SSI rate (%)	95% Confidence Interval	National SSI Rate (%)	National 95% confidence interval

Caesarean section	Light	626	6	1.0	0.4 to 2.1	1.3	0.9 to 1.5
Hip arthroplasty	Light	212	1	0.5	0.1 to 2.6	0.9	0.6 to 1.4
Repair of neck of femur	Light	112	1	0.9	0.2 to 4.9	0.9	0.5 to 1.7
Total	-	950	8	0.8	0.4 to	1.7	-

All surgical teams are engaged in implementing the surgical site infection bundle; however they are challenged by the fact that they cannot get outcome data (SSI rates) for surgeries out with the mandatory programme.

It had been anticipated that additional surveillance function could be provided as part of the ICNet (Infection Prevention & Control electronic case management system) contract to provide additional SSI data for clinical teams. However, many SSI are diagnosed clinically in the absence of microbiological confirmation. This means only laboratory confirmed SSI would be available on ICNet for investigation and follow up by the IPCT. In conjunction with surgical colleagues, there is scope to discuss and review what data could usefully be provided using the current version of ICNet to:

- improve SSI rates
- reduce harm to patients, and
- Reduce inefficiencies including unnecessary treatment and readmissions.

3.2.4 **Catheter Associated Urinary Tract Infection (CAUTI)**

Improvement work focusing on CAUTI has spread to 25% of applicable areas in acute adult wards and approximately 75% of district nurse teams.

Cross referencing of CAUTI outcomes recorded on safety crosses with microbiology database in the pilot ward has revealed that only 50% of CAUTIs have been recorded in the first 6 months of this year.

The underreporting may make it difficult to achieve the 30% reduction target as it is likely to increase before it decreases. The pilot wards are currently involved in rapid tests of change to improve the process of recording CAUTIs. It was decided by the clinicians that they wanted to measure both urinary and suprapubic catheters and both long term and short term catheters as they think that they could possibly have greater impact on the short term catheters.

A Pan Lothian Catheter count was completed on 27th July 2015 as a baseline measure. This will help to highlight which areas to target with the CAUTI work stream more effectively than the CSU data held on the laboratory database. As a result of integrated working across the community, primary care and acute sectors of NHS Lothian a patient held urinary catheter passport was launched at the end of July 2015. It is anticipated that this will have a positive impact on patients and their carers and CAUTI outcome data.

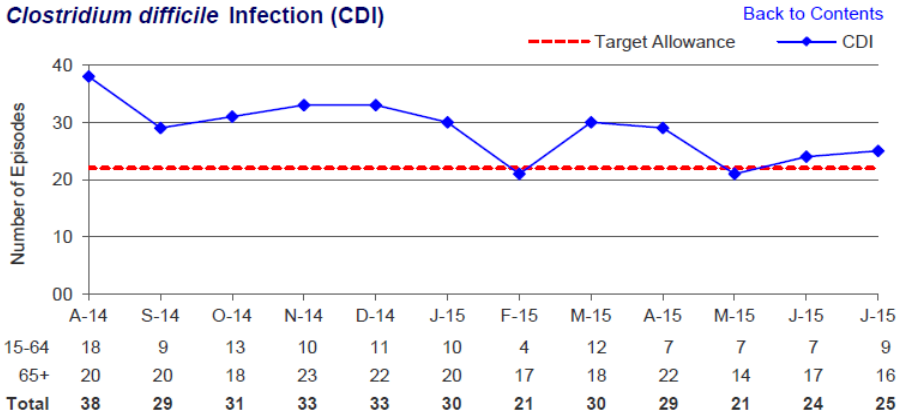
3.2.5 **Clostridium difficile**

The 2015/16 HEAT target for CDI is to achieve a rate of 0.32 per 1000 acute occupied bed days by March 2016. This equates to no more than 262 incidences of CDI in 2015/16.

As of July 2015, the board has a rate of 0.42 per 1000 AOBD. There have been 101 incidences of CDI year to date.

Although Lothian has seen an overall decrease in CDI rates this is not statistically significant. With continued focus, NHS Lothian could meet the CDI HEAT target as illustrated by Figure 3 below.

Figure 3



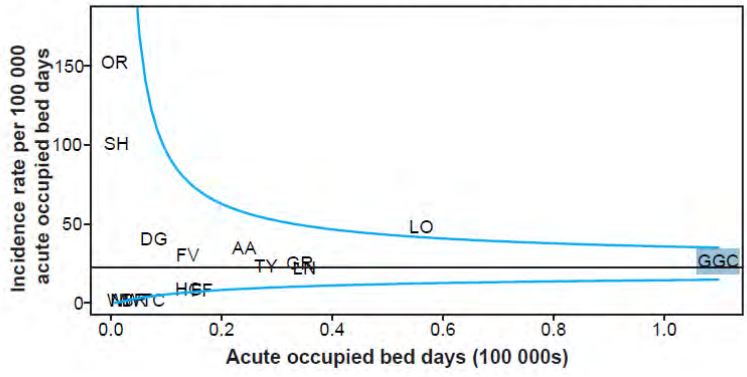
	A-14	S-14	O-14	N-14	D-14	J-15	F-15	M-15	A-15	M-15	J-15	J-15
15-64	18	9	13	10	11	10	4	12	7	7	7	9
65+	20	20	18	23	22	20	17	18	22	14	17	16
Total	**38**	**29**	**31**	**33**	**33**	**30**	**21**	**30**	**29**	**21**	**24**	**25**

Source: IPCT Monthly report July 2015

At present, the board is also considered an outlier in the 15-64year age group in comparison to the rest of NHS Scotland as illustrated in Figure 4 below. The reasons for this are being actively explored in conjunction with HPS and NHSL Public Health Team.

Figure 4

Figure 2: FIGURE 2: Funnel plot of CDI incidence rates (per 100 000 AOBDs) in patients aged 15-64 years for all NHS boards in Scotland in Q1 2015. NHS Fife and NHS Highland ovelap, as does NHS Borders, NHS NWTC and NHS Western Isles.



Source: HPS Quarterly report Q1 2015

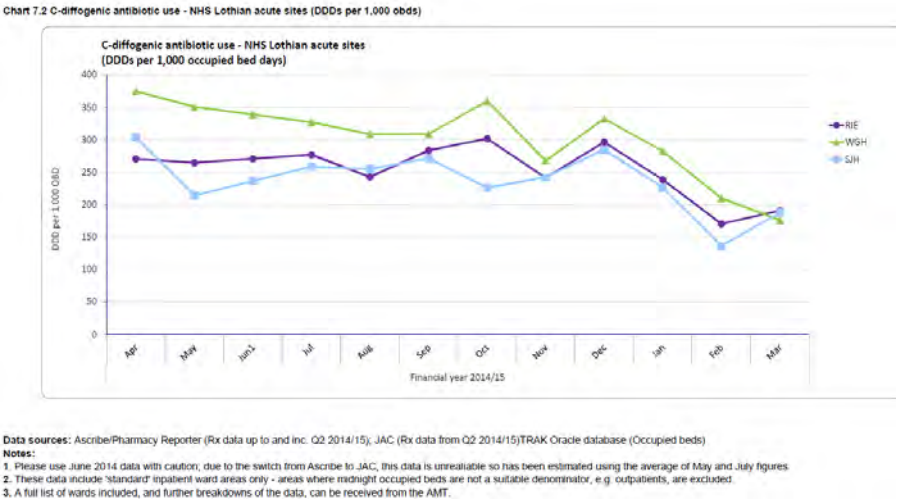
3.2.6 **Antimicrobial Prescribing**

To support the organisation to meet HEAT targets for CDI and SAB, antimicrobial prescribing indicators are audited. These prescribing indicators are set for both acute and primary care.

NHS Lothian actively promotes good antimicrobial stewardship through the multidisciplinary Antimicrobial Management Team (AMT). The AMT produce an annual work plan which provides further detail on they key delivery areas.

In February 2015 a strategy to reduce the use of C-diffogenic antibiotics, and increase the use of Gentamicin (appropriate for the treatment of Gram negative organisms) was introduced across NHS Lothian. Compliance with the antimicrobial policy is being adhered to.

Figure 5



Within primary care, the focus is on:

1) Empirical prescribing within continuing care medical ward, and measures:
   - Indication for antibiotic treatment documented in patient medical notes and/or prescription chart.
   - Choice of antibiotic compliant with local antibiotic policy
   - Duration of treatment documented in patient prescription chart
   - Documented duration of treatment compliant with local antibiotic policy

2) Empirical prescribing in medical admission units focuses on:
   - Indication for antibiotic treatment documented in patient medical notes and/or prescription chart.
   - Choice of antibiotic compliant with local antibiotic policy.
   - Duration of treatment documented in patient prescription chart

3) Compliance with NHS Lothian also monitors compliance against SIGN Guideline 104 (Antibiotic prophylaxis in surgery).

3.3 Leadership and Infrastructure Improvements

3.3.1 Leadership

Standard 1 of the HAI standards requires the organisation to demonstrate robust "*leadership and commitment to infection prevention and control to ensure a culture of continuous quality improvement throughout the organisation*"

Strong leadership is essential for effective decision-making, efficient use of resources and ensuring provision of high quality, safe effective person centred care. Clarity about who is responsible for the delivery of HAI related quality improvement projects is undoubtedly a critical factor in their success or failure. The IPCT are key stakeholders, but do not hold the clinical accountability for patient outcomes. This sits with the clinical teams who are responsible for delivering care.

To effectively promote and sustain a culture where 'infection control is everybody's business', senior management and clinicians must fully understand and engage in their own role in relation to IPC, and act as good role models for the wider multidisciplinary teams.

The IPCT must be visible in the clinical areas, and participate and provide subject matter expertise as part of multidisciplinary projects and meetings.

Prioritisation of HAI goals by the organisational leaders is essential. The IPCT in collaboration with clinical and improvement colleagues are seeking to simultaneously deliver improvement across a wide range of topics. These are all afforded the same level of risk and priority, and there has been limited evaluation on the impact on available resource. Data produced shows that in many cases short term improvement is made whilst there is a concentrated focus and external support, but that many fail to deliver sustained improvement when this is removed. In other projects, there is an ambition to deliver improvement, tools are produced and circulated with limited or no support for implementation. This is often referred to as the 'spray and pray' approach.

Opportunities for improvement are therefore the:

- Clear prioritisation of the goals for improvement within each year. This will allow maximum impact and benefit for patients, staff and the wider organisation.
- Improved use Pareto charts to identify areas of potential maximum impact to provide for the managers and clinical teams.
- Use of performance monitoring by managers will support achievement of HAI aims
- Roles and responsibilities in relation to HAI must be explicitly built into roles and job descriptions across all levels of the organisation. These are already explicitly mandated in the HIS HAI standards, and reflected in the Infection Prevention and Control Strategy 2015-17
- Roles should be tested and reviewed as part of ongoing appraisal and eKSF.
- Senior clinicians must act as role models and set a clear standard for the teams they manage

- Multidisciplinary team engagement and cooperation is critical in modelling good practice and behaviours. For example, in participating in MDT ward rounds with input from Microbiology and the IPCT to enhance communication and promote adherence to best practice
- The MDT must also lead investigations and identify learning and areas for improvement, use QI methods to ensure sustained improvement.
- Seek improved support of MDT ward rounds and clinical review (for example of CDI and SAB) to ensure support by enhanced working between anti-microbial team, microbiologists and ICCT
- In reducing quality inefficiency through the removal of duplicated work and effort, the IPCT can provide visible presence and leadership across sites. This has the opportunity to improve feedback, information and support in response to cases or incidents in real time
- The ICPT must take an active part in site based ICC and quality improvement projects.

