BOARD MEETING

DATE: **WEDNESDAY 3 AUGUST 2016**

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 22 June 2016	**BH**	*
1.2.	Running Action Note	**BH**	*
1.3.	Acute Hospitals Committee - Minutes of 7 June 2016	**KB**	*
1.4.	Audit & Risk Committee - Minutes of 20 June 2016	**JMcD**	*
1.5.	Healthcare Governance Committee - Minutes of 24 May 2016	**RW**	*
1.6.	Strategic Planning Committee - Minutes of 9 June 2016	**BH**	*
1.7.	Staff Governance Committee - Minutes of 30 May 2016	**AJ**	*
1.8.	Area Clinical Forum Proposed Constitution	**AM**	*
2.	**Items for Discussion** (subject to review of the items for approval) *(9:35am - 12:00pm)*		
2.1.	Corporate Risk Register	**DF**	*
2.2.	Medical Paediatrics Review - Update	**JC**	*
2.3.	Financial Position to June 2016	**SG**	*
2.4.	Quality & Performance Improvement	**AMcM**	*
2.5.	Healthcare Associated Infection	**DF**	*
3.	**NHS Lothian Realistic Medicine Board Seminar:** 18 August 2016 at 12:00 p.m. in the Boardroom, Waverley Gate.		

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

For further information please contact Peter Reith,☎ 35672, ✉ peter.reith@nhslothian.scot.nhs.uk

4. **Next Development Session:** 7 September 2016 at 9:30 a.m. in the Boardroom, Waverley Gate.

5. **Next Board Meeting:** Wednesday 5 October 2016 at 9:30 a.m. in the Boardroom, Waverley Gate.

6. Resolution to take items in closed session

7. Minutes of the Previous Private Meeting held on 22 June 2016 **BH** ®

8. Matters Arising

9. Business Cases

   9.1. Combined Business Case - East Lothian Community Hospital **SG** ®

   9.2. Initial Agreement for Cancer Services Bridging Programme at the Western General Hospital, Edinburgh **JC** ®

   9.3. Initial Agreement - Replacement of NHS Lothian Telephony System **AMcM** ®

   9.4. Royal Edinburgh Hospital Phase 1 **SG** ®

10. Preparations for the 2016 Annual Review **AMcM** **v**

11. Any Other Competent Business

Board Meetings in 2016

5 October 2016
7 December 2016

Development Sessions in 2016

7 September 2016
2 November 2016

Board Meetings in 2017

1 February 2017
5 April 2017
21 June 2017*
2 August 2017
4 October 2017
6 December 2017

Development Sessions in 2017

11 January 2017
1 March 2017
17 May 2017
19 July 2017
6 September 2017
1 November 2017

*Annual Accounts Meeting

DRAFT

1.1

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 22 June 2016 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mr M Ash; Councillor D Grant; Councillor R Henderson; Mr M Hill; Mrs C Hirst; Mr P Johnston; Councillor C Johnstone; Mr A Joyce; Mrs J McDowell; Mrs A Mitchell; Mr P Murray; Mr J Oates; Mr G Walker and Mrs L Williams.

Executive and Corporate Directors: Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Mr J Crombie (Chief Officer); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health & Health Policy); Professor A McMahon (Executive Nurse Director / Director of Strategic Planning, REAS & Prison Healthcare) and Dr S Watson (Chief Quality Officer).

In Attendance: Dr E Doyle (for item 20), Dr D Shortland (for item 20), Dr B Stenson (for item 20) and Mr D Weir.

Apologies for absence were received from Mrs S Allan, Mrs K Blair, Councillor H Cartmill, Mrs A Meiklejohn, Dr R Williams and Professor M Whyte.

Welcome and Introduction

The Chairman advised that Councillor Frank Toner had stepped down from the Board and thanked him for his years of service. Councillor Harry Cartmill who would replace Councillor Toner as the West Lothian Council Stakeholder member on the Board was welcomed in his absence.

Professor McMahon was welcomed to the Board in his new capacity as Executive Director of Nursing.

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.

14. Items for Approval

14.1 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. No such requests had been made.

14.2 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.

14.3 Minutes of the Board Meetings held on 6 April and 11 May 2016 – Approved.

14.4 Running Action Note – Approved.

14.5 Audit & Risk Committee – Minutes of 18 April 2016 – Endorsed.

14.6 Finance & Resources Committee – Minutes of 4 May – Endorsed.

14.7 Healthcare Governance Committee – Minutes of 15 March 2016 – Endorsed.

14.8 Strategic Planning Committee – Minutes of 24 March and 14 April 2016 – Endorsed.

14.9 East Lothian Integration Joint Board – Minutes of 25 February, 31March and 31 April 2016 – Endorsed.

14.10 Edinburgh Integration Joint Board – Minutes of 11 March and 13 May 2016 – Endorsed.

14.11 Mid Lothian Integration Joint Board – Minutes of 11 February, 17 March and 14 April 2016 – Endorsed.

14.12 West Lothian Integration Joint Board – Minutes of 23 March, 31 March and 5 April 2016 – Endorsed.

14.13 Schedule of Board and Committee Meetings for 2017 – The Board agreed the dates for Board and Committee meetings in 2017.

14.14 Committee Memberships and Terms of Reference – The Board agreed to appoint Lynsay Williams to the West Lothian Integration Joint Board, replacing Julie McDowell.

14.15 To Appoint Susan Goldsmith to West Lothian Integration Joint Board, replacing David Farquharson.

14.16 To nominate Martin Hill as Vice Chair of the West Lothian Integration Joint Board.

14.17 To confirm Peter Johnston as Vice Chair of the Finance and Resources Committee and ex-officio member.

14.18 To confirm Richard Williams as Chair of the Healthcare Governance Committee from 1 February 2016.

14.19 To agree amended Terms of Reference for the Finance and Resources Committee.

14.20 To agree amended Terms of Reference for the Acute Hospitals Committee.

15. NHS Lothian Patient Private Fund – Annual Accounts 2015/16

15.1 The Board agreed the draft Patient Private Fund Accounts for the year ending 31 March 2016 and agreed that the Chairman and Chief Executive sign the 'statement of Lothian NHS Board member's responsibilities' on the Boards behalf.

15.2 It was also agreed that the Director of Finance and the Chief Executive sign the abstract of receipts and payments' (SFR 19.0).

15.3 The Board also agreed to approve the Draft Patients Private Funds accounts for the year ending 31 March 2016.

16. Items for Discussion

16.1 Annual Report and Accounts for the Year Ending 31 March 2016

16.2 The Board noted that the draft annual accounts were subject to separate confidential circulation with the Board papers as they could not be presented in any public domain until laid before Parliament. This had been confirmed by officers within the Scottish Government Health and Social Care Directorate (SGHSCD). Copies had also been circulated to members of the Audit Committee for the meeting held on 20 June 2016.

16.3 The Board noted that the Audit and Risk Committee at their meeting held on 20 June 2016 had considered and approved the annual accounts and had recommended an amendment to the Governance Statement a copy of which was circulated to Board members. The Audit and Risk Committee had highlighted the need to strengthen the assurance process within and between Board Committees and this work would be taken forward through the course of the forthcoming year.

16.4 Members of the Board approved and adopted the annual accounts for the year ending 31 March 2016.

16.5 Members of the Board authorised the designated signatories (Chief Executive, Chair and Director of Finance) to sign the accounts on behalf of the Board, where indicated in the documents. Members of the Board also authorised the Chief Executives signature on the representation letter to the Auditors, on behalf of the Board.

17. NHS Lothian Corporate Risk Register

17.1 The Board noted the new style of report was now shorter in an attempt to reduce duplication with other Board papers. The new style of paper was endorsed by Board members with it being recognised that it picked up some of the issues including risk being worked on as a consequence of work being undertaken by the Corporate Governance Manager.

17.2 The Board were advised that table 1 in the report linked to the Quality and Performance Improvement Report that would be discussed elsewhere in the meeting. It was reported that the Audit and Risk Committee as part of its review of the risk tolerance measures relating to stroke had agreed to recommend to the Board a revised stroke appetite / tolerance measure from just stroke unit to total bundle compliance with a bundle appetite of 80% and tolerance of 75% from April 2016 to March 2017.

17.3 It was reported that the hospital associated infection rate had been achieved in April but not in May. It was recognised that there was bound to be differences in performance throughout the year and the data reported in the Board paper related only to the first two months of the year. It was suggested that a more robust data trend would be available for reporting at the August Board meeting. It was noted that it would be useful to have data reported on a moving average basis over 6 months given that it was not a month on month achievement.

17.4 The Chairman commented that the revised paper linked to the risk register, performance report and Board Governance Committees and demonstrated a better approach to managing risk and performance and albeit still work in progress the paper was a further step in the process of defining the governance process.

17.5 Assurance was sought around the stroke position that one target was not being substituted for an easier one. The Board were advised that the new target meant that NHS Lothian was moving into line with other Boards and that the target had increased from 70% to 80% because it had been felt that a sustained 70% delivery level had been achieved. The data related to performance between February and March 2016 and the target had therefore been achieved. It was agreed that future reports would make the measurement timescale clear. The point was made that the way in which bundled compliance was calculated did not make it easy to understand.

17.6 The Board noted that although the paper did not include a relationship between the corporate risk register with Integration Joint Boards (IJBs) that this would be an aspiration for the future. It was noted that the medical manpower reference to paediatrics at St John's Hospital had featured in the paper because it was topical for the current meeting although there were other medical manpower areas where difficulties were being experienced and these had previously been reported to the Board. The St John's reference had been intended to be a signpost comment rather than a comprehensive statement.

17.7 The point was made in respect of table 1 and the 4 hour access target that this referred to a risk tolerance of 5% of target. The improvement interim target was 95% and NHS Lothian performance had been at 93.3% so ergo within tolerance.

17.8 The Board agree the recommendations contained in the circulated report and agreed that the revised format of the Board paper was helpful.

18. Financial Position to 31 May 2016

18.1 The Board noted that there had been a marginal improvement in the financial plan forecast in respect of income and expenditure. It was noted the financial performance was off trajectory at month 2 with it being felt to be too early to make any year end predictions based on the data available to date. The main drivers for the current overspend were explained. It was noted that although no prescribing data was yet available that it was anticipated this would be a continuing pressure.

18.2 It was reported given there remained a gap between income and expenditure that there would be a need at some point following the quarter 1 financial review to come back to the Board to look at high risk schemes. Work continued with other Health Boards on national schemes although it was unlikely that there would be any financial benefit for NHS Lothian for 2016/17 largely because most of the issues being discussed nationally were already happening in Lothian.

18.3 Dialogue continued with the SGHSCD (Scottish Government Health & Social Care Directorate) around the Local Delivery Plan and the financial plan with it being noted that these had not yet been signed off although correspondence was expected soon. The Board noted that the SGHSCD had undertaken to look at the provision of an additional NRAC (National Resource Allocation Committee) contribution although this would not be at the level of £19m. It was anticipated details of the quantum of the contribution would be known by the end of the month.

18.4 The Board noted that work continued with Directors and managers to attempt to work within budget. It was reported that as the Board had not delivered a balanced financial plan in the current year that there was an increased need to rely on management actions. It was noted at this stage that the Board could not be given assurance about the achievement of year end financial balance. Consideration would be given to the possible factoring in of the 1% of reserves as part of the quarter 1 financial review process.

18.5 The Board were advised that although the new clinical quality approach would anticipate improvements in service both in terms of patient care and efficiency that no gains had yet been assumed in the financial plan. The 21 projects were being looked at as part of the Healthcare Academy work in order to identify areas of likely savings with some early indications emerging. The point was made specialties were being looked at in terms of measuring and reducing unwarranted variation and cost and if a reduction of 5% could be achieved in variation and waste then this would reduce the number of patients breaching the 12 hour target as well as other benefits in resource and patient outcomes although it would not result in a cost reduction. There remained a need to focus on issues that would reduce cost.

18.6 The Board were advised in terms of the quality management approach to the measurement of savings that in the past the NHS in general measured economies of scale meaning that the benefits of small initiatives had gone under the radar.

Cutting edge work was now underway to consider how to measure these and feed this into the financial plan.

18.7 The question was raised about how to get more successful delivery of the £20.4m of recovery plans identified as low and medium risk. It was reported in previous financial years the view had been taken to apply savings of the same amount across all budgets. In the current year a different approach had been applied to leave pressures in the original part of the service with each part of the system being required to mitigate these and identify other savings with a view to operating within resource limits. This approach had been broadly welcomed with it being anticipated that the additional management ownership would provide a better financial focus.

18.8 In response to a question it was reported in relation to additional cost pressures over and above those identified that additional pressures would in all likelihood emerge because of the size of the organisation. It was hoped that time spent with Directors and managers and the resultant increase of ownership of budgets would help to mitigate and minimise this eventuality although issues always emerged despite increased engagement.

18.9 The Board were advised that the current financial issue around junior doctors was surprising. A cost pressure had arisen in 2015/16 relating to rota compliance; fill rates and elements of support provided to junior doctors and nurse specialists. This pressure had continued into 2016/17. A new process had been established where junior doctors and managers paired up to work closer together. Additionally a group of junior doctors were coming together to look at issues like safer sustainable cover and waste variation. The Quality Improvement Programme was starting to reach out to junior doctors and it was felt that this would be a pathway to improvement.

18.10 It was noted that acute drug budgets now had more Clinical Director and Associate Medical Director focus around spend in this specific area. In forthcoming months it was expected there would be a real evidence of improvement through addressing issues like variation although high cost medicines would continue to remain a problem.

18.11 The question was raised in respect of the £20.1m gap in the financial plan whether this would be notionally allocated across areas until an agreement around the sum was reached with the SGHSCD and whether this allocation would be on a pro-rata basis around the set-a-side acute budgets. It was reported that changes to the set-a-side budget would need new IJB Directions. In response it was reported that the £20.1m would not be allocated and would sit where it landed as it was effectively an expenditure forecast against the income baseline. Non recurrent resource had already been allocated against prescribing and acute drugs. It was confirmed that the set-a-side budget and hosted services would have a share of the shortfall as discussed at Joint IJB/ NHS Lothian meetings.

18.12 The Board noted that the issue had been discussed at the Acute Hospitals Committee earlier in the week. A clear correlation had been evident between the ability to generate efficiency savings based on how acute and primary care sectors worked to achieve a reduced length of stay linked to discharging patients for assessment which would free up acute beds. If the system delivered on the

delayed discharge targets then this would facilitate the reduction in beds needed to release resource. The caveat however was that bed numbers could only be reduced if actual improvements happened in areas like length of stay and delayed discharges. There was a significant opportunity cost of failing to deliver delayed discharges and the inability to close beds.

18.13 The Board noted that IJBs were effectively commissioning bodies and allocated resource through Directions. The ideal situation would be that NHS Lothian and the IJBs would right what was currently wrong through Directions although it was stressed that quality and safety would always trump any decisions made by a commissioning body and that Directions would not be slavishly followed if these were out of sync with the Boards risk register. The focus of NHS Lothian and the IJBs should be to demonstrate improvements in issues like delayed discharges and length of stay as well as focus on other areas of service sustainability.

18.14 The question was raised about whether details would be available for the August Board meeting about inroads being made around the savings target. It was noted that this position had not yet been reached and that all parts of the system were looking at eliminating the deficit. The quarter 1 financial review would provide further intelligence although it would not eliminate the position.

18.15 It was encouraging that the Finance Directorate were able to demonstrate that they understood the cost base. The point was made that if the current data was annualised then this would equate to a £26.4m overspend at the year end. The question was raised at what point the high risk savings schemes would come forward to the Board accompanied by thorough analysis and plans. The suggestion was made that there was a need to deliver the balance at the end of the second quarter financial review. An issue was raised around the nursing overspend and the agency and bank spend position. There was a concern that bank spend might not reduce with the suggestion being made that this might be appropriate given the flexibility that it provided. It was not felt to be realistic to entirely eliminate spend in bank and agency.

18.16 The Board noted in respect of high risk schemes that following consideration of the quarter 1 financial review that a series of detailed performance meetings would be held with Directors and Senior Managers to address all of the high risk schemes. It was noted that dialogue continued with the SGHSCD and that the current focus was on the small number of Health Boards at risk on not delivering their financial position. It was noted that ongoing future discussions with the SGHSCD would include debate around high risk schemes like bed closures which if they went ahead would be back loaded towards the end of the financial year resulting in a smaller cost saving in-year. Part of the dialogue with the SGHSCD would be about how the benefit of the cost savings sat against care provided and the possible impact to patients over the winter period.

18.17 The Board were advised that the application of the 1% reserve along with the possible increase in the NRAC contribution would make a significant impact on the financial bottom line. It was noted that following discussions with the SGHSCD about accelerating some schemes reference would be made back to the Board about the impact of high risk schemes. It was noted that currently it was not possible to have that dialogue.

18.18 The Board were advised that NHS Lothian was not at NRAC parity and active and productive discussions were being held with the SGHSCD about a 3-5 year review around what the final financial position might look like. However it was not yet felt to be possible to come to the Board in the near future with radical solutions for high risk schemes.

18.19 The Board noted that targets had been set to eradicate nurse agency spend with currently services only being provided in relation to critical care and theatres where staff were otherwise unavailable. National work was underway in this regard. It was reported as a consequence of the move away from agency spend there had been a resulting move back to bank usage largely because nurse vacancies were not being filled. Initiatives were underway to improve the backfill position including nurse recruitment and open days, a focus on the management of single days of sickness absence (£1m benefit) and the management of annual leave (£2m benefit). All initiatives were focussed on retaining quality and safety.

18.20 The Chairman with reference to participation in national schemes commented if NHS Lothian was not obtaining benefit then consideration should be given to withdrawing resource. He also questioned why benefit was not being obtained from these schemes. It was confirmed in response that NHS Lothian was currently providing financial and other resource into the national programme. It was felt that the challenge was that too many people were involved in schemes which resulted in them losing focus. In addition there was a lack of focus on areas that would deliver savings across Scotland. This position had been discussed at the National Chief Executive Group meeting where the need for improvements around issues like imaging and laboratories which would provide national savings were referenced. The Director of Finance at the SGHSCD had been remitted to reconsider schemes where future focus should be directed.

18.21 The Chairman commented that NHS Lothian as a Board should apply upward pressure through Chairs, Chief Executives, Director of Finance and Medical Director etc meetings to effect change. He felt it was unacceptable not to receive a contribution from national schemes.

18.22 A point was raised about whether there were any national discussions around shared services. It was noted that there had been discussion but the process lacked ownership and direction which was a significant gap in the model. The Board were advised that currently there was a gap between rhetoric and reality. A key issue often was the payback period around capital investment and the lack of real savings because of the need to redeploy staff as part of the business case. This often brought into question whether the disruption was worth the risk.

18.23 The Board agreed the recommendations contained in the circulated paper and noted that it was not possible to provide assurance that year end financial position would be achieved at this point.

19. Quality and Performance Improvement

19.1 The Board noted that of the 35 standards that NHS Lothian was assessed against that it was only meeting 11 of these. There was however evidence in the remaining 24 areas that improvements were being made against the national position. It was reported that data continuity issues needed to be taken into account when considering the April position in respect of outpatient and diagnostic waits. It was noted that the Acute Hospitals Committee had been briefed on these areas as well as software problems at the Edinburgh Dental Institute which had led to the exclusion of waits from that location when assessing the overall waiting time position for April.

19.2 The Board noted that during April that standards had been met for both HAI measures although no pro-formas had been included in the Board report. Notification had been received that HAI performance had fallen short of the desired level in May. Pro-formas would be included in future reports to the Board.

19.3 It was reported that clarity was emerging around responsibility for performance standards between the Acute Hospitals Committee and the Healthcare Governance Committee.

19.4 Performance in Child and Adolescent Mental Health Services (CAHMS) had disappointingly deteriorated and a future report would be brought forward to the Board with proposals around the medium to long term position. In terms of drug and alcohol performance this was caveated around ongoing financial discussions including the Alcohol Drug Partnerships (ADPs) and IJBs. This work was considering how to manage and deliver inpatient and community targets.

19.5 The Board noted in respect of the 4 hour access target that for several days the previous week the Western General Hospital had achieved a 100% performance level. In terms of the treatment time guarantee work was being undertaken to identify the implications of withdrawing from the private sector and this would be reported through the appropriate Governance Committees.

19.6 The Chairman commented that the paper represented work in progress and demonstrated linkages with the Governance Committee structure and referenced back to the Boards risk register.

19.7 The point was made that the paper was now in a good format which allowed Board members to understand where performance was not on target. It was noted that the recommendations in the paper invited the Board to accept the report as assurance that performance on 11 measures were currently met. It was felt that for this assurance to be provided that the paper would need a subsidiary action plan which would be tested by the Board Committees in terms of assurance reporting. A request had been made through the Audit & Risk Committee that graded assurance was provided to the Board in future through the Governance Committees along with a clear management view of performance through the Action Plan.

19.8 In respect of CAMHS performance it was reported that discussion at the Strategic Planning Committee had referenced that school teachers were receiving training to pick up early issues in children which could be addressed at a more local level. It

was noted that work was underway with IJBs clarifying responsibilities in this area. Work was also underway to refresh the referral criteria as currently referrals were out stripping capacity. There was also an issue about the number of people involved in the assessment of children. It would be important to look at the total child service resource and how this was deployed to best effect.

19.9 The Board were advised in respect of endoscopy performance that there were two routes into the service. The first was through the diagnostic route via GP referral for cancer concerns which received urgent attention. The second was through national screening programmes like the national bowel screening initiative. The programme resulted in a large number of negative results and there was therefore an issue about the development of criteria before patients were scoped.

19.10 The Board agreed the recommendations contained in the circulated paper subject to 'satisfactory' being removed from recommendation 2.2.

20. Review of Medical Paediatric Inpatient Services in Lothian

20.1 The Chairman welcomed Dr's Shortland, Doyle and Stenhouse to the meeting. He advised that there would be 2 parts to the Board process the first of which would be to receive a summary from Dr Shortland on the process leading to the production of the final Royal College of Paediatrics and Child Health (RCPCH) Report. The second part of the process would involve Mr Crombie presenting the paper to Board members with the Board subsequently being asked to discuss the recommendations.

20.2 Dr Shortland commented that the RCPCH had been approached the previous year by NHS Lothian to undertake an independent review of Medical Paediatric Inpatient Services in Lothian. This had been a complicated review as it had looked at the whole pathway across 3 hospitals and had included engagement with the public as well as considering links between primary and secondary care. The Board noted that the RCPCH was not a regulatory body and could not invoke the report recommendations on the Board. The approach taken had been to benchmark local performance against professional standards and look wherever possible at health outputs. A key consideration when preparing the report was whether NHS Lothian could meet the standards and also whether it would be possible to appoint to the models referenced in the report in terms of doctors, nurses and ancillary workers. In addition it had been considered important to consider whether the preferred model was affordable.

20.3 The Board were advised by Dr Shortland that it had been recognised that NHS Lothian had made superhuman efforts to keep the service at St Johns Hospital open.

20.4 A key issue was around medical staffing in terms of junior doctors, middle grade and consultants. The main problem that the service was facing was the availability of tier 2 middle grade doctors who were crucial for decision making in paediatrics where there was a requirement for patients to be seen by a senior doctor within 4 hours. If middle grade doctors were not available then the responsibility passed to the consultant. Nationally 20% of middle grade staff were out with grade.

20.5 Dr Shortland explained in detail to the Board the difference between the 3 recommendations contained in the circulated paper.

20.6 The Board were advised that the RCPCH Review Team had been impressed with the commitment of staff at the Royal Hospital for Sick Children which was a small tertiary service. It was noted that staffing in subspecialties was an issue. The Acute Recovery Unit was understaffed although plans were underway to address this. It was felt that ambulatory care was not being fully embraced.

20.7 In conclusion Dr Shortland felt that there was a need to provide a safe service and to move away from traditional medical models as the current 3 tier model was not sustainable. There was also a need to embrace ambulatory care. In addressing the St John's Hospital issues it would also be important to maintain tertiary services.

20.8 Mr Crombie commended Dr Shortland and his team for taking this complicated review forward. It was noted that the NHS Lothian proposed response was detailed in the paper circulated with the agenda for the meeting. It was stressed that the review process had been Lothian wide with all affected hospitals being part of the review process.

20.9 The Board noted that a remarkable process of public engagement had been undertaken including an online survey which had been accessed by more than 2000 responders with a significant number of people having signalled interest in participating in the public engagement meeting. Additionally there had been engagement with the 4 local authority stakeholders through public meetings held in each area in Lothian in order to obtain public views on how best to take the service forward.

20.10 The Board noted that the paper addressed the specific recommendations made by the RCPCH for the St John's Hospital workforce as this was the pressing issue. It was advised that the raft of other recommendations made in the report would be subject to further detailed discussion.

20.11 The Board were advised that it was being proposed that option 1 be vigorously pursued as this was the correct decision and if implementable would provide a safe and sustainable service. The complexities of moving to this position should not be underestimated and the RCPCH report had elegantly stated that this would not be a solution that could be achieved overnight and would take a few years to implement. The constitution of option 1 would mean that there would need to be a resident consultant workforce.

20.12 It was noted that under the current national consultant contract that NHS Lothian could not compel existing consultants to work to a resident consultant model. The next step in implementing the RCPCH recommendations would to be engage with the St John's Hospital Consultant Group to determine what changes in support of a consultant model were mutually agreeable. The importance of securing the agreement of the consultant workforce to provide routine out of hours cover to deliver option 1 successfully could not be over stated.

20.13 The proposal was made to approve that while the staffing infrastructure for option 1 was being developed, the RCPCH interim solution, option 2, or a variation of this option agreed with St John's Hospital Consultant Team be implemented. It was advised that whichever interim model was agreed there would continue to be a 24 hour inpatients service at St John's Hospital but that this must demonstrate a reduced risk of an unplanned service collapse, stop the reliance on staff having to work excessive hours to cover locum shifts and end treble time payments to staff for this work. The Board were advised that this interim position would be put in place from the end of August 2016. It was noted that consultants had demonstrated a willingness to support a modification of option 2 and work was in progress to develop an option 2+.

20.14 The Board noted that the RCPCH report highlighted the growing pressure on the medical paediatricians at the Royal Hospital for Sick Children (RHSC) specifically the rising number of admissions through the acute receiving unit (ARU) service which had insufficient consultant staff to meet the demand and to meet the College standards for acute paediatrics set out in 'Facing the Future' 2015. The Board were therefore being recommended to make immediate additional investment in consultant staffing for the medical paediatricians/ ARU service at the RHSC.

20.15 As part of the response to the RCPCH report the Board was being asked to approve the proposal to appoint a Non Executive Board lead to Chair a Paediatric Programme Board which would take forward the reports wider recommendations about strategy, workforce, patient focus, infrastructure, safe guarding and governance.

20.16 The Board were advised that an initial assessment of the financial resources needed to deliver option 1 would be around £1.5m although some of this would already be spent and it was important that the position was known from the outset.

20.17 Mr Crombie concluded by emphasising the level of engagement undertaken to help people to understand the review and its aspirations to provide safe and sustainable paediatric services. It was noted that the report before the Board was the start of a journey and would require arduous work which would extend over the next few years. Mr Crombie commended the report to the Board.

20.18 The point was made that whilst the report and summaries had been succinct that there was a concern about timescales for implementation of the recommendations. It was pointed out whilst there had been heroic efforts in the past to keep the St John's Hospital Service open that on occasions this had been unsuccessful. The Board were advised that Mr Crombie had reflected on this point and felt that the timeframe was viable and this would be enhanced by developing measureable time points into the process around issues like recruitment which would be reported back to the Board as part of the assurance process. The creation of the Programme Board Chaired by a Non Executive Board member would provide governance assurance.

20.19 Mr Johnston commented that he welcomed the report and the clear outcome of the independent review process and potential solution. He advised however that he had major reservations about recommendation 2.4 in respect of option 2. He felt there was a need for a clear difference between option 2 and the position in place

when St John's Hospital services had temporarily closed. He pointed out that St Johns did not admit children between 8pm and 8am and this did not constitute a 24/7 service. He was also concerned about the need to maintain neonatal provision. Mr Johnston sought advice on what the clinical view was around the viability of option 2 as a safe and sustainable solution.

20.20 The Board were advised that the difference between option 2 and the position in place during the previous summer closures was that the ward would remain open for children with treatment plans in place which would result in the provision of a paediatric inpatient ward. The situation would be that post 8pm the service would see the transfer of children to the RHSC to allow consultant level assessment to happen. It was noted that when options had been discussed with clinicians they did not want to move to option 2 but preferred the proposed move to option 1. It had been agreed whilst the system was looking to progress to option 1 that they would consider moving to an option 2+ whilst noting the impact on recruitment.

20.21 Mr Johnston commented that the verbal explanation of option 2 was different from what was described in the Board paper. He sought assurance around the timeline of the end of August 2016 for the implementation of option 2.

20.22 The Chief Executive commented that if the RCPCH report recommendation around option 1 was accepted then this would take some time to deliver. Whilst option 1 was being pursued it would be prudent to move to an interim position of implementing option 2. If it was possible to influence the consultant body around job planned resident on-call rotas to provide appropriate cover then option 1 would be pursued vigorously although it was important to recognise these assurances were not currently in place. The Board were assured if between now and the end of August possibilities emerged around an enhanced option 2 model then this would be progressed. It was noted that currently consultants were keen to be included in debate and that this process would continue. Mr Johnston commented he was concerned if consultants did not support option 2 and had issues around a move to a variation model. The Chief Executive reminded the Board that one of the reasons for undertaking the RCPCH review process had been it produced options not previously considered which would maintain a 24 hour service and minimise the impact on patients who were stable and with treatment plans in place.

20.23 The Board were advised by Dr Doyle, Associate Medical Director for Women and Children's Services that option 2 or option 2+ was a viable proposition and that extended hours could be written into job plans and this could include options about extending admittance hours later into the evening. It was noted that option 2 could be delivered with little additional financial cost. The Board were advised that although consultants would prefer that option 1 was implemented that it was felt that option 2 would be a suboptimal interim solution.

20.24 It was noted that paediatricians could provide cover to neonatal services but not the other way round given the current levels of staffing. It was reported that currently there was insufficient staff to provide services on a 24/7 basis for neonatal services nor was there a safe out of hours alternative. In extremis the contingency for paediatrics was through the RHSC. The point was made however if the 24/7 consultant and paediatric advanced nurse practitioner workforce model could be delivered then this would be capable of covering the neonatal service.

20.25 The point was made by a Board member that the staff body were not supporting option 2 because they wanted to move to option 1 which was encouraging. It was pointed out however that NHS Lothian worked within the national perspective and this needed to be a realistic position given that the RCPCH report itself commented that achieving option 1 would take a number of years. On that basis option 2 was supported as a interim move with a view to moving towards an option 2+ position.

20.26 A question was raised about the implementation of option 1 given the previous comments about there being more jobs than consultants in the UK. In that regard consideration needed to be given to making the Lothian job as attractive as possible particularly in respect of on-call commitments. The question was raised about how the Board would know that work towards implementing option 1 was proceeding on track and in line with a critical path analysis approach. The question was also raised about whether any other part of the country had attempted to move to an option 1 model and failed.

20.27 Dr Shortland commented that it was important to recognise that 2% of units would close year on year largely because of the lack of staff. He stressed that the factor that made option1 work was that consultant staff signed up to the resident on-call model in their totality. He commented that the job model would not work if the job intensity was wrong. It was noted that in general clinical staff liked the model as it provided a work life balance. The Board discussed the attractiveness or otherwise of different rota options. It was noted however that to date consultants had not committed to the resident rota requirement. High level discussion would however continue.

20.28 The Chief Executive commented that a different approach from that adopted in the past was now needed. He stressed if the Board accepted the report recommendations then it would be fully endorsing the intent to deliver option 1 subject to obtaining the agreement of consultants to the resident rota. Moving to option 1 would make the service more attractive in recruitment terms and would avoid a two tier rota being in place. It was noted that elsewhere in the country option 1 had been achieved and sustained because consultants and other staff were keen for services to remain open. The successful implementation of option1 was therefore dependant upon the will of the workforce.

20.29 In terms of assurance to the Board that timelines etc for the implementation of option1 were being delivered it was recognised that the Board would want to pay close attention to progress and receive regular reports. It was noted that the management cohort implementing the move towards option 1 would not expect an open ended commitment from the Board to timelines and finance.

20.30 Dr Shortland in response to a question about whether the College would have recommended option 1 if it had felt that consultants would not sign up to the resident on-call rota advised that an assumption to sign up had been a key component of recommending option1. If consultants did not want to travel down that route then a version of option 2 might well have been the preferred model. He commented that the obstetric issue was a key one to the debate. Dr Shortland stressed that the success of option 1 was dependant upon consultant sign up.

20.31 The question was posed in terms of implementability what additional services would need to be provided around a resident consultant model to make it attractive in order to allow services to be provided differently in a way that would be covered by staff availability. Dr Shortland advised that there was published documentation that covered this issue and that in general people would not do more than 40% on resident cover as this allowed other work to be undertaken. If all staff groups signed up to a residential on-call rota then this removed the previous stigma around resident on-call rotas.

20.32 The Chief Executive stressed that the status quo was not deliverable nor sustainable because small numbers of staff were working excessive hours at excessive cost to the service. If the Board supported the recommendation to purse option1 and recognised the risk then an interim move to implement option 2 by the end of August would be progressed. In the intervening period if an option 2+ model presented then this would be pursued. It was noted that the interim option 2 model was sustainable and kept the unit open 24/7 and stopped stable children with treatment plans in place from being transferred.

20.33 Mr Johnston questioned how the Board would be advised of the emergence of any option 2+ model. The Chairman advised that the Board would be advised of any such development at its meeting in August as it would be important that it was kept informed of any significant developments.

20.34 The point was made that a first task for the proposed Non Executive led Paediatric Programme Board would be to address and develop a matrix of success. It was agreed that the Programme Board would be established quickly under the governance auspices of the Acute Hospitals Committee and would report through that mechanism to the Board.

20.35 Mr Johnston commented that the RCPCH report and the Board paper had his whole hearted support with the exception of recommendation 2.4 as it was currently framed. This position might change depending on whether or not an acceptable option 2+ emerged which he hoped would be the case.

20.36 The Board whilst recognising Mr Johnston's position in respect of recommendation 2.4 agreed the recommendations contained in the circulated paper.

21. Date and Time of Next Meeting

21.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 3 August 2016 in the Board Room, Waverley Gate, Edinburgh.

22. Invoking of Standard Order 4.8

22.1 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.

LOTHIAN NHS BOARD MEETING

RUNNING ACTION NOTE

1.2

Action Required	Lead	Due Date	Action Taken	Outcome
Integration Updates				
• Regular updates to future Board Meetings	**AMcM**	Ongoing		
Revised Corporate Communications Strategy				
• Arrange further discussion either at a development session or at a future Board meeting	**AB**	Ongoing	*Paper to future Board meeting*	
Delayed Discharges				
• 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	*For IJB Chief Officers to address*	
• The Slater Report to be considered in more detail at a future Board meeting	**AMcM/JC**			
Consent Agenda				
• Bring forward proposals for a review of the Consent Agenda process	**BH**	September 2015	*Process of evaluation underway*	
Implementation of the Royal College of Paediatrics and Child Health Recommendations				
• Regular updates to future Board Meetings	**JC**			
Workforce Risk Assessment				
• Regular updates to future Board Meetings	**AB/DF**			
Corporate Risk Register				
• On August Board agenda	**AMcM**			

ACUTE HOSPITALS COMMITTEE

The draft minutes of the Acute Hospitals Committee held on Tuesday 7 June are attached.

Key issues discussed included:

- RIE and Liberton - view from the bridge. Barometer of whole system. Activity levels, patient outcomes, management approach
- Budget allocation and £12m recovery plan for 16/17
- Maternity Programme Update - moving to Maternity Quality Improvement Board. Good progress being made
- Gynaecology Programme Board Update - again good progress and consideration of how model might be used elsewhere. Leadership and culture progress noted
- Integration Joint Board Directions. Themes noted and comments raised around pace of change, nature of change and how the system will work this year,
- Cleft services

Key issues on the horizon are:

- Activity levels and increased volume (particularly at RIE) leading to increased work-force pressures - what is behind the increased activity and how are we addressing this to ensure patient safety
- Plans for Liberton Hospital
- Financial challenges
- Delayed discharge
- Return on investment - looking more at financial benefits as well as cost pressures

Kay Blair, Acute Hospitals Committee Chair
13 June 2016

DRAFT

NHS LOTHIAN

ACUTE HOSPITALS COMMITTEE

Minutes of the Meeting of the Acute Hospitals Committee held at 2pm on Tuesday 7 June 2016 in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mrs K Blair (Chair); Mr A Joyce; Professor A McMahon; Mrs A Meiklejohn; Mrs A Mitchell and Mr J Oates.

In Attendance: Mr P Addison (Consultant in Plastic Surgery) (for Item 12); Mrs S Ballard-Smith (Nurse Director, Acute Hospitals Division); Mr C Briggs (Associate Director of Strategic Planning); Ms J Brown (Associate Director Human Resources); Mr O Campbell (Consultant Gynaecologist) (for Item 6); Dr B Cook (Associate Medical Director); Mr J Crombie (Chief Officer); Mr T Davison (Chief Executive); Dr E Doyle (Associate Divisional Medical Director); Mrs S Goldsmith (Director of Finance); Ms L McDonald (Site Director, Royal Infirmary of Edinburgh & Liberton Hospital); Dr F Mehendale (Consultant in Plastic Surgery)(for item 12); Dr S Nicholson (Consultant Gynaecologist) (for Item 6); Mr P Reith (Secretariat Manager); Dr F Schofield (Consultant Gynaecologist) (for Item 6) and Mrs C Young (Business Manager).

Apologies for absence were received from Dr D Farquharson and Mr G Walker.

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.

1. Minutes of the Previous Meeting

1.1 The previously circulated minutes of the meeting held on 1 March 2015 were approved as a correct record.

2. Running Action Note

2.1 The Committee noted the previously circulated Running Action Note.

3. Royal Infirmary of Edinburgh - A View from the Bridge

3.1 Ms McDonald gave a presentation on the Royal Infirmary of Edinburgh and Liberton Hospital explaining that the Royal Infirmary of Edinburgh had 777 of Lothian's 1,746 in patient beds whilst Liberton Hospital had a further 126 beds. The Royal Infirmary of Edinburgh delivered a range of district general, tertiary, regional and highly

specialist services and the Royal Infirmary of Edinburgh was Lothian's busiest centre for unscheduled acute receiving with a major and highly complex elective workload as well as a University teaching and training facility. In addition, it was an emergency hospital, outpatient centre and currently, a building site with the children's hospital, Department of Clinical Neurosciences and internal enabling works currently being undertaken.

3.2 The Committee noted that the Royal Infirmary of Edinburgh had 24 theatres running both night and day. Challenges included achieving the monthly 4 hour compliance for Accident and Emergency with breaches of the 12 hour guarantee and dealing with the 25,000 unscheduled admissions in 2015/16 during week days and 9,133 over the weekends.

3.3 Ms McDonald advised that the opportunities for the Royal Infirmary of Edinburgh and Liberton included the reprovision of the Children's Hospital and Department of Clinical Neurosciences, the development of a major trauma centre, the expansion of the acute medical unit, the redevelopment of the discharge lounge, working with Integration Joint Boards including development of alternatives to admission, further developments of the Quality Improvement approach and possible developments in the BioQuarter.

3.4 The Committee noted that the planned closure of Liberton Hospital in 2017 would be dependent on the development of new home care packages and the new delayed discharge approach, both of which were proving challenging. Delayed discharges were continuing to cause major problems and were resulting in cancelled operations and high levels of stress and frustration for both staff and patients.

3.5 The Chair thanked Ms McDonald for her presentation and commented that many of the problems faced were not specific to Lothian but required to be addressed at a National level by Scottish Government.

3.6 Mr Crombie commented that there was no magic wand available to fix these problems. The feedback being received from staff was in itself an achievement and was an important contribution to future planning of winter services.

3.7 Mr Davison commented that the Royal Infirmary of Edinburgh was not only NHS Lothian's but Scotland's biggest unscheduled care site. NHS Lothian was managing an unsustainable demand in the best way possible in circumstances where the required resources were simply not available. Pressures in Accident and Emergency varied significantly across different parts of Scotland, the greatest being experienced by Glasgow, Lanarkshire and Lothian. The biggest problem being faced was the dependence on hospital beds and the mindset required to change from providing a bed to supporting people at home.

3.8 Mr Davison advised the Committee that in the north of England the separation of scheduled and unscheduled care to different facilities was leading to significant improvements in the service. Undertaking more unscheduled care at the Royal Infirmary of Edinburgh and more scheduled care at the Western General Hospital was a possible way forward.

3.9 It was agreed that the feedback from staff showed the positive benefit that they were able and willing to raise concerns and ask for help when was most required. Mrs Mitchell queried why additional nursing staff could not be brought into assist when

high levels of demand were being experienced and Ms McDonald explained that additional staff were brought in where possible but there were simply not enough nurses to cope with the increasing demand.

3.10 The Chair commented that more work was needed to determine why patients were presenting at Accident and Emergency rather than going to their General Practitioner and much more of this work should be transferred to Primary Care. She was concerned at the number of compromises having to be made and noted that the "sticking plaster" approach was simply not working. She asked Members to let her have any comments and suggestions. **All**

3.11 It was suggested that work should be done to identify why patients in Lothian were more inclined to attend Accident and Emergency than in areas such as Grampian and Mr Davison advised that work had been done on this and the main factor was the distance from the Accident and Emergency facility. Many patients in Grampian lived more than 50 miles away from the mail Accident and Emergency unit and so tended to present to general practice or community hospitals rather than the Accident and Emergency Department.

3.12 Mr Davison reminded the Committee that previous efforts to increase the number of beds and the number of staff had simply lead to even more patients attending hospital and he felt the answer had to be about encouraging self-care, primary care and social care rather than hospital care.

3.13 The Chair thanked members for the contributions.

3.14 It was agreed that the Executive Team should be asked to consider the issues raised and to develop appropriate plans to address them if these were not already in place and to liaise with Scottish Government to address the problem. **JC**

3.15 The Chair advised that she would also engage with the Board and Audit & Risk Committee Chairs regarding increased activity in Accident and Emergency at the Royal Infirmary of Edinburgh. **KB**

4. Budget Allocation 2016/17

4.1 Mrs Goldsmith reminded the Committee of the available resources in the budget settlement for the acute sector and the planning assumptions which included overall wage increases, non pay cost pressure as well as efficiency target savings carried over meant the full year effect of the 2015/16 pressures was £23.7m. In addition to this, Scottish Medicines Consortium approvals on medicines growth, reductions in allocations and other pressures and other developments meant that for the financial plan 2016/17 the gap still to be addressed by the Division was £11.9m after all recovery actions had been taken and the Board had released all available support.

4.2 Mrs Goldsmith emphasised that the acute share of the baseline budget was 40% and its uplift was in direct proportion to the budget. £13m additional funding had been put into acute medicine to help address planning assumptions and other pressures.

4.3 Mr Davison suggested that the Committee might take a view on whether insulin pumps could be deferred for a year and start thinking about how other pressures could be addressed.

4.4 It was noted that 28% of the budget for acute services was now set aside for the Integration Joint Boards and Integration Joint Board budgets would be issued later that week.

4.5 Mrs Goldsmith advised that there was still an expectation that NHS Lothian should break even and she emphasised the need to identify smaller projects and gain the co-operation and support of the workforce.

4.6 Mr Joyce commented that skill mix was under discussion between staff side and management and Mrs Brown commented that managers were working hard to get agreements on ways ahead and reviewing management actions.

