

BOARD MEETING

DATE: WEDNESDAY 5 AUGUST 2015

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

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



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

AGENDA

Agenda Item

Lead Member

Welcome to Members of the Public and the Press

Apologies for Absence

1. **Items for Approval**

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|-------|---|------|---|
| 1.1. | Minutes of the Previous Board Meeting held on 24 June 2015 | BH | * |
| 1.2. | Running Action Note | BH | * |
| 1.3. | Performance Management | AMcM | * |
| 1.4. | Corporate Risk Register | DF | * |
| 1.5. | Healthcare Associated Infection Update | MJ | * |
| 1.6. | Local Delivery Plan 2015/16 | AMcM | * |
| 1.7. | Acute Hospitals Committee - Minutes of 8 June 2015 | KB | * |
| 1.8. | Audit & Risk Committee - Minutes of 22 June 2015 | JMcD | * |
| 1.9. | Finance & Resources Committee - Minutes of 8 July 2015 | GW | * |
| 1.10. | Healthcare Governance Committee - Minutes of 26 May 2015 | MB | * |
| 1.11. | Strategic Planning Committee - Minutes of 11 June 2015 | BH | * |
| 1.12. | East Lothian Shadow Integration Joint Board - Minutes of 2 April & 18 June 2015 | MA | * |
| 1.13. | Edinburgh Community Health Care Partnership - Minutes of 17 June 2015 | SA | * |
| 1.14. | West Lothian Shadow Integration Joint Board - Action Note of 2 June 2015 | FT | * |

2. **Items for Discussion** (subject to review of the items for approval) (9:35am - 12:00pm)

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|------|--|---------|---|
| 2.1. | Delayed Discharges | AMcM/JC | * |
| 2.2. | Inpatient Paediatric Service at St John's Hospital | JC | * |
| 2.3. | Acute Services Performance Update | JC | * |

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

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

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|------|---|---------|
| 2.4. | Workforce Risk Assessment | DF/AB * |
| 2.5. | Quality Report | DF/MJ * |
| 2.6. | Financial Position to June 2015 | SG * |
| 3. | Next Development Session: Wednesday 2 September 2015 at 9:30 a.m. in the Boardroom, Waverley Gate. | |
| 4. | Next Board Meeting: Wednesday 7 October 2015 at 9:30 a.m. in the Boardroom, Waverley Gate. | |
| 5. | Resolution to take items in closed session | |
| 6. | Minutes of the Previous Private Meeting held on 24 June 2015 | BH ® |
| 7. | Matters Arising | |
| 8. | Any Other Competent Business | |

Board Meetings in 2015

7 October 2015
2 December 2015

Development Sessions in 2015

2 September 2015
4 November 2015

Board Meetings in 2016

3 February 2016
6 April 2016
22 June 2016*
3 August 2016
5 October 2016
7 December 2016

Development Sessions in 2016

13 January 2016
2 March 2016
4 May 2016
20 July 2016
7 September 2016
2 November 2016

*Annual Accounts

DRAFT

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 24 June 2015, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Dr M Bryce; Councillor D Grant; Professor J Iredale; Mr P Johnston; Councillor C Johnstone; Mrs J McDowell; Mrs A Mitchell; Councillor F Toner and Dr R 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: University Hospitals and Support Services Division); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Professor A K McCallum (Director of Public Health and Health Policy) and Professor A McMahon (Director of Strategic Planning, Performance Reporting and Information).

In Attendance: Dr Cowan (General Practitioner for item 25); Mrs D Howard (Head of Financial Services for item 19); Ms L Irvine (Strategic Programme Manager for item 27); Mrs B Livingston (Financial Accountant for item 19); Dr C Morton (Chair GP Subcommittee for item 25); Mr D A Small (Joint Director Health and Social Care – East Lothian for item 25); Dr S Tucker (Clinical Director Lothian Unscheduled Care Service for item 25) and Mr D Weir (Corporate Services Manager).

Apologies for absence were received from Mrs K Blair, Mr A Joyce, Mrs A Meiklejohn, Mr G Walker and Mr G Warner.

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. The Chair declared a potential interest under agenda item 2.9 'Public Social Partnerships – A Vehicle for Delivery' in his role as a Non Executive Director of Hibernian Football Club Ltd. He advised if felt appropriate he would be happy to leave the meeting whilst this item was being discussed.

17. Welcome and Introduction

17.1 The Chairman welcomed members of the public to the meeting. He in particular welcomed Ms J Husband, Chief Executive, St Columba's Hospice and members of NHS Lothian staff who were attending to provide support to the debate around a number of agenda items.

18. Items for Approval

18.1 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.

- 18.2 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.
- 18.3 Minutes of the Board meeting held on 1 April 2015 – Approved.
- 18.4 Running Action Note – Approved.
- 18.5 Performance Management – The Board received the update on the existing performance against HEAT targets and other relevant standards.
- 18.6 Healthcare Associated Infection – The Board acknowledged receipt of the new format for Healthcare Associated Infection reporting template for June 2015 and acknowledged receipt of the Healthcare Associated Infection reporting template for June 2015. It was noted NHS Lothian's staphylococcus aureus bacteraemia target was to achieve a rate of 0.24 per 1000 bed days (\leq 184 incidences) by March 2016 with the current rate of 0.41. The Board further noted NHS Lothian's clostridium difficile infection target was to achieve a rate of 0.32 per 100 bed days (\leq 262 incidences by March 2016 with a current rate of 0.37). The Board acknowledged and supported ongoing actions to address gaps identified within the response to the Vale of Leven inquiry recommendations.
- 18.7 Corporate Risk Register – The Board noted that the April 2015 Board meeting had approved the changes to the corporate risk register recommended by the Audit and Risk Committee. It was agreed to use the updated NHS Lothian corporate risk register; highlights of which were contained in section 3.2 and set out in detail in appendix 1 to inform assurance requirements. The Board reflected on the current position that NHS Lothian remained outwith its risk appetite on corporate objectives where low risk appetite had been set.
- 18.8 Human Resources and Organisational Development Strategy: July 2015 – March 2018 – The Board approved the Human Resources and Organisational Development Strategy for the period July 2015 – March 2018.
- 18.9 Schedule of Board and Committee Dates for 2016 – Approved.
- 18.10 Acute Hospitals Committee – Minutes of 2 February and 7 April 2015 – Approved.
- 18.11 Audit and Risk Committee – Minutes of 20 April 2015 – Approved.
- 18.12 Finance and Resources Committee – Minutes of 11 March and 13 May 2015 – Approved.
- 18.13 Healthcare Governance Committee – Minutes of 24 March 2015 – Approved.
- 18.14 Staff Governance Committee – Minutes of 29 October, 11 February and 29 April 2015 – Approved.
- 18.15 Strategic Planning Committee – Minutes of 12 March and 9 April 2015 – Approved.

- 18.16 East Lothian Community Health Partnership – Minutes of 30 October 2015 and 5 March 2015 – Approved.
- 18.17 East Lothian Shadow Health and Social Care Partnership – Minutes of 26 February 2015 – Approved.
- 18.18 Edinburgh Community Health Partnership Subcommittee – Minutes of 11 February and 15 April 2015 – Approved.
- 18.19 Midlothian Shadow Health Community Health Partnership – Minutes of 19 February 2015 – Approved.
- 18.20 West Lothian Community Health and Care Partnership Sub-committee – Minutes of 16 April 2015 – Approved.
- 18.21 West Lothian Community Health and Care Partnership Board – Minutes of 7 April 2015 – Approved.
- 18.22 Patients Private Funds – The Board agreed the draft patient’s private funds accounts for the year ending 31 March 2015. It was agreed the Chairman and Chief Executive should sign the ‘statement of Lothian NHS Board member’s responsibilities’ on the Boards behalf. It was also agreed that the Director of Finance and the Chief Executive should sign the ‘abstract of receipts and payment’ (SFR 19.0). It was further agreed that the Board approved the draft Patients Private Fund accounts for the year ending 31 March 2015.

Items for Discussion

19. Annual Accounts for the Year Ending 31 March 2015

- 19.1 The Board noted that the draft annual accounts were subject to separate confidential circulation with the Board papers as these could not be presented in any public domain until laid before Parliament in the autumn. This had been confirmed by officers within the Scottish Government Health and Social Care Directorates (SGHSCD). Copies had also been circulated to Board members as part of the Audit Committee papers for the meeting held on 22 June 2015.
- 19.2 Members of the Board approved and adopted the annual accounts for the year ending 31 March 2015.
- 19.3 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 document. Members of the Board authorised the Chief Executive’s signature on the representation letter to the auditors, on behalf of the Board.

20. Workforce Risk Assessment

- 20.1 The Board noted that the circulated report provided updates on obstetrics and gynaecology; paediatrics; medicine of the elderly; general practice and health visitor training to ensure compliance with a named person and child statutory planning services legislation from August 2016.

- 20.2 Particular attention was drawn to the situation in respect of paediatric staffing at St John's Hospital which remained fragile. It was reported there had been long standing challenges with the paediatric medical workforce and this had been the subject of regular briefings and reviews over the last 5 years. It was noted in spite of extensive and repeated recruitment campaigns including international drives for both medical and advanced nurse practitioner staff, the middle grade out of hour's rota had remained fragile and was only covered on a month to month basis.
- 20.3 It was noted that the rota had continued to rely heavily on locum cover from a very small pool of people, some with European Working Time Regulations (EWTR) waivers to allow them to provide this cover on top of their full time day jobs. Over the last 12 months, the rota had become harder to manage due to a consultant vacancy which could not be recruited to and more recently a consultant going on maternity leave. Both of these consultants were job planned to do out of hour's resident middle grade shifts. The impact of this sustained reliance on a small workforce working additional hours in the past few years was beginning to become evident.
- 20.4 The Board were advised that in spite of these difficulties the team at St John's Hospital had maintained a safe and high quality service over the last few years. However over the last few months the out of hours rota had become more difficult to fill robustly with only 3 of the 9 out of hours sessions required each week having staff cover, the rest requiring locums. It was reported that in July 22 out of the 39 out of hours middle grades shifts required locum cover.
- 20.5 The Board were advised much of the locum middle grade cover was provided by existing consultants. It was advised that this remained a real and continuing challenge to NHS Lothian in delivering a sustainable financial and workforce model of care.
- 20.6 It was reported that annual leave planning for the St John's Hospital team had been well managed for July and August. However the peak summer holiday months always diminished the wider pool of people available to do adhoc locum work. Over the last few weeks additional pressures had arisen due to sickness absence with previous locum cover no longer being available. It was noted that these combined additional pressures had led to a short notice crisis in the rota on 3 occasions in June.
- 20.7 The Board were advised that looking ahead to July and early August that there were outstanding middle grade shifts at nights with no Foundation Year (FY) General Practice Specialty Training (GPST) cover. In addition there were also numerous day and evening shifts with no junior rota cover which compounded the pressure on the remaining staff.
- 20.8 The Board noted that all of the usual measures to secure locum cover had been activated without success and it was not possible to relocate staff from the Royal Hospital for Sick Children without creating similar gaps there which would impact on service sustainability and patient safety.
- 20.9 The Board were advised that the increased staffing gaps, the ongoing difficulties in trying to cover these and the significantly increased risk of a sudden service collapse

were presenting an unacceptable risk to patient safety and to staff over July and into August.

- 20.10 The question was raised given that staff had been working extra shifts for a number of years what the impact had been on them given this was not an interim position with health and safety considerations being highlighted as a concern. The Board were advised that the staff concerned were incredibly dedicated but were now tired and that the ability to maintain services required leadership and management. The point was raised that NHS Lothian had a duty of care to its staff and it was not fair to expect them to sustain this level of additional work. An update was reported in respect of Programme Board work in order to attempt to recruit additional staff with it being noted that 14 actions were predicted to be delivered in the calendar year.
- 20.11 The Board were advised by Mr Johnston that the residents of West Lothian valued the 24/7 children services at St John's Hospital and that any move away from this would be viewed seriously by West Lothian Council. Whilst the importance of ensuring the safety of staff and recognising their dedication was acknowledged it would be important to try and maintain this essential service.
- 20.12 The point was made that there was a need to look at the whole service across Lothian to include shift working. With particular reference to a suggestion by Councillor Toner it was reported that different skill sets were required to provide services at the Royal Hospital for Sick Children and St John's Hospital. At the Royal Hospital for Sick Children medical staff had developed specialist skills and were not confident in delivering general packages of care. It would also be important not to destabilise services beyond Lothian.
- 20.13 The Chief Executive commented that the Board remained committed to attempting to sustain 24/7 children services although in terms of a sustainable workforce and financial position this was not currently being delivered and had not been over a 3 year period. Currently consultant grade staff were carrying out middle grade duties which was inefficient and not sustainable. He pointed out that the desires of Mr Johnston and Councillor Toner represented two irreconcilable aims. The Chief Executive stressed that the service could not be kept open if it was not safe particularly in respect of comment and recommendations made following the Frances and Keogh Inquiry reports. It was pointed out that over a 3 year period the position had not improved with the unit having only recently been staffed over the course of a weekend at very short notice. In the event that the unit did fall over there would be emergency redirection of patients from West Lothian to Edinburgh. The Chief Executive stressed therefore that in planning for a safe and sustainable solution there was also a need to plan for the possibility of not being able to staff the unit. This would be covered in more detail at a meeting of the St John's Hospital Stakeholder Group to be held later in the day.
- 20.14 The Board agreed it would be important that Mr Crombie, Dr Farquharson and Dr Bryce as Chair of the Healthcare Governance Committee kept in close contact outwith the meeting to try and sustain the service and to also keep the SGHSCD updated on any issues. The point was made however that patient safety was paramount and would be the key determinant in any decisions made. The Chief Executive stressed at this point the Board was not being asked to agree any recommendations in respect of children's services at St Johns Hospital.

- 20.15 The Board received an update on 7 day working which had been introduced in response to a tragic incident where a trainee doctor in the West of Scotland had lost her life in a road traffic accident. It was noted in Lothian that the practice of working 7 consecutive nights had stopped in 2009 and the key issue for NHS Lothian was now to ensure that no doctor in training worked more than 7 days in a row by February 2016. The SGHSCD had also recommended that best practice would be to include a zero hours day prior to a block of nights when revising rotas for maximum 7 day working ensuring that trainees would be well rested before commencing nights.
- 20.16 The Board were advised that the workforce paper had been extended to cover all workforce areas including nursing the midwifery. The Executive Director of Nursing advised that nursing and midwifery was facing challenges in achieving safe and sustainable staffing levels with the main focus being on the transition to new models of care which would assist in managing costs. It was noted that sickness levels in nursing and midwifery were higher than in other areas. The Board were advised that health visiting and theatres were areas where recruitment difficulties were being experienced and that work was underway to address and enhance the recruitment process. It was noted that it was not felt that the adoption of national workforce tools would be sufficient to manage the transition and that this position would be discussed in detail at the September Board Development session.
- 20.17 Particular difficulties and challenges were being experienced in respect of health visiting and changes in the legislation in terms of the named person for children which would come into effect in 2016. It was noted that additional SGHSCD funding had been made available and that recruitment was in process. The Board were advised that whilst it was possible to recruit to training posts that there was a phasing issue and this represented work in progress at a point when people were continuing to retire from the service. It was noted that the position in respect of district nurses would be discussed at the primary care slot later on the agenda.
- 20.18 The Board were advised of the introduction of a model for revalidation by the Nursing and Midwifery Council that included a third party input which would begin in April 2016. It was noted that revalidation included confirmation of the registrants continued fitness to practice, that the registrant had met the requirements for practice and continuing professional development, had sought and received third party feedback which had informed their reflection on their practice and had sought and received third party confirmation that they had provided this evidence. It was noted that once the position was clearer and the risks and work had been modelled that a future report would be brought to the Board.
- 20.19 Councillor Grant sought confirmation that the present position in respect of Roodlands Hospital was manageable. It was noted that this position would improve in August with the recruitment of new staff although the service still relied on a consultant providing cover at the weekend. The Medical Director commented that he did not anticipate any problems during the summer period and that in the longer term there would be a need to revisit the model of care and service.
- 20.20 The Chairman commented whilst it was right and proper to have detailed debate around the workforce and sustaining safe patient care that the other discussion that needed to be held was around finance and available resources. He did not feel that the system fully understood the impact on finances caused by continuing shortages in specialist areas and nursing. He commented despite having recruited more staff

there were still gaps being covered by the private sector and extraordinary other actions. The Director of Finance commented that it would be possible to make an assessment of the impact of these issues. The Chairman commented this would be important in being able to evidence impacts in ongoing discussions with the SGHSCD.

- 20.21 The Board noted the recommendations contained in the circulated paper around the actions currently underway to ameliorate risks to service sustainability within certain specialties where high levels of risk had been identified.

21. Acute Services Performance Update

- 21.1 The Board were advised that at the end of April, 500 patients were waiting beyond the 12 week treatment time guarantee. 472 patients were treated in month beyond the guarantee. 3467 outpatients were waiting over 12 weeks. 18 week performance from referral to treatment remained stable at 85.1%.
- 21.2 It was advised that performance against both the 31 and 62 day cancer standard was provisionally placed at 96.2% which exceeded the 95% expected standard. Performance against the standards for colorectal and urology remained challenging for NHS Lothian.
- 21.3 Provisional information on diagnostic waiting times showed that 1448 diagnostic endoscopy patients were waiting longer than the 6 week standard and 146 radiology patients were also waiting longer than the standard. The Board were advised that the intermittent failure of the decontamination unit had stabilised. 3 consultant staff had been recruited and would take up post in early August. A trained nurse endoscopist had also been recruited which was a key component in the new model. It was noted however that it took time to train nurse endoscopists with 2 staff members going through training at the moment. Business cases were being developed for new decontamination units to sustain service delivery. Details of the endoscopy recovery plan were provided to the Board.
- 21.4 The Board noted that 19 patients were waiting beyond audiology standards at the end of April 2015. NHS Lothian continued to perform well against the IVF standard of 90% of patients commencing IVF treatment within 12 months.
- 21.5 NHS Lothian's overall performance against the 4 hour standard for the month of April 2015 was 93.56% (92.61% during March). Current performance in June was 95.1%. It was noted whilst summer brought some relief that attendances remained high with 22 patients having waited more than 12 hours. The Board were advised that during April 48 patients had waited longer than 8 hours and 22 patients had waited longer than 12 hours.
- 21.6 The Board were advised that the 2015 Winter Planning Project Board chaired by the Chief Officer had been established and included multi stakeholder engagement.
- 21.7 It was noted that the overall number of delayed discharges across NHS Lothian had increased from 148 in March 2015 to 172 in April 2015. A consequence of increased delayed discharges was a rise in the number of boarded patients with there being 1252 patients boarded in the week commencing 11 January with this

number having reduced to 588 on 17 May. This remained an issue and work was underway with council colleagues to improve the delayed discharge position.

- 21.8 The point was raised in respect of the endoscopy recovery plan given the age profile and increases in diagnostic and surveillance activity whether it would be possible to predict demand forward 3 years. In response it was advised that a 12 month forward position could be predicted although changing indicators made it difficult to predict beyond that point. The Board were advised that a new primary care test provided a diagnostic indicator to GPs with a protocol being developed and tested. Other advances were being made around consultant testing outcomes. 20 GPs were testing the new methodology with results expected by the end of September.
- 21.9 The Board noted in terms of engagement with social care departments to improve capacity that this was not currently bearing fruit in Edinburgh. It was noted that there had been recent leadership changes in Edinburgh and available resources were being looked at to see how to do things differently.
- 21.10 The Chief Executive commented that debate at the meeting demonstrated the need for the future triangulation of Board papers. He was of the view the worst position was to use available resources in the wrong place ie in the private sector or in facilities not fit for purpose. The optimum position would be to spend available resources in the correct place and until then to spend unavailable money in the correct place. The Chief Executive commented on the need to support earlier discharge of patients from hospital and to have people waiting at home for packages of care. It would be a key role for Integration Joint Boards to reconcile this as their budgets contained elements of acute spend.
- 21.11 The Board were advised that the overspend continued and if not arrested decisions would be needed about whether to continue to put resources into areas like treatment time guarantees and the private sector or divert it towards the deficit. It was noted that currently primary care prescribing was the area of largest overspend.
- 21.12 The outcome of a recent Board Development Session had concluded that social care provision in Edinburgh in particular was a major issue. The projected overspend for the City of Edinburgh Council Social Care Department was not sustainable and the redesign of services would take time. There was ongoing dialogue with the SGHSCD about bridging finance although this had not yet concluded.
- 21.13 The Chief Executive concluded that it was not possible to look at the Board paper in isolation and that the current waiting times plan would be compromised if the overspend was not arrested.
- 21.14 The recommendations in the circulated paper were agreed.

22. Quality Report

- 22.1 The Board noted that some of the detail in the paper would have been covered by other Executive Director reports or through the detail of papers contained in the consent section of the agenda. Work around septic and deteriorating patients continued.

- 22.2 The Board noted that the number of formal complaints remained fairly stable with the response rate of 20 days and 3 days remaining a challenge. It was noted that the complaints review was detailed in the Person Centred Culture paper later on in the agenda and would be discussed in private session.
- 22.3 The Board noted in respect of Hospital Standardised Mortality Ratio Data (HSMR) that none of the 3 acute hospitals was a statistical outlier and had seen reductions from the October – December 2007 baseline. It was noted that the report represented the position as detailed at the previous Board meeting as there had been no subsequent Information Services Division (ISD) report since then.
- 22.4 The Health Improvement, Efficiency, Access and Treatment (HEAT) targets for reduction in c-difficile and staphylococcus aureus bacteraemia were not being achieved. It was noted that healthcare associated infection had been addressed under a paper in the consent part of the agenda. The point was made that performance in both clostridium difficile and staphylococcus aureus bacteraemia in the first few months of the year was showing improvement although still off trajectory. It was hoped the improved position would be sustained although it was too early to be confident about this. Work continued to mitigate the position through the new antibiotic prescribing policy and also a pilot in respect of different cleaning detergents at the Western General Hospital. The Board were advised that the ongoing focus around Standard Infection Control Precautions (SICPS) in clinical areas and compliance with these would assist in infection control. Work around the Vale of Leven report continued to be reported through the Healthcare Governance Committee.
- 22.5 The Board noted that a working group looking at the stroke pathway was being chaired by the Medical Director for Medicine and would report in August.
- 22.6 The Board were advised that the outcome of recent announced and unannounced Healthcare Environment Inspectorate (HEI) inspections had demonstrated considerable improvements. All actions had been addressed.
- 22.7 The Chairman commented on the rising trend in staff absences and the impact on workforce shortages. The Board were advised that overall absences were monitored and were acceptable for an organisation of this type. The current level was 4.5% although this masked peaks and troughs. The Human Resources and Organisational Development department monitored areas where spikes were evident and spent time with managers to ameliorate the position. This was a constant issue and the assistance of Trades Unions and professional organisations in this critical area was welcomed.
- 22.8 The Board were advised that its own staff as well as the population was aging and with longevity came ill health. The Occupational Health Service (OHS) was currently being reviewed and by summer it was hoped a number of recommendations would be available to help support and manage sickness absence. The Chairman felt there was a need for more analysis as these were underlying determinants for future service provision. It was noted that future reporting of staff absences would continue through the Staff Governance Committee.
- 22.9 The Board noted that the Community Health and Care Partnership (CHCPs) received similar reports and in East Lothian there had been discussion about the

need for return to work interviews and the efficiency of the OHS. Future reporting would be through a central governance committee.

22.10 The point was made that the difficulty with the current reporting methodology was that investments in prevention initiatives were reported in parallel. It was agreed that future reporting on sickness and absence needed to be more comprehensive to take account of the debate at the current meeting.

22.11 The Board noted the recommendations contained in the circulated paper.

23. Financial Position to May 2015

23.1 The Board noted that the financial position to May 2015 was reporting an overspend of £4.2m and that the financial plan agreed at the April Board meeting was already in danger of being compromised. It was noted that this position had been reported to the SGHSCD along with the fact that the comparable position in the previous year had been a £3.5m overspend. The Board were advised however that the system did not have the flexibility that it had in the previous year and all available resource had been taken upfront when setting the financial plan.

23.2 The Board noted one of the key areas of overspend related to nursing and its ability to deliver efficiency savings and in that respect this was no different from the previous year. The GP prescribing budget however was the largest area of concern and the reasons for this position were not yet understood particularly in terms of the significant adverse movement since the beginning of the calendar year. Currently the overspend position on prescribing was £8m and insufficient resource had been put into the financial plan to recognise this level of spend. Discussion had been held with Joint Directors around the need to agree a refocus on prescribing. The suggestion was made that the work around the establishment of Integration Joint Boards had meant that engagement with GPs had been diluted and that there was a need to re-engage with them to reduce prescribing costs.

23.3 The Board noted that the Finance Director was looking at ways and options around year end management and a full report would be submitted to the 8 July Finance and Resources Committee to give an overview of the position.

23.4 The Director of Finance advised that the Board could be assured that NHS Lothian remained fully committed to achieving financial balance and in order to achieve this a number of actions had been introduced or would be put in place through the establishment of performance management meetings which would encourage managers to take risks without waiting for permission to take action to support financial balance.

23.5 It was noted that discussions were ongoing with SGHSCD to confirm current income assumptions and to explore other opportunities for additional in year and recurrent financial support. Actions to deliver a balanced outturn would be detailed and directed through the Finance and Resources Committee in the first instance with further detail provided at its next meeting on 8 July. It was noted that further detail around the financial position would be discussed in both the private session of the Board later in the day as well as at the next Finance and Resources Committee.

- 23.6 The point was made in respect of the prescribing overspend that this should be referred to as the primary care prescribing overspend as people other than GPs were responsible for prescribing to patients. Dr Williams expressed his concern at the term 'overspend' given that the budget set was below anticipated spend and that NHS Lothian prescribing costs per head of population remain the lowest in Scotland.
- 23.7 Councillor Toner commented from the paper that steps were needed including engagement with the SGHSCD to achieve a balanced budget. He felt it was important to both the Board and public to be aware of underfunding and the actions being taken to address this. The Chairman advised that this was exactly the process the Board was undertaking and suggested that nobody should be under any illusions that the heroic achievements in the previous financial year had in part prejudiced the ability to have a smoother ride in the current year. He reminded the Board that it had been agreed at the previous meeting to monitor the financial plan with a degree of intensity rather than relying solely on the comprehensive executive reports provided for both the Board and the Finance and Resources Committee. He reminded colleagues that a further update would be provided in private session. The financial position had been made visible to the SGHSCD. In response to Councillor Toner it was agreed that NHS Lothian would in the fullness of time wish to move to a point where its budget setting position was as detailed as that experienced by local authorities.
- 23.8 The point was made at the time of setting the financial plan the expectation and assumption had been that there would be effective delivery of LRP. The question was posed about whether the baseline had changed or whether saving schemes were not delivering to timescale. The Board were reminded that at the April meeting a financial plan had been set which was not in recurrent balance. In order to move to recurrent balance savings of £47m would need to be delivered to meet cost growth. It had been clear early in the process that it would not have been possible to deliver savings of that magnitude without it impacting on issues like Treatment Time Guarantee (TTG) delivery and end of life drugs. The Board were reminded that the biggest cost after staff and pay was drugs. It was noted that even with the current primary care prescribing position NHS Lothian was still below the Scottish average. In recognition of the above a revised LRP target of £30m had been set to deliver financial (not recurring) balance. At the point of finalising the financial plan the National Resource Allocation Committee (NRAC) formula had been reviewed with it being anticipated NHS Lothian would benefit by around £12m which would go a significant way to covering the £14m non recurring gap. Further consideration had been given to the achievability of the £30m LRP target which was felt to be challenging and it had been agreed to refine this to delivery of £20m recurrently and £10m non recurrently. Current thinking suggested delivery of the £10m non recurrent savings might be feasible although there was not confidence around 50% of the recurrent requirement despite intensive meetings with directors.
- 23.9 The Board were reminded that delivery of the financial plan was predicated on achievement of £30m of recurrent savings and living within budget. The July Board Development Session would focus on the financial position and with the SGHSCD there would be a need to discuss steps to address the overspend as it was not possible to reconcile continued spend in the private sector with balancing the books. The management team were considering areas of discretionary spend. The point was made that there was a need for continued engagement with SGHSCD as the Board was not an entirely autonomous body.

23.10 It was noted that although the go live date for Integration Joint Boards had been deferred until April 2016 a third statutory requirement would be the need to fund commissioning plans and in that regard Integration Joint Boards would receive details of the analysis around the financial position.

23.11 The Board agreed the recommendations in the circulated paper to support the arrangements to monitor financial performance throughout the year and ensure actions were implemented to deliver financial balance by the year end.

24. Health and Social Care Integration – Integration Joint Boards (IJBs)

24.1 The Board were advised that versions of all of the 4 Draft Integration Schemes had been submitted to the SGHSCD by the deadline date of 31 March 2015. Proposed changes had not been significant and the Board at its meeting on 1 April had delegated authority to the Chairman and Chief Executive to sign off the final schemes for resubmission. The schemes for Edinburgh, East Lothian and Midlothian had since received approval by the Cabinet Secretary and would achieve Parliamentary sign off on 27 June. The dates for those Integration Joint Boards (IJBs) going live was reported to the Board.

24.2 It was noted there had been a delay in submitting the West Lothian scheme and in terms of Parliamentary process it needed to sit in Parliament for 28 working days. The fact Parliament was in recess meant it would be 21 September before Parliamentary approval would be obtained.

24.3 The Board accepted the reassurance that none of the individuals proposed for membership of IJBs was disqualified from being a member. The Board agreed to:

- Appoint the Lothian NHS Board members set out in table 1 as voting members of the respective IJBs.
- To appoint the healthcare professionals identified in table 2 as non voting members of the respective IJBs.
- To nominate Professor McMahon as the NHS Board representative on each of the IJBs strategic planning groups.
- Note that progress with the development of the senior management structure and recruitment of the Chief Officer in Edinburgh was underway and that a further report on progress would come to the August meeting of the Board.
- The Board also noted that the first meeting of the Edinburgh Children's Joint Board had been held on 10 June 2015. NHS Lothian Non Executive representatives were Mrs Shulah Allan, Mrs Kay Blair and Mrs Alison Meiklejohn.

24.4 The Board discussed the position in respect of deputies and the Chairman suggested that the message to Non Executive Directors was that a suitably qualified proxy should be able to attend although this should not be regarded as the default position.

24.5 It was noted that the paper did not detail the role that the Community Health Partnership (CHP) had in respect of its statutory requirement for finance and performance reporting. The point was made that as each IJB established the CHP would disappear. The Board were reminded that at its meeting on 14 January 2015 the arrangements for the disestablishment of the CHP had been agreed and this position remained extant.

25. Primary Care and Lothian Unscheduled Care Services

25.1 The Chair welcomed Dr Cowan, Dr Morton, Dr Tucker and Mr Small to the meeting.

25.2 The Board were advised that the presentation before them represented an update on the short and medium term work arising from the January Board Development Session which had included significant representation from the GP Subcommittee. Subsequent to that meeting discussions had been held at the Healthcare Governance Committee about the need to move patient safety, GP capacity and recruitment on to the corporate risk register. The presentation to the Board would also detail actions that could be taken if the Board received an allocation from the SGHSCD for primary care. Capital investment proposals had also been prioritised.

25.3 Dr Cowan, Dr Morton, Dr Tucker and Mr Small provided the Board with a detailed presentation the main thrust of which was around the 2020 vision: focus for clinical teams in the community; frail elderly; workforce; workload – for quality and safety; information technology; working conditions; 2020 Vision – our new community hospital; the care home story; the hospital story; new models of care; care in nursing homes and new care home models; hospital at home; Hannah; the new simplicity model; community nursing reviews; Lothian unscheduled care service and the national review; the unsustainability of 4 day holiday weekends and finally an update on progress in relation to stages 1-3 of the process.

25.4 The Chair commented that he felt the time available at the meeting would not be sufficient to do justice to the 3 questions posed for simulation nor to address the 9 recommendations in the paper before the Board.

25.5 The question was raised about what constraints the GP contract placed on GPs. It was noted that the Scottish GP Committee were in the process of negotiating a new contract with the Scottish Government and that roadshows had been undertaken to inform GPs of progress. The main issue was that GPs received feedback on the general principles but not the detail of the contract. The Board were advised that current GP teams were efficient and there would be a need to ensure this continued. The point was made that there had been much more scope for GP discussion around the negotiation of the proposed new contract than had been the case for the current contract.

25.6 Support was expressed for the new simplified model of care as this fitted the model for other vulnerable groups of patients. It was important that GPs had a clear understanding of the social circumstances of patients. There was a need to recognise the lack of investment in GP training and research and development compared to other countries. It was noted that these issues would be addressed as part of national ongoing work.

- 25.7 A comment was made that there was a need for the Board to have sight of more data about the impact of proposals in the presentation in terms of patient safety and care. It was agreed that additional data would be developed and included in future reports.
- 25.8 The Board were advised there were currently 28 practices who would not register new patients with workload being a significant issue. The point was made if there was a shortage of GPs this affected mortality as did austerity measures. It was reported when an individual GP had more than 1800 patients on their list then morbidity and mortality rose. In Lothian the practices previously referred to were not registering patients in order to ensure that the quality of care did not diminish. The Vice Chair commented there was undeniable support for the 3 questions posed to the Board. The Edinburgh CHP had looked radically at GP practices and work was underway locally to look at opportunities for carers and new ways of integrating the service. It was felt future communications would be important in order to provide an understanding of how new models would be delivered.
- 25.9 Primary care delivery would be a main focus of the IJBs and engagement with GPs would therefore be crucial. It was noted that although there was no out of hours direct representation on the IJBs that feedback would be through clinical directors although it would be important to recognise perceptions would be different across each area. The point was made that good locality structures were in place to ensure the smooth transition of GPs into the IJB process.
- 25.10 Dr Williams welcomed the excellent paper which had build on the January Board Development Session. He felt that if anything it understated the investment needed. He questioned given that nobody had disagreed with the recommendations and proposals in the paper whether this meant that the Boards priority would be towards primary care investment. The Chairman suggested whilst there could be no dissent around 2 of the 3 questions that the second question around whether there was any more the Board could do to ensure safe primary care provision would require further debate before any commitments could be given.
- 25.11 The Board agreed the recommendations contained in the circulated paper.
- 25.12 The Chairman thanked colleagues for their comprehensive exposure of the issues and for their assessment of the best way forward. He apologised that more time had not been available to consider issues more thoroughly.
- 25.13 The Board were advised that the SGHSCD were expected to announce details around the anticipated primary care investment the following day. This would hopefully allow the next tranche of investment to be confirmed. Proposals would also be developed through the Strategic Planning Committee and the Integration Joint Board commissioning plans.

26. Improving Older People's Care in Edinburgh – 2015/2017

- 26.1 The Board were advised from the Strategic Planning Committee a number of areas had emerged to be addressed to facilitate a changed model of care to one which provided more focus on supporting people at home or in homely surroundings, rather than at hospital. The complex and detailed programme of work needed to improve the quality of care for older people particularly in Edinburgh, but closely interrelated

with East and Midlothian was described in detail to the Board by the Director of Strategic Planning, Performance Reporting and Information.

- 26.2 The Board noted that good progress was being made and that a Programme Board had been established to oversee progress.
- 26.3 The Vice Chair commented that whilst she supported in principle the recommendations contained in the circulated paper she felt that the Board had not had a chance to look at what was being meant around the establishment of an Integrated Care Facility and this needed devoted development time for further discussion in order for the Board to understand the consequences. The Director of Strategic Planning, Performance Reporting and Information undertook to circulate a more detailed paper and to address this issue as part of a forthcoming development session.
- 26.4 The question was posed in respect of the need to repatriate 38 patients whether any clarity had been obtained around the funds needed for bridging in Midlothian. The point was made that discussions were ongoing around SGHSCD requests for further information around support needed to make this a reality.
- 26.5 The Board agreed the recommendations contained in the circulated paper and noted that it was expected that a definitive strategy and costed action plan would be developed by September and presented to the Board in October 2015.

27. Public Social Partnerships – A Vehicle for Delivery

- 27.1 The Board noted that a copy of an electronic presentation which would have been provided had time permitted had been circulated to Board members. The Director of Strategic Planning, Performance Reporting and Information commented that he felt it was important that the Board were provided with details around the key role of the public social partnership in the delivery of the Royal Edinburgh campus reprovisioning programme and NHS Lothian strategic priorities. It was reported that the work undertaken in mental health was transferable to other areas of the service.
- 27.2 The Chairman reminded colleagues that he had declared an interest in this agenda item as a Non Executive Director of Hibernian Football Club Ltd. He commented that Ms L Irvine was present to support the paper and that if Board colleagues felt it necessary for him to remove himself from the meeting then he was happy to do so. It was agreed that there was no need for the Chairman to leave the meeting.
- 27.3 The Board noted the tremendous progress being made in developing the 4 Public Social Partnerships (PSP) workshops – Way Finder an academic practice partnership between NHS Lothian and Queen Margaret University to redesign rehabilitation services for people with complex mental health needs with a focus on shifting the balance of care back to the community – Green Space: art space a development to maximise the use of the extensive Royal Edinburgh Hospital campus and its trees and woodlands – Game Changer an exciting and innovative PSP led by NHS Lothian, Hibernian Football Club and Hibernian Community Foundation to unlock the power and passion associated with football and to make greater use of all Hibernian's physical, cultural and professional assets to delivery a better, healthier future for the most deprived and disenfranchised people in the community and the Rivers Centre a PSP to provide a focus on developing a specialist psychological

trauma centre which would deliver open access services to people of all ages within a community resource. It was reported there was potential to further develop PSPs with consideration being given around creating a unique environment and living space for people with dementia in Lothian as well as a PSP to support and complement the activities of the new community hospital.