3.3.2 Collaborative Working

There is an opportunity to review the structure, roles and responsibilities of the IPCT to ensure that there is protected resource to deliver mandatory activity (for example surveillance) without impacting on the ability to deliver a reactive service in response to emerging issues and demands, or supporting improvement projects.

Review of IPCT roles, priorities and resources is required with a risk assessment and proposal of how to address the gaps. The IPCT acts as a specialist resource across all NHS Lothian acute and community healthcare sites. The scope and remit includes educating, advising and supporting all clinical and non clinical services. It includes policy and guidance development at local and national level. The team are also currently responsible for data collection, entry, analysis and feedback of mandatory surveillance data, alert organism data and other audit.

The impact of new national and local initiatives (for example E.coli bacteraemia surveillance) on existing workload, or prioritisation of workload is often poorly considered as part of planning and implementation strategies. Where temporary funding is provided to support initial implementation, the IPCT may be expected to support and sustain ongoing delivery within existing resource. In the absence of additional funding or other resources, it must be recognised that new substantive activity has to be balanced within existing resource and may be to the detriment of direct clinical engagement, improvement work and visibility at clinical level.

Examples of this include the non-recurring funding for an IPC Quality Improvement lead, who has a specific role to play in HAI improvement, QI training and support for improvement projects. This funding has not been renewed, but there remain numerous IPC related improvement projects in progress, or in planning. No temporary or substantive funding has been allocated to support the introduction of mandatory E.coli Bacteraemia surveillance. Based on current incidence, the surveillance aspect of this programme is estimated to represent approximately 1.0 WTE. This currently must be resourced from the existing staff base.

Greater prioritisation and coordination would increase effective use of the existing staff resources with greater potential for learning and sharing knowledge, skills and functions such as ward rounds. There are a number of teams who have a role to play in improving IPC:

- Public Health Team
- Microbiologists and Virologists
- Antimicrobial Management Team
- Education and Development Team
- Quality Improvement Support Team, and
- External stakeholders (e.g. HPS, NES and HIS).

The challenge is that each team has a specific remit and projects and the improvement support is generally done in silos with duplication of effort.

Multi-disciplinary clinical teams should lead investigations and reviews (such SAB review) to ensure that the review accurately reflects the condition and treatment, clinical risks, and any local or organisational learning requirements and any learning requirement identified must be owned and progressed by the appropriate clinical teams, with support from the IPCT. This level of engagement with clinical teams has been challenging to date.

The recruitment of an Infection Control Doctor (ICD) to support the wider IPCT is an urgent requirement. This is key role in providing senior medical leadership, clinical and subject matter expertise to support delivery of the HAI agenda.

Sufficiently funded sessions for the ICD role to adequately reflect the workload and demand on clinical time would benefit the service greatly. NHS Lothian currently provides fewer funded sessions than NHS Greater Glasgow & Clyde, where they have a site specific ICD support in each Geographical area.

3.3.3 Data Management

There is an opportunity to reduce duplication of effort in gathering data or intelligence, generating reports, communicating information and data. This will reduce quality waste and quality inefficiency.

- **SICPs compliance audit data**

HAI standards require the IPCT to measure the implementation of key policies, procedures and guidance based on the infection risks within individual clinical areas and work closely with staff at the point of care and the safety team. This would include SICPs and TBP compliance monitoring.

There is significant inefficiency waste in the overlap of data collection, data entry and data reporting within the organisation. In many cases, data collected cannot be shown to inform education, or service improvement. There is also no clear mechanism for collating, comparing or viewing all HAI related compliance monitoring data in the one place.

Examples of this include:

- Wards and departments carry out quarterly self audit of SICPs compliance using standard tools. Results are compiled on QIDS, and compliance reports can be generated to ward level.
- SICPs compliance audits carried out by IPCT cannot be entered onto QIDS and are held on separately.
- SICPS compliance and environmental hygiene monitoring – currently monitored by numerous audits, walk rounds and checklists. No standard question set or audit tool is used, so limited ability to compare and contrast results
- Multiple action plans required as a result of visits/audit. There is currently no clear mechanism for collating, comparing or reviewing progress with actions required, sustainability of improvement or identifying recurring themes. All action plans are created in hard copy.
- TBP compliance is not consistently or robustly reported (as per the requirement of HAI standards) although some elements of compliance data is collected in hard copy or are available from other sources but not collated in a useable format.

Key improvements would therefore be:

- Streamline data collection and reporting systems and processes
- Reduce volume of data collection and reporting, and improve quality of data and systems for capture, analysis and feedback. This could include the use of Tableau scorecards
- Ensure that there is appropriate collation and reporting of all infection prevention & control data (data linkage). This will provide information which informs practice and helps drive improvement. Information and assurance must be fed back to clinical staff and fed forward to leadership teams.

By reducing variation, removing parallel processes and streamlining and refining reporting arrangements, the ICPN resource available could be more effectively deployed to support staff in the interpretation of data, and facilitating improvement work in response to these data. This would also reduce the burden of scrutiny on clinical teams and free up time to develop and deliver improvements required in response to audit and surveillance.

- **CDI, SAB and SSI data**

The IPCT are asked to provide (in different formats) data on CDI ,SAB and other data including SSI data, on a weekly, monthly, bi-monthly, quarterly and annual basis. In many cases, the same information is being requested and reported to different audiences more than once within each reporting period. This represents significant duplication of effort and impacts on resource available for other activities.

At the request of the Clinical Management Group (CMG) a standardised reporting template has been developed to bring key IPC data including SAB, CDI and antimicrobial data into one report. This work requires further development and testing to refine the process, and meet the needs of all stakeholders.

Further clarity and streamlining of which reports are required, for whom and how often is also required.

Due to IT constraints, there are challenges in how and where data is entered, collated, analysed and reported on. For example, alert organism data (e.g. CDI) is reported directly from the laboratory system (APEX) into ICNet. The IPCT use ICNet as the principal system for obtaining and communicating patient results, recording key patient and other information in relation to cases, and is the primary surveillance tool.

APEX also exports directly to ECOSS (the national Electronic Surveillance system). Mandatory data (for example HEAT target data for CDI) is extracted directly from APEX and checked before submission to HPS. This means there can be discrepancy in the data held on ICNET due to unresolved issues around system interfaces. Therefore there are limitations in the how the reporting function within ICNet can be used, as there is a risk that conflicting data is circulated.

The on-line chart generator tool is currently under utilised. This can be used by any member of staff to provide incidence and compliance data at ward, directorate, site or board level.

This may be due to a lack of confidence in the use of the tool, or a lack of confidence in interpreting the results, or a lack of clarity about how to use or share the information. It is also not clear how this data can be used in conjunction with other data to target or direct resources or improvement.

Key improvements will be:

- Identifying and addressing the reasons for the failure to use the existing chart generator tool within the organisation and the production of standardised reporting would reduce reliance on the IPCT for local data
- to resolve issues around IT interface issues between key electronic systems, including ICNet and TRAK.
- Reduce volume of data collection and reporting, and improve the quality of data and systems for capture, analysis and feedback. This could be achieved through improved interface between existing systems and improved use of existing functionality within ICNet
- Ensure that there is appropriate collation and reporting of all infection prevention & control data (data linkage). This would require IT support to develop or procure appropriate database options
- Improve how information which informs practice and helps drive improvement is shared, through Tableau dashboard. Information and assurance must be fed back to clinical staff and fed forward to leadership teams.
- Improve the use of Pareto charts to identify areas of potential maximum impact and test 90 day improvement cycles, for example to bring about rapid change in SABs as a result of pvc's
- Identifying funding to secure a substantive data analyst post to support the IPCT

3.3.4 **Policies and Procedures**

Providing evidence based infection prevention and control policies, guidelines and procedures which are easy to find, easy to read and easy to apply is a key area for development.

Many of the current policy documents are out with review timescales and must be addressed as a matter of priority.

Policies are now provided only on the intranet site due to concerns about the availability of out of date 'hard copy' policies available at ward level in the absence of an effective system for version control.

However, a number of challenges have been identified in relation to current provision:

- Staff access to computers can be limited, particularly for some staff groups (e.g. domestic staff) or out of core business hours
- Access to policies for community and peripatetic staff
- Sharing information across health and social care settings moving toward integrated working
- Lack of confidence in using electronic resources
- Relevance of information, and
- Presentation of information in a way which is meaningful to all readers

There is an opportunity to learn from successful systems developed and implemented across Oncology and Paediatrics. With support from IT and the Communications teams, other means of providing and communicating information should be explored, for example the use of Apps, social media and access to some printed materials.

3.3.5 **Education**

The HAI Standards require all staff to be provided with the necessary knowledge and skills in IPC to confidently and competently demonstrate behaviours integral to safe, effective person centred care.

The formal education programme includes mandatory induction, training & updates, tailored education to meet roles and responsibilities, learning and sharing of best practice and there are multiple integrated approaches. The organisation must evaluate provision, quality and uptake and respond to unmet needs.

Ad hoc training is not well reflected in training records. The variety of IPC related education and training attended by staff has (until recently) not been coded or captured.

Anecdotally, staff report that there is a lack of protected study time and that service pressures and demands mean that bookings on courses are cancelled, often at last minute.

Currently, compliance with mandatory HAI education is less than 80% across the organisation and the aim is to increase this to 90% within the next year.

Figure 6

April 2015 Directorate	Fire Safety Annual	Manual Handling Annual	Violence & Aggression	Equality & Diversity	Public Protection	Information Governance	Health & Safety	Resuscitation	Healthcare Associated Infection
NHS Lothian Average April 15	46.5%	55%	71.5%	64.5%	57%	55%	65%	69%	66%
	↑ 1.5%	↑ 1%	↑ 0.5%	↑ 1%	↑ 1%	↑ 1%	➡	↑ 1%	↑ 1%
NHS Lothian Excluding Facilities	48%	59%	75%	69%	60.5%	58%	69%	73.5%	70%
Scheduled Care	46%	58%	69%	67%	56%	55.5%	66%	72.5%	69%
Unscheduled Care	44%	59%	74%	67%	58%	56%	67%	77%	71%
Edinburgh CHP	52%	64%	89%	72%	68%	61%	75%	76%	74%
Corporate Services	56%	46%	63%	65%	57.5%	61%	66%	58%	61%
West Lothian CHcP	60% Grade Change	62%	89%	74%	67%	62%	75%	84%	75%
East Lothian CHP	36%	56%	81%	70%	65.5%	62%	73%	76%	70%
Midlothian CHP	39%	58%	81%	69.5%	65%	56%	72%	67%	72%
Strategic Services	52%	53%	65%	67%	56.5%	54%	66%	69%	64.5%
Facilities & Consort	33%	25.5%	39%	30%	25%	30%	34%	30%	31%

Red = less than 60%
Amber = less than 80%
Green = 80% or more

The key areas for development are therefore to:

- Robustly explore and understand barriers to uptake or participation in education and training, and work with others to address these
- Continue to revise and develop educational resources in relation to IPC in collaboration with Education leads
- Provide quality assurance of education packages delivered by non IPC staff
- Explore and develop a blended approach to teaching and learning which is appropriate to personal and service needs, role, experience and ability
- Promote uptake of existing NES modules and other resources
- Support MDT teams to undertake investigations and share the learning via established meetings including Morbidity & Mortality meetings, QI meetings and Grand Rounds
- Share learning through established post graduate education curricula and sessions
- Utilise Clinical Development Fellows to share learning and improvement
- Use Breakthrough Series Collaborative to bring together all the teams that contribute to HAI improvement to drive improvement in key priorities.
- Involve patients and their carers in understanding their responsibility and to challenge practice

3.4 In summary, the plan above seeks to improve the leadership and infrastructure support and increase care reliability across a range of evidence-based interventions to prevent and reduce harm to patients. The driver diagram in Appendix 1 summarises the approach and actions set out above.