4.7 The Chair thanked Mrs Goldsmith for her presentation and the Committee noted the position.

5. Maternity Programme Board Update

5.1 The Chair welcomed Dr Doyle to the meeting.

5.2 Dr Doyle advised the Committee that the Maternity Programme Board had been established in April 2014 in response to growing concerns over capacity issues. The diagnostic work had been completed over the summer of 2014 and a workshop held in late October 2014. As a result an action plan was developed at the workshop the implementation of which would be monitored by a re-named Maternity Quality Improvement Board.

5.3 The Committee noted that capacity issues had been reviewed by the Royal College of Obstetrics and Gynaecology and progress had been made on a number of capacity improvements including the introduction of a TRAK care accident and emergency style floor plan to allow real time monitoring of activity and ability to analyse flow; the design and use of an acuity tool to standardise prioritation of workload; the development of algorithms to support decision making and initial management for the most common attendances and multidisciplinary study days which had received excellent feedback.

5.4 It was noted that triage methods had changed and capacity improved. Most of the work was now complete and it was proposed to amend the terms of reference and named culture of continuous improvement a maternity quality improvement board acting as an overarching body to commission, assign, coordinate and monitor the continuous improvement activity within maternity services.

5.5 The Committee noted that the current neonatal EPR Badger system was outdated and no longer supported and was no longer available at St John's. The updated Badgernet system was now used in all neonatal units in England and in most of Scotland and would allow the two units to be more effectively linked and would support patient safety, audit and clinical governance across both units. It was noted that a huge amount of work had been undertaken and significant worries had been addressed.

5.6 Dr Doyle advised that iMatter was being be introduced into the Department that week facilitating staff feedback but there were already "soft indications" of an improvement.

5.7 The Committee noted that there had been some difficult decisions at the start of the exercise which had been supported with staff and project management had demonstrated to staff that something was happening.

5.8 The Chair thanked Dr Doyle and commented that she was very supportive of the work going on and was heartened by the outcomes and the progress being made.

5.9 The Committee agreed to support the renaming of the Maternity Programme Board to the Maternity Quality Improvement Board along with its updated terms of reference and membership and supported in principle the acquisition of the Badgernet patient electronic patient record (EPR) system for the neonatal units at St John's Hospital and the Royal Infirmary of Edinburgh.

6. Gynaecology Programme Board Update

6.1 Dr Nicholson introduced a circulated report providing an overview of the implementation of a service level quality improvement structure within the gynaecology service and the progress made to date.

6.2 It was noted that an introductory quality improvement event had been held in March 2015 to introduce everyone to quality improvement methodology and agree a structure/ aim of quality improvement groups and to brainstorm initial ideas for improvement. A subsequent 2 day workshop had been held in June 2015 to prioritise action plan improvement ideas and subsequently form initial workplans for the quality improvement groups.

6.3 The theme from the workshop was for a move from surgical to medical care in termination of pregnancies and from being inpatient hysterectomy to day case outpatient hysterectomies the impact had been an increase in day case work from 10-15% to 60% and the number of 9-12 terminations by surgery had been dramatically reduced by a move to medical procedures. This had resulted in the release of the Bruntsfield Suite at the Royal Infirmary of Edinburgh.

6.4 The Committee noted that good progress was being made and the model was being considered for use elsewhere. The next steps would be the upgrade to Ward 12 at St John's Hospital and the renovation of the Bruntsfield Suite at the Royal Infirmary of Edinburgh.

6.5 The Chair thanked the Dr Nicholson, Dr Schofield and Dr Campbell.

6.6 The Committee noted that the biggest challenge had been identifying sufficient outpatient nursing capacity for the clinical visits. Considerable consultant time was wasted if there were not sufficient nurses to staff the units and Mr Crombie advised that the position was being examined.

6.7 Mr Davison congratulated both teams on their work and commented that similar outstanding work was being carried out at St John's Hospital in Ophthalmology

where, with training, Band 3s were able to do ophthalmic work that would previously have required a Band 5. He was aware that there were many such innovations being explored and these should be helped by the Quality Initiative. Whilst cash and staff time were in short supply he would be keen to provide some sort of infrastructure support to continue exploring new and more efficient ways to deliver clinical services. He was interested in the variations in teams and workload and Dr Campbell advised that work had just started on examining who did the most and least work. Dr Nicholson advised that the quality initiative team was starting to update existing guidelines to improve the management of the service and agreed that guidelines for good practice could be developed.

6.8 Mr Davison raised realistic medicine and identification of inappropriate or unnecessary interventions and Mr Crombie advised that one of the reasons for bringing these presentations to the Committee was to allow the Committee to see what work was being carried out but also to give the staff an opportunity to explain what work was being carried out to develop and modernise the delivery of services. The quality initiative would build on this and would allow a Board strategy to be developed.

6.9 The Chair thanked the presenters and the Committee agreed to note the progress made to date by the quality improvement groups and noted that many of these changes would also lead to cost savings which would be reinvested in identifying and implementing similar changes throughout the organisation.

6.10 Mrs Goldsmith advised that Mr Marriot was currently undertaking work to look at all the quality improvement projects and the two pieces of work considered at the Committee would be added to these projects.

6.11 Mr Oates commented that information about these projects and what they were achieving should be widely circulated to inspire others to carry out similar such work and Mr Crombie advised that bringing these presentations to the Committee was a start of this process as was putting forward the projects for the awards process. **JC**

6.12 Mr Davison commented that there was a significant amount of data about these sorts of projects and work was underway to interlink this data for submission to the Clinical Forum.

7. Update on the Royal College of Paediatrics and Child Health Review of NHS Lothian's Medical Paediatric Services

7.1 Mr Crombie advised the Committee that the final report from the Royal College was not yet available but would be discussed at the Board meeting on 22 June 2016.

7.2 The Committee noted the position.

8. Integration Joint Board Directions

8.1 Mr Briggs introduced a circulated report giving and update on directions received from Integration Joint Boards for the financial year 2016/17 and the implications for NHS Lothian's services.

8.2 Mr Briggs explained that the themes were high level with the Integration Joint Boards just beginning to realise that directions were more difficult than they had thought. All Integration Joint Board wanted to secure best value and some 25% of the budget for University Hospitals was “set aside” under the strategic direction of the 4 Integration Joint Boards but managed by NHS Lothian through the University Hospitals Division.

8.3 The Committee noted that the mechanism for instructing how these monies were spent was through the directions process whereby binding instructions were issued to the NHS Board with regard to how it managed the delegated budgets. NHS Lothian could influence the content of these directions but could not reject them or instruct the Integration Joint Boards. The themes in these Directions relevant to the Acute Hospitals Division were:

- That there should be no investment or disinvestment in services under the purview of the Integration Joint Boards without explicit discussion with and agreement by those Integration Joint Boards.
- That NHS Lothian should continue to deliver functions delegated to the Integration Joint Board to extant standards and regulatory requirements.
- That Integration Joint Boards were clear in their desire to avoid destabilising extant systems.
- That the Integration Joint Boards saw 2016/17 as a developmental year where mechanisms must be developed within the Integration Joint Boards and NHS Lothian in order to provide appropriate performance management information, financial information, processes for the management of directions themselves and broader partnership working.
- That the Integration Joint Boards wished to secure best value and service delivery.
- That all 4 Integration Joint Boards wished to see more services delivered locally, both in terms of the avoidance of unnecessary admissions and timely discharge from institutions, but also in terms of additional scheduled services such as outpatients in non-acute settings.
- A desire to engage in and around the management of long term conditions.

8.4 The Committee noted that Mr Marriot had been working through the Directions and the Chief Executive would be writing to each of the 4 Integration Joint Board Chief Officers. He would then write to the Health and Social Care Partnerships to inform them what work to carry out.

8.5 The Committee noted that a number of cost centres had moved to the Integration Joint Boards and there were already a number of unintended consequences. The Committee noted that there was little detail in the directions with regard to the £163m of University Hospital services budget under the purview of the Integration Joint Boards and this could pose a risk to NHS Lothian as there was a clear tension in the common direction to neither invest or disinvest without explicit Integration Joint Board approval while continuing to deliver services to meet national standards.

8.6 The Committee noted that these risks spanned the full range of components of a clinical service, from decisions regarding prescribing policy all the way to decisions regarding the future shape and size of clinical services such as medical receiving.

This also had significant implications around capital planning in the major hospital sites.

8.7 The Committee noted that guidance on what the Integration Joint Boards wanted to do in a number of areas was still awaited and Mr Marriot would be meeting with the Integration Joint Boards monthly for the rest of the financial year.

8.8 Mr Davison commented that there would be a need to look at the whole system. As an example, type 2 diabetes patients had to be managed in Integration Joint Boards through Primary Care as the cost would be twice as much managing them in hospital.

8.9 The Chair commented that she found the directions inadequate and potentially more expensive. She was also concerned about that the paper showed an intention to passing more risk and assurance responsibilities onto the acute sector.

8.10 Mr Davison commented that he had some sympathy with the Committee's concerns but he was aware that NHS Lothian had not managed to transfer investment from the Acute to Primary Care service over the past 4 years. Ultimately, NHS Lothian had 50% of the representation on each Integration Joint Board and would therefore influence these decisions. He felt that there was the potential to use the position as a creative tension to help shift investment into primary care, social care and mental health. He reminded the Committee that NHS Lothian was still 100% in control of all the services for which they were responsible.

8.11 Mr Davison left the meeting.

8.12 Mr Briggs confirmed that a schedule of meetings with the Integration Joint Boards had been set up and action points supporting all plans had been produced.

8.13 The Committee agreed:

- To note themes identified in the Integration Joint Board directions paper.
- To note the process underway to further clarify directions and consider whether the approach and pace was appropriate.
- To note the issues raised by NHS Lothian in response to the directions.

9. Quality and Performance

9.1 Professor McMahon introduced a circulated report giving an update on the most recently available information on NHS Lothian's position against a range of quality and performance measures. He advised the Committee that the allocation of matrix to Board Committees had been discussed at the Healthcare Governance Committee which had considered that a number of the matrix allocated to the Acute Hospitals Committee were more relevant to the Healthcare Governance Committee and they would be communicating this.

9.2 Professor McMahon explained that following a review of the recurrence for those areas covered by diagnostic standards those patients waiting for cardiac MRI from April 2016 had been included. This had resulted in a reported rise in long waits for the examination and actions were progressing to reduce this number.

9.3 The Committee also noted that software issues at the Edinburgh Dental Institute had lead to the exclusion on any long outpatient waits being reported. Discussions with the systems suppliers were underway to resolve this issue.

9.4 Mr Crombie advised that the work carried out to pull work back from the independent sector had been completed and was being cross checked with the national access team to ensure that the methodology was accurate and the Lothian model would be rolled out throughout Scotland.

9.5 Mr Crombie reminded the Committee that there would be a significant reduction in NHS Lothian's use of the independent sector and a detailed report would be coming to the next Committee meeting. Whilst a number of procedures had been brought back in-house as a result of planned reorganisation of services, access for treatment time guarantees in some areas would be limited.

9.6 Mrs Goldsmith advised the Committee that the Cabinet Secretary for Health and Sport had just announced that the use of targets in the National Health Service in Scotland was being reviewed.

9.7 Mr Crombie advised that at discussions the previous week with the Director General of NHS Scotland it had been announced that the current position as of the previous week was that there were 4,500 patients exceeding the treatment time guarantees of which 420 were from NHS Lothian.

9.8 The Chair commented that whilst the format of the report was very clear it was disappointing that performance against targets was getting worse.

9.9 Professor McMahon commented that the overall results were mixed with improvements in some areas and that the increasing waiting times in others highlighted the task ahead.

9.10 Dr Cook commented that although performance around waiting times was disappointing areas around safety and quality of care were improving significantly.

9.11 The Committee agreed:

- To note the suggested allocation of matrix to Board committees outlined had been subject to further discussion.
- To note that the review of the returns for those areas covered by the diagnostic standard had lead to the inclusion of those patients waiting for cardiac MRI from April 2016. This had resulted in a reported rise in long waits for the examination. Actions were progressing to reduce this number.
- To note that software issues at the Edinburgh Dental Institute had lead to the exclusion of any long outpatient waits being reported. Discussions with the systems supplier were underway to resolve this issue. To accept the report as assurance that, over the measures considered, 14 were met and that lead Directors had action plans in place to address performance in those 21 where performance was not of the standard sought.

10. Divisional Financial Performance April 2016

10.1 Mrs Goldsmith introduced a circulated report giving an overview of the Acute Hospital Division's year to date and forecast outturn financial performance and providing an update on progress towards delivery of efficiency savings targets.

10.2 Mrs Goldsmith explained that it was always difficult to produce a month 1 report and some nonrecurring monies had not been included in the figures which were not as bad as might seem. This had reduced the overspend on month 1 to around £1m.

10.3 Mr Crombie commented that recruitment to posts was improving and this would reduce the use of the independent sector and agency staff.

10.4 Mrs Ballard-Smith advised that the worst month had been February when she had received 1 Whilst staff were being recruited not all were yet in post and the situation would continue to improve.,071 requests for escalations but that from 15 May to date she had received 3.

10.5 The Committee agreed to:

- Note the Division's financial performance in April (£1m) overspend.
- Note the release of baseline pressures funding for medicines (£4.14m) into operational budgets – (£0.345m in April).
- Note that the Division's share of the recurring gap on the 2015/16 financial plan had been passed out £2.097m) with (£0.175m).
- Agree the requirement to identify financial recovery actions in order to support the Board's statutory requirement to break even.
- Review both in-year and recurring performance against recovery plans and identify actions to offset slippage against planned trajectories.

10.6 Mrs Goldsmith left the meeting.

11. Annual Report of the Chair of the Acute Hospitals Committee

11.1 Mrs Young introduced the circulated report and the Committee noted that it suggested that members might wish to identify any specific development needs and consider how these could be addressed in the coming year. It was also noted that the programme of meetings for 2017 would have 5 rather than 4 meetings in the year and that there was the potential for more Executive and senior management support for the work of the Committee.

11.2 Mr Crombie reminded members that the Committee had only been in existence for a short period of time compared to other longer established Board committees and was performing well.

11.3 The Committee noted that as the Royal Victoria Hospital no longer functioned as a hospital its terms of reference would need to be amended. **PR**

11.4 The Committee agreed to approve the Annual Report of the Acute Hospitals Committee for 2015/16.

12. Specialist Paediatric Cleft Lip and Palate Surgery

12.1 The Committee received a circulated report on proposed changes to the Specialist Paediatric Cleft Lip and Palate Surgery service.

12.2 The Chair reminded members that surgical intervention for patients with conditions of the cleft lip and palate were nationally designated and commissioned by National Services Scotland on behalf of NHS Scotland.

12.3 Whilst there were currently 2 surgical teams, based in Edinburgh and Glasgow, National Services Scotland had undertaken a 5 year review which had concluded that there should be a single service on a single site, and that this should be in Glasgow.

12.4 These recommendations had been rejected by Board Chief Executives and a model of a single service on 2 sites mandated. By 2015 the Management Board had come to the view that the arrangements had not delivered the required outcomes and the National Specialist Services Committee had asked that NHS Lothian, NHS Greater Glasgow and Clyde and the National Specialist Services Committee form a Review Group and make a proposal on how services should be configured in future.

12.5 Both NHS Lothian and NHS Greater Glasgow and Clyde had bid for the service but the Review Group would be submitting a report to the National Specialist Services Committee on 8 June proposing the implementation of a single service, single site model in Glasgow.

12.6 The Chair welcomed Mr Addison and Dr Mehendale to the meeting.

12.7 Mr Addison expressed his concern to the Committee that if the cleft and palate service was moved to Glasgow highly skilled staff might be lost and the service might not be as good. He felt there could have been other workable solutions which had not been considered by the review. Dr Mehendale emphasised the importance of focussing on what was best for the children in Lothian and Scotland and commented that she felt that an Edinburgh based service would be best.

12.8 The Chair thanked Mr Addison and Dr Mehendale for their contributions and reminded the Committee that as this was a National Services Scotland commissioned service NHS Lothian did not have the power to reopen the debate.

12.9 Mr Addison and Dr Mehendale left the meeting.

12.10 Mr Crombie advised the Committee that whilst NHS Lothian had supported the clinical team in Lothian, the review had taken in a wider consensus and the conclusion had been that the service should be centralised in Glasgow. He appreciated that the Consultants were genuinely anxious about the ability of a centralised service to deliver the same quality of care.

12.11 The Committee noted that the Review Group had commissioned work to compare the services in Edinburgh and Glasgow. Edinburgh had the smallest service in the United Kingdom and both Edinburgh and Glasgow sat well within the funnel slot of performance. The data had been made publicly available and shared.

12.12 Dr Doyle had commented that National Services Scotland had indicated that it was content with the quality of service provided by the Glasgow unit.

12.13 It was noted that this had been a lengthy and stressful process but that a decision had now been made with the recommendation to National Services Scotland.

12.14 The Committee agreed to note the review process undertaken for the cleft service and the proposal that all special surgery be undertaken in the Royal Hospital for Children, Glasgow.

12.15 The Committee mandated the NHS Lothian representative on the review group and Nationalist Services Committee to put forward an NHS Lothian position which:

- Endorsed the proposal on the grounds of sustainability.
- Noted the value both families and staff placed on an outreach model of outpatient care, with the surgical team dedicating time in non-surgical sites, and ensure that this was delivered in the revised model.
- Expressed the view of NHS Lothian that its team had delivered a very good standard of care for patients with cleft conditions and the disappointment felt by staff that the service would not be delivered in Edinburgh.

13. Waiting Times Governance

13.1 Mr Crombie introduced a circulated report giving an update on waiting times governance since the previous report in November 2015.

13.2 Mr Crombie advised that work on the local access policy and reasonable offer had commenced and that the views of the Committee would be sought on this issue at its next meeting once the issue had been comprehensively considered.

13.3 The Committee agreed to receive the update and noted:

- The intention to seek the Committee's views at its next meeting on reasonable offer at locations outside Lothian as part of its review into the local access policy.
- A number of issues had been identified in regard to the provision of data to Information Services Division. Most significant amongst those highlighted were the backlogs of SMR submissions from across Lothian and the provision of outpatient waiting time information from the Dental Institute.
- Specific governance issues being progressed in mental health, cancer and accident and emergency.
- That the quarterly update to the Scottish Government on waiting times governance highlighted additional needs as an area requiring improvement and, following discussion with Government officials, that NHS Lothian was supporting a national event to identify the way forward on this issue.
- Sampling of waiting time records had informed actions underway to support improvement in relation to practice when the Dental Institute and also in the sending of letters more widely.

- That monitoring reports had identified a number of areas for improvement but no issue of significant concerns.
- A number of updates had been made to standards operating procedures.

14. Quality of Papers and Debate

14.1 The Chair commented that she felt the quality of papers and debate at the meeting had been excellent.

14.2 It was noted that Mrs Meiklejohn would not be putting herself forward for election as Chair of the Area Clinical Forum and would therefore not be a member at the next meeting. The Chair thanked Mrs Meiklejohn for her work as a member of the Committee.

15. Date of Next Meeting

15.1 It was noted that the next meeting of the Acute Hospitals Committee would be held on 6 September 2016 at 2pm in the Boardroom, Waverley Gate, Edinburgh.

AUDIT & RISK COMMITTEE

The draft minutes of the Audit & Risk Committee meeting held on 20 June 2016 are attached.

Key issues discussed included:

- The Committee accepted the Risk Management Annual Report 2015/16. High operational risks, including those from the health and social care partnerships and acute services risk registers, have been added to the corporate risk register. The Committee noted that the risk registers for the health and social care partnerships differ.
- The Committee discussed the internal audit report on the Integration Joint Board Performance Management Framework, which contained recommendations for improvement. It was noted that there will be a considerable amount of scrutiny on this subject and internal audit will continue to monitor progress.
- The Committee received the Annual Internal Audit Report, noting the high quality of the report and the excellent performance in the team. The Committee requested that the report be circulated to all Board members as it gives assurance to the Board as a whole.
- The Committee received the annual reports from Board Committees and noted improvements in these reports would be helpful to the preparation of its own annual report.
- The Committee agreed to recommend to the Board that they adopt the NHS Lothian Annual Accounts for the year ended 31 March 2016.

Key issues on the horizon are:

- A meeting has been convened for early August to facilitate the development of coordinated working between the NHS Lothian Internal Audit function with the Integrated Joint Boards.
- The process for appointment of a new internal audit partner is underway.

<u>Julie McDowell</u>
<u>Chair</u>
<u>14 July 2016</u>

NHS LOTHIAN

AUDIT AND RISK COMMITTEE

Minutes of the Audit and Risk Committee Meeting held at 9.30 am on Monday, 20 June 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms J. McDowell (chair), Non-Executive Board Member; Mr M. Ash, Non-Executive Board Member; Ms C. Hirst, Non-Executive Board Member; and Mr P. Murray, Non-Executive Board Member.

In Attendance: Ms J. Bennett, Associate Director for Quality Improvement and Safety; Ms H. Berry, Chief Internal Auditor; Mr C. Briggs, Associate Director of Strategic Planning (item 15.2); Ms C. Grant, Audit Scotland; Ms S. Goldsmith, Director of Finance; Mr B. Houston, Board Chairman; Ms D. Howard, Head of Financial Services; Mr A. Jackson, Assistant Director of Healthcare Planning (item 15.4); Mr M. Lavender, Scott-Moncrieff; Ms B. Livingston, Financial Controller; Mr C. Marriott, Deputy Director of Finance; Mr D. McConnell, Audit Scotland; Mr J. Old, Financial Controller; Mr A. Payne, Corporate Governance Manager; Ms B. Pillath, Committee Administrator; Ms K. Steele, Internal Audit Manager; Ms A. Timoney, Pharmacy Director (item 17.7).

Apologies: Mr T. Davison, Chief Executive; Mr D. Grant, Non-Executive Board Member.

The Chair reminded Members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Nobody declared an interest.

12. Minutes and Actions from the Previous Meeting (18 April 2016)

12.1 The minutes and action note from the meeting held on 18 April 2016 were approved as a correct record.

12.2 The Chair asked Mr Payne to give an update at a future meeting in relation to item 5.1.1 of the minutes, which related to examining the risks on the Corporate Risk Register.

13. Results from the Committee Member Survey

13.1 The Chair advised that the members would meet at a later date to consider any actions.

14. Risk Management (assurance)

14.1 <u>NHS Lothian Corporate Risk Register</u>

14.1.1 Ms Bennett noted the inclusion of high operational risks including the health and social care partnerships and acute services risk registers. This was in response to a recommendation from the Best Value Toolkit that the corporate risk register should be driven by the high operational risks, and was to show how these were aligned.

14.1.2 The healthcare associated infection risk had been reduced from high risk as NHS Lothian was now showing improvement in reducing incidences of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* in line with the Scottish Government HEAT targets and was no longer an outlier in terms of other Boards' reduction. There would be further consideration of the action plan at the Risk Management Steering Group.

14.1.3 Ms Bennett advised that as integration joint boards would have some corporate risks which could affect NHS Lothian's services, both East Lothian and Midlothian were using the DATIX risk management system which would allow oversight of the integration joint boards' risks. Further work would be taken forward in relation to the other integration joint boards.

14.1.4 Ms Hirst noted that some risks did not appear on all four health and social care partnership risk registers, for instance GP recruitment. Ms Bennett advised that there was oversight of all the risk registers, and noted that GP recruitment was recognised by NHS Lothian as a corporate risk, but was only on the health and social care operational risk registers of those areas with specific problems.

14.2 Risk Management Annual Report 2015/16

14.2.1 The annual report set out the process for identifying risk and improvement. The Committee accepted the report.

15. Internal Audit (assurance)

15.1 Internal Audit – Progress Report (June 2016)

15.1.1 The Committee approved the proposal that the Chief Internal Auditor and the Corporate Governance Manager would agree a protocol to ensure final internal audit reports would be routinely published on NHS Lothian's website. **HB/ AP**

15.1.2 The recommendations regarding the meeting between NHS Lothian and representatives from the audit Committees of integration joint boards were discussed and agreed. This would be a preliminary meeting involving the chief internal auditors of the integration joint boards, all of whom were also chief internal auditors of the respective local authority, and any proposals or agreements made would need to be formally approved by the local authorities and the NHS Board. Ms Berry advised that Midlothian had a draft service level agreement which would be presented to the integration joint board and Midlothian Council audit Committees for approval, and would form a model for the service level agreements of the other Boards.

15.1.3 The committee accepted the progress report and the Chair complimented Ms Berry on the quality of the report.

15.2 Strategic Planning (April 2016)

15.2.1 Ms Steele presented the report and advised that action was being taken forward to review the Board's strategic plan in light of the plans and directions of the four integration joint boards.

15.2.2 It was suggested that this area be revisited in a years' time as the processes for strategic planning had changed significantly since the implementation of the health and social care integration. Ms Berry confirmed that this could be considered in the annual audit planning.

15.2.3 The Committee accepted the report as the final version.

15.3 eHealth Strategy (April 2016)

15.3.1 Ms Berry commented that in her experience from many organisations it was common for service users and eHealth or IT departments to have different views as to how eHealth strategies and possibilities were effectively communicated. This may be attributed to a difficulty in securing effective general engagement in a technical subject area. The main issue highlighted in the report was therefore on communication. Mrs Goldsmith highlighted that the difference between the plans of eHealth and the ambitions of the organisation was discussed at the Strategic Planning Committee where it was felt that the strategy was more of a work programme and needed to be more strategic. The Strategic Planning Committee would be considering a revised eHealth strategy at a future meeting.

15.3.2 Mr Houston suggested that a model whereby eHealth teams worked directly with different departments on what was needed and what was possible would be more effective than writing a strategy in isolation and relying on service users attend consultation meetings.

15.3.3 Ms Berry confirmed that the subject of eHealth was on the annual audit programme every year and different aspects would be considered each year. The scope of this report was to review the arrangements for developing and implementing the eHealth strategy.

15.3.4 The Committee accepted the report as the final version.

15.4 Integration Joint Board Performance Management Framework (February 2016)

15.4.1 Ms Steele explained that the delay in receiving the report was due to a change to the performance indicators during the course of the audit fieldwork. The fieldwork was initially focussed on the common indicators for integration joint boards, but different indicators were later chosen based on the strategic plans, and the report needed to reflect that change. Mr Jackson noted that the recommendations in the report continued to be useful despite the change. The strategic indicators were still to be finalised, but operational indicators were in place and being used for reporting. This reflected the developing nature of the integration joint boards.

15.4.2 Ms Berry commented that there would be a considerable amount of scrutiny on this subject, and internal audit will monitor the progress as part of routine follow-up process which would be reported in the Internal Audit Progress report to each meeting of the Committee.

15.4.3 The Committee accepted the report as the final version.

15.5 Integration Joint Board Financial Assurance (April 2016)

15.5.1 It was recognised that risk sharing and risk management gaps had not yet been solved for the integration joint boards and that this needed more work. Ms Berry noted that 2016/17 was being considered as an interim year during which systems were being put in place, and the audit report ensured that arrangements were being made for this to happen.

15.5.2 In relation to the delegation of funds, Ms Goldsmith advised that this had been agreed with all integration joint boards for 2016/17; some cost centres had not been delegated but budget and expenditure would be matched. This would be considered again in the future.

15.5.3 Mr Murray noted that the PCNRAC calculation did not take deprivation into account. This calculation model had been requested by the integration joint boards but the detailed issues would be considered as part of ongoing review.

15.5.4 The Committee accepted the report as the final version.

15.6 Follow Up of Management Actions Report (June 2016)

15.6.1 The Committee considered a recommendation within the report to remove the actions arising from the 'Compliance with Policies and Procedures' audit from the follow up process. The Committee had previously agreed that it would receive update reports from the Corporate Governance Manager. The Committee deferred a decision on this recommendation until the September 2016 meeting when it would receive the first update report. **JMcD**

15.6.2 The Committee accepted the report as the final version.

15.7 Annual Internal Audit Report 2015/16 (June 2016)

15.7.1 The Committee agreed that the report was very useful in format and presentation and showed excellent performance in the team, and agreed this would also be circulated the Board Members as it gave assurance to the Board as a whole. **AP**

15.7.2 In response to a question from Mr Murray about the burden on staff of completing management actions, Ms Berry advised that actions would be discussed with management teams and priorities would be taken into account to ensure the work was manageable with the resource available.

15.7.3 In response to a question about audit reports reducing risk, Ms Berry advised that audits were targeted at areas on the risk register where assurance was needed.

15.7.4 The Committee chair commented on the excellent format and presentation of the report. The Committee accepted the report.

16. Counter Fraud (assurance)

16.1 Counter Fraud Activity and Fraud Referrals and Operations for year Ending 31 March 2016

16.1.1 In response to a question about the progress of cases that had been ongoing for some considerable time, Mr Old advised that these were in discussion with the Procurator Fiscal who would receive the full report before taking forward a decision on which management actions would be based.

16.1.2 In response to a question from Ms Hirst about how weaknesses identified in the system as part of incidents of fraud were addressed, Mr Old advised that recommendations from the Counter Fraud Service were taken on as actions, and actions were discussed with management. If a major system weakness was identified, the service may be referred to Internal Audit, and this had occurred occasionally.

16.1.3 The Committee accepted the recommendations in both reports, and were content that no further information or assurance was required in the reports.

16.2 Counter Fraud Services Patient Exemption Checking Annual Reporting 2015/16

16.2.1 The Committee accepted the recommendations in the report.

17. General Corporate Governance (assurance)

17.1 Healthcare Governance Committee Annual Report, 2015/16

17.1.1 It was noted that two assurance needs had been referred to the Staff Governance Committee, but did not appear in the Staff Governance Committee Annual Report. It was agreed that this discrepancy would be discussed with the Staff Governance Committee to determine whether this was an omission in the report or whether there was a gap in the system which needed to be addressed. Mr McConnell confirmed that as this was a specific discrepancy and not a case of non compliance with guidance that he approved of this approach. **AP**

17.1.2 The treatment time guarantee was not on an assurance statement for any Committee, but was included in the Governance Statement for the annual accounts. Ms Bennett advised that this area had previously been overseen by the Strategic Planning Committee, but that as this was not a governance Committee it had been allocated to the Healthcare Governance Committee from the year 2016/17. It was also considered through the risk management process as a corporate risk and assurance was provided in the performance report.

17.1.3 The Committee was advised that the authors of committee annual reports were provided with an extensive briefing and template materials to be used in preparing the reports. The Audit and Risk Committee's view was that the reports were not in the same format thereby making comparisons difficult. The Corporate Governance Manager agreed to use the Committee's feedback to inform and develop the process for 2016/17. **AP**

17.1.4 The Committee agreed to accept the report as a source of assurance to support the Governance Statement.

17.2 Finance and Resources Committee Annual Report 2015/16

17.2.1 The Committee agreed to accept the report as a source of assurance to support the Governance Statement.

17.3 Staff Governance Committee Annual Report 2015/16

17.3.1 The Committee agreed to accept the report as a source of assurance to support the Governance Statement.

17.4 Information Governance Assurance Board Annual Report 2015/16

17.4.1 The Committee agreed to accept the report as a source of assurance to support the Governance Statement.

17.5 Acute Hospitals Committee Annual Report 2015/16

17.5.1 The Committee agreed to accept the report as a source of assurance to support the Governance Statement. It was noted that the assurance needs of these group appeared to be still in development.

17.6 National Services Scotland Service Audit Reports 2015/16

17.6.1 The Committee accepted the reports from the service auditor as a source of significant assurance with respect to the Board's systems of internal control relating to practitioner services and the National IT Services contract.

17.6.2 Mr Payne informed the Committee that a third service auditor report had also been received which related to the National Single Instance, and that it too had an unqualified audit report; this report would be circulated to members for their information. **AP**

17.7 Loss of Medicines, Edinburgh Cancer Centre

17.7.1 Professor Timoney advised that it was a requirement for any store losses of a value greater than £40,000 to be reported to this Committee before being referred to the Scottish Government for approval. Professor Timoney summarised the report and advised that the remedial work had been completed by December 2015 and an electronic system had now been set up to monitor transfers between the supplier and NHS Lothian's pharmacy systems.

17.7.2 The incident and improvement plan had been shared with the pharmacy team working in all NHS Lothian departments as part of discussions on key performance indicators, one of which was stock write off. Following a suggestion from a Committee member, Professor Timoney also agreed to share the improvement plan with other Scottish Health Boards at the Chief Pharmacists Group and the National Pharmacy network.

17.7.3 The Committee confirmed that the Director of Finance should approach the Scottish Government Health and Social Care Department SGHSCD for its approval to write-off the loss of £58,950.

17.8 Schedule of Losses – SFR 18.0

17.8.1 Ms Goldsmith advised that losses on overseas patients were slightly higher in NHS Lothian than other Boards, as more overseas patients received treatment in Lothian. Recommendations to reduce losses in this area had been implemented and there was close work with other Boards to share improvements.

17.8.2 The Committee agreed to take a moderate level of assurance on the associated systems of internal control, and agreed that there should be more regular updates on the progress made to improve those systems, with the next report to be received in 6 months' time. **SG**

17.9 Edinburgh and Lothians Health Foundation Annual Report and Accounts 2015/16

17.9.1 The Committee was informed that the accounts had been audited by Scott-Moncrieff and accepted the recommendation to note the processes relating to the production and approval of the Foundation's accounts.

17.10 Patients Private Funds Annual Accounts 2015/16

17.10.1 The Committee approved the recommendations in the report, which included agreeing to recommend to the Board that it approve the draft Patients Private Funds Annual Accounts for the year ended 31 March 2016.

17.10.2 Ms Goldsmith informed the Committee that Mr Lavender of Scott-Moncrieff would be attending meetings in the future as part of the external audit team for the NHS Board's accounts.

8. Annual Accounts (decision)

8.1 Governance Statement

8.1.1 The Committee agreed that the Governance Statement should be included in the annual accounts, subject to a review of the final paragraph which related to the delivery of performance requirements. **AP**

8.2 Management Representation Letter

8.2.1 The Committee reviewed the draft Representation Letter to the external auditors confirmed that the statements represented confirmation to the external auditors on matters arising during the course of their audit of the accounts for the year ended 31 March 2016, and agreed to recommend that the letter be signed by the Chief Executive of NHS Lothian.

8.3 NHS Lothian Annual Audit Report 2015/16

8.3.1 Mr McConnell gave a brief overview of the report highlighting how the report was collated, key findings and the audit certificate.

8.3.2 The Committee accepted the report as a source of assurance to inform its review of the annual accounts.

8.4 NHS Lothian Annual Accounts for Year End 31 March 2016

8.4.1 The Committee agreed to recommend to the Board that they adopt the Annual Accounts for the year ended 31st March 2016 and recommend to the Board to authorise the designated signatories to sign the Accounts on behalf of the Board.

8.5 Audit Committee Annual Report and Assurance Statement 2015/16

8.5.1 The Committee agreed to amend the report to reflect the previously identified discrepancies between the committee assurance statements. The Committee agreed that this was an area for development not of such significance that would require to be disclosed in the Governance Statement. **AP**

8.5.2 The Committee approved the annual report subject to the above change being made.

8.6 Notification to Scottish Government Health Department Health and Wellbeing Audit Committee

8.6.1 The Committee approved the letter subject to ensuring that the Governance Statement disclosures were identical to those in the final Governance Statement. **AP**

9. Any Other Competent Business

9.1 Audit Scotland

9.1.1 On behalf of the Committee, Ms McDowell thanked Mr McConnell and Ms Grant and their colleagues at Audit Scotland for the service they had provided as external auditors for the past few years.

10. Date of Next Meeting

10.1 The next meeting of the Audit and Risk Committee would take place at **9.30** on **Monday 5 September 2016** in **Meeting Room 7, Second Floor, Waverley Gate**.

10.2 Further meetings in 2016 would take place on the following dates:
- 7 December 2016;

Healthcare Governance Committee

1.5

The draft minutes of the meeting held on Tuesday 24th May are attached.

Key issues discussed included:

Healthcare Associated Infection – Antibiotic Prescribing
The paper demonstrated that NHS Lothian was now prescribing antibiotics at Scottish average levels, including the '4c' antibiotics, linked to c.dif. Infections.
The interventions that had taken place in primary care to effect a reduction in use of antibiotics and of broad spectrum antibiotics in particular, included use of the Scottish Reduction in Antimicrobial Prescribing (ScRAP) Programme educational tool, speaking at PLT sessions, and facilitated discussions with individual GP practices including GPs and non-medical prescribers and looking at local data and education on infection management and managing patient expectations. Information was also available on the Lothian Prescribing Bulletin which was sent round all practices, and on the Lothian Joint Formulary which was circulated every time an update was made and was available online.
The Committee supported the next steps laid out in the paper and agreed to receive an update on progress in one year, and for statistics to be included in the regular Healthcare Associated Infection paper.

Death in Hospital
NHS Lothian had been asked to give assurance that all unexpected deaths were recorded and reviewed, and that actions were put in place in response to learning. A further update would be available at the September or November 2016 meeting, depending on the timing of the national review.

Private Healthcare
Funding had been withdrawn for the future referral to Private Healthcare services to treat NHS Lothian patients. The risks and mitigating actions would be outlined in an update paper from Mr Crombie at the next meeting in July 2016.

Quality and Performance Report
The format of the report had been updated so that risk, risk appetite, improvement plans and current status were included in the same paper with assurance that actions matched to risks.

Some education and training would be required for Committee Members, which Jo Bennett agreed to facilitate. It was noted that some responsibilities would be devolved to the Integrated Joint Boards. In order to ensure that Healthcare Governance Committee received assurance on its areas of responsibility the process of assurance for IJBs was being worked on, and Health and Social Care Partnerships would report to the Healthcare Governance Committee as a standing item at each meeting.

Public Protection Update
Concerns had been raised about the staffing levels in community nursing and health visiting. There had been recruitments to the Health Visiting Team and these were continuing, with an increase in training places from 22 to 40. All children had a named person and cases were being managed appropriately. Staff were addressing high priority areas. The risk was acknowledged and was recorded on the risk register. A weekly huddle monitored the situation and the Public Protection Team was working closely to support the Health Visiting Team.

Significant Adverse Events
Ms Bennett advised that work on reducing the backlog of Significant Adverse Events which had not been reviewed was in progress and that a number of measures had been put in place to improve efficiency with carrying out reviews within the statutory timeframe.
The majority of the mental health review backlog had been allocated to reviewers who had agreed to do extra time to work on these. All sudden or unexplained deaths in Lothian where the patient had had contact with NHS Lothian services in the year prior to death were investigated. The recommendations laid out in the paper were supported by the Committee, and it was agreed that there would be a further update at the meeting in July 2016 which would include timescales for actions put in place and evidence of learning and change of practice as a result of the reviews carried out.

Key issues on the horizon are:

Healthcare Associated Infection HEAT Target Update

Dr Farquharson advised that both *Clostridium difficile* Infection (CDI) and *Staphylococcus aureus* Bacteraemia (SAB) rates were reduced in the latest Health Protection Scotland quarterly report and were no longer an outlier amongst Scottish Health Boards. This data only covered one quarter and the next quarter report was awaited to determine whether the trend would continue and show that actions taken as part of the improvement plan had had effect.

Dr Richard Williams
Non Executive Director
Chair

NHS LOTHIAN

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 on Tuesday 24 May 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr R. Williams, Non-Executive Director (chair); Ms S. Allan, Non-Executive Director; Ms P. Eccles, Partnership Representative; Ms C. Hirst, Non-Executive Director; Ms A. Meiklejohn, Chair of the Area Clinical Forum, Non-Executive Director; Mr J. Oates, Non-Executive Director.

In Attendance: Ms J. Bennett, Clinical Governance Manager; Dr D. Farquharson, Medical Director; Mr J. Forrest, Chief Officer, West Lothian Health and Social Care Partnership; Ms J. Heslop, Chief Nurse, Royal Edinburgh Hospital (item 7.2); Mr B. Houston, Board Chairman; Dr S. Hurding, Medicines Management Advisor (item 3.1); Dr P. Lefevre, Associate Divisional Medical Director (item 7.2); Professor A. McMahon, Interim Nurse Director; Ms J. Morrison, Head of Patient Experience; Ms C. Myles, Chief Nurse, Midlothian Health and Social Care Partnership; Ms C. Philip, Lead Antimicrobial Pharmacist (item 3.1); Ms B. Pillath, Committee Administrator (minutes); Professor A. Timoney, Director of Pharmacy.

Apologies: Dr B. Cook, Medical Director, Acute Services; Mr T. Davison, Chief Executive, NHS Lothian; Ms W. Fairgrieve, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Mr A. Joyce, Employee Director, Non-Executive Director; Mr R. McCulloch-Graham, Chief Officer, Edinburgh Health and Social Care Partnership; Mr A. Sharp, Patient and Public Representative; Mr D. Small, Chief Officer, East Lothian Health and Social Care Partnership; Mr S. Watson, Chief Quality Officer.

Chair's Welcome and Introductions

Dr Williams 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.

1. Patient Story

1.1 Professor McMahon read out a poem written by a Cardiology patient who had had a positive experience at the Royal Infirmary of Edinburgh.

2. Committee Cumulative Action Note and Minutes from Previous Meeting (15 March 2016)

2.1 The updated cumulative action note had been previously circulated.

2.2 The minutes from the meeting on 15 March 2016 were approved as a correct record.

3. Matters Arising

3.1 Healthcare Associated Infection – Antibiotic Prescribing

3.1.1 The Chair welcomed Dr Hurding and Ms Philip to the meeting. Dr Hurding gave a presentation on NHS Lothian's antibiotic use in comparison to the national average. A paper had been previously circulated. This demonstrated that NHS Lothian was now prescribing antibotics at Scottish average levels, including the, the '4c' antibiotics.

3.1.2 Ms Philip described the interventions that had taken place in primary care to effect a reduction in use of antibiotics and of broad spectrum antibiotics in particular, including use of the Scottish Reduction in Antimicrobial Prescribing (ScRAP) Programme educational tool, speaking at PLT sessions, and facilitated discussions with individual GP practices including GPs and non-medical prescribers and looking at local data and education on infection management and managing patient expectations.

3.1.3 Data was available by practice level so that intervention could be targeted. Each practice received its own data and its position in relation to other practices on a regular basis. It was noted that there was also variation in prescribing by individuals working in the same practice.

3.1.4 In response to a question from Ms Hirst, Dr Williams explained that while antibiotic use was appropriate for certain indications, it was inappropriate use that needed to be reduced rather than stopping all antibiotic prescribing. The Lothian Joint Formulary indicated which antibiotic use was appropriate but there would always be complicated cases where an individual decision as to whether to prescribe outwit the formulary would be made. Education was required to ensure these decisions were made appropriately.

3.1.5 Professor Timoney noted that in addition to face to face sessions at GP practices, information was also available on the Lothian Prescribing Bulletin which was sent round all practices, and on the Lothian Joint Formulary which was circulated every time an update was made and was available online.

3.1.6 The Committee supported the next steps laid out in the paper and agreed to receive an update on progress in one year, and for statistics to be included in the regular Healthcare Associated Infection paper. **BP**

3.2 Nursing and Midwifery Annual Report

3.2.1 The Nursing and Midwifery Annual report had been previously circulated. NHS Lothian's ratio of midwifery supervisor to midwife was lower than the recommendation, however all staff received a review within a year or 18 months. Work was in progress to ensure that in addition to formal supervisors there were other systems in place for reviewing.

3.2.2 There had been no increase in adverse events as a consequence of not meeting the recommended ratio, and all incidents were investigated and reviewed.

4. Emerging Issues

4.1 Death in Hospital Work

4.1.1 Dr Farquharson noted that in response to concerns about the way that Healthcare Trusts in England were managing unexpected deaths in hospital, NHS Lothian had been asked to give assurance that all unexpected deaths were recorded and reviewed, and that actions were put in place in response to learning.

4.1.2 There were 42 regular Mortality and Morbidity meetings across Lothian, but the approach was not consistent across all. A national review would take place with the aim of making these meetings consistent across Scotland.