- 27.4 The Board noted that there was potential for significant income streams and links with other initiatives in order to develop and support the overall strategic direction. The Chairman commented that the primary objective of the presentation was for the Board to be aware of the potential power of these vehicles in terms of different ways of delivering services to particular parts of the community.
- 27.5 The point was made that it would be important for sustained work to be put in place to develop and ensure a robust evaluation of the PSP programme. It would also be important to consider how best to feedback to the SGHSCD.
- 27.6 It was noted in particular with regard to the Rivers Centre that it was hoped to speed up the process for people accessing the service as it was currently fairly lengthy and intensive.
- 27.7 The Board welcomed the proposals and sought an opportunity for more debate at a later date to address any issues that might emerge. The expanded use of the East Mains facility at Ormiston which was felt to be under utilised by the community was welcomed.
- 27.8 The Board agreed the recommendations contained in the circulated paper and the need to expand their understanding of the issues through further discussion potentially at a future Board Development Session.

28. Date and Time of Next Meeting

- 28.1 The next meeting of the Board would be held between 9.30am and 12.30pm on the 5 August 2015, in the Board room, Waverley Gate, 2-5 Waterloo Place, Edinburgh, EH1 3EG.

29. Invoking Standing Order 4.8

- 29.1 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.

RUNNING ACTION NOTE

Action Required	Lead	Due Date	Action Taken	Outcome
Renewing NHS Values				
<ul style="list-style-type: none"> • Arrange engagement sessions for service teams. 	AB	31/03/2015	<i>The Associate Director of Workforce is leading on this process. Meetings with management teams and partnership leads across NHS Lothian are being held to determine what they consider are the next priorities in embedding our values.</i>	In progress
<ul style="list-style-type: none"> • Development of the Implementation Plan to be included as a separate Board seminar. 	AB	31/05/2015	<i>The Associate Director of Workforce is leading on this process. This will be developed after the above is completed.</i>	In progress
NHS Lothian Homeopathy Service				
<ul style="list-style-type: none"> • Cease provision of an NHS Homeopathy Service in Lothian and cease NHS referral to the Glasgow Homeopathic Hospital from 1 April 2014. 	AMcM	01/04/14	<i>Judicial review still pending. NHS Lothian is represented by CLO.</i>	In progress
Scottish Public Services Ombudsman Case 201200092				
<ul style="list-style-type: none"> • Report to a future Board meeting on how NHS Lothian now deals with complaints and demonstrate the benefits in terms of improved performance. 	SRW	Ongoing	<i>A quarterly Customer Relations and Feedback Quality Report now goes to the Healthcare Governance Committee and the Board. This report goes into detail about complaints, trends and actions. It has been agreed that an external expert will now drive forward the review into how NHS Lothian handles all feedback and how it uses that feedback for quality improvement and service delivery purposes. There will also be a complete review of the role and function of the Customer</i>	In progress

Action Required	Lead	Due Date	Action Taken	Outcome
			<i>Relations and Feedback Team. A report on the options available will be produced by the end of January 2015.</i>	
Workforce Risk Assessment				
<ul style="list-style-type: none"> • Further consideration is needed in a future paper around overall developments, staffing, culture & values and their impact on individual areas including service redesign. • The Medical Director and Director of Human Resources & Organisational Development would take away the points raised and come back with proposals about how scope the job offer to candidates to make the posts as attractive as possible. • The Director of Human Resources & Organisational Development to bring a paper to a future Board meeting detailing how long posts had been vacant and by vacancy group. The report would show comparable data comparisons with other large organisations and examples of work being done to make jobs more attractive to include consideration of the benefits or otherwise of making regional appointments. • The Medical Director would consider how best to bring a paper to the Board to address the fundamental capacity issue in primary care. • Mr Crombie, Dr Farquharson & Dr Bryce would keep in close contact to try and sustain the St John's Paediatric out-of-hors service & keep the Scottish Government updated • Nursing working sustainability would be discussed at the September Board Development Session on 2 September. 	<p style="text-align: center;">AB</p> <p style="text-align: center;">AB/DF</p> <p style="text-align: center;">AB</p> <p style="text-align: center;">DF</p> <p style="text-align: center;">JC/DF/MB</p> <p style="text-align: center;">MJ</p>	<p style="text-align: center;">Autumn 2014</p> <p style="text-align: center;">TBC</p> <p style="text-align: center;">TBC</p> <p style="text-align: center;">Ongoing</p> <p style="text-align: center;">02/09/15</p>	<p><i>This work will be undertaken in the HR&OD Strategy which will come to the Board following consideration by the Staff Governance Committee.</i></p> <p><i>A paper on recruitment will be discussed at the Staff Governance Committee and then taken to the Board</i></p> <p><i>A paper is being considered at the February Board meeting.</i></p> <p><i>There is going to be a second Board Development Session with Primary Care colleagues to discuss this topic, and a new GMS contract is due in 2017. I think we have taken this action as far as we can, particularly as it involves changes to the GMS contract. We will monitor progress through the Workforce Risk Assessment Paper.</i></p>	<p style="text-align: center;">In progress</p> <p style="text-align: center;">In Progress</p> <p style="text-align: center;">Completed</p> <p style="text-align: center;">Completed</p>

Action Required	Lead	Due Date	Action Taken	Outcome
<ul style="list-style-type: none"> Progress modelling work to understand the impact on finances caused by continuing shortages in specialist areas & nursing. 	SG			
Integration Process & Milestones				
<ul style="list-style-type: none"> The four draft integration plans would be submitted to the Board in December. 	AMcM	December 2014	<i>All four schemes submitted and three have now been signed off by the Cabinet Secretary and will be placed before Parliament for 28 days. West Lothian being resubmitted for formal approval on the 26 May.</i>	December Board 4 schemes submitted to Scottish Government by 31 March
Strategic Plan				
<ul style="list-style-type: none"> An updated strategic plan to be brought to the Board in February 2015 to allow work to be concluded and to align with the timescale for the financial planning for the Board and establishment of new integration bodies for 2015 /16. The Board to also receive an implementation plan to deliver the health and inequalities strategy as part of the overall strategic plan in 2014 as well as a similar implementation plan to deliver the cancer strategy to the same timeframe. 	AMcM	February 2015 Board	<i>The Strategic Planning committee has now changed its remit and focus around delivery and implementation of the strategic plan. Full programme of work has been developed for the year.</i>	Progress Report signed off
Integrating Children Services in Lothian				
<ul style="list-style-type: none"> Formal consultation on the proposals to be undertaken between May & July 2014. 	AMcM	July 2014	<i>Children's integration agenda across all four partnerships. First meeting of the new Edinburgh Children's Board of Governance is on the 10 June.</i>	Plans in place. Board Development session will focus on the children's agenda

Action Required	Lead	Due Date	Action Taken	Outcome
<u>Staff Survey Results</u>				
<ul style="list-style-type: none"> The Board would receive a further presentation once the Staff Governance Committee had considered the survey outcomes in detail. 	AB		<i>A presentation will be provided at the April 2015 Board meeting.</i>	In progress
<u>CAHMS and Psychological Therapies</u>				
<ul style="list-style-type: none"> An update paper to be brought to the Board early in 2015. 	AMcM	February 2015	<i>Paper on performance around psychological therapies taken to April Board. New SG allocation of circa £560,000 is being split 50:50 between CAMHS and psychological therapies to support service development and capacity to meet demand.</i>	
<u>Integration Update</u>				
<ul style="list-style-type: none"> Update report to future Board meetings. 	AMcM	December 2014	<i>As above</i>	Draft Schemes and agreed delegation of services signed off at March 'Special' Board
<u>Unscheduled Care Update</u>				
<ul style="list-style-type: none"> Paper to December Board meeting. 	MJ	4 December	<i>Paper on December Board agenda</i>	
<u>Revised Corporate Communications Strategy</u>				
<ul style="list-style-type: none"> Arrange further discussion either at a Development Session or at a future Board meeting. 	AB	Ongoing	<i>Paper to future Board meeting.</i>	

Action Required	Lead	Due Date	Action Taken	Outcome
<u>Waiting Times, Performance, Progress & Elective capacity Investment (01/10/14)</u>				
<ul style="list-style-type: none"> Discuss investments and outcomes at the November Board Development Session. Future reports should include additional explanatory narrative as well as details of resource and capacity increases as well as the outcome form investments. 	JC	December 2014	<i>Full update report on Board agenda. Investments and outcomes that were discussed at the November Board Development Session.</i>	Being developed as part of 2015/16 Capacity Plan
	JC	Ongoing		
<u>Complaints Function</u>				
<ul style="list-style-type: none"> A review of the complaints functions was being undertaken to a tight timescale with the intention being to bring a paper to a future Board meeting to cover all of the complaints issues and to agree with the Board the level of granularity and frequency of future dedicated complaints papers to the full Board. It was agreed that the Director of Human Resources and Organisational Development would circulate a copy of the report to Board members. The main report would be submitted to the April Board meeting after discussion at the March meeting of the Healthcare Governance and Risk Committee. An update report and action plan to the June 2015 Board meeting. 	AB		<i>The complaints review is ongoing and on scheduled. The report is due at the end of January 2015. Progress has been reported to the Healthcare Governance Committee. Workshops have been organised for February. This work is on target for the April Board meeting.</i>	In Progress
	AB			
	MJ	June 2015		
<u>Consultant Vacancies</u>				
<ul style="list-style-type: none"> It should be possible to make recruitment advertisements more specifically focused around Edinburgh with the precedent already having being set through the Edinburgh and Lothian's Health Foundation. The suggestion was made that such an approach could be piloted for the next 20 vacancies. 	AB/DF		<i>Done. All jobs now advertised as "Edinburgh and the Lothian's".</i>	Completed

Action Required	Lead	Due Date	Action Taken	Outcome
<u>Corporate Objectives 2014/15 (1 April 2015)</u>				
<ul style="list-style-type: none"> Final report to be submitted to the June 2015 meeting with a narrative required on any red performance actions. 	AMcM	June 2015	<i>Taken to April Board and signed off</i>	
<u>Corporate Objectives 2015/16</u>				
Quarterly updates to be submitted to the Board.	AMcM	Quarterly	<i>As above</i>	
<u>Financial Position</u>				
<ul style="list-style-type: none"> The July Board Development session would focus on the financial position. 	SG	15/07/15	<i>Development session held</i>	
<u>Improving Older People's Care in Edinburgh</u>				
<ul style="list-style-type: none"> A strategy and costed Action Plan would be presented to the Board in October. 	AMcM	07/10/15		
<u>Public Social Partnerships - A Vehicle for Delivery</u>				
<ul style="list-style-type: none"> Expand further understanding of the issues through further discussion potentially as a future Board Development Session 	AMcM			

NHS Lothian

Board Meeting
5 August 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - PERFORMANCE MANAGEMENT

This paper aims to summarise the key points. The full paper is available to Board members at the meeting.

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

Of the standards and measures considered, 17 are graded red and 3 green.	3
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28 July 2015

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NHS Lothian

Board Meeting
5 August 2015

Director of Strategic Planning, Performance Reporting & Information

PERFORMANCE MANAGEMENT

1 Purpose of the Report

- 1.1 The purpose of this report is to provide an update to the Board on the most recently available information on NHS Lothian performance against HEAT targets and standards. The data as reported is through both local and national systems. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

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

3 Discussion of Key Issues

- 3.1 The HEAT system sets out targets and measures which the NHS Boards are monitored and the following table sets out NHS Lothian's current position against these, with a more detailed description of these being provided under item 4 of the paper where these are not provided elsewhere of the agenda.
- 3.2 Appropriate performance against delivery of targets is maintained through lead directors, committees and local management groups; the performance management paper provides an overview of that achievement.

Summary of Performance Position

Description	Current Status	Lead Director	Detail Available at:
Smoking Cessation.	Red	AKM	Section 4.1
Early Access to Antenatal Care	Green	AMcM	Section 4.2
Carbon Emissions	Red	AB	Section 4.3
Energy Efficiency	Green	AB	Section 4.3
Child and Adolescent Mental Health	Red	JF	Section 4.4
Psychological Therapies	Red	JF	Section 4.4
Delayed Discharge	Red	JC/DF/PG /EM/DS	Board Delayed Discharge Paper
Reduction in Emergency Bed Days	Red	JC/DF/PG/ EM/DS	Section 4.5
Clostridium difficile Infection (CDI) and Staphylococcus aureus Bacteraemia (SAB)	Red	MJ	Board Healthcare Acquired Infection Update
Detect Cancer Early	Red	AKM	Section 4.6
Cancer 31 day performance	Red	JC	Board Acute Services Performance Update
Cancer 62 day performance	Red	JC	Board Acute Services Performance Update
Stroke Bundles	Red	JC	Section 4.7
Inpatients and Daycases	Red	JC	Board Acute Services Performance Update
Outpatients	Red	JC	Board Acute Services Performance Update
18 Weeks	Red	JC	Board Acute Services Performance Update
Diagnostics	Red	JC	Board Acute Services Performance Update
Surveillance Endoscopy	Red	JC	Board Acute Services Performance Update
Audiology	Red	JC	Board Acute Services Performance Update
IVF	Green	JC	Board Acute Services Performance Update

4 Key risks and areas to highlight:

4.1 Smoking Cessation.

(Responsible Director: Director of Public Health and Health Policy)

The latest data published by ISD on Smoking Cessation covers up to 31/12/2014 and shows that the Board's performance was 769 successful quits against a target of 1140.

4.2 Early Access to Antenatal Care

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

The latest data published by ISD covers up to 31/12/2013 and shows that the Board's performance was 87.4% against a target of 76%. This was 15% above target.

Lothian's focus remains on the 10% not being booked within 12 weeks. Actions being taken to mitigate risks are:

- Meetings with ISD to ensure consistency of reporting and comparing of data.
- Regularly reviewing real time data on Maternity TRAK re: Quintiles linked to booking and births.
- Using data collected to inform work with Community Planning Partners and using the Early Years Collaborative methodology to engage women.

4.3 Carbon Emissions and Energy Efficiency Last updated February 2015

(Responsible Director: Director of Human Resources and Organisational Development)

Over the period from April to December 2014, reduction of CO₂ is 1.94% worst than target at 17,620 tonnes of reported emissions against a target of 17,284.

Reduction of energy was 4.27% better than the target of 596,290 GJ at 570,857.

4.4 Child and Adolescent Mental Health Services and Psychological Therapies (Responsible Director: Joint Director, West Lothian)

The waiting times and trajectory for CAMHS is detailed in the following table. In June 57% of children and young people seen for a first treatment were seen within 18 weeks. This level of performance against the target will remain similar as the service continues to focus on those with the longest waits in order to reduce the number of children and young people waiting over 18 weeks. It should be noted that a significant increase in referrals in the last quarter of 2014 which has continued in 2015 has impacted on the performance against the planned trajectory. The services has experienced, on average 45 more referrals each month in the last 6 months compared to the same period in the previous year.

CAMHS Performance Trend

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Percentage seen within 18 weeks*	67%	67%	63%	69%	57%	52%	53%	51%	50%	62%	49%	55%	57%
Trajectory for seen within 18 weeks	85%	88%	88%	88%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Total waiting at end of month	1,547	1,553	1,565	1,724	1,680	1,678	1,784	1,851	1,899	1,704	1,672	1,685	1,677
Those waiting more than 18 weeks	508	514	601	623	526	492	494	428	446	445	478	472	509

An action plan with predicted trajectories based on current capacity and capacity required to meet the 18 week target has been prepared in light of the action above and has been sent to the Minister for consideration. Again the emphasis is on funding and ability to recruit staff in order to be able to achieve the target and clear the backlog by the end of 2016.

Progress with a number of actions around a centralised booking team; referral pathways review and addressing sickness absence are a few of the immediate issues being addressed.

Psychological Therapies

Performance against the 18 week target for patients seen for treatment remains poor (44% in May and 40% in June) and will continue at present level until the considerable backlog of patients waiting over 18 weeks is cleared.

Further work on the demand and capacity for psychological therapies and CAMHS is being undertaken to provide an updated position to the board and support discussions with the Minister in relation to NHS Lothian's performance against the target and actions to be taken to improve access to these services.

Psychological Therapies Trajectory

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Percentage seen within 18 weeks*	52%	52%	32%	52%	40%	36%	36%	44%	34%	41%	39%	44%	40%
Initial Trajectory for seen within 18 weeks	81%	82%	83%	86%	88%	90%	90%	90%	90%	90%	90%	90%	90%
Total waiting at end of month	2438	2442	2542	2645	2911	3010	3113	3095	3105	3176	3190	3341	3261
Those waiting more than 18 weeks	800	802	814	859	910	1018	1144	1201	1167	1237	1254	1257	1173

As with Child and Adolescent Mental Health, an action plan with predicted trajectories based on current capacity and capacity required to meet the 18 week target has been prepared and submitted to the Health Minister for his consideration. The letter sets out what we have done to date as well as further actions which could be taken were funding available. If all funding requests could be met and staff could be recruited we may be able to clear the backlog and have in place a balanced position for 90% patients seen within 18 weeks by the end of 2016 but this would be challenging.

4.5 Reduction in Emergency Bed Days

(Responsible Directors: Chief Officer and Joint Directors)

The Board's performance at 4,853 against a target of 4,745 places is 2.2% above target.

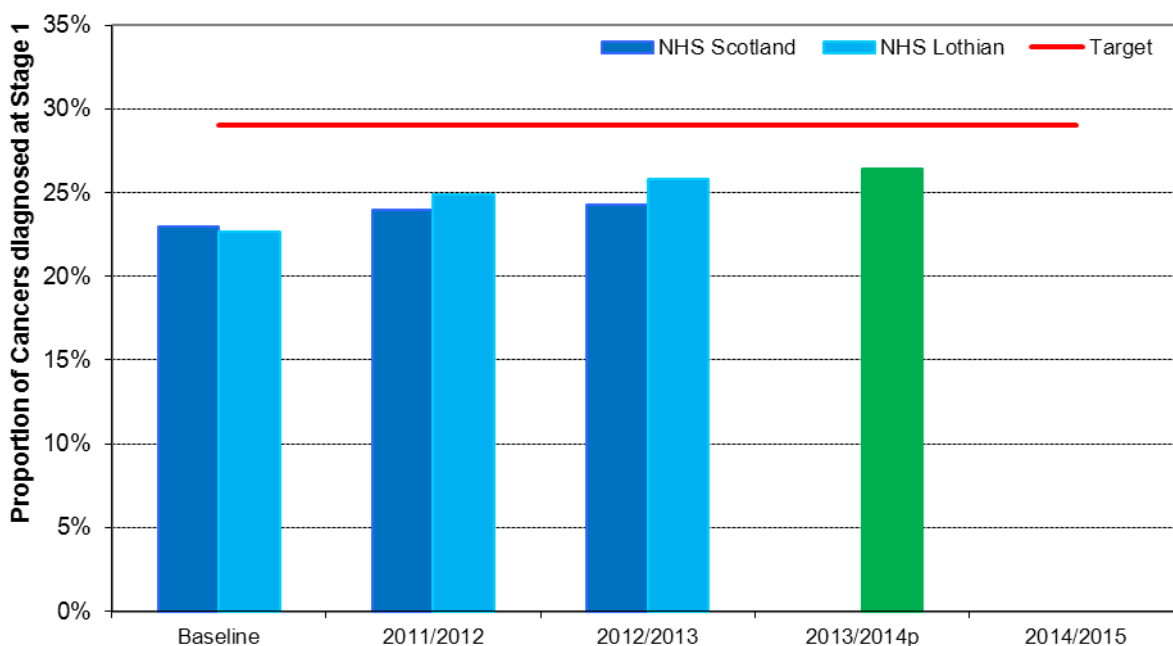
The HEAT target reduces month-on-month by 0.3% with the aim of reducing by 8.7% to 4,709 between April'11 and March'15. Currently the monthly target is at 4,745 (Dec.'14). The latest provided figures (ISD, May 2015) show that for the previous rolling year (Jan.'14-Dec.'14) NHS Lothian has seen an overall decrease of 13.5% (interim) in bed days. Lothian had reported ahead of target in the previous month (0.38%) but increases to the previous 6-month data has returned a slight increase for the rolling year. The likelihood is delays in SMR01 returns which is being followed up.

4.6 Detect Cancer Early

(Responsible Director: Director of Public Health and Health Policy)

The DCE HEAT target is based on increasing the combined proportion of Breast, Bowel and Lung cancers diagnosed as stage 1 cancer.

The chart below provides an update, based on national ISD published data, against the HEAT target. Current published performance is shown for both NHS Scotland overall (1st bar in each year shown), and for NHS Lothian (second bar in each year shown). The final (green) bar shown for the period 2013/2014 provides the most up to date performance data for the NHS Lothian local programme. This is based on local programme management data which covers all of calendar years 2013 and 2014.



Since the DCE programme baseline position NHS Lothian's performance has moved from 22.64% (Scotland: 22.96%) to 25.80% (Scotland:24.30%) , based on national, validated ISD published data.

Our local programme management information shows a further positive movement to **26.4%** of breast, lung, and bowel cancers diagnosed at stage 1. Validated national data for the 2013 & 2014 period will be published by ISD on the 18th of August 2015. A national target of 29% of breast, lung, and bowel cancers combined, diagnosed at stage 1, is to be reached by the end of 2015.

4.7 Stroke

(Responsible Director: Chief Officer)

Lothian's performance against the bundle has been inconsistent: March 62.4%, April 65.7% and May 57.4%. The stroke bundle target to be met by March 2016 has recently been agreed by the Chief Officer and service managers and is increased from 65% to 70%. Service managers and the Board felt it was important to set a trajectory that would challenge the current performance and drive improvement and consistency.

Since last financial year 2014/15, stroke performance has been monitored against a composite stroke bundle, which measures the proportion of patients with an initial diagnosis of stroke receiving four key elements of care. NHS Boards are expected to demonstrate an increase in the number of patients receiving the bundle. From March 2015 to May 2015 performance in each of the four elements changed as follows;

- Access to a stroke unit by the day after admission – decreased from 73.3% to 66.7% [March 73.3%, April 77.5% and May 66.7%] (local target = 85%)
- Imaging undertaken within 24 hours – remains stable and consistently exceeding the national target [March 97%, April 96.1% and May 95.1%] (national target = 90%)
- Swallow screen on the day of admission – increased from 83.2% to 83.6% [March 83.2%, April 81.4% and May 83.6%] (local target = 90%)
- Aspirin by the day following admission – decreased from 87.9% to 85.9% [March 87.9%, April 89.6% and May 85.9%] (local target = 90%)

In May, 68 patients received the stroke bundle of care compared to 62 in April. However due to the increased activity, (122 in May compared to 102 in April) this resulted in a lower performance (57.4% compared to 65.7%).

An NHS Lothian Stroke Collaborative has been formed to lead cross site improvement work for Lothian with an initial focus on sustainable delivery of the stroke standards. The group met for the first time in mid June to review each site's patient pathway and agree a number of tests of change.

The stroke unit nursing teams across the sites have focussed on completing online stroke education modules and registering for the stroke training sessions to ensure all staff nurses are appropriately skilled. This is monitored by the Stroke Improvement Team at the Scottish Government and backfill money is available for study leave. Outreach models and processes are continuing to be developed, and will be modified and enhanced under the leadership of the new charge nurses at both RIE and WGH when they took up their appointments in June/July.

The disappointing performance in aspirin treatment was discussed at the six-monthly review of our performance by the Stroke Improvement Team on 29th June. This has now been investigated and with missing records now included this has now increased to 91% for May.

5 Risk Register

- 5.1 Responsible Directors have been asked to ensure that any risks associated with their targets have been clearly identified within the risk register. Risks are escalated to the corporate risk register as appropriate i.e. delayed discharges.

6 Impact on Inequality, Including Health Inequalities

- 6.1 As a report on progress, this paper does not require impact assessment in its own right. The HEAT performance framework has been subjected to impact assessment, with programmes assessed individually for impact on health inequalities in the wider population since April 2010 rather than overall.

7 Involving People

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

8 Resource Implications

- 8.1 There are no resource implications relating directly to the provision of this report. Financial implications are reported as appropriately to the Board, CMT and other committees.

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Board Meeting
5 August 2015

Medical Director

SUMMARY PAPER - CORPORATE RISK REGISTER

This paper summarise the key points in the full paper.

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

	Para
<ul style="list-style-type: none"> • The top 4 risks at Very High 20 are:- <ul style="list-style-type: none"> ○ Healthcare Associated Infection ○ Achieving the 4-Hour Emergency Care standard ○ Achieving the Delayed Discharge targets at 2 and 4 weeks ○ The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. 	3.2.1
<ul style="list-style-type: none"> • Table 1 sets out a Quarter 1 update of the NHS Lothian Corporate Risk Register as approved by the April 2015 Board. 	3.2.2
<ul style="list-style-type: none"> • A number of emerging risks and rationales will be presented to the Audit & Risk Committee in August 2015 for inclusion on the Corporate Risk Register. These include General Practice Workforce Sustainability, Nursing Workforce Sustainability and Facilities Fit for Purpose. These risks will be set out in the October 2015 Board Corporate Risk Register paper for discussion. 	3.4
<ul style="list-style-type: none"> • The Risk Register review findings against the Audit Scotland Best Value Toolkit for Risk Management were approved by the June 2015 Audit & Risk Committee, along with an improvement plan. 	3.5.1
<ul style="list-style-type: none"> • Compliance with NHS Lothian's Risk Appetite is set out in Table 2, which suggests NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 2/2.2: Deliver Safe Care), patient experience (Corporate Objective 2/2.1: Deliver Person-centred Care) and improving the way we deliver unscheduled care (Corporate Objective 2/2.3: Appropriate Unscheduled Care). NHS Lothian is also outwith risk appetite for health population (Corporate Objective 1) and Financial Planning (Corporate Objective 3/3.1), where a medium appetite has been set. 	3.6

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14 July 2015
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NHS Lothian

Board Meeting
5 August 2015

Medical Director

NHS Lothian Corporate Risk Register

1 Purpose of the Report

- 1.1 The purpose of this report is to set out NHS Lothian's Corporate Risk Register for assurance.

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

2 Recommendations

- 2.1 Use the updated NHS Lothian Corporate Risk Register; highlights of which are contained in section 3.2 and set out in detail in Appendix 1 to inform assurance requirements
- 2.2 Reflect on the current position that NHS Lothian remains outwith its Risk Appetite on corporate objectives where low risk appetite has been set.
- 2.3 Note that the June Audit & Risk Committee approved the risk review findings and improvement plan.

3 Discussion of Key Issues

- 3.1 As part of our systematic review process, the risk registers are updated on Datix on a quarterly basis at a corporate and an operational level. Risk are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used, is based on the same risk scoring matrix, remains unchanged.
- 3.2 This report sets out the Quarter 1 position. Table 1 below provides a summary of the corporate risks and movement in risk grading over last 4 quarters. Appendix 1 provides additional details of each individual risk with recent 2015 updates. When a risk's adequacy of control is inadequate or uncertain, the rationale is stated on the individual risk.
- 3.2.1 There are 10 risks in total; the top 4 risks at Very High 20 are:-
- Healthcare Associated Infection
 - Achieving the 4-Hour Emergency Care standard
 - Achieving the Delayed Discharge targets at 2 and 4 weeks
 - The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.

3.2.2 If you have an electronic version of this report, links to each risk in Appendix 1 have been embedded in the below table (please click on individual Datix risk number in the table).

Table 1

Datix ID	Risk Title	Initial Risk Level	Jul-Sept 2014	Oct-Dec 2014	Jan-Mar 2015	Apr-Jun 2015
1076	Healthcare Associated Infection (Standing item on Board Agenda)	High 12	High 16	High 16	↑ Very High 20	Very High 20
3600	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge. (Standing item on Board Agenda)	High 12	High 12	High 12	↑ Very High 20	Very High 20
3203	Achieving the 4 hour emergency target (split into two separate risks March 2015 – 3203 & 3726)	High 10	High 10	High 10	↑ Very High 20	Very High 20
3726	Achieving the Delayed Discharge targets at 2 and 4 weeks (new risk)	Very High 20	-	-	Very High 20	Very High 20
3480	Patient Safety - Delivery of 4 SPSP Workstreams. (Safety Measures in Quality Report)	High 16	High 16	High 16	High 16	High 16
3211	Achievement of National Waiting Times Targets (Standing Board Agenda item under Performance Report)	High 12	High 12	High 12	↑ High 16	High 16
3454	Patient Experience – Management of Complaints and Feedback. (Complaints reporting and Person-Centred Culture Programme reported to Board)	High 12	High 12	High 12	↑ High 16	High 16
3527	Medical Workforce Sustainability	High 16	High 16	High 16	High 16	High 16
3455	Health & Safety – Management of Violence & Aggression. (Reported at H&S Committee, via Staff Governance Committee Minutes)	Medium 9	High 15	High 15	High 15	High 15
3567	Health & Social Care Integration	High 16	High 16	High 16	↓ Medium 9	Risk Closed 26/06/15

3.3 The risk concerning the development of NHS Lothian Integration Schemes has been closed as they have now been approved. Service risks related to integration are being examined to inform NHS Lothian risk reporting at a local and corporate level.

3.4 A number of emerging risks were examined by the RMSG in June 2015 and have been discussed at Board governance committees. These are General Practice Workforce Sustainability, Nursing Workforce Sustainability and Facilities Fit for Purpose. These risks will be set out in the October 2015 Board Corporate Risk Register paper for discussion.

3.5 Review of NHS Lothian Risk Registers

In June 2014, the Audit & Risk Committee approved a review of NHS Lothian’s risk management system using the Audit Scotland Best Value Toolkit for Risk Management. The review methodology included a review of documentation and discussions with RMSG members and senior management teams to assess current strategy and practices against Audit Scotland’s matrix and identify opportunities for improvement. Discussion sessions were held with a sample of senior/clinical teams and relevant risk registers were reviewed.

3.5.1 The review has been completed and the findings have been presented and approved at the June 2015 Audit & Risk Committee.

3.6 Risk Appetite Reporting Framework

NHS Lothian’s Risk Appetite Statement is:-

“NHS Lothian operates within a low overall risk appetite range. The Board’s lowest risk appetite relates to patient and staff safety, experience and delivery of effective care. The Board tolerates a marginally higher risk appetite towards delivery of corporate objectives including clinical strategies, finance and health improvement.”

Table 2

	Current Status	Current Position	Data Report
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.2 Deliver Safe Care) Low Risk Appetite			
<ul style="list-style-type: none"> Scotland target to reduce acute hospital mortality by 20% (Scotland-14.4%) with a tolerance of 15-20% by Dec 2015 ¹ 	Green	12.7%	Quality Report (Graphs 7-9)
<ul style="list-style-type: none"> Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015 	Green	99.7%	Patient Safety Programme Annual Report (July)
<ul style="list-style-type: none"> Achieve 184 or fewer SAB by March 2015 with a tolerance of 95% against target. n=193 to 184 	Red	311 (as at June 2015)	Quality Report (Graph 12) HAI report on Board Agenda
<ul style="list-style-type: none"> Achieve 262 or fewer C.Diff by March 2015 with a tolerance of 95% against target. n=275-262 	Red	361 (as at June 2015)	Quality Report (Graph 11) HAI report on Board Agenda
<ul style="list-style-type: none"> Reduce falls with harm by 20% with a tolerance of 15-20% by Dec 2015 	Green	20%	Quality Report (Graph 15)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.1 Deliver Person-centred Care) Low Risk Appetite			
<ul style="list-style-type: none"> 95% of patients would rate their care experience as good/very good, with a tolerance of 93-95% 	Green	98%	In-depth patient surveys, Person Centred Culture paper

¹ This is a Scotland-wide target which NHS Lothian will contribute to.

	Current Status	Current Position	Data Report
<ul style="list-style-type: none"> 90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95% 	Tbc	Tbc	To be collected
<ul style="list-style-type: none"> Staff absence below 4% with a 5% tolerance (4-4.2%) 	Red	4.7%	Quality Report (Graph 6)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.4 Scheduled Care & Waiting Times) Low Risk Appetite			
<ul style="list-style-type: none"> 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90% 	Green	87%	Scheduled Care Report
<ul style="list-style-type: none"> 95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95% 	Green	92%	Quality Report (Graph 18)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.3 Appropriate Unscheduled Care) Low Risk Appetite			
<ul style="list-style-type: none"> 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98% 	Red	94%	Quality Report (Graph 17) Unscheduled Care report on Board Agenda
<ul style="list-style-type: none"> No of patients will wait no more than 14 days to be discharged by April 2015 with a tolerance of 13 to 14 days 	Red	109	Quality Report (Graph 5)
<ul style="list-style-type: none"> No of patients will wait no more than 28 days to be discharged from hospital by April 2015 with a tolerance of 26-28 days 	Red	71	Quality Report (Graph 5)
<ul style="list-style-type: none"> 90% of all stroke patients to be admitted to stroke unit on day of admission following a stroke with a tolerance of 85-90% 	Red	66.7%	Quality Report (Graphs 19-21)
Corporate Objective 1 – Protect & Improve the Health of the Population. Medium Risk Appetite			
<ul style="list-style-type: none"> Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas 	Red	32.5%	Performance Report on Board Agenda
<ul style="list-style-type: none"> At least 80% of women in each SIMD percentile will be booked for antenatal care by 12th week of gestation 	Green	87.4%	Performance Report
Corporate Objective 3 – Secure Value & Financial Sustainability (LDP 2015-16 – 3.1 Financial Planning) Medium Risk Appetite			
<ul style="list-style-type: none"> In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5% 	Red	£2,487k overspend at period 2 (inc. unachieved LRP), equating to 2.3%	Period 2 Finance Report Finance report on Board Agenda
<ul style="list-style-type: none"> For the year to date, the overspend against the total core budget for the year to date is not more than 0.1% 	Red	£4,188k overspend for the year-to-date (inc. unachieved LRP) equating to 1.9%	Period 2 Finance Report

3.6.1 The above reporting would suggest NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set with respect to patient safety (Corporate Objective 2/2.2), patient experience (Corporate Objective 2/2.1) and improving the way we deliver unscheduled care (Corporate Objective 2/2.4). NHS Lothian is also outwith risk appetite for health population (Corporate Objective 1) and Financial Planning (Corporate Objective 3/3.1), where a medium appetite has been set.

4 Key Risks

4.1 The risk register process fails to identify, control or escalate risks that could have a significant impact on NHS Lothian

5 Risk Register

5.1 Not applicable.

6 Impact on Health Inequalities

6.1 The findings of the Equality Diversity Impact Assessment are that although the production of the Corporate Risk Register updates, do not have any direct impact on health inequalities, each of the component risk areas within the document contain elements of the processes established to deliver NHS Lothian's corporate objectives in this area.