4 Key Risks

4.1 Failure to meet HEAT targets for CDI and MRSA
4.2 Failure to comply with national HAI standards, with potential to negatively impact on patient experience and outcomes of external scrutiny.
4.3 Failure to make and sustain improvement in relation due to lack of clinical ownership and engagement.
4.4 Failure to identify, investigate, advise and act on surveillance data or other information due to issues with IT infrastructure.
4.5 Demands on IPCT staff resource to meet mandatory reporting requirements and timescales at the cost of providing proactive engagement and support at clinical level.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register 1076 is currently graded high due to reported incidences of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection impacting on negative trend to achieving Health Efficiency Access Treatment Target. The risk register covers Norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Inequality, Including Health Inequalities

6.1 There is no change to policy or procedure set out in this paper.

7 Involving People

7.1 Involving patients and families in the prevention and control of infection is essential and is integral to the improvement plan.

8 Resource Implications

8.1 The resource implications are:
- Financial resources to improve IT system interface and improve reporting systems and processes
- Potential for additional staff resource to ensure effective delivery of core mandatory function and reactive service.

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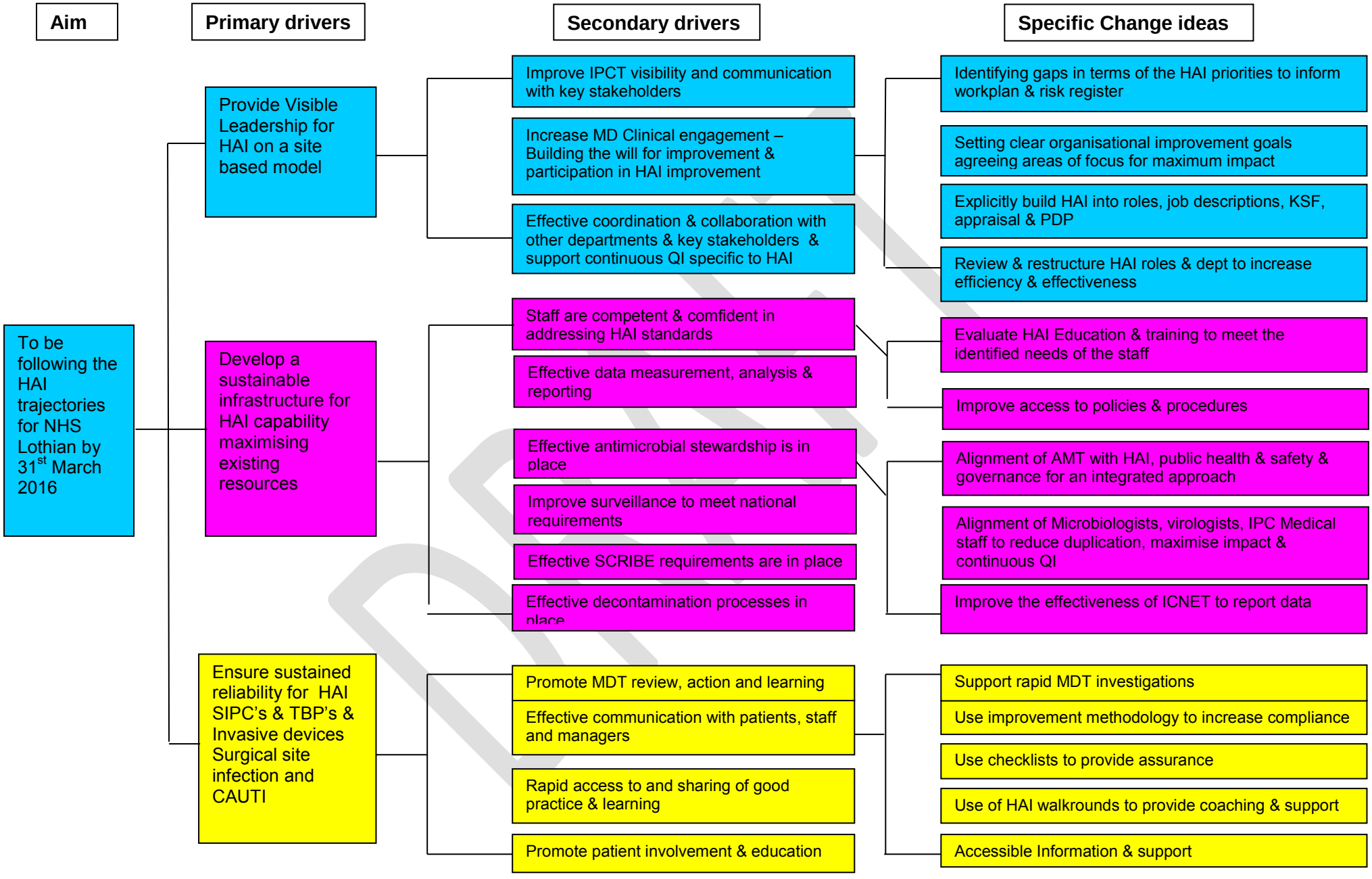
List of Appendices

Appendix 1: NHS Lothian Infection Prevention & Control Improvement Plan

NHS Lothian Infection Prevention & Control Improvement Plan

APPENDIX 1



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NHS LOTHIAN

2.11

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

GETTING IT RIGHT FOR EVERY CHILD - UPDATE & SCOTTISH GOVERNMENT PROGRESS UPDATE

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

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

• A Scottish Government (SG) DL letter outlining the Children and Young People (Scotland) Act 2014, Getting it Right for Every Child (GIRFEC) legislative requirements was sent to CEs earlier this year with a request for update on NHS Board Implementation Plans.	3.1
• Professor Alex Mc Mahon has been appointed as the GIRFEC Board Executive Lead for implementation of GIRFEC.	3.1
• The Act introduces a range of new duties for Health Boards including undertaking of the GIRFEC ***Named Person Service*** and statutory child planning for all pre-school children. **This particular duty becomes a legislative requirement from August 2016.**	3.1 & 3.2
• To support the new duties SG have agreed to fund an additional 500 Health Visitor (HV) posts in Scotland this being 61 for Lothian over a 42 month period by 2018-19. Part funding was received during 2015-16 this being to fund the first 14 of the total 61 new posts.	3.3
• NHS Lothian currently has significant HV vacancy and recruitment issues (18%) anticipated to rise to 30% by December 2015 unless we can recruit external this currently being a greater issue in Midlothian where vacancy rates are currently 58% and rising.	3.4
• NHS Lothian are unlikely to fill current vacancies and recruit to the additional 14 new SG funded posts by August 2016 therefore a range of internal and local initiatives to support HVs deliver are being proposed.	3.4
• NHS Lothian will not be at full HV workforce capacity until 2018/19 at the earliest unless we can retain current workforce and recruit from out with Lothian.	3.4 & 3.5
• The HV recruitment issues are recorded on the Corporate Risk Register and GIRFEC Implementation log. It is proposed using some of the current HV underspend to fund a corporate HV recruitment campaign, utilising a mixed media approach. Costs being quantified.	4.1,5.1& 5.2

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NHS LOTHIAN

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

GETTING IT RIGHT FOR EVERY CHILD - UPDATE & SCOTTISH GOVERNMENT PROGRESS UPDATE

1 The purpose of this report is to:

1.1 To update the NHS Board on the progress in implementing the Getting it Right for Every Child (GIRFEC) Requirements (Parts 4, 5 and 18) of the Children and Young People's (Scotland) Act 2014.

2 Recommendations

2.1 Acknowledge that the Director of the Children and Families Directorate, of the Scottish Government, issued a DL letter to NHS Board Chief Executives (CE) in July 2015 requesting **1.** That NHS Board Chief Executives to nominate a named Executive Lead for Parts 4, 5 and 18 of the Act and that Professor Alex Mc Mahon has been appointed to that role. **2.** That a progress report on implementation across key domains be submitted by end of August 2015 (Appendix 1).

2.3 Acknowledge that Scottish Government have agreed to fund an additional 61 WTE Health Visitor (HV) posts in Lothian by 2018 to meet the Children and Young People (Scotland) Act, Named Person and Child Planning requirements and that a part funding recurring allocation of £884k has been received from Scottish Government (SG) in July 2015-16.

2.4 Note that a HV workforce plan and progress report was submitted to SG in June 2015 (Appendix 2) and that this plan is subject to on-going corporate review and performance monitoring and reporting through the Corporate Objective and LDP monitoring process.

2.5 Acknowledge the current HV vacancy rate and the challenges in the training and recruitment of HVs to current and anticipated vacant posts together with the SG 2015-16 funded 14 new posts to support delivery of the Named Person service as described within the Children and Young People (Scotland) Act 2014.

2.6 Support a corporate approach to the training and recruitment of HVs including using some of the current under spend in HV services to fund a significant recruitment campaign, utilising a mixed media approach.

3 Summary of the Issues

3.1 As previously reported the Children and Young People (Scotland) Act 2014 introduces a range of new duties for Health Boards including undertaking of the Named Person Role in relation to children's well-being and statutory child planning for all pre-school children. This particular duty becomes a legislative requirement from August 2016 and as per specified in the Draft Statutory Guidance on Part 4,5

& 18 of the Act, will be undertaken by HVs for the majority of children and by a Family Nurse Partnership nurse for those children up to age 2 years on the FNP programme. Professor Alex Mc Mahon has been notified to AG as the NHS Lothian Executive Director Lead for GIRFEC implementation. The NHS Lothian Progress Report demonstrates significant progress in NHS Lothian's commitment to improving the health and wellbeing of children and our plans in implementing GIRFEC (Appendix1) However issues in relation to HV recruitment and building sufficient additionality to enable delivery of the named person service by August 2016 persist and these concerns have been communicated to the SG GIRFEC team both within our response and during subsequent informal discussions..

3.2 Taking account of the new Named Person legislation and the proposed introduction of a new universal 0-5 years HV pathway there are workload and workforce implications for the Health Visiting Services nationally and in Lothian. It should be noted there is a national shortage of qualified HVs in Scotland and an extensive training programme is underway across all NHS Boards.