4.1.3 A further update would be available at the September or November 2016 meeting, depending on the timing of the national review. **DF**

4.2 Healthcare Associated Infection HEAT Target Update

4.2.1 Dr Farquharson advised that both *Clostridium difficile* Infection (CDI) and *Staphylococcus aureus* Bacteraemia (SAB) rates were reduced in the latest Health Protection Scotland quarterly report and were no longer an outlier amongst Scottish Health Boards. This data only covered one quarter and the next quarter report was awaited to determine whether the trend would continue and show that actions taken as part of the improvement plan had had effect. There would be a full report at the next meeting. **DF**

4.3 Private Healthcare

4.3.1 Funding had been withdrawn for the future referral to Private Healthcare services to treat NHS Lothian patients. This would affect waiting times, but work was in progress to increase capacity in NHS Lothian, particularly in orthopaedics, plastics and ENT, which were areas of the private sector most used currently.

4.3.2 The risks and mitigating actions would be outlined in an update paper from Mr Crombie at the next meeting in July 2016.

5. Committee Effectiveness

5.1 Corporate Risk Register

5.1.1 The updated Risk Register had been previously circulated. The development of risk registers for the Integrated Joint Boards was in progress. Clear action plans were included for all the high risk areas. Dr Williams advised that Integrated Joint Board updates would be received by the Committee as a standing item starting from the next meeting in July 2016. It was suggested that a further update on primary care recruitment would be included in the paper for the next meeting. **JB**

5.1.2 It was noted that in table 1 of the report which highlighted the high risk areas, it would helpful if each of the risks showed which Board Committee had responsibility for each area. The action plans to mitigate risks were laid out in the Quality and Performance Report which was a standing item of this Committee. **JB**

5.2 Quality and Performance Report

5.2.1 The paper had been previously circulated. The format of the report had been updated so that risk, risk appetite, improvement plans and current status were included in the same paper. The Committee agreed that the new layout was helpful and that it was important for assurance that actions were matched to risks.

5.2.2 Item 3.2 in the paper showed allocation of areas to the appropriate Committee for assurance. This paper had been approved in principle at the Board but further work was required to ensure that the correct areas were allocated to the correct Committee. Those newly allocated to Healthcare Governance Committee on the table were not all currently discussed at the Committee, so some education would be required for Committee Members, which Jo Bennet agreed to facilitate Some areas allocated to the Acute Hospitals Committee could be considered to be Lothian wide issues and not confined to acute services, so committee members felt these may need to be moved back to the Healthcare Governance Committee where they sat currently. The paper would be brought back after further discussion had taken place.

5.2.3 It was noted that some responsibilities would be devolved to the Integrated Joint Boards. In order to ensure that Healthcare Governance Committee received assurance on its areas of responsibility the process of assurance for IJBs was being worked on, and Health and Social Care Partnerships would report to the Healthcare Governance Committee as a standing item at each meeting. Ms Morrison noted that options for integrating some of the patient experience data with the IJBs needed to be considered, particularly the 'Tell us Ten Things' questionnaire.

5.2.4 Members approved the recommendations laid out in the paper.

5.3 Primary and Community Care Assurance Need – Feedback from Workshop

5.3.1 A paper had been previously circulated. The actions laid out in the action plan were approved but it was noted that timescales needed to be added to give assurance that these were being carried out.

5.3.2 Members approved the recommendations laid out in the paper.

5.4 Healthcare Governance Committee Annual Report and Assurance Need

5.4.1 The Committee's Annual Report had been previously circulated. The report highlighted that Members had stated development needs in better understanding on the national policy context and training required in some of the areas of assurance part of the responsibilities of the Committee. Overall Members felt comfortable that the Committee was meeting its requirements.

5.4.2 Ms Allan noted in relation to page 1 of the report that more reports to the Committee relating to volunteers and carers would be useful.

5.4.3 Members approved the report, which would then be submitted to the Audit and Risk Committee for assurance.

6. Person Centred Culture

6.1 Person Centred Culture Report

6.1.1 A paper had been previously circulated. Professor McMahon noted that returned 'Tell us Ten Things' questionnaires gave the lowest scores for the questions about food and noise, but gave high scores for quality of care. The response rate was only 5% and actions to increase this were in progress but responses received were nevertheless useful. Wards received a lot of positive feedback in the form of letters and cards from patients and their relatives which was not collated centrally – consideration was being given as to how this could be done.

6.1.2 Improvements in the response time for complaints were being made and discussion on how to work in line with the Scottish Public Services Ombudsman's requirements was in progress and Ms Hirst was part of this. Ms Morrison advised caution on expecting rapid improvement as there had been more sickness and resignations in the Complaints Team and more recruitment was in progress.

6.1.3 Ms Hirst suggested that it would be useful if more information was included in the report on what changes and improvements were taking place in clinical areas as a result of the feedback received from patients. This would be part of the work of the new complaints assurance committee that would be set up.

6.1.4 Ms Meiklejohn asked for assurance ward and clinical staff were being offered opportunities for development of skills to improve early and local resolution of issues raised by patients. Ms Morrison noted that this was being encouraged on visits to wards but there had not yet been any training directive. Ms Hirst suggested that more fundamental changes were required to staff training and a dialogue with the nursing colleges was required to develop conflict resolution training as part of nursing training. Ms Myles noted that 'difficult conversations' training had been held for managers in Midlothian and that it had been agreed to also offer this training to ward staff.

6.1.5 Members were assured that patient experience was being captured and supported the next steps laid out in the paper.

7. Safe Care

7.1 Public Protection Update

7.1.1 A concern was raised in the previously circulated paper about the staffing levels in community nursing and health visiting which meant there was a risk of concerns about child protection issues not being raised. There had been recruitments to the Health Visiting Team and these were continuing. There were places for 40 health visiting students for the next academic year, an increase from 22 places last year.

7.1.2 All children had a named person and cases were being managed appropriately. Staff were addressing high priority areas but there was not the volume of staff or

experienced staff as before. Recruitment and temporary help from other areas would address this but in the meantime the risk was acknowledged and was recorded on the risk register. A weekly huddle monitored the situation and the Public Protection Team was working closely to support the Health Visiting Team.

7.1.3 Members supported the recommendations laid out in the paper.

7.2 Significant Adverse Events

7.2.1 A paper had been previously circulated. Ms Bennett advised that work on reducing the backlog of Significant Adverse Events which had not been reviewed was in progress and that a number of measures had been put in place to improve efficiency with carrying out reviews within the statutory timeframe.

7.2.2 The Chair welcomed Dr Lefevre to the meeting and gave an in depth report on the background of the backlog of Significant Adverse Event reviews in Mental Health, covering all sudden and unexpected deaths, and on the actions being taken to improve this. It was agreed that in order for learning to be useful the backlog needed to be cleared and the process made more efficient so that new reviews were undertaken at the appropriate time.

7.2.3 The majority of the mental health review backlog had been allocated to reviewers who had agreed to do extra time to work on these, and it was expected that they would all be completed in the next three months. A further six cases were pending response from mortuary and Police reports as to whether they needed to be treated as suicide reviews.

7.2.4 A change in job plan to include reviews as part of the duties of clinical staff was suggested. Currently reviews were carried out as part of additional activities which meant time was limited. A decision was yet to be made as to whether a small team of expert dedicated reviewers would be created, or whether a wider pool of clinicians trained to carry out reviews as part of their other duties would be established.

7.2.5 In relation to the case in the media currently that the death of a patient with learning disabilities in a Healthcare Trust in England was not investigated, Dr Lefevre advised that all sudden or unexplained deaths in Lothian where the patient had had contact with NHS Lothian services in the year prior to death were investigated.

7.2.6 As the number of opened reviews were increasing through time, it was questioned whether the actions put in place to clear the backlog would be enough to manage the number of reviews in the future. Professor McMahon advised that capacity was being built up and that this would continue to be reviewed. Ms Heslop added that the changes in the review process so that only relevant areas were considered within a review should also speed up the process.

7.2.7 In relation to using examples of good practice elsewhere in Scotland, Dr Lefevre advised that Healthcare Improvement Scotland were reviewing the process and giving feedback which included suggestions based on good practice in other areas. There had been liaison with NHS Greater Glasgow and Clyde, which had

successfully reduced a backlog by establishing a resource of dedicated expert reviewers to carry out all reviews.

7.2.8 The recommendations laid out in the paper were supported by the Committee, and it was agreed that there would be a further update at the meeting in July 2016 which would include timescales for actions put in place and evidence of learning and change of practice as a result of the reviews carried out. **JB**

7.3 Update on Essential Care – Falls and Pressure Ulcers

7.3.1 A paper had been previously circulated. The Committee had sought further assurance on these areas which constituted the top five themes of significant adverse events. Falls improvement and pressure ulcer management were part of the Scottish Patient Safety Programme (SPSP).

7.3.2 Members felt assured that actions were being put in place to reduce falls with harm, but would require further updates on pressure ulcer management. Ms Bennett advised that new national targets meant that both would be managed and monitored and that base rates would be established to show improvements made.

7.3.3 It was noted that approximately 1 in 3 patients with pressure ulcers have acquired these in the community. The focus for improvement is in acute areas but work was also being done in community hospitals and mechanisms for reporting from nursing homes and through community nursing needed to be established by working with the Integrated Joint Board.

7.3.4 It was noted that delirium, cognitive impairment in stroke, amputees, and brain surgery patients, and end stage dementia all increased the risk of falls and there would be extra focus on these areas.

7.3.5 Members approved the recommendations laid out in the paper.

7.4 Scottish Patient Safety Programme Walkrounds Update

7.4.1 A paper had been previously circulated which examined the benefits derived from the walkrounds in terms of learning and improvement actions taken. 90% of all actions generated from the walkrounds were completed. It was noted that staff and managers valued the walkrounds and agreed that they should continue.

7.4.2 Some improvements to the current format suggested included more involvement of consultants on the walkrounds, building on the patient feedback as part of the visit, for instance engaging with staff on how they get feedback from patients, identifying areas for quality improvement and development, and extension of the visits to primary care areas.

7.4.3 Some of the main themes picked up on the visits were not within the control of the service itself, for instance building and environmental problems, and recruitment, so more work was required to establish how these organizational themes could be worked on. It was suggested that actions could be included in the Performance Report.

7.4.4 The volume of work required to organise and administrate visits and to write up feedback to clinicians was acknowledged.

7.4.5 Triangulation of data so that it could be used by other teams including the Patient Experience Team would be useful. More feedback to clinicians on how organisational actions were being taken up would also be useful. The committee thought the paper had been worthwhile, and suggested an annual update.

7.5 Evaluation of Winter Performance

7.5.1 A paper had been previously circulated. 90% of patients had received treatment within four hours against the target of 95%. There had been very high numbers of patients at both St John's and the Royal Infirmary's Emergency Departments. There had been some four hour breaches and some eight and twelve hour breaches. Primary care staffing shortages could have contributed to this and the Health and Social Care Partnerships were working with Mr Crombie to resolve issues. Winter beds had been opened. Professor Timoney noted that pharmacy planning regarding opening of winter beds had been improved from the previous year.

7.5.2 A Winter debrief report had also been sent to the Scottish Government on 20 May 2016; this would be circulated to the Committee and there would be a further update at the next meeting in July 2016. **JC**

7.5.3 It was noted that although the data covered November to March as 'winter' contingency planning was now continuous as bad weather and infection outbreaks suggested the peak demand was October to April.

7.6 TRAK Write Access for Students

7.6.1 A paper had been previously circulated. It was acknowledged that access to patient's care plans which were now electronic was a fundamental part of training, and the option to give students write access to TRAK was supported. The risk and need for supervision was recognised as was the need for resource to support training, with some funding from NHS Education Scotland likely. It was noted that students in other Scottish Health Boards also did not have access to TRAK.

8. Effective Care

8.1 Homecare Medicines Service Update

8.1.1 An update report had been previously circulated. The main report would be received by the Committee at the next meeting in July 2016.

9. Exception Reporting Only

Members noted the following previously circulated items for information:

9.1 Voluntary Services Annual Report;
9.2 Occupational Health Clinical Governance Annual Report;
9.3 Diabetes Managed Clinical Network Annual Report;
9.4 Medicines Governance Strategy;

9.5 Governance of Independent Providers Update;
9.6 Involving People Update;
9.7 Trauma and Orthopaedic Peer Review Feedback Report, January 2016.

10. Other Minutes: Exception Reporting Only

Members noted the previously circulated minutes from the following meetings:

10.1 Area Drug and Therapeutics Committee, 1 April 2016;
10.2 Clinical Management Group, 9 February 2016, 8 March 2016;
10.3 Lothian Infection Control Advisory Committee, 15 March 2016;
10.4 Health and Safety Committee, 23 February 2016;
10.5 Acute Hospitals Committee, 1 March 2016;
10.6 Clinical Policy and Documentation Group, 26 April 2016.

11. Date of Next Meeting

11.1 The next meeting of the Healthcare Governance Committee would take place at **9.00** on **Tuesday 26 July 2016** in **Meeting Room 7, Second Floor, Waverley Gate**.

11.2 Further meetings in 2016 would take place on the following dates:
- 27 September 2016;
- 29 November 2016.

STRATEGIC PLANNING COMMITTEE

The draft minutes of the meeting held on 9 June 2016 are attached.

Key issues discussed included:

- **Integrated Joint Board Directions**
  IJBs are responsible for influencing 25% of the acute sector spend. Work is underway to clarify with IJBs and local authorities the basis of allocations and the need to move from historical based allocations to a more choice basis. Action plans are being developed to support continued dialogue. The Acute / IJB Interface Group provides a mechanism to discuss and agree common themes which will include input to the development of the Acute Hospitals Plan.

  A discussion paper will be presented in August 2016 outlining risks and lessons learnt from working with multiple Council boundaries.

- **Internal Audit Report – NHS Lothian Strategic Plan**
  A review of the strategic priorities outlined in Our Health, Our Care, Our Future 2014-24 will be undertaken. A report will be brought back to the committee in December 2016.

- **Children and Young People (Scotland) Act 2014**
  There is a legislative requirement to take forward the development, completion, approval and annual reporting associated with the four Lothian Joint Children's Service plans by April 2017. Three yearly plans to ensure principles associated with Getting It Right For Every Child (GIFREC) need to be produced and reviewed annually. There is a need to develop clear processes associated with performance monitoring of the named person legislation and availability of the health visitor workforce.

- **Implementation of the Children's Strategy**
  Strategy implementation has focussed on early years due to health visitor pressures. Key issues being taken forward relate to universal health services, new models of delivery services in communities, population changes, reprovision of acute paediatric services. CAHMS performance was also discussed and noted a workforce review is being undertaken.

- **Sophie Pathway and Children's Community Outpatient Services**
  Outpatient data is being reviewed to determine the most appropriate model for future service provision, including the co-location of services and IT linkage to support provision of joint appointments.

Key issues on the horizon are:

- IJB Directions – further paper to be developed for discussion and agreement.
- Development of a 5 yea strategic framework for nursing and midwifery
- NHS Lothian Hospital Plan
- Updates on Midlothian and East Lothian IJB Strategic Plan
- RHSC / DCN Re-provision

Brian Houston/Chairman
Alex McMahon, Nurse Director and Director of Strategic Planning
14 July 2016

DRAFT

NHS LOTHIAN

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 9.30am on Thursday 9 June 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG.

Present: Mr B Houston (Chair); Mr M Ash; Dr D Farquharson; Mrs S Goldsmith; Mr M Hill; Mr A Joyce; Professor A K McCallum; Professor A McMahon and Mr P Murray.

In Attendance: Mr C Briggs; Ms K Grieve; Ms F Mitchell and Mr D Weir.

Apologies for absence were received from Mrs J Anderson, Mrs K Blair, Mr A Boyter, Mr J Crombie, Councillor D Grant, Mrs C Harris, Councillor R Henderson and Mr D A Small.

14. Declaration of Financial and Non Financial Interest

14.1 The Chair reminded members that they should declare any financial and non financial interest that 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.

15. Minutes of the Previous Meeting Held on 14 April 2016

15.1 The minutes of the previous meeting held on 14 April 2016 were approved as a correct record subject to the following minor amendment: - minute 5.18 'Mrs Ash' to read 'Mr Ash'.

16. Matter Arising from the Previous Meeting

16.1 East Lothian Community Hospital Capacity for Surgical Treatment and Diagnostics – It was noted the issue around the provision of general anaesthetic services at the East Lothian Community Hospital had been subsequently discussed by the East Lothian IJB (Integration Joint Board) who although having concerns had accepted that the provision of general aesthetic services was not practical. There had at the meeting been issues of concern raised about the decant arrangements in the interim period between the old hospital closing the new one opening.

16.2 Health and Inequalities Strategy – Christie Commission Report – An update was provided on a meeting held between the Chairman, Mr Murray and Professor Christie with it being noted that the outputs of this meeting had been shared with the Chief Executive. The Chairman reported that he would discuss with the Chief Executive whether there was a case for building issues around the Christie Commission Report into the quality impact approach or indeed as part of the Board Development Session Programme.

16.3 The Committee noted that Board Chairs and Chief Executives had been encouraged by the Scottish Government to develop cross boundary partnership work even in the

absence of supporting guidance and regulations being in place. The point was made that irrespective of different governance structures that there remained a body of work to be done to ensure the delivery of appropriate outcomes around the health and inequality agenda. It was suggested that community planning might be an appropriate forum to progress this work in future.

17. Integration Joint Board Directions

17.1 The Committee received an update report highlighting the themes identified in IJB Directions and noted the process underway to further clarify directions. The report also highlighted a number of issues raised by NHS Lothian in response to the Directions.

17.2 It was noted that the paper before the Committee was a variation of a paper considered at the Acute Hospitals Committee earlier in the week. The paper therefore had an acute sector focus with it being intended that this would be the area for the benefits of the creative tensions created by the establishment of the IJBs to be felt given that IJBs would be responsible for influencing 25% of the acute sector spend. NHS Lothian had received Directions from all 4 IJBs and a common list of themes was identified in the circulated paper.

17.3 The process for NHS Lothian responding to the Directions was explained in detail. It was noted that NHS Lothian remained responsible for health service provisions. In terms of the key issues and points raised by NHS Lothian it was reported that ongoing discussions would identify appropriate action plans which would be worked up between NHS Lothian and the IJBs.

17.4 Whilst the detail of the emerging points highlighted in the paper was welcomed concern was expressed around the process of disintegration of responsibility for strategic planning. The need for a coherent and consistent challenge was stressed. The question was posed about whether the IJBs were being met with as a collective body in order to obtain early warning of emerging issues. The Committee were advised that there was a willingness to work collectively and regular meetings were held with IJB teams and colleagues from finance and strategic planning within NHS Lothian. The process would be bolstered by the recent recruitment of strategic planning lead planners who would link with IJB and other partners.

17.5 The Committee noted in particular that the acute IJB Interface Group Chaired by Professor McMahon and attended by all 4 IJBs provided a mechanism to bring together and discuss common themes. In addition a major area of work for the Strategic Planning Committee would be around the development of the Acute Hospitals Plan.

17.6 The point was made that NHS Lothian had in place a good strategic plan that contained non disease specific pathways that allowed outcomes to be delivered by NHS Lothian and the IJBs. It was felt that there were opportunities to look at other health systems particularly in England where disintegration had occurred to allow coherent planning to take place. This would provide an opportunity to address issues of contention before they arose particularly in respect of non delegated functions.

17.7 The point was made that the propositions within the strategic plan would need to be reviewed in terms of IJBs planning assumptions to ensure that they were consistent and bound together. There was a view that IJBs should be joint signatories to the NHS Lothian strategic plan given the influence that they would have on 25% of the spend in the acute sector. Reference was made to the fact that the lack of investment for patients with alcohol related brain damage would mean more cost incurred in the acute sector rather than in community alternatives. In that regard it would be important to ensure that any performance criteria set was supported by the IJBs. It was recognised that this represented a different way of working.

17.8 In terms of prescribing growth and in particular for expensive drugs there might be an argument for developing a hosted serviced. It was suggested that discussions around diabetes and drug and alcohol services would be a good starting point to obtain clarity of understanding. The point was made that IJBs would not be in a position to invest in areas that NHS Lothian had disinvested in and nor was the Integrated Change Fund intended to plug funding gaps.

17.9 It was reported in terms of set a side and hosted service budgets that work was underway to go back to IJBs and local authorities to confirm the basis of future allocations with it being noted that the current model was historically based and should be moved to reflect a more choice basis. Specific discussion ensued in respect of different models of allocating prescribing budgets and a need for a common approach to be agreed between NHS Lothian and the IJBs.

17.10 It was noted that 2016/17 would be the financial year where a number of areas like prescribing would need to be revisited and agreement reached. It was suggested that this work would progress following the quarter 1 financial review. It was recognised if IJBs had to divert money into areas like expensive drug expenditure then this had a corresponding impact elsewhere.

17.11 In terms of planning policy and protocols it was agreed given the complexity of this area that there was a need to take the circulated paper to the next level and develop an overview paper for discussion at the next meeting. It would be important that this paper defined when IJB Chief Officers would be expected to be representing their partnership and when they would be operating on an IJB basis as there was still a lack of clarity in this area.

17.12 The question was raised about whether the Scottish Government should be engaged in terms of lessons learned and whether these should be replicated across other NHS Boards as this might support the overall process. Discussion ensued about whether the risk register had been updated. It was noted that an understanding of risk would be part of the ongoing planning process. In terms of engagement with the Scottish Government around lessons learned it was agreed that the most productive way forward would be for NHS Lothian to give thought to producing a discussion paper given that it was one of only 2 Boards with multiple Council boundaries. A draft paper would be brought forward to the August meeting of the Strategic Planning Committee.

AMcM

17.13 The Strategic Planning Committee agreed the recommendations contained in the circulated paper.

18. Internal Audit Report – NHS Lothian Strategic Plan 2014/24

18.1 It had been felt that it would be useful for the Committee to discuss the recommendations in the circulated Internal Audit report which touched on numerous important issues. An action plan on the recommendations contained in the Internal Audit report would be brought back to the Strategic Planning Committee in December and would consider linkages with the Acute Hospitals plan and "Our Health Our Care Our Future" as well as the 4 IJBs strategic commissioning plans.

18.2 The Committee were advised that the risk section fitted closely with the Local Delivery Plan and financial discussions on how NHS Lothian and IJBs fitted together and this would be included in the paper to the Committee.

18.3 The suggestion was made that the final section of the NHS Lothian strategic plan needed to be reviewed to reflect current strategic priorities. It was noted that the process of producing the Acute Hospitals plan would pick up this iterative point of the process. It was noted that this process would identify a new set of actions.

18.4 It was suggested that the target date of June 2016 for the revision of the NHS Lothian strategic plan needed to be revised. A full report would be brought back to the Committee in December 2016.

18.5 The Committee approved the recommendations contained in the circulated paper and noted the positive Internal Audit report.

19. Children and Young People (Scotland) Act 2014 Statutory Requirements and Guidance on Children's Service Planning

19.1 The Committee received a paper and update report on the new legislative requirements for Local Authorities and Health Boards in relation to the development, completion, approval and annual reporting of the 4 Lothian Joint Children's Service Plans that required to be completed by April 2017.

19.2 It was noted that the Scottish Government were currently consulting on statutory guidance to support implementation of part 3 of the Act and NHS Lothian and partners were feeding into this process. It was noted that final approval of all Lothian Children Service's Plan would be through the NHS Board and Local Authority mechanisms.

19.3 The Committee noted that 3 yearly plans would be produced which would be reviewed annually to confirm that GIRFEC (Getting it Right for Every Child) principles were being applied and complied with. An update was provided on progress being made by individual IJBs. It was noted that this paper linked to other papers to be discussed later in the agenda.

19.4 An update was provided around work underway to comply with the forth coming named person legislation and the plans that were in place. The committee noted that a mixed planning economy was in place around children's services and this linked back to the role and supporting arrangements for community planning mechanisms. It was felt there was a need to develop a mechanism to make cleaner and clearer processes around performance monitoring. It would be important that this process avoided the burden of a detailed narrative for performance outcomes with a schematic

approach being more beneficial to maximise the performance scrutiny and assurance process.

19.5 The Committee were advised that within each Community Planning Forum there was a group that looked at children's services and it would be useful to consider what input these would have in the performance management arrangements. An update was provided on the specific arrangements for children's services within each Community Planning Partnership. It was noted that there would be benefit in developing a product planning approach of assurance of issues that needed to come through the Strategic Planning Committee. The key issue would be to identify the issues that really needed to come through the Strategic Planning Committee. It was noted that there were still issues around governance that needed to settle down.

19.6 The Committee agreed the recommendations contained in the circulated paper and noted that schematic work would be undertaken to show the before and after position.

20. Update on Implementation of Children's Strategy

20.1 The Committee received an update on the implementation of the NHS Lothian Strategy for Children and Young People 2014-2020 'Improving the Health and Wellbeing of Lothian's Children and Young People'. An update on defined strategic outcomes was provided to the Committee.

20.2 It was noted that there had been particular focus on the early years agenda because of pressures in terms of Health Visitor availability for which a rigorous national recruitment campaign had been undertaken with it being hoped that a new pathway for Health Visitors would help to deliver the aims of the strategy through more home visiting. An update was also provided on the school nursing service and the new national approach to deliver to those patients who were vulnerable and with special needs. The Committee were provided with details of key issues that had been taken forward including universal health services for children and young people; new models of delivering health services to children and young people in communities; population changes; legal landscapes; reprovision of acute paediatric services in Lothian and the performance matrix for strategy outcomes. It was noted although some work was running behind schedule that steps were being taken to catch-up.

20.3 The Committee were advised in terms of universal access that patients were assessed on their level of need and that families with higher levels of need would receive a proportionate response. The point was raised in terms of Child and Adolescent Mental Health Services (CAMHS) that despite increased investment that performance was going in the wrong direction although it was recognised it was not a position unique to Lothian. It was noted that demand was increasing and there were potential issues about the threshold for accessing the Lothian service with it being anticipated that continued joint working would assist in this area. GP referral patterns were being looked at and some trends were becoming evident. It was noted that workforce limitations would require a different approach in future. The Committee were advised that the Interim Nurse Director was looking at the totality of the workforce with a view to adopting a more generic approach to address capacity issues.

20.4 The Committee noted in terms of CAMHS clinical leadership that a new clinical lead had been appointed which would demonstrate a renewed focus in this area. It was

agreed that the CMT paper would be brought forward to the Strategic Planning Committee.

20.5 The point was made that reductions in community based preventative services in local authorities because of budget cuts had resulted in some children not having received informal contact in the early years which had led to an escalation of referrals to the CAMHS service. It was agreed there was a need to quantify the evidence of the consequences of budget cuts elsewhere.

20.6 The Committee were advised that the Scottish Government were undertaking a population mental health needs assessment of young people and this would provide non deniable data to inform the Lothian plans and determine models of care to include addressing the gaps caused be others. An update was provided on the steps being undertaken to address issues around the Millerfield facility which was being looked at by the Accommodation Group.

20.7 An update was provided on positive work with the City of Edinburgh Council around 'growing children with confidence' which it was felt would assist in addressing lower level mental health issues with children through increased teacher confidence.

20.8 The Committee agreed the recommendations contained in the circulated report. It was further agreed that the Committee would receive a copy of the previous Corporate Management Team paper on CAMHS.

21. Sophie Pathway and Children's Community Outpatient Services

21.1 The Committee were advised that work continued between NHS Lothian and Local Authority professional staff groups as well as ongoing literature reviews. The focus of the service was on what was important to children and their families. It was noted that although current services were valued by families that there were now more complex issues that needed to be addressed. Children's outpatient data from Trak was being reviewed to determine the service provision for the future which would include the co-location of services.

21.2 Ongoing work would think about shifting activity out to areas of need as there was already a lot of community provision that could be delivered more effectively. A further workstream would be to linkup IT services to work towards joint appointments although this would require to be done on a systemic basis.

21.3 It had been discovered that there were multiple management arrangements in place around children's services with there being a recognition for the need for more generic specialists as a lot of children's issues could be resolved at a lower level thereby reducing the need for escalation to more specialist acute services.

21.4 A further joint training event was being arranged following the recent successful GP training event on Getting It Right For Every Child. This training would focus on the most common issues for referral to the Royal Hospital for Sick Children. The aim of this work was to increase GP confidence in dealing with child health need and to reduce unnecessary referrals to the Royal Hospital for Sick Children.

21.5 The Committee noted that the paper had been supported by the Acute Division Senior Management Team.

21.6 Mr Murray commented that he would be happy to facilitate the use of retained fire stations for areas where there were no other facilities. It was noted that children found fire stations a very attractive venue. He was of the view that the public sector estates should be used more effectively and innovatively and that an asset based register should be developed.

21.7 The offer from Mr Murray was welcomed and accepted with it being noted that vacated space at Waverley Court, The City of Edinburgh Council HQ was now being used. The Health and Social Care Partnerships were keen to be flexible about changing arrangements to meet the needs of children.

21.8 The suggestion was made that the Acute Hospitals plan for NHS Lothian should include an overall estates perspective. It was felt to be important that when one NHS facility closed and another public sector venue was utilised that this should be captured as the savings would be significant.

21.9 The Committee agreed the recommendations contained in the circulated paper.

22. Date and Time of Next Meeting

22.1 The next meeting of the Strategic Planning Committee would be held at 9.30am on 11 August 2016 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

STAFF GOVERNANCE COMMITTEE

1.7

The draft minutes of the meeting held on 30 May 2016 are attached.

Key issues discussed included:

- The committee received a presentation from members of Project Search which is a partnership between NHS Lothian, the City of Edinburgh Council, Edinburgh College and Into Work providing employment and learning opportunities for young people with a disability. This updated the Committee on the programme that has been followed and which has resulted in the members being successful in gaining employment with NHS Lothian.

- A further update on the current position with Mandatory Training compliance was received by the Committee.

- The Committee also received the final progress report on the Staff Governance Action Plan for 2015-16, the completed Staff Governance Monitoring Framework Return for submission to the Scottish Government and also the Staff Governance Annual Report.

- A paper was also discussed on the progress with the Big Lottery Funded Project to Improve the Career Progression for Black Minority Ethnic Nurses in NHS Lothian.

- An update was also received on the current progress with the implementation of iMatter across NHS Lothian.

Key issues on the horizon are:

- Whistleblowing remains an important topic on the agenda. The review of the current policy needs to be finalised and also the monitoring arrangements put in place.

- Mandatory training compliance and in particular compliance with the Information Governance module on the back of the recent ICO Report will be a key issue.

Alex Joyce
Employee Director

DRAFT

NHS LOTHIAN

STAFF GOVERNANCE COMMITTEE

Minutes of a Meeting of the Staff Governance Committee held at 9.30am on Monday 30 May 2016 in Training Room11, Comely Bank Centre, 13 Crewe Road South, Edinburgh.

Present: Mr A Joyce (Chair); Mr A Boyter; Dr D Farquharson; Ms H Fitzgerald; Mr S McLauchlan; Mrs A Mitchell and Mr J Oates.

In Attendance: Mrs R Kelly (Associate Director of Human Resources - Governance); Professor A McCallum (Director of Public Health & Health Policy); Mr P Reith (Secretariat Manager) and the staff and members of Project SEARCH.

Apologies for Absence were received from; Councillor D Grant; Mr B Houston; Councillor C Johnstone and Professor A McMahon.

Declaration of Financial and Non-Financial Interest

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

1. Presentation by the Members of Project SEARCH

1.1 The Chair welcomed the staff and members of Project SEARCH to the meeting.

1.2 Mr Boyter explained that Project SEARCH was a partnership between NHS Lothian, the City of Edinburgh Council, Edinburgh College and Into work providing employment and learning opportunities for young people with a disability.

1.3 The Committee received a presentation from two members of Project SEARCH explaining the types of internships provided, outlining the skills learned, tasks undertaken and classes provided.

1.4 The Committee noted that the next phase of the project would be for all members completing the course to be found employment within NHS Lothian by the end of June 2016 and that two members of the group were now in permanent employment within the Western General Hospital and two were due to start at the Royal Edinburgh Hospital and Royal Infirmary of Edinburgh that week.

1.5 The Chairman thanked the members of the group for their presentation which is appended to these minutes.

1.6 The Chair asked how sustainable the project was and the Committee noted that Big Lottery and European Union funding had been applied for as there was only funding for one further year unless NHS Lothian could pickup the funding for the tutor and job coaches.

1.7 Mr Boyter advised that the project fitted in well with NHS Lothian's Human Resources Strategy in respect of socially responsible recruitment. He had been very impressed with the presentation and hoped that going forward, even in difficult financial circumstances, funding could be found for this kind of programme.

1.8 In an open discussion with members of the project it was suggested that early assimilation training to address any concern that applicants might have with working in the NHS and covering issues such as curtains drawn around beds would be useful.

1.9 Mr Boyter thanked the members and staff of Project SEARCH and congratulated the members on their presentation skills. The members of Project SEARCH left the meeting.

1.10 Mr Boyter advised that he had been to see the project on six occasions and was confident that none of the members would let NHS Lothian down. The positive interactions between members and patients were inspiring and embodied why it was important to continue with the project.

1.11 The Chair advised that he was happy to champion this project.

2. Minutes of the Previous Meeting

2.1 The previously circulated Minutes of the Staff Governance Committee meeting held on 27 January 2016 were approved as a correct record.

3. Matters Arising

3.1 Internal Audit Report on Organisational Culture - Mrs Kelly advised that the internal audit on organisational culture requested by the Chief Executive had now started and would run for 28 days involving a number of aspects of the organisation and its culture.

3.2 Statement of Assurance Needs - The Committee noted that the Chair and Mrs Kelly had met with Alan Payne and the Chair had discussed the issue of how Integration Joint Boards would impact on the statement of assurance needs. It had been intimated that this should not make any difference to the Staff Governance Committee as NHS staff working for Integration Joint Boards remained under the purview of the Staff Governance Committee whilst staff working for the Local Authority would come under the Local Authorities' arrangements. There would therefore be two parallel lines to ensure a safe working environment.

4. Mandatory Training Compliance

4.1 Mr Boyer introduced a circulated report giving an update on actions being taken to improve mandatory training compliance.

4.2 The Committee noted that for the first time NHS Lothian was showing, on average, above 60% compliance on all mandatory topics. Only two topics remained at an

amber rating with the majority comfortably sitting above 70%. It was noted that this would remain as a standing item on the Staff Governance Committee agenda. **AB**

4.3 Mrs Kelly advised that the dashboard on mandatory training compliance had now gone live and would enable managers to see who had and had not done the required mandatory training and allow them to take the appropriate actions.

4.4 The Chair advised that management of mandatory training compliance would also be regularly discussed at Local Partnership Forums.

5. Staff Governance Action Plan 2015-16 Final Progress Report

5.1 Mrs Kelly introduced the circulated Staff Governance Action Plan for 2015-16 in the Scottish Government mandated format.

5.2 In terms of progress it was noted that the communications strategy, the implementation of iMatter, performance appraisal and personal development plans, NHS Lothian values, organisational change, whistle blowing and sickness absence were in the amber category which meant they were not yet fully achieved but significant progress had been made. All other key actions had been achieved. Mrs Kelly advised that those areas in which there was still work to be done would feature in the action plan paper for 2016/17.

5.3 Mrs Mitchell commented that timelines would be helpful as they would give an indication of how progress was moving forward.

5.4 Mr Oates asked if there was correlation between staff appraisals and the achievement of mandatory training.

5.5 Mr Boyter advised that the Scottish Government was currently looking at replacing eKSF, the current form of appraisal with team appraisals.

5.6 Mrs Kelly advised that an appraisal add-on was being developed for the new Human Resources system but in the interim the use of eKSF had been extended for a further year.

5.7 The Committee noted progress on the Staff Governance action plan.

6. Staff Governance Standard Scottish Government National Annual Monitoring Return 2015/16

6.1 Mrs Kelly introduced the circulated annual monitoring return for 2015/16 to the Scottish Government on the Staff Governance Standard. It was noted that the draft had already been submitted to the Scottish Government to meet the deadline of 6 May 2016 as the postponement of the Staff Governance Committee meeting had meant that the return could not be approved in time.

6.2 The Committee noted that the return reflected the work that had been undertaken during the year and examples of good practice. NHS Boards were required to given an overview of what they were planning to do to resolve any issues identified in the return and demonstrate compliance with the PIN guidelines.

6.3 Mrs Mitchell queried the response on whistleblowing and Mrs Kelly advised she had been struggling to put in something on best practice as NHS Lothian had very few examples of this.

6.4 Professor McCallum commented that the primary care and the dental team had supported dental practice staff who were whistleblowers. That group of staff had been very modest about their own achievements and whilst there would be other examples of good practice it was unclear how information on these could be collected centrally. It was agreed to add this example to the return.

6.5 Mr Boyter commented that every month he received a report from the National Whistleblowing Help Line advising that there had been no whistleblowing reports from NHS Lothian. Providing support for whistleblowers was difficult because of the need for confidentiality and whilst local arrangements were in place to provide support these were difficult to publicise.

6.6 Mrs Mitchell commented that there was a need for some way and process of being aware centrally of instances of whistleblowing and in particular agreeing a method of how the organisation dealt with such reports.

6.7 It was agreed that Mrs Kelly would liaise with Professor McCallum around the wording of the return. **RK**

7. Annual Report of the Chair of the Staff Governance Committee

7.1 The Committee noted the circulated annual report of the Chair of the Staff Governance Committee including member's feedback on the effectiveness of the Committee. It was commented that development opportunities in support for members of the committee in undertaking their role needed to be considered further in the coming year as it had been raised as an issue in the feedback forms and it was agreed that it would be helpful if members could identify what kind of training they felt was required.

7.2 Mrs Kelly advised that Redmain Training had carried out a course for Audit and Risk Committee members and members of the Staff Governance Committee were asked to email the Chair and Mrs Kelly with any suggestions. **All**

7.3 It was noted that the committee had worked with the Healthcare Governance and Audit and Risk Committee's and had contacted the Integration Joint Boards to see what their requirements where. Two Integration Joint Board Chairs were members of the committee and it was agreed that the other 2 Chairs could be invited to attend Staff Governance Committee meetings. The Chair agreed to suggest this to the Integration Joint Boards concerned. **AJ**

8. Big Lottery Funded Project to Improve Career Progression for Black Minority Ethnic Nurses in NHS Lothian

8.1 Mr Boyter introduced a circulated report giving an update on the big lottery funded projects to improve career progression for black minority ethnic nurses.

8.2 Mr Boyter reminded the Committee that this was a 5 year project started in January 2015 and the first year had completed all the agreed actions for that year. Mr Boyter advised that it was proposed to add in monitoring and progress of the project would be reported to the committee 2 - 3 times each year.

8.3 Mrs Kelly advised that staff were being educated as to why their information on ethnicity was required and results were improving.

8.4 Mr Oates asked if the reports to the big lottery fund could be considered by the committee first and Mr Boyter advised that this would be done. **AB**

8.5 The Committee agreed to note the progress made to date and supported the plans for continuing with the project whilst noting the risk to the project and seeking a further progress report early in 2017.

9. Fair Warning Lessons Learned and Recommendations for Process Improvement

9.1 Professor McCallum introduced a circulated report proposing improvements in the process of investigation and reporting of fair warning incidents.

9.2 Professor McCallum advised the Committee that NHS Lothian had undergone a consensual audit by the Information Commissioners Office in February 2016 following a series of breaches. It was noted that a failure to demonstrate continuing improvement in reducing the risk of future breaches by timely reporting and learning from incidents would increase the risk of fines of up to £500k by the Information Commissioner in the event of a future breach.

9.3 It was noted, that in spite of frequent warnings, there were still a number of instances in which staff inappropriately accessed confidential information and the recommendations contained in the report were being made to improve the position. The position would continue to be monitored and if outcomes were not improved the position would be re-examined.

9.4 The Committee agreed to approve the following recommendation:

- Line managers must inform the Information Governance Team of any breach of confidentiality on the same working day that this is discovered. Line managers must ensure that fact finding and identifying the improvements in a way that confidentiality is safe guarded that arise following any incident must be undertaken separately from any investigation of employee conduct.

- To ensure that delays in the investigation process do not undermine the organisations ability to respond to and learn from breaches of confidentiality, the following process improvements are recommended:

    - All incidents will continue to be recorded on Datix and the information Governance Team alerted.
    - Monthly progress reporting will continue.
    - All investigations should be concluded within 3 months and, if any potential for delay is identified at the 6 week stage, this will be escalated

to the Caldicott Guardian and Associate Director of Human Resources (Services).

- The outcomes of any investigation and recommendations for learning or improvement should be reported in writing to the Information Governance Team. A proforma has been drafted to support this process and is awaiting formal approval from the Information Governance Assurance Board.
- The outcomes noted under the previous item will be summarised in the quarterly report to the Information Governance Assurance Board and noted in the report from the committee to Healthcare Governance.
- To request a paper on how to strengthen staff selection, training and understanding of confidentiality and information governance to reduce the risk of future incidents.

10. Litigation Annual Report 2014/15

10.1 The Chair introduced the circulated report and advised that its purpose was to provide assurance on NHS Lothian Litigation Management. The Committee noted that the Audit & Risk Committee had noticed an increase in claims from staff, mostly in estates and facilities and had asked the Staff Governance Committee to consider this to see if there were any emerging issues. A key issue identified had been that low paid staff were being targeted by no win no fee lawyers and this was contributing to the increase in claims.

10.2 The Committee noted that a number of programmes to improve safety were in place and would contribute to mitigation against future claims. These programmes addressed both generic safety issues and specific issues which linked to the themes for claims.

10.3 The Committee took the view that no further action could be identified to reduce claims and the Chair undertook to respond to the Chair of the Audit and Risk Committee. **AJ**

11. iMatter Continuous Improvement Model - Update

11.1 Mrs Kelly introduced a circulated report progress in relation to the implementation of the iMatter Continuous Improvement Model.

11.2 The Committee noted that implementation was still on target and that in the areas so far implemented, the NHS Lothian response rate was 82% compared to the current NHS Scotland response rate of 66%. The report detailed future cohorts to be introduced and it was noted that an iMatter Steering Group was being established and an iMatter faculty to train people was being set up.

11.3 Mrs Mitchell commented that the results were very encouraging and emphasised the importance of make best use of the information obtained.

11.4 The Committee agreed to note the continued progress being made towards rolling out iMatter and the next cohorts to implement the model.

12. Information Commissioner's Office Report

12.1 Professor McCallum gave a verbal report on the report of the Information Commissioner's Office. Areas of previous concern already discussed included subject access requests and records management training.

12.2 The auditors had felt that there was limited assurance around training and development and mandatory training and had found it difficult to understand the Scottish system.

12.3 The Information Governance part of the report to the Healthcare Governance Committee had already been implemented and there was a need to ensure greater clarity on what precisely the Staff Governance Committee could do in this area.

12.4 Professor McCallum emphasised the need for measureable outcomes for training plans so that progress could be monitored. Currently the focus was on what was going wrong rather than what was working well.

12.5 The auditors had not understood that mandatory training and induction were different issues and had felt that 80% was not an appropriate level for compliance. There was a need to capture data on more than mandatory training and improvements should made to e-learning.

12.6 Amongst other recommendations were that there should be a whole organisation training analysis.

12.7 Professor McCallum commented that how NHS Lothian responded to these recommendations was problematic.

12.8 Mr Boyter commented that it would be necessary to see and analyse the detailed report. He noted that as the Health and Safety Executive could not prosecute simply for not agreeing with them he wondered what the position was with the Information Commissioner.

12.9 Professor McCallum advised that whilst some of the recommendations would need to be implemented the full report would need to be analysed and an action plan drawn up. This would be discussed at the next meeting of the Information Governance Assurance Board.

12.10 Mrs Mitchell commented that it would be helpful if all training received could be recorded on a single system.

12.11 The Committee agreed to note the position.

13. Whistleblowing Update

13.1 Mrs Kelly advised the Committee that there was a need for a review of the whistleblowing policy. The PIN guidelines and other NHS Board policies had been examined by the HR Policy Group and in line with these policies, NHS Lothian should be considering the introduction of named contacts for whistleblowing. Mrs Kelly would write to the Corporate Management Team about this and feedback at the next meeting.