7 Resource Implications

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

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22 July 2015
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List of Appendices

Appendix 1: Summary of Corporate Risk Register
Appendix 2: Corporate Objectives – Rationales for Tolerances

NHS Lothian Corporate Risk Register

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
1076	2: Improve the quality and safety of health care	Healthcare Associated Infection	<p>Healthcare Associated Infection: There is a risk of patients developing an infection as a consequence of healthcare interventions; this can lead to an extended stay in hospital, increased mortality and morbidity and further treatment requirements. Factors that can contribute to the development of HAI are: failures in leadership or weak governance arrangements; absence of, or inadequate training and education; poor communication; absence of robust surveillance systems, poor antimicrobial stewardship, failure to comply with Infection Prevention and Control Policies and procedures; poor practice in relation to invasive devices; inadequate decontamination of equipment and the environment and the use of equipment that is not safe for use. It should also be noted that some healthcare associated infections can also result from unintended consequences of appropriate treatment.</p> <p>The consequences of poor practice relating to prevention of healthcare associated infection could lead to increased incidence of infection or outbreaks which result in harm to patients, visitors, staff and the wider public. This has the potential to adversely affect the organisation through impact on capacity, patient flow and adverse publicity damaging the reputation of NHS Lothian.</p>	<p>Leadership and Governance: UHS and CHP Infection Prevention and Control Committees are well established and report to board through LICAC. In addition to LICAC and local committees, Infection Prevention and Control routinely report at a senior management level to CMG/Healthcare Governance and bi-monthly board papers. NHS Lothian has an Infection Prevention & Control team in place. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid & East and West Lothian) established with responsibility for both acute and community settings within their remits.</p> <p>Education: There is a HAI Education Strategy which defines the training and education requirements for staff of all disciplines across the organisation. Line Managers have a responsibility to identify appropriate courses and ensure compliance with mandatory education as part of personal development planning and performance appraisal. IPCT develop, deliver and evaluate a range of education and training packages in response to local and organisational needs. HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro. IPCT provide support for NES Cleanliness Champions Programme accessible to all staff to increase an understanding of Infection Prevention and Control Precautions.</p> <p>Communication: IPCNs work collaboratively with clinical and non clinical services to communicate risk, support improvement and escalate concerns as appropriate. A Problem Assessment Group (PAG) or Incident Management Teams (IMT) is convened to investigate and manage any significant event or outbreak. These teams are supported by the wider multi-disciplinary team and any external stakeholders as appropriate. The Communications Team provide support to manage public release of information as required. The Infection Prevention and Control Service provides a single point of contact duty nurse 7 days per week between 0830-1600hrs facilitating access to Infection Prevention and Control advice for clinical teams, which includes notification to clinical areas of incidences of alert organisms.</p> <p>Surveillance IT systems are in place to allow IPCNs to monitor incidence, trends and patterns of HAI within their clinical remits. Weekly and Monthly reports with progress made against HEAT Targets are shared with clinical teams and senior management and are widely available on the Intranet. Clinical Teams carry out a Clinical Risk Assessment (CRA) to identify patients potentially at risk of MRSA colonisation on admission/transfer as they could potentially pose a risk to themselves and others of acquiring an infection. Patients positive to MRSA have an associated Trak alert supporting clinical teams to identify and take appropriate action to minimise the risk. Enhanced investigation and surveillance is carried out of all SAB and CDI incidences. An SBAR Report is provided to clinical and senior management teams where 2 or more cases are identified within the same clinical area within a defined timescale. NHS Lothian complies with all mandatory surveillance reporting requirements outlined within HDL 2006 (38).</p>	<p>Risk Reviewed: June 2015</p> <p>Risk has been updated to reflect the HAI Standards released Feb 2015. Control measures have been reviewed and updated.</p> <p>Risk and control measures have been reviewed against the Risk assessment matrix and has been reassessed from almost certain to possible and target from possible to unlikely</p> <p>Risk Grade/Rating decreased High/12</p> <p>Currently there is no dedicated ICD in NHS Lothian there is potential for loss of strategic leadership medical role within Infection Prevention and Control (IPC). With no designated lead there is inconsistent representation and potential for conflicting advice and opinions in meetings, policy development guidance reviews. There has also been a negative impact through the loss of the role on site specific support for joint clinical working between medical microbiology and infection prevention and control nursing. In addition, the Professional Meeting which was a joint meeting between Senior Infection Prevention and Control Nurses and Medical Microbiologist/Virologists has been temporarily suspended due to staffing shortages within the medical team and the need to prioritise clinical aspects of work. This has potential to reduce cohesive and joint approach to working between medical and nursing teams and impact on the progress and development of joint pieces of work such as policies and standard operating procedures.</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 4	Melanie Johnson	Fiona Cameron	Healthcare Governance Committee

1076	2: Improve the quality and safety of health care	Healthcare Associated Infection	<p>Controls Continued:</p> <p>Antimicrobial Stewardship The Antimicrobial Management Team are responsible for the review and development of the Antimicrobial Prescribing Guidelines. They also provide oversight of antimicrobial use and compliance with guidelines and report findings to clinical teams to help drive improvement. Summary Reports are also provided to Clinical Management Team. NHS Lothian has 2 (1.6 WTE) dedicated antimicrobial pharmacists within the Antimicrobial Management Team who provide specialist advice and support to the organisation in the development of guidance and policy.</p> <p>Policies and Guideline NHS Lothian has adopted the National Infection Prevention and Control Manual and has an ongoing programme of 2 yearly policy and development review. A range of other procedures and guidelines and resources are available to staff via the intranet. In addition to the monitoring for Standard Infection Control Precautions there is an established programme of Patient Experience Quality Indicator (PQI) Audits. This audit takes place at two levels, level 1 Clinical Management Teams and, level 2 Senior Management. Results and progress against action plan from the PQI's are monitored through local site management groups and the Healthcare Environment Inspectorate (HEI) Steering Group. Audit results are posted through the patient safety programme QIDs system, allowing clinical areas to directly enter data onto database and obtain reports to monitor own trends and patterns. The QIDs system also allows reporting and monitoring against the collection of tools developed by Patient Safety Programme to support good practice to minimise potential risk for patients.</p> <p>Invasive Devices: Clinical Teams monitor compliance with invasive devices care bundles and are supported in making improvements by the Scottish Patient Safety Programme Team.</p> <p>Decontamination: There is a Decontamination Strategy Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment. There is an established programme of Domestic and Estates monitoring which provides oversight of compliance with national cleaning specification and other standards.</p> <p>Procurement of Equipment NHS Lothian's Procurement Strategy in support of the Efficiency and Productivity Programme and the Medical Devices Committee oversee the purchase of procurement and the supply of equipment and medical devices with input from the IPCT. In addition, IPCT contribute to Commodity Advisory Panels both locally and nationally as required.</p> <p>ICD Individual Medical Microbiologists have remit areas and can be contacted by IPCNs for advice. The Clinical Scientist within the IPCT shadowed the ICD for CDI ward rounds and continues to provide support. Ward rounds are undertaken by Infectious Diseases Consultant and Medical Microbiologists. It has been agreed that it would be appropriate for the IPCNs to join this round and patients giving cause for concern will be added to the medical ward round. Long term it is essential this role gap is addressed and Microbiology are currently in the progress of recruiting consultants to address the service gaps. Once fully recruited the ICD role will be revisited.</p>	A review into maximising multi-disciplinary working across a range of professionals providing infection control advice and support is taking place.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 4	Melanie Johnson	Fiona Cameron	25/06/2015
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ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3600	3: Secure Value & Financial Sustainability	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	<p>NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target.</p> <p>On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years.</p> <p>The December 2014 Finance Board paper update the Board on the current financial challenge.</p> <p>If the Board and management fail to systematically and robustly respond to this challenge now it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.</p>	<p>The Board has already established a financial governance framework and systems of financial control.</p> <p>NHS Lothian is currently reliant on non-recurring efficiency savings. A detailed Action Plan, attached to this risk, is in place and is regularly reviewed by the Senior Finance Team.</p> <p>Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years, combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested.</p>	<p>Risk Reviewed: July 2015</p> <p>Month 3 Finance report indicates the controls are not working.</p> <p>Detailed plan to review financial performance in each area to agree action for recovery.</p> <p>Quarter 1 review planned with Scottish Government. Longer term plan being prepared to align recovery with Quality Improvement.</p> <p>Risk Grade/Rating remains Very High/20</p>	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Susan Goldsmith	Craig Marriot	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3203	2: Improve the quality and safety of health care	Unscheduled Care: 4 hour Performance	<p>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 98% resulting in sub optimal care experience and outcome.</p>	<p>A range of governance controls are in place for Unscheduled Care notably:</p> <ul style="list-style-type: none"> - Bi monthly NHS Lothian Board oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area. -The bi-monthly Acute Hospitals Committee as well as formal SMT meetings. Both are chaired by the Director for Unscheduled Care. - The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis. - Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, StJ). - NHS Lothian's Winter Planning Project Board will be responsible for ensuring sustainable performance throughout the winter period <p>A number of performance metrics are considered and reviewed, including:</p> <ul style="list-style-type: none"> - 4 hour Emergency Care Standard and performance against trajectory - 8 and 12 hour breaches - Attendance and admissions - Delayed Discharge (see Corporate Risk ID 3726) - Boarding of Patients - Winter Planning - Length of Stay (LOS) - Cancellation of Elective Procedures - Finance <p>Adherence to national guidance/ recommendations</p> <p>Plethora of work now focussed around the Scottish Government's <i>6 Essential Actions</i> initiative to support achievement of 98% target for 4 hour performance.</p>	<p>Risk Reviewed: July 2015 Risk Grade/Rating remains Very High/20 Following Risk being reviewed in March 2015 A&R Committee, agreement reached in developing separate controls/ plans for achieving goals for 4 hour performance and Delayed Discharge Work is being developed in line with the Scottish Governments 6 Essential Actions initiative. Following launch in May, Boards now involved in taking forward set of actions (per site) to support a step change in performance. Priority interventions will focus on:</p> <ul style="list-style-type: none"> • Clinical Leadership • Escalation procedures • Site safety and flow huddles • Workforce capacity • Basic Building blocks models • Proactive discharge • Flow through ED/ Acute Receiving • Smooth admission/ discharge profiling <p>Further work will be absorbed as part of our winter planning arrangements that support improvements in 4 hour performance and are sustainable throughout the winter period. This will be led by the Winter Planning Project Board</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jim Crombie	Neil Wilson	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3726	2: Improve the quality and safety of health care	Unscheduled Care: Delayed Discharge	There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	<p>A range of governance controls are in place for Unscheduled Care notably:</p> <p>NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area.</p> <p>The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a fortnightly basis</p> <p>The bi-monthly Acute Hospitals Committee as well as formal SMT meetings.</p> <p>Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON</p> <p>NHS Lothian's Winter Planning Project Board will be responsible for ensuring sustainable performance throughout the winter period</p> <p>A number of performance metrics are considered and reviewed, including:</p> <ul style="list-style-type: none"> - Attendance and admissions - No. of Delayed Discharges (by Local Authority Area) - Length of Stay (LOS) - Bed Days Lost <p>NHS Lothian strategy to improve unscheduled care performance and delayed discharge is being delivered under the umbrella of the Scottish Government's <i>6 Essential Actions</i> initiative.</p>	<p>Risk Reviewed: July 2015 Risk Grade/Rating remains Very High/20</p> <p>Action to help tackle DD across NHS Lothian include:</p> <ul style="list-style-type: none"> • Creation of Community Clinical Support Workers • Hospital to Home' pilot in partnership with a voluntary organisations • Rapid Elderly Assessment Team (REACT) service in West Lothian • Comprehensive Assessment for Elderly People COMPASS (Edinburgh) • Implementation of 'Discharge to Asses' models • Discharge Hubs in the Royal Infirmary of Edinburgh, the Western General Hospital and St John's Hospital • Orthopaedic Pathway Review • Joint Venture with CEC to create additional bed capacity • implementation of the 'Moving On' guidance <p>Recent performance has resulted in NHS Lothian formally escalating its concerns with City of Edinburgh Council in July 2015 re its discharge profile/ discharge capacity and the impact this is having on patient experience and overall performance</p> <p>The Winter Planning Project Board met on 1st July 2015 and has identified the need for robust joint winter readiness plans to be in place by November 2015. This will include details on:</p> <ul style="list-style-type: none"> • Agreed data set to assist with developing a wider capacity plan that covers all health and social care areas • Plans will have a focus on discharge capacity as well as bed capacity • Clear measures in terms of escalation procedures • Counter any demand as a result of the extended 4 day break during the festive period. • Dealing with DD will be imperative to ensuring sustainable performance throughout the winter period. <p>Monthly meetings in place through to November – the next meeting due to take place on 19th August 2015.</p>	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jim Crombie	Neil Wilson	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3480	2: Improve the quality and safety of health care	Delivery of SPSP Work Programme	There is a risk that NHS Lothian does not reliably implement the 4 workstreams of the Patient Safety Programme leading to potential patient harm	<ul style="list-style-type: none"> The Quality Report, reported to the Board monthly, contains a range of measures that impact and relate to patient safety. Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response. The Patient Safety Programme reports to relevant governance committees of the Board setting out compliance with process and outcome safety indicators and includes external monitoring. Incident Management Policy and Procedure (2011). Quality Improvement Strategy (2011-14) sets out a range of improvement programmes to improve safety and outcomes of care. Quality of care which includes patient safety issues is subject to internal audit and compliance with recommendations, and is reported via Audit & Risk Committee and HCG Committee when appropriate. Quality Assurance Mechanism proposed to validate self reporting of patient safety data Quarterly visit by HIS to discuss progress actions and monthly submission of data Adverse Event Improvement Plan in place monitored via HCG Quality Management Group at the Board initiated to strengthen governance, monitor and inform improvement of a range of improvement programmes including Patient Safety Programme. Site Based Quarterly Reports including Patient Safety Data (QIDS) sent monthly. Single System medicines reconciliation group. 	<p>Risk Reviewed June 2015:</p> <p>Improvements can be demonstrated but compliance with 10 Essentials is variable and priorities work at testing phase. Outcomes have shown improvements but not achieved all SPSP goals. Risk grade/rating to remain High/16</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Dr David Farquharson	Jo Bennett	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3211	2: Improve the quality and safety of health care	Achievement of National Waiting Times Targets	<p>There is a risk of:</p> <p>Lack of management of national waiting times targets for a number of reasons due to lack of core capacity or appropriate use of what is available</p> <p>Overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money.</p> <p>Lack of robust management process and staff capability to deliver consistent management of waiting lists.</p> <p>Risk of adverse publicity relating to failure to meet waiting times targets.</p>	<p>Monthly Access Performance and Government Group meeting chaired by Director of Planning, Performance Reporting and Information oversees this area. These are supplemented by weekly scheduled reviews between this Director and Directors of Operations.</p> <p>It considers:</p> <ul style="list-style-type: none"> • Performance against trajectory across a range of measures (including waiting time standards) • Finance • Governance position, in terms of adherence to national guidance and local access policy/SOPs <p>This meeting reports to the Acute Services Committee with a comprehensive overview on governance arrangements provided in September 2014.</p> <p>Papers on CAMHS and psychological therapies presented to the Board in April 2015 outlining difficulties in delivering standards of 18 weeks coming into force in December. Further investments were approved.</p>	<p>Risk Reviewed: July 2015</p> <p>Controls updated.</p> <p>Risk Grade/Rating remains High/16</p>	Satisfactory: controls adequately designed to manage risk and working as intended	High 16	Low 1	Jim Crombie	Andrew Jackson	NHS Lothian Board

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3527	3: Secure value and financial sustainability	Medical Workforce Sustainability	<p>There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff.</p> <p>Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.</p>	<ul style="list-style-type: none"> •In response to a request from the SEAT Planning Board, a medical workforce risk assessment tool has been developed and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. •For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group. This group will co-ordinate actions across Boards within SEAT and feed into the national medical workforce planning processes co-ordinated by NES/SG. •A report is taken to each Board meeting updating the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. The main challenges have been in Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Radiology and Medicine for the Elderly. •For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. •A Medical Workforce Group has being established who are looking at medical workforce issues in Ophthalmology and Radiology. The group will also be looking at the Greenway Report on 'Shape of Training' and how this framework should support changes to the medical staffing model. 	<p>Reviewed by A&R Committee 17/02/2015</p> <p>Agreed risk should remain on Corporate Risk Register.</p> <p>June 2015: Risk Reviewed</p> <p>Risk Grade/Rating remains as High/16.</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Dr David Farquharson	Nick McAlister	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3454	2: Improve the quality and safety of health care	Management of Complaints and Feedback	<p>There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times.</p>	<p>NHS Lothian Board approved in full the Listening and Learning form Feedback and Complaints report (Jan 2015) proposes a devolved approach to complaints and feedback. Organisational change process will dissolve the current Customer Relations & Feedback Team and a new Patient Experience Team will be established. The Head of Patient Experience was appointed in June 2015. This team will bring together complaints and feedback with patient experience and provide enhanced reporting arrangements to the committees and Board.</p> <p>In January 2015 the first Person Centred Culture report was presented to the Healthcare Governance Committee and brings together complaints performance and patient experience reports</p> <p>As of May 2015 sickness / absence within the current CRaFT remains high at 32% and complaints performance against the 2 national targets will be improved</p> <p>In June complaints and feedback reports have been sent to the operational management teams to identify those complaints that are over 50days</p> <p>The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care.</p> <ul style="list-style-type: none"> The Healthcare Governance Committee provides assurances to the Board on person-centred, safe, effective care provided to patients across NHS Lothian as set out in its Assurance Need Statement, including clinical incident reporting and response. The Quality Improvement Strategy (2011-14) set out a range of improvement programmes to improve patient experience and outcome of care. <p>The National Person Centred Health & Care Programme has been concluded and work is being undertaken nationally to embed patient experience into the existing quality improvement programmes.</p> <p>Tell us Ten Things questionnaire was reviewed in November 2014 and aligned to the "5 Must dos". This has now been rolled out to the three main adult hospitals and further discussions are required as to wider dissemination</p> <ul style="list-style-type: none"> Delivering Better Care commitments have been agreed and plans are now in place to deliver on the required actions from the HIS Older People's review and the updated vulnerable Patient's Quality Improvement Framework. This activity is reported to the Board through the Executive lead. These plans are informed by inspection reports produced by Healthcare Improvement Scotland, local audit and regular checks i.e. PQI, mock OPAH ,frailty bundle audit and via the Clinical manager ward assurance checklists. The tools in use have been adapted and updated to reflect the person centred agenda. <p>HIS Older People in Acute Care had their initial Board Assessment day on 16th April 2014, an unannounced inspection is awaited. There has been intense work on each of the Adult Acute Sites to raise the profile of OPAH and each site has a nominated lead.. The new Older peoples Standards were published in June ; Board will be notified when they will be assessed against these new standards. The PQI tool is being amended and currently in the test phase..</p> <ul style="list-style-type: none"> Quality of care is subject to Internal Audits and compliance with audit recommendations reported via Audit & Risk Committee and Healthcare Governance Committee The Delivering Better Care established on 2012 as a resource for staff (primarily nursing) but where appropriate, other disciplines continue to deliver support to clinical areas on the key ambitions of harm reduction work is now on going to streamline programmes of work for 2015/16 working more closely with Clinical Governance and using improvement methodology. As part of the improving care to vulnerable patient's support manual with detailed information inclusive of a rapid patient essential care check sheet was implemented within acute and community In patient facilities during 2013 and has recently been reviewed and the e-version on all PC's has been updated. <p>March 2015 the Vulnerable People Manual was refreshed and updated, there is ongoing work on the web page.</p> <p>Rationale for Adequacy of Controls is through the newly developed quality management group discussions are ongoing.</p>	<p>Risk Reviewed: July 2015</p> <p>Risk reviewed and controls updated.</p> <p>Risk Grade/Rating remains High/16</p>	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Medium 6	Melanie Johnson	Jeannette Morrison	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3455	2: Improve the quality and safety of health care	Management of Violence & Aggression	There is a risk of Corporate Prosecution by HSE under the Corporate Homicide Act or the H&S at Work Act Section 2, 3 and 33 or any relevant H&S regulations If the risk from violence and aggression incidents are not adequately controlled. Highest risk would be under H&S at Work Act Section 2 and 3. If we harm our staff (2) or visitors to our sites (3). There is also a statutory requirement to provide an absolute duty of care regarding NHS Lothian staff safety and well being.	<ul style="list-style-type: none"> •Closed loop Health & safety management system in place. •Robust H&S Committee structure. •Violence & Aggression related policies and procedures in place (attached document). •Competent specialist V&A and H&S advice in place. Robust Occupational Health Services. Learning lessons through incident investigation. • The Interim Director of Occupational Health & Safety delivers an annual report to the NHSL H&S Committee with specific actions related to controlling violence & aggression risk within these reports. <p>ROSPA OSA Audit complete and action plan in place. NHS Lothian Health and Safety Strategic Plan endorsed. Specific actions related to controlling violence & aggression risk are contained within these reports.</p>	<p>Risk Reviewed: June 2015</p> <p>The "Description" and "Controls In Place" columns have been adapted to reflect a particular focus on Violence and Aggression Risks.</p> <p>Risk Grade/Rating remains High/15</p>	Adequate but partially effective; control is properly designed but not being implemented properly	High 15	Medium 6	Alan Boyler	Ian Wilson	Staff Governance Committee

Corporate Objectives – Rationales for Tolerances

Corporate Objective 2/2.2 - Improve the Quality & Safety of Healthcare (Low Risk Appetite)

1. High reliable organisations within Health and outwith Health consider safety improvement a key organisational priority.
2. National indicators and targets for the Patient Safety Programme and Health Protection Scotland are as follows:-
 - Reduce Acute Hospital Mortality by 20% by December 2015 (SPSP)
 - Achieve 95% harm free care by December 2015 (SPSP)
 - To achieve 184 or less SAB by March 2015 (HEAT)
 - To achieve 254 or less CDI by March 2015 (HEAT)
 - Reduce falls with harm by 20% by December 2015 (SPSP)
3. NHS Lothian has determined a low risk appetite to achieving this objective and accordingly the following which equals a set of targets and tolerance ranges are set out below:
 - Reduce Acute Hospital Mortality by 20% but will tolerate 15% by December 2015
 - Achieve 95% harm free care but will tolerate a range of 93-95% by December 2015
 - Will achieve 184 SABS by Mar 2015 but will tolerate not achieving this target by 5%. 184-193 which equates per month to 15-16 cases.
 - Will achieve 254 CDI by March 2015 but will tolerate not achieving this target by 5%. 262-275 which equates per month to 22-23 cases.
 - Reduce falls with harm by 20% by December 2015 but will tolerate a 15-20% reduction
 - Reduction in staff harm to be agreed with executive lead

Corporate Objective 2/2.1 – Improving Patient & Staff Experience (Low Risk Appetite)

1. “High Reliable Organisations” report benchmarks for positive customer/staff feedback at 95%
2. NHSL has determined a low risk appetite for Patient/Staff Experience, compared to Finance.
3. Accordingly, the Board has set a Target of 95% for this measure – this is the level the Board strives to achieve as a minimum
4. The Board is however prepared to “tolerate” a range of 93-95% as acceptable (“green”) for reporting purposes.

Corporate Objective 2/2.4 – Improving the way we deliver Scheduled Care (Low Risk Appetite)

There are national performance targets around the management of scheduled care. The Board has determined a low risk appetite for improving the way we deliver scheduled care. Accordingly, the Board has set the target in line with the national target, but will tolerate a range of 5% below target as acceptable (green) for reporting.

Corporate Objective 2/2.3 – Improving the way we deliver Unscheduled Care (**Low Risk Appetite**)

There are national performance targets around the management of unscheduled care. The Board has determined a slightly higher risk appetite for improving the way we deliver unscheduled care. Within the context of national targets, the Board has set the target in line with the national target. It is however prepared to tolerate a range of 5% below the target as acceptable (green) for reporting. Key targets will be reported in the risk appetite reporting table to the Board.

Corporate Objective 1 – Protect and Improve Health in Lothian for all (**Medium Risk Appetite**)

Improving health of the population is seen as a long-term strategic objective and as such NHS Lothian risk appetite is slightly higher. There are key national targets for Health Improvement, however, NHS Lothian will tolerate a range 10% below target for key indicators reported in the Risk Appetite Reporting Framework.

Corporate Objective 3/3.1 – Ensure the delivery of a sustainable financial framework (**Medium Risk Appetite**)

The Board has set a slightly higher risk appetite with respect to delivery of financial balance and Finance have proposed two indicators for financial reporting that are in the reporting framework.

NHS Lothian

Board Meeting
5 August 2015

Executive Nurse Director

SUMMARY PAPER - HEALTHCARE ASSOCIATED INFECTION UPDATE

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

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

<ul style="list-style-type: none"> Progress against Health Efficiency Access Treatment Targets 	3.1
<ul style="list-style-type: none"> <i>Staphylococcus aureus</i> Bacteraemia: NHS Lothian's <i>Staphylococcus aureus</i> Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days (≤ 184 incidences) by March 2016 with a current rate of 0.40. 	3.2
<ul style="list-style-type: none"> <i>Clostridium difficile</i> Infection: NHS Lothian's <i>Clostridium difficile</i> Infection target is to achieve a rate of 0.32 per 1000 bed days (≤ 262 incidences by March 2016 with a current rate of 0.35. 	3.3
<ul style="list-style-type: none"> Mandatory Surgical Site Infections: During January-March 2015 there were 950 procedures performed and 8 Surgical Site Infections detected with a rate of 0.8%. 	3.4
<ul style="list-style-type: none"> Ebola Preparedness: following the success from the training session provided by the Army Medical Services in April 2015, a further 3 open days have been arranged in July, August and September 2015. 	3.5
<ul style="list-style-type: none"> Antibiotic Prescribing Guidelines: the first set of results since implementation of the revised guidelines showed a reduction in usage of broad spectrum "4C" antibiotics and an increase in gentamicin use. Possible adverse effects of increased gentamicin prescribing are being closely monitored. 	3.6
<ul style="list-style-type: none"> Healthcare Environmental Inspectorate: the report from the unannounced inspection at the Royal Infirmary of Edinburgh on 28-29th April 2015 was published on 22nd June 2015 noting 4 requirements and 1 recommendation. The report from the unannounced inspection at Western General Hospital on 26-27th May 2015 was published 20th July 2015. 	3.7
<ul style="list-style-type: none"> Healthcare Associated Infection Standards Strategy and Improvement Matrix: with the commencement of Site Infection Control Committee's, it would be proposed that the Strategy and Improvement Matrix would be converted to Local Site Action Plans with named staff members responsible for delivery and associated timeframes. 	3.8
<ul style="list-style-type: none"> Vale of Leven Enquiry: 32 recommendations now fully implemented, 26 mostly implemented and 6 partially implemented. The Scottish Government has advised that the original action plan submitted in January 2015 will be published unedited on the Scottish Government website. 	3.9

Fiona Cameron
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 6 July 2015
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HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

- 1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian. Any member wishing additional information should contact the Executive Nurse Director in advance of the meeting.
- 1.2 The data reporting is in the new quarterly report format as agreed with Clinical Management Group and Clinical Governance combining infection control and antimicrobial data and patient safety data (Appendix 1).

2 Recommendations

- 2.1 The Board is recommended to:
 - acknowledge receipt of the Healthcare Associated Infection Reporting Template for July 2015. (Appendix 2)
 - note NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days (≤ 184 incidences) by March 2016 with a current rate of 0.40.
 - note NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days (≤ 262 incidences by March 2016 with a current rate of 0.35).
 - acknowledge receipt of draft Healthcare Associate Infection Standards Strategy and Improvement Matrix (Appendix 3)
 - acknowledge and support ongoing actions to address gaps identified within the response to Vale of Leven Inquiry recommendations.

3 Discussion of Key Issues

3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets March 2016

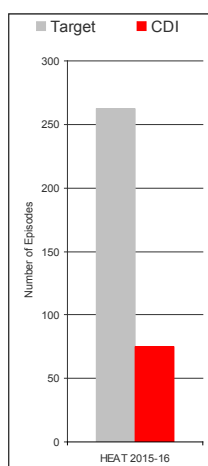


Figure 1: No. of CDI Episodes 2015-16

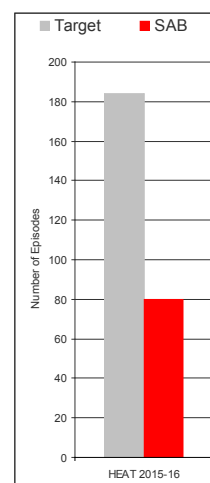


Figure 2: No. of SAB Episodes 2015-16

3.2 Staphylococcus aureus Bacteraemia: NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days (≤ 184 incidences) by March 2016 with a current rate of 0.40.

There were 23 episodes of *Staphylococcus aureus* Bacteraemia in June 2015 (3 Meticillin Resistant *Staphylococcus aureus*, 20 Meticillin Sensitive *Staphylococcus aureus*), compared to 22 in May 2015 (1 Meticillin Resistant *Staphylococcus aureus*, 19 Meticillin Sensitive *Staphylococcus aureus*).

Target Date	Target	Actual
Year Ending 31/3/2013	213	255
Year Ending 31/3/2014	219	243
Year Ending 31/3/2015	184	282
Year Ending 31/3/2016	184	80*

* Cumulative to date

3.2.1 Key Messages:

- Health Protection Scotland's Commentary on quarterly epidemiological data on *Staphylococcus aureus* bacteraemias in Scotland (Q1, 2015) was published on 7 July 2015 noting NHS Lothian as having a significant increase in cases during this period with a rate of 40.1 (compared to 36.4 in Quarter 4, 2014).

3.3 Clostridium difficile Infection: NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days (≤ 262 incidences) by March 2016 with a current rate of 0.35.

There were 24 episodes of *Clostridium difficile* Infection in patients aged 15 or over in June 2015, compared to 22 in May 2015.

Target Date	Target	Actual
Year Ending 31/3/2013	418	364
Year Ending 31/3/2014	313	425
Year Ending 31/3/2015	262	393
Year Ending 31/3/2016	262	75*

* Cumulative to date

3.3.1 Key Messages:

Health Protection Scotland's Commentary on quarterly epidemiological data on *Clostridium difficile* infection in Scotland (Q1, 2015) was published on 7 July 2015 noting NHS Lothian as an outlier in the 15-64 year funnel plot with a rate of 46.3 (compared to 57.9 in Quarter 4, 2014). For patients aged 65 years and over NHS Lothian's rate was 35.6 (compared to 40.1 in Quarter 4, 2014).

3.4 Mandatory Surgical Site Infections (SSIs): During January-March 2015 there were 950 procedures performed and 8 Surgical Site Infections detected with a rate of 0.8%.

Table 1: Number of procedures and Surgical Site Infections by procedure category within NHS Lothian, 01/01/2015 to 31/03/2015

Category of procedure	Surveillance Type	Number of procedures	SSIs	SSI rate (%)	95% Confidence Interval	National SSI Rate (%)	National 95% confidence interval
Caesarean section	Light	626	6	1.0	0.4 to 2.1	1.3	0.9 to 1.5
Hip arthroplasty	Light	212	1	0.5	0.1 to 2.6	0.9	0.6 to 1.4
Repair of neck of femur	Light	112	1	0.9	0.2 to 4.9	0.9	0.5 to 1.7
Total	-	950	8	0.8	0.4 to	1.7	-

*Source –*Source – NHS Lothian Quarter 1 2015 SSI Summary Report - Light Surveillance HPS.

Summary

- The Surgical Site Infection rate for caesarean section (inpatient and Post discharge surveillance to day 10) for NHS Lothian is marginally up this quarter from 0.9 to 1.0. The six Surgical Site Infections were post-discharge infections and were classified as superficial infections and all were investigated appropriately.
- The Surgical Site Infection wound criteria are now available electronically in Maternity Trak for the Community Midwives to complete at day 10 post discharge.

3.5 Ebola Preparedness: Following the success from the training session provided by the Army Medical Services in April 2015, a further 3 open days have been arranged in July, August and September 2015 giving the opportunity for more key staff members to attend the training in planning, training and the delivery of care in an Ebola Environment.

3.6 Antibiotic Prescribing Indicators: in clinical areas where Empirical Prescribing Indicators are measured, compliance with guidelines was just below the target level for all three acute sites and ranged from 85 to 90%. Documentation of indication for antibiotic treatment was at the target level of 100% for all three acute sites but documentation of antibiotic duration was below target level at 40 to 70%.

The results for the prescribing indicator for oral antibiotic prescribing in downstream medical wards showed that documentation of antibiotic indication was at the target level at 95% for all three acute sites, compliance with antibiotic policy was at target for the RIE but below target for the WGH at 90% and also for SJH at 80%. Documentation of oral antibiotic duration was below target for all the sites at 45 to 85%.

Antibiotic Prescribing Guidelines: revised UHS Antibiotic Prescribing Guidelines were implemented on 2nd February 2015 to facilitate use of more narrow spectrum and less broad spectrum antibiotics for empiric treatment of infection. The first set of results since implementation of the revised guidelines showed a reduction in usage of broad spectrum "4C" antibiotics and an increase in gentamicin use. Possible adverse effects of increased gentamicin prescribing are being closely monitored.

- 3.7 Healthcare Environmental Inspectorate: The report from the unannounced inspection at the Royal Infirmary of Edinburgh on 28-29th April 2015 was published on 22nd June 2015 noting 4 requirements and 1 recommendation.

The report from the unannounced inspection at Western General Hospital on 26-27th May 2015 was published 20th July 2015. There were no requirements or recommendations.

The Healthcare Associated Inspectorate Self Assessment was completed and associated evidence was returned to the Inspectorate by their deadline of 12th June 2015.

- 3.8 Healthcare Associated Infection Standards Strategy and Improvement Matrix: Appendix 3 outlines the draft Healthcare Associated Infection Standards Strategy and Improvement Matrix which is directed at all staff members (including Contractors), describing in detail the role and responsibilities allocated to different staff groups (from Ward to Board) in relation to Infection Prevention and Control. The Strategy and Improvement Matrix is to provide the Board with assurance that infection prevention and control is being constantly monitored and reviewed to ensure best practice for patient and staff safety. With the commencement of Site Infection Control Committee's, it would be proposed that the Strategy and Improvement Matrix would be converted to Local Site Action Plans with named staff members responsible for delivery and associated timeframes. The Chair of each of the Site Infection Control Committee's would be responsible to ensure this is completed for their remits.

- 3.9 Vale of Leven Enquiry: The deadline to return the updated action plan against the recommendations noted within the Vale of Leven Enquiry Report has been extended to 31 July 2015 to allow the document to be considered and agreed at both the Partnership Committee and Area Clinical Forum. There has been significant progress against the action plan with 32 recommendations now fully implemented, 26 mostly implemented and 6 partially implemented compared to 14 fully implemented, 33 mostly implemented and 17 partially implemented in January 2015.

The Scottish Government have published their response to the Vale of Leven Inquiry Report on 18 June 2015 noting their commitment to taking action to ensure that all 75 recommendations are fully implemented. It notes a variety of actions such as the establishment of an Implementation Group and Reference Group as well as investigating how Scottish Government, NHSScotland and other organisations can collaborate to go even further than Lord MacLean's recommendations to avoid the serious shortcomings identified at the Vale of Leven Hospital from happening again.

The Scottish Government has advised that the original action plan submitted in January 2015 will be published unedited on the Scottish Government website with the anticipation that the updated document will also be published.

4 Key Risks

- 4.1 The key risks associated with the recommendations are:

- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- Based on current data for both *Clostridium difficile* Infection and *Staphylococcus aureus* Bacteraemia NHS Lothian is currently reporting amber for progress against the Health Efficiency Access Treatment Target.

5 Risk Register

- 5.1 The Healthcare Associated Infection Corporate Risk Register 1076 is currently graded high due to reported incidences of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection impacting on negative trend to achieving Health Efficiency Access Treatment Target. The risk register covers Norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Inequality, Including Health Inequalities

- 6.1 Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. Accordingly, changes made are reducing the burden of Healthcare Associated Infection.

7 Involving People

- 7.1 Patient public representatives are actively involved during the Healthcare Environment Inspectorate inspections, with one member sitting on the Healthcare Environment Inspectorate Steering Group. Other patient public representatives sit on the Infection Control Committees for Acute and Community and Lothian Infection Control Advisory Committee.

8 Resource Implications

- 8.1 Infection Prevention and Control is an invest to save service. The excess cost of each episode of *Staphylococcus aureus* Bacteraemia and *Clostridium difficile* Infection is variable, depending on increased length of stay and additional treatment requirements.

Fiona Cameron

Head of Infection Prevention and Control Services

6 July 2015

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List of Appendices

Appendix 1: Clinical Management Group Quarterly Infection Report July 2015

Appendix 2: Healthcare Associated Infection Reporting Template for July 2015

Appendix 3: Healthcare Associated Infection Standards Strategy and Improvement Matrix

**NHS Lothian Quarterly Infection and Antimicrobial Prescribing Report - July 2015**

Date produced: 7th July 2015

This report is in development. The initial focus for development has been the acute sites. A briefer report is available monthly. Brief commentary is provided alongside each figure.

N.B. This report has been produced in May due to issues with data availability. However, in future, quarterly reports will be produced in April, July, October and January.

Note that for data on infections, infections are attributed to the clinical area from which the sample was sent.

Contacts

Infections data janathan.daniel@nhslothian.scot.nhs.uk

Antimicrobial data eilidh.fletcher@nhslothian.scot.nhs.uk

Primary Data sources

Prescribing data: Ascribe (to June 2014); JAC (from June 2014)

Activity data: TRAK oracle

Infections data: Apex labs system

Please see individual sheets for other data sources

Abbreviations

DDD - Defined Daily Dose

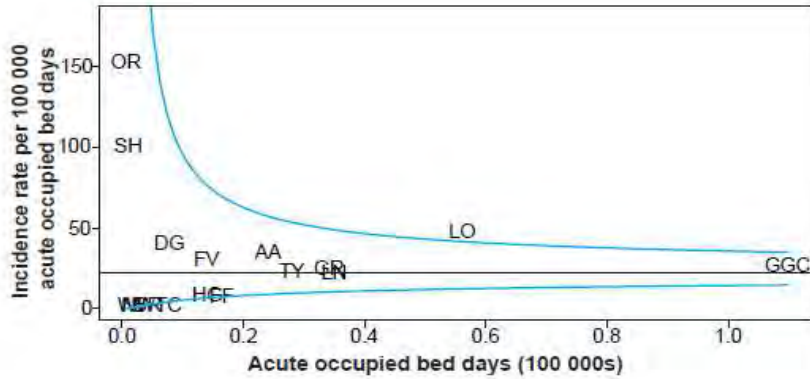
The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults.

OBD - Midnight Occupied Bed Days

CDI - Clostridium difficile infection

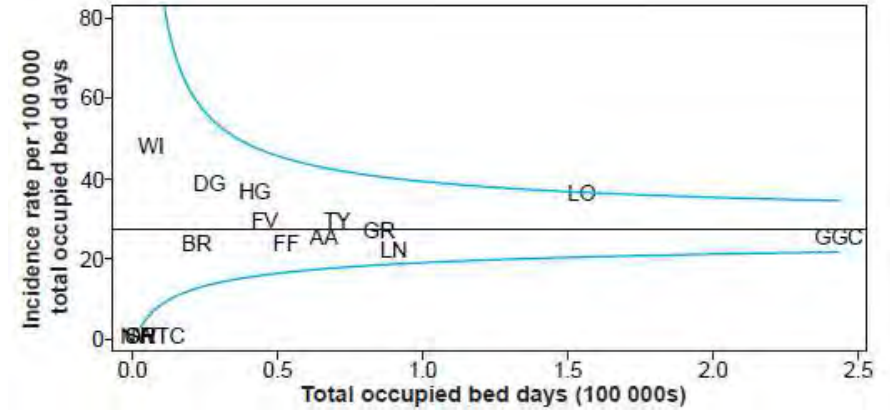
For SPC charts: **pa** - process average, **LCL** - lower control limit, **LWL** - lower warning limit

1.1 Funnel plot of CDI incidence rates per 100,000 bed days in patients aged 15-64 for all NHS Boards (Q1 2015)



LO = Lothian;
 Note that NHS Fife, and NHS Highland overlap as do NHS NWTC, NHS Borders, and NHS Western Isles.
 Lothian rate shows a decrease (not statistically significant) from the previous quarter, but is outwith the control limits for this quarter and therefore is statistically different compared with other boards.
 Source: HPS quarterly publications (<http://www.hps.scot.nhs.uk>)

1.2 Funnel plot of CDI incidence rates per 100,000 bed days in patients aged 65+ for all NHS Boards (Q1 2015)



LO = Lothian;
 Note that NHS Shetland, NHS Orkney and NHS NWTC overlap
 Lothian rate shows a decrease (not statistically significant) from the previous quarter and is within the control limits and therefore is not statistically different compared with other boards.
 Source: HPS quarterly publications (<http://www.hps.scot.nhs.uk>)

Table 1.1a CDI incidence rates per 100,000 bed days (15-64 years)

Comparison with previous quarter

	Cases	Bed days	Rate
2014 Q4	33	57,021	57.9
2015 Q1	26	56,117	46.3

Table 1.1b CDI incidence rates per 100,000 bed days (15-64 years)

Comparison with previous financial year

	Cases	Bed days	Rate
Year ending March 2014	133	220,425	60.3
Year ending March 2015	129	227,454	56.7

Data to the left shows the current quarter (2015 Q1) and year ending March (2015) compared to the previous quarter and year.

Neither change is statistically significant.