3.3 In response to the legislative requirement of Named Person role, Scottish Government have committed to an additional 500 HV posts across Scotland and allocated £20 million recurring funding over an incremental four year time line (2014 – 19) to NHS Boards. **In response to this NHS Lothian are expected to recruit an additional 61 wte HVs during this same period.. This is calculated as 14 WTE during 2015-16.**

3.4 Building HV capacity remains a top priority in NHS Lothian and this is reflected in our HV workforce plan that was submitted to SG in June 2015 (Appendix 2). As reported in the October LDP Performance Report our HV vacancy rate is a concern and running on average 20-30%. This coupled with the national short supply of HVs makes it difficult to recruit. We remain committed to reducing our vacancy rate through training sufficient HVs to meet the SG required additionality however this will not be achieved until 2019. The current HV Visiting Workforce in Lothian is as follows:

- The current NHS Lothian HV establishment is 158 wte. NHS Lothian have been running with high HV vacancy rates for the last two years and as previously reported have taken steps to address. While predicting and reporting the HV vacancy rate to reduce to 7.5 wte with 2 wte anticipated vacancies in the October LDP Report there has been a number of unexpected resignations in the past 2 months. The current gap in the HV Visiting Workforce across Lothian is 27 wte (18%) with a further 9.3 wte resignations anticipated to be enacted before the end of December, that will potentially push us up to 30% vacancy rate. This position together with the requirement to demonstrate an additional 14 wte posts funded from new SGHD monies is the subject of a significant external recruitment campaign, utilising a mixed media approach.
- The greatest proportion and impact of the establishment gap is within Midlothian H&SCP, currently 58% and a short life group involving representatives from all H&SCP, Health Visiting, Midwifery, Staff Partnership and Corporate Services is taking forward an action plan to manage the pressures in the Lothian HV system.
- We planned to train 2 cohorts of HVs, a total of 26 Health Visitors during 2015-16 however our current wte of Specialist Practitioner Supervisors (SPSs) has reduced unexpectedly due to 2 SPSs taking up HV Lecturer posts at Queen Margaret

University. This situation affects the required SPS:HV Student ratio and will necessitate a reduction in the January 2016 cohort of students from 10 to 7. This means that we will therefore only be able to train 23 HVs during 2015 -16 as opposed to the planned 26 and this will further impact on the Boards ability to fill vacancies and generate the SG required HV additionality.

3.5 Despite best efforts NHS Lothian will not have trained sufficient HVs by 2016 and will not be at full HV capacity until 2018/19 at the earliest unless we can recruit from out with Lothian. This situation will need to be carefully risk managed and a range of corporate and local solutions including solutions with partner organisations are being discussed to ensure that all 0-5 years children have a Health Visiting and Named Person Service by August 2016.

4 Key Risks

4.1 To implement GIRFEC and deliver a Named Person Service through a named HV for every child by end of August 2016 will be challenging. If capacity is not increased and / or augmented NHS Lothian we will be at risk of not delivering the new legislative requirements as outlined within the Children and Young People (Scotland) Act. We are currently in discussion with our Community Planning Partners in the four Lothian Local Authorities and Third Sector organisations to explore innovative capacity building solutions to support the health visiting / named person service and these will be considered by the local H&SC management teams and proposals brought to Corporate Management Team for approval in early 2016.

4.2 Retaining existing HVs and HV staff nurses is also a priority. It is imperative that staff nurse vacancies are recruited to in sufficient time to ensure continued operational delivery by HV teams.

5 Risk Register

5.1 The supply, vacancy and recruitment issues for HVs are included in the NHS Lothian corporate risk register under the wider nursing and midwifery workforce risk. The controls in place are being amended to reflect the increasing action around maintaining the Health Visiting service in areas of greatest vacancy. The key mitigating factor being of increasing the number of staff training to become HVs is essential if NHS Lothian is to be fully compliant with the statutory responsibilities outlined in the Children and Young People (Scotland) Act by 2016.

5.2 A corporate approach to the training and recruitment of HVs has been agreed by CMT and a plan has been put in place. It is proposed to use some of the current HV service underspend to fund a national recruitment campaign, utilising a mixed media approach. Costs for this campaign are currently being finalised

6 Impact on Inequality, Including Health Inequalities

6.1 HVs are integral to ensuring that all children have the best start in life and achieve their developmental milestones and the HV service is crucially important in supporting primary care and local authorities in reducing inequalities. Ensuring an equitable and accessible HV workforce in all four Lothian Community Planning Partnership areas is essential in supporting the reduction in inequalities for children and families.

7 Involving People

7.1 Concerns about the capacity within the HV workforce are well recognised throughout Scotland and NHS Lothian and the four Lothian Community Planning Partnerships. Our staff and NHS partnership representatives are fully involved in developing our plans and managing the risks.

8 Resource Implications

8.1 NHSL have received £884,000 for 2015-2016 from the Scottish Government. This is in line with the Scottish Government's commitment to providing a step increase of funding to recruit an additional 500 HVs across Scotland. It was agreed at the May CMT how this funding would be spent and that no recurring LRP would be taken from HV budgets.

8.2 The new 2015-16 funding is being used as agreed to train the additional 26 (23) HVs during 2015-16 and it is hoped that the creation of an additional 14 wte posts will be within the system by September 2016.

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20 November 2015
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List of Appendices

Appendix 1: NHS Lothian Progress Report
Appendix 2: Health Visitor Workforce Plan

APPENDIX 1

To: **Olivia McLeod, Director**
Children and Families Scottish Government

From: **Professor Alex Mc Mahon, NHS Lothian Executive Implementation Lead, Children and Young People (Scotland) Act 2014**

Subject: **Progress with Implementation of the Children and Young People (Scotland) Act 2014, in relation to Parts 4, 5 and 18 within NHS Lothian as at 31 August 2015.**

General Overview

The Children and Young People (Scotland) Act 2014, including the GIRFEC 2016 legislative requirements, is firmly embedded within NHS Lothian Corporate Objectives and our plans are reported and performance monitored as part of the Corporate Objectives performance reporting system and also reported through the NHSL Local Delivery Plan (LDP) reporting mechanism to Scottish Government. GIRFEC is embedded within the four Lothian Integrated Children and Young People's Service Plans and is also embedded within the NHS Lothian Children and Young People's 2015-2020 Strategic health Plan.

Professor Alex Mc Mahon, Director, Strategic Planning, Performance Reporting and Information is the NHS Lothian Executive Lead for implementing this Act and Sally Egan, Associate Director & Child Health Commissioner is leading strategic planning and implementation of GIRFEC within NHS Lothian and also leads integration of children and young people's health services within the four Lothian Community Planning Partnerships. We also appointed a GIRFEC Development Manager in June 2015 for an 18 month period to support delivery of the GIRFEC implementation plan across the organisation and our four Lothian Community Planning Partnerships.

Progress & Challenges in Implementing the Named Person Service

- The NHS Lothian Children and Young Peoples Act Implementation Steering Group are responsible for developing and agreeing the NHS specific organisational training and development requirements. We do however confer with our statutory and third sector partners re all aspects of our local integrated GIRFEC Implementation Plans. There is an NHSL specific GIRFEC Implementation Plan to ensure that NHS Lothian is in a state of readiness to implement GIRFEC and the Named Person service by August 2016, this being subject to our current understanding of the requirements as specified in the most recent draft of the statutory guidance.

- All NHS Lothian staff receive GIRFEC awareness raising as part of our recruitment and induction process and depending on their job will undertake additional training both single and multi-agency on Named Person responsibilities. Currently every preschool child known to NHS Lothian has a named / allocated Health Visitor or Family Nurse and it has been agreed that these groups of staff will undertake the role of named person as part of the ***Named Person Service***.

- We have been working towards GIRFEC implementation across the four Lothian partnerships for the past 5 years including introduction of staged assessment from pre birth through the various life stages. GIRFEC planning meetings and evidence of interagency child plans are well embedded within services that said there is now a national debate as to what constitutes a ***Targeted Intervention*** and therefore the need for a ***Statutory Child's Plan***. This is causing some confusion for staff and clear

guidance is required. We are currently progressing child planning meetings and creating ***Child Plans*** based on our interpretation of the national practice model requirements and the suggested minimum data set and we eagerly await the revised statutory guidance to ensure clarity and compliance.

- We are currently engaged with colleagues in nursery, education, and independent school sector to ensure we have robust Named Person Service transition pathways in place by June 2016. In the main the HVs and Family Nurses are currently exercising the Named Person role in terms of co-ordination of care and assessment of wellbeing for all children birth to age 3 years. For children 3-5 years the HV service is largely supported by our nursery key workers and teachers to deliver the named person service. Our HVs are in the main responsible for initiating child planning meetings for those children birth to 3 year olds but for older pre-school children these meetings may be initiated by a range of early years workers. Where there are child protection or welfare concerns the HV service generally lead initial planning meetings but do not always lead in the development of what will in the future be deemed ***Statutory Child Plans*** as this tends to be undertaken by a designated Lead Professional. The actual development and management of the Child Plans is currently undertaken by Children and Families or Education in the four Lothian Local Authorities. We are unclear as to whether these arrangements will continue and discussions are on-going in the respective partnerships.

- We have recently reviewed and updated our pan Lothian GIRFEC awareness training and will be reviewing level 2 & 3 GIRFEC training and cross referencing with our Child and wider Public Protection training once we are in receipt of the final ***Statutory Guidance.*** GIRFEC awareness and named person responsibilities are specified within our mandatory NHS Lothian Induction, Public Protection and CAPSM training. ***This training is supported by a e-Learning foundation module which has been reviewed and updated during July 2015.*** We work closely with the local HEI and our GIRFEC training materials will be used with the 2015/16 intake of HV students at Queen Margaret University. We are also working with NES and the HEIs specifying the additional CPD requirements for those staff who will become Named Persons.

Key Challenge

- We currently have a significant number of HV vacancies due to retirement and inability to recruit due to national short supply. This is coupled with the GIRFEC requirement to create an additional 61 WTE SG funded posts. Essentially NHS Lothian are unable to grow the HV workforce to the anticipated required numbers to implement all elements of parts 4, 5 & 18 of the act by August 2016 and this presents NHS Lothian and their partners with significant risk. ***Growing the Workforce*** planning intention to SG in May 2015. This template fully outlines the workforce challenges and NHS Lothian's proposed solutions and incremental steps to ensure that there is a skilled and competent HV workforce in place by September 2018 (enclosed).

Next Steps

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- We are currently developing interagency transition arrangements from pre birth to school entry to ensure every child is known to the named person service and has an allocated named person. As stated above we will not be up to the SG agreed HV establishment to fully implement GIRFEC by August 2016 and will consider further the use of HV and interagency skill mix to augment the HV and Named Person Service.

- We are reviewing child planning arrangements in the four Children CPPs in light of the envisaged revised final Statutory Guidance.

- We will continue to support and develop practitioner's skills in delivering effective child assessment and planning (training and practice development), including ensuring children and young people and parent's are included and their views assist in informing the process.

- We are preparing practitioners for implementation of the enhanced HV Universal Pathway that is envisaged to commence simultaneously or shortly after implementation of the Named Person Service.

Progress with Assessment, Information Sharing & Care Planning

- NHS Lothian has developed an electronic Child Health Record within the wider Electronic Patient Record and administration system known as TrakCare. This includes the Health Visitor child record. The GIRFEC national practice model influenced the design of this bespoke record and as such we have built in an assessment tool that enables HVs to work through an assessment of wellbeing compliant with GIRFEC national practice model. The tool enables generation of a documented assessment for all children with additional needs, reports on concerns / progress and enables recording of the health and wellbeing chronology and the creation of a child's health plan. The tool encompassed a range of alerts that can be seen by all NHS staff. The system has a mechanism for ***Request for Service*** from internal and external agencies that can be used manually or electronic by email for interagency exchange of information.

- The Health Visitor/Family Nurse Partnership (FNP) electronic child record can be viewed and accessed with appropriate permissions by all health care providers using TrakCare. These include, CAMHS, Adult Mental Health, LAC Nursing & NHSL Child Protection Services, A&E, all RHSC wards, Radiology, Maternity, Community Child Health, Community Children Nurses, and Paediatric AHPs. This allows for the NHS Lothian single agency child record and health plan to be viewed by all NHS care providers apart from GPs who are not TrakCare users. GPs do however work through the various teams to send and receive information and know how to access information from the Health Visiting and other Community Child Health Systems. Printed materials from the record can be shared with mothers and partner professional's out with NHS Lothian if appropriate and of course proportionate to need. There is also the ability to PDF ***Request for Service & Care Summary notifications*** from TrakCare to non NHS Lothian professionals.