13.2 In terms of monitoring, it would only be possible to monitor whistleblowing incidents being reported through Human Resources at present.

13.3 The Committee noted that the NHS Lothian numbers were consistent with other NHS Boards and this had been discussed with other Deputy Directors of Human Resources and there was a need to consider monitoring mechanisms.

13.4 Mrs Mitchell advised that the issue was what managers did about something that did not come through the formal declaration of whistleblowing. It was necessary to make both staff and managers aware of the Boards policy. There would be a meeting of whistleblower champions to discuss this and she would welcome any information from NHS Lothian.

13.5 Mrs Kelly advised that complaints made by staff would go through Human Resources rather than the complaints department and more information on how other Boards were monitoring this would be helpful. It was agreed that this should be a standing item on the agenda. **RK**

14. Statement of Assurance Needs Update

14.1 The Committee noted and agreed the previously circulated statement of assurance needs for the Staff Governance Committee noting that most categories were satisfactory but questioned the somewhat contradictory formal conclusion 'adequate but ineffective' on a number of items as being contradictory.

15. Proposed Revised Reporting Arrangements for the Health and Safety Committee

15.1 Mr Boyter advised the Committee that discussions had been held with the Board Chair as to where the Health and Safety Committee should sit and a paper would be submitted to the Board proposing making the Committee a formal Committee of the Board and not reporting through the Staff Governance Committee.

15.2 The Committee noted the position.

16. Health and Safety Committee

16.1 The Committee noted the minutes of the Health and Safety Committee held on 23 February 2016.

17. Lothian Partnership Forum

17.1 The Committee noted the minutes of the Lothian Partnership Forum meetings held on 19 January and 8 March 2016.

18. Workforce Organisational Change Group

18.1 The Committee noted the action notes of the Workforce Organisational Change Group meetings held on 25 January, 22 February, 21 March and 25 April 2016.

19. Date of Next Meeting

19.1 It was noted that the next meeting of the Committee would be held on Wednesday 27 July 2016 at 9.30am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

NHS LOTHIAN

1.8

Board Meeting
3 August 2016

Alison Meiklejohn, Chair Area Clinical Forum

AREA CLINICAL FORUM CONSTITUTION

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approves the proposed amended constitution of the Area Clinical Forum, agreed at the Area Clinical Forum meeting held on 7 July 2016.

2 Recommendations

The Board is recommended to:

2.1 Approve the proposed amended constitution for the Area Clinical Forum

3 Discussion of Key Issues

3.1 The constitution (Appendix 1) has been revised to update the Forum's membership; incorporate reference to engagement with Integration Joint Boards; include the Chief Quality Officer in the ex-officio membership of the Forum, reflect CEL 16, equalise status of all professional committees and to clarify arrangements in the need for any vote.

4 Key Risks

4.1 There are no risks associated with this proposal.

5 Risk Register

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

6 Impact on Inequalities

6.1 This document is to advise the NHS Board of a constitutional amendment to the Area Clinical Forum. An equality impact assessment is not required for this document.

7 Involving People

7.1 This paper does not specifically propose any strategy/policy or service change.

8 Resource Implications

8.1 There are no resource implications involved.

Alison Meiklejohn
Chair, Lothian Area Clinical Forum
3 August 2016
Alison.Meiklejohn@nhslothian.scot.nhs.uk

List of Appendices
Appendix 1: Lothian Area Clinical Forum Constitution July 2016

LOTHIAN NHS BOARD

AREA CLINICAL FORUM

CONSTITUTION

1 NAME

The Committee will be known as the Lothian NHS Board Area Clinical Forum.

2 CORE FUNCTIONS

The Area Clinical Forum is a statutory Professional Advisory Committee of NHS Lothian. Further guidance is available in CEL 16 (2010). Core functions of the Area Clinical Forum include but are not restricted to:

- reviewing the business of professional advisory committees to ensure co-ordination of clinical matters across each of the professional groups;
- the provision of a clinical perspective on the development of the Local Delivery Plan and the strategic objectives of the NHS Board;
- sharing best practice and encouraging multi professional working in healthcare and health improvement;
- ensuring effective and efficient engagement of clinicians in service design, development and improvement;
- providing a local clinical and professional perspective on national policy issues;
- ensuring that local strategic and corporate developments fully reflect clinical service delivery;
- taking an integrated clinical and professional perspective on the impact of national policies at local level through the ACF Chair, being fully engaged in NHS Board business; and supporting the NHS Board in the conduct of its business through the provision of multi professional clinical advice.

3 ROLE OF THE AREA CLINICAL FORUM CHAIR

The Chair of the ACF is appointed by Scottish Ministers as a non executive member of NHS Lothian Board, is accountable to NHS Lothian Board Chairperson, and has an important role in terms of:

- providing a multiprofessional clinical perspective on strategy development and service delivery issues considered by the NHS Board;
- explaining the work of the NHS Board and promoting opportunities for clinicians to be involved in decision making locally;
- championing multiprofessional co-operation across the clinical disciplines and providing a vital link between the NHS Board and the ACF; and
- actively participating in national arrangements to promote and develop the role of ACFs.

4 MEMBERSHIP OF THE FORUM

The membership of the Forum will be as follows:

The Chair and Vice Chair of each of the following recognised professional advisory committees -

Lothian Area Dental Committee
Lothian Area Allied Health Professions Committee
Lothian Area Medical Committee
Lothian Area Nursing & Midwifery Advisory Committee
Lothian Area Optical Committee
Lothian Area Pharmaceutical Committee
Lothian Area Healthcare Scientists Committee
Lothian Area Psychology Committee

Provision should also be made to augment the membership by including representation from any new professional advisory committee established at the behest of the Scottish Government or the NHS Board.

Members and their deputies must be clinicians with a current professional registration.

Integration Joint Boards (IJBs) Professional Representation
The Professional lead for Clinical and Care Governance within each IJB will receive a standing invitation to attend meetings and will be circulated with copies of the agenda and previous minutes

Ex Officio Members
The Director of Public Health and Health Policy; Medical Director; Nurse Director and Chief Quality Officer of NHS Lothian will receive a standing invitation to attend meetings and will be circulated with copies of the agenda and previous minutes.

Attending
Persons other than members may be invited to attend a meeting for discussion of specific items at the request of the Chair or Secretary. Such persons will be allowed to participate in the discussion but will not have a vote.

5 SUB-COMMITTEES

The Forum may appoint ad hoc Sub-Committees as appropriate to consider and provide advice on specific issues.

6 TENURE OF OFFICE

The Committee membership will be reviewed in September of each year.

The membership is drawn from the Professional Committees; tenure of office will be reviewed each alternate year, with tenure of office ranging from two years to a max of eight years.

7 OFFICERS OF THE FORUM

a Chair of the Area Clinical Forum

The Forum will elect a Chair in September of each alternate year.

The Chair of the Area Clinical Forum will be chosen by the members of the Forum from among the Chairs of recognised professional advisory committees.

If more than one person puts themselves forward, then an election shall be held. The Administrator to the forum shall act as returning officer. The vote shall be by secret ballot. If there are more than two candidates, then the person with the fewest votes will be eliminated from each round of the election until one candidate has a simple majority.

When an election for Chair is being held in advance of taking office, then the people eligible to stand for election and to vote will be those representing their respective advisory committees at the time the new Chair takes office. Each advisory committee will have one vote.

In cases where the members of an Area Clinical Forum choose to replace their Chair before the expiry of their term of appointment as a member of the NHS Board, the new Chair would have to be formally appointed as a NHS Board member. In the same way, if NHS Board membership expires and is not renewed, then that person must resign as Chair of the Area Clinical Forum (but may remain as a member of the Forum).

b Vice Chair

The Vice Chair will be elected in the same way as the Chair every two years.

8 NOTICE OF MEETINGS

The NHS Board will provide secretariat support to the Forum who will be responsible for ensuring that the agenda and relevant papers are issued at least one week before meetings whenever possible.

9 MINUTES

Secretariat support will ensure that minutes are drawn up of each meeting and are sent to
each ACF member
the Chair of NHS Lothian Board
the Chief Executive of NHS Lothian
the Director of Public Health and Health Policy
the Medical Director of NHS Lothian
the Nurse Director of NHS Lothian
the Director of Strategic Planning, Performance and Reporting
the Chief Quality Officer
IJB Chief Operating Officers
IJB Professional leads for Clinical and Care Governance

10 MEETINGS

Meetings will be held at least four times per year.

A quorum of the Forum will be four members from regulated groups.

11 COMMITTEE DECISION

Each professional advisory committee will have one vote.

Where the Forum is asked to give advice on a matter and a majority decision is reached the Chair will report the majority view but will also make known any minority opinion and present the supporting arguments for both view points.

12 CONFIDENTIALITY AND CONFLICT OF INTEREST ISSUES

Elected members will be required to be objective and to ensure confidentiality and professional advice where there may be conflicts of interest. Any conflicts of interest should be declared at the start of each meeting.

Confidentiality will be a corporate responsibility of the Committee and any members of working parties will require to agree to confidentiality and to maintain discretion in relation to issues.

13 ALTERATIONS TO THE CONSTITUTION

Alterations to the Constitution may be considered annually. Amendments must be seconded and supported by two-thirds of the members present and voting at the meeting.

The constitution will be submitted to the NHS Board for approval.

JULY 2016; approved at NHS Lothian Board XXXXXXX

NHS LOTHIAN

2.1

Board Meeting
3 August 2016

Medical Director

SUMMARY PAPER - NHS LOTHIAN CORPORATE RISK REGISTER

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

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

• Consider the Very High and High Corporate Risks to inform and provide context for papers and issues discussed on the Board agenda.	2.1
• There are 13 risks in total (set out in Table 1), with one risk HAI being reduced from Very High (20) to High (16) since the last quarter.	3.3
• The Board'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*."	3.4
• In Table 1, the Current Risk Tolerance Measures are highlighted either in green or red to indicate if the measure is within or outwith tolerance. These targets and associated action plans are detailed in the Summary of Performance Position within the Quality & Performance Improvement Report.	3.5

Jo Bennett
Associate Director for Quality Improvement & Safety
29 July 2016
Jo.bennett@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board meeting
3 August 2016

Medical Director

NHS LOTHIAN CORPORATE RISK REGISTER

1 Purpose of the Report

1.1 The purpose of this report is to inform the Board of the risks on the corporate risk register, and the current performance against its risk appetite and tolerances.

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

2 Recommendations

2.1 Consider the Very High and High Corporate Risks to inform and provide context for papers and issues discussed on the Board agenda.

3 Discussion of Key Issues

3.1 The Board needs to assure itself that adequate improvement plans are in place to attend to the corporate risks and in most instances are set out in the Quality & Performance Improvement paper presented to the Board and relevant governance committees (see Table 1 below).

3.2 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.

Corporate Risk Register

3.3 There are 13 risks in total (set out in Table 1), with one risk HAI being reduced from Very High (20) to High (16) since the last quarter.

3.4 The Board'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.*"

3.5 In Table 1 below, the Current Risk Tolerance Measures are highlighted either in green or red to indicate if the measure is within or outwith tolerance. These targets and associated action plans are detailed in the Summary of Performance Position within the Quality & Performance Improvement Report.

Table 1

Risk Title	Jan-Mar 2016	Current Risk Tolerance Measures (if applicable)	Link to current performance in the Quality & Performance Improvement Report or other Board paper
The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	Very High 20	In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%	Please refer to the Financial Update as at 31st May 2016 report.
		For the year to date the overspend against the total core budget for the year to date is not more than 0.1%	Please refer to the Financial Update as at 31st May 2016 report.
Achieving the 4 hour emergency target 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.	Very High 20	95% of patients are to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment with tolerance of 93-98%. NHS Boards are to work towards 98%.	Please refer to Summary Position within the Quality & Performance Improvement Report
Achieving the Delayed Discharge targets at 2 weeks 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.	Very High 20	No patient will wait no more than 14 days to be discharged, with an appetite of 14 days, and a tolerance of 15 days	Please refer to the Delayed Discharge page within the Quality & Performance Improvement Report
General Practice Sustainability (new risk – October 2015) 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 and premises difficulties.	Very High 20	No measure	No paper for this Board meeting
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, including TTG. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology.	High 16	No measure	Please refer to the paper on the Implementation of the Royal College of Paediatrics and Child Health Recommendations
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	⇩ High 16 Reduced June 2016	Staphylococcus aureus Bacteraemia Achieve a rate of no higher than 0.24 per 1,000 bed days (no more than 184 incidences) with a tolerance	Please refer to the SAB page within the Quality & Performance Improvement Report

Risk Title	Jan-Mar 2016	Current Risk Tolerance Measures (if applicable)	Link to current performance in the Quality & Performance Improvement Report or other Board paper
stay in hospital, increased mortality and morbidity and further treatment requirements.		of 95% against target. n=193 to 184	
		Clostridium difficile Infection Achieve a rate of no higher than 0.32 per 1,000 bed days (aged 15+) (no more than 262 incidences) with a tolerance of 95% against target. n=275 to 262	Please refer to the CDI page within the Quality & Performance Improvement Report
Patient Safety - Delivery of four SPSP Work streams. There is a risk that NHS Lothian does not reliably implement the 4 workstreams of the Patient Safety Programme leading to potential patient harm	High 16	Reduce falls with harm by 20% with a tolerance of 15-20%	Please refer to Summary Position within the Quality & Performance Improvement Report
		Scotland target to reduce acute hospital mortality by 20% with a tolerance of 15-20%	Please refer to Summary Position within the Quality & Performance Improvement Report
		Achieve 95% harm free care with a tolerance of 93-95%	No paper for this Board meeting. The performance level is taken from the Patient Safety Programme Annual Report (July 2015).
		No of all patients admitted to hospital with an initial diagnosis of stroke should receive the appropriate elements of the stroke care bundle, with an appetite of 80% and a tolerance of 75%	Please refer to the Stroke Bundle page within the Quality & Performance Improvement Report
Achievement of National Waiting Times Targets There is a risk of not meeting the national waiting times targets for a number of reasons due to lack of core capacity, demand exceeds capacity or resources are not optimally utilised Withdrawal from independent sector April 2016 sees a deteriorating performance for some specialties Financial overspend due to reliance on ad hoc additional capacity – i.e. waiting list initiatives/ locums; and risk of not achieving Value for Money.	High 16	90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Please refer to the Referral to Treatment (18 weeks) page within the Quality & Performance Improvement Report
		95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%	Please refer to Summary Position within the Quality & Performance Improvement Report
Patient Experience – 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	High 16	Patients would rate out of 10 their care experience as 9.5, with a tolerance of 9.	Please refer to the Patient Experience page within the Quality & Performance Improvement Report

Risk Title	Jan-Mar 2016	Current Risk Tolerance Measures (if applicable)	Link to current performance in the Quality & Performance Improvement Report or other Board paper
of patients/families in their care. It is also acknowledged that a number of other corporate risks impact on this risk such as the processes and experience of unscheduled care, patient safety and waiting times. This includes the management of and learning from complaints.			
Facilities Fit for Purpose (accepted back on the Corporate Risk Register October 2015) 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.	High 16	No measure	No paper for this Board meeting
Health & Safety – Management of Violence & Aggression. (Reported at H&S Committee, via Staff Governance Committee Minutes) 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.	High 15	No measure	No paper for this Board meeting
Nursing Workforce – Safe Staffing Levels (new risk – October 2015) 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 compromising safety and incurring additional spend from related supplementary staffing.	High 12	No measure	No paper for this Board meeting
Roadway / Traffic Management (Risk placed back on the Corporate Risk Register December 2015) (Reported at H&S Committee, via Staff Governance Committee Minutes) There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites	High 12	No measure	No paper for this Board meeting

3.3 The risk appetite reporting framework currently contains performance on the following risk tolerance measures, but they do not directly correlate to risks that are

on the corporate risk register. Nevertheless they are still pertinent to the Board's objectives and the risks being managed.

Current Risk Tolerance Measures	Link to current performance in the Quality & Performance Report or other Board paper
Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas, with a 10% tolerance (36-40%). (Target = 293 minimum per quarter)	Please refer to Summary Position within the Quality & Performance Improvement Report
At least 80% of women in each SIMD percentile will be booked for antenatal care by 12th week of gestation, with a 10% tolerance (69.3-77%)	Please refer to Summary Position within the Quality & Performance Improvement Report
Staff absence below 4% with a 5% tolerance (4-4.2%)	Please refer to the Staff Sickness Absence page within the Quality & Performance Improvement Report

3.4 The Risk Management Steering Group (RMSG) is currently examining the very high risks in detail to assess the risks both individually and across the number of very high risks, and will report through the Audit & Risk Committee in September 2016 and Board in October 2016.

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 Inequality, including 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 Involving People

7.1 This report does not relate to the planning and development of health services, nor any decisions that would significantly affect people. Consequently public involvement is not required.

8 Resource Implications

8.1 The resource implications are directly related to the actions required against each risk.

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29 July 2016
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NHS LOTHIAN **2.2**

Board Meeting
3 August 2016

Chief Officer

MEDICAL PAEDIATRICS REVIEW - UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the actions which have been taken to progress the recommendations of the Royal College of Paediatrics and Child Health (RCPCH) Review of Medical Paediatric services in Lothian following the Board's meeting on 22 June 2016, and consider and approve the Paediatric Programme Board's recommendations about the next steps.

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

2 Recommendations

2.1 Review and support the ongoing actions and discussions which have been taking place with all the relevant clinical teams, to progress the recommended resident consultant model for the St John's Hospital (SJH) Paediatric service (Option 1 in the RCPCH report)

2.2 Agree the proposed pan- Lothian Job Plans for eight Consultant posts (including the vacant post at SJH) to support both the new model at SJH and the Royal Hospital for Sick Children (RHSC) service and to agree to an immediate recruitment drive

2.3 Agree the drive for more Advanced Paediatric Nurse Practitioners (APNPs) and note the recruitment underway for trainees to start in the autumn and the advertisement out for trained Practitioners

2.4 Note that the Paediatric Programme Board, which has representation from the clinical teams at SJH, RHSC and the Neonatal service, Royal Infirmary of Edinburgh (RIE) has been established and has met, chaired by a Non Executive Director of NHS Lothian Board

2.5 Note that the Paediatric Programme Board has considered the RCPCH's recommended interim option, which the Board accepted in principle at its meeting on 22 June 2016 (Option 2) and has concluded that this option should not be recommended as an interim position because of concern about the potential clinical risk.

2.6 Note and commend the commitment of the SJH clinical team in their efforts to keep the Paediatric services there running as currently, by working up an interim Resident model rota which could be put in place from September 2016 until January/ February 2017, while recruitment to the new posts above takes place

2.7 Agree that the Programme Board and the SJH team should be given a further week to demonstrate that this interim Resident rota is workable and sustainable for a period of 5 months, accepting that this puts pressure on the service if the model is found not to be robust and an alternative needs to be implemented by the beginning of September

2.8 Agree that at this stage, the only other interim option which is Option 3 , the Short Stay Assessment unit model, should not be actively pursued unless no other viable interim option can be put in place

3 Discussion of Key Issues

Paediatric Programme Board

3.1 At its meeting on 22 June 2016, the Board agreed to set up a Paediatric Programme Board, to be chaired by a Non Executive Director, to oversee the implementation of the RCPCH's recommendations as approved by the Board.

3.2 Mr George Walker has been appointed as Chair of the Programme Board and the Vice Chair is Mr Martin Hill, Non Executive Director. A Project Manager has been identified and the first meeting of the Programme Board took place on 27 July 2016.

3.3 The Programme Board's members include two Consultant Paediatricians from SJH, two from RHSC and one Consultant Neonatologist from RIE, as well as senior Nursing and Medical Management, Partnership and Finance.

3.4 The Programme Board's immediate tasks have been to oversee progress with the proposed resident consultant staffing model for the SJH service, to ensure that the urgent medical workforce pressures at RHSC are addressed and to agree the safest interim option for the SJH Paediatric service from the end of August.

3.5 Throughout July, the clinical teams on all sites have been meeting together weekly to discuss both the short term and longer term staffing and service models and these discussions have also included representatives from the Emergency Departments at both SJH and RHSC, as well as the GP Out of Hours service (LUCS) and the Scottish Ambulance Service (SAS).The output from these meetings has been fed back into the Paediatric Programme Board to inform its discussion.

Resident Consultant staffing model (RCPCH recommended model, Option 1)

3.6 In order to clarify the clinical team's support for the RCPCH's recommendation that the longer term SJH's service and workforce model should become a resident consultant one, individual meetings have been taking place with each of the SJH Consultants and non-consultant career grades to clarify their personal intentions with respect to undertaking resident out of hours shifts described as a requirement for implementing Option 1 in the RCPCH report. Some of these meetings are still to take place due to the summer holidays and the final position will not be clear until mid August.

3.7 It has also been agreed that individual discussions should take place with each of the RHSC Consultants to determine if any of them would also provide support for the SJH resident model and these meetings will take place during August.

Pan Lothian Job plans- Consultant Recruitment

3.8 Through discussion with the RHSC paediatricians and the SJH's team, there has now been agreement that all the Consultant posts which are to be advertised should have job planned commitments to provide resident consultant out of hours cover at SJH as well as to support the RHSC Acute Medical Receiving unit. The detail of the proposed job plans and specifically, the appropriate amount of out of hours cover, is now being

finalised and the posts will be ready to go to recruitment in August. It has been agreed that if any of the successful candidates wish to work less than full time, they will still require to contribute fully to the out of hours work.

3.9 As well as the posts originally recommended to support RHSC, there will need to be additional posts advertised in order to cover both sites and progress the Resident Consultant model at SJH. The Programme Board's recommendation is that eight posts should be advertised on Monday August 8th, and this would include the vacant SJH Consultant post. There is a strong view that block recruitment of this nature is likely to be more successful than staggered recruitment, even if the first round does not recruit to all posts, as it signals a clear commitment and intent to prospective candidates.

Advanced Paediatric Nurse Practitioner Recruitment

3.10 Internal adverts were circulated in early July inviting nursing staff at RHSC and SJH to note interest in undertaking the Advanced Paediatric Nurse Practitioner Master course starting this autumn. This course takes 16 months and the intention is that these staff will provide support on both sites when their training is complete. It is expected that two places will be taken up this year.

3.11 An external advert has also been placed for the recruitment of trained Advanced Paediatric Nurse Practitioners, to work across services in Lothian and the closing date is in August.

Deanery Discussions

3.12 There has been discussion with the Dean of Postgraduate Medicine about the distribution of Trainees in future and this has confirmed that while it remains inappropriate for Trainees to be allocated to SJH for out of hours overnight and weekend work because of the low training value of the case mix, one or two Trainees could in future be allocated there in the daytime. From a Training perspective, this would be subject to the SJH team completing a curriculum mapping exercise to demonstrate what training can be offered. From a service perspective, given that Trainees are a limited resource, the allocation of Trainees to SJH would have an impact on one or more of the other hospitals in the South East Scotland Region.

3.13 A meeting was held on 29 July with the South East Scotland Health Boards, the South East Scotland Workforce Planning Team, the Postgraduate Dean and the Training Programme Directors, to review this and it was confirmed that the service hierarchy previously agreed between the Boards to determine the prioritisation of Trainee allocation remained unchanged and that the quality of the Training programme in South East Scotland had improved very significantly over the last few years, as demonstrated in GMC surveys.

3.14 However, at the meeting, it was formally agreed that the potential to allocate a small number of Trainees to SJH for the daytime, as and when the total number of available Trainees allowed, would be kept under active review.

Interim Service options – Option 2 in RCPCH Report

3.15 Discussions to define and agree the best interim option for SJH (Option 2 in the RCPCH report, or a variant of this agreed by the clinical teams) have been taking place at weekly meetings throughout July, as described above.

3.16 These discussions have highlighted significant concerns from all the clinical teams about Option 2 as defined by the RCPCH and a lack of support to implement this model.

3.17 The Paediatric Programme Board has now considered all the views expressed and on the advice of its seven medical and nursing members, has concluded that this option carries too much clinical risk and should not be supported. The key risks, benefits and resource issues of this option are set out below.

COMPONENT OF OPTION 2	BENEFITS	RISKS	RESOURCES
Children not admitted to SJH after 20.30		Risk of the ward closing de facto after 22.00 as medical and nursing staff may be risk averse to admitting/keeping children in the ward. Risk because of this of not having the right staffing resource in the right place.	Beds, nursing staff, and medical cover at RHSC but difficult to plan for and resource as impact uncertain.
Children thought to be at risk of deterioration transferred to RHSC in the evening	Children will be in an inpatient unit best equipped to meet their needs.	Deterioration is not always predictable in children. PEWS and similar early warning scores not highly sensitive or specific. Significant responsibility on nursing staff overnight who will not have the on site paediatric backup they are used to.	Evening ward round by resident consultant. Increased transfers by ambulance. Staff to accompany children for transfer.
Children will continue to attend SJH Emergency Department(ED) after 20.30 and either be sent home or transferred to RHSC	Local A+E service still available OOH	Parents may opt to go straight to RHSC or delay attending SJH until the next day. Lack of clarity for parents / public about when to take a child to SJH. Children will not be assessed by a paediatrician with the same level of skills as currently happens.	Increased calls and attendance by on-call consultant. Increased ambulance transfers.

COMPONENT OF OPTION 2	BENEFITS	RISKS	RESOURCES
Consultant rota 08.00 to 22.30 seven days a week	Always a senior decision maker available when children are being admitted	Increased OOH commitment required from current trained staff, particularly at weekends with knock on effect on day-time working	Day time DCC to cover clinics will be reduced so impact on outpatient services.
SCBU OOH will be covered by neonatal staff and SJH staff who have this already in their job plans	Procedures and policies can be brought in line with neonatal unit at RIE	Potential gaps in rota and need to cover	3 neonatologists, 1 staff grade, 2 clinical fellows, ANNP with support from SJH consultant on call.
Children's ward after 22.30 will be covered by nursing staff with consultant on-call from home	Children with low-acuity conditions/treatment can stay nearer home or be transferred back from RHSC	Delay in having unexpectedly ill child being assessed and stabilised by experienced paediatrician.	Communication with HAN team at RHSC at 03:00. CC at RHSC to take responsibility for phoning SJH children's ward.
Children's ward remains open	Easier to move to recruit and retain staff and move to Option 1 than if ward closes overnight		

Alternative interim proposal – SJH team

3.18 The SJH team have discussed and put forward an alternative interim proposal which would involve most of them committing on a time limited basis to work in a resident model, pending the recruitment of more consultants and Advanced Nurse Practitioners. It is understood that any rota would require to be European Working Time Directive compliant to prevent reliance on over working, so there would be an impact on daytime activity, particularly outpatient clinics. Any locum cover required would be paid at time and a third, not triple time as at present.

3.19 An outline rota for September and October was put forward at the Programme Board meeting on 27 July 2016 and discussed in detail. The SJH team's commitment was fully recognised, commended and supported, however, it was acknowledged that the rota presented to the meeting was very draft and had significant gaps. It was agreed however that when a number of new consultants started to take up post, this proposed resident rota would begin to become realistic.

Option 3- Short Stay Assessment Unit

3.20 Accepting that the recommended longer term model for SJH would take time to implement, that the RCPCH's proposed interim solution (Option 2) for end of August onwards was agreed by all to have too many risks, and if the SJH team interim proposed model could not in fact be delivered immediately, the Programme Board then considered the only remaining option, which was the Option 3 model in the RCPCH report. This model would see the SJH Paediatric service temporarily revert to a Short Stay Assessment unit with no inpatients overnight, while recruitment to Consultant posts took place.

3.21 It was noted that Option 3 and Option 2 had some similar features and risks and specifically, that under both options, there would be no paediatrician presence in SJH overnight to support immediate assessment should a sick child be brought to the Emergency Department (ED) during the night. Both options would still involve having Neonatal out of hours presence however to cover the Special Care Baby Unit (SCBU) and the Labour Ward. The risk assessment of this option is set out in the Table below.

COMPONENTS OF OPTION 3	**BENEFITS**	**RISKS**	**RESOURCES**
Children not admitted to SJH for in-patient care	Clear cut patient pathways – LUCS, ED, Parents, SAS. Resources can be targeted more specifically. RHSC Service can be planned better. Known model of service, from in-patient closures 2012 & 2015 although these were summer months.	More children than need to going to RHSC in case in-patient admission required	Transport requirements will need to be clarified, with SAS and LUCS.
Children will continue to attend SJH ED	ED services could be augmented by paediatric nursing staff released from ward night shift cover as during previous temporary closures. These staff could also support patient transfers.	No on site paediatrician out of hours to support ED for walk ins. (Consultant on call from home still)	Increased calls and attendance by on-call consultant. Staff who cover SJH ED overnight will require to attend paediatric clinical decision making and simulation training. Transport / ambulance requirements.
Inpatient ward closed temporarily		Risk of this temporary closure impacting on recruitment unless strong recruitment campaign launched at same time.	
SCBU OOH will be covered by neonatal staff and SJH staff who already have this in their job plans.	Procedures and policies can be brought in line with Neonatal Unit RIE	Potential gaps in rota and need to cover	3 Neonatologists, 1 staff grad, 2 clinical fellows, ANNP, with support from SJH Consultant on call.

3.22 The view at the Programme Board meeting was that while everyone had been striving to find an appropriate and safe staffing model which maintained the inpatient service seamlessly throughout this transition period, the Short Stay Assessment Unit model presented less risk for patient care and for staff than Option 2 and that if the SJH team interim resident model could not be guaranteed, the Short Stay Assessment Unit option should be recommended to the NHS Lothian Board, on the basis that the Board's commitment to reinstating a sustainable inpatient service as soon as possible was made clear and that recruitment to the new posts was progressed as quickly as possible.

Current Recommendation

3.23 Following further discussion after the Paediatric Programme Board meeting, the SJH team have made it clear that they are absolutely committed to finding an interim solution that keeps the Paediatric inpatient service running at SJH and that they do not want to see any reduction in the service, even in the short term.

3.24 They have continued to work up an interim Resident rota and it is now recommended that their more detailed proposals for a 5 month temporary resident rota should be considered fully by the Paediatric Programme Board, before any final decision is made. This will delay a final decision being recommended to the NHS Lothian Board, however, it is felt that the SJH team should be given every opportunity to develop a viable proposal.

4 Key Risks

4.1 There is a risk that the SJH interim Resident rota may not be viable, or sustainable for a period of 5 months.

4.2 There is a risk associated with a delay in confirming the interim model and getting this into operation going into the busier winter months.

4.3 There is a risk of recruitment failing to achieve sufficient results or not quickly enough, if posts are not seen as reasonably attractive in terms of their out of hours commitment.

4.4 There is a risk around the longer term commitment of the existing SJH team to the Resident Consultant model.

5 Risk Register

5.1 There are no new risks for the NHS Lothian Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 An Integrated Impact Assessment will require to be carried if the agreed interim model of service results in changes to pathways of care for children.

7 Involving People

7.1 The RCPCH Review has fully involved all stakeholders throughout and the NHS Lothian Board also held Public meetings throughout Lothian to involve local communities and feed in their view.

8 Resource Implications

8.1 The resource implications were outlined in the Board paper on 22 June 2016 and the Programme Board will now take on the task of working through the detail of both the transitional and the permanent costs associated with the agreed plans.

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2 August 2016
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List of Appendices

Appendix 1: Paediatric Programme Board Membership

APPENDIX 1

Membership of the Paediatric Programme Board

George Walker	Non Executive Director, Chair
Martin Hill	Non Executive Director, Vice Chair
Dr Edward Doyle	Associate Medical Director
Lynda Cowie	Associate Nurse Director for Children & Young People
Fiona Mitchell	Service Director
Dr Paul Eunson	Clinical Director, Medical Paediatrics, Lothian
Dr Aniela Tybulewicz	Paediatrician, St John's
Dr Helen Rhodes	Paediatrician, St John's
Dr Sonia Joseph	Paediatrician, RHSC
Dr Laura Jones	Paediatrician, RHSC
Professor Ben Stenson	Consultant, Neonatal Unit
Andrew Bone	Finance Business Partner
Jenny McKinnon	Partnership
Oliver Campbell	Programme Manager

NHS LOTHIAN

Board Meeting

3 August 2016

2.3

Director of Finance

SUMMARY PAPER - FINANCIAL UPDATE AS AT 30 JUNE 2016

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

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

Point	Paragraph
• The financial position as at June 2016 is a deficit of £4.5m.	2.1
• A further £6m NRAC funding has been received from the Scottish Government, reducing the Financial Plan gap to £14.1m.	2.1
• To deliver a breakeven position a total of £44.4m of recovery plans will be required to be delivered in full. To date £30.4m of low and medium risk recovery plans have been identified.	3.1, 3.12
• The Board paper on the corporate risk register identifies two risk tolerance measures for the Board's risk appetite relating to Finance. The Board is currently breaching both of these tolerances.	3.6
• Early signs are that the ban on the use of agency nursing is having an impact with the use of supplementary staffing in Nursing on a downward trend.	3.7

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20 July 2016
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NHS Lothian

Board Meeting

3 August 2016

Director of Finance

FINANCIAL UPDATE AS AT 30TH JUNE 2016

1 Purpose of the Report

1.1 The purpose of this report is to provide an update on the financial performance of NHS Lothian against the Board's 2016/17 Local Delivery Plan ("LDP").

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 are asked to accept the paper and note the following:

- The financial position as at June 2016 is reporting a deficit of £4.5m;
- A further £6m NRAC funding has been received from the Scottish Government. This funding reduces the Financial Plan gap to £14.1m;
- Ongoing actions are being progressed to reduce the predicted financial deficit in order to achieve a year-end balanced position; however no assurance can be given of a breakeven position at the year end.

3 Discussion of Key Issues

2016/17 NHS Lothian Local Delivery Plan

3.1 The Board submitted its LDP for 2016/17 at the end of June and further to this submission has received confirmation from the Scottish Government of a further £6m NRAC funding in year. Taking this additional funding into account the Board requires to deliver £44.4m of savings in order to breakeven by 31 March 2017. Currently £30.4m of recovery actions have been identified.

3.2 As part of budget sign off process which is currently concluding, all areas of NHS Lothian are continuing to review services, staffing levels and ongoing areas of pressure in order to achieve a break even position by year-end.

3.3 As at 30 June 2016 the Board's overspend against the Revenue Resource Limit is £4.5m. If this trend continues and there are no further benefits generated from financial recovery activities, then the Board is predicted to be overspent by £18.2m at the year end.

3.4 The Quarter 1 Review is currently being undertaken to establish a detailed year-end forecast. This process will include a full review of the deliverability of currently identified Financial Recovery Plans and assessment of any emerging pressures.

Financial Position as at June 2016

3.5 Table 1 (below) shows that pay expenditure is the most significant driver of the month 3 position. Within that nursing, medical and support service costs are the main driver of the pay overspend.

Table 1: Financial Position to 30th June 2016

	Mth 1	Mth 2	Mth 3	YTD
	£000	£000	£000	£000
Pay	(1,511)	(1,179)	48	(2,642)
Non Pay (incl GP Prescribing)	999	(1,128)	(1,699)	(1,828)
Income	369	42	414	825
Efficiency Savings	(1,477)	(544)	(375)	(2,396)
	(1,620)	**(2,809)**	**(1,612)**	**(6,041)**
Reserves Flexibility	0	0	1,500	1,500
Total	**(1,620)**	**(2,809)**	**(112)**	**(4,541)**

3.6 The Board paper on the corporate risk register identifies two risk tolerance measures for the Board's risk appetite relating to Finance. The Board is currently breaching both of these tolerances.

3.7 There is a particular focus on nurse staffing expenditure this financial year, with monthly performance meetings with the Chief Nurses and the Director and Assistant Director of Nursing, accompanied by the Deputy Director of Finance. These meetings review key metrics with the intention of reducing overall nursing expenditure position to within budgeted levels whilst maintaining and improving quality and safety. Early indications are that these meetings are productive, with both supplementary and permanent nursing showing signs of recovery plans achieving required results. Although the average nursing sickness level is at 5.5% and still in excess of the target 4%, the position is improved on the same time frame last year.

Table 2: Nursing and Supplementary Staffing Analysis

	Uplifted Apr - Sept 15/16 Ave	Apr 16	May 16	June 16
	£000's	£000's	£000's	£000's
Agency	178	412	232	172
Bank	1,667	2,098	2,237	1,612
Total Supplementary	**1,845**	**2,511**	**2,469**	**1,784**
Permanent	**31,534**	**30,701**	**30,607**	**30,497**

3.8 The medical staffing overspend of £1.3m is driven for the most part from the continued pressure on junior medical staffing within acute services (£0.8m). Initial analysis work is progressing and will inform the management actions that are being developed with the service to address the overspend.

3.9 Non pay costs overall, after three months, are reporting an overspend of £770k, with medical supplies and out of area treatments substantially worse than trend.

Primary Care Prescribing

3.10 The £1.3m overspend reported to June reflects a prorata share of the Financial Plan forecast of £5.5m. Each Partnership is committed to managing this overspend as part of their overall position.

3.11 NHS Lothian is currently undertaking an external review of primary care prescribing with support from colleagues across the health board to review further opportunities to reduce the overall level of growth and maximise savings opportunities.

Financial Recovery Plans

3.12 To deliver a breakeven position, the Financial Plan required £44.4m of recovery plans to be delivered. To date £30.4m of recovery plans have been identified as low and medium risk in terms of the ability of management to deliver against these plans.

3.13 Schemes defined as high risk, either because of the financial risk associated with them or the potential impact on services, have been excluded from delivery estimates at this stage although there is a clear expectation that business units will continue to progress these schemes.

3.14 The requirement to deliver £44.4m of recovery actions incorporates the unmet efficiency savings target carried forward from previous years totalling circa £13m. £2.4m of the £4.5m overspend reported for the year to date relates to carry forward efficiency targets yet to be removed and these will continue to be phased in on a monthly basis as part of the overall position.

Other Actions to Achieve Financial Sustainability

3.15 There are a number of additional financial recovery initiatives underway across NHS Lothian with the aim of reducing expenditure in order to achieve financial balance for 2016/17. As highlighted above, the 2016/17 financial plan has a £14.1m deficit against available resources and there is a requirement to continue to review opportunities to reduce this gap during the year in order to give certainty that a break even position for 2016/17 is achievable.

3.16 The Quarter 1 review will provide an opportunity to give early consideration to the anticipated year-end position, and progress from services in terms of financial recovery plans and achievement of a balanced position.

3.17 NHS Lothian has been in regular dialogue with the SGHSCD around our financial position and this will continue, recognising the financial risk to breakeven.

4 Key Risks

4.1 At this stage, elements of assumed funding in the Financial Plan are just being confirmed, for example proposed reductions to values in Bundles and Alcohol and Drug Partnership funding. Plans are still being agreed and will need to be implemented to reduce the expenditure in line with the confirmed reductions.

4.2 Non delivery of recovery actions by individual Business Units to the value required to cover the gap in the financial plan.

5 Risk Register

5.1 There is nothing further to add to the Risk Register at this stage, although this will be reassessed as part of the Q1 review.

6 Impact on Inequality, including Health Inequalities

6.1 There are no implications for health inequalities or general equality and diversity issues arising directly from the issues and recommendations in this paper.

7 Involving People

7.1 The implementation of the financial plan and the delivery of a breakeven outturn will require service changes. As this particular paper does not relate to the planning and development of specific health services there was no requirement to involve the public in its preparation. Any future service changes that are made as a result of the issues raised in this paper will be required to adhere to the Board's legal duty to encourage public involvement.

8 Resource Implications

8.1 The financial results deal principally with the financial governance on operational management of existing resources and no resource implications arise specifically from this report.

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20 July 2016
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List of Appendices

Appendix 1 - NHS Lothian Income & Expenditure Summary 30 June 2016
Appendix 2 – NHS Lothian Summary by Operational Unit to 30 June 2016

Appendix 1

NHS Lothian Income & Expenditure Summary to June 2016

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)	Period Variance (£k)
Medical & Dental	239,058	59,838	61,081	(1,243)	(527)
Nursing	383,441	97,726	99,005	(1,279)	258
Administrative Services	87,265	21,391	21,074	317	230
Allied Health Professionals	61,190	15,313	15,437	(125)	33
Health Science Services	37,162	9,141	9,016	125	38
Management	9,673	2,436	2,113	323	132
Support Services	51,962	12,716	13,447	(732)	(170)
Medical & Dental Support	9,492	2,086	2,304	(218)	(81)
Other Therapeutic	24,918	6,596	6,411	185	91
Personal & Social Care	2,460	652	627	25	66
Other Pay	(3,011)	(3,484)	(3,457)	(26)	(22)
Emergency Services	11	11	12	(0)	(1)
Pay	**903,621**	**224,422**	**227,070**	**(2,648)**	**48**
Drugs	122,291	29,722	29,315	408	174
Medical Supplies	85,440	22,613	23,334	(721)	(775)
Maintenance Costs	5,652	1,385	1,599	(214)	(9)
Property Costs	39,953	9,717	8,698	1,019	429
Equipment Costs	25,119	6,095	6,882	(787)	(134)
Transport Costs	9,663	2,500	2,446	54	(3)
Administration Costs	146,246	18,525	18,383	142	(71)
Ancillary Costs	11,638	2,916	3,075	(159)	(144)
Other	13,715	(13,785)	(14,071)	287	(158)
Service Agreement Patient Serv	97,067	23,468	24,268	(799)	(638)
Non-Pay	**556,784**	**103,159**	**103,928**	**(770)**	**(1,329)**
Gms2 Expenditure	110,144	31,384	31,206	178	140
Ncl Expenditure	3	1	0	1	0
Other Primary Care Expenditure	87	22	28	(6)	(1)
Pharmaceuticals	147,486	36,764	37,941	(1,177)	(505)
Primary Care	**257,719**	**68,170**	**69,175**	**(1,005)**	**(366)**
Other	**(1,338)**	**(330)**	**(282)**	**(48)**	**(4)**
Income	**(1,743,814)**	**(69,277)**	**(70,101)**	**824**	**414**
Revenue Resource Limit	**0**	**0**	**(1)**	**1**	**0**
Savings Target Non-Pay	(11,454)	(2,396)	0	(2,396)	(375)
OPERATIONAL POSITION	**(38,482)**	**323,748**	**329,790**	**(6,041)**	**(1,612)**
Additional Reserves Flexibility	1,500	1,500	0	1,500	1,500
TOTAL	**(36,982)**	**325,248**	**329,790**	**(4,541)**	**(112)**

NB. The above table relates to Core Services only. There is £36.982 m of Non Core Budget not shown above that balances the annual budget to zero.