Source: HPS quarterly publications (<http://www.hps.scot.nhs.uk>)

Table 1.2a CDI incidence rates per 100,000 bed days (65+ years)

Comparison with previous quarter

	Cases	Bed days	Rate
2014 Q4	62	154,503	40.1
2015 Q1	55	154,654	35.6

Table 1.2b CDI incidence rates per 100,000 bed days (65+ years)

Comparison with previous financial year

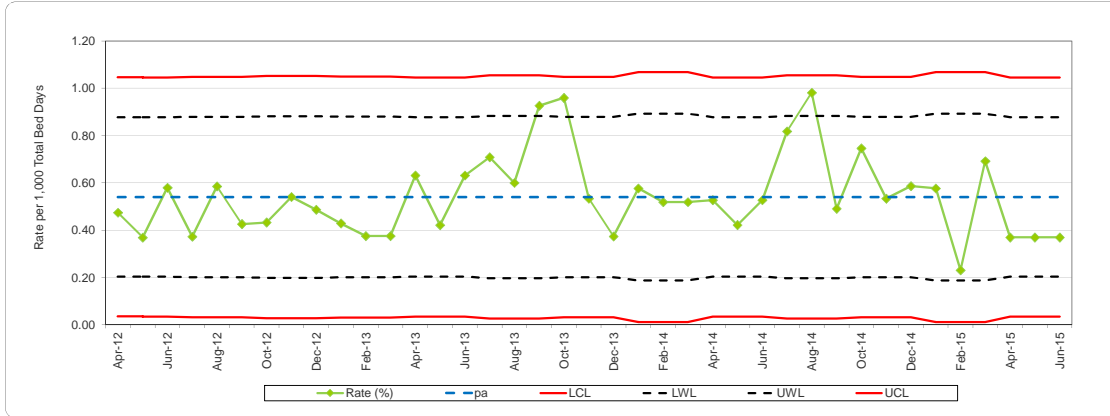
	Cases	Bed days	Rate
Year ending March 2014	281	609,839	46.1
Year ending March 2015	264	608,073	43.4

Data to the left shows the current quarter (2015 Q1) and year ending March (2015) compared to the previous quarter and year.

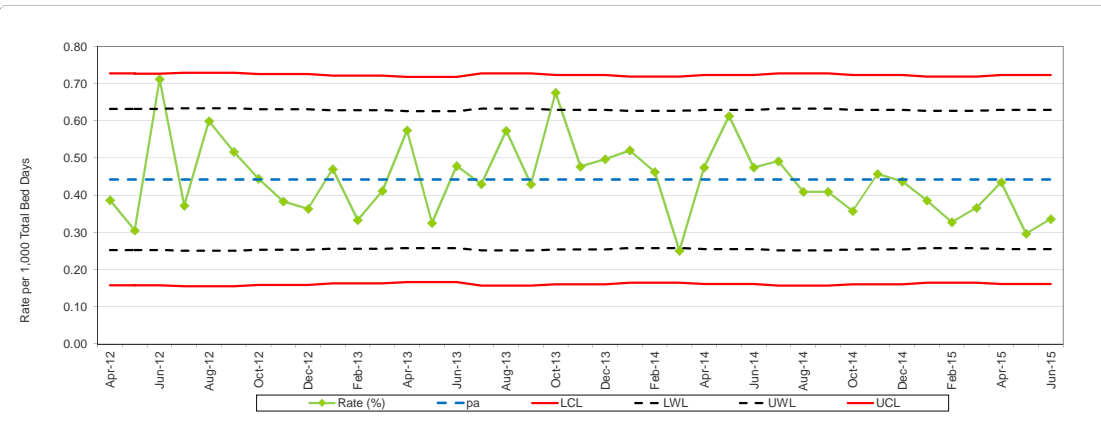
Neither change is statistically significant.

Source: HPS quarterly publications (<http://www.hps.scot.nhs.uk>)

2.1 u-chart - NHS Lothian CDI rate per 1,000 bed days for 15-64 year age group (Apr 2012-Jun 2015)

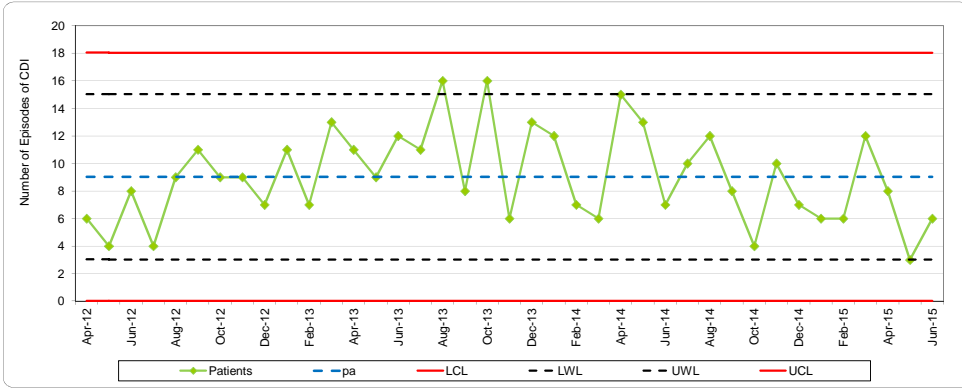


2.2 u-chart - NHS Lothian CDI rate per 1000 OBDs for 65 and over age group (Apr 2012-Jun 2015)

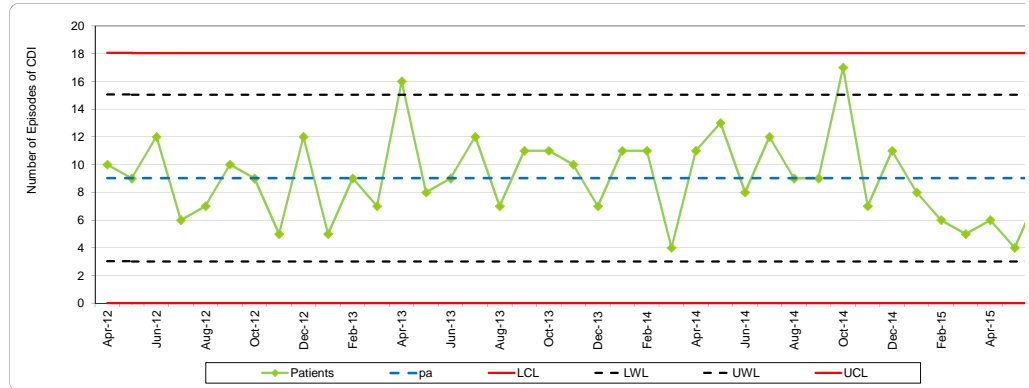


Source: IPCT
 All data
 No change in rate for either age group.

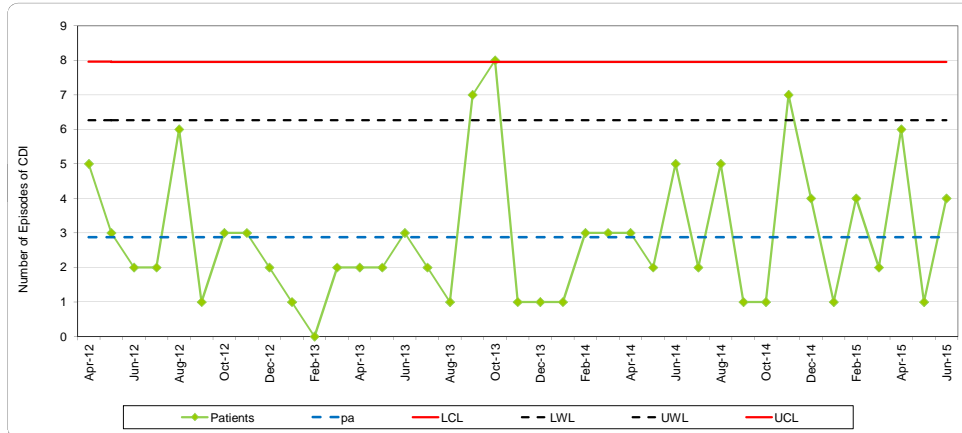
2.3 c-chart of number of episodes of CDI per month in RIE in pts aged 15+ (Apr 2012-Jun 2015)



2.4 c-chart of number of episodes of CDI per month in WGH in pts aged 15+ (Apr 2012-Jun 2015)

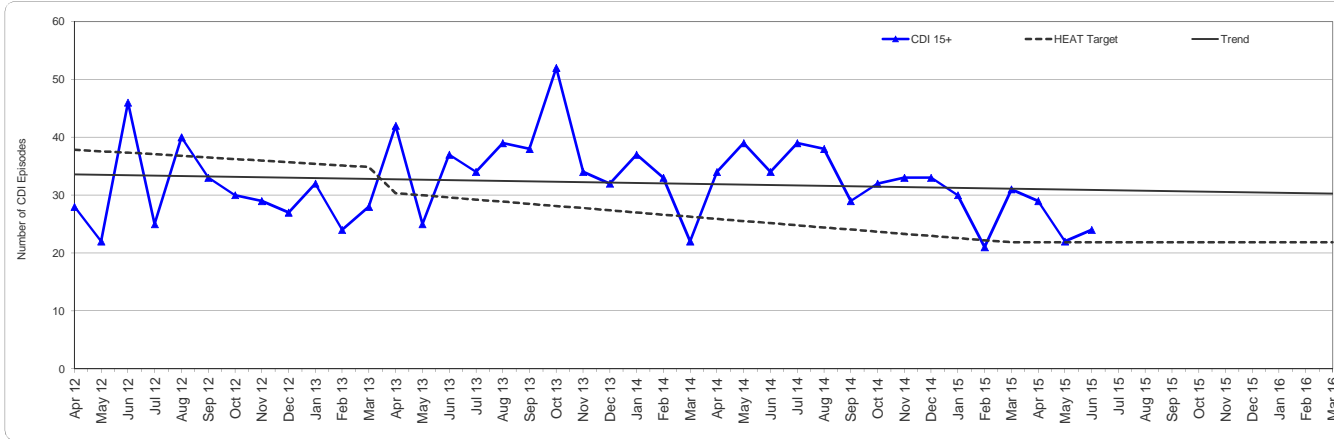


2.5 c-chart of number of episodes of CDI per month in SJH in pts aged 15+ (Apr 2012-Jun 2015)

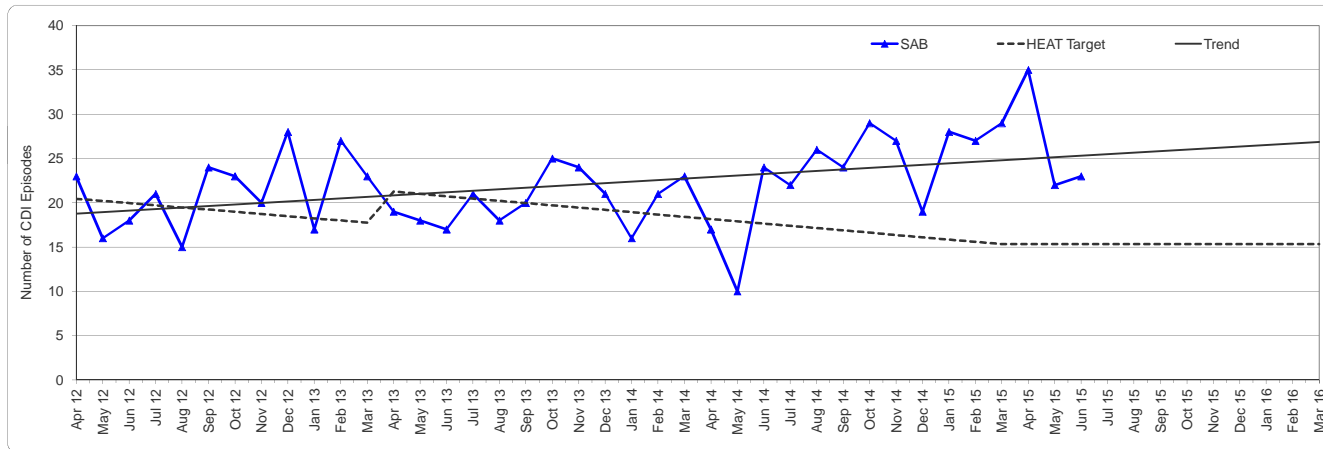


Source: IPCT
All data
No change in number of episodes at any of 3 main sites.

3.1 CDI Progress against HEAT target - NHS Lothian



3.2 SABs progress against HEAT target - NHS Lothian

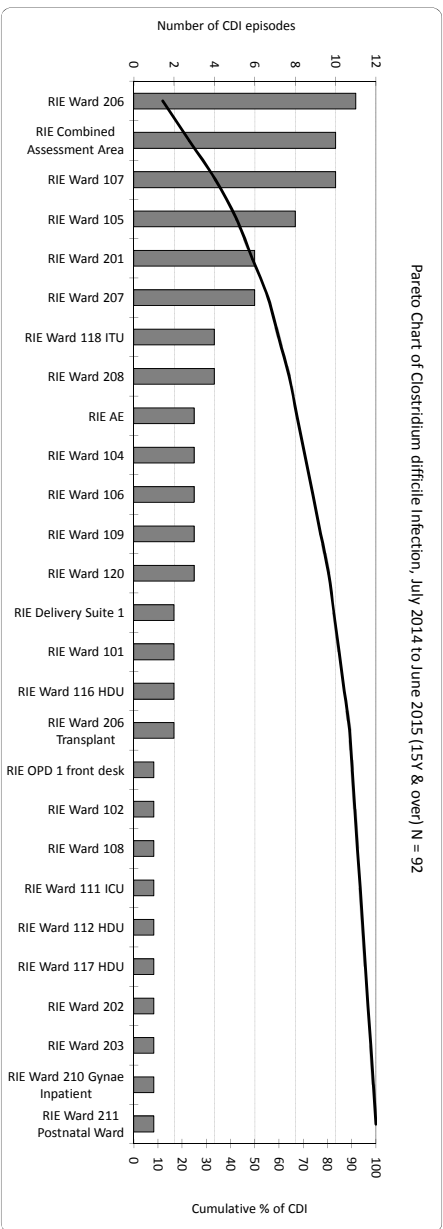


Source: IPCT
All data

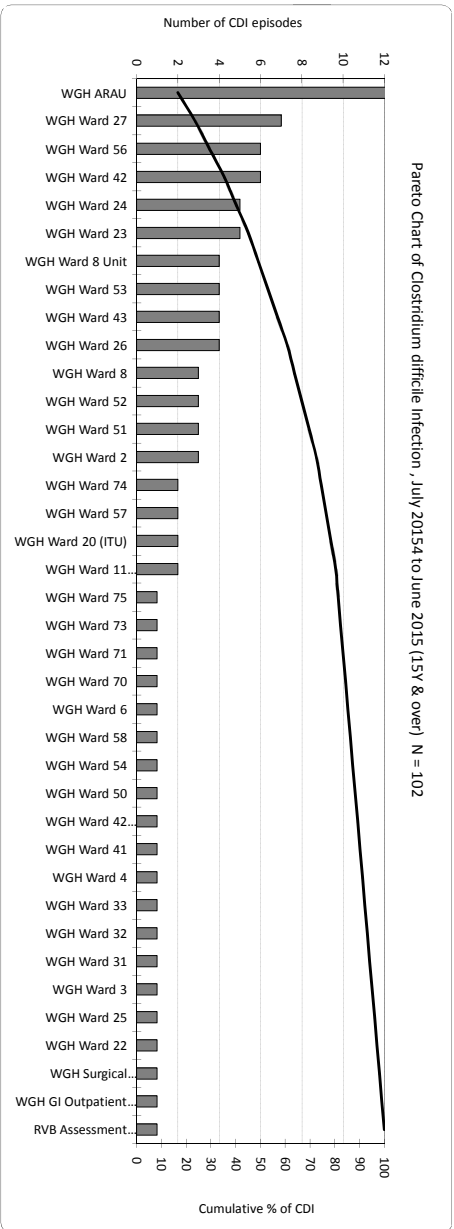
NHS Lothian's Clostridium difficile Infection Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 to occupied bed days (<262 incidences) by March 2016 in patients aged 16 and over, with a current rate of 0.35 (75 incidences). NHS Lothian has seen a decrease in trend but still not in line with the HEAT target.

NHS Lothian's Staphylococcus aureus Bacteraemia Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days (<184 incidences) by March 2016 with a current rate of 0.40 (80 incidences). NHS Lothian has seen an increase in trend over the last 12 month period.

4.1 Pareto chart of RIE CDI Infection (Jul 2014-Jun 2015)

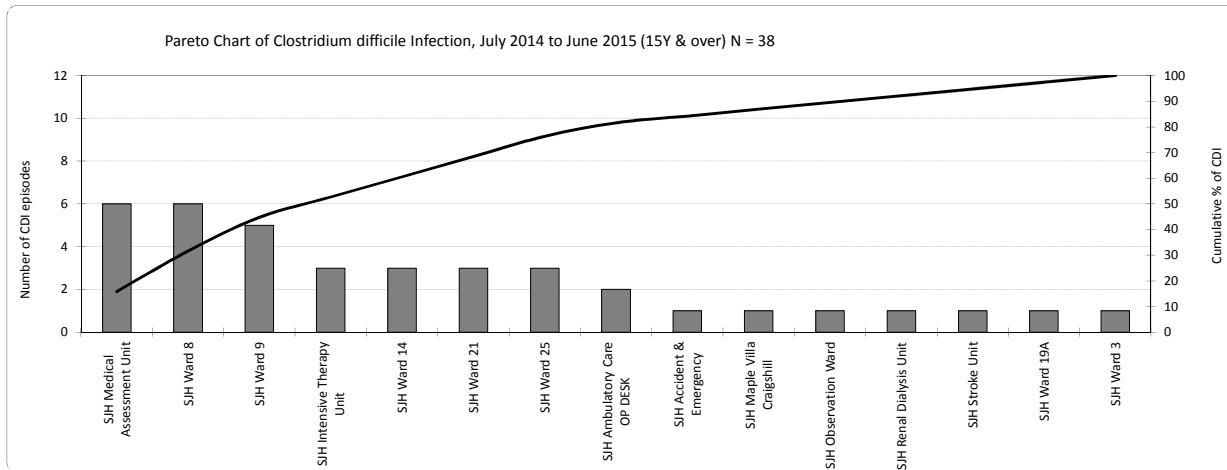


4.2 Pareto chart of WGH CDI Infection (Jul 2014-Jun 2015)



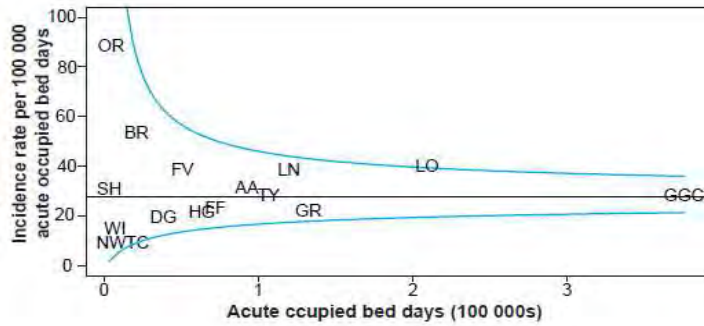
Source: IPCT
 All data Wards on the left hand side of the graph are those with the highest numbers of CDI attributed to them.

4.3 Pareto chart of SJH CDI infection (Jul 2014-Jun 2015)

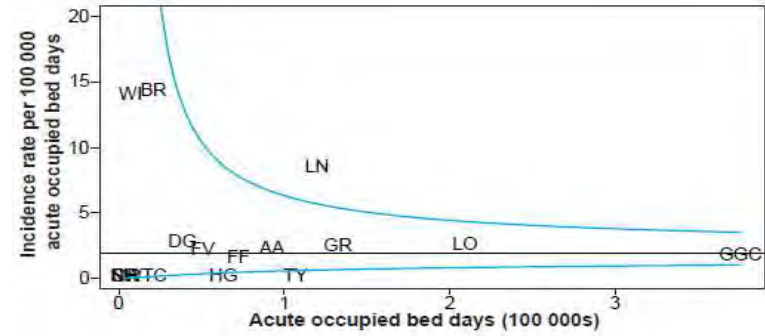


Source: IPCT
 All data
 Wards on the left hand side of the graph are those with the highest numbers of CDI attributed to them.

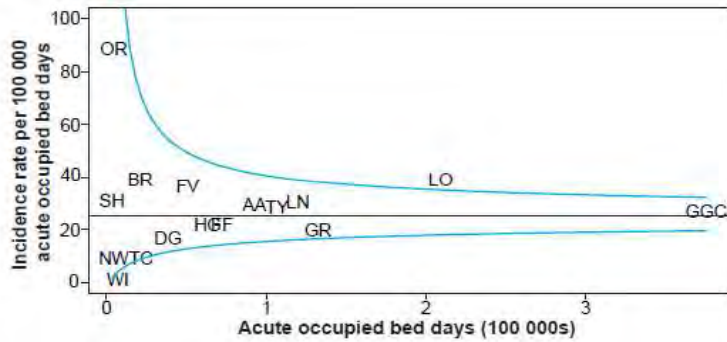
5.1 Funnel plot of *S.aureus* bacteraemia rates per 100,000 OBDs for all NHS Boards (Q1 2015)



5.2 Funnel plot of MRSA bacteraemia rates per 100,000 OBDs for all NHS Boards (Q1 2015)



5.3 Funnel plot of MSSA bacteraemia rates per 100,000 OBDs for all NHS Boards (Q1 2015)

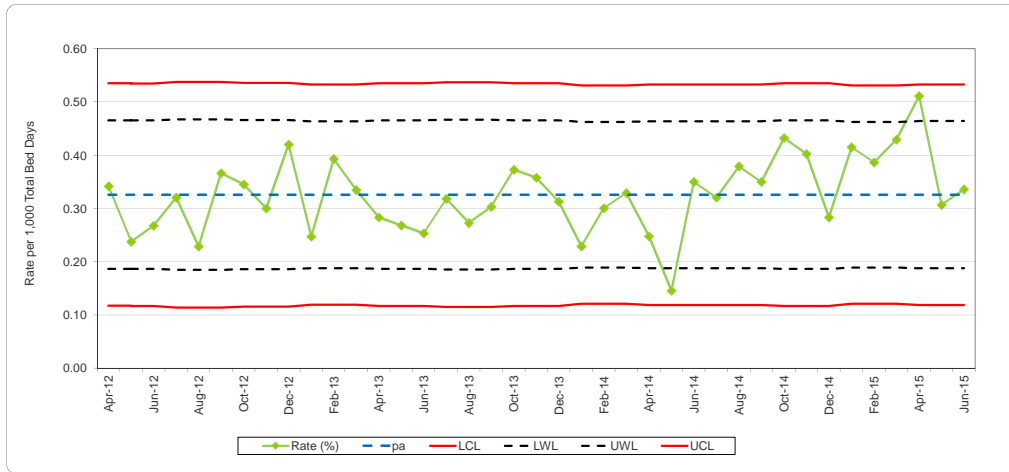


LO = Lothian;

Lothian rates are within the control limits and therefore is not statistically different compared with other boards. in the SABs and MRSA funnel plots. However, NHS Lothian is an outlier in the MSSA analysis.

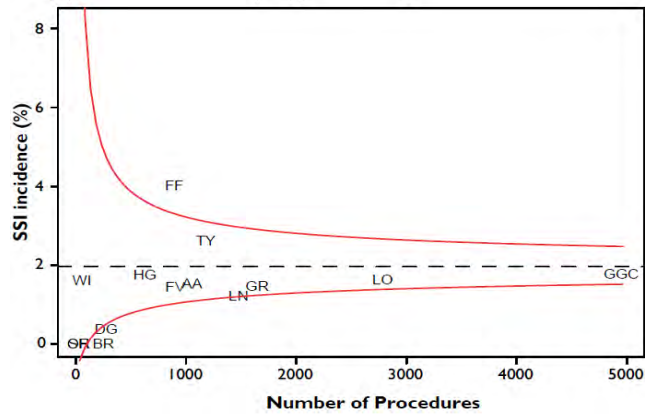
Source: HPS quarterly publications (<http://www.hps.scot.nhs.uk>)

5.4 u-chart of *Staphylococcus aureus* Bacteraemias rate in NHS Lothian (Apr 2012-Jun 2015)

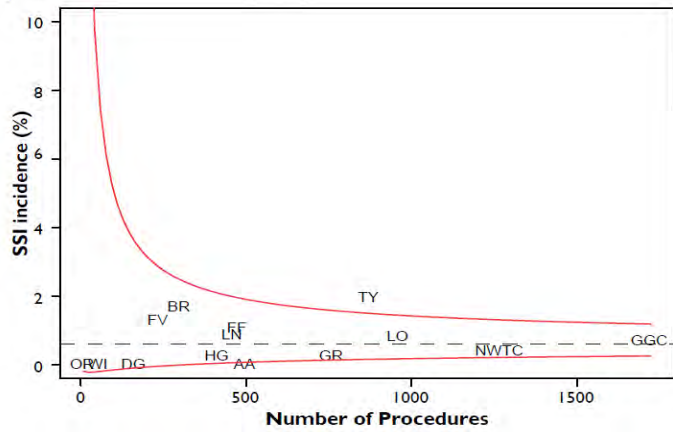


Source: IPCT
 All data
 No change in rate.

5.6 Cumulative incidence (number of SSI per 100 procedures) for caesarean section (inpatient and PDS until day 10) procedures, by NHS board in 2013

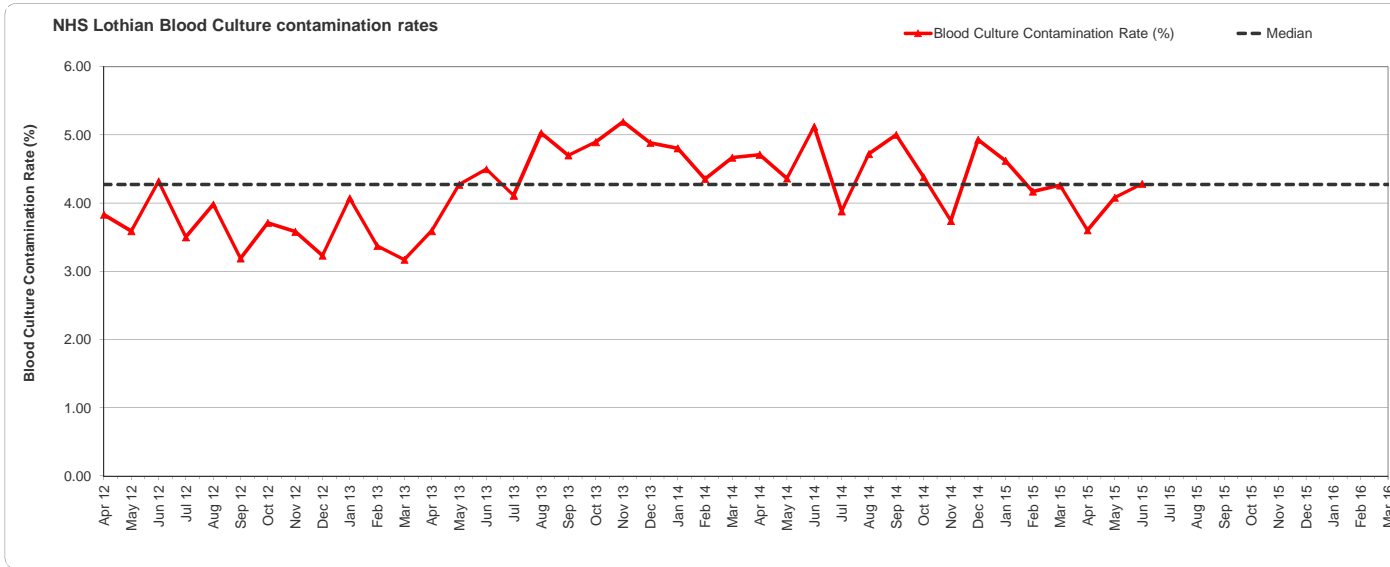


5.7 Cumulative incidence (number of SSI per 100 procedures) for hip arthroplasty (inpatient and readmission to day 30), by NHS board in 2013



LO = Lothian
 Source: HPS
 All data
 Lothian inside the control limits for both measures and therefore not statistically different to other boards for this year's data.
 Updated data will be available end of July 2015.

6.1 Blood culture contamination rates



Source: IPCT
 All data
 During June 2015 there were 3,672 sets of blood cultures taken in NHS Lothian. Of these, 136 (3.70%) of the blood culture was considered to be contaminated.

During the previous 12-month period, there were a total of 44,148 blood cultures collected of which 4.23% were considered to be contaminants.

6.3 Ward closures

No up to date aggregate data are currently available.

6.4 Number of wards that have exceeded CDI trigger levels

Location Description	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Total
RIE Ward 206	0	1	1	1	2	2	0	0	0	2	2	0	11
WGH ARAU Beds	2	1	0	2	0	1	1	1	0	2	0	1	11
RIE Ward 107	0	1	1	1	2	1	2	0	0	1	0	1	10
RIE Ward 105	3	1	0	0	2	1	0	0	1	0	0	0	8
WGH Ward 27	3	0	1	0	0	0	1	1	0	0	1	0	7
RIE Ward 207	0	0	0	1	2	0	0	1	0	1	0	1	6
SJH Medical Assessment Unit	0	2	0	0	0	1	0	2	0	1	0	0	6
SJH Ward 8	0	0	0	1	1	1	0	1	0	2	0	0	6
WGH ARAU Trolleys	2	1	0	1	0	1	0	0	0	1	0	0	6
WGH Ward 42	0	2	0	0	0	1	0	1	1	0	1	0	6
WGH Ward 56	0	1	2	0	0	1	1	0	1	0	0	0	6
AAH Charles Bell Pavilion 1	0	0	0	0	1	1	2	0	1	0	0	0	5
GP: Tranent Medical Practice	1	0	2	0	0	1	0	0	1	0	0	0	5
SJH Ward 9	0	0	0	0	1	1	0	0	0	0	0	3	5
WGH Ward 24	1	0	0	2	0	0	0	0	0	1	0	1	5
RIE Ward 118 ITU	0	0	0	0	0	0	0	1	3	0	0	0	4
RIE Ward 208	0	1	0	0	0	0	1	0	2	0	0	0	4
WGH Ward 53	0	0	1	2	0	1	0	0	0	0	0	0	4
WGH Ward 8 Unit	1	0	0	2	0	0	0	0	1	0	0	0	4
RIE Combined Assessment Area 6	0	0	1	0	0	0	0	0	2	0	0	0	3
RIE Ward 120	0	0	2	0	0	0	0	0	0	1	0	0	3
WGH Ward 2	0	0	0	2	0	1	0	0	0	0	0	0	3
WGH Ward 52	0	0	0	0	0	0	0	0	1	0	0	2	3

Source: IPCT

All data

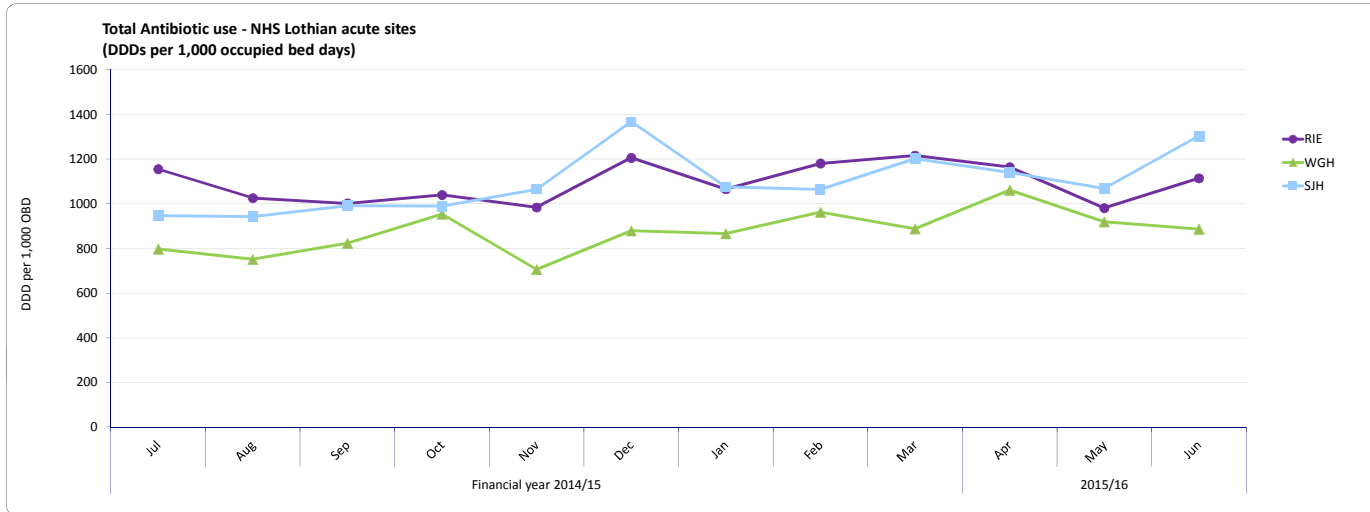
These represent clinical areas where there have been > 2 CDI in the given time period.

7.1 Total antibiotic use - NHS Lothian acute sites (DDDs per 1,000 obds)

	Financial year 2014/15									2015/16		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
RIE	1155	1026	1002	1040	984	1206	1066	1181	1216	1164	981	1114
WGH	798	751	824	954	706	879	867	963	888	1062	919	887
SJH	946	942	992	990	1065	1368	1075	1065	1202	1140	1069	1304

Source: AMT
All data

7.1 Total antibiotic use - NHS Lothian acute sites (DDDs per 1,000 obds)



Data sources: Ascribe/Pharmacy Reporter (Rx data up to and inc. Q2 2014/15); JAC (Rx data from Q2 2014/15)TRAK Oracle database (Occupied beds)

Notes:

1. These data include 'standard' inpatient ward areas only - areas where midnight occupied beds are not a suitable denominator, e.g. outpatients, are excluded.
2. A full list of wards included, and further breakdowns of the data, can be received from the AMT.

7.2 4C and pip-taz antibiotic use - NHS Lothian acute sites (% of antibiotics used)

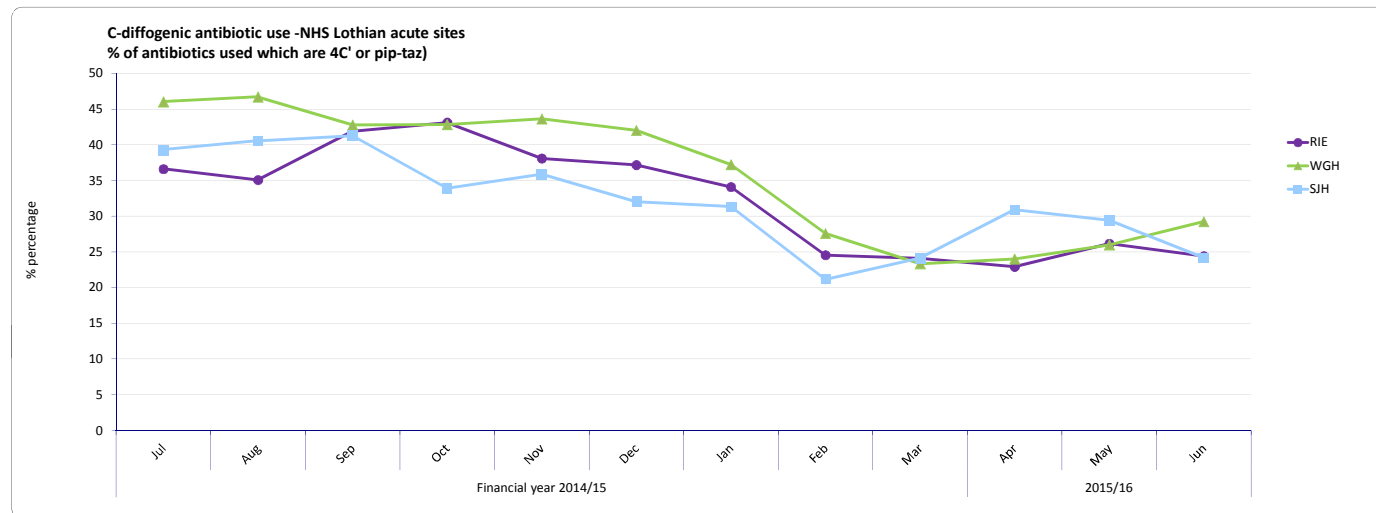
	Financial year 2014/15									2015/16		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
RIE	37	35	42	43	38	37	34	25	24	23	26	24
WGH	46	47	43	43	44	42	37	28	23	24	26	29
SJH	39	41	41	34	36	32	31	21	24	31	29	24

Source: AMT

All data

The data appears to show a decrease in the use of 4C drugs from the beginning of 2015. However, more data is required before it can be seen if this is a longer-term trend.