- We have agreed local processes for our Local Authority and Police colleagues if they require to identify a child's named person and we are currently reviewing these to ensure there is a NHS Lothian wide ***fail safe, one point of contact,*** for identifying a Childs Named Person.

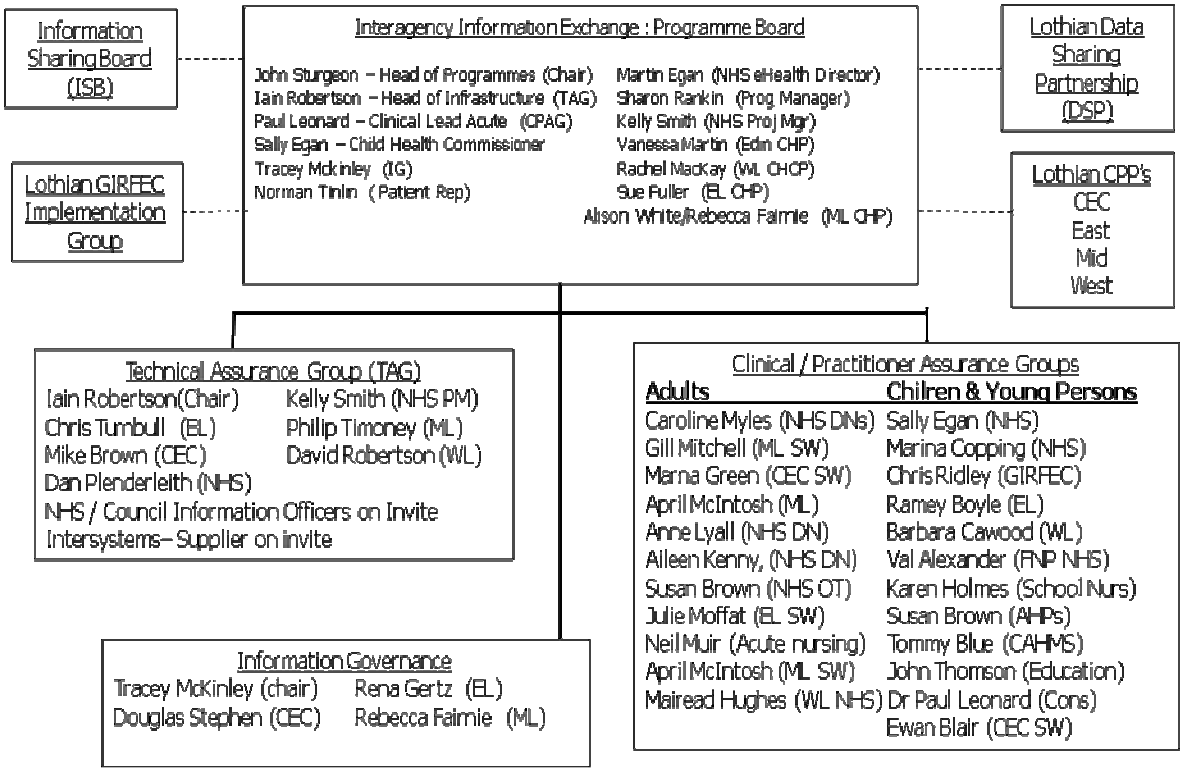
- A multi-agency ***Practitioners Guide to Information Sharing, Confidentiality and Consent*** to Support Children and Young People's Wellbeing was launched by the Chief Executive, NHS Lothian in November 2014 and is available to all NHS and partner agency staff. This document is accessible on the GIRFEC page on the NHS Lothian intranet and is used as part of GIRFEC awareness and training. This guide will be subject to full review in February 2016 and will take account of any changes within the Final Statutory Guidance.

Progress with Interagency Electronic Sharing of Information

- Interagency Information Sharing is a key priority for NHS Lothian and partners. The Lothian Information Exchange Programme Board has responsibility for Adult and Children & Young People electronic Information Exchange solutions. NHS Lothian has in place the Interagency Information Exchange System (Clinical Portal) which will support data sharing across our partner organisations. Currently the system is live with agreed adult data sets from Health and Social Care within the Edinburgh Adult H&SC partnership. This technical integration will be extended to the other three Lothian Local Authorities during 2016. Simultaneously we are developing solutions to enable the electronic sharing of children and young people's information. Initially this will be between Health and

Social Care, with a view that other organisations can come on board in the future for example education with their system SEEMIS. Initially this solution will meet the needs for sharing demographics, relationships, risks, alerts & some compulsory measures. The schematic below outlines the various work streams that sit within the programme and the overarching governance framework.

Lothian Interagency Exchange Framework



Next Steps

- The focus for 2016 will be the development of Children and Young Persons / GIRFEC information sharing electronic functionality and utilisation of the agreed national processes.

- There is on-going review of our service readiness for effective information sharing between services. Our key challenges will be the sharing of information short term in the absence of our IIE and SEEMIS interface and in those partnerships out with Edinburgh. We also seek clarity on what constitutes a Statutory Child's Plan and how these plans will be recorded, viewed, shared and stored over time.

- There is currently an EYC test of change to identify workflows for sharing information between NHS Lothian and Independent Schools (which constitute 22% of our school age children)

- The Child Health Commissioner is leading on the transition pathway and information sharing policy and process for transition of Children into mainstream and Independent School. Discussions are on-going across Lothian to ensure that wellbeing concerns identified within health can be shared for all children as appropriate with the receiving mainstream and independent schools.

Public Awareness of the Getting it Right for Every Child in Lothian

During our Children and Young People's Health Strategy consultation we outlined to parents the key elements of the Children and Young People (Scotland) Act 2014 and our strategic plan is GIRFEC and UNCRC focussed and proofed. It is our view that there are differing levels of knowledge about the Getting it Right For Every Child and within the public domain. We feel we have much more to do during the next 12 months including preparation of practitioners in dealing with questions from parents and wider public.

Challenge

- Our key concern / challenge is that there has not been a national campaign to raise public awareness in relation to the Act and wider GIRFEC requirements and we feel this would be beneficial particularly in light of the Judicial Review and subsequent media responses. However we also hope that national validated materials for public and parent awareness and information sharing purposes will be made available to all agencies for local customisation.

Next Steps

- An NHS Lothian GIRFEC External Communication Plan is in the final development stage and this will support the roll out of GIRFEC awareness to the local communities and prospective and actual parent population during the second quarter of 2016.

- A comprehensive GIRFEC training pack will provide a menu of materials and PowerPoint presentations to be used across Lothian in a variety of formats and settings and will be available to download from NHS Lothian GIRFEC site. We are working closely with our four local authority partners and our NHS Border and Border LA to ensure there is consistency of message in all materials used during public awareness raising sessions.

- We will continue to work closely with our local authority and third sector partners to deliver multi-agency training to staff and community interest groups.

LOCAL IMPLEMENTATION TEMPLATE

Growing the Workforce

Progress Status
Not commenced
In progress/ongoing
Completed

Actions Required	Progress/Issues/Concerns	Status	Lead/ Responsibility National Level	Next Steps
1. Undertake a robust HV Workforce analysis using the National Caseload Weighting Tool and identify shortfalls.	Completed May 2015 and findings / proposals for workforce development agreed by NHS Lothian Corporate Management Team on 11 May. In addition, a review of NHSL HV workforce configuration and staff age profile was completed recently using data as at January 2015. Analysis performed by ISD when calculating number of HVs (across Scotland) used 2012 mid year population **estimates from NRS** (49,558 for 0-4 age group in Lothian) which was then split using the National SIMD deciles to give a total of 230 WTE HVs required to cover the Lothian caseload. However, when applying the National SIMD deciles to		Executive Nurse Director & Associate Director Planning / Child Health Commissioner	Build in 22.5% for predicted absence and recalculate. Review of Community Staff Nurse Role and WTE as some of these roles may need to be converted to additional HV posts to ensure continuity of care by the named person / HV within the new pre birth to school entry pathway.

	our Lothian caseload using **SIRS** (48,058 for 0-5 age group not attending school) the WTE required is 223, compared to 250 when applying the Health Board SIMD deciles. Concerns have been raised by Chief Nurses and Clinical Nurse Managers relating to the use of national rather than Health Board SIMD deciles for the caseload weighting calculation. This relates to a potentially skewed picture of demands on HV workforce when national data is used, which does not reflect the true workload of staff locally.			
2. Develop local plan to achieve locally agreed trajectories for maximising the HV Workforce including determining the number of new students required over the next 2-3 years.	Local plan completed and signed off by Corporate Management Team on 11May 2015. Concerns noted relating to current vacancy rates, age profile of workforce (54% of Band 6 HVs are over 50) and additional HVs needed to meet legislative and new pathway requirements. Plan agreed that sets out timetable and numbers to		Executive Nurse Director & Associate Director Planning / Child Health Commissioner	The HV workforce plan is ambitious and its implementation will be reviewed quarterly by Executive Nurse Director & Child Health Commissioner and reported through the NHS Lothian Children and Young People's Implementation Group to the Corporate Management Team to ensure we remain on trajectory and manage risk effectively.

	be trained over next 3 years. NHS Lothian plan to train a minimum of 114 HVs over the next 3 years **(new posts plus current vacant posts and anticipated posts to meet population increase)**			
3. Work with local education providers to agree training places and local arrangements.	Agreement with QMU to provide 2 intakes per year from 2015/16 - one in September and one in January. This amounts to training of 110 new HVs and 15 new Clinical Practice Teachers between 2015-18.		Community Chief Nurses and Clinical Nurse Managers	Detailed with NHS Lothian 5 year workforce plan. This can be shared electronically if required. It should be noted that the plan is dependent on attracting and recruiting sufficient students as detailed. As per above this will be closely monitored by the Executive Nurse Director.
4. Ensure organisational processes and managerial support is in place to enable Mentors and Practice Teachers to provide both high quality placements and support for Health Visiting students in line with NMC and HEI requirements.	As per 2 above. We will have 11 CPTs in June 2015 and have plans in place to incrementally train and build up the numbers of CPTs from 11 to 26 by 2018. The plan for Sept 2015 is that:- - experienced CPTs (5) twill take on 1 Year CPT, 1 Year 2 CPT and 1 HV student - 6 newly qualified CPTs will take on 1		Community Chief Nurses and Clinical Nurse Managers	Options for part time training and other approaches (distance learning) to achieving the HV, SPQ are being explored with education providers at national level. NHS Lothian is working closely with colleagues nationally to ensure that we are able to train staff without draining nursing resource across NHS Scotland.

	year 1 CPT and 1 HV student - 5 Year 2 CPTs will take on 1 HV student Given that the dates for new HVs qualifying will be spread out as a result of the dual intake each year, this will allow newly qualified CPTs to only take on 1 HV and one year 1 CPT initially, increasing to 2 HV students when qualified.			