Appendix 2

NHS Lothian Summary by Operational Unit to June 2016

Description	University Hosp Support Serv (£k)	Reas (£k)	Edinburgh Partnership (£k)	East Lothian Partnership (£k)	Midlothian Partnership (£k)	West Lothian Hsc Partnership (£k)	Facilities And Consort (£k)	Corporate Services (£k)	Strategic Services (£k)	Inc + Assoc Hlthcare Purchases (£k)	Reserves (£k)	Total (£k)
Annual Budget	**666,312**	**69,691**	**272,294**	**79,809**	**56,770**	**130,154**	**151,791**	**88,827**	**7,350**	**(1,605,642)**	**45,662**	**(36,982)**
Medical & Dental	(824)	(106)	(51)	(98)	15	(80)	(0)	60	(158)	0	0	**(1,243)**
Nursing	(874)	(231)	(216)	47	5	(8)	(13)	29	(19)	0	0	**(1,279)**
Administrative Services	261	13	(38)	(25)	(13)	(25)	40	133	(29)	0	0	**317**
Allied Health Professionals	(352)	27	107	30	20	74	(3)	(27)	(1)	0	0	**(125)**
Health Science Services	25	(9)	93	4	0	32	0	(20)	(0)	0	0	**125**
Management	(2)	0	113	21	17	16	16	139	4	0	0	**323**
Support Services	(60)	3	(2)	(15)	0	(14)	(623)	(19)	(1)	0	0	**(732)**
Medical & Dental Support	(191)	0	0	0	0	(24)	0	(3)	0	0	0	**(218)**
Other Therapeutic	18	17	37	(0)	(5)	35	(2)	86	(0)	0	0	**185**
Personal & Social Care	(17)	(35)	9	(3)	0	0	(0)	72	0	0	0	**25**
Other Pay	22	0	0	0	16	0	(34)	(30)	0	0	0	**(26)**
Emergency Services	0	0	0	0	0	0	(0)	0	0	0	0	**(0)**
Pay	**(1,996)**	**(321)**	**53**	**(40)**	**54**	**7**	**(620)**	**420**	**(205)**	**0**	**0**	**(2,648)**
Drugs	550	38	(18)	(85)	(23)	(29)	(0)	11	(36)	0	(0)	**408**
Medical Supplies	(555)	5	(191)	(50)	(2)	(37)	130	(20)	(0)	0	0	**(721)**
Maintenance Costs	(64)	(31)	(8)	(15)	(0)	(28)	(57)	(10)	(1)	0	0	**(214)**
Property Costs	(8)	16	77	(39)	(5)	60	899	21	(1)	0	0	**1,019**
Equipment Costs	(344)	7	(33)	(45)	(6)	9	(68)	(305)	(2)	0	0	**(787)**
Transport Costs	(33)	(17)	57	4	17	5	78	(35)	2	(24)	0	**54**
Administration Costs	133	(181)	109	79	2	57	(239)	(145)	327	(0)	0	**142**
Ancillary Costs	44	(9)	(14)	(2)	3	11	(176)	(13)	(2)	0	0	**(159)**
Other	11	3	24	75	(14)	(107)	13	282	0	0	0	**287**
Service Agreement Patient Serv	87	(62)	(39)	(55)	(0)	117	48	(117)	372	(1,150)	0	**(799)**
Non-Pay	**(177)**	**(231)**	**(35)**	**(133)**	**(30)**	**58**	**627**	**(331)**	**658**	**(1,174)**	**(0)**	**(770)**
Gms2 Expenditure	(1)	(3)	49	28	29	85	(0)	(9)	0	0	0	**178**
Ncl Expenditure	0	0	0	1	0	0	0	0	0	0	0	**1**
Other Primary Care Expenditure	(6)	0	0	0	0	0	0	0	0	0	0	**(6)**
Pharmaceuticals	(1)	(39)	(228)	(191)	(307)	(411)	0	0	0	0	0	**(1,177)**
Primary Care	**(7)**	**(42)**	**(179)**	**(162)**	**(278)**	**(326)**	**(0)**	**(9)**	**0**	**0**	**0**	**(1,005)**
Other	**(1)**	**0**	**(5)**	**0**	**0**	**(45)**	**0**	**2**	**0**	**0**	**0**	**(48)**
Income	**494**	**17**	**(74)**	**7**	**1**	**36**	**71**	**(1)**	**33**	**240**	**0**	**824**
Revenue Resource Limit	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**1**
Savings Target Non-Pay	(1,606)	(251)	(518)	88	54	214	(131)	(152)	(94)	0	0	**(2,396)**
OPERATIONAL POSITION	**(3,293)**	**(829)**	**(759)**	**(240)**	**(200)**	**(56)**	**(52)**	**(70)**	**392**	**(934)**	**(0)**	**(6,041)**
Additional Reserves Flexibility	0	0	0	0	0	0	0	0	0	0	1,500	**1,500**
TOTAL	**(3,293)**	**(829)**	**(759)**	**(240)**	**(200)**	**(56)**	**(52)**	**(70)**	**392**	**(934)**	**1,500**	**(4,541)**

NB. The above table relates to Core Services only. There is £36.982 m of Non Core Budget not shown above that balances the annual budget to zero

2.4

NHS LOTHIAN

Board Meeting
3 August 2016

Nurse Director

SUMMARY PAPER - QUALITY AND PERFORMANCE IMPROVEMENT

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
Overall of the 35 assessed, 15 standards were met, while 20 were not.	Table 1, Page 4

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Analytical Services
29 July 2016
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NHS LOTHIAN

Board Meeting
3 August 2016

Nurse Director

QUALITY AND PERFORMANCE IMPROVEMENT

1 Purpose of the Report

1.1 This report provides an update on the most recently available information on NHS Lothian's position against a range of quality and performance measures.

1.2 Any member wishing additional information on a particular measure should contact the lead director, identified in section 4 of the paper, for that performance information in advance of the meeting. Matters relating to the monitoring and assurance changes proposed should be directed towards the Interim Nurse Director.

2 Recommendations;

2.1 The Board is invited to accept this report as assurance that performance on 15 measures, including those relating to the Hospital Scorecard, are currently met.

2.2 The Board is recommended to ask its Committees to form their initial views on assurance for those areas not met.

3 Process and Recent Performance

3.1 This paper draws together those measures historically featuring in the Quality Report with those from the Performance Reporting paper in line with the process agreed by the Board in December 2015. Where a standard has not been achieved, a completed proforma has been provided by the responsible director to allow the issue to be explored in more depth by providing an explanation of current performance and a timescale for improvement as well as detailing underlying actions.

3.2 In April 2016, the Board received proposals outlining the alignment of metrics to its committees for the purposes of assurance. These proposals have been subject to further reflection within the committees, particularly at Healthcare Governance and were further discussed at a meeting of the Board Committees' Chairs in July. This resulted in the agreement of a standard approach to describe assurance and its trial. It is recommended, in light of this, that the Board ask for the Committees for their initial views on assurance in areas where the quality and performance standard is not met.

3.3 Members may also wish to note that engagement sessions have been scheduled to occur over August and September with those completing the proforma. These sessions are intended to identify learning and spread best practice in their completion.

3.4 Members will recall that previously data issues prevented those outpatients waiting at Edinburgh Dental Institute from being including in waiting time reports. This absence has now been addressed with months from March 2016 updated from those previously provided. Work continues with the Dental Institute on improving data quality aspects in this area.

3.5 It is appropriate that two future changes impacting next time are brought the attention of the committee. Firstly, in line with recommendations to the Corporate Management Team, the responsibility for the oversight of post-diagnostic support following diagnosis of dementia will transfer from the Chief Officer, University Hospitals and Support Services to the IJB Chief Officers. Secondly, the reporting of delayed discharges will alter following this cycle to take account of the changes in national definitions due to occur. This will create discontinuities from figures reported to date and limit the potential for historical comparisons.

3.6 Table 1 sets out compliance - whether the target is met, recent trend and comparative position, and allows assessment of variation from standards. Those targets not met are covered in further detail in section 4. Of those considered, 15 were met whilst 20 were not. Assessment will not be possible for the Dementia standard until further national work is concluded.

3.7 NHS Lothian's comparative position against overall Scottish performance is also set out. Positive assessments are graded green, those which are not red.

3.8 For those areas unmet, the responsible member of the Corporate Management Team has provided a proforma contained detail on the area concerned, recent performance and proposed actions. Updated proforma were not provided for either Primary Care Access or Delayed Discharges (East Lothian). Accordingly those areas detail the recent trend in performance alone, unaccompanied by an action plan or narrative.

Table 1: Summary of Performance Position

Measure[1]	Type[2]	Status[3]	Trend[4]	Published Status vs. National Position[5]	Target/Standard	Latest	Reporting Date	Data Updated since Last Cycle[6]	Proforma Narrative Updated Since Last Cycle[7]	Lead Director
Safe[8]										
Cardiac Arrest	Quality	Not Met	N/A	Not Applicable	0.95 per 1,000 discharges (median)	1.58 (median)	Jun 2016	✓	✓	DF
Falls With Harm	Quality	Met		Not Applicable	0.24 per 1,000 occupied bed days (median)	0.22 (median)	Jun 2016	✓	Not Applicable	DF
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)	LDP	Not Met	N/A	Worse	0.32 (max) (<262)	0.35 (48)	08 July 2016	✓	✓	DF
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)	LDP	Not Met	N/A	Better	0.24 (max) (<184)	0.26 (35)	08 July 2016	✓	✓	DF
Hospital Standardised Mortality Ratios (HSMR) (20% reduction)	Quality	Met		Better	All sites within HS Limits & <=1	RIE – 0.73; SJH – 0.79; WGH – 0.65	Dec 2015	×	Not Applicable	DF
Timely										
Four hour Unscheduled Care (% seen)	LDP	Met	↑	Worse	95% (min)	95.5%	Jun 2016	✓	Not Applicable	JC
48 Hour GP Access – access to healthcare prof	LDP	Not Met	↓	Worse	90% (min)	85%	Mar 2016	×	Not Applicable	DS
48 Hour GP Access – GP appt	LDP	Not Met	↓	Worse	90% (min)	75%	Mar 2016	×	Not Applicable	DS
Alcohol Brief Interventions (ABIs)	LDP	Met		Better	9,757 (Annual)	28,972	Mar 2016	×	Not Applicable	AMcM
CAMHs[9] (18 Weeks)	LDP	Not Met	↓	Worse	90% (min)	57%	Jun 2016	✓	✓	AMcM
Cancer (31-day) (% treated)	LDP	Met		Worse	95% (min)	96.2%	Jun 2016	✓	Not Applicable	JC
Cancer (62-day) (% treated)	LDP	Met		Better	95% (min)	97.7%	Jun 2016	✓	Not Applicable	JC
Diagnostics (6 weeks) - Gastroenterology/ Urology Diagnostics		Not Met	↓	Worse	0 (max)	1,640	Jun 2016	✓	✓	JC
Diagnostics (6 weeks) - Radiology									✓	
Diagnostics (6 weeks) - Vascular Labs									✓	
Drug & Alcohol Waiting Times (3 weeks)	LDP	Not Met	↑	Worse	90% (min)	82.7%	Mar 2016	×	✓	AMcM
IPDC Treatment Time Guarantee (12 weeks)	LDP	Not Met	↑	Better	0 (max)	399	Jun 2016	✓	✓	JC
IVF (12 months)	LDP	Met		Worse	90% (min)	100%	Jun 2016	✓	Not Applicable	JC
Outpatients (12 weeks)	LDP	Not Met	↓	Worse	95% (min)	81% (10,135)	Jun 2016	✓	✓	JC
Psychological Therapies (18 Weeks)	LDP	Not Met	↓	Worse	90% (min)	68%	Jun 2016	✓	✓	JF
Referral to Treatment (18 Weeks)	LDP	Not Met	↓	Worse	90% (min)	81.3%	Jun 2016	✓	✓	JC
Stroke Bundle (% receiving)	Quality	Not Met	↓	Not Applicable	80% (min)	54.6%	May 2016	×	✓	JC
Surveillance Endoscopy (past due date)		Not Met	↓	Not Applicable	0 (max)	3,290	Jun 2016	✓	✓	JC
Effective										
Delayed Discharges (over 2 weeks) – East Lothian IJB		Not Met	↓	Worse	0 (max)	99	Jun 2016	✓	Not Applicable	DS
Delayed Discharges (over 2 weeks) – Edinburgh IJB									✓	RMG
Delayed Discharges (over 2 weeks) – Midlothian IJB									✓	EM
Delayed Discharges (over 2 weeks) – West Lothian IJB									✓	JF
Efficient										
Hospital Scorecard – Standardised Surgical Readmission rate within 7 days	Quality	Met		Not Applicable	All NHS L Sites (RIE; SJH & WGH), Within Hospital Scorecard Limits	RIE – 24.5; SJH – 18.8; WGH – 26.1; NHS L – 22.1	Dec 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Standardised Surgical Readmission rate within 28 days	Quality	Met		Not Applicable		RIE – 51.5 ; SJH – 30.3; WGH – 53.0; NHS L – 43.3	Dec 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Standardised Medical Readmission rate within 7 days	Quality	Met		Not Applicable		RIE – 52.8; SJH – 59.6; WGH – 57.6; NHS L – 52.1	Dec 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Standardised Medical Readmission rate within 28 days	Quality	Met		Not Applicable		RIE – 115.9; SJH – 122.1; WGH – 114.7; NHS L – 111.6	Dec 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Average Surgical Length of Stay - Adjusted	Quality	Met		Not Applicable		RIE – 0.92; SJH – 0.85; WGH – 1.15; NHS L – 1.0	Dec 2015	Not Applicable	Not Applicable	DF
Hospital Scorecard – Average Medical Length of Stay - Adjusted	Quality	Met		Not Applicable		RIE – 0.86; SJH – 1.4; WGH – 1.23; NHS L – 1.1	Dec 2015	Not Applicable	Not Applicable	DF
Staff Sickness Absence Levels (<=4%)	LDP	Not Met	↑	Better	4% (max)	4.54%	May 2016	✓	×	AB
Equitable										
Early Access to Antenatal Care (% booked)	LDP	Met		Better	80% (min), for each SIMD quintile[10]	Lowest SIMD is 1 – 88.0%	Apr 2016	✓	Not Applicable	AMcM
Smoking Cessation (quits)	LDP	Met		Better	293 (min)	314	Jan - Mar 2016	✓	Not Applicable	AKM
Person-Centred										
Complaints (Three-Day)	Quality	Not Met	↑	Worse	100%	91%	Jun 2016	✓	✓	AMcM
Complaints (20-Day)	Quality	Not Met	↑	Worse	80% (min)	68%	Jun 2016	✓	✓	AMcM
Detecting Cancer Early (% diagnosed)	LDP	Not Met	↑	Better	29% (min)	27.1%	2014 & 2015	✓	✓	AKM
Dementia	LDP	TBC[11]	N/A	Not Applicable	100% (1 Year (Min))	5.3	Apr 2016	×	×	JC
Patient Experience (9.5/10 – Overall Experience)	Quality	Not Met	↑	Not Applicable	9.5/10	8.91	May 2016	✓	✓	AMcM

[1] Much of this reporting uses management information and is therefore subject to change
[2] LDP – Local Delivery Plan standard.
[3] ***Status*** – describes where Current meets or does not meet Target.
[4] ***Trend*** - '↑','↓', '-' - describes Improvement or Deterioration for Current, where Status is 'Not Met', against an average of the last two relevant reported data points. 'N/A' indicates Trend is not applicable for this measure. Black shading indicates that Trend is applicable but that status is 'Met'.
[5] ***Published Status vs. National Position*** – describes most recent published Lothian position against the most recent (directly comparable) published national position to comply with Official Statistics' requirements - either for rates (incl. %) or against NRAC share. These may refer to different time periods than Latest.
[6] ***Update*** – Current performance figure, Status, Trend and Published Status updated, where applicable, since last reporting cycle. Updates on comparative performance following publication not indicated.
[7] ***Update*** – Current performance figure, Status, Trend and Published Status updated, where applicable, since last reporting cycle. Updates on comparative performance following publication not indicated.
[8] 6 Domains of Healthcare Quality http://www.ahrq.gov/professionals/quality-patient-safety/talkingquality/create/sixdomains.html
[9] ***Abbreviations*** – CAMHS - Child and Adolescent Mental Health Services; CDI- Clostridium difficile Infection; SAB Staphylococcus aureus Bacteraemia; IPDC – Inpatient and Day-case; IVF – In Vitro Fertilisation.
[10] SIMD - Scottish Index of Multiple Deprivation, http://www.gov.scot/Topics/Statistics/SIMD
[11] The data published by ISD on the dementia standard reports the rate of referral for post diagnostic support based on 100,000 per population. We are currently awaiting confirmation from ISD regarding what the expected rate would be in order to evaluate performance against the standard. Please also see Proforma

4 Exceptions Proformas (for Performance Areas where Status is 'Not Met', or 'TBC')

Cardiac Arrest

Healthcare Quality Domain: Safe

Cycle 7 - for reporting at August 2016 meetings

Target/Standard:

- 50% reduction in Cardiac Arrests with Chest Compressions Rate by December 2015 from February 2013 (1.9 per 1,000), baseline.

Responsible Director[s]: Executive Director: Medical Director

Performance:-

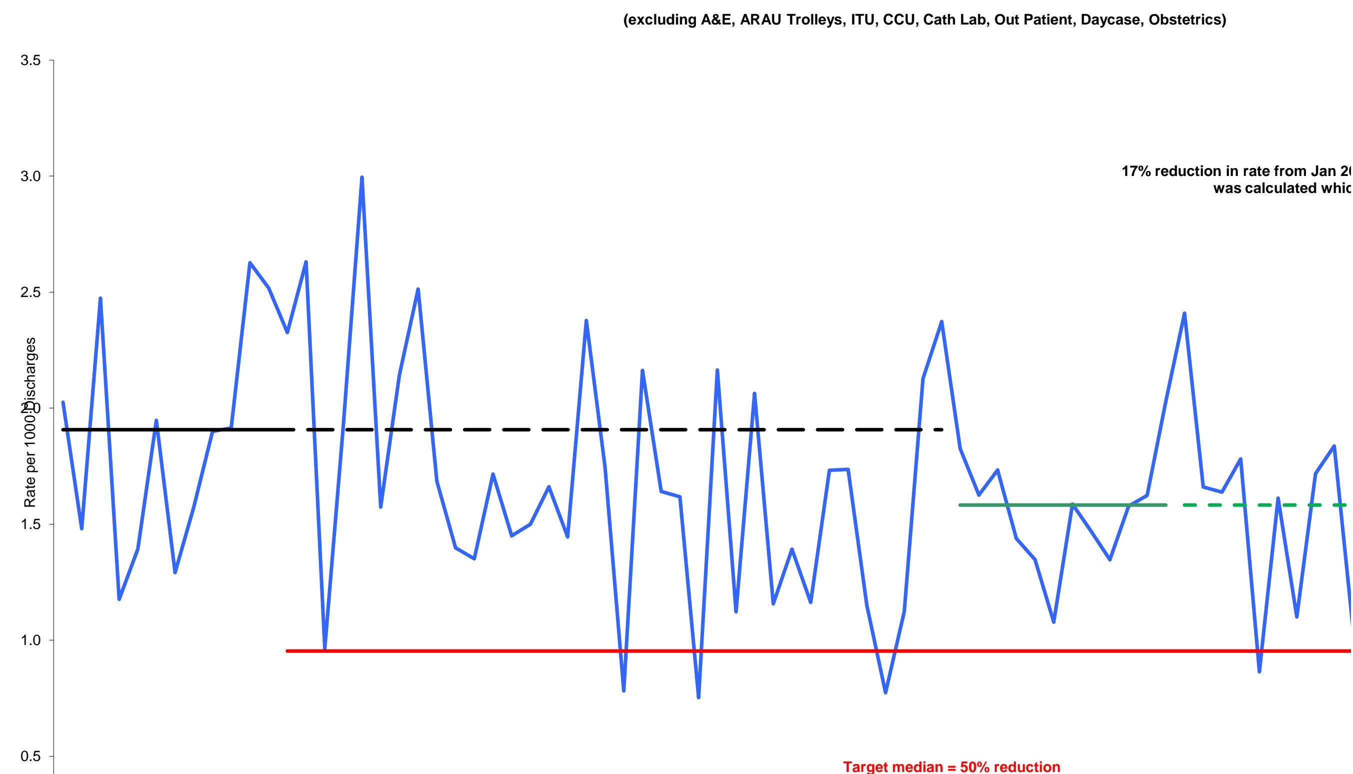
Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	N/A	Not Applicable	0.95 per 1,000 (median)	1.58 per 1,000 (median)[12]	June 2016	Yes	Yes	DF

Summary for Committee to note or agree

- **NHS Lothian have achieved a 17% reduction and the median is 1.58 which is below the Scottish median of 1.61 and across Scotland the reduction has been 17%.**

Recent Performance – 17% against Standard

Figure 1: NHS Lothian Cardiac Arrest Rate per 1,000 Discharges



Timescale for Improvement

[12] Data is sourced from the 2222 Database

HIS evaluating improvement goal.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Local cardiac arrest reviews using a structured tool and development of the database.	December 2016	Organisational learning & identification of themes for targeted improvements and a sustained reduction in cardiac arrests. MDT engagement to identify themes & actions for improvement	Changes in process and increase the days between cardiac arrest in a number of wards with 6 of the pilot wards achieving greater than 300 days between.	Pilot initiated and exploring best practice from other boards.
Aim: 95% of people with physiological deterioration in acute care will have a structured response. Implementation of the Structured Response Tool (in conjunction with education within Deteriorating Patient work-stream).	April 2016	The tool has demonstrated that it supports reliable communication, decision making and management of deteriorating patients by clinical teams, as well as enabling learning from events which informs the improvement process	Testing in surgery RIE & oncology has demonstrated improved early recognition and appropriate management of deterioration with improved documentation. Considering adoption of structured response tool within the context of paper lite and based on service feedback.	Rolled out April/May 2016 as part of NEWS implementation for acute sites. Monthly monitoring and reporting to the service. Complete for NEWS.
NEWS chart implementation. (In conjunction with Deteriorating Patient work-stream & Education team). NEWS is evidence based to be sensitive to early physiological deterioration and to trigger an appropriate graded response with a reduction in cardiac arrests and mortality. NEWS replaces the current SEWS chart.	April 2016	Adopting the National standardised chart which is used in all Boards including SAS in Scotland to reduce variation and improve communication. Linked to the Structured Response Tool to support timely identification & management of deterioration by facilitating accurate recording of observations with appropriate early escalation & graded response.	Alignment with national approach. Ensures consistency for patients moving across Boards. Provides greater sensitivity and support for patients deteriorating.	Rolled out in April/May 2016 for Acute sites – complete. Planning rollout in inpatient sites in Primary Care.
Implementation of sepsis screening and management using NEWS, sepsis boxes, education, training and simulation.	Dec 2016	To improve the recognition and management of sepsis to reduce mortality from sepsis. As part of our scoping work in 2015 70% of patients in NHS Lothian who deteriorated had sepsis.	ISD % unadjusted sepsis mortality has shown a statistically significant reduction in RIE from 28% to 15%, SJH has remained stable but there has been an increase at WGH from 10% -13% however it is well below the Scottish median of 21% and WGH has a low HSMR	SEPSIS bundle rollout continues and plans in place to further test, implement and monitor. NHS Lothian has been chosen as a national pilot for SEPSIS management in primary care working with Lothian Unscheduled Care Service.
In NHS Lothian pilot areas >80% of patients have advanced conditions and are at risk of deterioration and dying & 51% of cohort died within 12 months. Development of anticipatory care planning with patients and families nearing the end of their lives to discuss potential future deterioration & facilitate shared decision making with reliable documentation. This is informed by policy context and baseline data including cardiac arrest reviews which demonstrate need for 'upstream' engagement with patients & families. Prototyping of a structured review and testing implementation is taking place. Evolving themes include the need for concurrent MDT communication skills education & patient/carer engagement in the testing & implementation.	Prototyping phase with September 2016	• Avoidance of cardiopulmonary resuscitation for patients who either do not want or will not have a good outcome to CPR; • Person centred decision making and optimal engagement with patients and families with effective communication of these decisions; • Clear communication of plan for deterioration to facilitate a bespoke Structured Response in the event of deterioration; • Timely transition to end of life care; • Support appropriate identification of patients with anticipatory care planning needs; • Closely linked with Deteriorating patient work-stream and the development of the Structured Response Tool.	Data from small tests in 8 MoE/Stroke wards (c.200 patients) demonstrate sustained improvement in documented discussions with patients & their families regarding future wishes & plan for further deterioration.(>80% of patients have documented AnCP/future wishes discussion). In test areas data demonstrates improved access to Key Information Summary on admission & improved AnCP information within discharge documentation.	Prototyping testing with input from AnCP forum including expert palliative care, primary & secondary care input. Next steps include MDT communication skills workshops and test of structured review tool within MAU & an oncology ward. December 2016
Exploring electronic observation systems including electronic track & trigger.	Dec 2016	NHS Fife have demonstrated a reduction in Cardiac arrests since implementation of track & trigger system as one aspect of their improvement programme.	Timely access to data to inform improvement. With respect to response to deterioration	Bought hardware, e.g. monitors. Exploring how it interfaces with TRAK to provide timely data to the service.

Comments

Reasons for Current Performance

The Cardiac Arrest rate for the three major acute hospitals is low, and below the Scottish rate. All three sites are approximately the same rate and do not give cause for concern. The HIS 50% reduction from our low baseline rate by December 2015 was ambitious and we now predict that our cardiac arrest rate could be reduced by a further 10% by 2020. In order for us to achieve this, identification and management of deterioration and greater numbers of earlier anticipatory care plans and DNACPR will need to be in place reliably in the above plans across all three acute sites.

Healthcare Acquired Infection – Clostridium difficile Infection (CDI)

Healthcare Quality Domain: Safe

Target/Standard: NHS Boards' rate of Clostridium difficile infections (CDI) in patients aged 15 and over is 0.32 cases or less per 1,000 total occupied bed days.

Responsible Director[s]: Executive Director: Medical Director

Performance:-

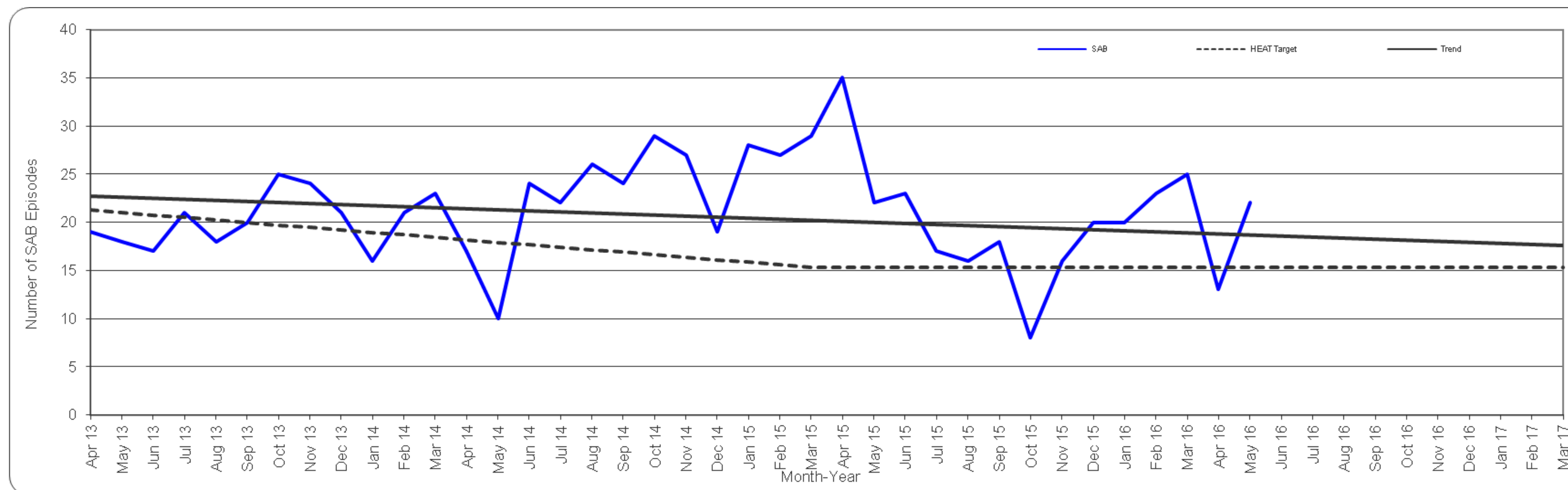
Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	N/A	Worse	0.32 (max) (<262)	0.35 (48)	08 July 2016	Yes	Not Applicable	DF

Summary for Committee to note or agree

- **The performance year for reporting is April 2016- 31st March 2017. The reporting rate is based on 2 month of data April- May and can therefore not be used as an indicator of trend or potential success at this early stage. June data is not available due to reporting timelines.**
- **Health Protection Scotland published quarter 1 data (January –March 2016) indicated that whilst NHS Lothian's *Clostridium difficile* Infection incidence of 0.30 was higher than that of the NHS Scotland average incidence of 0.27 the Board is no longer an outlier.**

Recent Performance – Numbers Achieved against Standard

Figure 1: CDI Progress against HEAT target – NHS Lothian (Number of CDI Episodes per Month) Source: Infection Prevention and Control Team



Timescale for Improvement

The trends and patterns will be monitored and remedial actions taken as required

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Development of more detailed action plan in conjunction with Quality Improvement ***Responsible Person(s):* Lead Infection Prevention and Control Nurse/Patient Safety Programme Manager / Clinical Management Group.**	February 2016	All staff involved in the prescribing and administration of antimicrobials have a role to play in prevention of healthcare associated CDI. A multidisciplinary approach is essential to the prevention of CDI. The detailed action plan must include contributions from clinical teams if this is to be effective.		**Complete**
Establish local IPC Committees to increase local ownership of data and corresponding actions for improvement ***Responsible Person(s):* Site Associate Medical Directors**	March 2016	Increased local ownership and knowledge of data provides the opportunity for the site based teams to address issues more effectively and promptly. This needs to include a mechanism for identifying prescribers that consistently deviate from policy prescribing and discussing the reasons why, resulting either in revision of the policy or alteration in prescribing behaviour.		**Complete**
Establishment of a Multi-disciplinary review team to improve robustness of CDI case identification and reporting to ensure all CDI patients being reported meet the definitions as advised by HPS. ***Responsible Person(s):* Lead Infection Prevention and Control Nurse / Lead Infection Control Doctor / IPCT Clinical Scientist / Microbiology Clinical Lead / Microbiology Laboratory manager**	April 2016	All *Clostridium difficile* positive laboratory results do not necessarily mean the patient has infection. It is essential that individual cases are reviewed through a patient centred approach to ensure they meet the definitions of infection in order to reduce the over reporting of CDI Incidence. Reduce the number of patients receiving unnecessary treatment and extended stay in hospital Reduce the pressures on single room accommodation for isolation There is scope to significantly improve the time to diagnosis of CDI but this would need to involve laboratory management e.g. having more GDH/toxin testing runs per day and not carrying over samples for testing to the next working day. Funding of PCR testing for C difficile may also resolve which GDH positive patients with diarrhoea are not carriers of C difficile and rule out the diagnosis in situations where there is currently uncertainty. There is a weekly multidisciplinary ward round to review patients and the documentation of daily stool frequency and consistency (using Bristol stool chart) using standardised definition when a patient has loose stools. The IPCNs visit each new inpatient diagnosed with CDI to ensure transmission based precautions are in place, reducing risk of cross transmission. NHS Lothian increased availability of single use equipment and additional reusable equipment to support designated equipment for use with patients confirmed positive for CDI infection.		**Complete – This group has been established and is now business as usual** A multidisciplinary group of microbiology and virology medical staff, clinical scientists, biomedical scientists and infection prevention and control team met on 18th March and 29th April to review all steps in the laboratory processing of stool for C difficile from sample receipt in order to improve the time taken to generate a result (in view of Vale of Leven recommendation 41). Actions from this have addressed a reduction in acceptable turn around time for C difficile toxin to 1 day, a change of assay to facilitate throughput , avoidance of carrying samples into the following day for testing and a review of interpretative comments on C difficile laboratory results to improve clarity. Discussions regarding the role of PCR to reduce diagnostic uncertainty when an “equivocal” result is generated also featured but it was recognised that introduction of such limited testing would require a business case. Collaborative working across disciplines is being facilitated by the development and launch of the NHS Lothian Infection Service. A multidisciplinary review of inpatients with abnormal C difficile laboratory results occurs at least once per week at SJH, RIE and WGH which assesses whether the diagnosis is correct, that cases of CDI are severity scored and treatment choice is optimal , patient placement is optimal and transmission based precautions are in place. This review also is able to advise when single room isolation is no longer required and can more promptly free up single rooms. As the incidence of patients with CDI has fallen, there has been a move to a more proactive review of all these aspects of CDI management on the same day as a toxin positive result is identified. Methodology to ensure that microbiology medical staff are

				electronically and immediately informed of when wards breach their trigger of 2 CDI cases was been agreed. A monthly multidisciplinary review meeting of all CDI cases from the previous month commenced on 20/5/16 to ensure that there is standardisation of approach to case management and that data submitted to the national surveillance programme from Lothian is accurate before publication nationally.
Improved Antimicrobial Stewardship Key preventative strategies primarily hinge on good antimicrobial stewardship, and management of other risk factors for CDI such as prescription of Proton pump inhibitors (PPI). Antimicrobial Management Team to ensure that data is shared with areas of high use antimicrobials and those utilising antimicrobials associated with high risk CDI. Information will be made available on the AMT Intranet page. Associate Medical Directors and Practitioners should utilise the data to review prescribing patterns and increase education to reduce the use of high risk antimicrobials. ***Responsible Person(s):* Antimicrobial Management Team / Associate Medical Directors / General Practitioners** Establish an explicit governance framework of how to address persistent non compliance with NHS Lothian antibiotic prescribing policies when this occurs ***Responsible Person(s):* Clinical Governance** Regular review of antimicrobial policies (including surgical prophylaxis) which use 4C Antibiotics and explore non 4C alternatives. ***Responsible Person(s):* Clinical Teams / Antimicrobial Management Team / Associate Medical Directors**	Nov. 2016	The national data demonstrates whilst NHS Lothian is the lowest user of antibiotics in primary care, use of the 4C antibiotics remain proportionally higher than other Boards. This is despite an 11.5% reduction last year. The national dataset AMIDS combines primary care and secondary care antibiotic use. This shows marked reductions in total 4C use in 2014 and again in 2015. Additionally it shows our CDI cases to be falling against a rise in the cumulative Scottish cases. Data from the antimicrobial pharmacists shows a drop in use of coamoxyclav and Tazocin since last Feb in the some but not all acute settings. It is essential this is addressed to ensure consistency and reduction across the Board as appropriate. Use of 4C antibiotics remains an issue in the management of community acquired pneumonia in the over 65s where practice in Lothian is to use coamoxyclav as per CURB65 score in Thorax guidance whereas other boards recognise the failings of the CURB65 scoring in the over 65s who have chronic cognitive decline unrelated to pneumonia severity. The use of the high risk antimicrobials has also been noted as a choice for bone infection and diabetic foot infections. Some urological and haematology/oncology antibiotic policies have also been noted as dependant on fluoroquinolones in Lothian but for which other boards have greater non quinolone option. To further reduce CDI as a consequence of 4C use and to bring NHS Lothian's use of 4C in line with NHS Scotland. This has been identified by Health Protection Scotland as an area for NHS Lothian that could have a significant impact on acquisition rates		The Antimicrobial team (AMT) continues to work with clinical teams and GPs to improve medicine management. In response to a cluster of CDI in a care of the elderly ward a revised antibiotic formulary to be used for frail elderly patients has been introduced which promotes avoidance of all 4C antibiotics. The effects of this in terms of impact on CDI, mortality and adverse effects will be monitored and reviewed by the AMT with a view as to whether it can be rolled out to other hospitals. More explicit interpretative comments have been added automatically in microbiology to all positive urine culture results to assist guidance to an appropriate antibiotic treatment choice with least potential to cause or exacerbate CDI. Review of the treatment duration and choice for bloodstream infection secondary to pyelonephritis has been undertaken by AMT with a view to reducing duration of 4C exposure. There is agreement that Antimicrobial stewardship issues should now feature as a standing item at site infection control committees and the Pan Lothian Infection Control Committee to improve awareness of site specific issues and governance regarding them. Review of surgical prophylaxis policies is underway and has begun for Obstetrics policies. The AMT has discussed and is exploring improved access to ALERT antibiotics and antibiotics that can be used for 4C avoidance to reduce instances when antibiotic does are missed or default reliance on a 4C option as alternatives are less readily promptly available at ward level. NHS Lothian Review of broad spectrum antibiotics in primary care (2016) has been produced to explore why Lothian's use of 4C antibiotics is higher than other boards. The invest-to-save ward round undertaken to review the use of IV antimicrobials and promote IV to Oral switch has also provided advice on general prescribing.
Prompt access to appropriate antimicrobial therapy including treatments for CDI is essential to aid recovery, help reduce potential for environmental contamination with C difficile spores and reduce hospital stay	July 2016	The issue of missed doses of antibiotics and delays for accessing antibiotic treatment potentially hampers recovery, prolongs hospital admission and increases risk of relapse and environmental contamination with spores if diarrhoea continues. Improved communication required between prescribers and		The AMT in February 2016 has discussed these issues and is exploring improved access to ALERT antibiotics and antibiotics that can be used for 4C avoidance via site emergency drug cupboards to reduce instances when antibiotic does are missed or default reliance on a 4C option

Responsible Person(s): **Pharmacy / Senior Charge Nurse**		nursing team to ensure all antibiotics prescribed are available or ordered if required.		as alternatives are less readily promptly available at ward level.
Development of a strategy for primary care 4C prescribing authorised and supported by the medical director for primary care. ***Responsible Person(s):*** **Medical Director for Primary Care / GP Sub Committee**	March 2017	There is tension between GP requests for access to all antibiotic options for treatment of UTI versus restrictive reporting which is practiced in other Scottish boards. Lack of restrictive reporting makes reducing 4C antibiotic use harder		**NHS Lothian Review of broad spectrum antibiotics in primary care (2016) has been produced to explore why Lothian's use of 4C antibiotics is higher than other boards.**
Improve access to alternatives to 4C antibiotics such as pivmecillinam, fosfomycin, aztreonam, and promote their use where they have a recognised role. Guidelines on their use are available and widely accessed via Microguide app. Shared learning from other boards that have implemented such changes successfully to allay hypothetical fears of prescribers to move from their traditionally preferred antibiotic of choice to ones with less potential collateral damage. ***Responsible Person(s):*** **Antimicrobial Management Team / Associate Medical Directors / Medical Director for Primary Care**	February 2017	To further reduce CDI as a consequence of 4C use and to bring NHS Lothian's use of 4C in line with NHS Scotland.		Aztreonam is now approved on formulary for NHS Lothian. Alterations to antibiotic guidance are updated in real time on the microguide app. Video guidance regarding how to prescribe gentamicin has been produced as an educational package to facilitate its preferential use. The Scottish antimicrobial pharmacists e-mail group has been used to compare strategies for 4C avoidance in mild and severe community acquired pneumonia management.
Staff undertaking administration of antimicrobials should be encouraged to complete the NES stewardship education package. ***Responsible Person(s):*** **Associate Nurse Directors / Associate Medical Directors**	March 2017	To improve staff knowledge and understanding. The course is available electronically via Learn Pro and is anticipated that the tutorial will take around 1-2 hours of online learning time.		NHS Lothian is implementing the NHS Education Scotland Antimicrobial stewardship workbook for registered nurses.
The Lothian loose stool policy to be reviewed to ensure no ambiguity and that all advice is clear. ***Responsible Person(s):*** **Lead Infection Prevention and Control Nurse / Lead Infection Control Doctor**	April 2016	The existing flow chart remains in use pending full review unfortunately this has been delayed due to additional work pressures and priorities		Delayed now anticipate July 2016
Development of a enhanced surveillance report for CDI similar to that provided for SABs ***Responsible Person(s):*** **IPCT Clinical Scientist / Head of Infection Prevention and Control Services**.	April 2016	Revise and improve the information included in CDI monthly report (and reports to senior management) to reflect key areas for learning & improvement.		Delivery date reassessed as July 2016 Agreement on data for inclusion has been reached with ICD, Clinical scientist and lead IPCN. Monthly case review meetings are being organised with first one scheduled w/b 16th May. The subsequent report will be available for June 2016. This report will be consulted for format and user acceptability and revised accordingly
All patients should be risk assessed when presenting with diarrhoea symptoms to support appropriate isolation and correct sampling promptly requested. IPCT Risk Assessment uploaded to TRAK to support clinical team completing risk assessment. ***Responsible Person(s):*** **Lead Infection Prevention and Control Nurse / TRAK Management Board / Associate Nurse Directors / Senior Charge Nurse**	April 2016	With the introduction of Paperlite System and the transition of nursing risk assessment documentation, infection control risk assessment which covers diarrhoea illnesses, highlighting patients who are admitted with CDI symptoms which will automatically develop associated action plan which will direct patient to be isolation and transmission based precautions utilised.		**Complete**

Comments
Reasons for Current Performance Clostridium difficile can often be an unintended consequence of antimicrobial use. Investigations indicate many of these patients have had complex health care needs resulting in multiple courses of antimicrobial therapy. All investigations and case reviews have found the cases to be individual unrelated infections and not as a result of cross transmission. The above actions supported by the clinical teams could improve NHS Lothian performance in reducing the incidence of CDI. The support from Clinical Teams is essential to any successful reduction.