Chart 7.2 C-diffogenic antibiotic use - NHS Lothian acute sites (DDDs per 1,000 obds)



Data sources: Ascribe/Pharmacy Reporter (Rx data up to and inc. Q2 2014/15); JAC (Rx data from Q2 2014/15)TRAK Oracle database (Occupied beds)

Notes:

1. These data include 'standard' inpatient ward areas only - areas where midnight occupied beds are not a suitable denominator, e.g. outpatients, are excluded.
2. A full list of wards included, and further breakdowns of the data, can be received from the AMT.
3. The following antimicrobials are considered c-diffogenic: Cefaclor, Cefadroxil, Cefalexin, Cefixime, Cefotaxime, Cefradine, Ceftazidime, Ceftriaxone, Cefuroxime, Ciprofloxacin, Clindamycin, Levofloxacin, Moxifloxacin, Norfloxacin, Ofloxacin, Co-amoxiclav, Piperacillin Tazobactam

7.3 Gentamicin use - NHS Lothian acute sites (DDDs per 1,000 obds)

	Financial year 2014/15									2015/16		
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
RIE	10	8	10	10	8	13	16	30	32	32	32	35
WGH	20	21	18	17	16	25	16	34	29	39	31	35
SJH	8	11	12	13	11	13	11	17	21	18	18	26

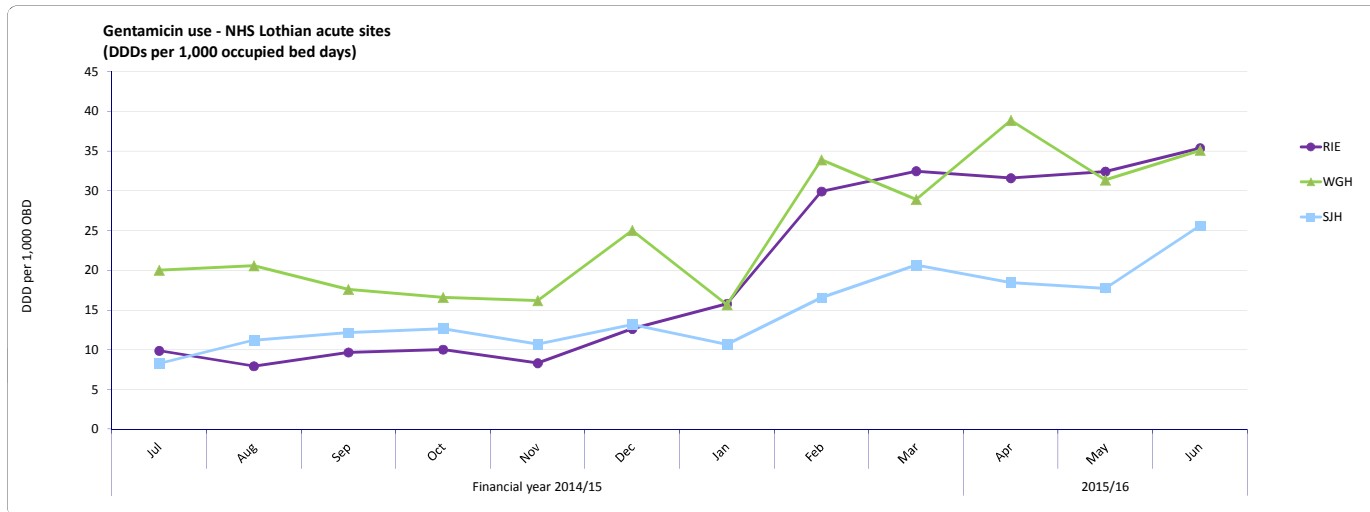
Source: AMT

All data

Note that these data are now slightly out of date.

Overall use is low, compared to total Abx use, but a clear increase in use can be seen from January 2015 onwards. This trend appears to be continuing.

Chart 7.3 Gentamicin use - NHS Lothian acute sites (DDDs per 1,000 obds)

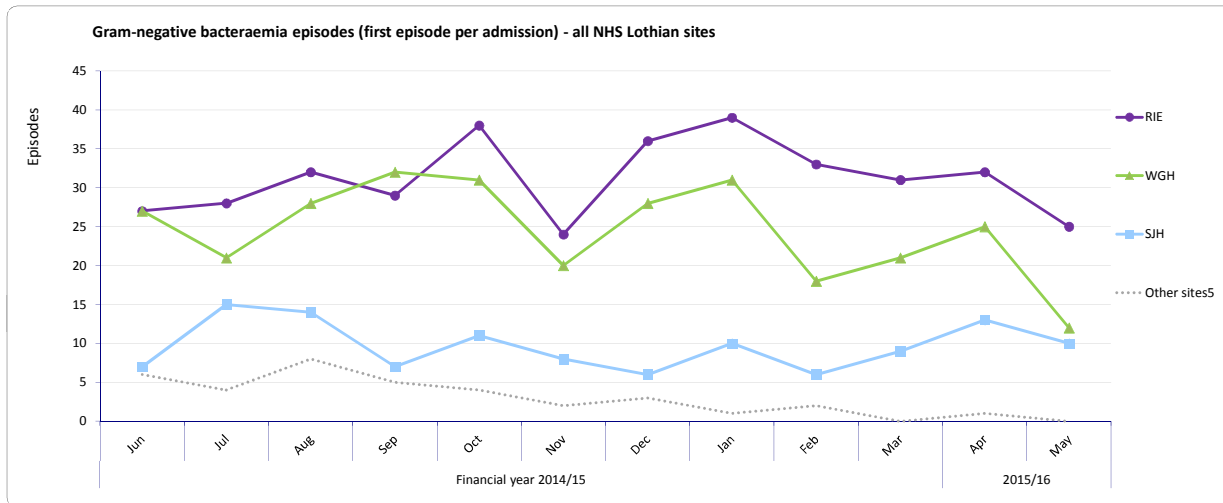
**Data sources:** Ascribe/Pharmacy Reporter (Rx data up to and inc. Q2 2014/15); JAC (Rx data from Q2 2014/15) TRAK Oracle database (Occupied beds)**Notes:**

1. These data include 'standard' inpatient ward areas only - areas where midnight occupied beds are not a suitable denominator, e.g. outpatients, are excluded.
2. A full list of wards included, and further breakdowns of the data, can be received from the AMT.

8.1 Reported gram-negative bacteraemia results (first episode within a stay)^{1,2,3,4}

	Financial year 2014/15										2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
RIE	27	28	32	29	38	24	36	39	33	31	32	25
WGH	27	21	28	32	31	20	28	31	18	21	25	12
SJH	7	15	14	7	11	8	6	10	6	9	13	10
Other sites ⁵	6	4	8	5	4	2	3	1	2		1	
NHS Lothian	67	68	82	73	84	54	73	81	59	61	71	47

8.1 Monthly Gram-negative bacteraemia reported



Reported gram-negative bacteraemias.
Source: IPCT

8.2 Rate of gentamicin use in GNB cohort^o

	Financial year 2014/15										2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
Total GNB cases	67	68	82	73	84	54	73	81	59	61	71	47
Cases receiving gentamicin	13	12	18	7	16	15	20	27	40	42	43	32
% receiving gentamicin	19.4%	17.6%	22.0%	9.6%	19.0%	27.8%	27.4%	33.3%	67.8%	68.9%	60.6%	68.1%

8.3 Survival in GNB cohort^{7,8}

	Financial year 2014/15										2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
GNB cases	67	68	82	73	84	54	73	81	59	61	71	47
28-day survival (n)	54	58	67	62	72	46	60	72	47	56	58	41
28-day survival %	80.6%	85.3%	81.7%	84.9%	85.7%	85.2%	82.2%	88.9%	79.7%	91.8%	81.7%	-
90-day survival (n)	47	50	60	57	69	44	56	65	46	54	54	41
90-day survival %	70.1%	73.5%	73.2%	78.1%	82.1%	81.5%	76.7%	80.2%	78.0%	-	-	-

Data sources: APEX (supplied by Infection Control Team); TRAK Oracle database (Inpatients/A&E/Discharge/Orders records); National Records for Scotland (mortality data)

Notes:

1. First episode only - defined as the first reported positive result during a patient admission episode. The patient episode may begin with either an A&E attendance or an inpatient admission.
2. Patients aged 16+ only.
3. Excludes any cases where sample received from UoE Forensic Labs, Reference Labs and pathology.
4. Site reported as the site where the sample was taken; it might not necessarily be the site where the patient spent the majority of their admission.
5. 'Other sites' include AAH, Liberton and Roodlands.
6. The patient having a gentamicin level tested during their stay is used as a proxy for 'treated with gentamicin'.
7. Mortality data taken from a combination of NRS Vital events data and TRAK discharge data - mortality data not available for non-Scotland residents, unless patient died within a NHS Lothian site.
8. Survival rates calculated from date of positive GNB test.

The percentage of patients with a reported gram-negative bacteraemia receiving gentamicin within 3 days of a positive test has increased from 33% in January 2015 to 67% in February 2015 and this percentage has been sustained over the past five months.

Both 28 and 90 day survival rates fluctuate considerably and mortality rates post-February have been within the usual range.

9.1 Acute Kidney Injury in patients discharged from WGH2, 2, 3

Please note, this analysis is currently still being developed and is in draft format. Please use any figures with caution

9.1.1 Number of discharges meeting criteria for AKIN stage

	Financial year 2014/15										2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
No AKIN stage	1091	1071	1057	1123	1000	1111	1070	1036	1108	1037	994	946
AKIN 1	98	90	86	81	85	91	81	81	94	88	91	83
AKIN2	11	8	11	11	9	6	8	3	13	7	10	9
AKIN3	28	34	34	38	27	30	44	42	37	34	36	29
Total discharges included	1,228	1,203	1,188	1,253	1,121	1,238	1,203	1,162	1,252	1,166	1,131	1,067

9.1.2 Percentage (%) of discharges meeting criteria for AKIN stage

	Financial year 2014/15										2015/16	
	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May
No AKIN stage	88.8%	89.0%	89.0%	89.6%	89.2%	89.7%	88.9%	89.2%	88.5%	88.9%	87.9%	88.7%
AKIN 1	8.0%	7.5%	7.2%	6.5%	7.6%	7.4%	6.7%	7.0%	7.5%	7.5%	8.0%	7.8%
AKIN2	0.9%	0.7%	0.9%	0.9%	0.8%	0.5%	0.7%	0.3%	1.0%	0.6%	0.9%	0.8%
AKIN3	2.3%	2.8%	2.9%	3.0%	2.4%	2.4%	3.7%	3.6%	3.0%	2.9%	3.2%	2.7%

Notes:

1. Daycases are excluded, as are stays less than 48 hours and stays without at least 2 creatinine measurements - stages cannot be calculated for these stays.
2. All admissions to the WGH are considered - if patients are discharged and readmitted within 2 days, it is considered the same stay.
3. AKIN stage 3 cases may not include cases who need RRT (unless they fulfill the other stage 3 criteria) as this can't be identified with the data currently available.
4. AKIN stage calculated based on the serum creatinine levels measured at any time between the patients stay in the WGH when the discharge from one of the study wards occurred.

The data presented are released for **clinical and management information** purposes. They contain individual information about patients. Analysis from the data may also result in small numbers which could be potentially disclosive. Please ensure that circulation is restricted and that patient confidentiality is

9.2 Monthly medication error Datix reports - all NHS Lothian sites

	Financial year 2014/15						2015/16					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
n of medication error reports	259	215	219	261	215	213	221	190	273	261	266	177
n related to gentamicin	5	3	-	1	-	1	-	2	6	6	3	1
% related to gentamicin	1.9%	1.4%	-	0.4%	-	0.5%	-	1.1%	-	2.3%	1.1%	0.6%

Source: Datix, All data
 An increase in gentamicin-related medication incidents has been seen post-antimicrobial policy change. Data for June suggests these may be decreasing, but should be used with caution as may not be complete.

9.3 Monthly medication error Datix reports - Royal Infirmary of Edinburgh

	Financial year 2014/15						2015/16					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
n of medication error reports	66	60	68	73	55	51	54	43	66	83	67	37
n related to gentamicin	2	3	-	-	-	1	-	1	2	3	1	-
% related to gentamicin	3.0%	-	-	-	-	-	-	2.3%	-	3.6%	1.5%	-

Chart 9.2 NHS Lothian Medication error Datix reports

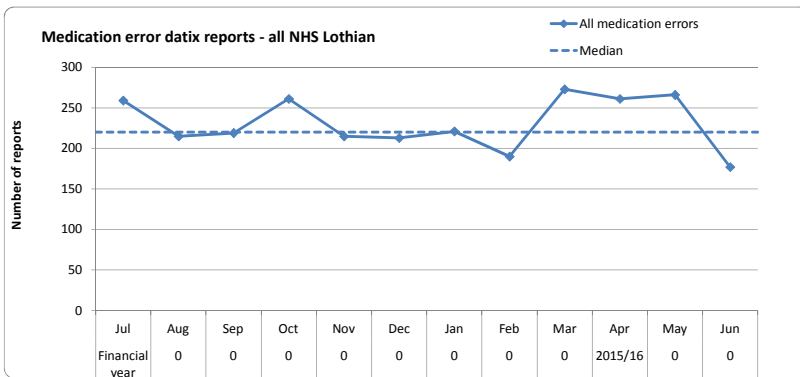
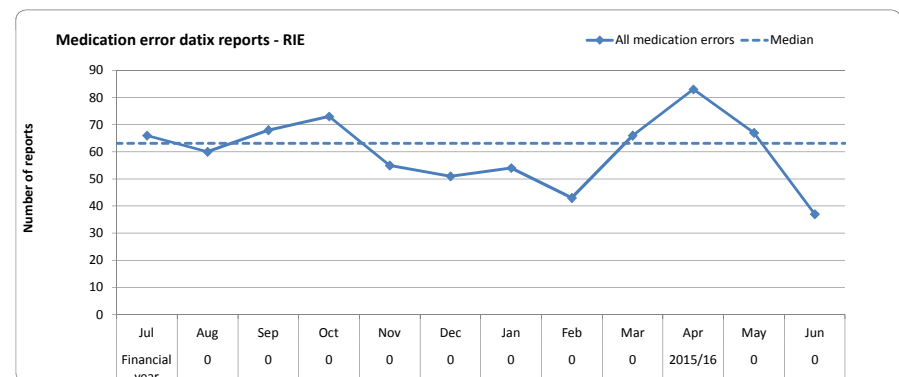


Chart 9.3 RIE Medication error Datix reports



9.4 Monthly medication error Datix reports - Western General Hospital

	Financial year 2014/15						2015/16					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
n of medication error reports	69	52	61	59	57	59	63	49	82	49	76	48
n related to gentamicin	2	-	-	-	-	-	-	-	3	2	1	1
% related to gentamicin	-	-	-	-	-	-	-	-	-	-	1.3%	2.1%

Source: Datix, All data
An increase in gentamicin-related medication incidents has been seen post-antimicrobial policy change, except in SJH.

9.5 Monthly medication error Datix reports - St John's Hospital

	Financial year 2014/15						2015/16					
	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
n of medication error reports	26	18	18	27	16	22	23	20	20	17	22	11
n related to gentamicin	-	-	-	-	-	-	-	-	1	-	-	-
% related to gentamicin	-	-	-	-	-	-	-	-	5.0%	-	-	-

Chart 9.4 WGH Monthly medication error Datix reports

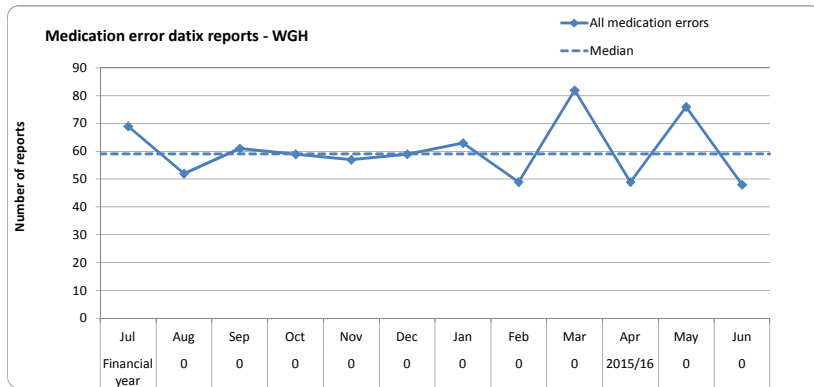
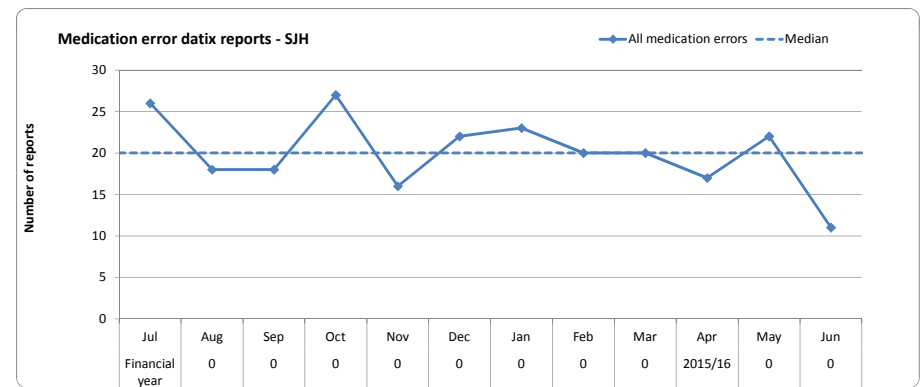


Chart 9.5 SJH Monthly medication error Datix reports



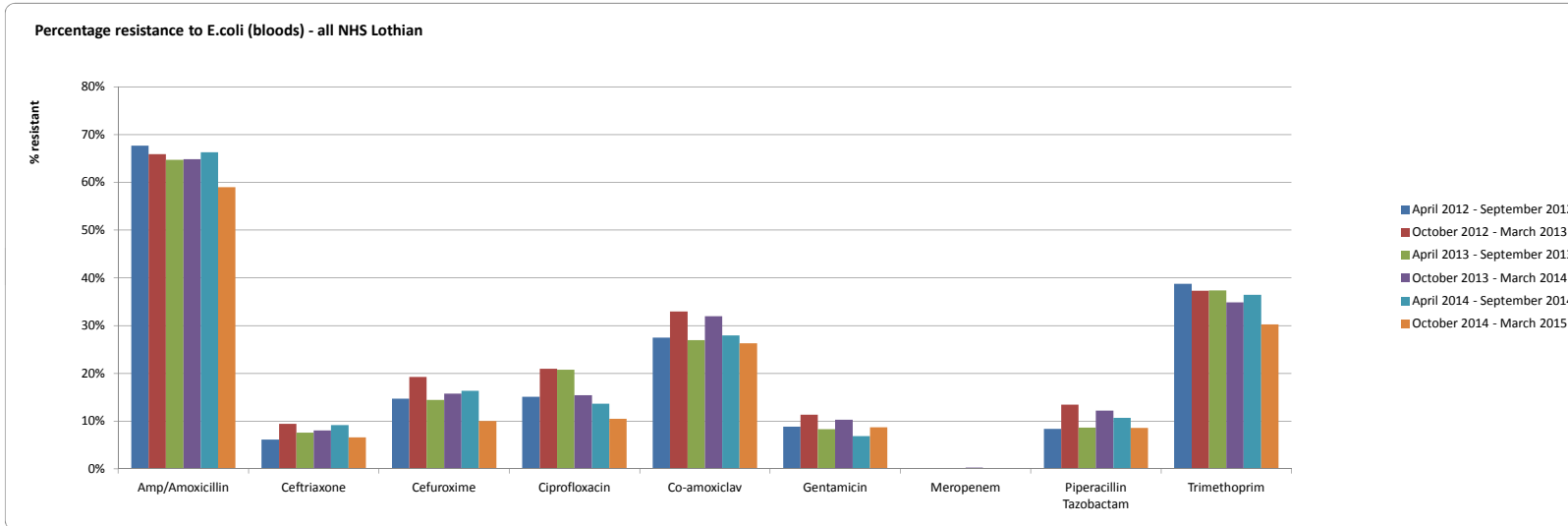
10.1 Resistance to *E.Coli* (bloods) - all NHS Lothian

	April 2012 - September 2012			October 2012 - March 2013			April 2013 - September 2013			October 2013 - March 2014			April 2014 - September 2014			October 2014 - March 2015		
	Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant	
		n	%		n	%		n	%		n	%		n	%		n	%
Amp/Amoxicillin	337	228	67.7%	343	226	65.9%	337	218	64.7%	344	223	64.8%	365	242	66.3%	400	236	59.0%
Ceftriaxone	326	20	6.1%	329	31	9.4%	330	25	7.6%	346	28	8.1%	359	33	9.2%	391	26	6.6%
Cefuroxime	672	99	14.7%	686	132	19.2%	664	96	14.5%	697	110	15.8%	727	119	16.4%	798	80	10.0%
Ciprofloxacin	338	51	15.1%	343	72	21.0%	337	70	20.8%	350	54	15.4%	365	50	13.7%	400	42	10.5%
Co-amoxiclav	338	93	27.5%	343	113	32.9%	337	91	27.0%	350	112	32.0%	365	102	27.9%	399	105	26.3%
Gentamicin	338	30	8.9%	343	39	11.4%	337	28	8.3%	350	36	10.3%	365	25	6.8%	400	35	8.8%
Meropenem	338	0	0.0%	343	0	0.0%	337	0	0.0%	350	1	0.3%	365	0	0.0%	400	0	0.0%
Piperacillin Tazobacta	322	27	8.4%	341	46	13.5%	334	29	8.7%	336	41	12.2%	365	39	10.7%	397	34	8.6%
Trimethoprim	338	131	38.8%	343	128	37.3%	337	126	37.4%	350	122	34.9%	365	133	36.4%	400	121	30.3%

Source: APEX, AMT
All data

Limited post-antimicrobial policy change data is available. Updated figures will be available in October 2015.

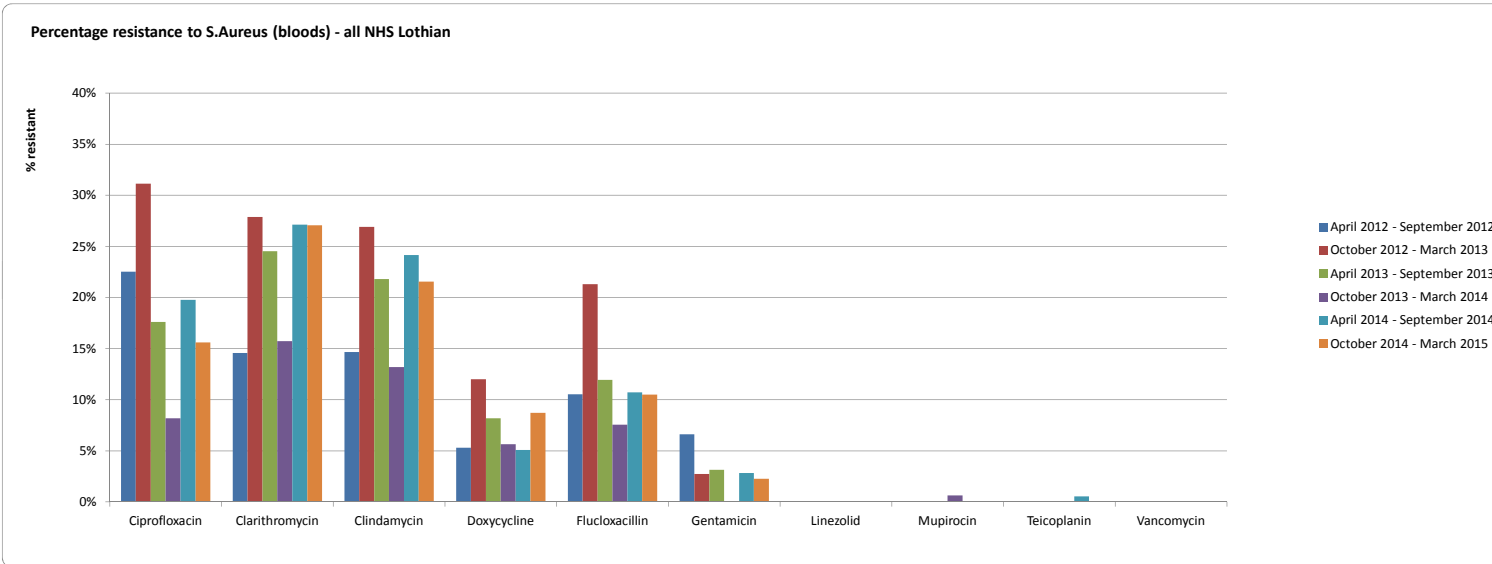
Chart 10.1 Resistance to *E.Coli* - all NHS Lothian



10.2 Resistance to *S.Aureus* (bloods) - NHS Lothian

	April 2012 - September 2012			October 2012 - March 2013			April 2013 - September 2013			October 2013 - March 2014			April 2014 - September 2014			October 2014 - March 2015		
	Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant	
		n	%		n	%		n	%		n	%		n	%		n	%
Ciprofloxacin	151	34	22.5%	183	57	31.1%	159	28	17.6%	159	13	8.2%	177	35	19.8%	218	34	15.6%
Clarithromycin	151	22	14.6%	183	51	27.9%	159	39	24.5%	159	25	15.7%	177	48	27.1%	218	59	27.1%
Clindamycin	150	22	14.7%	182	49	26.9%	156	34	21.8%	159	21	13.2%	178	43	24.2%	218	47	21.6%
Doxycycline	151	8	5.3%	183	22	12.0%	159	13	8.2%	159	9	5.7%	177	9	5.1%	218	19	8.7%
Flucloxacillin	152	16	10.5%	183	39	21.3%	159	19	11.9%	159	12	7.5%	177	19	10.7%	219	23	10.5%
Gentamicin	151	10	6.6%	183	5	2.7%	159	5	3.1%	159	0	0.0%	177	5	2.8%	219	5	2.3%
Linezolid	150	0	0.0%	182	0	0.0%	158	0	0.0%	159	0	0.0%	178	0	0.0%	218	0	0.0%
Mupirocin	150	0	0.0%	182	0	0.0%	158	0	0.0%	159	1	0.6%	178	0	0.0%	218	0	0.0%
Teicoplanin	151	0	0.0%	182	0	0.0%	158	0	0.0%	157	0	0.0%	178	1	0.6%	218	0	0.0%
Vancomycin	150	0	0.0%	184	0	0.0%	158	0	0.0%	157	0	0.0%	178	0	0.0%	219	0	0.0%

Chart 10.2 Resistance to *S.Aureus* (bloods) - NHS Lothian



Source: APEX, AMT
All data

Limited post-antimicrobial policy change data is available. Updated figures will be available in October 2015.

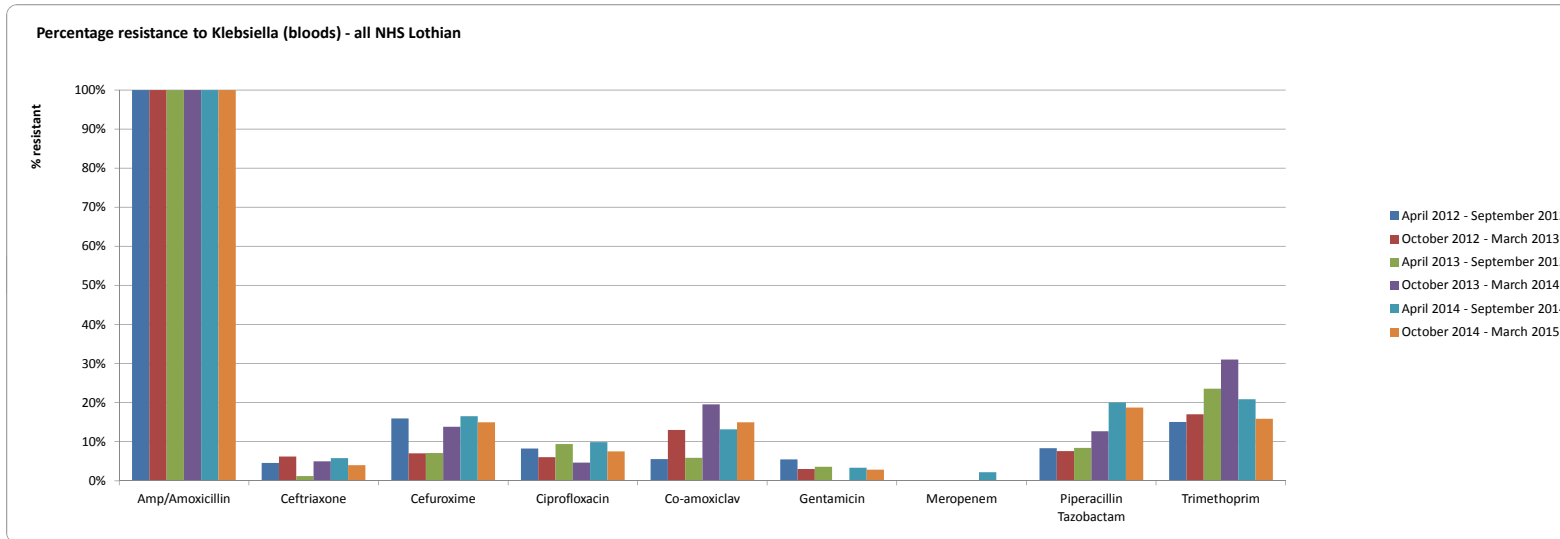
10.3 Resistance to klebsiella (bloods) - NHS Lothian

	April 2012 - September 2012			October 2012 - March 2013			April 2013 - September 2013			October 2013 - March 2014			April 2014 - September 2014			October 2014 - March 2015		
	Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant		Tested	Resistant	
		n	%		n	%		n	%		n	%		n	%		n	%
Amp/Amoxicillin	73	73	100.0%	100	100	100.0%	85	85	100.0%	87	87	100.0%	91	91	100.0%	107	107	100.0%
Ceftriaxone	66	3	4.5%	97	6	6.2%	83	1	1.2%	81	4	4.9%	87	5	5.7%	100	4	4.0%
Cefuroxime	144	23	16.0%	200	14	7.0%	170	12	7.1%	174	24	13.8%	182	30	16.5%	214	32	15.0%
Ciprofloxacin	73	6	8.2%	100	6	6.0%	85	8	9.4%	87	4	4.6%	91	9	9.9%	107	8	7.5%
Co-amoxiclav	72	4	5.6%	100	13	13.0%	85	5	5.9%	87	17	19.5%	91	12	13.2%	107	16	15.0%
Gentamicin	73	4	5.5%	100	3	3.0%	85	3	3.5%	87	0	0.0%	91	3	3.3%	107	3	2.8%
Meropenem	72	0	0.0%	100	0	0.0%	85	0	0.0%	87	0	0.0%	91	2	2.2%	107	0	0.0%
Piperacillin Tazobactam	72	6	8.3%	92	7	7.6%	83	7	8.4%	87	11	12.6%	90	18	20.0%	107	20	18.7%
Trimethoprim	73	11	15.1%	100	17	17.0%	85	20	23.5%	87	27	31.0%	91	19	20.9%	107	17	15.9%

Source: APEX, AMT
All data

Limited post-antimicrobial policy change data is available. Updated figures will be available in October 2015.

Chart 10.3 Resistance to klebsiella (bloods) - NHS Lothian



Data sources: APEX; AMT Antimicrobial Resistance Report

Notes:

1. Sensitivities reported from Apex
2. Tests have not been de-duplicated
3. Intermediate resistances reported as resistance
4. NHS Lothian includes all NHS Lothian sites - including GP and community
5. Blood specimens only
6. S. Aureus figures include Staphylococcus aureus and MRSA
7. Klebsiella figures include: Klebsiella oxytoca, Klebsiella ozaenae, Klebsiella pneumoniae and Klebsiella species

11.1 Scottish Antimicrobial Prescribing Group (SAPG) Prescribing Indicators

These data (which capture whether indication for therapy and duration of therapy have been recorded plus whether the choice of therapy is compliant with local policy) have not been included at aggregate level but are available on QIDS for some areas.

Antimicrobial Stewardship - Antimicrobial Team IV to Oral Switch (IVOS) ward round

11.2 Number of IV reviews where an intervention was recommended - selected RIE/WGH/SJH wards

	Financial year 2014/15					2015/16	
	Nov	Dec	Jan	Feb	Mar	Apr	May*
Total number of reviews	54	197	221	194	296	270	176
Number of interventions recommended	23	103	90	111	149	99	94
% intervention recommended	42.6%	52.3%	40.7%	57.2%	50.3%	36.7%	53.4%

Data sources: IVOS ward rounds data

Notes:

1. A review is completed by an ID Clinician/AMT Pharmacist if the patient has been on IV for 48hrs+ or is on an IV 'alert' antibiotic.
2. Clinicians/pharmacists could recommended one of the following interventions: Stop abx; switch to an oral alternative; narrow spectrum or refer to the OPAT service.
3. If none of the interventions are recommended, the clinician/pharmacist will recommend 'continue & review'.

Source: AMT

All data from Antimicrobial IV-to-Oral switch ward rounds. Following a pilot in 2013/14, rounds re-started in November 2014 and visit non-specialist wards in RIE, WGH and SJH.

An increase in interventions was seen during February 2015. However during the pilot ward rounds, the % interventions recommended ranged from 45% to 61%, so data for February is within these limits. The % of interventions recommended in April decreased sharply, however it appears this was an isolated case as opposed to the start of any trend.

*May data is provisional; please use with caution.

NHS Lothian

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
MRSA	1	1	4	3	4	1	3	1	2	6	1	3
MSSA	21	25	20	26	23	18	25	26	27	29	21	20
Total	22	26	24	29	27	19	28	27	29	35	22	23

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	15	18	9	13	10	11	10	4	12	7	7	7
Age 65 plus	24	20	20	18	23	22	20	17	18	22	14	17
Total	39	38	29	31	33	33	30	21	30	29	21	24

Hand Hygiene Monitoring Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
AHP	96.92	95.49	96.95	96.74	93.92	94.86	95.49	95.28	95.73	96.48	96.52	-
Ancillary	91.45	91.60	90.19	90.77	94.70	91.58	93.19	89.31	92.33	92.41	88.63	-
Medical	92.84	94.96	93.22	93.69	94.39	93.45	90.91	94.11	92.82	93.30	93.35	-
Nurse	98.58	98.11	98.48	98.23	98.20	98.19	98.09	98.54	98.58	98.24	98.33	-
Board Total	96.75	96.75	96.74	96.70	96.65	96.37	95.97	96.66	96.66	96.70	96.54	-

Cleaning Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	96.44	96.25	95.60	96.10	95.70	95.10	94.95	95.40	94.55	94.25	95.55	95.25

Estates Monitoring Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	96.93	96.46	96.80	96.40	97.20	97.10	96.65	96.60	94.75	95.85	96.40	96.15

ROYAL INFIRMARY OF EDINBURGH

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
MRSA	1	1	2	0	2	0	2	0	0	4	1	0
MSSA	12	14	12	9	13	11	15	15	16	11	10	9
Total	13	15	14	9	15	11	17	15	16	15	11	9

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	2	6	2	2	2	2	1	0	5	2	1	2
Age 65 plus	9	6	6	2	8	5	5	6	7	6	2	4
Total	11	12	8	4	10	7	6	6	12	8	3	6

Cleaning Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	97.09	97.07	96.60	97.01	96.63	96.72	96.27	96.55	96.62	96.92	96.61	96.53

Estates Monitoring Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	96.92	96.63	95.82	96.33	97.98	96.10	95.45	95.47	95.99	96.45	95.87	95.94

WESTERN GENERAL HOSPITAL

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
MRSA	0	0	0	2	1	1	0	1	2	1	0	0
MSSA	5	7	6	7	6	6	2	7	6	12	7	7
Total	5	7	6	9	7	7	2	8	8	13	7	7

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	6	5	2	7	2	2	4	3	3	3	2	3
Age 65 plus	6	4	7	10	5	9	4	3	2	3	2	5
Total	12	9	9	17	7	11	8	6	5	6	4	8

Cleaning Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	97.52	96.87	95.01	96.33	94.02	93.55	92.89	93.42	93.22	94.53	94.65	94.17

Estates Monitoring Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	99.04	98.31	97.86	98.24	97.75	97.73	98.17	97.83	96.50	95.36	96.07	95.33

ST JOHNS HOSPITAL

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
MRSA	0	0	1	1	0	0	0	0	0	0	0	3
MSSA	3	2	1	5	1	1	5	2	3	3	3	4
Total	3	2	2	6	1	1	5	2	3	3	3	7

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	1	0	0	0	2	1	0	1	0	0	0	0
Age 65 plus	1	5	1	1	5	3	1	3	2	6	1	4
Total	2	5	1	1	7	4	1	4	2	6	1	4

Cleaning Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	95.13	95.05	93.83	95.43	95.38	95.02	95.76	95.92	94.51	94.52	95.79	94.75

Estates Monitoring Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	94.42	93.51	94.75	95.29	95.63	95.43	95.53	95.01	94.97	95.97	95.45	95.16

LIBERTON HOSPITAL

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
MRSA	0	0	0	0	0	0	0	0	0	1	0	0
MSSA	1	1	0	3	0	0	0	0	1	0	0	0
Total	1	1	0	3	0	0	0	0	1	1	0	0

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	0	0	0	0	0	0	0	0	0	0	0	0
Age 65 plus	2	0	1	0	0	0	1	1	1	1	0	0
Total	2	0	1	0	0	0	1	1	1	1	0	0

Cleaning Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	97.67	97.61	96.83	97.70	97.02	96.71	96.87	96.77	96.23	96.96	97.87	96.63

Estates Monitoring Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	96.93	95.94	93.66	95.12	97.43	98.11	98.04	97.99	98.61	97.37	97.52	97.84

ROYAL HOSPITAL FOR SICK CHILDREN

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
MRSA	0	0	1	0	0	0	0	0	0	0	0	0
MSSA	0	1	1	0	3	0	3	2	1	3	1	0
Total	0	1	2	0	3	0	3	2	1	3	1	0

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	0	0	0	0	0	0	0	0	0	0	1	1
Age 65 plus	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	0	0	0	0	0	0	0	1	1

Cleaning Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	95.18	95.20	93.67	94.21	95.13	95.83	94.11	94.47	91.83	92.61	94.22	93.47

Estates Monitoring Compliance (%)

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Board Total	99.19	99.87	97.59	97.21	98.29	99.00	96.61	97.91	95.15	95.82	97.77	95.83

COMMUNITY HOSPITALS

Community Hospitals include the following hospitals and care facilities

- Astley Ainslie Hospital
- Corstorphine Hospital
- Ellen's Glen House
- Ferryfield House
- Findlay House
- Marie Curie Hospice Edinburgh
- Midlothian Community Hospital
- Roodlands Hospital
- Royal Edinburgh Hospital
- Royal Victoria Hospital
- St Columba's Hospice
- St Michaels Hospital
- Tippethill Hospital

Staphylococcus aureus Bacteraemia Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
MRSA	0	0	0	0	1	0	1	0	0	0	0	0
MSSA	0	0	0	2	0	0	0	0	0	0	0	0
Total	0	0	0	2	1	0	1	0	0	0	0	0

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	0	0	0	0	1	2	2	0	1	0	0	0
Age 65 plus	2	0	1	0	0	2	0	1	0	0	1	1
Total	2	0	1	0	1	4	2	1	1	0	1	1

OUT OF HOSPITAL INFECTIONS

Clostridium difficile Infection Monthly Case Numbers

	Jul 2014	Aug 2014	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015
Age 15-64	6	7	5	4	3	4	3	0	3	2	3	1
Age 65 plus	4	5	4	5	5	3	9	3	6	6	8	3
Total	10	12	9	9	8	7	12	3	9	8	11	4



HAI STANDARDS STRATEGY and IMPROVEMENT MATRIX

2015-2017

Contents Page

Contents

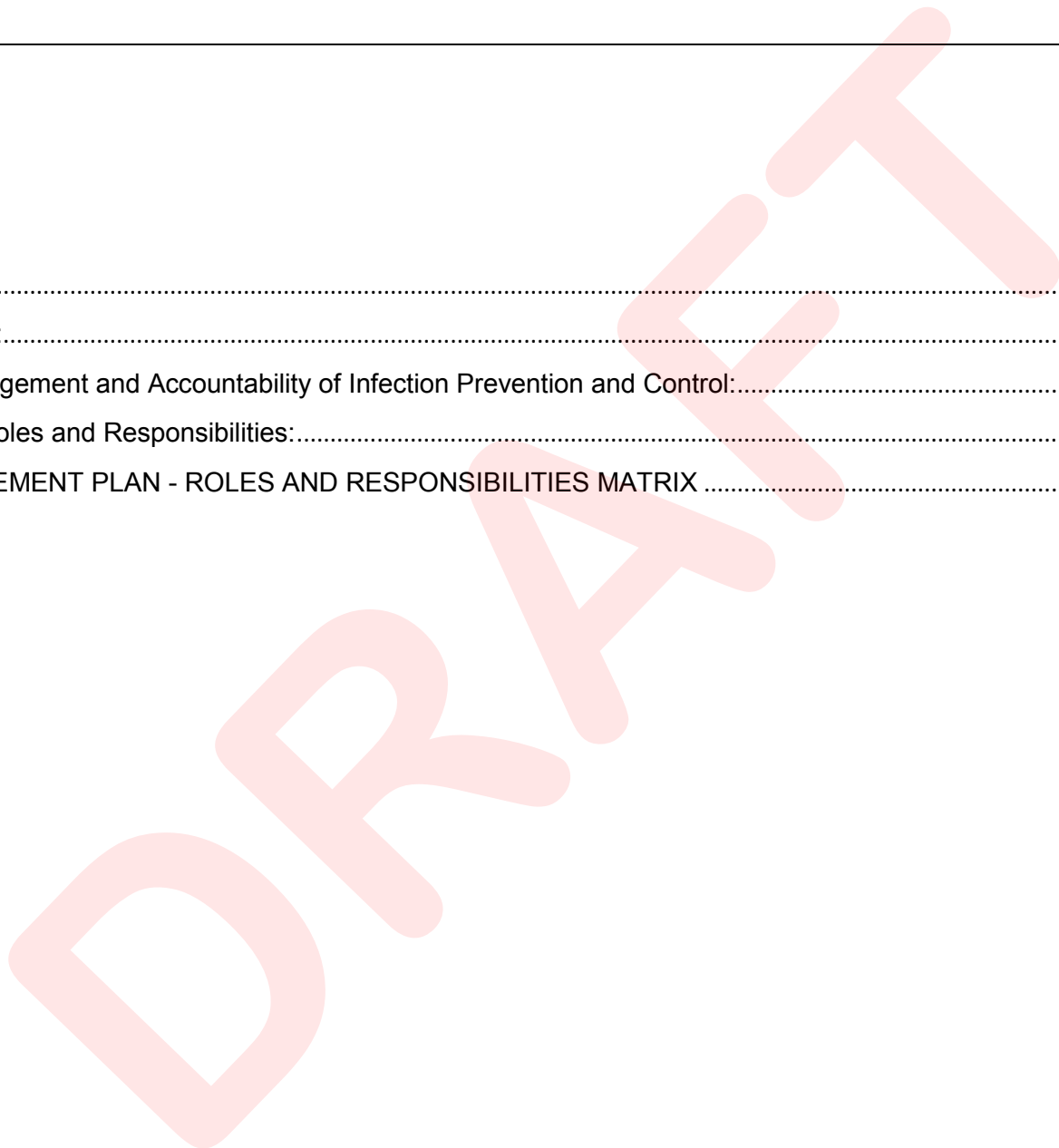
Overview:3

Principles of the Strategy:.....6

Key Forums for the Management and Accountability of Infection Prevention and Control:.....7

Standard 1 Leadership Roles and Responsibilities:.....9

APPENDIX 1 – IMPROVEMENT PLAN - ROLES AND RESPONSIBILITIES MATRIX16



Overview:

NHS Lothian recognises that the effective prevention and control of healthcare associated infection is essential to patient and staff safety and to the overall performance of the organisation. The strategic approach to healthcare associated infection as reflected in this document is fundamental to the delivery of the Board's objectives in relation to patient safety, clinical governance and performance. Effective prevention and control systems and the development of a committed approach to learning will ensure that NHS Lothian continues to develop and improve the safety and quality of patient care.