The Role of the Health Visitor and Pathways of Care

Actions Required	**Progress/Issues/Concerns**	**Status**	**Lead/ Responsibility National Level**	**Next Steps**
1. Consider the capacity of the Health Visitor workforce to deliver the additional visits	NHS Lothian plan to support Health Visiting teams so they are able to meet national requirements i.e. the role of the Named Person and in line with guidance on the caseload weighting and universal pathway as follows: • Train a minimum of 114 HVs over the next 3 years **(new posts plus current vacant posts and anticipated population increase)** • Provide an infrastructure		Community Chief Nurses supported by the Health Visitor and School Nursing Workforce Development Group	In line with the redefined role for HVs, NHS Lothian are doing further review and redesign of HV Team structure as part of a wider review of all Early Years provision in the four Lothian CPP areas. During the initial 2015-18 period community staff nurses will continue to support the HVs including delivering some of the additional visits to ensure compliance with the incremental introduction of the new pathway. The banding of HVs and any proposed

	for HVs that supports them to undertake their legislative requirements and not be burdened doing administrative functions that can be undertaken by others • Enhance career pathway options for practitioners to include more advanced practitioners at Band 7 to provide enhanced supervision and support of B6 HVs			changes to this is outwith NHS Lothian's direct control and requires to be raised and discussed at the national Children and Young People's Nursing Advisory Group and at the Scottish Partnership Forum.
2. Support the existing workforce to move to the new model pathway	Plans as set out in 1 above. Further, workforce development will take place through provision of support and training around the new pathway. A Test of Change is planned (starting June 2015) using Early Years Collaborative PDSA methodology to identify the optimum time and format for antenatal joint contact between HV and Midwife. Test will involve weekly contact between Midwife and Health Visitor to agree HPI by 16 weeks. This will enable prioritisation of surveillance visits utilising		Community Chief Nurses supported by the GIRFEC Development Manager and the Clinical Nurse Managers	A GIRFEC Development Manager has been appointed for the next 18 months and will lead in conjunction with the Clinical Midwifery and Clinical Nurse Managers in developing the various pathways and processes to support transitions including antenatal to postnatal to HV and this will include transition from NICU / SCBU.

	whole HV workforce, including Band 5 for low risk families. Staff involved in test of change to be trained in early June and this will also be used as opportunity to 'test out' and evaluate newly developed GIRFEC training prior to roll out.			
3. Consider local processes around the named person	NHS Lothian has established an Act Implementation Group to develop local protocols. Workshop with HVs and Midwives were held in February to inform development of local processes. Health Visitor and School Nursing Workforce Development Group currently reviewing Named Person documentation to ensure it is fit for purpose. Training will then be provided to HVs to ensure clarity on these and information sharing. 'Practitioners Guide to Information Sharing,		Child Health Commissioner and GIRFEC Development Manager	It is proposed to develop a new role of GIRFEC Administrator to support the HVs with the additional administrative function in exercising the Named Person role. These posts are envisaged to be Band 4 roles and will undertake all the planning, coordinating and recording of multi-agency children's statutory planning meetings. Based on projected activity a total of 8 Administrators will be appointed HV to school transition - currently HVs only share information with school nurses and not with head teachers but work is going on pan Lothian to define a roadmap for information between Named Persons e.g. health to education or sharing with lead professional. Tests of Change are underway in West and East Lothian to inform more fully what needs to be done. The Child Health Commissioner is leading

	Confidentiality and Consent' has been developed jointly by NHSL, 4 Local Authorities in Lothian and Police Scotland and is currently being rolled out. It is available on NHS Lothian GIRFEC intranet pages and therefore available to all staff. NHS Lothian is developing a child health portal which will in this phase allow the delivery of the shared core health and social care information. The initial implementation of the Interagency Information Exchange (IIE) for Children and Young Persons is focussing on sharing information between TRAK and SCI Store in NHS Lothian and SWIFT (social care system) in City of Edinburgh Council (CEC). SEEMIS and Police systems will be added at a later point. Steps to get to a live position between NHS Lothian and CEC (other local authorities will follow) are: • Consent workshop with the aim of getting to an agreed model that can be supported		Child Health Commissioner and Maternal & Child Health Clinical Information Manager	across Lothian on the Integrated Information Exchange requirements between health, social care and education. The Child Health Commissioner is leading on the transition pathway and information sharing policy and process for transition of Children into Independent School. Discussions are on-going across Lothian to ensure that wellbeing concerns can be shared for all children as appropriate.

	by IIE – 1st June 2015. • Finalise the requirements and dataset – planned sign off by working group by mid/end June. • Submit Requirements and data sets and get Information Governance approval – planned for end June. Development team (for NHS Lothian) will then need to review and provide timescales along with any development needs required for SWIFT.			
4. Consider local process for additional health review points	As per 3 above Tests of Change are underway around joint contact between midwife and HV antenatal. Additional visits would be based on assessed level of need by HV.			This work will be led by the GIRFEC Development Manager, our Early Years Collaborative Improvement Advisor and Dr Graham MacKenzie, Consultant in Public Health with responsibility for Early Years.

Education for the Future

Actions Required	Progress/Issues/Concerns	Status	Lead/ Responsibility National Level	Next Steps
1. Working with HEI's to ensure that the learning environment offers an appropriate quality experience for HV students.	NHS Lothian GIRFEC training materials will be used for next intake of HV students at QMU. The HV course at QMU has just undergone an extensive revalidation process to ensure that the curriculum is fit for purpose.		Child Health Commissioner and Community Chief Nurses	We are also working closely with NES as they are keen to adopt NHSL materials for national use.
2. Ensure that the practice learning experience of the revised HV education enables students to meet the requirements of the programme.	All placements in the community are assessed and monitored to meet the requirements of the NMC and NES. NES are currently consulting on the CPD requirement for existing HVs and Community Practice Teachers (CPTs) As previously stated, NHSL are ensuring training of additional CPTs and spread over 2 intakes per year. Also revised model of supervision between CPT and student HV as a result of dual intake.		Community Chief Nurses and Clinical Nurse Managers	We are working closely with the Senior Lecturer in QMU as we move forward with implementing GIRFEC and the named person service within NHS Lothian . We have reviewed our local training and have developed a standard presentation that can be adapted for a range of audiences to raise awareness on the implications of the Children and Young People's Act including the named person service in health and QMU have agreed to use this as part of initial induction for HV students in September.

3. Put in place a model of educational supervision that meets statutory requirements.	The educational supervision of health visiting students is intended to comply with best practice as outlined by NES and the NMC. All health visiting students will have access to a qualified practice supervisor responsible for ensuring the standard and quality of their training experience.		Community Chief Nurses and Clinical Nurse Managers	We will ensure that our HV Community Practice Teachers receive ongoing CPD. We will survey HV students at the end of their placement. Child Health Commissioner and Heads of Health in the four Lothian CPPs will undertake an accommodation survey during summer 2015.
4. Consider local review of education for Health Care Support Workers (HCSW) in line with new HV service	As per no. 1 in 'The Role of the Health Visitor and Pathways of Care' above we have significant skill mix which includes staff nurses which was put in place in response to service development and redesign and in mitigation of the growing number of HV vacancies. This ensures the needs of our families are being met and the role of the HV staff nurse is now well embedded within HV teams.		Community Chief Nurses and Clinical Nurse Managers	We will continue to work creatively with our partners in developing new and improved ways of working and developing the Early Years workforce.

	The role of staff nurses is one that NHS Lothian needs to maintain, particularly in relation to the vital role they play in ensuring delivery of the preschool immunisation programme. As per para 1, table 1 above, review of Community Staff Nurse role and numbers planned with a view to identifying potential need to convert some staff nurse posts to HV posts to ensure continuity of care by Named Health Visitor. Further, as per section 3, table 2 above, NHSL plan to develop a new role of GIRFEC Administrator to support the HVs with the additional administrative function in exercising the Named Person role. LearnPro GIRFEC module for all staff has been updated and we will be raising staff awareness of this over the coming months.			Review of Community Staff Nurse role and numbers planned with a view to identifying potential need to convert some staff nurse posts to HV posts to ensure continuity of care by Named Health Visitor. We also plan to commence a staff nurse development programme in conjunction with Queen Margaret University for those staff nurses who wish to undertake the HV course in future years. Posts approved and will be recruited to by end of September 2015.
5. Introduce a clear career pathway from HV initial qualification through advanced practice to consultant HV.	NHSL are currently reviewing career pathway in relation to opportunities, particularly in relation to Band 7 team		Executive Nurse Director	Will be included as part of the ongoing HV workforce plan and CPD plans. We recognise that by 2019 we may have a surplus of Community Practice

	managers and band 7 ANPs.			Teachers but the plan would be to develop these roles to ensure a robust supervision model for Band 6 HVs.
6. Undertake an immediate review of numbers of CPTs required.	Done in May 2015. Numbers established as above.		Chief Nurses and Clinical Nurse Managers.	The CPT to anticipated HV student intakes 2015-2020 ratio will be under review by the Nurse Director and Chief Nurses.

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NHS LOTHIAN

2.12

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - INTEGRATION AND GOVERNANCE OF CHILDREN'S SERVICES IN NHS LOTHIAN

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

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

• The Children and Young People (Scotland) Act 2014 introduces a range of new duties for Health Boards including undertaking of the GIRFEC, Named Person Service for all pre-school children from August 2016. This legislative function will be the responsibility of the NHS Board.	3.1
• Management of Edinburgh Health Visiting, School Nursing and Lothian Family Nurse Partnership services transferred from the Edinburgh shadow Health & Social Care Partnership to the NHS Lothian Women's and Children's Directorate and these services are managed by the Associate Nurse Director who reports direct through the acute hospitals governance structures and through the Acute Hospitals Nurse Director on all professional matters. • The Edinburgh Integrated Children's Services Board was established in July 2015.	3.7
• In West Lothian Health Visiting and School Nursing services continue to be managed as previously with transfer of arrangements from the CHCP to the West Lothian Health and Social Care Partnership. The governance for these services will be through the appropriate NHS Lothian committees.	3.8
• Midlothian Council and NHS Lothian have decided not to include the Council's children's services within the IJB. The Midlothian revised proposals are outlined fully in the accompanying Board paper.	3.9
• In East Lothian, NHS Lothian has agreed to delegate management and governance responsibility for Health Visiting and School Nursing services to the Integration Joint Board (IJB).	3.10
• The future management and governance of Children's Mental Health Services that are currently managed as part of the REAHs will be reviewed during 2016.	3.12

Sally Egan
Associate Director & Child Health Commissioner
20 November 2015
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NHS LOTHIAN

Board Meeting
2 December 2015

Director of Strategic Planning, Performance Reporting & Information

INTEGRATION AND GOVERNANCE OF CHILDREN'S SERVICES IN NHS LOTHIAN

1 Purpose of the Report

The purpose of the report is to:

1.1 Update the Board on the progress in integrating Children and Young People's Services within the City of Edinburgh Aligned Partnership and the recently established Health and Social Care Partnerships in East Lothian, Midlothian and West Lothian.

1.2 Outline the proposed governance arrangements for planning and delivery of children's services in the Edinburgh Aligned Management Directorates and the East Lothian, Midlothian and West Lothian Health and Social Care Partnerships.

2 Recommendations

The Board is asked to acknowledge and approve:

2.1 The recently established aligned management and governance arrangements for the planning and delivery of Edinburgh's Integrated Children's Services as outlined in Appendix 1.

2.2 The proposed management and governance arrangements for the planning and delivery of West Lothian Integrated Children's Services as outlined in Appendix 2.

2.3 The revised proposal not to delegate Midlothian Council Children's Services in Midlothian to the Integration Joint Board but to have an aligned planning and management structure that promotes and delivers integrated children's services through strengthened strategic planning, service planning and partnership working within the governance arrangements for Midlothian as outlined in the accompanying Midlothian paper ***Integration and Governance of Children's Services in Midlothian*** the Children and young People's planning and governance as outlined in Appendix 3.