Healthcare Acquired Infection – Staphylococcus aureus Bacteraemia (SAB)
Healthcare Quality Domain: Safe
Cycle 7 – for reporting at August 2016 meetings
Target/Standard: NHS Boards' rate of Staphylococcus aureus Bacteraemia (including MRSA) (SAB) cases are 0.24 or less per 1,000 acute occupied bed days.
Responsible Director[s]: Executive Director: Medical Director
Performance:-

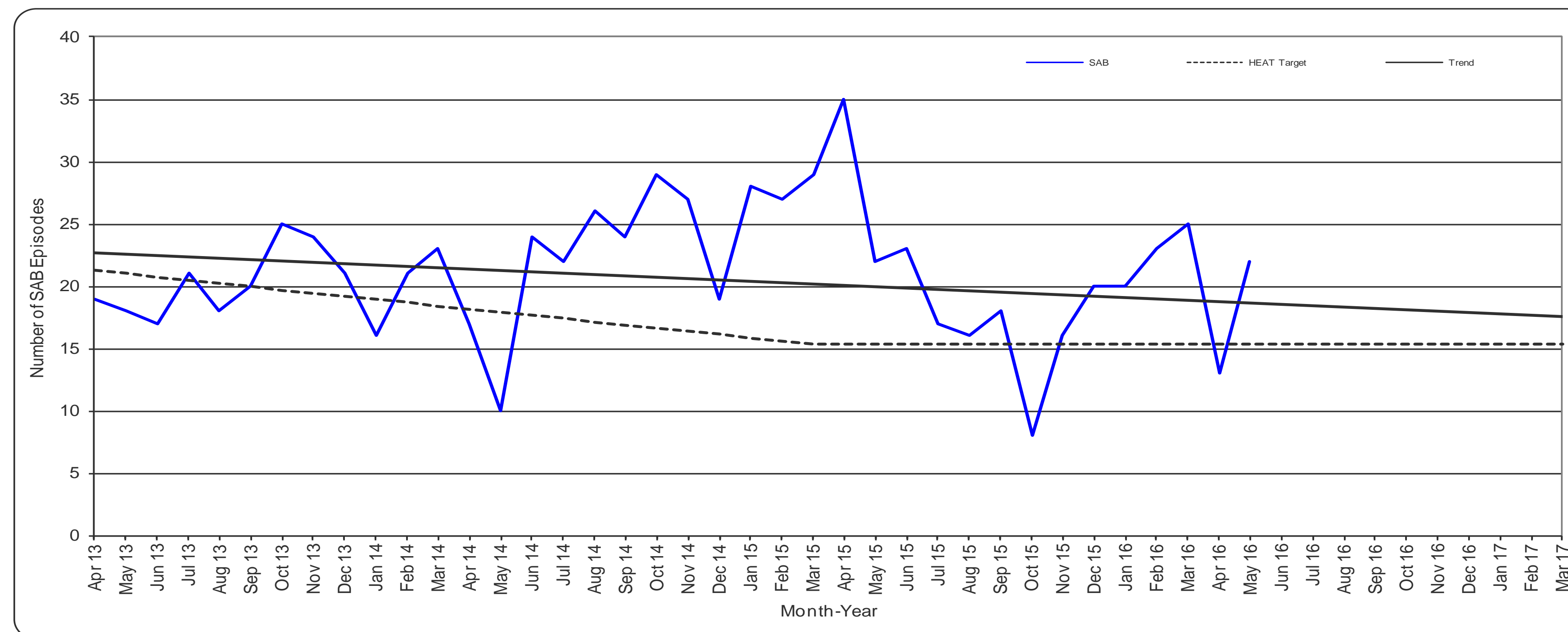
Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	N/A	Better	0.24 (max) (<184)	0.26 (35)	08 July 2016	Yes	Not Applicable	DF

Summary for Committee to note or agree

- **Performance target is for reporting year April 2016- 31st March 2017. The reporting rate is based on 2 month of data and can therefore not be used as an indicator of trend or potential success at this early stage**
- **Health Protection Scotland published quarter 1 data (January –March 2016) indicated NHS Lothian *S. aureus* bacteraemia incidence (predominantly due to MSSA bacteraemia), rate of 0.33 was the same as the overall NHS Scotland *Staphylococcus aureus* Bacteraemia incidence.**

Recent Performance – Rates against Standard

Figure 1: SABs progress against HEAT target – NHS Lothian – Number of SAB Episodes per Month Source: Infection Prevention and Control Team



Timescale for Improvement
The trends and patterns will be monitored and remedial actions taken as required

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Development of more detailed action plan in conjunction with Quality Improvement. ***Responsible Person(s):* Lead Infection Prevention and Control Nurse/Patient Safety Programme Manager / Clinical Management Group**	February 2016	A multidisciplinary approach is essential to the prevention of *Staphylococcus aureus* Bacteraemia. The detailed action plan includes contributions from clinical teams if this is to be effective. All staff involved in insertion, maintenance and interventions utilising invasive lines have a role to play in prevention of healthcare associated infections.		**Complete**
Infection Prevention and Control to improve quality of information reported to clinical and senior teams in relation to SAB. ***Responsible Person(s):* Head of Service Infection Prevention and Control**	First report issued Dec. 2015	Previous reporting only reported the number of SABs in each area, enhanced surveillance aims to identify source. Feedback from enhanced surveillance will engage clinical teams more in the review of cases which has previously predominately been undertaken by Infection Control. A multidisciplinary approach is better able to differentiate between preventable and non preventable infection Enhanced surveillance will raise awareness of cause/ source in order that clinical teams can target local actions to reduce healthcare associated SABs such as those related to invasive devices. Through multidisciplinary discussion the number of SAB categorised as “source unknown” should drop enabling more opportunities for intervention having identified the most likely source and reason for the bacteraemia.	Feedback from enhanced surveillance raises awareness of cause/ source in order that clinical teams can target local actions to reduce healthcare associated SABs such as those related to invasive devices. Report has been positively received by clinical teams	**Complete**
Additional resources to support education and clinical practice to work with clinical teams in the reduction of invasive device related SABs. Quality Improvement and education of all staff involved in the care of invasive devices is essential to ensure safe practice. The two staff appointed must deliver local education to improve practice in areas with highest incidence of device related infection. ***Responsible Person(s):* Head of Education and Employment / Patient Safety Programme Manager / Practice Education Facilitator / Quality Improvement Facilitator**	Staff appointed Nov. 2015 Nov 2016	Temporary funding from Quality Improvement and Education Department has resourced 1 WTE each within their respective teams for 1 year	2 staff appointed on temporary contracts. They are undertaking review of current practice to support the development of targeted education at clinical level	**Staff appointments Complete**
Through education and patient safety ensure all levels of staff involved in insertion, maintenance and use of invasive lines deliver safe and effective practice and demonstrate competency and compliance in use of asepsis. Essential all medical staff as well as nursing staff are appropriately trained and competent in the handling of lines. ***Responsible Person(s):* Head of Education and Employment / Patient Safety Programme Manager / Associate Medical Directors / Associate Nurse Directors. / Senior Charge Nurse / Consultants**	Nov. 2016	Evidence of education and improvement in the management of invasive lines.	Education is progressing. There is a focus on areas that have been identified within the enhanced SAB reviews as having device related SABs	March 2017

Shared learning and practices from areas where invasive lines infection rates are low should be developed through quality improvement teams. ***Responsible Person(s):*** **Quality Improvement Teams**	Dec. 2016	RIE ITU demonstrates extremely low line related infections and have consistently ensured education of staff to reduce and prevent incidents. Clinical areas should learn from areas where there is good practice.	The data is reported to local infection control committees and quality improvement teams to facilitate local actions	Complete
A review of skin preparation products to ensure the correct product CA2CSKIN is being utilised supported by updated communication and education. ***Responsible Person(s):*** **Senior Charge Nurses / Consultants / Procurement / Stores Top Up** Standardise transparent dressings utilised for invasive vascular devices to ensure compliance with best guidelines Establish a quality improvement project to consider the efficacy and benefit of using antimicrobial lock solutions e.g. taurolock. ***Responsible Person(s):*** **Quality Improvement /Procurement**	June 2016	There remains confusion regarding which skin preparation product should be used. Lothian advocates the use of Clinell Alcoholic 2% Chlorhexidine wipes. It has been observed in practice that CA2C200 for equipment are being used in areas for use on skin and invasive devices removal rather than the correct CA2CSKIN product. This may partly arise through too many products being made available at ward level to select from and thereby using the wrong product for the wrong purpose.	Practice of using antimicrobial lock solutions e.g. taurolock has been reviewed as part of epic3 guidelines as routine use of device is not advised. Use in clearly defined clinical areas maybe beneficial. The appropriate dressing type is available to order or through top up. Clinical teams are responsible for ensuring that the appropriate dressings are used	Complete
Catheter care should be reviewed and catheter use needs to be discouraged when not absolutely necessary and access to alternatives explored. Roll out of SPSP CAUTI Bundle to areas reporting catheter associated infections using the Pareto charts to prioritise implementation. ***Responsible Person(s):*** **Patient Safety Programme Manager/Clinical Nurse Managers/Senior Charge Nurses**	March 2017	The SPSP CAUTI reduction work has shown a reduction in the number of short term catheters inserted and the time to removal in the pilot ward at RIE. The catheter passport has been introduced across the board and catheter alternatives are being advocated. This would benefit SAB and E coli bacteraemia incidence.	The HPS initial report demonstrated that 7.9% of ECB had a urinary catheter as source. Urinary Catheters account for approximately 2% of SAB, therefore the impact of CAUTI Bundle may have limited impact on reduction of overall SAB incidence.	
Improve compliance with National MRSA Screening Clinical Risk Assessment ensuring decolonisation/suppression therapy is implemented where clinically indicated. ***Responsible Person(s):*** **Lead Infection Prevention and Control Nurse / TRAK Management Board / Associate Nurse Directors / Senior Charge Nurse**	April 2017	With the introduction of Paperlite System and the transition of nursing risk assessment documentation, infection control risk assessment which covers MRSA is covered within document highlighting patients who are admitted with MRSA which will automatically develop associated action plan which will direct patient to be isolation and transmission based precautions utilised. Whilst MRSA SABs are low it is important that we do not become compliant. Currently IPCT participating in research project carried out by Glasgow Caledonian University to identify barriers to screening compliance.	The upgrade to TRAK to include the HAI risk assessment has been completed. However the unintended consequence has disrupted the extract of information required for MRSA CRA which is submitted to HPS. Discussions with IT to address disruption in capability	
Evaluate the impact of routine decolonisation to reduce the incidence of Hickman and PortaCath related SAB should be considered with a view to implementation in other units with high central line use. ***Responsible Person(s):*** **Quality Improvement Teams / Clinical Teams / Microbiology**	July 2016	Decolonisation is being used in the renal unit as a strategy to prevent dialysis line SAB and possibly could be used as a strategy to prevent Hickman line and PortaCath related SAB also.	A multidisciplinary Short Life Working group is being established at WGH to address strategies to reduce a disproportionately higher incidence of line related SAB at WGH site. A range of strategies to reduce tunnelled line related SAB will be considered.	
Review of blood culture sampling practice and education for front door areas Test of Change within Emergency Department at the RIE on the effectiveness of grab bag approach to blood culture sampling. Grab bags would contain all equipment required for safe sampling and a reminder message outlining what is best	Oct. 2016	Improved quality of sampling reduces the risk of contamination. This contamination can be interpreted as infection, resulting in patients receiving additional treatment and extended stay and over reporting of actual infection rates. These interventions are designed to improve blood culture taking and reduce wastage of laboratory time and resource in		

practice within the pack. ***Responsible Person(s):*** **Clinical Nurse Manager / Clinical Lead RIE ED / All Medical Staff** Ensure education of all staff undertaking blood culture to ensure competency and safe practice. ***Responsible Person(s):*** **Clinical Lead / All Medical Staff / Clinical Nurse Manager / Phlebotomists** Review blood culture contamination rates as a standing item discussed weekly at ward safety briefs and at departmental M&M meetings, Ensure feedback and education of staff with poor technique, reducing the risk of contaminated samples. ***Responsible Person(s):*** **Clinical Lead / Clinical Nurse Manager**		working up contaminated samples. They are labour intensive to deliver and therefore this creates an additional cost.		
Introduction of the Visual Phlebitis scoring as part of the patient safety bundle. ***Responsible Person(s):*** **Patient Safety Programme Manager / Senior Charge Nurses**	March 2017	Early recognition of phlebitis can prompt staff to remove the cannula and reduce the risk of progression to SAB associated with Peripheral Vascular Cannulas (PVC). PVC is identified as one of the key preventable sources and reduction in these could support move to achieving of 0.24 rate in 2016/17. Episodes of venflon associated soft tissue infection are unacceptably common in Lothian. Optimal management of all invasive devices is essential. Where there is evidence of infection they should be removed and antimicrobial treatment commenced appropriately when required.		
Raise awareness of risks associated with unsafe injection practices with People Who Inject Drugs (PWIDs). Frontline clinical teams to ensure opportunities for education to PWIDs when presenting within acute setting. ***Responsible Person(s):*** **Associate Medical Directors / Associate Nurse Directors**	December 2016	In the current HEAT target year there have been17 incidences where PWIDs have developed SAB as either direct or contributing factor from recreational use of IV drugs. Preventative strategy through harm reduction services to provide information leaflets written jointly by NHS Lothian staff and Scottish Drugs Forum, education regarding safe injecting, use of filters, skin preparation, optimising wound care within needle exchanges and outreach centres and buses. Identify PWID on admission to acute services and promote information leaflets as a preventative strategy. Provide information to PWID SAB patients prior to discharge to minimise risk of further SAB associated with injecting practice.	Selling of Novel Psychoactive Substances is illegal throughout the UK. Greater use of an educational leaflet on acute sites written jointly by NHS Lothian and Scottish Drugs Forum explaining how S aureus infections arise from drug injecting is being considered.	

Comments
Reasons for Current Performance:

48 Hour GP Access

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard:

1. At least 90% of people should have 48-hour access to the appropriate healthcare professional;
2. at least 90% of people should be able to book an appointment with a GP more than 48 hours in advance.

Responsible Director[s]: Executive Director: Medical Director

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
1. Not Met	↓	Worse	90% (min)	85%	March 2016	No	Not Applicable	DS
2. Not Met	↓	Worse	90% (min)	75%	March 2016	No	Not Applicable	DS

Summary for Committee to note or agree

Recent Performance – Numbers against Standard

Timescale for Improvement

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status

Comments

Reasons for Current Performance

Child & Adolescent Mental Health Services (CAMHs)

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: No child or young person will wait longer than 18 weeks from referral to treatment in a specialist CAMH service from December 2014. Following work on a tolerance level for CAMH services waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the target should be delivered for at least 90% of patients.

Responsible Director[s]: Nursing Director/ Strategic Planning

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	90% (min)	57%	Jun 2016	Yes	Yes	AMcM

Summary for Committee to note or agree

- **57% of patients who were seen for a 1st treatment appt were seen within 18 weeks (compared to 56% in May)**
- The number of people seen for a 1st treatment **appt decreased by 4** (292 compared to 296 in May)
- The total number of **patients waiting decreased by 139** (1857 compared to 1996 in May)
- The number of patients **waiting over 18 weeks decreased by 47 patients** (817 compared to 864 in May)
- The number of **patients waiting over 1 year has decreased from 76 in May to 65 in June.**

Recent Performance – Performance against 18 Week Standard

Table 1: CAMHs Performance Trend

Figures from April 2015 have been revised due to inclusion of Tier 4 data from April onwards

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Percentage seen within 18 weeks	58%	57%	60%	71%	76%	59%	61%	54%	65%	56%	73%	70%	60%	56%	57%
Revised Trajectory*															
Total waiting at end of month	1,687	1,709	1,708	1,737	1,737	1,668	1,677	1,826	1,900	1,929	2,060	2,078	2,085	1,996	1,857
Those waiting more than 18 weeks	478	472	509	639	694	680	730	687	709	747	815	888	931	864	817

(* Note: Revised Trajectory to now be finalised following agreement of additional investment)

Table 2: Patients Seen for First Treatment

Number seen	within 18 wks	over 18 wks	% within 18 wks	% over 18 wks
292	166	126	57%	43%

Table 3: Patients Still Waiting at Month End

Number waiting	within 18 wks	over 18 wks	% within 18 wks	% over 18 wks
1,857	1,040	817	56%	44%

Figure 1: Number of Children & Young People Waiting Over 18 Weeks

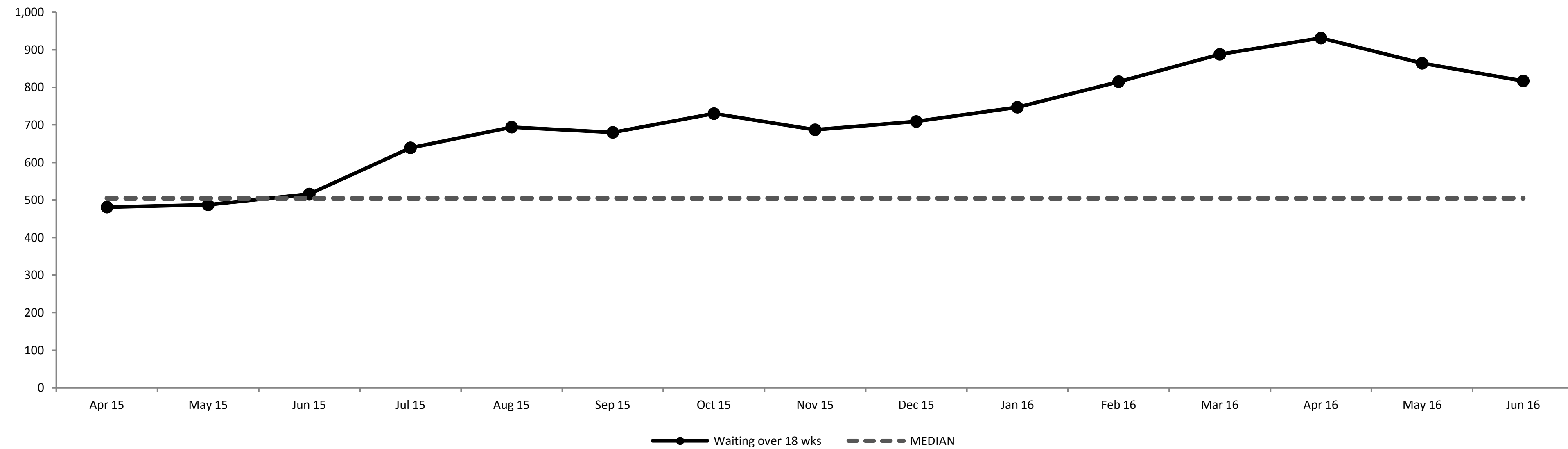
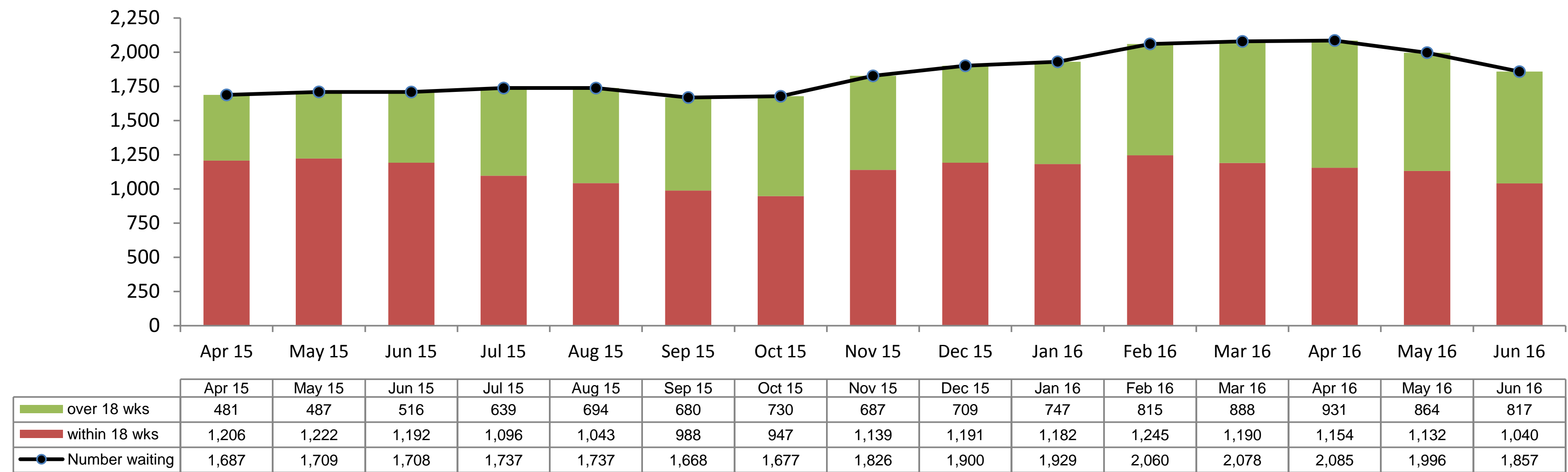


Figure 2: Number of Children & Young People Waiting at Month End



	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
over 18 wks	481	487	516	639	694	680	730	687	709	747	815	888	931	864	817
within 18 wks	1,206	1,222	1,192	1,096	1,043	988	947	1,139	1,191	1,182	1,245	1,190	1,154	1,132	1,040
Number waiting	1,687	1,709	1,708	1,737	1,737	1,668	1,677	1,826	1,900	1,929	2,060	2,078	2,085	1,996	1,857

Timescale for Improvement

The CAMHS Executive Management Team were due to sign off a revised trajectory by end of June reflecting the actions planned and the anticipated impact. This was delayed to mid July due to the timing of key meetings to agree the improvement and investment plan. This was signed off by the Corporate Management team on 11 July.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
A single prioritised amendments / additions work-plan for TRAK with named analytical, data and system support staff from clinical services, e-health and planning.	Completed and monitored via CAMHS Executive and REAS CMT.	Transparency of progress; alignment of TRAK work; reporting of progress formally to the management teams enabling escalation and resolve of issues.	Completion of TRAK tasks has enabled improved performance.	Amber
Development of a single implementation plan for the introduction of Patient Focused Booking across CAMHS.	To be reviewed as part of the June Action Plan Completed	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appts. Improved compliance with waiting times rules related to reasonable offer, unavailability and clock resets		Amber
Development of a single implementation plan for the introduction of Text Reminder system CAMHS.	Expected implementation: June 2015. Delayed due to finalisation of Improvement Plan.	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appts.		Amber
Completion of updated Demand Capacity Activity Queue (DCAQ), for CAMHS whose data is recorded and reported from TRAK.	1st April 2016 Completed To be refreshed periodically.	Confirm the DCAQ for each service enabling monitoring of agreed capacity against demand and activity.	Baseline established.	Amber
Review of current referral thresholds and ratio of accepted referrals. Plan to liaise with NHS GG&C to compare practice and adopt relevant learning.	June 2016 Completed.	Improvement in management of demand to reduce capacity used in relation to inappropriate referrals.		Amber
A proposal to reduce the community development role of CMHW in CAMHS teams for 12 months and thus increase the direct clinical capacity of these staff is being considered.	June 2016 Completed	Provide additional capacity to reduce long waits. Initial scoping suggests around an additional 25 new patient appts would be available each month. Risks of stopping community capacity building thus further increasing referral rates to specialist CAMHS is being considered as part of the Risk Assessment.		Amber
Reduce combined median DNA and CNA for first appointments from 23% by 5% by end of June and by 10% by end of September 2016	30th June 2016. Completed.	Improved use of clinical capacity which will mean more patients can be removed from the waiting list per wte per month	This test of change has been highly successful by end of May 2016 weekly median has reduced from 23 to 18.5 which is a reduction of 19.5%	Amber

Comments

The Corporate Management Team agreed a CAMHS Recovery Plan to address those who have waited longest on the generic waiting list. Capacity will be increased due to changes in the clinical model and additional investment. **Clear communication on changes has been sent to** referrers, children and young people and their families, partner agencies and CAMHS staff. The CMT agreed to receive an update in March 2017 which will include a plan to meet and maintain the waiting time standard by September 2017.

Reasons for Current Performance

Increased demand – 20% increase year on year for last three years. Referrals increased from 4,608 to 5,970. This is an additional 1,362 patients comparing end of March 14 to March 16.

Mitigating Actions

Staffing recruited using the Mental Health Innovation funding (£278,000) and Building Capacity Funding (£210,000 from July 16/17 increasing to £334,000 in subsequent years) will prioritise those children and young people who have waited the longest.

Using TRAK data to identify GP practices with high referral rates - Link workers identified to liaise with the GPs regarding suitable referrals/updates on CAMHS. Too soon to see if this intervention impacts on referral rates.

Review of Emotional Wellbeing and Children and Young People's Mental Health Services underway in Edinburgh sponsored by the Edinburgh Integrated Children's Service Partnership Board.
Proposal to increase capacity for direct clinical contact of CMHWs in CAMHS teams for 12 months.

Reduced capacity

A number of staff on short term contracts funded by non-recurring funding have ended.

Diagnostics – Gastroenterology/ Urology Diagnostics

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: A six week maximum waiting time for eight key diagnostic tests (four for Gastroenterology/ Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs - please see separate proformas for Radiology, and Vascular Labs data)), from 31st March 2009.

Responsible Director[s]: Chief Officer

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	1,640	Jun 2016	Yes	Yes	JC

Summary for Committee to note or agree

- **Analysis of demand and capacity has identified a gap in capacity for patients referred for endoscopy procedures;**
- **Patients referred via the Bowel Cancer Screening Programme or as an urgent patient with suspicion of cancer are being prioritised. This cohort of patients are generally receiving an appointment within 14 days from referral but this is impacting on the ability to see routine patients within 6 weeks;**
- **Improvement in the Flexible cystoscopy performance is notable.**

Key Diagnostic Tests - Gastroenterology/ Urology Diagnostics

The four diagnostic tests in Gastroenterology/Urology Diagnostics are Colonoscopy, Upper Endoscopy, Flexible Sigmoidoscopy (Lower Endoscopy - excluding Colonoscopy) and Flexible Cystoscopy.

Recent Performance: Numbers against Standard

Table 1: Gastroenterology/ Urology Diagnostics - Numbers over 6 Week Standard

	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Colonoscopy	49	25	151	100	51	285	303	421	654	674	680	639	406	457	418	210	229	448	507	568
Upper Endoscopy	72	36	261	288	367	654	761	841	978	846	778	850	592	497	504	389	433	552	567	620
Flexible Sigmoidoscopy (Lower Endoscopy)	17	13	99	115	87	262	284	294	310	278	235	246	171	162	173	142	162	209	198	192
Flexible Cystoscopy	602	514	495	288	237	247	224	296	410	470	487	571	179	46	28	27	37	43	73	56
Total	**740**	**588**	**1,006**	**791**	**742**	**1,448**	**1,572**	**1,852**	**2,352**	**2,268**	**2,180**	**2,306**	**1,348**	**1,162**	**1,123**	**768**	**861**	**1,252**	**1,345**	**1,436**

Timescale for Improvement

Recent DCAQ work has supported the development of a trajectory until end September 2016.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Continue to support evening	January	This number has reduced since end of April to 14 per month	**14 additional slots per month**	Ongoing on a reduced

lists via NHS	onwards	due t o staff availability		basis over Summer months
To maximise use of Regional Endoscopy unit (REU)at QMH for routine repeats. Introduce Patient Focus Booking for this unit	Commence May 2016	Increase use of REU ensuring identifiable capacity for planned repeats Patient focus booking is good for patients and reduces short notice CNAs and DNAs	Example of one weeks activity at REU under the new system Booked Capacity 90.1% DNA Rate (Points) 2.7% DNA Rate (patients) 3.6% Actual Utilisation 87.7% which is a much improved position	Ongoing and being measured and monitored
Introduce the full time nurse validation and telephone screening model for repeat endoscopies.	1st June 2016	45% reduction in total numbers validated then telephone screened was achieved within NHS Lanarkshire, same model we are implementing. This was largely driven by patient choice. These patients may historically have been DNAs and therefore ensuring capacity is maximised	Safe managed reduction in planned repeat list by clinical validation and telephone pre-assessment screening. Patients most in need of early scope identified, reduction in DNA more efficient use of capacity. Since start of new process 35% reduction of patients contacted.	Newly implemented :stats on all patients validated being gathered
Progress Faecal Calprotectin workstream to reduce demand on the service	July 2016	Significant reduction in referral to outpatients and ultimately reduction in endoscopy procedure		Progressing this work – currently engaging with stakeholders about new referral pathway
Introduced band 2 contacting pts in the evening to confirm attendance at procedure	May 2016	Reduction in DNAs More efficient use of capacity	Already significant improvement seen in Roodlands historically very high DNAs now weekly report of 95- 100% attendance. Problem remains where small numbers of patients confirm attendance on phone week prior to scope and then still fail to attend GP letter being agreed to inform GPs.	May, June, July initially
Introduce a pt letter that advises direct access pts that they have been added to waiting list for procedure	July 2016	Reduce DNA rate improved patient experience with better communication		System problems implementing letter resulted in delay in implementation
Weekly meeting with waiting list office to maximise capacity and highlight booking issues earlier	May 2016	Increase utilisation/reduced DNAs improved communication closer working between service and booking team	Early escalation of issues close working with booking team. Changes as a result of meeting – introduction of telephoning reminder relay evening service , reduction in last minute booking creation of consultant list to manage urgents, training and familiarisation by senior endoscopy nurses to the booking team resulting in greater knowledge of service and less errors	On going
Introduction of monthly Endoscopy Service NHS Lothian wide operational meeting	June 2016	All SCNs, bookers and management team face to face meeting to discuss issues and opportunities for sharing good practice and efficiencies. Opportunity to tackle and resolve issues that ultimately resulted in inefficiencies		1st Meeting 9th June 2016

Comments - Gastroenterology/Urology Diagnostics

The level of demand for endoscopy tests are outstripping core provision resulting in an ongoing reliance on external capacity. Additional capacity had been arranged to bridge this shortfall and reverse the trend in increasing numbers waiting over 6 weeks. Although much improved at performance at the end of December fell short of the level agreed with SGHD. The withdrawal from private sector since 1st April 2016 resulted in a deteriorating position

Reasons for Current Performance

Demand continues to outstrip capacity. Additionally there is no longer capacity through independent providers. Rising referral rates. Reduced volunteers for Waiting list initiatives.

Mitigating Actions

Additional internal sessions have been organised to maximise utilisation of internal core resource. Reviews of referrals continue to be completed to ensure patients on waiting lists remain clinically appropriate. Additional work is ongoing to review overall endoscopy room utilisation to maximise utilisation of core funded capacity. To compensate for the DNA rate, a number of lists are being overbooked to support full use of the available capacity. Telephone initiatives, use of nurse validation and introduction of Patient Focus Booking with return patients being streamed to REU. Review of all nurse endoscopist job plans to increase fixed sessions

Diagnostics - Radiology

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: A six week maximum waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs from 31st March 2009. Please see separate proformas for Gastroenterology/Urology Diagnostics, and Vascular Labs data).

Responsible Director[s]: Chief Officer

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	1,640	Jun 2016	Yes	Yes	JC

Summary for Committee to note or agree

We are continuing to take actions to reduce waiting times for key radiology tests.

Key Diagnostic Tests - Radiology

The four diagnostic tests in Radiology are Computed Tomography (CT), Magnetic Resonance Imaging (MRI), Barium Studies and Ultrasound.

Recent Performance: Numbers against Standard

Table 1: Radiology - Numbers over 6 Week Standard[13]

	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	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
CT	0	0	0	0	0	2	3	15	8	6	12	9	9	3	2	6	2	5	6	7	3	19
MRI	0	1	0	1	1	0	2	108	123	106	60	38	111	77	6	11	12	17	16	204	172	176
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
General Ultrasound	1	7	21	67	90	40	15	23	13	30	4	5	10	1	5	5	3	9	3	3	3	3
Total[14]	**1**	**8**	**21**	**68**	**91**	**42**	**20**	**146**	**144**	**142**	**76**	**52**	**130**	**81**	**13**	**22**	**17**	**31**	**25**	**214**	**178**	**198**

Timescale for Improvement against Target/Standard - Radiology

31st July 2016

Actions Planned and Outcome - Radiology

Action	Due By	Planned Benefit	Actual Benefit	Status
External provision of CT and MRI – 8 CT and 19 MRI mobile van days	End of July 2016	650 patient examinations per month	Sustain TTG	As planned
Additional US and CT sessions booked where staff availability permits	End of July 2016	Pending staff availability	Sustain TTG	Ongoing
Reduce reporting beyond 6 weeks (weekly report to consultants to highlight long waits and overall position)	End of July 2016	Improved scan to report times	Sustain TTG	Ongoing
Will investigate causes of MRI scanner downtime, appear unconnected	End of July 2016	Avoid lost capacity	Sustain TTG	Ongoing

Comments - Radiology

For Current Performance

175 patient Radiology examinations tripping the 6 weeks referral to unverified report at end **June 16**.
154 are MRI. Mobile scanner downtime has resulted in lost capacity mainly for Lumbar MRI. Delayed reporting at DCN due to reduced external provision in June (now improving).
RHSC MRI requiring GA, trippers reduced to 1 now. Cardiac MRI delays much improved, no external support required currently.
Demand for MRI Lumbar spine still a pressure requiring external provision and reporting.

[13] From Oct 15 inclusive onwards, Vascular Labs figures are not included in 'General Ultrasound' but are reported on the separate Vascular Labs proforma;
[14] Minus Vascular Labs, from Oct 15 inclusive onwards.

Diagnostics – Vascular Labs

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: A six week maximum waiting time for eight key diagnostic tests (four for Gastroenterology/Urology Diagnostics, and four for Radiology (one of which covers data for Vascular Labs. Please see separate proformas for Gastroenterology/Urology Diagnostics, and Radiology data)), from 31st March 2009.

Responsible Director[s]: Chief Officer

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	1,640	June 2016	Yes	Yes	JC

Summary for Committee to note or agree

- A national shortage of Healthcare Scientists (HCS) has resulted in a vacancy being unfilled and a reduction in service capacity;
- The service has increased productivity, and in May 2016 brought in staff from out with NHS Lothian to support a reduction in waiting times;
- The service is also prioritising training to develop the HCS workforce and to support the service in the longer term.

Key Diagnostic Tests - Vascular Labs

The diagnostic test for **Vascular Labs** was previously included in General Ultrasound (until September 2015 inclusive).

Recent Performance: Numbers against Standard

Table 1: Vascular Labs - Numbers over 6 Week Standard

	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Vascular Labs	11	22	29	55	27	29	47	26	6

Timescale for Improvement against Target/Standard - Vascular Labs

This continues in light of the capacity shortfall as a result of the national shortage of HCS

Actions Planned and Outcome - Vascular Labs

Action	Due By	Planned Benefit	Actual Benefit	Status
External Vascular Scientist input being brought into service in order to reduce waiting times	End of May 2016	Reduction in patients waiting over 6 weeks	As planned- currently only 6 patients waiting over 6 weeks	Complete (as per performance above)
Increase productivity by increasing patient facing direct clinical care workload and offering overtime to staff	End of August 2016	Increase capacity in vascular laboratory	As planned	Ongoing

Comments - Vascular Labs

Reasons for Current Performance

A national shortage of Healthcare Scientists (HCS) has resulted in a vacancy being unfilled and a reduction in capacity.

Drug & Alcohol Waiting Times

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard:

The Scottish Government set a target that by June 2013, 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery. This was one of the national HEAT (Health improvement, Efficiency, Access, Treatment) targets, number A11.

This target was achieved in June 2013 and has now become a Local Delivery Plan (LDP) standard - that 90% of clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%).

Responsible Director[s]: Director of Strategic Planning, Performance Reporting & Information

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Worse	90% (min)	82.7%	Mar 2016	No	Yes	AMcM

Summary for Committee to note or agree

All services in the area (NHS, Council & 3rd Sector)

- The Lothian wide figure remains below target by 7% but has improved by 3% since the last quarter.
- On a geographical basis services in Midlothian, East Lothian and West Lothian are all exceeding the target.
- Edinburgh's performance is similar to the last quarter

NHS Lothian Substance Misuse Services

- NHSL SMS Services in East and Midlothian continue to meet / exceed the target.
- Within Edinburgh NHSL SMS services have shown a 10% improvement since Dec 15, although still below target at 75%.
- West Lothian NHSL SMS services have continued to show an improving trend in the last 4 quarters from 38% to over 77%..

Actions

- Plans are being implemented in Edinburgh and West Lothian to enhance productivity and capacity within the teams.
- The forecasted Q1 figures for 16/17 should continue to show an improvement and progress towards the targets for Edinburgh and West Lothian.

Recent Performance – Numbers Against LDP Target

Table 1: % Seen within 3 Weeks

	Sep 14	Dec 14	Mar 15	Jun 15	Sep 15	Dec 15	Mar 16
NHS Lothian	**90.6**	**85.8**	**87.1**	**83.3**	**82.8**	**79.9**	**82.7**
Edinburgh City Alcohol & Drug Partnership (ADP)	87.1	79.3	80.8	80.3	80.6	75.8	75.3
Midlothian and East Lothian ADP (MELDAP)	96.6	98.0	96.8	92.2	95.2	94.0	96.7
East Lothian	98.8	100.0	96.7	91.5	96.0	90.5	98.1
Midlothian	94.6	96.3	96.9	93.3	94.5	98.0	95.4
West Lothian ADP	96.3	94.3	97.3	86.0	80.5	82.2	93.0

Timescale for Improvement

Discussions ongoing with Edinburgh ADP and currently addressing pressures in South East Edinburgh as well as aiming to build consistency and increase productivity & capacity across all areas. Further work still to take place re individual localities and revised trajectory once budgets for 16/17 are agreed.

The review of residential services necessary due to the reduction in funding may have implications for the performance against the LDP Standard.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status

The Lothian Substance Misuse Collaborative and the three ADP's and the IJB's are working to take proposals forward to each organisations Board to state what is being done but will need to be done to ensure sustainable services and meet the waiting times target.

In addition NHS Lothian and the ADP's and Health and Social Care Partnerships have agreed to take forward the recommendations through a piece of commissioned work.

Recommendations from the report are :

- *The report identifies savings of about 1m which could be used to fund ARBD or the 22% reductions in ADP funding but unlikely to fully support both as investments in community services also required*
- *It estimates ARBD saves NHSL £798K in terms of cost per bed day in Milestone compared to acute beds and whilst the beds have not been released if ARBD closes these people will make their way back into acute beds. Of the 62 referrals to the unit 61 came from Acute Care Physicians*
- *It suggests potential income generation by expanding ARBD and charging other HBs which may cover our costs if done properly. However could LEAP and Ritson be safely relocated in Milestone as another option?*
- *The report suggests that the BBV part of Milestone provides "time and space" for a very small percentage of the population with a BBV and suggests that services could be re-provided in communities to meet the needs freeing up the building for the services mentioned above*
- *The report states that LEAP should be the default placement for residential rehab (but it has to adapt and change its thresholds).*
- *Ritson- Report suggests a new model which has better community detox, a day programme and a smaller in patient unit. It should be Co located with LEAP and with same team across both but working separately. LEAP to take those on more that 30mls methadone (current limit)*
- *The report suggests co-location and it is to be identified where, it does show that there is no value for money in trying to do in patient detox locally as East/Mid and West all use more than their funded share.*
- *Apparently Gartnavel have a model worth looking at*

Partnerships have also identified non recurring funding to sustain the current ARBD unit whilst these recommendations are pursued.

Timelines are Dec 16 for this all to be concluded.

Comments

Reasons for Current Performance

Substance Misuse Directorate (SMD) performance in the City of Edinburgh has been below 90% for some months and pulls the average for all services in NHS Lothian down (across health, social care and the voluntary sector). There have been pressures in other areas, but these have been short term and resolved.

Reasons for the pressures in the city are:-

1. Short term contracts for EADP funded posts, which constitute the majority of staff – this results in high levels of staff turnover, whose caseloads need to be absorbed by remaining staff, who are then unable to take on new cases from the waiting list. We have asked that the organisation (*REAS*) take the redeployment risk of giving permanent contracts to staff, to reduce turnover;
2. Contracting budgets – reductions yet to be quantified in the budgets from April 16 onwards may make delivery difficult;
3. Bottlenecks in the patient pathway, reducing capacity for discharge to primary care, which reduces the SMD capacity to take on new cases. Several GP practices in the city are receiving direct support from HSCPs as they have excess activity for the resources available to them. Approximately 30% of GP practices currently have restricted lists.

The SMD SMT will use the productivity work to maximise capacity in local services.

Inpatient & Day Case (IPDC) Treatment Time Guarantee (TTG)

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: From the 1 October 2012, the Patient Rights (Scotland) Act 2011 establishes a 12 week maximum waiting time for the treatment of all eligible patients due to receive planned treatment delivered on an inpatient or day case basis.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Better	0 (max)	399	Jun 2016	Yes	Yes	JC

Summary for Committee to note or agree

Use of independent sector ceased from April 1 2016; internal capacity is unable to fully cover this previous activity which will impact on performance. Details of DCAQ work including efficiency improvements that we are undertaking are described below.

Recent Performance – Numbers beyond Standard

Table 1: Treatment Time Guarantee Patients waiting beyond standard at month end

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Urology	137	123	92	104	133	143	116	76	33	23	37	59	122	136	182
General Surgery	48	39	18	29	21	15	18	9	12	25	30	51	51	71	59
Neurosurgery	6	12	14	8	6	5		6	14	24	39	35	45	53	54
Orthopaedic Surgery	88	86	60	55	62	40	32	24	25	28	42	52	73	52	32
Ear Nose and Throat	39	38	33	13	28	19	13	15	4	16	18	31	37	37	18
Plastic Surgery	114	106	89	86	95	79	55	36	23	15	13	16	22	24	15
Paediatric Surgery	21	15	3	12	12	5	5	3	4	2	3	7	4	8	9
Others	47	57	40	40	41	39	38	24	12	28	39	38	50	35	30
Total	**500**	**476**	**349**	**347**	**398**	**345**	**277**	**193**	**127**	**161**	**221**	**289**	**404**	**416**	**399**

Table 2: Treatment Time Guarantee Patients seen beyond 12 weeks

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
TTG Seen	476	463	389	314	314	368	293	276	207	163	219	297	297	404	398

Figures on Inpatient list size and unavailability are shown in the following table (Table 3). The use of unavailability and choice codes in Lothian remains low.

Table 3: List Size and Unavailability

Inpatients	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Total List Size (TTG)	8,941	8,692	8,642	8,421	8,599	8,826	8,820	8,944	9,140	9,216	9,809	8,814	8,625	8,628	8,856
Available	7,911	7,644	7,453	7,264	7,543	7,907	8,070	7,952	8,081	8,518	8,332	7,949	7,727	7,623	7,668
Unavailable	1,030	1,048	1,189	1,157	1,056	919	750	992	1,059	698	757	865	898	1,005	1,188
Percentage Unavailable	11.5%	12.1%	13.8%	13.7%	12.3%	10.4%	8.5%	11.1%	11.6%	7.6%	7.7%	9.8%	10.4%	11.6%	13.4%
Non-TTG	1,180	1,244	1,246	1,187	1,048	1,023	1,013	1,012	1,069	1,110	1,090	1,063	976	1,073	1,091

Timescale for Improvement

Following recent DCAQ work a trajectory has been developed for TTG until end of September . All services currently developing trajectories until March 2017.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Detailed review of Acute Services' available capacity and demand undertaken to inform our future capacity plans and financial planning process. This Demand, Capacity, Activity and Queue exercise has examined service performance against key performance indicators and identify scope for improvement with recommendations to specialties. Work has now moved from data collection and analysis to performance improvement monitoring.	Initial output end Jan 2016. Quarterly meetings established with each service. First series of meetings held April 2016, second series of meetings scheduled end July 2016.	Improved performance against agreed efficiency targets, example improved Day Case rate.		Quarterly meetings established with services to monitor performance.
Implementation of a Theatres Improvement Programme – a significant programme with multiple work streams to improve theatre efficiency.	Full implementation by December 2016	Overall improved theatre efficiency Reducing cancellations Redesigning pre-op assessment		
Service review of all booked theatre lists one week in advance to ensure optimum booking and theatre efficiency.	Ongoing	Maximise theatre utilisation	See comments below	
Implement a phone reminder to all booked patients in advance of TCI date. Pilot in Head & Neck for two months and monitor impact. Commenced February 2016.	End of March 2016	To reduce late cancellations enabling the slot to be backfilled reducing wasted theatre time. Year To Date (YTD) (Apr-Nov) Theatre cancellations within 24 hours – 396 cases. YTD Theatre utilisation hours used – average 85%.	See comments below	Ongoing
Establish extent to which specialties plan routine elective patients requiring to be preoperatively assessed are appointed no later than week 4 of their journey – ensure consistent approach is taken.	End April 2016	Confidence that all patients on the waiting list are fit for surgery. Ensuring larger pool of patients prepped and ready to fill vacant theatre slots at short notice.		
Development of trajectories and detailed actions maximising internal capacity; . New trajectories build up from, DCAQ work. Process endorsed by SG early May. Work now underway to develop trajectories until End March 2017.	End July 2016.	Optimise internal capacity and maintain focus on delivery of TTG		

Comments

Reasons for Current Performance

Demand for services is greater than core capacity.

Cessation of independent sector

As services have been clearing backlog of patients, if patients are cancelled either by patient or by hospital, they remain on waiting list as already >than 12 weeks, as unavailability cannot be applied.

Performance target is for 12 weeks, therefore if late cancellation due to hospital reason i.e. bed pressures, urgent cases etc there is limited ability to re book within 12 week TTG date.

Lack of willingness to undertake waiting list initiatives in some specialties or within theatre teams.

Head and Neck Pilot results:
We introduced the following steps to help reduce No. Of cancellation / DNA's

- TCI's less than 2 weeks are phoned and offered their surgery Date
- Patients booked out with 2 weeks are lettered, then contacted Via Phone to confirm they will be attending for surgery
- Patients who we are unable to contact Via Phone we send them a reminder letter
- Weekly meeting with WLO / team lead & co-ordinators to go through The planned V Actual

ENT remains under 90% despite the above actions, On 3/05/16 we introduced a 6 week Pilot where we will drill down to patient level information, looking at the following details:

- Has patient confirmed / if not has review letter been sent
- Date pt confirmed
- Cancellations / replacement of pt's
- Total number of hours booked per theatre
- End of week review / confirmation of full list.
- Looking back at previous week / reflect on Planned V Actual
- Take actions

Progress Update:

- numbers for cancellations at less than 24 hours is high due – I've asked that No. Of pt's booked at less than 24 hours to feature on the utilisation report going forward to highlight the good work the service are doing to backfill.
- Our planned V Actual pilot has highlighted the discrepancies between the time allocated by the surgeon on the waiting list form and operating time – further discussions with clinical leads on going
- Unpredictable On the day cancellation continue – medical reasons and patient no longer wishes / requires operation – further work with CD's required.