The Matrix is based on Health Improvement Scotland HAI Standards (2015) which require NHS Scotland Health Boards to “*demonstrate the implementation of evidence based infection prevention and control measures*”.

This strategy is directed at all staff (including Contractors). It describes in detail the roles and responsibilities allocated to different staff groups (from Ward to Board) in relation to HAI Standards. Evidence of implementation and improvement will provide the Board with assurance that infection prevention and control is being constantly monitored and reviewed to ensure best practice for patient and staff safety.

All staff are expected to understand the importance of infection prevention and control procedures, particularly the value of hand hygiene and the application of Standard Infection Control Precautions (SICPs). It is not acceptable for members of staff or students to plead ‘ignorance’ of their responsibility for Infection Prevention and Control. All staff have an implicit responsibility to ensure that they comply with infection prevention and control and take the necessary actions to prevent the spread of infections as failure to follow guidance may put the staff member, their colleagues or patients at risk.

Whilst the Board has the strategic responsibility for ensuring infection prevention and control issues are addressed, it is the Infection Prevention and Control Team who provide the routine operational support to staff. But it is important to emphasise that Infection Prevention and Control is “**everyone’s responsibility**”

	HAI Standard	Rationale	Areas for Improvement:	Improvement Criteria
1.	NHS Lothian to demonstrate leadership and commitment to infection prevention and control to ensure a culture of continuous quality improvement throughout the organisation.	Robust leadership in infection prevention and control is essential for effective decision-making, efficient use of resources and ensuring the provision of high quality safe, effective, person-centred care.	Compliance with Infection Prevention & Control Polices and Practice Monitored through QID results aiming for >95% and observations of good practice and compliance with uniform policy.	Patients and visitors have confidence that NHS Lothian has effective leadership and governance in place. NHS Lothian is able to demonstrate achievements in continuous improvement in infection prevention and control practice
2.	Education on Infection Prevention and Control is provided and accessible to all healthcare teams to enable them to minimise risks that exist in care settings.	To minimise the infection risk associated with healthcare, all staff are provided with the necessary knowledge and skills in infection prevention and control too confidently and competently demonstrate behaviours integral to safe, effective and person-centred care.	Compliance with HAI Mandatory Updates >95%.	People using the services are assured that staff delivering care are educated and trained in infection prevention and control, and use their learning to ensure care is safe, effective and person-centred.
3.	NHS Lothian has effective communication systems and processes in place to enable continuity of care and infection prevention and control throughout the patient's journey.	Patients are vulnerable to infection s and some present an infection risk to other patients, visitors and staff. As a single patient journey can involve staff in multiple care settings, effective care provider communications are vital in infection prevention and control, and safe, effective and person-centred care. Wherever possible, patients and their representatives must be assured of, and involved in, communications regarding their care	Patient documentation should include record of discussions regards any HAI acquisition and treatment including any information leaflets provided to patient and/or family. Senior Management and IPCN Weekly Ward Round undertaken, documented and actions for improvement identified highlighted to the clinical teams.	Patients receiving treatment in, or visiting one or more care setting will receive effective communication on infection-related risks and will be involved in care decisions taken to mitigate these risks
4.	NHS Lothian has a Surveillance system in place to ensure rapid response to Healthcare Associated Infections	HAI Surveillance is the ongoing and systematic collection, analysis and interpretation of data, relating to HAI, which is used to reduce the risk of infection and improve patient outcomes.	Audits and surveillance must be undertaken in accordance with national guidance. Trends and patterns should be monitored and changes escalated for action as required e.g. increased Surgical Site Infection Rates or decrease in SICPs audit results. Staff awareness of local results.	NHS Lothian can demonstrate that surveillance systems are in place to detect, respond to and reduce infection-related incidents.
5.	NHS Lothian demonstrates effective antimicrobial stewardship.	Antimicrobial stewardship, in the form of a co-ordinated programme, has been shown to reduce inappropriate antimicrobial use, improve patient outcomes and reduce adverse	Evidence of appropriate Antimicrobial stewardship and compliance with NHS Lothian policy. Contribution to IV Oral	: Every patient will get the most appropriate antibiotic (type, dose, route and duration) in a timely fashion for their infection,

		consequences of antimicrobial use including antimicrobial resistance, toxicity and unnecessary costs.	Switch as appropriate. Appropriate documentation including rationale, duration, start/stop dates etc.	according to the national policy and/or guidelines
6.	NHS Lothian demonstrates implementation of evidence based infection prevention and control measures.	The minimum standard of infection prevention and control to be practiced by all staff, in all care settings, for all care procedures is the application of standard infection control precautions, as detailed in chapter one of the National Infection Prevention and Control Manual. SICPs are the most effective means to prevent cross-transmission and cross-infection with micro-organisms in care settings.	Clinical areas must complete and submit SICPs audits with a minimum of 20 observations per quarter for all SICPs with the exception of Hand Hygiene which remains monthly. All areas should supply action plans and be able to demonstrate improvement between quarters where results below optimum result of 95%.	Policies will be current and reflect national guidance, clinical teams will be supported to implement and management will monitor to facilitate compliance
7.	Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters.	Invasive devices present a significant infection risk to patients. These risks can be minimised by: <ul style="list-style-type: none"> • Avoidance of device use where possible • Following evidence-based procedures for insertion and maintenance • Removing the device as soon as there is a clinical indication to do so 	Improved compliance with relevant patient safety programme bundles e.g. PVC/CVC, VAP and CAUTI aiming to achieve both process and outcome measures.	Every individual with an invasive device is reassured that staff are competent, any device in situ the insertion and maintenance are clearly documented in patient's records and include date of insertion and reason for insertion
8.	The Environment and equipment (including reusable medical devices used) are clean, maintained and safe for use. Infection risks associated with the built environment are minimised.	Effective decontamination is critical in the provision of a safe, clean environment and equipment. The built environment must be designed, planned, constructed, refurbished and maintained to minimise the risks of infection. The standards covers the decontamination, management and maintenance of: <ul style="list-style-type: none"> • Reusable communal patient care equipment • Reusable medical devices • The built environment 	FMT Scores reflect national targets and are quality assured for accuracy. Observations of near patient equipment/mattresses confirm compliance with SICP results. HAI Scribes available for any works being undertaken.	Patients using our service have confidence that they are being cared for in a clean, safe care environment and that all equipment used will be clean and free from contamination
9.	All equipment acquired (this being equipment that is procured, loaned, donated, in-house manufactured, or for use within a trial or research) for the care environment is safe for use.	The infection risk to patients is minimised by having an acquisition process in place that ensures all equipment (including reusable medical devices) is safe for its intended use. Safety refers to minimise the risk of transmission of infection.	Evidence of procurement policy compliance for any purchases out with national contract.	Patients will be confident that all medical devices and communal patient equipment being used by staff and/or in the healthcare and social care setting meet the required level of safety, quality and performance

Principles of the Strategy:

The following principles underpin the strategy:

- That infection prevention and control will be embedded in the core processes and systems of the Board, including guidelines and procedures, operational policies, education and training the business planning cycle, and business case development.
- That infection prevention and control will be integrated and converge with business planning, performance management and corporate governance.
- Infection prevention and control will be actively managed and positive assurance sought
- That infection prevention and control is the responsibility of all staff within their own sphere of work
- That high-risk infection prevention and control areas and activities will attract focus and attention.
- That there will be learning from root cause analysis, data review, incidents, claims, complaints and national reports and explicit roll-out of identified improvements.

There is a significant amount of national guidance available to NHS Board to ensure they have sufficient effective systems and processes in place to assure patients and staff that the healthcare provided is of a quality that safeguards patients in both hospital and community care. These include

- Revised HAI Standards issued 2 February 2015
- Health Protection Scotland: Standard Infection Control Precautions (SICPs)
- HAI SCRIBE (Healthcare Associated Infection. System for Controlling Risk In the Built Environment)
- Vale of Leven Enquiry Report

Within NHS Lothian there are national and local policies/strategies in place which can be found on the intranet page.

- Infection Control Manual and associated Standard Operating Procedures
- HAI Education Strategy
- HAI Patient Information Leaflets
- Non Compliance with Hand Hygiene Policy.

Key Forums for the Management and Accountability of Infection Prevention and Control:

Infection Prevention & Control Committees (IPCC)

Within NHS Lothian each of the acute hospitals has an operational Infection Prevention and Control Committee chaired by Site Director meeting monthly. The site based committees report to Pan Lothian IPCC chaired by the HAI Executive Lead which meets every 3 months.

There is Community Health Partnership IPCC chaired by Clinical Director for Edinburgh CHP which meets every 3 months.

It is the responsibility of each site based IPCC to develop local actions plans based on the HAI Standards Strategy and Improvement Matrix including named responsible staff members for delivery and time frames for achievement.

Pan Lothian IPCC and CHP ICC report to Lothian Infection Control Advisory Committee.

The IPCCs are the main forum for discussion concerning changes to policy or practice relating to infection prevention and control. The committees have a multi-disciplinary membership which includes representation from senior management and all directorates. The committees are responsible for:

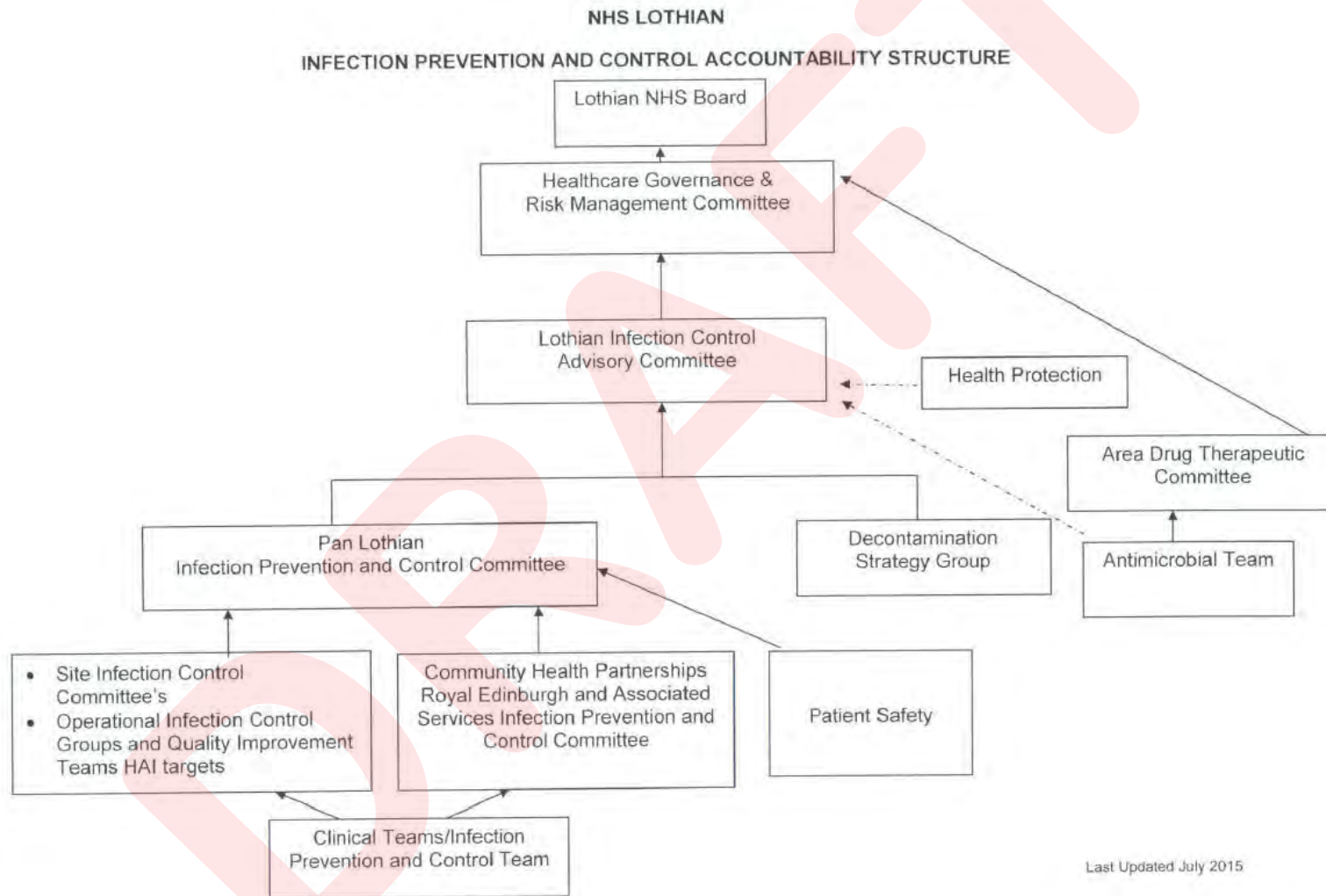
- The ratification of NHS Lothian's policies and guidelines relating to infection prevention and control, ensuring appropriate consultation has taken place, that policy documents have been impact assessed and that they are endorsed by NHS Lothian Board where appropriate.
- Oversight of surveillance of infection control and antimicrobial prescribing in NHS Lothian.
- Reviewing IMT Debrief Notes to ensure that lessons learned are applied across the whole organisation.
- Oversight of performance of NHS Lothian against national standards relating to infection prevention and control.
- Endorsement of the annual infection prevention and control work programme and reports.

Lothian Infection Control Advisory Committee

Chaired by the Director of Public Health, the Lothian Infection Control Advisory Committee oversees the prevention and control of infection across NHS Lothian incorporating:

- Infection Prevention and Control
- Health Protection Team
- Emergency Planning
- Clinical Governance
- Domestic Services
- Environmental Health

Figure below shows NHS Lothian's Infection Prevention and Control Accountability and Structure



Standard 1 Leadership Roles and Responsibilities:

It is recognised that effective healthcare associated infection prevention and control requires commitment and active involvement of all employees. It is therefore vital that the infection prevention and control process is communicated and embedded throughout the organisation from the Executive Team including Board Members to Clinical Teams on the ward. Appendix 1 outlines the Infection Prevention and Control Roles and Responsibilities Matrix.

Chief Executive and NHS Lothian Board designates responsibility for the prevention and control of infection as a core part of the Board's clinical Governance. The Board have designated specific responsibility relating to Healthcare Associated Infections to the HAI Executive Lead who is a member of the Board. The Chief Executive has appointed a Head of Service for Infection Prevention and Control who reports directly to the HAI Executive Lead.

HAI Executive Lead has designated specific responsibility relating to the control of healthcare associated infections within NHS Lothian. The HAI Executive Lead is responsible for the Board approved Infection Prevention and Control Programme. The HAI Executive Lead chairs the UHS Infection Control Committee.

Nurse Director/Associate Nurse Directors have delegated responsibility to ensure the further development and implementation at operational level of the Infection Prevention and Control Improvement Matrix.

Medical Director has delegated responsibility to support the implementation and further development of the infection prevention and control strategy.

Head of Education and Employment responsible for ensuring the Board has an HAI Education Strategy identifying the level and type of training required based on the Skills for Health Occupational Standards (January 2012). The Strategy is available within HR Online within the Intranet and outlines the HAI training requirement for staff with:

- Non direct patient contact – such as medical secretaries, hospital administration staff, van drivers
- Direct Patient Care, Non Clinical Contact – such as ward clerks, clinic reception staff, non-patient porters laboratory staff, pharmacist and social workers
- Direct Patient Care, Clinical Contact – such as registered and non registered practitioners, under and post graduate students and portering staff who have direct patient contact.
- Frontline Healthcare Associated Infection Control Specialists, Link Trainers who require advanced knowledge in all aspects of healthcare associated infections, direct clinical contact and those with no direct patient care.

Department of Clinical Governance will support the senior managers/ward staff in the delivery of effective healthcare associated infection prevention and control practice, education and audits through the QID system. These include:

- The Quarterly Standard Infection Control Precautions
- VAP Bundle

- PVC Bundle
- CVC Insertion and Maintenance Bundles
- Point of Care Priorities which includes Sepsis, Surgical Site Infections and CAUTI.

Site/Service Managers within NHS Lothian include Site Director, Associate Nurse Directors, Associate Medical Directors, General Managers and Clinical Service Manager, who have been designated by the Board to be responsible for their specific site/service, e.g. Royal Infirmary of Edinburgh, St John's Hospital etc. Site/Service Managers are responsible for ensuring there is effective infection prevention and control processes and policies are implemented within their remit area which includes:

- Dissemination of the strategy details, development of local action/delivery plan and allocation of responsibilities for implementation to site/service managers and staff
- In conjunction with Lead or Geographical Lead Infection prevention and control nurse, identify directorate/site specific infection control issues that might not have been addressed explicitly within the Strategy
- Ensuring that infection prevention and control is incorporated into the directorate/site decision making, service planning, performance management, project management, maintenance and refurbishment, and other related processes.
- Monitoring site infection rates and compliance audits for example Standard Infection Control Precaution (SICP) Audits, MRSA National Screening results and Patient Safety Bundles.
- Ensuring that infection prevention and control is included as a core item on all management team briefings/meetings.
- In the event of an incident, ensuring appropriate investigation is carried out and participating in Incident Management Team Meetings if required.
- Reporting via performance and clinical practice and standards reviews on the directorate/site infection prevention and control management performance in addition to new and emerging risks, major changes of priority on existing risks and key actions.
- Ensuring, where necessary, healthcare associated infections prevention and control risks are reported on the Risk Register.
- In accordance with Vale of Leven requirement carry out week Senior Managers Walk round for their site/remit with an Infection Prevention and Control Nurse

Clinical Nurse Managers in addition to contributing to the responsibilities outlined above, Clinical Nurse Managers will have responsibility for:

- Leading and driving a culture of cleanliness in clinical areas.
- Ensuring implementation of NHS Lothian's Infection Prevention and Control Manual, Policies and Procedures.
- Identifying healthcare associated infections prevention and control training needs to ensure that staff and volunteers are able to work safely and comply with NHS Lothian's policies and procedures, including mandatory training requirements.
- Monitoring standards of cleanliness in clinical areas.
- Promoting infection prevention and control awareness responsibilities amongst employees, service users, contractors and partners.
- In conjunction with Infection Prevention and Control Team leading root cause analysis and where required promote learning and practice improvement.

- Ensuring effective ward management by Charge Nurses which includes implementation of infection prevention and control policies, the provision of high standards of essential patient care and the maintenance of a safe and clean and patient friendly environment.
- Attending the relevant Infection Prevention and Control Committees to role.

Antimicrobial Management Team (AMT) to support the prudent prescribing of antimicrobials across both primary and secondary care within NHS Lothian. The key members of the AMT comprise a Lead Clinician, Chairperson, Microbiologist, and Antimicrobial Pharmacist, Head of Service for Infection Prevention and Control and Data Analyst. The aim of the AMT is to:

- Reduce antimicrobial resistance
- Promote prudent antimicrobial prescribing
- Develop a strategic approach to systematic identification and containment of future resistant organisms

Microbiologist/Virology Teams are accountable to the Medical Director and provides clinical leadership on all matters relating to infection prevention and control. The Microbiologists and Virologists provide a 24 hour Duty Service 7 days a week. In addition, they advise on surveillance and clinical policies development and provide access to specialist infection prevention and control advice and support to both acute and community settings. The Microbiologists/Virologists depending on the incident chair the Problem Assessment Groups or Incident Management Team.

Head of Service for Infection Prevention and Control is accountable to the HAI Executive Lead and has overall responsibility for the management of processes and risk assessment relating to infection prevention and control. The Head of Infection Prevention and Control Services is responsible for working closely with Scottish Government Health Department, Health Improvement Scotland, Health Protection Scotland and other agencies on improving practice.

In particular the Head of Service for Infection Prevention and Control is responsible for:

- Providing managerial support to the infection prevention and control team
- Co-ordinating the prevention and control of infection throughout NHS Lothian wide
- Delivering the Board approved Infection Prevention and Control Programme
- Challenging non compliance with local and national protocols and guidance relating to prevention and control of infection, decontamination, antimicrobial prescribing and cleaning
- Producing an annual report on the state of HAI, decontamination and cleaning in NHS Lothian

Lead Infection Prevention and Control Nurse will provide specialist knowledge and advice on all matters pertaining to infection prevention and control and is responsible for:

- All areas of infection prevention and control in relation to production, review and implementation of local policies, protocols and guidelines with input from other appropriate clinical and non clinical staff
- Leading the Infection Prevention and Control Audit Programme
- Developing and maintaining partnership working with other infection control specialists, partner organisations and patient

Infection Prevention and Control Team is responsible for the surveillance and monitoring of infection within NHS Lothian. Providing operational advice and support to all staff on infection prevention and control matters. The team comprises of Head of Service, Lead Infection Prevention and Control Nurse, Geographical Lead Infection Prevention and Control Nurses, HAI SCRIBE Lead Infection Prevention and Control Nurse, Infection Prevention and Control Nurses, Clinical Scientists, Cleanliness Champions Programme Facilitator, HAI Quality Improvement Facilitator and Administration Team.

Responsibilities relating to Specific Groups of Staff:

All staff have a responsibility to ensure patient safety through the implementation of the best possible infection prevention and control practice. As an employee of NHS Lothian everyone has a responsibility for and a role to play in managing infection prevention and control which includes:

- Being aware of NHS Lothian's infection prevention and control policies and procedures
- Adhering to infection prevention and control as required within their role
- Alerting managers to any infection control risks or environmental deficits within the service area that requires urgent attention.
- Participation in annual mandatory infection prevention and control training either via Leanpro or Toolbox talks
- Maintaining a clean and safe environment.
-

Non compliance with infection prevention and control policies by any staff member may general disciplinary action

Consultants: Consultant staff have a responsibility to ensure they abide by the Board's infection prevention and control protocols and procedures and to act as a positive role model for junior doctors and other staff of hand hygiene and all other infection prevention and control issue including the application of standard infection control precautions. Infection prevention and control performance should be included as a measure in appraisals of all junior doctors within their teams. Failure to abide by NHS Lothian's infection prevention and control procedures may result in disciplinary action taken against the practitioner.

Locums/Agency Staff: Any Locum or Agency Staff must be made aware on commencement of their duties where to access information on infection prevention and control procedures and how to contact the Infection Prevention and Control Duty Nurse for advice. Their daily supervisor must ensure they understand the Board's commitment to preventing and controlling infection, and to have the necessary skills to comply with the infection prevention and control requirements placed upon them. Failure to abide by NHS Lothian's infection prevention and control policies and procedures may result in termination of the temporary contract.

Unit Operational/Locality/Area Operational Managers: are to provide a positive role model to the rest of the staff and to spearhead infection prevention and control initiatives jointly with the Infection Prevention and Control Team. They advise on how strategic decisions on infection control issues can be implemented and drive such implementation forward through the role of the Senior Charge Nurses and Service Leads.

Senior Charge Nurses/Ward Managers: Senior Charge Nurses are responsible for ensuring that the following Standard Infection Control Precautions (SICPs) are complied with:

- Patient Placement
- Hand Hygiene
- Respiratory Hygiene (Cough etiquette)
- Personal Protective Equipment
- Re-useable Patient Care Equipment
- Control of the Environment
- Management of Linen
- Management of Blood and Body Fluids
- Waste Disposal
- Occupational Exposure Management

These standard precautions should be embedded into practice and become routine, safe practice by all staff for which they have day-to-day responsibility. This can best be achieved by being a good role model, and through being accessible and visible on a daily basis. Performance of the above standard precautions should become core to all nurse appraisals with onward referral for further training where skills are found to be lacking.

Further infection prevention and control issues for which senior nurses are responsible for include:

- Appropriate use of indwelling devices
- Managing and recording accidents and incidents
- Good communication with other healthcare workers, patients and visitors
- Training and education

Senior Charge Nurses must also ensure that access to the online infection prevention and control manual and associated policies and standard operating procedures/guidelines is available in all work areas and that all staff know how to obtain infection control advice at all times via IPCN Duty Nurse during core hours, their allocated infection prevention and control nurse or contacting Duty Microbiologist/Virologist Out of Hours.

Nurses (all Grades): All nurses have a day-to-day responsibility to ensuring that the SICPs listed above are maintained to the best of their ability. They have the responsibility to prevent and reduce the spread of infection by the use of good infection control practices.

Any nurse who feels they do not have the necessary skills to achieve the high standards expected of them should approach their line manager for advice. Line Managers must ensure that nursing staff are released to attend infection prevention and control courses.

Nursing staff may be asked to participate in the 10 Standard Infection Prevention and Control Audits which are to be carried out with 20 observations/questions asked per clinical area on a quarterly basis with the results logged by the deadline within the Quality Improvement Data System (QIDS) that is utilised within NHS Lothian.

All Nurses should know how to access the online infection prevention and control manual and associated policies and standard operating procedures/guidelines and know how to obtain infection control advice at all times via IPCN Duty Nurse during core hours, their allocated infection prevention and control nurse or contacting Duty Microbiologist/Virologist Out of Hours if further advice is necessary.

Compliance with infection prevention and control practices should be incorporated into the appraisal process. Failure to abide by NHS Lothian's infection prevention and control policies and procedures may result in disciplinary action taken against the nurse.

Allied Health Professionals: such as therapists and technicians will come into contact with patients in a variety of ways; i.e. direct or indirect physical contact.

All AHPs have a day-to-day responsibility for ensuring that the SICPs listed above are maintained to the best of their ability. They have the responsibility to prevent and reduce the spread of infection by the use of good infection prevention and control practices.

Any AHP who feels they do not have the necessary skills to achieve the high standards expected of them should approach their line manager for advice. Line Managers must ensure that AHPs are released to attend courses where infection prevention and control training has been identified as a need.

All AHPs should know how to access the online infection prevention and control manual and associated policies and standard operating procedures/guidelines and know how to obtain infection control advice at all times via IPCN Duty Nurse if further advice is necessary.

Domestic Staff: Are employed to maintain a clean environment and hold joint responsibility with care staff for achieving this. All Domestic staff must have clear roles and responsibilities which are known throughout the work area. Schedules of cleaning should be displayed, reviewed and maintained. Problems should be immediately reported to the line manager to ensure prompt remedy.

All other staff including Healthcare Assistants/Support Workers/Portering Staff/Estates Staff: All staff have to attend induction sessions where information will be provided on the importance of infection prevention and control relevant to the role that they carry out. Further training is available as part of the infection prevention and control education programme. They must ensure that they are familiar with the relevant infection prevention and control procedures for their role, and where they feel they do not have the necessary skills to deal with infection prevention and control issues, they should seek advice from their line manager. Failure to abide by NHS Lothian's infection prevention and control policies and procedures may result in disciplinary action taken against the member of staff.

Estates Team have the responsibility to ensure that they comply with infection prevention and control policies such as Healthcare Associated Infection System for Control in the Built Environment (HAISCRIBE) to ensure that all new builds and refurbishments carried out in clinical areas comply with required national standards.

Contracted Staff: All contracted staff must abide by this policy and the associated guidelines. Those employing contracted staff have a responsibility to ensure they are aware of the requirements of the organisation, before work is commenced. NHS Lothian reserves the right to review and cancel the contract of any contractor who is non-compliant with their infection control responsibilities under this policy.

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APPENDIX 1 – IMPROVEMENT PLAN - ROLES AND RESPONSIBILITIES MATRIX

HAI Standard 1: NHS Lothian to demonstrate leadership and commitment to infection prevention and control to ensure a culture of continuous quality improvement throughout the organisation.

Rationale: Robust leadership in infection prevention and control is essential for effective decision-making, efficient use of resources and ensuring the provision of high quality safe, effective, person-centred care.

Areas for Improvement: Monitored through QID results aiming for >95% and observations of good practice and compliance with uniform policy.

Improvement Criteria: Patients and visitors have confidence that NHS Lothian has effective leadership and governance in place. NHS Lothian is able to demonstrate achievements in continuous improvement in infection prevention and control practice.

Leadership in the Prevention and Control Of Infection	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	All staff to be aware of their role in maintaining a safe care environment ensure compliance with SICPs and TBPs at all times Be prepared to challenge and/or escalate as appropriate practice where breaches	Ensure compliance is monitored and use local data to assess and improve the quality of care. Ensure, reporting structure, guidance, training and education to facilitate the delivery of effective infection prevention and control standards.	Monitor compliance ensuring action plans developed and implemented Support SCN in escalation as appropriate through reporting structure, Ensure compliance with training and education to facilitate the delivery of effective infection prevention and control.	Ensure have a working knowledge, appropriate to role in the organisation of the IPC Policies and procedures as well as national and local priorities that impact on care within NHS Lothian. Support in the provision of resources and equipment as appropriate	Ensure have a working knowledge, appropriate to role in the organisation of the IPC Policies and procedures as well as national and local priorities that impact on care within NHS Lothian. Support in the provision of resources and equipment as appropriate	Ensure that HAI issues are addressed by Board Management Ensure there is strategic, operational and quality assurance systems in place with Clinical Governance	Ensure there is an infection prevention and control accountability framework. Ensure that data from variety of sources is utilised to support learning and continuous improvement in infection prevention and control	Responsible for ensuring the infection prevention and control team have the necessary expertise and leadership skills to support the organisation. Ensure risk assessments are undertaken to ensure continuity of safe patient care	Provide support through provision of resources, suitable environment, reporting structure, guidance, training and education and data that facilitate the delivery of effective infection prevention and control.	Provide specialist IPC/ Medical Microbiology Advice to all staff.

HAI Standard 2: Education on Infection Prevention and Control is provided and accessible to all healthcare teams to enable them to minimise risks that exist in care settings.

Rationale: To minimise the infection risk associated with healthcare, all staff are provided with the necessary knowledge and skills in infection prevention and control too confidently and competently demonstrate behaviours integral to safe, effective and person-centred care.

Areas for Improvement: Compliance with HAI Mandatory Updates >95%.

Improvement Criteria: People using the services are assured that staff delivering care are educated and trained in infection prevention and control, and use their learning to ensure care is safe, effective and person-centred.

Education to support the prevention and control Of infection	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	Undertake mandatory and appropriate infection prevention and control training relevant to role. (See HAI Education Strategy) Able to demonstrate knowledge and competence in the delivery of care, and act as role models in the promotion of infection prevention and control.	Ensure mandatory training in PDPs and monitor compliance at appraisal. Ensure local induction includes IPC information / training appropriate to department and role. Responsible for identifying issues relating to infection prevention and control at point of care.	Monitor compliance with mandatory training taking action when evidence of non or poor compliance Support the Senior Charge Nurse to identify additional IPC training appropriate to role/dept utilising HAI education strategy	Ensure staff are enabled to undertake mandatory and additional training appropriate to role/dept.	Ensure staff are enabled to undertake mandatory and additional training appropriate to role/dept.	Promote the contribution of HAI education in professional training programmes. Ensure progress is reviewed by the ICC	Ensure infection prevention and control education is included in HAI work programme	Develop and deliver educational material for the IPCT and clinical teams. Support the HoS and Education Department in development and review of HAI Education Strategy Act in role as HAI Education Lead for IPC ensuring IPC Staff develop and maintain knowledge and skills	Deliver Educational material to clinical teams Undertake relevant qualifications and maintain own knowledge and skills	Provide specialist Medical Microbiologist expertise to the development of educational programmes

Standard 3: NHS Lothian has effective communication systems and processes in place to enable continuity of care and infection prevention and control throughout the patient’s journey.

Rationale: Patients are vulnerable to infections and some present an infection risk to other patients, visitors and staff. As a single patient journey can involve staff in multiple care settings, effective care provider communications are vital in infection prevention and control, and safe, effective and person-centred care. Wherever possible, patients and their representatives must be assured of, and involved in, communications regarding their care.

Areas for Improvement: Patient documentation should include record of discussions regarding any HAI acquisition and treatment including any information leaflets provided to patient and/or family. Senior Management and IPCN Weekly Ward Round undertaken, documented and actions for improvement identified highlighted to the clinical teams.

Improvement Criteria: Patients receiving treatment in, or visiting one or more care setting will receive effective communication on infection-related risks and will be involved in care decisions taken to mitigate these risks.

Communication between organisations and with the Patient or their representative	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	Provide HAI information to patients relevant to their care. Ensure risk assessments are completed and advice documented.	Ensure HAI information leaflets are available to patients and stocked appropriately.	Ensure HAI information is available to patients.	Seek assurance that patient information systems are in place.	Undertake IPC walk rounds and review patient records in accordance with VoL requirements and take action when non compliance is identified.	Promote the culture of openness around HAI information. Ensure progress is reviewed by the ICC. Describe organisational accountability and support for effective communication systems and processes.	Ensure that gaps in information materials are addressed. Ensure that patient public reps. are involved in the planning and development of measures to prevent and reduce HAI.	Support the development of patient information leaflets and advice on methods of accessing these.	Develop patient information leaflets.	Provide specialist IPC/ Medical Microbiology advice to the development of patient information materials.