2.4 The review of the role and remit of the current NHSL Chief Nurse Committee will ensure robust professional governance arrangements are in place that support delivery of integrated children's services in Edinburgh and the Health and Social Care Partnerships.

2.5 The Lothian NHS Board is asked to note:

The agreed management and governance arrangements for the planning and delivery of East Lothian Integrated Children's Services as outlined in Appendix 4.

3 Discussion of Key Issues

3.1 The Children and Young People (Scotland) Act 2014 introduces a range of new duties for Health Boards including undertaking of the GIRFEC, Named Person Service, in relation to children's well-being assessment and statutory child planning for all pre-school children from August 2016.. This legislative function will be the responsibility of the NHS Board and therefore cannot be delegated to IJBs and implementation performance reporting will be through the Strategic Planning Committee of the NHS Board.

3.2 In March 2014 the NHS Board agreed proposals for integration of Children and Young People's Services in the four Lothian Community Planning Partnership areas. The new arrangements included an NHS & City of Edinburgh aligned management structure in Edinburgh with Health Visiting, Family Nurse Partnership and School Nursing management transferring to the NHS Women's and Children's Directorate, with an outline proposal for the creation of a new Children's Integrated Services Board to ensure governance and accountability. In East Lothian, Midlothian and West Lothian it was agreed that services would be managed by the new shadow Health and Social Care Partnerships which have since been established.

3.3 On 4 March 2015 the NHS Board agreed the Lothian Integration Scheme submissions. Children's Health and Council Services were not included in Edinburgh and West Lothian. Health Visiting and School Nursing services were included in East and Midlothian. Midlothian stated the intention to include Children's Social Work services in the future. East Lothian indicated that a future decision would be made on this issue.

3.4 It is important to recognise that the IJB(s) are not committees of the NHS Board, but that the legislation and regulations on integration of health and social care envisages IJBs having a governance role for delegated functions. Work is underway to integrate this role with NHS Board committees to provide appropriate governance without duplication. Full details on the Integration Schemes can be found by following the link below.
http://www.nhslothian.scot.nhs.uk/OurOrganisation/BoardCommittees/LothianNHSBoard/BoardPapers/Lists/BoardPapers/Special%20Board%20Meeting%2004-03-15.pdf

3.5 On 4 March 2015 the NHS Board also agreed proposals to cease the CHP Sub-Committees and the CHCP Boards, in anticipation of establishing the new Integration Joint Boards. It was agreed at this time that the alternative governance arrangement until the establishment of IJBs for Health Visiting and School Nursing services, irrespective of where managed, would be provided through the other NHS Board committees (e.g. Strategic Planning Committee, Staff Governance Committee, Healthcare Governance Committee) with recognition that there would need to be a strengthening of wider children's planning, delivery and governance.

3.6 In May 2015 the NHS Board approved an operational management structure for East Lothian which includes Health Visiting and School Nursing in an integrated Children's Wellbeing structure managed by a jointly appointed Head of Service. In the months that have followed since submission and approval of the Health and Social Care integration schemes and establishment of the IJBs the Director of Strategic Planning, the Child Health Commissioner, the Edinburgh Directors and the Joint Directors have sought to strengthen partnership working across all children

and young people's services to ensure that there is robust children and young people's service planning, delivery and governance mechanisms in all areas of Lothian.

3.7 In August 2015 the management of Edinburgh Health Visiting, School Nursing and Family Nurse Partnership services transferred from the Edinburgh shadow Health & Social Care Partnership to the NHS Lothian Women's and Children's Directorate and these services are managed by the Associate Nurse Director who reports to the Director W&C and through the Acute Hospitals Nurse Director on all professional matters. In accordance with previous proposals, the Edinburgh Integrated Children's Services Board was established in July 2015. The role and remit and a governance structure chart is described and illustrated in Appendix 1, and essentially the health governance remains as was within the NHS Lothian arrangements with the Children's Integrated Board reporting to the NHS Lothian Strategic Planning Committee and the Edinburgh Education, Children and Families Committee.

3.8 In West Lothian Health Visiting and School Nursing services continue to be managed as previously with transfer of arrangements from the CHCP to the West Lothian Health and Social Care Partnership. The governance for these services will be through the appropriate NHS Lothian committees. Strategic planning and development of Children's Services in West Lothian is undertaken through the recently refreshed Children and Young People's Strategic Planning Group that reports to the respective NHS Board and West Lothian Council committees. The Role and Remit and Structure chart is included in Appendix 2.

3.9 Midlothian Council and NHS Lothian have further examined this intention and have now decided not to include the Council's children's services within the IJB. The Midlothian revised proposals are outlined fully in the accompanying Board paper and children's planning governance arrangements illustrated in Appendix 3. Essentially services will be managed by Midlothian Health and Social Care Partnership but governance of Health Visiting and School Nursing services will be through the appropriate committees of NHS Lothian Board and the Midlothian council. A Chief Nurse has also been appointed and reports to the NHS Board Executive Nurse Director on all professional nursing matters.

3.10 In East Lothian, NHS Lothian delegated management and governance responsibility for Health Visiting and School Nursing services to the Integration Joint Board (IJB). Therefore governance for these services will be through the governance arrangements being developed between the IJB and the relevant NHS Lothian committees as illustrated in Appendix 4. East Lothian Council has not agreed to delegate responsibility for Children's Social Work Services to the IJB at this time therefore the governance of these services will be through the appropriate Council Committees and the East Lothian Council. However the line management responsibility for all Health Visiting, School Nursing and Children's Social Work services in East Lothian will be through the recently appointed Head of Children's Wellbeing with operational responsibility for all council services moving to this post by April 2016.. Overall strategic development of Children's Services in East Lothian is through the Children and Young People's Strategic Partnership that reports through the Resilient People Partnership to the Community Planning Partnership Board. Professional accountability for Health Visiting and School Nursing remains with the East Lothian Chief Nurse who reports to the NHS Lothian Executive Nurse Director.

3.11 There will be a refresh of the NHS Lothian Chief Nurse Committee terms of reference is underway to ensure that there is a robust mechanism to ensure corporate approach to implementation of the GIRFEC, Named Person Service, legislative requirements and workforce capacity and planning.

3.12 The future management and governance of Children's Mental Health Services that are currently managed as part of the REAHs will be reviewed during 2016.

4 Key Risks

4.1 There are no key risks identified with the recommendations outlined in this report.

5 Risk Register

5.1 There are no new risks noted from these proposals for NHS Lothian's risk register.

6 Impact on Inequality, Including Health Inequalities

6.1 The local development of Integrated Children and Young People's Community Services should help us address areas of inequality more effectively and efficiently throughout Lothian.

7 Involving People

7.1 Stakeholders have been fully involved in developing plans for integrating children's services including the public consultation on the NHS Lothian Children and Young People's Strategy and the consultation on the four Lothian Integration Schemes.

7.2 Lothian Partnership Forum representatives have been involved and engaged in developing plans for transferring management arrangements and will continue to be fully engaged in developing plans for integrating children's services.

8 Resource Implications

8.1 The development of Integrated Services will be managed within existing budgets. It is anticipated that efficiencies can be achieved through the development of more shared resources and business support functions.

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20 November 2015
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List of Appendices:

Appendix 1: Edinburgh Integrated Children's Services Board –Purpose & Remit
Appendix 2: West Lothian Children's Strategic Planning Structure and Governance
Appendix 3: Midlothian Children's Planning and Governance
Appendix4: East Lothian Structure and Governance Chart

APPENDIX 1

INTEGRATED CHILDREN'S SERVICES BOARD

Purpose and Remit

Background:

The **Integrated Children's Services Board** (ICSB) operates on a consensual basis, similar to the former Joint Board of Governance for adult services in Edinburgh. It builds on and supports the work of the successful Children's Partnership and Partnership Chief Officer Group and has oversight of all children's services within the city of Edinburgh in line with the Community Plan and Integrated Plan for Children and Young People.

(It should be noted that similar developments of integrated children's services in East, Mid and West Lothian will require to be addressed as they arise.)

Purpose

Through the development of appropriate management structures and reporting and monitoring processes, the ICSB ensures a holistic view of all children's services in Edinburgh from universal to specialist and acute services and including transition arrangements for young people moving into adult services.

The ICSB holds senior management within children's health, education and social work in Edinburgh accountable for the delivery of efficient and effective services, improved outcomes for children, young people and families in line with the requirements within the Children and Young People (Scotland) Act 2014.

The ICSB will promote effective and efficient co-production and joint commissioning processes to support service delivery where appropriate.

Remit

The work of the ICSB strengthens existing partnership working arrangements by:

- Maintaining clear oversight of the shared vision for children's services and delivery of the Integrated Plan for Children and Young People
- Ensuring a corporate approach across CEC and NHS Lothian to the delivery of children's health, social work and education services in Edinburgh
- Ensuring compliance with the statutory responsibilities within the Children and Young People (Scotland) Act and fulfilling the expectations of the Care Commission and Joint Inspectorate
- Developing a reporting framework to ensure the accountability of senior managers for their leadership of integrated service delivery across children's health, social work and education services
- Proposing and monitoring resource allocation - within the budgetary resources available to NHS Lothian and CEC - to meet joint service targets and statutory responsibilities in accordance with the Integrated Plan and to meet the requirements of the Children and Young People (Scotland) Act 2014

- Building on – and extending - the important interface with adult treatment and care services in terms of improving transition for young people into adult services and better supporting families

Membership:

Membership of the ICSB comprises:

City of Edinburgh Council:

- 3 x Elected Members
- Director of Children and Families
- Chief Social Work Officer

NHS Lothian:

- 3 x Non-Executive Members
- General Manager for Children's Services
- Child Health Commissioner
- 1x Staff Partnership representative

In attendance:

Voluntary Sector representative (through EVOC) (1)

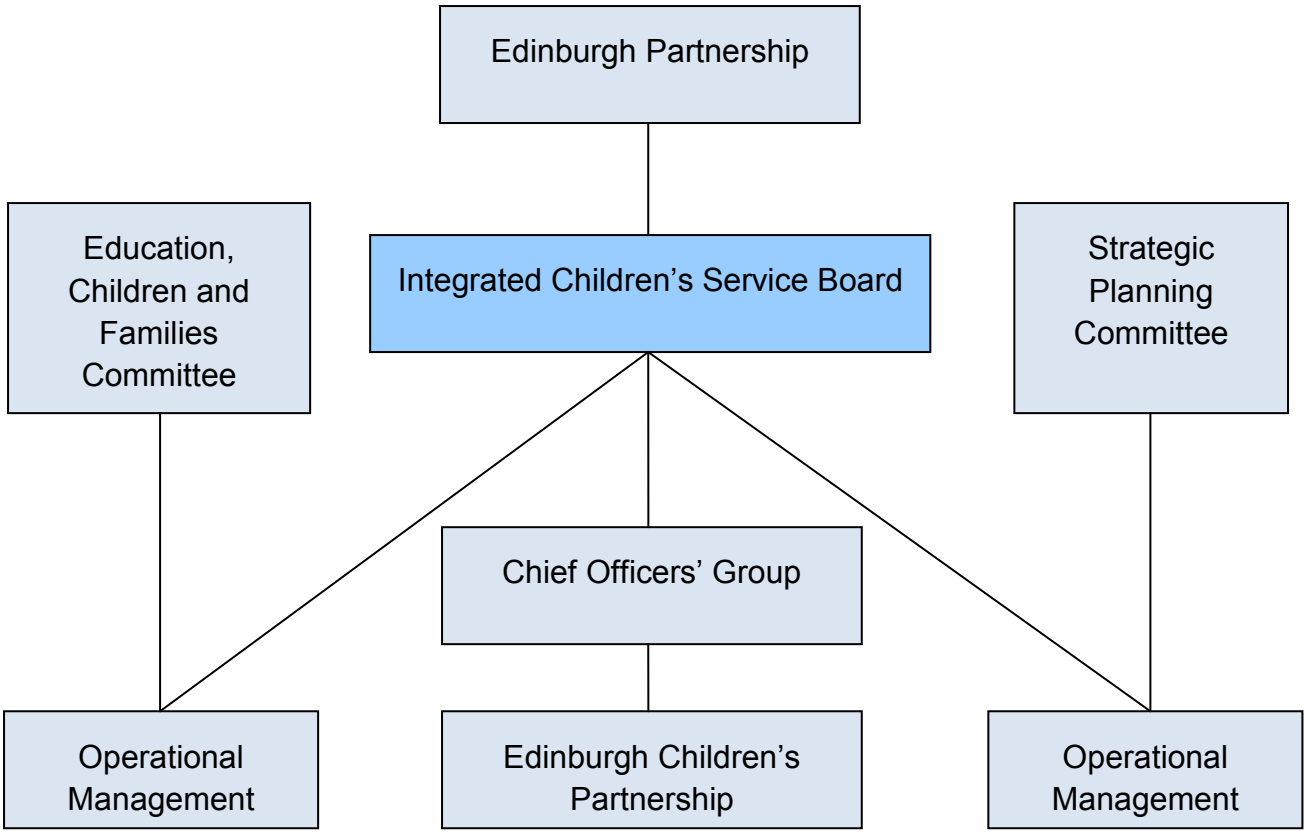
Police Scotland representative (1)