	Oct	Nov	Dec	Jan	Feb.	march	April	May
Ent	84%	76%	84%	83%	83%	86%	81%	81.32%
OMFS	96%	87.80%	85.20%	105%	108%	92%	104%	90.22%
Plastics	81%	83.90%	86.20%	84%	97%	91%	91.32%	87.47%

pt's cancelled within 24 hours

	Oct	Nov	Dec	Jan	Feb.	march	April	May
pt's cancelled within 24 hours	59	69	41	56	47	35	41	50

Theatre Utilisation

	Oct	Nov	Dec	Jan	Feb.	march
Ent	84%	76%	84%	83%	83%	86%
OMFS	96%	87.80%	85.20%	105%	108%	92%
Plastics	81%	83.90%	86.20%	84%	97%	91%

pt's cancelled within 24 hours

	Oct	Nov	Dec	Jan	feb	march
pt's cancelled within 24 hours	59	69	41	56	47	35

Outpatients

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: From the 31 March 2010, no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic. This includes referrals from all sources.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	95% (min)	81% (10,135)	June 2016	Yes	Yes	JC

Summary for Committee to note or agree

The software issue impacting on reporting at the Dental Institute has been effectively addressed. Patients there are now included, with updated figures presented from March 2016.

Use of independent sector ceased from April 1 2016; internal capacity is unable to fully cover this previous activity which will impact on performance. Details of DCAQ work including efficiency improvements that we are undertaking are described below.

Recent Performance – Numbers beyond Standard

Table 1: Trend in Outpatients over 12 weeks – Key Specialties
(April 2016 excludes Edinburgh Dental Institute)

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
GASTROENTEROLOGY	477	671	902	1,208	1,334	1,360	1,375	1,292	1,439	1,445	1,547	1,617	1,845	2,087	2,327
TRAUMA AND ORTHOPAEDIC SURGERY	515	665	558	912	1,291	1,623	1,847	1,982	2,165	2,366	2,166	1,916	2,201	2,255	2,321
GENERAL SURGERY (EXCL VASCULAR)	454	583	632	854	1,036	1,141	1,197	1,110	1,120	1,387	1,535	1,375	1,684	2,064	2,042
EAR, NOSE & THROAT (ENT)	431	504	541	872	1,093	1,040	681	478	373	394	390	345	492	596	827
VASCULAR SURGERY	21	23	21	28	93	182	281	293	308	341	326	296	333	339	362
UROLOGY	398	438	321	606	648	542	525	390	377	407	404	353	386	391	351
ORAL MEDICINE	2	2	25	59	48	65	91	89	104	126	159	167	231	298	344
NEUROLOGY	124	125	72	100	107	82	59	49	51	56	62	48	79	184	240
OPHTHALMOLOGY	336	378	326	475	395	412	335	212	157	192	188	121	189	224	216
ORAL SURGERY	4	6	59	60	57	39	21	36	70	75	81	39	76	136	195
OTHERS	705	866	735	913	831	942	1,079	848	978	1,036	1,128	759	744	830	910
Total over 12 Weeks	**3,467**	**4,261**	**4,192**	**6,087**	**6,933**	**7,428**	**7,491**	**6,779**	**7,142**	**7,825**	**7,986**	**7,036**	**8,260**	**9,404**	**10,135**

Table 2: List Size and Unavailability

Outpatients	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Total List Size	46,547	48,672	50,243	53,046	52,040	50,788	50,850	48,845	47,999	47,199	48,434	48,681	51,574	52,886	54,777
Available	45,843	47,951	49,004	51,930	50,867	49,746	50,011	47,890	46,516	46,319	47,485	47,874	50,912	51,652	53,490
Unavailable	704	721	1,239	1,116	1,173	1,042	839	955	1,483	880	949	807	662	1,234	1,287
Percentage Unavailable	1.5%	1.5%	2.5%	2.1%	2.3%	2.1%	1.6%	2.0%	3.1%	1.9%	2.0%	1.7%	1.3%	2.3%	2.3%

Timescale for Improvement

Following recent DCAQ work an out-patient trajectory has been developed until end September.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Review of Acute Services' available capacity and demand undertaken to inform our future capacity plans and financial planning process. This Demand, Capacity, Activity and Queue (DCAQ) exercise examined service performance against key performance indicators and identify scope for improvement with recommendations to specialties. Move from data collection and analysis to performance monitoring and improvement trajectories. Cessation of independent sector capacity from April 2016, factored into DCAQ work	Initial output end Jan 2016. Programme of further work around performance monitoring –quarterly review process in place First series of review meetings undertaken April 16 next round scheduled end July 16.	Improved performance against agreed efficiency targets, example reduced DNA rate.		Phase two currently being developed. Ongoing
In line with the National Towards Our Vision for 2020 Delivering Outpatient Integration Together Programme. Aim of the programme is manage flow through consistently and sustainably delivering a suite of changes. Progress following work streams; • Advice Only – Allows clinician to provide advice as an alternative to an outpatient appointment where appropriate and safe to do so. • Accommodation Matrix – 'At a glance' view of physical clinic space which is used by Outpatient Service Manager and Clinical Service Managers to identify available staffed clinic space and facilitate clinic reconfiguration without additional resource, thus increasing capacity for both new and review patients. • Return Patient List – Demand for return patients will be captured. Allowing return patients to be seen at clinically appropriate times. Capacity can be planned in advance; rescheduled return appointment through cancellation will decrease, protecting new patient slots. • Patient Initiated Follow-Up – Reduce the number of return appointments allowing patients to re-engage when they are unwell and require secondary care intervention. Appointments will be released which can be transferred to new patients. Early planning stages within Dermatology, Rheumatology and Gynaecology. • Review of the Refhelp service for GPs focusing on key specialties under significant pressure. GP and Specialist engagement in the review, with a relaunch planned for August/September 2016.	Specific work streams have various local target dates but overall programme delivering by 2020.	Decrease in number of new outpatient appointments (better demand management). Achieve upper quartile for the return: new ratio. Decrease DNAs.		Progressing each of these work streams

Comments

Reasons for Current Performance

Demand greater than capacity.
Overall increase in demand of 2% but significant rises seen in General Surgery, Dermatology, Ophthalmology and Gastroenterology.
Return demand in some key specialties impacting on additional capacity- i.e. additional in house clinics required to manage return demand rather than new.
Cessation of independent sector capacity
DCAQ exercise to identify any mismatch in outpatient demand and capacity and take actions to address this.
Ensuring specialties are achieving the agreed efficiency targets.
Implementing actions in line with National Programme of Outpatient Redesign.

Psychological Therapies

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: The Scottish Government has set a target for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies from December 2014. Following work on a tolerance level for Psychological Therapies waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the Psychological Therapies target should be delivered for at least 90% of patients.

Responsible Director[s]: Joint Director, West Lothian

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	90% (min)	68%	Jun 2016	Yes	Yes	JF

Summary for Committee to Note or Agree

"Building Capacity" allocation has been agreed. 10.5 WTE Clinical staff will be recruited on a permanent basis. They will initially concentrate on seeing those patients who have waited the longest. Interviews are set for Mid August. The revised trajectory will reflect the focus on longest waits.

- Lothian will be implementing Mastermind which is an online course of computerised cognitive behaviour therapy (cCBT). It is currently in place in Lanarkshire, Tayside, Forth Valley, Fife and Grampian. There are on average 6,500 referrals to Mastermind across Scotland every year. Mastermind is an evidence based intervention with an established protocol and is in scope for A12. The focus for this psychological treatment is for those with mild to moderate presentations of anxiety and depression. Clinically significant improvements have been established using the CORE outcome measure pre and post intervention; this continues to be monitored across all Boards. An implementation group will be established and it is planned that the service will be available in the Autumn.

Psychological Therapies (inc. Mental Health Services, Clinical Health Psychology, Neuropsychology and GSH services in 3rd Sector)

Overall, 68% of patients who were seen for a 1st treatment appt were seen within 18 weeks

- At the end of June 3,791 patients were waiting for assessment or treatment for Psychological Therapy of which 1,183 had waited over 18 weeks

Clinical Health Psychology & Neuropsychology

- No patient breached 18 weeks in Clinical Health Psychology services
- No patients breached 18 weeks in Neuropsychology services
- There were 485 patients waiting with the CHP and Neuropsychology services at the end of June of which 3 patient had waited over 18 weeks

Guided Self help services

- No patients breached 18 weeks
- There were 39 patients waiting GSH services at the end of June all of which had waited less than 18 weeks

Psychological Therapies delivered by the mental health services only:

- **46% of patients were seen within 18 weeks**
- Number of people seen for a 1st **treatment in June decreased by 13 patients from May** (290 compared to 303)
- The total number of people waiting **increased by 73** (3,267 compared to 3,194 in May)
- The number of people waiting over 18 weeks at the end of June **increased by 106** (1,180 compared to 1074 in May)

- The number of people reported as **waiting over 1 year at the end of June was 127** (compared to 121 in May).

Recent Performance – Percentages against Standard

Table 1: Psychological Therapies Performance Trend - Revised October 2015 (including CHP, NeuroPsychology & Guided Self Help (low intensity psychological intervention - GSH) [3rd sector])

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Percentage seen within 18 weeks	39%	44%	40%	45%	46%	47%	68%	69%	73%	66%	70%	72%	72%	69%	68%
Trajectory for seen within 18 weeks*															
Total waiting at end of month	3,190	3,341	3,261	3,219	3,150	3,015	3,457	3,540	3,697	3,426	3,480	3,548	3,707	3,700	3,791
Those waiting more than 18 weeks	1,254	1,257	1,173	1,146	1,108	1,085	1,069	985	1,041	902	892	1,013	1,073	1,075	1,183

*Revised Trajectory to be agreed by end of July 2016 in line with agreed investment plan.

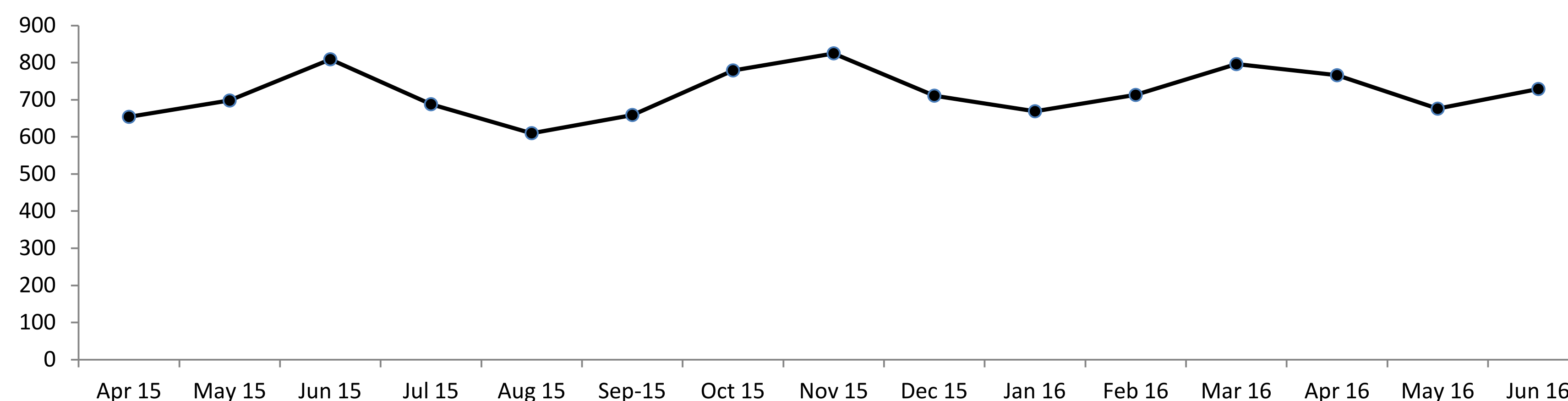
Table 2: Patients seen for 1st Treatment

	Patients seen for 1st treatment (adjusted)				
Service	Number seen	within 18 wks	over 18 wks	% within 18 wks	% over 18 wks
Psychological Therapies (Mental Health)	290	132	158	45.5%	54.5%
Clinical Health Psychology	134	134	0	100.0%	0.0%
Neuropsychology	49	49	0	100.0%	0.0%
GSH (3rd Sector)	22	22	0	100.0%	0.0%
Overall Position	**495**	**337**	**158**	**68.1%**	**31.9%**

Table 3: Patients Waiting at Month End

	Patients waiting at month end (adjusted)				
Service	Number waiting	within 18 wks	over 18 wks	% within 18 wks	% over 18 wks
Psychological Therapies (Mental Health)	3,267	2,087	1,180	63.9%	36.1%
Clinical Health Psychology	358	355	3	99.2%	0.8%
Neuropsychology	127	127	0	100.0%	0.0%
GSH (3rd Sector)	39	39	0	100.0%	0.0%
Overall Position	**3,791**	**2,608**	**1,183**	**68.8%**	**31.2%**

Figure 1: Referrals for All Mental Health Psychological Therapy Services



Timescale for Improvement

The revised trajectory will be set by the end of July – this was delayed due to agreement being reached on the allocation of the "Building Capacity funding. This was signed off on 23 June. All posts have now been advertised and interviews are set for mid August. These posts will focus on those who have waited longest.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Updated Service Improvement plans for each service / team delivering psychological therapies.	Ongoing and reported and monitored via A12 Project Board.	Standardised reporting and monitoring and ability to escalate issues to Senior Management through the Project Board.	As per planned benefit.	Amber
A single prioritised amendments / additions work-plan for TRAK with named analytical, data and system support staff from clinical services, e-health and planning.	Completed and being monitored via A12 Project Board.	Transparency of progress; alignment of TRAK work; reporting of progress formally to the Project Board enabling escalation and resolution of issues.	As per planned benefit.	Amber
Development of a single implementation plan for the introduction of Patient Focused Booking across all service delivering psychological therapies.	Original date was May 2016. Due to configuration issues now anticipated July 2016.	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appointments. Improved compliance with waiting times rules related to reasonable offer, unavailability and clock resets.		Amber
Development of a single implementation plan for the introduction of Text Reminder system across all service delivering psychological therapies.	Expected implementation: June 2016. Delayed – anticipated delivery August 2-16	Reduction in DNA and CNA appointments and therefore reducing loss of capacity through non attended appointments.		Amber
Agreement of norms per WTE for direct clinical contact (appointments) based on banding and role across teams delivering psychological Therapies. Improved reporting of expected versus actual activity. Use of the Meridian work allocation tool to increase direct clinical contact within Edinburgh teams.	Completed	Increased number of total appointments available for psychological therapies. Increase in new patient treatment appointments available each month	Detailed under 'Summary for Committee to Note'.	Green
Further development of the Meridian work allocation tool to streamline completion whilst retaining benefits of the tool.	1st March 2016	Continue to maximise clinical capacity through forward planning of workload and ensuring appointments slots utilised.	Tool has been revised	Green
Completion of updated DCAQ for all general adult services.	Completed	Confirm the DCAQ for each service enabling monitoring of agreed capacity against demand and activity.		Green
Completion of remaining DCAQ for all services / teams whose data is recorded and reported from TRAK.	Completed	Confirm the DCAQ for each service enabling monitoring of agreed capacity against demand and activity. .	Agreed capacity for each team in March 2016. Delivery against capacity monitored on weekly basis	Amber

Introduction of Lothian-wide Group Programme funded by Mental Innovation funding.	1 February 2016	Document and agree expected activity and monitor actual over monthly periods.		Green

Comments

Reasons for Current Performance

Incomplete data
A small number of specialist services delivering psychological therapies are still unable to report data due TRAK configuration, service configuration or extracts not being available from TRAK.
To mitigate - prioritised work-plan for TRAK and service / team improvement plans.

Reduced capacity
Reduction in capacity due to contracts ending which were funded on non-recurring basis.
Revised DCAQ continues to highlight capacity issues for adult mental health services. DCAQ has consistently demonstrated a capacity gap in *General Adult Psychology Services* as being 13.1 WTE. An additional 12 WTE are required to clear the queue of patients waiting.

Increased demand
Increase in demand due to the increasing efficacy and awareness of the positive contribution of psychological therapies to improving patients' outcomes.

To mitigate –
Updated DCAQ for all services / teams.
Reviewing the range of psychological therapies available and ensuring delivery of those with the most robust evidence bases are prioritised and matched to those who will most benefit.
Building Capacity funding will be target at those who have waited longest.

18 Weeks Referral to Treatment

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: 90% of planned/elective patients to commence treatment within 18 weeks of referral.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	90% (min)	81.3%	Jun 2016	Yes	Yes	JC

Summary for Committee to note or agree

Use of independent sector ceased from April 1 2016; internal capacity is unable to fully cover this previous activity which will impact on overall RTT performance. Details of DCAQ work including efficiency improvements that we are undertaking are described in OP and IP/DC proformas.

Recent Performance – Percentages towards Standard

Table 1: 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	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
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	84.0	82.5	82.8	83.0	82.4	82.4	83.0	82.9	81.3
Number of patient journeys within 18 weeks	13,415	13,877	13,042	11,811	12,044	11,838	13,626	12,446	12,417	13,795	13,297	12,631	13,820	13,642	13,000	13,133	11,931	12,396	12,791	13,157	13,067	13,303
Number of patient journeys over 18 weeks	2,163	2,014	2,137	1,873	2,103	1,996	1,861	2,001	1,849	2,265	1,941	2,201	2,449	2,604	2,749	2,720	2,443	2,647	2,736	2,688	2,703	3,061
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	87.4	86.3	86.1	86.8	87.0	87.1	87.0	87.0	89.3

Timescale for Improvement

None provided.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Pursue significant programmes of work to improve efficiency and reduce patient waits for IP and OP access: Theatre Efficiency Programme; Demand and Capacity Programme, and Outpatient Redesign Programme.	DCAQ Phase1 - end of January 2016. Phase to monitoring of performance against key indicators started April 2016. Second round of performance meetings scheduled end July 16. Theatre programme- December 2016. Outpatient programme – 2020.	Improved performance against agreed efficiency targets, example improved Day Case rate. Improved demand management.		Progressing individual work-streams
Ensuring clinic outcome data is completed - achieve target of 80% clinic outcome completeness for all specialities.	End September.	Clocks stop appropriately in line with clinical pathway.		

Comments

Reasons for Current Performance

Challenges within specific specialties as highlighted on the Outpatient and TTG proformas.

Stroke Bundle

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: This is a **New Standard**, implemented from 1st April 2016:

80% of all patients admitted to hospital with an initial diagnosis of stroke should receive the appropriate elements of the stroke care bundle.

Additional information

The key elements of the stroke care bundle are:-

1. Admission **to the stroke unit on the day of admission, or the day following presentation** at hospital;
2. Screening by a standardised assessment method to identify any difficulty swallowing safely due to low conscious level and/ or the presence of signs of dysphagia **within 4 hours of arrival at hospital;**
3. CT/ MRI imaging **within 24 hours** of admission; and
4. Aspirin is given **on the day of admission or the following day where** haemorrhagic stroke has been excluded, or other contraindication, as specified in the national audit.

Responsible Director[s]: Executive Director: Chief Officer

Performance:

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Not Available	80%	54.6%	May 2016	No	Yes	JC

Summary for Committee to note or agree

Stroke care is part of the Clinical Quality Programme during 2016, and stroke services have been identified as a priority to be supported by NHS Lothian's Quality Management Strategy. This brings exciting opportunities to refocus the delivery of improvement of stroke services using this quality improvement approach. Stroke colleagues on the Leadership Course are engaged with projects relating to improving access to the stroke unit by 7 day working, TIA pathway and prioritisation; improved use of patient-focussed goals and efficiency of the stroke rehabilitation pathway; and improving time to carotid interventions for patients presenting with TIA and stroke. The projects are ongoing and support from NHS Lothian Quality Improvement leaders is continuing. The future monthly Stroke Pathway Management Team meetings will focus on quality improvement and actions resulting from the improvement work being undertaken in all the stroke units.

The majority of bundle fails are for admission to the stroke unit and swallow screen – 54 patients failed the bundle, with 23 only failing to access the stroke unit, and 21 only failing the swallow screen and five failing both access and swallow screening the remaining five fails were for CT scan or aspirin. The swallow screen standard is now within four hours of admission and performance had improved month on month since November, but dipped again in April and May due to this rigorous standard. The nursing teams in the stroke units and at front doors are making focussed efforts to improve performance against this challenging target, but with patients often not getting their first assessment until close to four hours, they are then not identified as stroke until after this time. The majority of patients who failed swallow screen, received it between four and six hours. St John's action plan between ED, MAU and PAA has refocused on the role of the stroke bundle nurse, training staff to do the screen, and written documentation.

There are increasing numbers of patients being seen and receiving initial diagnoses of stroke and this has meant performance against stroke unit admission remains challenging and unmet. Bed pressures across all sites and boarding patients in stroke beds have also impacted on admissions to new stroke patients. Performance for imaging remains steady and meets the updated national standard, and performance for aspirin treatment remains steady but hasn't met the national target of 95%.

Performances in this report are against the amended national standards (from April 2016) for swallow screen and brain scan, and new national target for stroke bundle.

Recent Performance – Numbers achieved towards standard

Table 1: Stroke Bundle Performance
(provisional data for management, and liable to change)

	Sep 2015	Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April 2016	May 2016	Target
Stroke Bundle Performance	**66.3%**	**79%**	**65.1%**	**65%**	**71.3%**	**66.1%**	**67.7%**	**57.5%**	**54.6%**	**80%**
1. Access to stroke unit by day after admission	71.1%	83%	75.8%	69%	77%	66.7%	74.7%	72.5%	65.6%	**85%**[15]
2. Swallow screen within 4 hours of admission	90.4%	89.1%	82.9%	83.5%	86.9%	84.7%	87.9%	77.2%	74.8%	**100%**[16]
3. Imaging undertaken within 24 hours	96.2%	97.5%	98.4%	97.1%	97.5%	98.3%	97%	96.9%	97.5%	**95%**[17]
4. Aspirin by the day following admission	92.1%	95.5%	93.8%	88.7%	94.5%	93.4%	88.9%	92.9%	94.7%	**95%**

Timescale for Improvement

A trajectory has been agreed with SGHD and set out below (Local trajectory agreed at 70% for 2015/16. National target of 80% to be enforced from April 2016):-

Oct 2015	Nov 2015	Dec 2015	Jan 2016	Feb 2016	Mar 2016	April 2016	May 2016	June 2016	July 2016	Aug 2016	Sep 2016	Oct 2016
70%	70%	70%	70%	70%	70%	80%	80%	80%	80%	80%	80%	80%

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Outreach service at WGH is delivered within ward nurse staffing establishment by senior band 5s and above.	Completed	Increased capacity to identify and take care of more patients, at an early stage.	To be determined. Audit of calls from ARU to Outreach underway.	
Full complement of band 6 nurses in stroke and MoE wards (101, 201, 104, 202 and 203) at RIE to enable stroke nurse to attend front door for sweeps throughout the night.	End of July 2016	Senior cover for 24/7 stroke outreach service at RIE.		Band 6 rotations now not happening, but looking at different shift patterns.
Late evening telephone and in-person sweeps to front door to identify late admissions for swallow screens. Meeting arranged with RIE Front Door staff as there is inconsistency with swallow screening now, particularly with new 4 hour target. Decrease in performance in May due to amended target of 100% within 4 hours.	In progress	Early identification of stroke pts and appropriate pathway agreed for them.	Early identification of stroke patients.	Daily activity. MAU nurse (RIE) trained to be a swallow trainer.
Single point of contact to optimise use of stroke capacity. Daily 9.30am teleconference call discuss bed availability and potential for transfer(s) from RIE to WGH depending on other demands for beds, eg from ITU, ARAU and DCN. Potential boarders, non-stroke patients, transfers and discharges identified to create capacity for new strokes to be admitted to stroke units.	In progress	North zone patients to be transferred to WGH if beds are available and clinically safe. Acute stroke beds are used appropriately pan-Lothian.		In place and in testing phase
Stroke team identified to undertake the improvement work across four areas and are undertaking training courses in Quality Improvement. E.g. auditing patients who do not need to be admitted to stroke unit, but receive stroke care and discharged from AMU; patient destination once rehabilitation is no longer required.	In progress	Currently staff from both WGH and RIE are part Cohort 1 of QI Leadership and QI Improvements Skills Training		QI Clinical Skills course Report Out - Sept 2016
Rehabilitation triage to identify 'fast track' patients for increased intensity of treatment and earlier sign-posting to Intermediate Care Services (ICS).	In progress	Decrease LOS, more patients going home quicker	Free up beds earlier in ISU and improve bundle performance. Regular BOXI reports from TRAK to reflect the numbers of referrals are being developed by AHP Informatics Lead.	Early indications show a reduced LOS for small number of patients on fast track referral to ICS. An ongoing tally sheet is in use to determine if this change is real. Fast track to ICS will continue to take place, based on the basis of ICS capacity.
Boarding plan for escalation of ISU beds at RIE	End of July 2016	Appropriate patients can be boarded out to enable new acute strokes to be admitted to the unit.		Draft document circulated for comments, with stroke unit agreement by 7th July. Consultants and hospital management agreement by end July.
Refocus on the role of the stroke bundle nurse at St John's, training of staff in swallow screening and completion of written documentation.	In progress	Prompt identification of stroke patients and appropriate pathway in place.		In progress

Comments

[15] 85% is Local Trajectory; 90% is National Target.
[16] From April 2016 standard has changed from 90% on day of admission, to 100% within 4 hours of admission.
[17] From April 2016 standard has changed from 90% within 24 hours, to 95% within 24 hours of admission.

Reasons for Current Performance

Access to stroke unit breaches: High demands on stroke unit beds across all sites.

RIE: There were capacity issues at RIE with 19 breaches: 11 patients were either discharged or admitted to the Stroke Unit by day 3; four required palliative care or MoE bed for co-morbidities; two were transferred to WGH.

SJH: Three patients at SJH failed the access standard as the ward was closed due to norovirus.

WGH: Two of the breaches at WGH were admitted to the stroke unit by day 3, and another required palliative care.

Swallow screen: 56% of the fails across all sites received a screen within eight hours and the majority within five hours. Other patients were missed by the stroke unit sweep to the front door and delays in being identified as a patient with stroke. Two in-hospital stroke patients also failed as they were 'last seen well' out-with the four hour window.

Surveillance Endoscopy

Healthcare Quality Domain: Timely

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: No patient should wait past their planned review date for a surveillance endoscopy.

Responsible Director[s]: Executive Director: Chief Officer

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Not Available	0 (max)	3,290	June 2016	Yes	Yes	JC

Summary for Committee to note or agree

- Surveillance scopes have continued to prove challenging;
- Activity in independent sector ceased 1 April 2016;
- Booking of the Regional Endoscopy Unit (REU) has transferred to External Provider Office;
- As well as reviewing options to increase capacity, the service has introduced a nurse led 'pre-assessment' process aimed at reducing demand. May 2016.

Recent Performance – Numbers Against Standard

Table 1: Surveillance and Review Patients Overdue Appointment

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Colonoscopy	614	621	611	627	686	741	869	1,017	1,142	1,265	1,347	1,456	1,596	1,790	2,030
Upper Endoscopy	320	326	307	340	369	404	436	497	546	597	605	602	637	666	730
Flexible Sigmoidoscopy	109	119	126	135	155	165	153	168	182	187	186	197	206	220	236
Flexible Cystoscopy	196	164	200	235	290	327	342	355	374	273	120	73	114	145	82
Other	93	104	100	105	98	106	111	127	138	142	133	139	162	186	212
Total	**1,332**	**1,334**	**1,344**	**1,442**	**1,598**	**1,743**	**1,911**	**2,164**	**2,382**	**2,464**	**2,391**	**2,467**	**2,715**	**3,007**	**3,290**

Timescale for Improvement

Based on recent DCAQ work a trajectory has been developed until Sept 2016. Timelines for various actions outlined below.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Completion of DCAQ for Endoscopy to confirm overall gap in list capacity	Quarterly monitoring process throughout 2016	Accurate measure of available capacity vs demand for both surveillance and new diagnostics		Next round of review meetings in July.
Transfer of booking of surveillance scopes to EPO, providing a dedicated resource.	May 2016	Improved use of capacity at REU, reduced length of wait, reduce DNAs	Improved utilisation and reduced DNA rates.	Transfer occurred in May.
Plan for additional flexi cystoscopy activity to clear surveillance and planned repeat backlog.	Continuous evaluation of demand new and backlog demand against capacity; clear focus on reducing longest waits.	Reducing backlog and longest waits.		Continuing to evaluate.
Introduction of 'pre-assessment' service for surveillance patients to support demand management.	Commenced May 2016	Clinical triage of patients to improve appropriateness of procedures and compliance with BSG guidelines – delivering best possible standard of care to patients.	31% patients clinically removed from waiting list following first tranche of patient contact. 159/440	Weekly evaluation of impact.

Comments

Reasons for Current Performance

Underlying capacity gap for endoscopy with additional demand pressures evident through bowel screening programme. Endoscopy units also balancing provision of urgent in-patient scoping to support in-patient flow and reduced length of stay.
Consultant vacancy in Urology service resulting in shortfalls in flexible cystoscopy sessions.
Previous poor utilisation of REU with high DNA's

Mitigating actions

New Consultant Urologist appointments to commence in May 2016 providing additional flexible cystoscopy capacity.
Continued focus on booking process for surveillance patients appointed to the Regional Endoscopy Unit to maximise uptake of capacity and reduce DNA's and cancellations.
Monitor impact of model for 'pre-assessment' service for all surveillance patients requiring a procedure.

Delayed Discharges – East Lothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Better	0 (max)	99	Jun 2016	Yes	Not Applicable	DS

Summary for Committee to note or agree

Recent Performance – Delayed Discharges

Table 1: Breakdown in NHS Lothian Hospitals at census point

	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
1. All Delays Recorded	403	382	392	394	364	358	355	318	319	280	302	315
2. All ISD Reportable Delays	248	237	253	258	257	244	249	231	206	182	203	231
3. ISD Reportable Delays excluding X codes (All Time Bands)	188	180	199	201	188	173	161	154	134	112	134	164
a. Those over 2 weeks	104	108	126	122	117	90	76	69	54	51	60	99
b. Those over 4 weeks	69	75	73	77	75	46	47	43	34	37	32	46

Table 2: ISD Delays excluding X Codes by Health & Social Care Partnership at census point

Health and Social Care - IJB	3. All Time Bands						a. >2 weeks						b. >4 weeks					
	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Edinburgh	122	95	82	67	85	120	61	54	38	32	43	75	36	32	23	25	23	36
East Lothian	**19**	**15**	**25**	**15**	**20**	**21**	**7**	**8**	**7**	**8**	**7**	**13**	**5**	**6**	**5**	**6**	**3**	**4**
Midlothian	3	12	10	11	11	13	0	0	1	2	2	3	0	0	0	1	1	1
West Lothian	14	29	13	17	13	6	3	6	6	7	5	4	3	3	4	3	3	2
All (inc. other)	161	154	134	112	134	164	76	69	54	51	60	99	47	43	34	37	32	46

Timescale for Improvement – East Lothian IJB

Actions Planned and Outcome – East Lothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status

Comments – East Lothian IJB

Reasons for Current Performance

Delayed Discharges – Edinburgh Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	99	Jun 2016	Yes	Yes	RMG

Summary for Committee to note or agree

- Targets for the reduction of delayed discharge levels up to May 2016 were proposed based on scheduled investments and anticipated benefits. These targets were approved by the Scottish Government. Additional funding from the Scottish Government was linked to achieving the target of 100 for the total number of people delayed by February 2016 in the Edinburgh Partnership, and 50 by May 2016 compared with 121 in December, again for the Edinburgh Partnership.
- A comprehensive programme of actions to address delayed discharge for Edinburgh residents is being overseen by the Patient Flow Programme Board which is scheduled to meet on a fortnightly basis.
- Work is underway to set targets for the forthcoming months.

Recent Performance – Delayed Discharges

Table 1: Breakdown in NHS Lothian Hospitals at census point

	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
1. All Delays Recorded	403	382	392	394	364	358	355	318	319	280	302	315
2. All ISD Reportable Delays	248	237	253	258	257	244	249	231	206	182	203	231
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Table 2: ISD Delays excluding X Codes by Health & Social Care Partnership at census point

Health and Social Care - IJB	3. All Time Bands						a. >2 weeks						b. >4 weeks					
	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
Edinburgh	**122**	**95**	**82**	**67**	**85**	**120**	**61**	**54**	**38**	**32**	**43**	**75**	**36**	**32**	**23**	**25**	**23**	**36**
East Lothian	19	15	25	15	20	21	7	8	7	8	7	13	5	6	5	6	3	4
Midlothian	3	12	10	11	11	13	0	0	1	2	2	3	0	0	0	1	1	1
West Lothian	14	29	13	17	13	6	3	6	6	7	5	4	3	3	4	3	3	2
All (inc. other)	161	154	134	112	134	164	76	69	54	51	60	99	47	43	34	37	32	46

Timescale for Improvement – Edinburgh IJB

A trajectory for the period to May 2016 was agreed with SGHD for the Edinburgh partnership, and set out below:-

Reportable Delays excluding x codes					>2 weeks (derived from all reportable delays excluding x codes)					>4 weeks (derived from all reportable delays excluding x codes)					All targets
Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jan 16	Feb 16	Mar 16	Apr 16	May 16	From June 16
118	100	80	55	50	64	46	26	1	0	36	33	15	0	0	TBD

Actions Planned and Outcome – Edinburgh IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Continued work on the work streams initiated following the key stakeholder event in March 2016: a) addressing delays within the pathway b) admission avoidance.	Ongoing	Reductions in delayed discharge Reduced delays across the pathway		Work is underway and progress is being closely monitored by the Chief Officer's senior management team.
Locality Hub development – employment of additional clinical support workers	Ongoing	Support people to leave hospital and avoid readmission	To be determined – monitoring and evaluation is being developed.	The model, originally piloted in South East, is now being tested across the four localities.
Review reablement provision to ensure effective use of the resource. This is part of the demand management work stream, being led by EY.	June 2016	With more effective targeting of the reablement service to people who are likely to benefit, it is anticipated that there will be a greater reduction in the level of support needed.		New selection criteria for the service and the referral and service pathways have been agreed and came into operation on 1 June. Monitoring of performance has commenced and is being monitored by the four-weekly Reablement Steering Group.

Comments – Edinburgh IJB

The number of reportable delays in Edinburgh increased in June. Compared with May 2016, there was also an increase in the number of people who had waited more than two weeks and four weeks. The previous targets (for May) for both the headline figure (120 delays against a target of 50) and the target for those waiting for two weeks or longer (75 against a target of 0) were missed.

Reasons for Current Performance

Waiting for domiciliary care was the largest waiting reason at census. This is being addressed through the demand management action noted above.

Delayed Discharges – Midlothian Integrated Joint Board (IJB)

Healthcare Quality Domain: Effective

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.

Responsible Director[s]: Chief Officer and Joint Directors

NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	99	Jun 2016	Yes	Yes	EM

Summary for Committee to note or agree

- The performance within Midlothian is currently off-target, which is a result of pressures within care at home in the West of the County, which is resulting in an increased number of patients who are delayed. An action plan has been developed within Midlothian to address this performance issue with the Provider, with the aim of reaching a resolution by August.

Recent Performance – Delayed Discharges

Table 1: Breakdown in NHS Lothian Hospitals at census point

	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16	May 16	Jun 16
1. All Delays Recorded	403	382	392	394	364	358	355	318	319	280	302	315
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a. Those over 2 weeks	104	108	126	122	117	90	76	69	54	51	60	99
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Table 2: ISD Delays excluding X Codes by Health & Social Care Partnership at census point

Health and Social Care – IJB	3. All Time Bands						a. >2 weeks						b. >4 weeks					
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Midlothian	**3**	**12**	**10**	**11**	**11**	**13**	**0**	**0**	**1**	**2**	**2**	**3**	**0**	**0**	**0**	**1**	**1**	**1**
West Lothian	14	29	13	17	13	6	3	6	6	7	5	4	3	3	4	3	3	2
All (inc. other)	161	154	134	112	134	164	76	69	54	51	60	99	47	43	34	37	32	46

Timescale for Improvement – Midlothian IJB

A trajectory has been agreed with SGHD and set out below (or please provide alternative information, if a trajectory has not been agreed):- The target for Midlothian in the number of patients waiting over 2 weeks is set out below though, as previously noted, work has begun in planning for delivery against the 72 hour target and a trajectory has been development which will be aligned to the new reporting processes for delayed discharge which are due from end of July.

May 2016	June 2016	July 2016	Aug 2016	Sept 2016	Oct 2016	Nov 2016	Dec 2016	Jan 2017	Feb 2017	March 2017	April 2017	May 2017
0	0	0	0	0	0	0	0	0	0	0	0	0

Actions Planned and Outcome – Midlothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Action Plan developed and being implemented to address under-performance by Care at Home provider	31 July 2016	Increase in care packages	To be determined and will be monitored on a weekly basis	Discussions taking place with key agencies to progress action plan
Increased capacity within Hospital Inreach Team to support improved discharge across acute and community sites	31 Aug 2016	Reduced length of stay and delays	To be determined	Recruitment process underway and short-term arrangements being put in place
Development of dementia and complex care beds within Partnership run Care Home to support increased choice for LA funded service users	30 Sept 2016	Reduced length of stay and delays, particularly for dementia patients	To be quantified	New staffing model being implemented within the Care Home to reflect changed focus of care

Comments – Midlothian IJB

Reasons for Current Performance

The continued performance below target is a reflection on the ongoing issues in relation to Packages of Care at Home, particularly in the West of the County as a result of difficulties being experienced by local providers. The proposal for another provider taking on this work did not materialise therefore other actions are now being progressed.

Delayed Discharges – West Lothian Integrated Joint Board (IJB)
Healthcare Quality Domain: Effective
Cycle 7 - for reporting at August 2016 meetings
Target/Standard: No patient should wait more than 14 days in hospital once they are ready for discharge.
Responsible Director[s]: Chief Officer and Joint Directors
NHS Lothian Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↓	Worse	0 (max)	99	Jun 2016	Yes	Yes	JF

Summary for Committee to note or agree

- Target to reduce delayed discharge level to 0 is based on scheduled investments and anticipated benefits.
- A comprehensive programme of actions to address delayed discharge is incorporated within the West Lothian Frailty Programme which is focussed on improvements across the whole system of Health and Social Care. The Frailty Programme Board has been revised and actions taken to review the whole programme and clearly identify priorities for further work.
- Care at Home Contract has been fully implemented in April 2016 and it is anticipated that this will contribute to achievement of 0 delays. Time from request to provision of Package of Care is being closely monitored. There are some issues with one of the care at home providers and we are working to resolve these as timeously as possible
- June position shows improvement in number of delays down to 4 >2 weeks and 2>4 weeks.

Recent Performance – Delayed Discharges

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West Lothian	**14**	**29**	**13**	**17**	**13**	**6**	**3**	**6**	**6**	**7**	**5**	**4**	**3**	**3**	**4**	**3**	**3**	**2**
All (inc. other)	161	154	134	112	134	164	76	69	54	51	60	99	47	43	34	37	32	46

Timescale for Improvement – West Lothian IJB

An official trajectory for West Lothian has not been agreed with the SGHD.

Local improvement targets would aim to achieve compliance by end of 2016.

Actions Planned and Outcome – West Lothian IJB

Action	Due By	Planned Benefit	Actual Benefit	Status
Established Frailty Programme with following aims • To design a whole system model of care for frail elderly adults that meet overall IJB strategic priorities • To reduce hospital admission and re-admission and minimise delayed discharge • To contribute to the financial efficiencies of the IJB • To identify areas of skills development to support the new model of care	March 2017	Reduction in emergency admission Reduction in delayed discharge.	Delays over 2 weeks average 5 per month for calendar year Frailty programme work streams being reviewed and priorities identified	Amber
Embedding of new Care at Home contract	April 2016	Increase capacity of Care at Home provision Reduction in delayed discharge	Care at Home Contract fully implemented from April 2016 Proportion of reablement capacity blocked with clients with unmet needs reduced as independent providers are providing more packages of care leading to increased capacity in Reablement and Crisis Care teams	Green
Further development and expansion of REACT	Sept 2016	Reduction in emergency admission Reduction in delayed discharge	REACT providing acute care at home, good evidence of success in reducing admission and high level of patient and carer satisfaction. Development plan in progress within overall Frailty Programme	Amber
Comprehensive needs assessment is in progress which will inform the IJB Commissioning Plan for Older People	Sept 2016	Clear identification of needs for older population	Needs Assessment will inform priorities for IJB and Commissioning Plan Priorities identified within Strategic Plan	Green

Comments – West Lothian IJB

Reasons for Current Performance

Performance improved over year to date across all time bands with downward trend from high of 29 delays in February to 6 in June.

Transition to the new Care at Home contract contributing to some delays during this period with home care packages the main reason for delay. It is anticipated this will continue to improve as new contract is embedded.

Staff Sickness Absence

Healthcare Quality Domain: Person Centred

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: 4% Staff Hours or Less Lost to Sickness

Responsible Director[s]: Director of Human Resources and Organisational Development

Performance:-

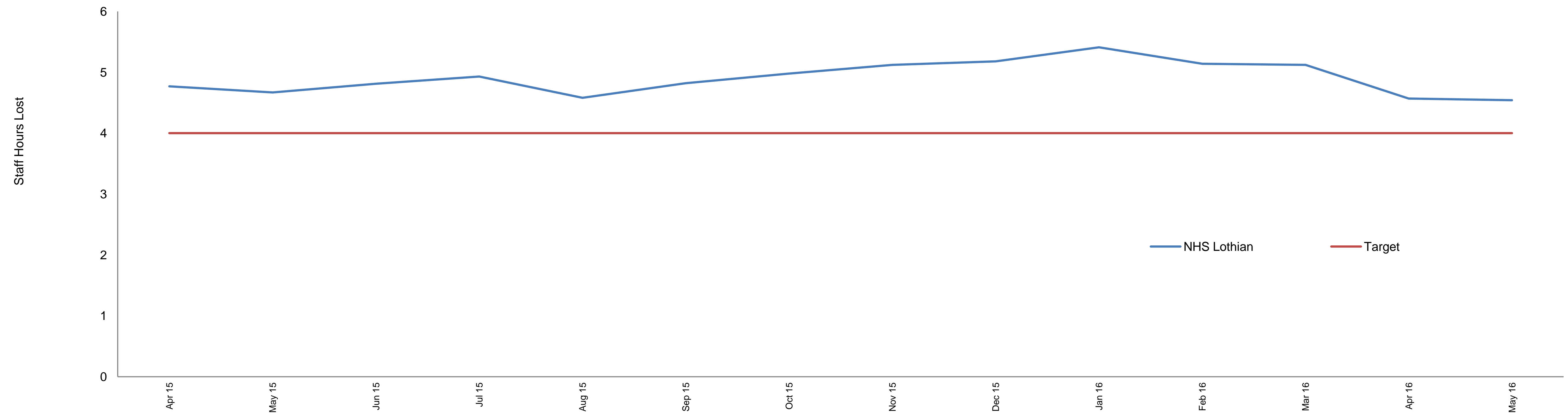
Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Better	4% (max)	4.54%	May 2016	Yes	No	AB

Summary for Committee to note or agree

- Performance remains below standard but an improvement seen from the previous month

Recent Performance – % against Standard

Figure 1: NHS Lothian Staff Sickness Absence (% Staff Hours Lost)



Timescale for Improvement

A trajectory has not been agreed with SGHD.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Attendance Management Training Sessions continue to be held.	Ongoing			
Master Classes have also been held to assist managers in dealing with difficult conversations at work in the context of staff absence.	-			Completed
Targeted support has been put in place for absence hotspots i.e. Nursing Bands 1-5 and A&C Bands 1-4.	Ongoing			
Absence Review Panels have taken place to review how absence cases are being handled and provide further advice and guidance.	-			Completed
An Absence Dashboard is being set up to facilitate effective performance monitoring.	-			Completed
As part of the Sustainable Workforce Programme Board a sickness absence project has been set up to focus on what support needs to be provided to managers to assist them with their management of absence.	Ongoing			

Comments

Reasons for Current Performance

Whilst NHS Lothian continues to perform better that the NHS Scotland average it has to be noted that the overall NHS Scotland performance in relation to sickness absence has deteriorated. We continue to be challenged in achieving the 4% standard with the added dimension of an aging workforce. The HR function will continue to provide a range of technical support and governance frameworks to support the management of sickness absence, ultimately it is the line managers who will need to ensure that they manage absence appropriately in their areas for the required reduction in absence to the 4% level to be achieved. Outlined above are some of the actions that we are currently taking to support managers with this task.