Provision of Infection Control Advice	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	<p>Ensure familiar with SICPs and TBPs. Demonstrate good practice to trainees, new staff or direct reports. Share advice provided by the IPCT with colleagues. Seek specialist IPC advice when issues cannot be resolved within own knowledge</p>	<p>Ensure all staff are aware how to access Infection Control Manual, and demonstrate knowledge of SICPs and TBPs. Include IPC advice in ward safety briefings. Escalate for specialist advice as appropriate</p>	<p>Provide support for implementation of IPC advice where there are conflicting priorities e.g. limited isolation facilities. Seek advice when issues cannot be resolved within own knowledge. Include IPC advice in ward safety briefings/ team meetings. Monitor compliance with SICPs and TPBs</p>	<p>Provide support to SCN and CNM in the challenges of competing pressures in the implementation of advice e.g. patient placement, closures and limited single rooms. Seek advice when issues cannot be resolved within own knowledge. Include IPC advice in ward safety briefings/ team meetings</p>	<p>Supports the service delivery manage competing priorities e.g. patient placement, waiting times versus IPC closures</p>	<p>Ensure that appropriate HAI advice is available to NHS Lothian</p>	<p>Provide an efficient and effective IPC advisory service.</p>	<p>Provide general and specialist infection prevention and control advice to staff.</p>	<p>Provide general and specialist infection prevention and control advice to staff.</p>	<p>Provide specialist IPC/ Medical Microbiology Advice to all staff.</p>

HAI Standard 4: NHS Lothian has a Surveillance system in place to ensure rapid response to Healthcare Associated Infections.

Rationale: HAI Surveillance is the ongoing and systematic collection, analysis and interpretation of data, relating to HAI, which is used to reduce the risk of infection and improve patient outcomes.

Areas for Improvement: Audits and surveillance must be undertaken in accordance with national guidance. Trends and patterns should be monitored and changes escalated for action as required e.g. increased Surgical Site Infection Rates or decrease in SICPs audit results. Staff awareness of local results.

Improvement Criteria: NHS Lothian can demonstrate that surveillance systems are in place to detect, respond to and reduce infection-related incidents.

	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
HAI Surveillance	Participate in data collection/ submission. Contribute to the investigations in to acquisition and source. Take corrective action as appropriate	Implement local & national surveillance as required. Ensure compliance with audit programme Review audits and develop action plan for improvement as appropriate	Review action plan and escalate unresolved issues	Review action plan and escalate unresolved issues to risk register	Check that action has been taken to address issues on risk register.	Ensure review of the audit programme by the ICC. Promote the culture that infection prevention and control is everyone's business	Develop quality assurance systems. Supply adequate specialist support. Ensure there is a robust HAI audit programme.	Ensure quality assurance of data collection is carried out by IPCNs	Support audit methodology design. Quality Assure data collection	Provide specialist Medical Microbiology expertise to audit design and clinical leadership towards resulting change in practice.

HAI Standard 5: NHS Lothian demonstrates effective antimicrobial stewardship.

Rationale: Antimicrobial stewardship, in the form of a co-ordinated programme, has been shown to reduce inappropriate antimicrobial use, improve patient outcomes and reduce adverse consequences of antimicrobial use including antimicrobial resistance, toxicity and unnecessary costs.

Areas for Improvement: Evidence of appropriate Antimicrobial stewardship and compliance with NHS Lothian policy. Contribution to IV Oral Switch as appropriate. Appropriate documentation including rationale, duration, start/stop dates etc.

Improvement Criteria: Every patient will get the most appropriate antibiotic (type, dose, route and duration) in a timely fashion for their infection, according to the national policy and/or guidelines.

Antimicrobial Stewardship	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	Comply with current antimicrobial policy/guidelines Demonstrate awareness of antimicrobial guidelines relevant to their role and responsibility.	Comply with current antimicrobial policy /guidelines. Ensure that current antimicrobial guidelines are appropriately displayed.	Comply with current antimicrobial policy /guidelines. Ensure that current antimicrobial guidelines are available for clinical team.	Ensure that current antimicrobial guidelines are available for clinical team.	Ensure that current antimicrobial guidelines are available for clinical team.	Describe the organisations accountability and support for antimicrobial stewardship.	In conjunction with the Antimicrobial Management Team demonstrate that guidelines reviews are completed every two years.	Ensure IPCNs have a baseline knowledge of empiric prescribing	Ensure ABX data is included as appropriate in patient monitoring and escalate as appropriate to Microbiologist /Virologist where issues identified during investigations and monitoring of patient care	Ensure there is Microbiology representation on the Antimicrobial Management Team. Monitor resistance trends and patterns adjusting advice and guidance as appropriate

HAI Standard 6: NHS Lothian demonstrates implementation of evidence based infection prevention and control measures.

Rationale: The minimum standard of infection prevention and control to be practiced by all staff, in all care settings, for all care procedures is the application of standard infection control precautions, as detailed in chapter one of the National Infection Prevention and Control Manual. SICPs are the most effective means to prevent cross-transmission and cross-infection with micro-organisms in care settings.

Areas for Improvement: Clinical areas must complete and submit SICPs audits with a minimum of 20 observations per quarter for all SICPs with the exception of Hand Hygiene which remains monthly. All areas should supply action plans and be able to demonstrate improvement between quarters where results below optimum result of 95%.

Improvement Criteria: Policies will be current and reflect national guidance, clinical teams will be supported to implement and management will monitor to facilitate compliance

Infection Prevention and Control Policies and Procedures	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	Implement policies, protocols and procedures and seek guidance from line manager where required. Ensure compliance with SICPs and TBPs and be prepared to challenge or escalate breaches as appropriate	Implement current guidance e.g. SICPs and monitor compliance through observation and audit. Receive monitoring information on compliance e.g. CDI ward round feedback and take actions to address gaps	Demonstrate clinical leadership towards implementation. Receive monitoring information on compliance e.g. CDI ward round feedback, review QiDS results and support improvement plans	Review monitoring information and ensure compliance and improvement or sustained practice addressing gaps with relevant manager	Seek assurance that policies are implemented and compliance maintained and quality assured.	Ensure review of policies and their sign off as Chair of the ICC.	Co-ordinate policy development and review. Ensure policy development is included in HAI work programme.	Provide tailored advice for implementation	Provide tailored advice for implementation	Provide specialist IPC/ Medical Microbiology expertise to policy development and clinical leadership towards implementation

HAI Standard 7: Systems and processes are in place to ensure the safe and effective use of invasive devices, for example, peripheral venous catheters, central venous catheters and urinary catheters.

Rationale: Invasive devices present a significant infection risk to patients. These risks can be minimised by:

- Avoidance of device use where possible
- Following evidence-based procedures for insertion and maintenance
- Removing the device as soon as there is a clinical indication to do so

Areas for Improvement: Improved compliance with relevant patient safety programme bundles e.g. PVC/CVC, VAP and CAUTI aiming to achieve both process and outcome measures.

Improvement Criteria: Every individual with an invasive device is reassured that staff are competent, any device in situ the insertion and maintenance are clearly documented in patient's records and include date of insertion and reason for insertion.

Insertion and Maintenance of invasive Devices	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	Follow key practice recommendation on how and when invasive devices are to be used, maintained, monitored and removed, documenting within patients records,	Demonstrate knowledge of risks associated risks with invasive devices and seek to minimise use.	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues.	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues.	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues.	Show commitment to the safe use of devices – monitoring data and noting any SBARs provided identifying device-related issues.	Ensuring that appropriate senior managers are aware of any increased incidents/ trends for infections relating to invasive devices	Provide reports on the surveillance of infections relating to invasive devices.	In the event of an infection caused by invasive device follow IPCT SOP which involves investigation, root cause analysis and development of SBAR	Provide specialist IPC/ Medical Microbiology Advice to all staff. Review patients for IV oral Switch ABX therapies as appropriate

	<p>Demonstrating knowledge of associated risks Challenge colleagues who do not follow best practice on the use of invasive devices.</p>	<p>Ensure patients, or their representative involved in the decision making process and where appropriate the care and monitoring of device use.</p> <p>Monitor compliance with insertion and maintenance bundles</p>	<p>Monitor/Audit documentation relating to invasive devices within patients notes escalating any gaps in information required.</p>						<p>Monitor/Audit documentation relating to invasive devices within patients notes escalating any gaps in information required.</p>	
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HAI Standard 8: The Environment and equipment (including reusable medical devices used) are clean, maintained and safe for use. Infection risks associated with the built environment are minimised.

Rationale: Effective decontamination is critical in the provision of a safe, clean environment and equipment. The built environment must be designed, planned, constructed, refurbished and maintained to minimise the risks of infection. The standards covers the decontamination, management and maintenance of:

- Reusable communal patient care equipment
- Reusable medical devices
- The built environment

Areas for Improvement: FMT Scores reflect national targets and are quality assured for accuracy. Observations of near patient equipment/mattresses confirm compliance with SIPC results. HAI Scribes available for any works being undertaken.

Improvement Criteria: Patients using our service have confidence that they are being cared for in a clean, safe care environment and that all equipment used will be clean and free from contamination.

Decontamination	Operational Management					Infection Prevention and Control Team				
	All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
	Ensure all near patient equipment is effectively decontaminated between use Carrying out cleaning duties and responsibilities as required and documented as appropriate	Review local cleaning schedules for near patient equipment and mechanism for documentation completion Ensure SIPC audits for re-usable patient Care equipment and control of environment completed and action plan developed to address deficits.	Review audit results and monitor progress against action plans Quality assure equipment and control of the environment results being reported	Review monitoring information and ensure compliance with audit standard ensuring improvement	Review site monitoring information and take action (from environmental audits) when non compliance is identified	Ensure progress is reviewed by the Infection Control Committee	Ensure monitoring systems are developed and reviewed	Ensure quality assurance of data from wards is collected.	Provide advice for implementation Quality assure data collection	Provide specialist medical microbiology advice

HAI Standard 9: All equipment acquired (this being equipment that is procured, loaned, donated, in-house manufactured, or for use within a trial or research) for the care environment is safe for use.

Rationale: The infection risk to patients is minimised by having an acquisition process in place that ensures all equipment (including reusable medical devices) is safe for its intended use. Safety refers to minimise the risk of transmission of infection.

Areas for Improvement: Evidence of procurement policy compliance for any purchases outwith national contract.

Improvement Criteria: Patients will be confident that all medical devices and communal patient equipment being used by staff and/or in the healthcare and social care setting meet the required level of safety, quality and performance.

		Operational Management					Infection Prevention and Control Team				
		All Staff	Senior Charge Nurses	Clinical Nurse Manager/ Departmental Lead	Associate Nurse Directors	Site Directors	HAI Executive Lead	Head of Infection Prevention and Control Services	Lead Infection Prevention and Control Nurse	Infection Prevention and Control Nurse	Microbiology/ Virology Teams
Acquisition of Equipment	Contact local Infection Prevention and Control Nurse when considering purchase of any non-standard equipment (including reusable medical devices).	Prior to purchasing any non-standard equipment ensure Infection Prevention and Control Team have reviewed and approved choice	Prior to purchasing any non-standard equipment ensure Infection Prevention and Control Team have reviewed and approved choice.	Ensure that staff comply with policies and procedures for the acquisition of equipment. Review all incidences recorded within DATIX associated to near misses with equipment.	Ensure that staff comply with policies and procedures for the acquisition of equipment. Review all incidences recorded within DATIX associated to near misses with equipment.	Ensure that staff comply with policies and procedures for the acquisition of equipment.	Support members of the Infection Prevention and Control Team to represent NHS Lothian on National CAP Panels for new equipment	Support Procurement in development of Procurement Policy. Support members of the Infection Prevention and Control Team to represent NHS Lothian on National CAP Panels for new equipment	Provide advice to local teams wishing to purchase new equipment not already agreed on national procurement list. Provide expert advice at CAP Panels reviewing new equipment for "Fit For Purpose" taking into consideration infection prevention and control requirements.	Provide specialist medical microbiology advice as and when required.	
	Utilising DATIX Escalate any issues with current patient equipment		Review all incidences recorded within DATIX associated to near misses with equipment.								

NHS Lothian

Board Meeting
5 August 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - NHS Lothian Local Delivery Plan 2015/16

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

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

<ul style="list-style-type: none"> The paper provides a quarterly progress update on delivery of the 2015-16 Local Delivery Plan (LDP) 	1.1
<ul style="list-style-type: none"> Appendix 1 sets out the agreed actions in the LDP and progress that has been made against these in year. Many targets are reported to the Board on a bi-monthly basis in the performance report, waiting times report, HAI and Quality reports, therefore this report does not provide red, amber or green status. 	1.2
<ul style="list-style-type: none"> Progress against a number of LDP (HEAT) Standards, particularly 2 week delayed discharge target, delivery of CAMHS and psychological therapies targets and stroke performance are not as we would want and are covered in separate reports to the Board. 	1.4
<ul style="list-style-type: none"> The Board has been appraised of the financial position in year and actions to address this alongside workforce planning elements of the LDP. 	1.5
<ul style="list-style-type: none"> Board members are asked to note the risks against the delivery of the LDP particularly in relation to very high and high risks. 	2.2 and 4.1
<ul style="list-style-type: none"> The Board notes a Quarter 1 2015 review took place on 27 July 2015 in advance of the Annual Review meeting on 3 August 2015. 	2.3
<ul style="list-style-type: none"> The LDP six improvement priorities relate to health inequalities and prevention, antenatal and early years, person centred care, safe care, primary care and integration. 	3.1
<ul style="list-style-type: none"> The LDP also outlines how NHS Lothian will support delivery of LDP Standards, Financial Planning, Workforce and Community Planning 	3.2

Alyson Cumming

Strategic Programme Manager

23 July 2015 alyson.cumming@nhslothian.scot.nhs.uk

NHS Lothian

Board Meeting
5 August 2015

Director of Strategic Planning, Performance Reporting & Information

NHS Lothian Local Delivery Plan 2015/16

1 Purpose of the Report

- 1.1 The purpose of this report is to provide a quarterly progress update associated with the delivery of the 2015-16 Local Delivery Plan (LDP) action. The LDP was approved by the Board on 1 April 2015.
- 1.2 Appendix 1 sets out the agreed actions in the LDP and the progress that has been made against these in year. Progress has been reported through use of narrative as many of the targets that need to be achieved are reported to the Board on a bi-monthly basis in the performance report; waiting times report; HAI and Quality reports as well as the quarterly review of corporate objectives. Therefore this report does not provide a red, amber or green status report.
- 1.3 The Board has made much progress in the year to date to progress the integration agenda; the children's agenda as well as developing our plans for primary care, health inequalities and cancer care and treatment. We are also progressing our thinking and developing a business case to drive the quality improvement agenda which will support service and pathways redesign which in turn will drive safety and quality and efficiency and productivity.
- 1.4 It is important to note however that progress in relation to a number of the HEAT targets and standards, particularly the 2 week delayed discharge target; delivery of the target for CAMHS and psychological therapies and stroke performance are not as we would want and these are reported under cover of separate reports to the board but do require to be highlighted here.
- 1.5 The Board has been appraised of its financial position in year and actions to address this but this alongside workforce planning are key elements of the LDP for this year.

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

2 Recommendations

- 2.1 To seek Board members comment or questions relating to progress against the priorities outlined in the LDP report (appendix 1)
- 2.2 The Board notes the risks against delivery of the LDP, particularly in relation to very high and high risk areas relating to delivery of LRP and performance as set out in section 4.1

- 2.3 That the Board also notes that a Quarter 1 review took place on the 27th July in advance of the Annual Review on the 3rd August. Feedback on this review will be feedback to the Board on the 5th August along with any outcomes from the Annual Review.

3 Discussion of Key Issues

- 3.1 The Scottish Government have outlined six improvement priorities for focus within the 2015-16 LDP relating to:
- Health inequalities and prevention
 - Antenatal and early years
 - Person Centred Care
 - Safe Care
 - Primary Care
 - Integration
- 3.2 The LDP also outlines how NHS Lothian will support delivery of:
- LDP Standards (previously HEAT standards and targets)
 - Financial Planning
 - Workforce
 - Community Planning
- 3.3 In addition to this report, NHS Lothian Board also receives regular reports associated with financial plans, workforce plans, performance, integration and community planning.
- 3.4 An update on delivery of the 2015-16 LDP is outlined in Appendix 1.

4 Key Risks

- 4.1 The key risks associated with delivery of the LDP are predicated on NHS Lothian's ability to delivery local investment plans assumptions and have been identified as:
- Very High Risk – Bed reductions, income assumptions, deficit in social care investment
 - High Risk – Local reinvestment programme/financial balance, delivery of scheduled care treatment time guarantees, unscheduled care, Edinburgh and East Lothian delayed discharge position, changes to Individual Patient Treatment Review process, introduction of parental and adoption leave, Hepatitis C Drugs cost, SGHD Allocations, Capital Programme and Equal Pay
 - Medium Risk – Pay(Terms and Conditions), prescribing, rebates and property sales

5 Risk Register

- 5.1 Responsible Directors have been asked to ensure risks associated with targets and plans are clearly identified on the Risk Register and risks are escalated to the Corporate Risk Register as appropriate i.e. finance, delayed discharges.

6 Impact on Inequality, Including Health Inequalities

6.1 All approved strategies and plans that support delivery of the LDP will have been subject to Equality and Diversity Impact Assessment.

7 Involving People

7.1 NHS Lothian's LDP is aligned to Our Health, Our Care, Our Future: NHS Lothian Strategic Plan 2014 -2024 which was subject to a public consultation in 2014. On going strategic and service change developments will also be subject to public and staff engagement.

8 Resource Implications

8.1 NHS Lothian faces challenges in the delivery of the financial plan associated with the 2015-16 LDP and has been subject to detailed discussion at the Board meetings and Board Development Sessions during 2015.

8.3 The Scottish Government has provided further clarity relating to national investment in primary care services, however there is still no confirmation as to how any additional allocations will be received by NHS Boards.

Alyson Cumming

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23 July 2015

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List of Appendices

Appendix 1: 2015-16 Local Delivery Plan Progress Report

NHS Lothian 2015-16 Local Delivery Plan

Progress Report

July 2015

Improvement Priority	LDP Milestones	Progress Update
Health Inequalities and Prevention	<u>Health Inequalities Strategy</u> Increase in targeted community benefits as new projects specified (Nov 2015) Training Developed for Different Staff Groups (Dec 2015) Complete Pilot of Integrated Impact Assessment and identify impact assessment leads in each area (April 2015)	<ul style="list-style-type: none"> NHS Lothian Health Inequalities Strategy progress report went to the June 2015 Strategic Planning Committee. Key actions relate to procurement, employability and impact assessment were reported. Integration Joint Boards Strategic Plans should include actions to address health inequalities through the Needs Assessment within the new health and social care partnerships. All four draft strategic plans will come to the Board's Strategic Planning Committee for comment. A strategy implementation group has been established and meets quarterly to monitor implementation of actions. A draft Health Inequalities Aide Memoire has been developed to inform scrutiny of papers and proposals presented to NHS Lothian Board / Committees to help assess if proposals are likely to increase / reduce health inequalities
	<u>Health Promoting Hospital Services (HPHS)</u> Development of HPHS Priorities Action Plan	<ul style="list-style-type: none"> NHS Lothian Health Promotion Service 2014-15 Annual Report was published in July 2015. http://www.nhslothian.scot.nhs.uk/Services/A-Z/HealthPromotionService/AboutUs/Documents/Health%20Promotion%20Service%20Annual%20Report%202014-15.pdf
	<u>Tobacco</u> Smoke free grounds by 1 April 2015	<ul style="list-style-type: none"> NHS Lothian grounds became smoke free on 1 April 2015.
Antenatal and Early Years	Health Visitor Population	<ul style="list-style-type: none"> Challenges remain in recruitment and retention of Health Visitors to support delivery of a named person associated with the Children and Young People (Scotland) Act 2014. An additional 82 WTE Health Visitors are required to meet the named person legislation and there are circa 25 vacant Health Visitor posts in Lothian. A paper outlining key actions and risks was considered by the Corporate Management Team in May 2015. There were 28 WTE Band 6 Health Visitor vacancies at 7 July 2015

Antenatal and Early Years	Health Visitor Population	<ul style="list-style-type: none"> • 15 student Health Visitors will complete training in September 2015, recruitment to Health Visitor posts across Lothian is being progressed. • 16 student health visitors will begin training in September 2016 and a further 10 students in January 2016. • Recruitment for administrative support for Health Visitors is being progressed • The Executive Nurse Director and Child Health commissioner are meeting bi –monthly to manage risks in partnership areas • Work is underway to progress a regional approach to recruitment of Health Visitors from across the UK
	Implementation of NHS Lothian Children and Young People’s Strategy	<ul style="list-style-type: none"> • Good progress is being made and a progress report will be submitted to the Strategic Planning Committee on 13 August 2015.
	Family Nurse Partnership - 4 th team in place by July 2015	<ul style="list-style-type: none"> • A fourth Family Nurse Partnership Team is now in place and will begin to recruit clients from 1 August 2015. This is a hybrid team with six nurse supporting Lothian and two nurses support in the Borders. • Edinburgh has a sustained service which was celebrated at an event at Edinburgh Castle in March 2015 • Due to pressure associated with client numbers, there will be a slight delay in rolling out the service to East Lothian which will begin in late 2015 / early 2016.
	NHS Lothian Maternity Services Strategy 2016 – 2021	<ul style="list-style-type: none"> • Work is underway to develop an NHS Lothian Maternity Services Strategy 2016- 2021. The first draft will be taken to the Strategic Planning Committee in October 2015 for review and sign off and will come to the Board in December.

<p>Person Centred Care</p>	<p>Tell Us Ten Thing –Local Patient Experience Survey Programme</p>	<ul style="list-style-type: none"> • A patient experience survey (183 returns) undertaken in all wards at the Royal Infirmary of Edinburgh in March 2015 indicates out of a possible maximum weighted score of 10, responses to 8 of the 10 questions asked scored over 8. The highest scores related to ‘treated with kindness and compassion’ by the staff looking after you (score 9.48) and ‘staff did everything they could to help control your pain’ (score 9.13). The results below 8 related to patients being bothered by noise at night from the hospital staff (score 6.66) and happy with the food / meals I received (score 7.25) • In order to realise the aim of 90% of patients using our services have a positive experience of care and get the outcomes they expect, a Patient Experience Quality Improvement Plan has been developed, key aspects to the plan include: <ul style="list-style-type: none"> - NHS Lothian organisational culture and leadership improves patient, family and staff experience - Direct care delivery is reliable and is delivered in acute collaboration and partnership with patients and staff including the physical environment - Staff are engaged with the organisation to deliver services centred on the needs of people including the physical environment - Staff are open when dealing with people raising concerns or complaint - That there is an infrastructure in place to support system change underpinned by measurement
	<p>Feedback and Complaints</p>	<ul style="list-style-type: none"> • A draft Annual Feedback and Complaints Report 2014-15 has been produced which outlines improvements undertaken to consult with the public about planned changes in NHS Lothian to ensure a conscious effort is made to keep the person as the centre of all that NHS Lothian does. The draft plan was submitted to the Scottish Government and Scottish Health Council on 30 June 2015 for review and feedback has been sought from members of the public. The report will be presented to the Healthcare Governance Committee in July 2015. • Following the external review of the complaint process undertaken earlier this year by Dorothy Armstrong – Listening and Learning from Complaints and Complaints, this report was fully supported by NHS Lothian Board in January 2015 and supports a devolved approach to complaints and feedback. The current Customer Relations and Feedback Team are going through organisational change, the Head of Patient Experience has been appointed and we are working with colleagues in HR and Partnership to support the staff to establish the Patient Experience Team.

<p>Person Centred Care</p>	<p>Feedback and Complaints</p>	<ul style="list-style-type: none"> • The Patient Experience Team will have two main functions – complaints and feedback and the proactive approach to patient experience through the use of patient stories and surveys. The complaints and feedback devolved approach is being tested in 3 areas: the Western General Hospital, Royal Edinburgh and Associated Services and Edinburgh CHP. This is going well and we are now looking for others to be part of phased 2 which we are planning will be begin in October 2015. The learning and reflections from the 3 tests areas will be incorporated into phase 2. • The Healthcare Governance Committee has received progress reports at the January, March, May and July meetings and there was a presentation given by the Executive Nurse Director at the private session on the 24 June 2015 at the NHS Lothian Board.
	<p>Lothian House of Care</p>	<ul style="list-style-type: none"> • NHS Lothian continues to support implementation of the House of Care approach to support delivery of person centered care. A House of Care update report was submitted to the NHS Lothian Strategic Planning Committee in June 2015. Recommendations to the Committee included involvement of the Clinical Change Cabinet with the House of Care Collaborative to explore how the House of Care approach can support the Choosing Wisely initiative and that Health and Social Care Partnerships continue to work with the House of Care Collaborative to explore opportunities for a common framework to delivery person centred care. • The first phase (2015-16) of the House of Care collaboration will focus on working with between 10 and 15 GP practices in areas of relative deprivation and two or three services e.g. heart failure and chronic pain. The second phase of the work (2016-17) will seek to identify and support more partners other than GP practices and NHS services and explore the House of Care approach for people who have a higher proportion of social rather than healthcare needs. Initial funding of £70,000 was received in 2014-15 from the Scottish Government to support House of Care earlier adopter sites.

Safe Care	Scottish Patient Safety Programme and Quality Improvement	<ul style="list-style-type: none"> • NHS Lothian remains committed to the Scottish Patient Safety Programme. Priorities for action during 2015-16 include spread and sustainability set within a Quality Improvement infrastructure. An annual report associated with the Scottish Patient Safety Programme will be available towards the end of 2015. • A policy relating to 'Choosing Wisely' is being developed to understand the risks of over diagnosis and over treatment, acknowledge the wishes and goals of patients and to recognise the limits of treatments when considering harm, costs and the potential outcomes which might be achieved. • Development of an NHS Lothian Quality Improvement Academy is also in the process of being developed aligned with the work undertaken to date regarding the establishment of the Clinical Change Cabinet and the 'Choosing Wisely' work above.
	Hospital Associated Infections	<ul style="list-style-type: none"> • Delivery of LDP standards associated with healthcare associated infections (CDifficile and MRSA / MSSA) continues to be challenging. A review of environmental cleaning and standards will be undertaken in 2015-16 with the aim of reducing CDifficile.
Primary Care	Take forward work to support the priority areas outlined within the Strategic Plan	<ul style="list-style-type: none"> • Primary care has been the subject of on-going discussion, a paper and presentation was taken to the June 2015 Strategic Planning Committee and NHS Lothian Board. • NHS Lothian has agreed to circa £1.1m investment in 2015-16 to support domiciliary phlebotomy, enhanced service for Type 2 diabetes, very long acting contraception, training of advanced nurse practitioners, support to practices to grow list sizes and pilot alternative models of general practice access. • Capital investment of £1.26m has been approved to support creation of additional capacity within general practices • Additional investment of circa £968,000 is required to support recruitment and retention within primary care. Financial support will be sought from the Scottish Government in association with the recent national primary care investment announcement.

Integration	Establishment of Health and Social Care Partnerships and Integration Joint Boards	<ul style="list-style-type: none"> • Integration Schemes for City of Edinburgh, East Lothian and Midlothian have been approved and the Integration Joint Boards (IJBs) in these areas were established on 27 June 2015. The first formal meetings of the East Lothian and Edinburgh IJB's have taken place with Midlothian in August and West Lothian in October, • The Integration Joint Boards are currently drafting their Strategic Commissioning Plans and Needs Assessments which will then be subject to a period of public consultation. Draft plans are expected at the August and perhaps also the October NHS Lothian Strategic Planning Committee. • The Partnerships in Midlothian, Edinburgh and West Lothian are developing management structures which will be subject to consultation. • The East Lothian partnership management structure has been finalised and recruitment to posts is being taken forward • East Lothian have appointed their Chief Officer. The others are underway.
	Support for the Care of Older People	<ul style="list-style-type: none"> • A progress report and plans to improve arrangements for the care of older people was presented to the Strategic Planning Committee and NHS Lothian Board in June 2015. • The four Lothian Integrated Joint Boards have been asked to build this work into their Strategic Commissioning Plans • A multidisciplinary and multiagency group has been established to review the model of care for older people to support capacity issues in general practice • A costed programme for the work that needs to be taken forward in Edinburgh is being developed and will be submitted for consideration by NHS Lothian Board and the Integrated Joint Boards in October 2015. This plan alongside the development of the Edinburgh Strategic Commissioning plan will need to fundamentally transform the performance in Edinburgh in relation to people delayed in hospital or 'boarding'.
LDP Standards	Monitoring and Reporting Performance	<ul style="list-style-type: none"> • Delivering for Patients, an appendix to Our Health, Our Care, Our Future: NHS Lothian Strategic Plan 2014 - 2024 outlines NHS Lothian's commitment to meet and sustain treatment time guarantees and outpatient standards. Implementation of Delivering for Patients is supported through a Programme and Priority Leadership Group to ensure delivery of the national waiting times standards in Lothian. This group oversees the progress of the Clinical Management Teams reviewing and managing performance and to ensure associated risks are managed.

		<ul style="list-style-type: none"> • NHS Lothian continues to be challenged in the delivery of the LDP Standards (previously HEAT targets), regular performance reports are submitted to the Corporate Management Team and NHS Lothian Board. The Board should note that progress is not cited here as the most up to date position is being worked on at the time of the report being written but will be provided at the 5 August 2015 NHS Lothian Board meeting through the standard Board reports on elective and unscheduled care waiting times; the performance paper and Quality and HAI papers.
Financial Planning	Deliver Financial Balance	<ul style="list-style-type: none"> • A Quarter 1 review meeting with Scottish Government officials to discuss the seriousness of the financial and performance position will take place on 27 July 2015 prior to the 2015 Annual Review meeting. • NHS Lothian is investing significantly in quality improvement infrastructure and capacity and is establishing a Quality Improvement Academy to support training and development of improvement methodology to improve quality and reduce cost. Support for the Academy is being sought from the Edinburgh and Lothian Health Foundation • NHS Lothian has commissioned work through Deloitte to undertake a data diagnostic review to support pathway improvements. Early work has indicated there are opportunities across the frailty pathway to reduce lengths of stay and further analysis associated with theatre data is being undertaken to inform improvements in general surgery. A further update report will be completed by the end of August 2015 • NHS Lothian and City of Edinburgh Council are working in collaboration to seek national support in the provision of bridging finance in light of the recent delayed discharge position and difficulties with provision of social care packages. Bridging finance would allow additional step down beds to be purchased whilst plans for integrated care facilities for the elderly are progressed. • Clarification is being sought from the Scottish Government relating to the Individual Patient Treatment Request process given the overspend position associated with prescribing • Assumptions that NHS Lothian and partnerships may get additional monies for mental health and also for 'winter'.

Workforce	Reduction in Workforce Expenditure	<ul style="list-style-type: none"> • A Human Resources and Organisational Development Strategy June 2015 – August 2018 was approved by NHS Lothian Board in June 2015. The 5 priorities for action outlined in the strategy relate to Healthy Organisation Culture, Sustainable Workforce, Capable Workforce, Integrated Workforce and Effective Leadership and Managers • A revised management structure has been implemented within the acute services to support a reduction in workforce expenditure • A review of the corporate administration function is being undertaken and will report in October 2015
	Effective Leadership and Management	<ul style="list-style-type: none"> • A Clinical Change Cabinet which brings together clinicians from across NHS Lothian has been established to support development of the new strategic direction around organisational culture and behaviours. The Cabinet will focus on how we work together to improve quality while using the resources to create sustainability.
Community Planning Partnerships	Continue to work with partner organisations to support engagement in community planning	<ul style="list-style-type: none"> • A NHS Lothian Board Director and Non Executive Director have been appointed to each of the four CPP's • The Edinburgh Community Plan was taken to the April Board meeting of NHS Lothian. The other three plans are expected to be taken to Board or Committees as appropriate. • NHS Lothian and the four community planning partnerships have been actively engaged in the development of the legislation around the Community Empowerment • Key relationships between the CPP's and the development of the four IJB's strategic commissioning plans will be important during this year • The Edinburgh Joint Board of Governance for Children's Services has been established.

ACUTE HOSPITALS COMMITTEE

The draft minutes of the meeting held on Monday 8 June are attached.

Key issues discussed included:

- Acute Services Update, including discussion around waiting times, obstetrics, project boards, theatre resource, balanced scorecard, HAIs, Princess Alexandra Eye Pavilion
- Delayed discharges remain a serious challenge. The position around endoscopy performance is also disappointing. The committee sought assurance that actions to address issues had been identified and implemented.
- Kay Blair agreed to be the non-exec lead on the follow up to the maternity peer review of Women's Services.
- Alison Mitchell agreed to be the non-exec lead on the Sick Kids and DCN Programme Board. Alison will also deputise for the Chair of the Acute Committee.
- The Committee's Statement of Assurance Needs - its content, assurance, effectiveness.
- The 14/15 financial outturn and the month 1 (April) position, which again highlights issues and challenges. The committee spent some time looking at the LRP hub and its objectives; the need to share best practice around LRP opportunities; the need to have meaningful, local targets and incentives; the need for support and good working relationships between finance and those delivering clinical services; the necessity of continued good housekeeping amidst new initiatives.

Key issues on the horizon are:

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

Kay Blair, Acute Hospitals Committee chair
9 June 2015

DRAFT

NHS Lothian

Acute Hospitals Committee

Minutes of the Meeting of the Acute Hospitals Committee held at 2:00 pm on Monday, 8 June 2015 in the Meeting Room 5.4, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

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

In Attendance: Mrs S Ballard-Smith (Divisional Nurse Director); Ms J Brown (Associate Director, Human Resources); Mr J Crombie (Chief Office); Mr C Marriott (Deputy Director of Finance); Mr P Reith (Secretariat Manager) and Mr N Wilson (Unscheduled Care Manager).

Apologies for absence were received from Ms M Johnson.

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.

16. Minutes of the Previous Meeting

16.1 The previously circulated minutes of the meeting held on 7 April 2015 were approved as a correct record.

17. Running Action Note

17.1 The Committee noted the previously circulated running action note.

18. Significant Adverse Event – Obstetrics

18.1 Mr Crombie spoke to a previously circulated confidential report on a significant adverse event in obstetrics. He explained the background to the event and advised that robust processes had now been put in place and were being regularly audited. He had personally reviewed the audit and was satisfied that the issue had been resolved.

18.2 The Committee agreed to note the report and the recommendations contained therein.

19. Finance Outturn and Month 1 (April) Position

19.1 The Committee noted a previously circulated report giving an update on the outturn financial performance of the Divisions of Scheduled and Unscheduled care for the 12 months to the end of March 2015.

- 19.2 Mr Marriott gave the background to the clearance meeting for the 2014/15 annual accounts and advised that he was not aware of any surprises. Reserves had been used to meet the deficit and achieve financial breakeven.
- 19.3 It was noted that the April position was consistent with forecast performance and that there was no evidence of material improvement arising from recovery actions and local reinvestment plan delivery in-month. Mr Marriott advised that the Efficiency and Productivity Team was actively pushing out to assist in the achievement of recovery plans and ensure that the financial position was a priority with local management. It was noted that clinicians were now involved in procurement at hospital level and the process was becoming more joined up. Communication with staff was improving and the importance of having a team that could explain to service managers what they were required to do was recognised. The Committee sought assurance that the new LRP Hub would deliver improvements.
- 19.4 It was noted that a number of key efficiency and productivity projects had been identified but the change had to come from the top down and the measure of success would be the degree to which staff were empowered and motivated to implement change.
- 19.5 The Chair commented that the acute services faced a challenging financial position with a disappointing April position. It was encouraging that vigilant and robust plans were in place and more information was required on what effect these were having. Local communications initiatives were encouraging and it was important to identify good practice as soon as possible whilst continuing good housekeeping amidst the new initiatives. The Committee needed to hear that support mechanisms were in place to ensure the development of financial recovery plans.
- 19.6 The Committee noted that there were a number of local "good housekeeping" initiatives to improve efficiency and reduce waste and agreed that such good practice needed to be shared throughout the organisation.
- 19.7 The Committee agreed to note the recommendations contained in the circulated report and to have a future agenda item around the sharing of good practice. JC

20. Acute Services Update

- 20.1 Mr Crombie introduced a previously circulated report providing an overview of acute services which replaced the previous separate scheduled care and unscheduled care reports.
- 20.2 The Committee noted NHS Lothian's status against waiting time standards for the period up to April 2015 and the performance against the 4 hour accident and emergency standard.
- 20.3 Mr Crombie advised that some additional staff had been recruited and core capacity was up 22% in terms of ability to deliver services. The objective was to achieve full compliance with standards by the end of October. The Committee noted that, in respect of patients being boarded, there had been engagement with the local authorities and performance over the next few months would be crucial.

- 20.4 It was noted that delayed discharges remained a serious challenge and that the position around endoscopy performance was also disappointing. The Committee received assurance that actions to address these issues had been identified and implemented and that full compliance would be achieved by the end of October 2015.
- 20.5 The Committee noted the Scottish Government's most recent initiative in support of unscheduled care performance and the '6 Essential Actions to Improving Unscheduled Care' that took a systematic approach in supporting Boards to improve their overall unscheduled care performance. These were: clinically focussed and empowered hospital management; hospital capacity and patient flow alignment; patient rather than bed management; medical and surgical processes arranged to 'pull' patients from Emergency Departments; 7 day services and ensuring patients were cared for in their own home.
- 20.6 It was anticipated that the priority actions to be taken by each acute hospital site to improve the patient's journey against these essential actions would support a step change in performance during 2015 with a target of 2% increase for sites by 6 July; 95% attainment nationally by 13 July and 98% attainment by November 2015, with sustained patient flow over winter.
- 20.7 Following an external review of vascular services undertaken in February the main findings and recommendations from the review noted that the facilities at the Royal Infirmary of Edinburgh vascular unit were of an extremely high standard and access to critical care was found to be particularly impressive. The unit, however, was not currently delivering the full range of training required by the vascular surgical curriculum and immediate improvement was needed in terms of team working. There were also a number of practices that were not consistent with seamless patient care which should be addressed immediately.
- 20.8 The Vascular Programme Board had been established to progress this programme, including a full action plan in response to the recommendations in the report. The Committee noted that the official report from the Royal College of Obstetrics and Gynaecology's Peer Review of Women's Services had concluded that there were no specific patient safety concerns within the service and recognised that many of their initial findings had already been identified by the service and included in the Maternity Board Action Plan.
- 20.9 The Chair advised that she had agreed to be the Non Executive lead on the follow-up to the Peer Review of Woman's Services.
- 20.10 The Committee also noted that Mrs A Mitchell had agreed to be the Non Executive lead on the Royal Hospital for Sick Children and Department of Clinical Sciences Programme Board and would also deputise for the Chair of the Acute Hospitals Committee when required.
- 20.11 The Committee noted that the initial agreement for the redesign and reprovision of the Princess Alexandra Eye Pavilion had been supported by the Strategic Planning Committee and the Finance & Resources Committee and would now go to the Scottish Government for approval to proceed to an outline business case.
- 20.12 It was noted that the 2014/15 average percentage sickness for scheduled care and unscheduled care were both slightly above the HEAT standard of 4% but that in the context of NHS Lothian's overall performance, the performance in acute services was second only to corporate services. Areas requiring greater focus in 2015/16 were being addressed.