Lead Officers from NHS Lothian and CEC by agreement/as required

Meeting Structure:

- The Chair is agreed by the membership and will rotate annually between NHS Lothian and CEC
- Meetings will be held quarterly
- Secretariat functions will be jointly provided through CEC and NHS Lothian (NHS Lothian Year 1, CEC Year 2 etc)

Structural Relationships:



West Lothian Children's Strategic Planning Group

Governance: Terms of Reference and Membership

Children and Families Strategic Planning Group

A. Remit of the Strategic Planning Group

The focus of the Children and Families Strategic Planning Group is the development of a co-ordinated approach and vision for the delivery and planning of services for children and families in West Lothian and includes:

1. Ensuring the implementation of the Children and Young People (Scotland) Act 2014 and overseeing the implementation of the following components of the Act:

   Part 1 – Rights of Children
   Part 3 – Children's Services Planning (GIRFEC)
   Part 4 – Provision of Named Person (GIRFEC)
   Part 5 – Child's Plan
   Part 9 – Corporate Parenting
   Part 10 – Aftercare
   Part 11 – Continuing Care

2. Overseeing the implementation of the Re-shaping Children's Services Programme.

3. Ensuring the development of the Strategic Commissioning Plan for services for children and young people

4. Ensuring the implementation of the Community Justice Re-design with regards to elements relating to Youth Justice and Early and Effective Intervention.

5. Ensuring the imbedding of and Early Intervention and Prevention Approach to the planning and delivery of services for children, young people and their families

6. Ensuring that progress towards achieving key outcomes is monitored and reported through the Community Planning Process

7. Acting as a conduit between community planning partnership and operational activity

8. Ensuring that there are appropriate linkages to other strategic planning groups

9. Acting as a key consultative group for major policy development

10. Developing processes which maintain a regular and effective means of communication between partnerships

11. Supporting and developing shared information and intelligence systems;

12. Promoting joint staff training and development

B. Frequency

The Children and Families Strategic Planning Group will meet on a quarterly basis.

C1. Lead Officer

The Children and Families Strategic Planning Group will be chaired by Jane Kellock, Head of Social

Policy (Interim).

C2. Contact

The Lead Officer will be supported by Sharon Houston, who is the main contact for any enquiries.

D. Governance Reporting

The Children and Families Strategic Planning Group will report to the Community Planning Partnership Board, to NHS Lothian's Strategic Planning Committee and Health Governance Committee and West Lothian Council's governance structure – Policy Development and Scrutiny Panel and the Council Executive.

E1. Membership Profile

Participants are chosen to provide the relevant knowledge and expertise to fulfil the remit of the Children and Families Strategic Planning Group. Representation on the Strategic Planning Group will be drawn from council services, NHS Lothian, SCRA, Prison Services, Police Scotland Third and Private sector.

This will include:

- Heads of Service to enable key change
- NHS Lothian Child Health Commissioner
- Community Planning Manager
- Chairperson of Senior Officer Review Group
- A representative of the Child Protection Committee
- Senior Officer of Police Scotland
- Representative from SCRA
- Director of HMP Addiewell
- Relevant third sector managers
- Senior Managers WLC
- NHS Public Health, Child Protection and Senior Operational Manager

NOTE: The Integrated Joint Board is responsible for school nursing and health visiting as a delegated function and professional governance for all NHS staff sits with the Health Care Governance Committee

APPENDIX 4

CHIEF EXECUTIVE NHSL

CHIEF EXECUTIVE ELC

Joint Director

EAST LOTHIAN COUNCIL AND COMMITTEES

NHS LOTHIAN BOARD AND COMMITTEES

IJB

CHILDREN'S SERVICES GOVERNANCE ARRANGEMENTS

Head of Access and Older People / Chief Nurse

LUCS (GP OUT OF HOURS LOTHIAN WIDE)

Service Group – Hospitals and Care Homes

Service Group – Access and Prevention

Service Group – Primary Care

Head of Adult Services / Chief Social Work Officer

Service Group – Mental Health, Drugs and Alcohol, Criminal Justice

Service Group – Complex Care

Cross Cutting Functions (decisions to be made on structure)

Adult Social Work Service

OT Service

Public Protection

Clinical Director

Head of Children's Wellbeing

NHS SERVICES

Service Group - Health Visiting & School Nursing

ELC SERVICES

Service Group - Protection and Family Support

Service Group- Long Term Care & Support

Service Group - Child Protection

CHILDREN'S SERVICES PLANNING

EAST LOTHIAN PARTNERSHIP

RESILIENT PEOPLE PARTNERSHIP

CHILDREN AND YOUNG PEOPLE'S STRATEGIC PARTNERSHIP

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NHS LOTHIAN **2.13**

Board Meeting
2 December 2015

Chief Officer, Midlothian Integration Joint Board

INTEGRATION AND CHILDREN'S SERVICES IN MIDLOTHIAN

1 Purpose of the Report

1.1 This report advises Lothian NHS Board on the proposed development of closer partnership working between NHS Lothian and Midlothian Council Education and Children's Services.

2 Recommendations

2.1 The Board is asked to note and endorse

1. The proposal not to seek to include Children's Services in the Integration arrangements in Midlothian.

2. The proposal to review and strengthen the governance and strategic planning arrangements for Midlothian Children's Services**.**

3. The proposal to strengthen local management arrangements for children's health services.

4. The proposal to design a new lifetime service for children and adults with severe and complex needs.

3 Discussion of Key Issues

3.1 Integration of Health and Social Care

The Public Bodies Act (2014) requires that Councils and Health Boards establish formal integrated arrangements for health and social care. The regulations prescribed a number of functions which must be subject to these new arrangements. The regulations also give some local discretion about additional services which could be included in the integration arrangements. Midlothian Council has agreed that Criminal Justice Services should be included as a delegated function**.**

3.2 Children's Services

In developing the local arrangements for the integration of health and social care, Midlothian Council and NHS Lothian agreed to approve, in principle, the possible inclusion of both Children's Services in the Partnership's remit, at an appropriate time in the future. A report to the Board on 3rd December 2014 indicated that "In Midlothian and East Lothian it is the intention that children's (social care) services will be delegated to the Integration Joint Board (IJB) at a later date as part of a second phase of integration. This will require a revised Scheme to be resubmitted to

Scottish Government for approval during 2015/16" The initial proposed timescale for Children's Services moving to become part of the integration structure was April 2016 allowing some time for the new Adult Care arrangements to become established. In Midlothian the possibility of the inclusion of Children's Services (social care) in the integration arrangements is complicated by the fact that Education Services cannot be delegated to an Integration Joint Board. In Midlothian a decision to include Children's Services would pose a significant challenge to sustaining the benefits of the well-established integrated structure of Children's' Services and Education**.**

The Board agreed on 4 March 2015 to delegate school nursing and health visiting to Midlothian IJB in the first phase rather than phase two as had been originally planned.

3.3 **Developments 2014/15**

New Legislation**:** In 2014 the Children and Young People's Act was enacted. This brought additional responsibilities to services for children particularly in relation to delivering the "named person" provision across education and health. In addition, within Education and Children's Services particularly the CYP Act has brought significant changes, for example; Children and Young People are entitled to stay in Care until age of 21;provision of a single child's plan; provision of nursery placements for 2 year olds; further support to Kinship Carers; and provision of Corporate Parenting Support**.**

Establishment of IJB**:** The complexity of the arrangements for the establishment of Integration Joint Boards, prescribed in regulations has resulted in a delay in full implementation. While the Midlothian IJB has been formally constituted, meeting for the first time on 20 August 2015, it will not assume full delegated responsibility for Health and Care until its Strategic Plan comes into effect in April 2016.

3.4 **Future Proposals**

3.4.1 The proposal to consider the inclusion of Children's Services in the new integrated arrangements for adult care was based upon a judgement that the need for closer working between Children's Services and Health Services was equally important to those arrangements planned in adult care. Whilst the need for strong partnership working remains a priority, given the potential risk of weakening the working relationships between Education and Children's Services, it is proposed that alternative approaches rather than formal integration be pursued. These are as follows**:**

3.4.2 One step will be to seek to develop stronger governance arrangements for all Children's Services across health and council services through the existing GIRFEC Board which reports in to the Community Planning Board (see Appendix 1).

3.4.3 In light of the changes to local and Lothian-wide management arrangements for health services arising from Integration, a review is required to ensure that the delivery of Children's Health Services in Midlothian is robustly coordinated**.**

3.4.4 One key aspect of joint working between adult and children's services relates to services to children with severe and complex needs. It is proposed that that specific

work is undertaken to consider the benefits and viability of establishing a lifelong integrated service to ensure a smooth transition to adult services. It is important to consider the impact on health services within this planned redesign.

4 Key Risks

4.1 While close working between health, education and children's services is vital there is no simple structural solution available. The legislation does not permit Education's inclusion in formal Integration arrangements. The current organisation of children's services and education sitting within the same Council Directorate would have to be disassembled and there is a risk that the progress made over the last five years would be disrupted and weakened through more structural change.

5 Risk Register

5.1 Risks associated with this report will be addressed within the local risk register systems in Midlothian.

6 Impact on Inequality, Including Health Inequalities

6.1 There are no immediate proposals for service redesign in this report which would impact on inequality. Any specific proposals such as the option of designing a whole-life service to children (and adults) with complex needs will be subject to an impact assessment.

7 Involving People

7.1 Midlothian Council has been involved and is supportive of the proposals in this report.

8 Resource Implications

8.1 There are no resource implications arising from this report. The intention is to design new arrangements which are cost neutral

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12 November 2015
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List of Appendices

Appendix 1: GIRFEC Governance Chart

NOTE: The Integrated Joint Board is responsible for school nursing and health visiting as a delegated function and professional governance for all NHS staff sits with the Health Care Governance Committee

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