Complaints: 3-Day & 20-Day Acknowledgement/Response Rate

Healthcare Quality Domain: Person Centred

Cycle 7 - for reporting at August 2016 meetings

Target/Standard:

1. 3-Day Response [Acknowledgement] Rate – 100% formal acknowledgement within 3 working days;
2. 20-Day Response Rate – 80% of complaints responded to within 20 days.

Responsible Director[s]: Executive Director: Interim Nurse Director

Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
1. Not Met	↑	Worse	100%	91%	June 2016	Yes	Yes	AMcM
2. Not Met	↑	Worse	80% (min)	68%	June 2016	Yes	Yes	AMcM

Summary for Committee to note or agree

- **There is no nationally agreed target for complaints and we are required to submit data quarterly to Information Statistics Division that is published annually on their website.**
- **NHS Lothian have set a local stretch target of 80% response rate for 20 days;**
- **As the data is reviewed (extracted from DATIX) on a monthly basis it is anticipated that the previous months performance may be amended for accuracy;**
- **The denominator (number of complaints received) will change every month;**
- **Complaints only account for part (May 68%) of the team's activity as there are other types of feedback (concerns, comments, enquiries and compliments).**

Recent Performance – Numbers against Standard

Figure 1: NHS Lothian 3-Day Formal Complaints Acknowledgment Rate

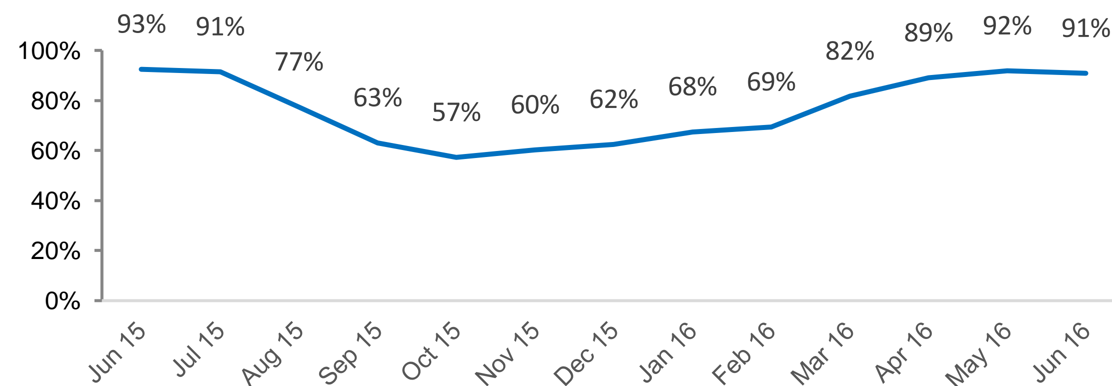
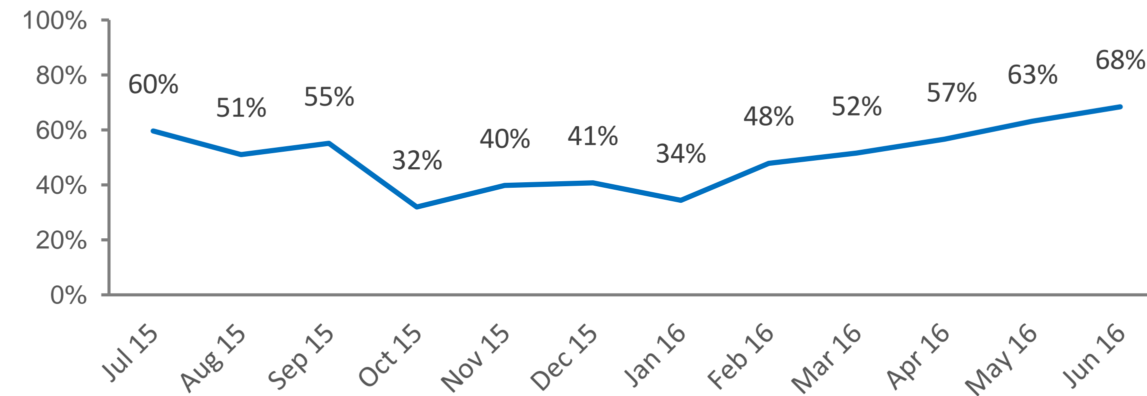


Figure 2: NHS Lothian 20-Day Complaints Response Rate



Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:-

	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Measure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Patient Feedback paper went to April 2016 Board meeting included enhanced complaints information including enhanced complaints information including themes.	Completed			
Reviewed targets with Executive Director in absence of nationally agreed targets and have set a target of 80% of complaints to be acknowledged which was agreed with Lothian Professional Nurses Forum at their April meeting.	April 2016	Agree trajectory with LPNF		
Appoint to vacant posts	June 2016	Improved performance for targets		
Non-Executive appointed as Board Champion for complaints & feedback				
Quality Assurance Committee being set up with first meeting planned in August				

Comments

Reasons for Current Performance

Improvements have been seen in both 3-day (8 consecutive data points) and 20-day (5 consecutive data points) response rates.
Sickness within the team during May was 9%.

Detecting Cancer Early (DCE)

Healthcare Quality Domain: Person Centred

Cycle 7 - for reporting at August 2016 meetings

Target/Standard: The DCE HEAT standard is for NHS Scotland to achieve a 25% improvement in the percentage of breast, colorectal and lung cancer cases (combined) diagnosed at stage 1. This is to be achieved by the combined calendar years of 2014/2015 and is the equivalent of a national rate of stage 1 diagnosis for breast, colorectal and lung cancer (combined) of 29.0%.

Responsible Director[s]: Director of Public Health & Public Policy

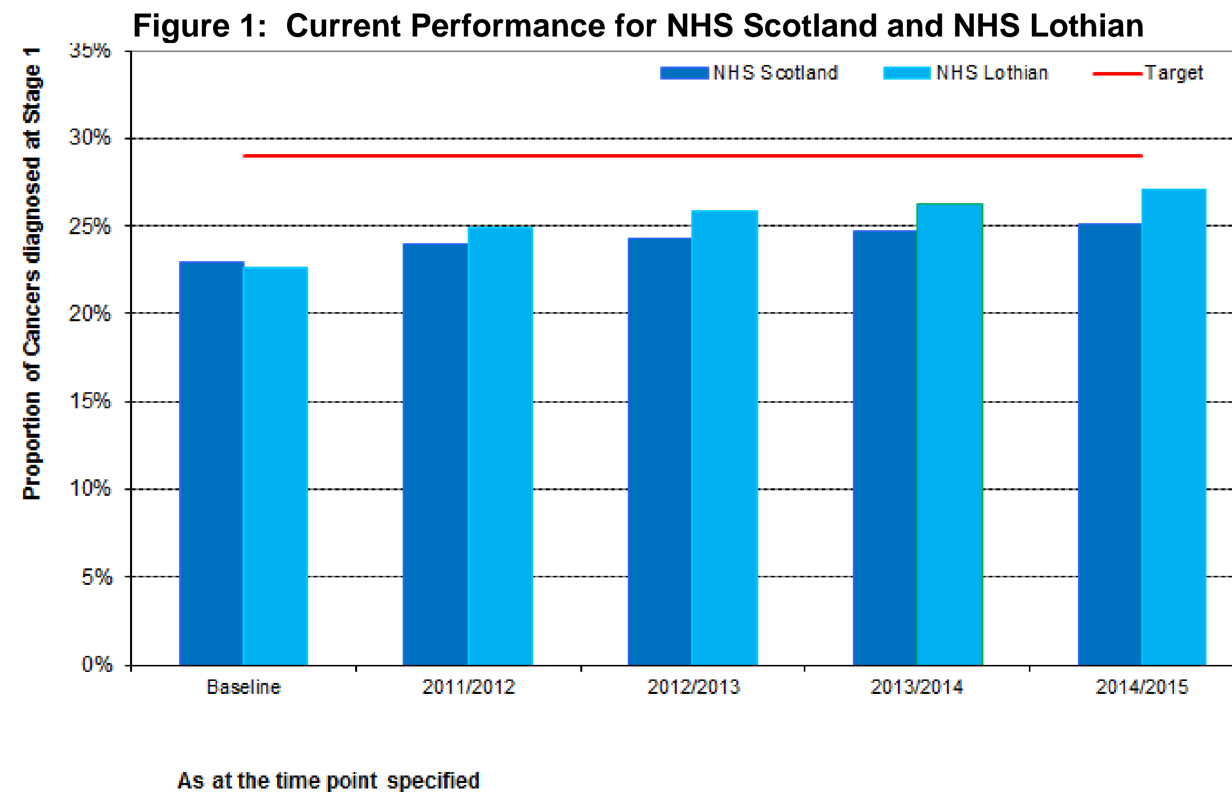
Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Better	29% (min)	27.1%	2014 & 2015	Yes	Yes	AKM

Summary for Committee to note or agree

NHS Lothian's performance over time against this target has been consistently above the All Scotland position and has followed a continued upwards trajectory in detection of stage 1 combined cases, as shown in the chart below. NHS Lothian has increased the percentage of breast, colorectal and lung cancers (combined) detected at stage 1 by 19.9% from the baseline years of 2010 & 2011 to the final reporting period of 2014 & 2015. Scotland as a whole saw an increase of 8.0% in the same period. In NHS Lothian over the 2014 & 2015 period 27.1% of breast, colorectal and lung cancers (combined) were detected at stage 1 compared with 25.1% for Scotland as a whole. NHS Lothian delivered the second highest percentage improvement of all the mainland Boards. However along with all other mainland Boards we fell short of the final targeted performance level of 29% of breast, colorectal and lung cancers (combined) being detected at stage 1.

Recent Performance – Numbers Against LDP Target



Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:-

	Baseline Period (2010 & 2011) – Actual Figure	Reporting Period 4 (2014 & 2015) – Target Figure
NHS Scotland	*23.2%*	*29.0%*
NHS Lothian	*22.6%*	*29.0%*

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Investment in the Lothian DCE programme in 2016/17	31/3/16 outcome awaited	Stage 1 detection performance improvement, particularly via the breast and bowel screening programmes.		Ongoing

Comments

NHS Lothian's programme is aligned to the 5 DCE work streams; public awareness, informed decision making in screening, primary care detection and referral behaviour, increasing diagnostic capacity, data evaluation and outcomes. Key initiatives during 2015/16 included rollout of digital mammography, policy changes to cervical age range and frequency changes, new referral pathways for lung cancer, multi-disciplinary audit, implementation of the bowel screening quality and outcomes framework (sQoF) and support for targeted social marketing (television and radio platforms, use of social media and field activity e.g. football matches and shopping centres).

Reasons for Current Performance

Mitigating Actions: Impact on colorectal performance across all Boards will be subject to the conclusion of the bowel screening QoF (March 2015). Discussions remain ongoing with finance colleagues concerning budgets for 2016/17 - lack of funds are likely to compromise NHS Lothian's future performance.

Dementia
Healthcare Quality Domain: Person Centred
Cycle 7 - for reporting at August 2016 meetings
Target/Standard: People newly diagnosed with dementia will have a minimum of 1 year of post-diagnostic support (PDS).
Responsible Director[s]: Executive Director: Chief Officer, Acute Services
Performance:-

Status	Trend	Published Status vs. National Position	Target	Latest	Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
TBC[1]	N/A	Not Applicable	100% (1 Year (Min))	5.3	Apr 2016	No	No	JC

Summary for Committee to note or agree

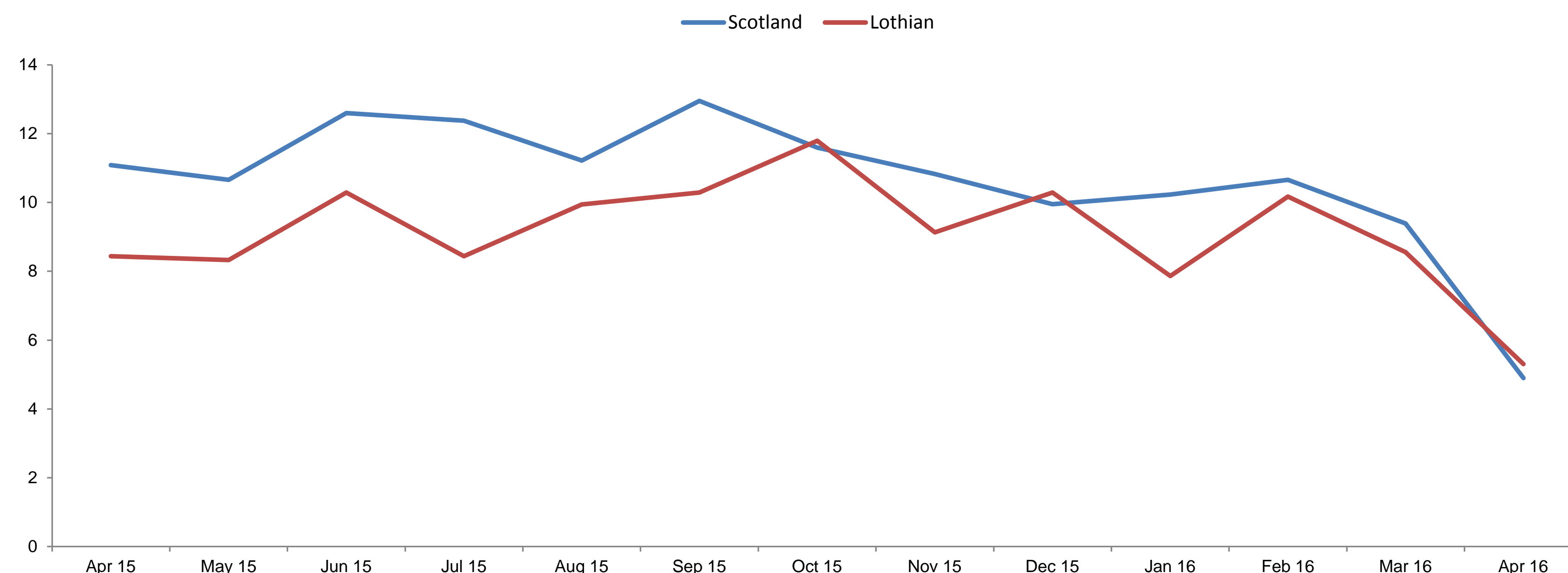
- [1]The data published by ISD on the dementia standard reports the rate of referral for post diagnostic support based on 100,000 per population. We are currently awaiting confirmation from ISD regarding what the expected rate would be in order to evaluate performance against the standard;
- The numerator is based on month of diagnosis rather than month of referral so there is always a lag time between month of publication and rate per month, with the rate continuing to increase for previous months in each subsequent publication;
- NHS Lothian's rate for referral for Post diagnostic support is currently in line with the overall national rate;
- The rate is only currently published at Health Board level not by IJB/ locality level. This has been requested from ISD.

Recent Performance – % against Standard

Table 1: Rate of Referral to PDS in each month for those Diagnosed with Dementia

	Apr 15	May 15	Jun 15	Jul 15	Aug 15	Sep 15	Oct 15	Nov 15	Dec 15	Jan 16	Feb 16	Mar 16	Apr 16
Scotland	11.1	10.7	12.6	12.4	11.2	13.0	11.6	10.8	10.0	10.2	10.7	9.4	4.9
Lothian	8.4	8.3	10.3	8.4	9.9	10.3	11.8	9.1	10.3	7.9	10.2	8.6	5.3

Chart 1: Rates of Referral to PDS in each month for Scotland and NHS Lothian, for those Diagnosed with Dementia - Source: ISD



Timescale for Improvement

A trajectory has not been set due to the proposed changes in the methodology in relation to measuring expected prevalence of dementia.

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Improve capture of PDS being delivered by secondary care mental health services through the development of a questionnaire on TRAK to capture required data for ISD submission.	Completed	Increase reported rate of referral for PDS.	The reported rate has increased. For example our rate for August 15 was 0.7, following capture of additional data it is now 9.3 and our rate is comparable with the Scottish average across most months.	Completed
Improve recording of diagnosis in TRAK. • Procedures agreed and implemented with local teams • Routine reports to feedback performance to teams in place	Ongoing	Increased recording of all diagnosis to allow comparison of actual versus expected rates for diagnosis of dementia.	Initial Position for % of patients on older adult services caseloads (with at least 1 attended appointment with a consultant) who had a diagnosis of dementia recorded in TRAK in May 2015 was 21%.Position reported in January 16 was 75%.	Will continue to monitor recording
Awaiting further guidance from ISD to develop reporting of diagnosis and referral rate by Partnership area.	July 2016	• Enable reporting of performance by IJB; • Increase local ownership of performance and improvement planning.		Awaiting ISD guidance
Awaiting ISD guidance to inform boards of proposed changes regarding the methodology of anticipated rates for diagnosis of dementia.	TBC (ISD)	• Allow more accurate evaluation of performance against the standard at Board and partnership level.		

Comments

NHS Lothian's rate for referral for Post diagnostic support is currently in line with the overall national rate;

Reasons for Current Performance

Improving recording of diagnosis remains a priority.

Patient Experience – Tell us Ten Things (TTT) Inpatient Survey (Question 10 – Overall Experience)

Healthcare Quality Domain: Person Centred

Target/Standard: 9.5 out of 10

Responsible Director[s]: Executive Director: Interim Nurse Director

Performance:-

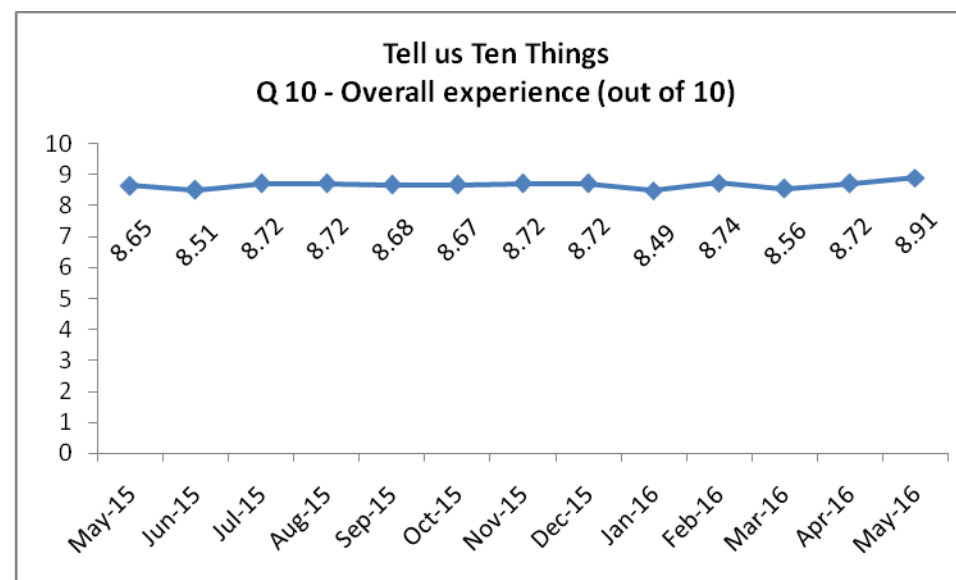
Status	Trend	Published Status vs. National Position	Target	Current	Current Reporting Date	Data Updated since Last Cycle?	Narrative Updated since Last Cycle?	Lead Director
Not Met	↑	Not Applicable	9.5/10	8.91	May 2016	Yes	Yes	AMcM

Summary for Committee to note or agree

To note.

Recent Performance – Numbers against Standard

Figure 1: NHS Lothian 'Tell Us Ten Things' Inpatient Survey Results



Timescale for Improvement

A trajectory has been agreed with SGHD and set out below:- **N/A**

	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date	Date
Measure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure	Figure

Actions Planned and Outcome

Action	Due By	Planned Benefit	Actual Benefit	Status
Agreed with Director's of Nursing Group an initial stretch target of 10% return rate.				
Improved circulation of TTT site and local reports to ensure ANDs receive these.				
Reviewing return rates to highlight areas where there is a very poor return rate.				
Midlothian to test TTT survey in community hospital setting and will test the use of an electronic data-capture system.				
Discussions with Senior Charge Nurses / Clinical Nurse Managers to highlight return rates and consider local actions to improve responses.				
A submission has been made to the July HCG committee to align the measure to the national Person Centre Health & Care Programme (9/10).				

Comments

Reasons for Current Performance

Patient Experience staff have been asked to prioritise complaints and feedback activity.

5 Risk Register

5.1 Not applicable.

6 Impact on Inequality, including Health Inequalities

6.1 The production of these updates do not have any direct impact on health inequalities but consideration may be required elsewhere in the delivery of the actions identified.

7 Involving People

7.1 As the paper summarises trends in performance and identifies remedial action, no impact assessment or consultation is expected.

8 Resource Implications

8.1 The resource implications are directly related to the actions required specified in the proforma.

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29 July 2016
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List of Appendices

Appendix 1: Technical Document

APPENDIX 1

Measure	Target/Standard	Source for Current Data
Smoking Cessation (quits)	NHS Boards to sustain and embed successful smoking quits at 12 weeks post quit, in the 40% most deprived SIMD areas (60% in the Island Boards).	Smoking Cessation Database
Early Access to Antenatal Care (% booked)	Percentage of maternities booked for antenatal care within 12 completed weeks - the target is for 80% of women in each SIMD quintile to be booked within 12 weeks.	Discovery
CAMHs (18 Weeks)	No child or young person will wait longer than 18 weeks from referral to treatment in a specialist CAMH service from December 2014. Following work on a tolerance level for CAMH services waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the target should be delivered for at least 90% of patients.	Management Information
Psychological Therapies (18 Weeks)	The Scottish Government has set a target for the NHS in Scotland to deliver a maximum wait of 18 weeks from a patient's referral to treatment for Psychological Therapies from December 2014. Following work on a tolerance level for Psychological Therapies waiting times and engagement with NHS Boards and other stakeholders, the Scottish Government has determined that the Psychological Therapies target should be delivered for at least 90% of patients.	Management Information
Delayed Discharges (over 2 weeks)	No patient should wait more than 14 days in hospital once they are ready for discharge.	EDISON
Healthcare Acquired Infection - CDI (rate per 1,000 bed days, aged 15+)	NHS Boards' rate of Clostridium difficile infections (CDI) in patients aged 15 and over is 0.32 cases or less per 1,000 total occupied bed days.	NHS Lothian Infection Prevention and Control Team
Healthcare Acquired Infection - SAB (rate per 1,000 acute bed days)	NHS Boards' rate of Staphylococcus aureus Bacteraemia (including MRSA) (SAB) cases are 0.24 or less per 1,000 acute occupied bed days.	NHS Lothian Infection Prevention and Control Team
4-hour Unscheduled Care (% seen)	95% of patients are to wait no longer than 4 hours from arrival to admission, discharge or transfer for A&E treatment. NHS Boards are to work towards 98%.	Management Information
Cancer (31-day) (% treated)	31-day target from decision to treat until first treatment for all cancers, no matter how patients were referred. For breast cancer, this replaced the previous 31-day diagnosis to treatment target.	Management Information
Cancer (62-day) (% treated)	62-day target from receipt of referral to treatment for all cancers. This applies to each of the following groups: any patients urgently referred with a suspicion of cancer by their primary care clinician (for example GP) or dentist; any screened-positive patients who are referred through a national cancer screening programme (breast, colorectal or cervical); any direct referral to hospital (for example self-referral to A&E).	Management Information
Stroke Bundle (% receiving)	The stroke bundle covers four targets: 1. Percentage admitted to a Stroke Unit within 1 day of admission – 90%; 2. Percentage with swallow screen on day of admission – 90%; 3. Percentage with brain scan within 24 hours of admission – 90%; 4. And percentage of ischaemic stroke patients given aspirin within 1 day of admission – 95%.	Management Information
IPDC Treatment Time Guarantee (12 weeks)	From the 1 October 2012, the Patient Rights (Scotland) Act 2011 establishes a 12 week maximum waiting time for the treatment of all eligible patients due to receive planned treatment delivered on an inpatient or day case basis.	Management Information
Outpatients (12 weeks)	From the 31 March 2010, no patient should wait longer than 12 weeks for a new outpatient appointment at a consultant-led clinic. This includes referrals from all sources.	Management Information
Referral to Treatment (18 Weeks)	90% of planned/elective patients to commence treatment within 18 weeks of referral.	Management Information
Diagnostics (6 weeks)	A six week maximum waiting time for eight key diagnostic tests (four for Endoscopy (a) & four for Radiology (b)) from 31st March 2009.	Management Information
Surveillance Endoscopy (past due date)	No patient should wait past their planned review date for a surveillance endoscopy.	Management Information
IVF (12 months)	The Scottish Government have set a target that at least 90% of eligible patients will commence IVF treatment within 12 months. This is due for delivery by 31 March 2015.	Management Information
Drug & Alcohol Waiting Times (3 weeks)	The Scottish Government set a target that by June 2013, 90% of people who need help with their drug or alcohol problem will wait no longer than three weeks for treatment that supports their recovery. This was one of the national HEAT (Health improvement, Efficiency, Access, Treatment) targets, number A11. This target was achieved in June 2013 and has now become a Local Delivery Plan (LDP) standard - that clients will wait no longer than 3 weeks from referral received to appropriate drug or alcohol treatment that supports their recovery (90%).	ISD Scotland
Detecting Cancer Early (% diagnosed)	The DCE HEAT standard is for NHS Scotland to achieve a 25% improvement in the percentage of breast, colorectal and lung cancer cases (combined) diagnosed at stage 1. This is to be achieved by the combined calendar years of 2014/2015 and is the equivalent of a national rate of stage 1 diagnosis for breast, colorectal and lung cancer (combined) of 29.0%.	ISD Scotland
Staff Sickness Absence Levels (<=4%)	4% Staff Hours or Less Lost to Sickness	Management Information (SWISS)
Cardiac Arrest	50% reduction in Cardiac Arrests with Chest Compressions Rate by December 2015 from February 2013 (1.9 per 1,000), baseline.	Management Information (Local Audits (Resuscitation Officer Database))
Falls with Harm	"Harm" is 'Moderate, Major Harm or Death'. 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. 20% reduction in inpatient falls and associated harm, on a baseline median of 30 per month, by March 2016.	Management Information (Datix)
Hospital Standardised Mortality Ratios (HSMR) (20% reduction)	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.	ISD Scotland
48 Hour GP Access - access to healthcare profession; or GP appointment.	48 hour access or advance booking to an appropriate member of the GP team (90%) - Patients can speak with a doctor or nurse within 2 working days; or Patients are able to book an appointment 3 or more working days in advance.	Scottish Government
Alcohol Brief Interventions (ABIs)	Sustain and embed alcohol brief interventions in 3 priority settings (primary care, A&E, antenatal) and broaden delivery in wider settings.	Management Information
Hospital Scorecard - Standardised Surgical Readmission rate 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. This measure has been standardised by age, sex and deprivation (SIMD 2009).	ISD Scotland
Hospital Scorecard - Standardised Surgical Readmission rate within 28 days	As for 7 day readmissions.	ISD Scotland
Hospital Scorecard - Standardised Medical Readmission rate 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. This measure has been standardised by age, sex and deprivation (SIMD 2009).	ISD Scotland
Hospital Scorecard - Standardised Medical Readmission rate within 28 days	As for 7 day readmissions.	ISD Scotland
Hospital Scorecard - Average Surgical Length of 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).	ISD Scotland

Hospital Scorecard - Average Medical Length of 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).	ISD Scotland
Complaints (3-Day; & 20-Day)	3-Day Response [Acknowledgement] Rate – 100% formal acknowledgement within 3 working days; & 1. 20-Day Response Rate – 85% of complaints responded to within 3 days.	Management Information (Datix)
Dementia	People newly diagnosed with dementia will have a minimum of 1 years post-diagnostic support	Management Information

* 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.

NHS LOTHIAN

2.5

Board Meeting
3 August 2016

Medical Director

SUMMARY PAPER - HEALTHCARE ASSOCIATED INFECTION

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

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

• Local Delivery Plan Standards Table 1: The 2016/2017 Local Delivery Plan Standards for NHS Lothian's *Staphylococcus aureus* Bacteraemia is to achieve a rate no higher than 0.24 per 1000 bed days (≤184 incidences) by March 2017. For *Clostridium difficile* Infection the 2016/2017 Local Delivery Plan standard is to achieve a rate of no more than 0.32 per 1000 bed days (≤262 incidences). NHS Lothian's current rates for *Staphylococcus aureus* Bacteraemia incidence is 0.26 (n=35) and for Clostridium difficile Infection incidence is 0.35 (n=48).	3.0
• *Staphylococcus aureus* Bacteraemia: There were 35 incidences of *Staphylococcus aureus* Bacteraemia diagnosed for the period April to May 2016.	3.1
• *Clostridium difficile* Infection: There were 48 incidences of *Clostridium difficile* Infection diagnosed in patients aged 15 or over for the period April to May 2016), using Health Protection Scotland surveillance programme reporting criteria.	3.2
• Healthcare Environment Inspectorate: The Liberton Hospital unannounced inspections report was published on 22nd June 2016 noting 2 requirements.	3.3

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8 July 2016
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NHS LOTHIAN

Board Meeting
03 August 2016
Medical Director HAI Executive Lead

HEALTHCARE ASSOCIATED INFECTION (HAI) UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress toward achievement of Local Delivery Plan performance for Healthcare Associated Infection across NHS Lothian. Any member wishing additional information should contact the Medical Director in advance of the meeting.

2 Recommendations

2.1 The Board is recommended to:

- Accept this report as an update on incidence of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection. The data is for the 2 month period 1st April 2016 – 31st May 2016. The figures for June are not yet available due to reporting timelines. Due to the time period available it is too early to report on performance trend.
- Accept the improvement action plans for both Healthcare Associated Infections 2016/2017 Local Delivery Plan Standards submission within the Quality & Performance Reporting template.

3 Discussion of Key Issues

The 2016/2017 Local Delivery Plan Standards for NHS Lothian's *Staphylococcus aureus* Bacteraemia is to achieve a rate no higher than 0.24 per 1000 acute occupied bed days ($\leq$184 incidences) by March 2017. For *Clostridium difficile* Infection the 2016/2017 Local Delivery Plan standard is to achieve a rate of no more than 0.32 per 1,000 total occupied bed days ($\leq$262 incidences). NHS Lothian's current rates for *Staphylococcus aureus* Bacteraemia incidence is 0.26 (n=35) and for Clostridium difficile Infection incidence is 0.35 (n=48). The current statistics are reflected in Table 1.

The improvement action plans for both Healthcare Associated Infections 2016/2017 Local Delivery Plan Standards were submitted to Healthcare Governance Committee and the Board in June 2016. The action plan is now monitored and submitted through Performance Reporting.

Table 1: Local Delivery Plan April 2016- March 2017

	Clostridium difficile Infection		*Staphylococcus aureus* Bacteraemia		Cleaning Compliance	Estates Monitoring Compliance	Hand Hygiene Monitoring Compliance
	Number	Percentage	Number	Percentage	Percentage	Percentage	Percentage
April 2016- March 2017 Local Delivery Plan Standard	≤262		≤184		90%	90%	90%
Current Performance							
	Clostridium difficile Infection		*Staphylococcus aureus* Bacteraemia		Cleaning Compliance	Estates Monitoring Compliance	Hand Hygiene Monitoring Compliance
NHS Lothian	**48**	**100**	**35**	**100**	95.7%	95.5%	**95.9**
Royal Infirmary of Edinburgh	8	25	18	51	96.9%	98.8%	94.2
Western General Hospital	10	19	6	17	95.4%	92.2%	97.4
St Johns Hospital	13	25	7	20	95.5%	94.7%	97.2
Liberton Hospital	1	2	1	3	98.3%	97.5%	95.2
Royal Hospital for Sick Children	0	0	2	6	94.6%	95.1%	96.0
Community Hospitals	0	0	1	3			
General Practices	16	30	0	0			
Unknown	0	0	0	0			

Notes on Table 1

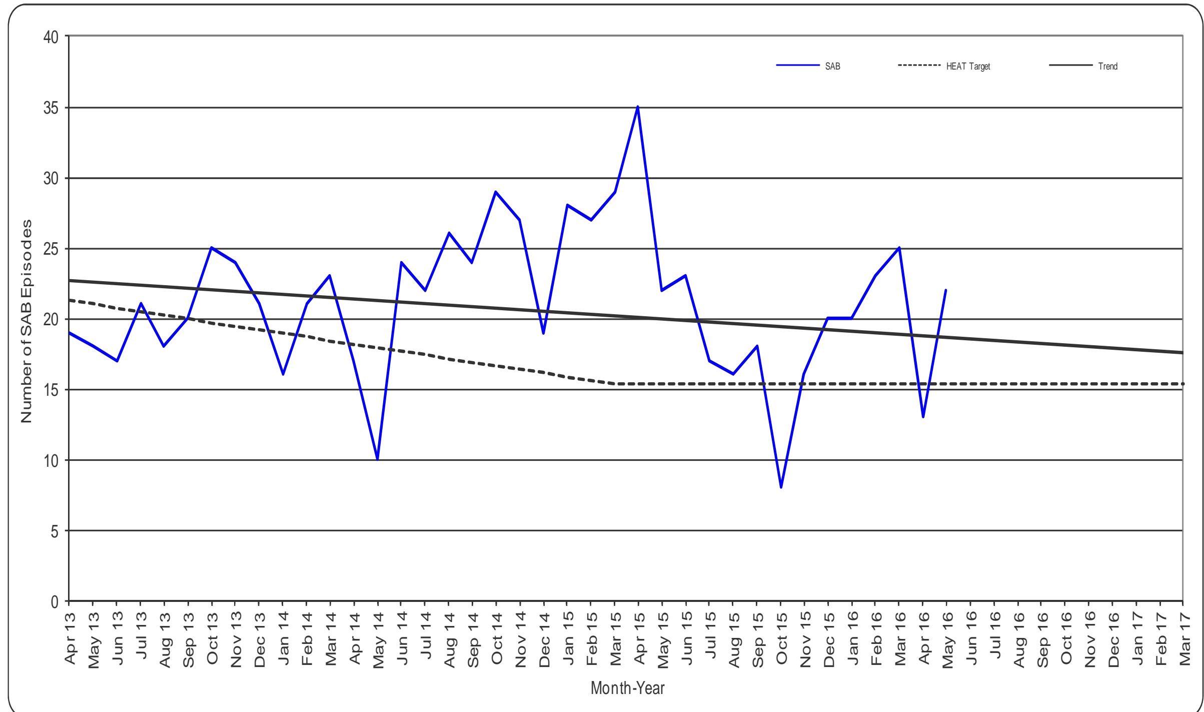
- The table shows the location where the sample (which identified infection) was collected. However this does not identify the source of the infection.
- The National Facilities Monitoring Tool is the source of data for the performance on cleaning compliance and estates monitoring.
- The Patient Safety Quality Improvement Data System is the source of data for the performance on hand hygiene monitoring.

3.1 *Staphylococcus aureus* Bacteraemia

- There were 35 incidences of *Staphylococcus aureus* Bacteraemia diagnosed for the period April to May 2016.
- The most up to date publically available data from Health Protection Scotland is the quarterly report from January to March 2016, which shows that NHS Lothian's incidence rate of 0.33 (per 1,000 Acute Occupied Bed Days) was the same as the overall NHS Scotland *Staphylococcus aureus* Bacteraemia incidence. The incidence of *Staphylococcus aureus* Bacteraemia in Scotland continues to plateau. *Staphylococcus aureus* Bacteraemia incidence in NHS

Lothian continue to show variation around a mean with periods of lower incidence which are not sustained.

Figure 1: NHS Lot*hian Staphylococcus aureus* Bacteraemia: April 2013 - May 2016



3.2 *Clostridium difficile* Infection

- There were 48 incidences of *Clostridium difficile* Infection diagnosed in patients aged 15 or over for the period April to May 2016), using Health Protection Scotland surveillance programme reporting criteria.
- The most up to date publically available data from Health Protection Scotland is the quarterly report from January to March 2016, which indicated that whilst NHS Lothian's *Clostridium difficile* Infection rate of 0.30 per 1,000 total occupied bed days was higher than that of the NHS Scotland average incidence of 0.27 the Board is no longer an outlier.
- Yearly trends in *Clostridium difficile* Infection incidence (comparing year-ending March 2015 with year-ending March 2016) show that there was a decreases in NHS Lothian. Figure 2 shows the *Clostridium difficile* Infection incidence in NHS Lothian for age group 15-64 years, suggesting an improvement in process with incidences consistently lower than the average.
- Yearly trends in patients aged 65 and above (comparing year-ending March 2015 with year-ending March 2016) show that there were decreases in NHS Lothian and Scotland overall. The decrease in incidence in NHS Lothian in the over 65 year age group from March 2015 (43.4) compared with March 2016 (34.4) is noted by Health Protection Scotland as being statistically significant. Figure 3 shows NHS Lothian continues to show an overall downward trend in the over 65 age group.
- Following increased incidence of *Clostridium difficile* Infection at St John's a revised antimicrobial prescribing policy for the frail elderly has been introduced across the medical wards to further reduce potential exposure of this patient group to antibiotics known to be associated with causing *Clostridium difficile* Infection.

Figure 2: NHS Lothian *Clostridium difficile* Infection – 15 to 64 years: April 2013 to May 2016

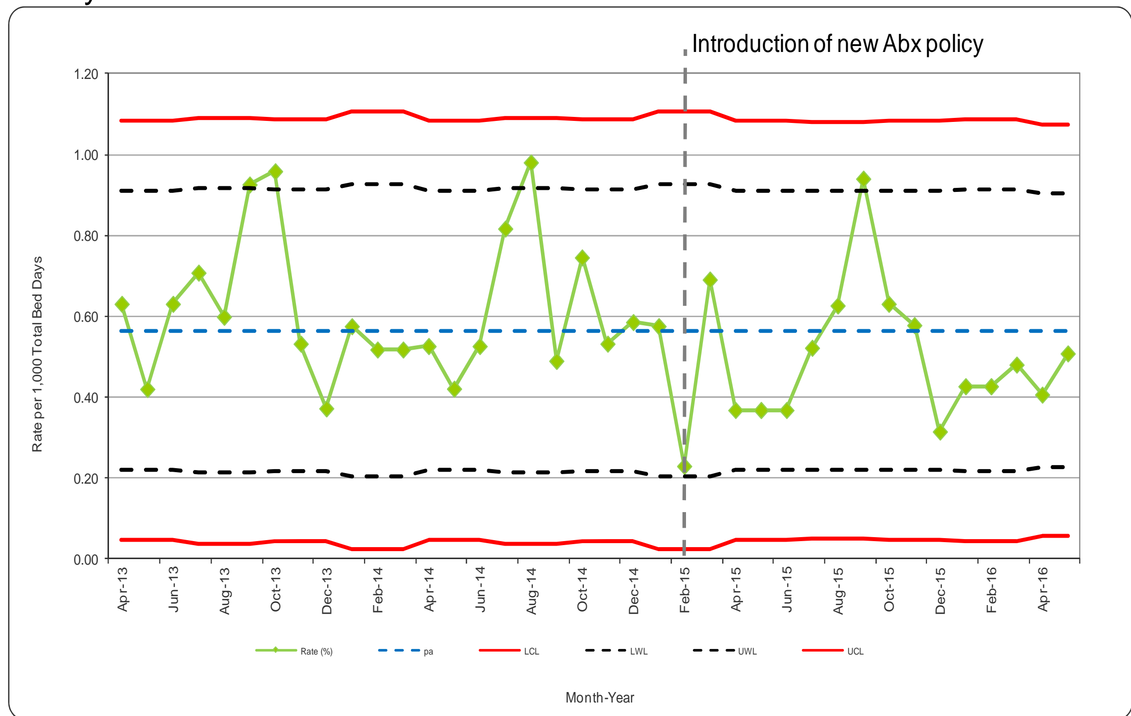
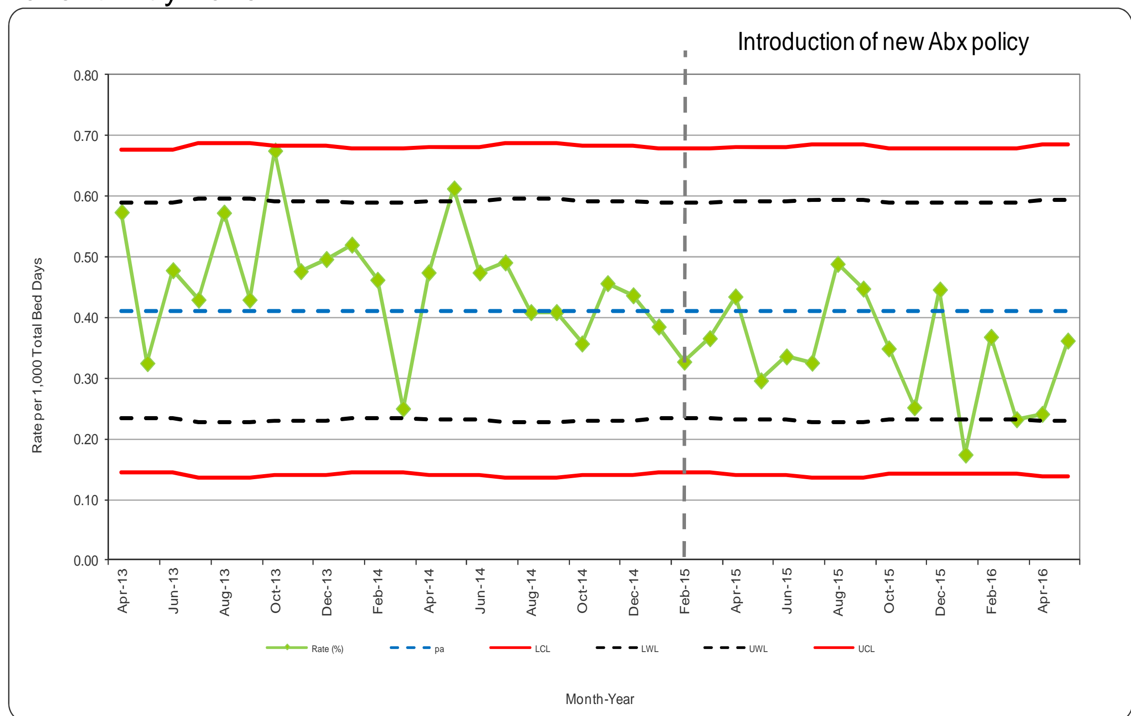


Figure 3: NHS Lothian *Clostridium difficile* Infection – 65 years and over: April 2013 to May 2016



3.3 <u>Healthcare Environment Inspectorate</u>: Liberton Hospital received an unannounced inspection on 13-14 April 2016. The report and action plan was published on 22 June 2016 noting 2 requirements.

4 Key Risks

4.1 The key risks associated with the recommendations are:

- *Staphylococcus aureus* Bacteraemia require the patient to undergo additional interventions and prolonged courses of treatment which may extend stay in hospital.
- The use of antimicrobials in 21st century healthcare can be unavoidable and necessary for the appropriate management of infection or prevention of infection but some antimicrobials have greater association with causing *Clostridium difficile* infection and their inappropriate or unnecessary use may result in avoidable episodes of CDI as well as increased risk of resistant organisms.

5 Risk Register

The Healthcare Associated Infection Corporate Risk Register 1076 is currently graded high due to the reported incidence rates of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection.

6 Impact on Inequality, Including Health Inequalities

6.1 Healthcare Associated Infection is more common in patients with co-morbidities as they require increased interventions and therefore have increased contact with healthcare services.

7 Involving People

7.1 Patient public representatives are actively involved during the Healthcare Environment Inspectorate inspections. There is patient public representation on the Community Health Partnership and Pan Lothian Infection Control Committees as well as 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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