20.13 Mrs Ballard-Smith arrived at the meeting.

20.14 The Committee noted that the professional view was that 12 hour shifts provided the optimal capacity but there was no massive body of evidence around any of the options for good rota management.

20.15 The Chair commented that the new reporting format outlining issues and giving details about the actions taken was a better way of presenting performance.

21. Statement of Assurance Needs

21.1 The Committee noted the previously circulated statement of assurance needs and Mrs Meiklejohn undertook to work with Mr Wilson on its development. **NW/AM**

21.2 The Chair thanked Mr Wilson for his work in producing the statement of assurance needs.

22. Deloitte Deep Dive

22.1 Mr Marriott gave a general update on the position of the Deloitte Deep Dive which was a whole system diagnostic tool and was similar to the approach being taken by other NHS Boards in Scotland. The process would be linking in to work with Intermountain Healthcare and should result in improvements in quality.

22.2 Mr Marriott undertook to bring back a further report to the committee at its September meeting. **CM**

23. NHS Lothian University Hospitals and Support Services – New Structure and Revised Management Arrangements

23.1 Mr Crombie introduced a previously circulated report detailing the revised structure and management arrangements for the University Hospitals and Support Services. The number of site directors and service managers had reduced from 9 to 6 with Site Directors for the Royal Infirmary of Edinburgh, Western General Hospital and St John's Hospital, Service Directors for Women's and Children and Pan Lothian diagnostic / theatres / critical care / anaesthetics as well a General Manager for EPO outpatients. In addition there was a Nurse Director for Acute Services, a Medical Director for Acute Services and a Director for Allied Health Professions.

23.2 The Committee noted the changes to the senior management structure and that the new structure, which had been developed with full partnership involvement would be implemented in July 2015. The Committee was keen to have regular updates on the structure and how it was delivering better outcomes. **JC**

24. Quality of Papers and Debate

24.1 Mrs Mitchell commented there had been a good debate on the items and that it would be useful to be able to drill down into more performance detail than would normally be discussed at the Board.

24.2 The Chair commented that this was something that could be done by all Committees and commented that the detail in the Finance paper had been improved.

24.3 Mr Marriott commented that the Finance report was trying to explain what was being done to solve problems and he welcomed comments from Committees on the report's format.

25. Date of Next Meeting

25.1 It was noted that the next meeting of the Committee would be held on Monday 1 September 2015 at 2:00 p.m. in meeting room 5.4 at Waverley Gate, Edinburgh and that it was intended that the agenda would include details of the Integration Joint Board budgets.

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

Key issues discussed included:

- The Committee received a report about the ongoing work to address the issue of compliance with policies and procedures. A working group has been established to take forward a review. The Committee asked to have a detailed report on this subject at its next meeting in September.
- The Committee reviewed and accepted an improvement plan for NHS Lothian's Risk Management Arrangements.
- The Committee accepted the Annual Internal Audit Report 2014/15 which concluded that NHS Lothian has a framework of controls in place that provides reasonable reassurance regarding the effective and efficient achievement of the organisation's objectives and the management of key risks.
- The Committee received the External Audit – 2014/15 Annual Audit Report which concluded that the Board's financial position was currently stable but that there are significant challenges in the foreseeable future in relation to the identification of recurring savings and ensuring that the Board remains within its funding limits.

Key issues on the horizon are:

- The Committee has asked the Chair of the Staff Governance Committee and the Head of Human Resources to bring forward a detailed action plan outlining the timescales for progression of compliance to mandatory training at its next meeting in September.
- The Committee agreed that the Board should use a co-sourcing arrangement with an external firm for the Chief Internal Auditor function and that management should ensure that there is no break in the continuity of the service. The Deputy Director of Finance assured the Committee that the procurement process would proceed with the aim of having a three year contract to commence on 1 October 2015.

Julie McDowell

Chair

DRAFT

NHS Lothian

Audit & Risk Committee

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 22 June 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Ms J McDowell (in the Chair); Mr M Ash; Dr M Bryce; Councillor D Grant; and Councillor C Johnstone.

In Attendance: Ms J Bennett (Associate Director of Quality Improvement & Safety); Ms H Berry (Interim Chief Internal Auditor); Mr A Boyter (Director of Human Resources & Organisational Development); Mr T Davison (Chief Executive); Mrs S Goldsmith (Director of Finance); Mrs C Grant (Audit Scotland); Mr B Houston (Chairman); Ms D Howard (Head of Financial Control); Mr A Joyce (Employee Director); Mrs B Livingston (Financial Controller); Mr D McConnell (Audit Scotland); Mr C Marriott (Deputy Director of Finance); Mr A Payne (Corporate Governance & VFM Manager); Mr D Proudfoot (Deputy Chief Internal Auditor); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Ms Johnson and Dr McCallum.

The meeting was preceded and followed by a closed meeting of members only.

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.

10 Minutes of the Previous Meeting

10.1 Minutes of the previous meeting held on 20 April 2015– The Committee approved the circulated minutes as a correct record.

11 Matters Arising

11.1 Matters Arising from the Meeting of 20 April 2015 – the Committee received the paper detailing the matters arising from the Audit & Risk Committee meeting held on 20 April 2015, together with the action taken and the outcomes.

11.1.1 Mr Boyter advised that the issue surrounding policies and compliance had been brought to the Staff Governance Committee for consideration. The Committee's view was that it was primarily the responsibility of line management to be assured on compliance with policies & procedures. It was agreed that the executive lead with responsibility for each of the nine sections of mandatory training has been asked to review their sections, and report back to the Committee on the best way to proceed. The Committee is expecting a report in July.

11.1.2 The Committee agreed that Mr Boyter and Mr Joyce would bring forward a detailed action plan outlining the timescales for progression of compliance to mandatory training as a source of assurance to the Audit & Risk Committee's September meeting.

AB/AJ

11.1.3 Mr Davison drew the Committee's attention to ongoing work in NHS Lothian in relation to the review of policies and procedures, including the establishment of a working group to take forward the review. Though members took assurance from the establishment of the working group, the Committee asked that Mrs Goldsmith and Mr Boyter provide a detailed report on this subject to the September meeting.

SG/AB

11.1.4 The Committee accepted the actions detailed within the Running Action Note.

11.2 Advice on Declarations of Interest – the Committee reflected on comprehensive guidance detailed within the report.

11.2.1 The Committee agreed to accept the report.

11.3 2014/15 Annual Report from the Staff Governance Committee - The Committee accepted the report as a source of assurance to support the Governance Statement subject to Mr Joyce updating the disclosure section at the end to reflect the Committee's discussion on mandatory training and compliance with policies and procedures.

AJ

12. Risk Management

12.1 NHS Lothian Corporate Risk Register Update

12.1.1 Ms Bennett gave a detailed overview of the report.

12.1.2 The Committee discussed the future financial position and the challenges it presented to the Board in terms of living within its risk appetite. The Committee's view is at this time it does not have assurance that there are systems and action plans in place to bring the Board back within its risk appetite.

12.1.3 Mr Davison advised the Committee that the July Programme Board Seminar would focus on the first quarter review. ;

12.1.4 Members agreed that risk 3567, 11: Improve Integration – Integrated Joint Boards could be removed from the corporate risk register, in light of the fact that the integration schemes had now all been approved. However it was recognised that through the process of implementing the integration schemes, different specific risks relating to integration will likely be generated at various levels of risk management. This process may lead to a new risk on the corporate risk register for any specific matters which must be decided by the Board, such as the allocation of resources to the newly created integration joint boards.

12.1.5 The Committee agreed to accept the report.

12.2 Evaluation of NHS Lothian's Risk Management Arrangements – Improvement Plan

12.2.1 Mrs Bennett gave a detailed overview of the report. She drew the Committee's attention to the improvements made over the past two years, the process of continuous review and senior management input.

12.2.2 Members were advised that work in the coming year would focus on strengthening links at operational level.

12.2.3 The Committee agreed to accept the report.

13 **Internal Audit & Counter Fraud Reports**

13.1 Internal Audit – Reports with Green Ratings June 2015 (Annual Stock-Taking; Health & Social Care Integration)

13.1.1 Ms Berry introduced the report. She concluded that a good framework on controls were in place though some improvements were required to the operation of those controls within the service.

13.1.2 The Committee agreed to accept the Report with Green Ratings – June 2015.

13.2 Internal Audit – External Contractors & Consultants May 2015

13.2.1 The Committee was assured that Internal Audit were satisfied that the management response was appropriate.

13.2.2 The Committee agreed to accept the External Contractors & Consultants – May 2015 report.

13.3 Internal Audit – Information Governance May 2015

13.3.1 The Committee agreed to accept the Information Governance – May 2015 report.

13.4 Internal Audit – Re-provision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences May 2015

13.4.1 The Committee agreed to accept the Re-provision of the Royal Hospital for Sick Children and Department of Clinical Neurosciences May 2015 report.

13.5 Internal Audit – Capacity Planning May 2015

13.5.1 The Committee agreed to accept the Capacity Planning – May 2015 report.

13.6 Internal Audit – Annual Internal Audit Report 2014/15 June 2015

13.6.1 Ms Berry introduced the report which provided the following overall conclusion:.. .

“Overall, Internal Audit’s work indicates that NHS Lothian has a framework of controls in place that provides reasonable assurance regarding the effective and efficient achievement of the organisation’s objectives and the management of key risks.

Proper arrangements are in place, in the areas Internal Audit has reviewed, to promote value for money, deliver best value and secure regularity and propriety in the administration and operation of the organisation.”

13.6.2 Ms Berry advised that the Committee that it would receive the report on Workforce Planning – Nursing & Midwifery in September.

13.6.3 The Committee agreed to accept the Annual Internal Audit Report 2014/15 – May 2015.

13.7 Internal Audit – Progress Report June 2015

13.7.1 The Committee accepted the Internal Audit Progress Report – June 2015.

13.8 Counter Fraud – Progress Report June 2015

13.8.1 The Committee accepted the Counter Fraud – Progress Report June 2015.

13.9 Fraud Referrals & Operations for Year to 31 March 2015

13.9.1 The Committee accepted the report on Fraud Referrals and Operations for year to 31 March 2015.

13.10 NHS Lothian: Patient Exemption Checking and Potential Fraud 2014/15

13.10.1 The Committee accepted the report on Patient Exemption Checking and Potential Fraud for 2014/15.

13.11 Evaluation of Co-sourcing and Selection of a Permanent Solution for Internal Audit

13.11.1 Mr Payne gave an overview of the findings from the evaluation. He drew the Committee’s attention to the improved efficiency in the conduct of the internal audit programme, and the marked improvement in the presentation of reports. He advised that more progress can be made in terms of how the internal audit function adds value through quality, however the changes to the methodology are having a positive impact which is being acknowledged by auditees.

13.11.2 The Committee agreed to support the recommendation that the Board should go in to a co-sourcing arrangement with a firm to provide a Chief Internal Auditor and Manager, with the option to expand support as and when necessary. It was also agreed that the previously agreed organisational structure for internal audit should be reviewed. If it is still regarded as appropriate, then the vacancies in that structure should be filled on the presumption that the Chief Internal Auditor and one manager will be co-sourced, so as to bring the period of uncertainty for current employees to an end.

13.11.2 The Committee agreed that management should ensure that there is no break in the continuity of the service. The Deputy Director of Finance assured the committee that the procurement process would proceed with the aim of having the three-year contract beginning on 1 October 2015.

14. General Corporate Governance

14.1 2014/15 Healthcare Governance Committee Annual Report to Lothian NHS Board.

14.1.1 The Committee accepted the report as a source of assurance to support the Governance Statement.

14.1.2 The Committee agreed that the annual report of the acute hospitals committee should be provided as a source of assurance for future years.

AP

14.2 Lothian NHS Board Annual Report of the Chair of the Finance & Performance Review Committee Period Ending 31 March 2015

14.2.1 The Committee accepted the report as a source of assurance to support the Governance Statement.

14.2.2 Mrs Goldsmith drew the Committee's attention to ongoing work related to the availability of data to make informed decisions.

14.3 2014/15 Annual Report from the Information Governance Assurance Group.

14.3.1 The Committee accepted the report as a source of assurance to support the Governance Statement.

18.4 NHS National Services Scotland (NSS) Service Auditor Reports

18.4.1 The Committee accepted the report as a source of assurance to support the Governance Statement.

14.5 SFR 18.0 – Summary of Losses and Payments for the Year Ended 31 March 2015

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

14.6 Foundation Annual Report and Accounts

14.6.1 The Committee agreed to accept the report.

14.7 NHS Lothian Patients' Private Funds – Annual Accounts 2014/15

14.7.1 The Committee reviewed the NHS Lothian Patients' Private Funds – Annual Accounts 2014/15.

- 14.7.2 The Committee agreed to recommend that:
- That the Chairman and the Chief Executive sign the “Statement of Lothian NHS Board Members’ Responsibilities² on behalf of the Board.
 - That Director of Finance and Chief Executive sign the “Abstract of receipts and payments”.
 - That the Board approve the draft Annual Accounts 2014/15.

14.8 Results from Committee Member Survey

14.8.1 Mr Payne presented the findings of the survey to the Committee.

14.8.2 The Committee agreed to accept the report.

15. **Annual Accounts**

15.1 Governance Statement 2014/15

15.1.1 Mr Payne presented the draft statement and explained the process undertaken to prepare it.

15.1.2 In response to Mr Ash’s query Mr Davison confirmed that the issue relating to financial challenges in Edinburgh, related specifically to the arrangements in the City of Edinburgh, arather than a general concern for all integration joint boards. . The committee was assured that none of the other directors of health & social care had raised any issues in their certificates of assurance.

15.1.3 The Committee confirmed it was content with the 2014/15 Governance Statement.

15.2 Representation Letter -

15.2.1 The Committee reviewed a draft Representation Letter to the external auditors. The Committee:

- Confirmed that the statements properly represent confirmation to the external auditors on matters arising during the course of their audit of the accounts for the year ended 31 March 2015.
- Agreed that the letter be signed by the Chief Executive.

15.3 External Audit – 2014/15 Annual Audit Report

15.3.1 Mr McConnell gave a brief overview of the report highlighting how the report was collated, key findings and the audit certificate therein. He concluded that the Board’s financial position was currently stable, however there are significant challenges in the foreseeable future in relation to the identification of recurring savings and ensuring that the Board remains within its funding limits.

15.3.2 The Committee accepted the report as a source of assurance.

15.4 Annual Accounts for the Year ended 31 March 2015.

15.4.1 The Committee received the annual accounts for 2014/15, noting that a detailed scrutiny of had occurred in advance of the meeting. The Committee agreed to recommend that the Board approve the annual accounts for 2014/15.

15.5 NHS Lothian, Audit Committee Annual Report from the Chair – Year Ending 31 March 2015

15.5.1 The Committee reviewed the draft report and confirmed that the report should be enhanced to reflect discussions surrounding risk appetite, and some of the key remarks within the external auditors' annual reports on the financial position. **AP**

15.5.2 Following a brief update from Mr Proudfoot and Mrs Goldsmith the Committee approved its 2014/15 annual report subject to the agreed amendments.

15.6 Lothian NHS Board Audit Committee – 2014/15 Notification to the Health & Wellbeing Audit and Risk Committee.

15.6.1 The Committee approved the notification letter for submission to the Scottish Government.

16 Items for information

16.1 There were no items for information.

17. Any Other Competent Business

17.1 Mr Proudfoot's Retirement

17.1.1 Members thanked Mr Proudfoot for his contributions and support over the years and wished him well for the future.

18. Date of Next Meeting

18.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 7 September 2015 at 9:00 in Waverley Gate, Edinburgh. Committee members only are asked to attend by 8.45 for the scheduled 15-minute pre-meeting.

DRAFT

NHS Lothian

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 10:00am on Wednesday 8 July 2015 in the Nancy Loudon Meeting Room, Chalmers Centre, 2A Chalmers Street, Edinburgh.

Present: Mr G Walker (Chair); Mrs Kay Blair; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Mr B Houston and Mr P Johnstone.

In Attendance: Mr N Bradbury (Capital Finance Manager); Mr J Crombie (Chief Officer); Mr J Glover (Service Manager, Royal Edinburgh Hospital); Mr I Graham (Director of Capital Planning & Projects); Professor A McMahon (Director of Strategic Planning, Performance Reporting & Information) and Mr P Reith (Secretariat Manager).

Apologies for absence were received from Professor J Iredale and Ms M Johnson.

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.

The Chairman commented on a successful and informative visit to the Princess Alexandra Eye Pavilion and thanked the staff involved for their work. The Committee noted the high quality of service being provided in a building no longer fit for purpose in the 21st century. The Committee also had the opportunity to visit the Lauriston Building and Chalmers Centre.

14. Minutes of the Previous Meeting

14.1 The minutes of the previous meeting held on 13 May 2015 were approved as a correct record.

15. Running Action Note

15.1 The Committee received the previously circulated running action note detailing outstanding matters arising, together with the action taken and the outcomes. Mrs Goldsmith advised that there was no further information on the outcome of the spending review and a further report would be given to the September meeting.

16. Matters Arising

- 16.1 Finance & Resources Committee Annual Report – Mrs Goldsmith advised that the Committee's comments on the lack of adequate data to enable it to fully discharge its responsibility had been included in the governance statement.
- 16.2 Western General Hospital Masterplan – Mrs Goldsmith advised that due to time constraints and the timing of the meeting, the Western General Hospital Masterplan would be going to the next meeting of the Strategic Planning Committee in August before being considered by the Finance & Resources Committee at its September meeting. Mr Davison commented on the need for the Masterplan to be as creative as possible and emphasised that if beds were added to the Royal Infirmary of Edinburgh at the Bio-quarter campus this would impact on the way in which the Western General Hospital was redeveloped.

17. Financial Position to 31 May 2015

- 17.1 Mrs Goldsmith introduced a previously circulated report giving an overview of the financial position to 31 May 2015 and a materialisation of risks and issues outlined within the financial plan.
- 17.2 The Committee noted that whilst this report had been to the Board meeting on 24 June, Appendix 4 on the risks to the financial plan had been revisited. Finance staff were in the process of analysing the third month in the financial year and a full quarterly review looking at all options would be undertaken.
- 17.3 It was noted that at this early stage it was not be possible to say how financial balance would be achieved by the end of the financial year. The Scottish Government Health & Social Care Directorates had been notified of this and she had met with the Director of Finance at the Scottish Government.
- 17.4 Mrs Goldsmith emphasised that the problem was that NHS Lothian was currently out of financial balance and would require to get back into financial balance before the position could be resolved.
- 17.5 Mrs Blair commented that whilst NHS Lothian was very good at bringing forward new services, it was much more difficult to determine what services should no longer be provided in order to find the funding for new developments.
- 17.6 Mrs Goldsmith agreed with Mrs Blair and confirmed that some unpalatable decisions would require to be made in the current financial year emphasising that such changes would not happen overnight and would take time to implement.
- 17.7 Mr Davison advised that the governance statement in the annual accounts had tried to lay the foundation for the need for such changes and the Board had to engage with the Scottish Government over the choices open to it. He reminded the Committee that NHS Lothian had asked the Scottish Government for a first quarter review rather than waiting for a six-monthly review.

- 17.8 Mr Davison commented that in the meantime it was important to concentrate on the years ahead and he outlined possible options that could be taken. There were two main areas of discretionary spend; the rate at which NHS Lothian started using new drugs and spending on private sector healthcare in order to achieve the legally binding time to treatment guarantee.
- 17.9 Mr Houston commented that NHS Lothian required to start managing risk in a greater amount of detail to ensure a proper balance between achieving financial targets and performance targets.
- 17.10 Mr Johnstone suggested that one thing that NHS Lothian could exert some control over was the non delivery of efficiency savings as failure to achieve Local Reinvestment Plan targets weakened any case for additional funding.
- 17.11 Professor McMahon advised that a number of these issues would be covered at the next Board Development Session on 15 July 2015. He reminded the Committee that changes in service provision would require formal consultation and there would always be a time-lag before such savings could be delivered.
- 17.12 Dr Farquharson advised the Committee that he had spoken with colleagues in the West of Scotland in order to compare NHS Lothian's performance to what they were achieving. NHS Greater Glasgow and Clyde was spending three times as much as NHS Lothian on hepatitis C treatment and he was examining NHS Lothian's Independent Patient Treatment Review approvals to ensure that Lothian's position was in step with other NHS Boards.
- 17.13 The Chair commented that Board members would need to be prepared for the annual review with the Cabinet Secretary and Professor McMahon advised that part of the following week's Development Session would be devoted to this.
- 17.14 Mrs Blair commented that she was still hearing stories about inefficiencies in basic services and emphasised the need for NHS Lothian to review how to improve in these areas.
- 17.15 The Committee agreed to note that the financial position at 31 May 2015 showed an overspend of £4.188m which had been reported to the Board at its meeting on 24 June. The Committee recognised that the conditions for financial balance laid out in the financial plan were not being met and noted the updated assessment of financial risk in the current year. It was noted that this would be reflected in the Quarter 1 review and would inform the required action to achieve balance.

18. Primary Care Prescribing

- 18.1 Mrs Goldsmith introduced a previously circulated report informing the Committee of the financial pressures surrounding the primary care prescribing budget and seeking support for the necessary actions to alleviate the expected cost pressures in 2015/16.
- 18.2 The Committee noted that the budget for primary care prescribing had previously been increased annually as part of the financial plan and that this uplift had been consistent in the two years prior to 2015/16.

- 18.3 Mrs Goldsmith commented that prescribing had gone out of balance because of pricing and short supply with no reversal being seen. The main problem was the global market but as any saving in prescribing were taken out of the budget for the Local Reinvestment Plan the overspend was increasing. It would therefore be necessary for NHS Lothian to further improve the management of its prescribing budget.
- 18.4 Mrs Goldsmith reminded the Committee that from 1 April 2016 it would be the responsibility of Joint Directors and the Finance Department to ensure that the Integration Joint Boards were able to deliver services within their budget. She reiterated the need for NHS Lothian to compare itself with the rest of Scotland to see if there were any ways of improving its prescribing position. It would be important for proposals to come from primary care and pharmacy as to how this might be achieved.
- 18.5 Dr Farquharson commented that general practitioners tended to see the problem as one of insufficient funding and advised that, in his view, the shortage of medicines would continue.
- 18.6 Mrs Goldsmith advised that one of the fundamental problems was that prices were agreed on a United Kingdom basis and when pre-set volumes were exceeded, a rebate was obtained from the pharmaceutical companies. This would normally go back into prescribing but that had not been possible in 2015/16 and the money had instead been used by Scottish Government to fund new medicines.
- 18.7 Mr Houston asked if comparative data with other NHS Boards in Scotland was available and Mrs Goldsmith advised that, whilst such data was available, the difference between NHS Lothian and other Boards was reducing as other Boards were emulating NHS Lothian's longer established good practices.
- 18.8 The Chair expressed his concern that prescribing costs could have a seriously adverse effect on Integration Joint Board budgets. An event with new Integration Joint Board Chairs and the Cabinet Secretary was being held in August and work was underway to ensure that this subject was on the agenda for discussion.
- 18.9 Mrs Goldsmith commented that it was unlikely that 3 of the 4 local authorities in Lothian would be willing to share risk associated with prescribing costs with NHS Lothian.
- 18.10 The Chair questioned whether a 3% Local Reinvestment Plan target was realistic and Mr Davison commented that the current process involved identifying the gap between the cost of providing services and the funding available and setting that as the local reinvestment target. The big issue was that £25m of funding needed to be shifted from the acute sector to primary care and that whilst this had been discussed with the guiding coalition no progress had been made.
- 18.11 Mrs Goldsmith commented that the Local Reinvestment Plan was separated from the idea of the overall resource and the concept of living within that resource. A far more effective way of managing the process would be identifying the overall available resource and then working out how to deliver services within that resource.

- 18.12 The Committee noted that the financial risk associated with GP prescribing would be moved to high and would be reflected in the Quarter 1 review and noted that the Community Health (& Care) Partnerships / Integration Joint Boards had identified a range of actions to proactively manage expenditure, but that this would not be sufficient to mitigate the level of forecast overspend.
- 18.13 The Committee agreed to express its significant concern over the impact that prescribing costs and other increasing costs together with the failure to achieve the Local Reinvestment Plan target would have on the ability of the Board to reach a balanced financial outcome at the end of the financial year.

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19. Integration Joint Boards Hosted Services – Financial Assurance and Risk Sharing Protocol

- 19.1 Mrs Goldsmith introduced a previously circulated report which further developed the paper on the creation of Integration Joint Boards presented to the Committee at its meeting on 5 May 2015. It was noted the report further examined the financial risks around the hosted services delegated to Integration Joint Boards and considered the current risk sharing agreements between the Community Health Partnerships around the GP Prescribing and General Medical Services budgets.
- 19.2 Mrs Goldsmith reminded the Committee that whilst work was in progress, full financial delegation to Integration Joint Boards would not occur until 1 April 2016. One area causing confusion was that the NHS had more flexibility in budgeting compared to local authorities and work in hosted services would require to be carried out before they could be delegated to the Integration Joint Boards. The Integration Joint Boards would need to work with NHS Lothian on how hosted services budgets were distributed and this was being developed with Chief Officers.
- 19.3 The Committee noted that some service areas would be retained with others being delegated to Integration Joint Boards at the end of the year once due diligence had been completed.
- 19.4 Mrs Goldsmith advised that Integration Joint Boards would have a Section 95 Accountable Officer who would be responsible for confirming to Integration Joint Boards if they had sufficient resources to deliver their strategic plan.
- 19.5 Mr Davison commented that a fundamental problem was that NHS Lothian received 14.5% of the NHS budget in Scotland to provide services to 16% of the population. He suggested a strategic commissioning plan with less NHS and private provision and more third sector provision would be the only way to deliver more services for less money.
- 19.6 Mrs Blair expressed her concern at the difficulty in identifying the necessary time and skills to achieve this and emphasised the need for NHS Lothian to have further discussions about its level of risk appetite.
- 19.7 The Committee noted the previously circulated updates relating to financial assurances for the hosted services that would be delegated to the Integration Joint Boards; noted that the financial risk arrangements for set aside budgets would be the

subject of the a separate paper to the Committee and agreed to support the proposed interim arrangements for the financial risk sharing mechanism between NHS Lothian and the Integration Joint Boards for hosted services.

20. Property and Asset Investment Programme 2015/16

- 20.1 Mr Graham introduced a previously circulated report providing an update on the Property and Asset Investment Programme 2015/16.
- 20.2 Mrs Blair asked if the difficulties faced by the new Southern General Hospital in Glasgow were being taken on board for the new Royal Hospital for Sick Children and Department of Clinical Neurosciences.
- 20.3 Mr Graham advised that many of the press headlines had been as a result of creative interpretation of statistics and confirmed for example that eHealth would be discussing the move with Greater Glasgow and Clyde colleagues. The committee noted that a theatre requiring reconfiguring had been interpreted as a theatre not working.
- 20.4 Mrs Goldsmith reassured the Committee that an exercise would be held to analyse lessons learnt from the Southern General Hospital.
- 20.5 The Committee recognised the financial performance to date and the highlighted key risks and issues arising from the Property and Asset Investment Programme; recognised the requirement to prioritise major infrastructure developments in the context of the strategic plan and other priorities and confirmed the submission of the Board's Property and Asset Management strategy to the Scottish Government for review and compilation of the NHS Scotland Asset and Facilities Management Report.

21. Update on the Impact of ESA 2010 on NHS Lothian's Non Profit Distributing Model and HUB Design Build Finance and Maintain Programme

- 21.1 Mrs Goldsmith introduced a previously circulated report giving an update on the implications of revised European guidance on statistical classification on the Non Profit Distributing Model and HUB Design Build Finance and Maintain Programme as a defected NHS Lothian project. This was referred to 'ESA 2010'.
- 21.2 The Committee noted the risk of such projects being classified as on the balance sheet at a government level and noted that the Scottish Futures Trust was leading the work to understand the impact on the national programmes and what mitigating measures would be required. It was noted that these actions would be different for non profit distributing and projects reflecting the different structures.
- 21.3 It was noted that this would impact not only on the Lothian Bundle project for the replacement of general practice premises in Lothian but also on the redevelopment of the Royal Edinburgh Hospital and progress on the East Lothian Community Hospital.

- 21.4 Mr Davison commented that the arrangements for future projects such as the Bioquarter would need to be undertaken in a way which did not run into these difficulties.
- 21.5 The Committee agreed to note the current status of revenue funded projects being progressed by NHS Lothian and following the conclusion of amendments to the territory partnering agreement and the HUBCO shareholders agreement to delegate authority to the Director of Finance to sign the amended documents.

22. Backlog Maintenance

- 22.1 Mr Graham introduced a previously circulated report providing an update on the Backlog Maintenance Programme and seeking approval for the ongoing commitment to allocate funding annually from the Property and Asset Management Investment Programme.
- 22.2 The Committee noted that NHS Lothian's overall exposure to backlog maintenance had been significantly reduced over the past few years and that the best way to continue this reduction was the rationalisation of the estate.
- 22.3 The Committee received an assurance that tackling backlog maintenance remained a priority for the capital programme and that key areas of risk were being prioritised; agreed to support the ongoing action plan and risk appetite for the Finance & Resources Committee in relation to the reduction of backlog maintenance and noted that NHS Lothian's ability to deliver the Scottish Government's objective to eliminate all significant and high risk items in 5 years would be challenged on both the Western General Hospital and St John's Hospital sites without significant capital investment.

23. Disposal of Surplus Properties

- 23.1 Mrs Goldsmith introduced a previously circulated report seeking approval to declare a number of properties surplus to Lothian Health Board's requirements and to allow the properties to be disposed of in accordance with the Scottish Government's Property Transaction Handbook.
- 23.2 Mr Graham advised that a number of these properties were currently used for residential accommodation for learning disability and providing a residential service for patients who would otherwise be inpatients at the Royal Edinburgh Hospital. The current leases had expired and the favoured option was the sale of the properties to the organisation providing those services. In response to a question from Mrs Blair, Mr Graham confirmed that all sales contained a standard Scottish Government clause that meant that NHS Lothian would receive a percentage of any uplifted value, which could for example be up to 25% if the properties were subsequently sold.
- 23.3 The Committee agreed to grant approval to declare the properties listed in the circulated paper surplus to current requirements, allowing them to be trawled around other government bodies and if no interest was noted, marketed for sale taking cognisance of the current market climate and in accordance with the Scottish Government's Property transaction Guidance.

24. Initial Agreement for the Reconfiguration of Learning Disability Inpatient Services at the Royal Edinburgh Hospital

- 24.1 Mr Glover introduced a previously circulated report together with the initial agreement for the reconfiguration of Learning Disability Inpatient Service at the Royal Edinburgh Hospital.
- 24.2 Mr Glover advised that the services would be re-provided at a cost of £1.1m and would lead to significant increases in the quality of care and personal enhancement as well as increasing efficiency and leading to £0.8m recurring savings.
- 24.3 The Committee noted that the existing Islay Centre would be replaced by a unit identical to the Harris Unit which had already been in service since 2013 and had led to significant reductions in the number of incidents leading to substantially improved patient and staff satisfaction. Staff turnover and sickness rates in the Harris Unit had reduced to almost zero since the reconfiguration and the Unit's staff reported feeling significantly more positive about their work. This had been reflected in improved clinical outcomes for patients, with one individual for whom the prognosis was long term inpatient care now deemed fit for discharge.
- 24.4 The Committee thanked Mr Glover for his presentation and congratulated the staff on the success of the Harris Unit.
- 24.5 The Committee noted that the proposals had been developed after looking at what other Health Authorities did, especially in Morpeth and Mr Johnstone suggested that this model should be replicated across Lothian where appropriate.
- 24.7 Committee was reassured that the Masterplan continued to envisage 120 integrated care beds on the site and the new units would have no impact on this.
- 24.8 The Committee agreed to approve the initial agreement for the reconfiguration of inpatient facilities at the Islay Centre on the Royal Edinburgh Hospital site subject to the business case reflecting that the 120 integrated beds on the Royal Edinburgh site would be unaffected and agreed to approve the progression of the proposal to a Standard Business Case.

25. Replacement of a Vascular Room at the Western General Hospital

- 25.1 Mr Crombie introduced a previously circulated report seeking approval for the replacement of a vascular room at the Western General Hospital.
- 25.2 Mr Crombie explained that whilst there was a facility at the Royal Infirmary of Edinburgh it could not cope with the demand in Lothian and a facility was required at the Western General Hospital as well. The proposal was patient safety led and the capital was fully provided for in the Property and Asset Management Programme. There would be no impact on revenue costs.

25.3 Mrs Goldsmith advised that the proposal had been approved by the Lothian Medical Equipment Replacement Group and the Lothian Capital Investment Group and that a system had been developed for prioritising the replacement of such equipment,

25.4 The Committee noted that the proposal had been approved by the Lothian Medical Equipment Replacement Group and the Lothian Capital Investment Group and approved the expenditure of £1.2m to replace a vascular room at the Western General Hospital.

26. Property and Asset Investment Programme 2015/16 – Business Case Monitor

26.1 Mr Graham introduced a previously circulated report giving a detailed overview of the major capital projects.

26.2 The Committee agreed to note the progress and performance to date of each of the projects and the associated key risks and issues.

27. Western General Hospital Masterplan and Edinburgh Bioquarter

27.1 Mr Davison advised the Committee that there would be a need for some time to be spent on the Western General Hospital Masterplan and Edinburgh Bioquarter at a future meeting.

28. Cottage at the Royal Infirmary of Edinburgh

28.1 The Committee noted that a cottage adjacent to the service corridor with the Royal Infirmary of Edinburgh had come on the market and a purchase was being proposed in order to remove a number of restrictions and assist with the boundary improvement programme. It was noted that this transaction was under the delegated limit.

29. Date of Next Meeting

29.1 It was noted that the next meeting of the Finance & Resources Committee would be held on Wednesday 9 September 2015 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

The draft minutes of the meeting held on 26 May 2015 are attached.

1. Key issues discussed included:

1.1 GP Recruitment

The Committee was pleased to receive and discuss an update paper raising significant concerns regarding recruiting and retaining adequate numbers of GPs to deliver high quality primary care health care services across NHS Lothian. The Chair subsequently communicated with Dr Catriona Morton, Professor Alex McMahon and Dr Richard Williams to ensure that this matter was being progressed. A paper with proposals to improve the situation will be presented to the Board in June 2015.

1.2 Healthcare Associated Infection Update

The update report received by the Committee raised concerns about NHS Lothian's failure to meet the HEAT targets for reduction of *Clostridium difficile* Infection and *Staphylococcus aureus* Bacteraemia. An action plan for improvement will be presented by the Nurse Director at the next meeting.

1.3 Maternity Services Update

A helpful and detailed update was received from Maternity Services, demonstrating improvement which provided assurance that the previous concerns about the quality of patient care were being fully addressed.

1.4 Healthcare Governance Committee Annual Report

The report highlighted the assurance needs of the Healthcare Governance Committee that had not been met. These included complaints and patient feedback, Healthcare Associated Infection and the systems and processes related to compliance with mandatory training, which is being addressed by the Staff Governance Committee.

Dr Morag Bryce
Chair of the Healthcare Governance Committee
18 June 2015

NHS Lothian

Healthcare Governance Committee

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 am on Tuesday 26 May 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Dr M. Bryce, Non-Executive Board Member (chair); Ms S. Allan, Non-Executive Board Member; Ms W. Fairgrieve, Partnership Representative; Ms N. Gormley, Patient and Public Representative; Mr A. Joyce, Employee Director, Non-Executive Board Member; Ms A. Meiklejohn, Chair of the Area Clinical Forum, Non-Executive Board Member; Dr R. Williams, Non-Executive Board Member.

In Attendance: Ms L. Baxter, Public Involvement Co-ordinator (item 6.1); Ms J. Bennett, Clinical Governance Manager; Dr C. Bickler, GP (item 8.1); Ms L. Cowie, Chief Nurse, Edinburgh CHP; Mr J. Crombie, Chief Officer, University Hospitals Services; Dr D. Farquharson, Medical Director; Ms C. Harris, Communications Team Manager; Mr B. Houston, Board Chairman; Dr C. Love, Consultant Obstetrician (item 8.2); Professor A. McMahon, Director of Strategic Planning; Ms F. Mitchell, Women and Children's Services (item 8.2); Dr D. Northridge, Cardiology Consultant (item 8.1); Ms B. Pillath, Committee Administrator (minutes); Mr A. Sharp, Patient and Public Representative (observing); Dr J. Tomlinson, Consultant in Public Health Medicine (item 10.1); Mr D. White, Assistant General Manager, Edinburgh CHP; Ms M. Wilson, Chief Midwife (item 8.2).

Apologies: Mr A. Boyter, Head of Human Resources; Ms M. Christie, Head of Health, West Lothian CHCP; Dr B. Cook, Associate Medical Director; Mr T. Davison, Chief Executive; Ms P. Eccles, Partnership Representative; Mr J. Forrest, West Lothian CHCP Manager; Ms M. Johnson, Director of Unscheduled Care; Professor A. McCallum, Director of Public Health and Health Policy; Professor A. Timoney, Director of Pharmacy; Cllr F. Toner, Non-Executive Board Member.

Chair's Welcome and Introductions

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

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

1. Patient Story

1.1 Ms Wilson read out a letter from a patient who was complimentary about the care she had received in Maternity Services.

2. Committee Cumulative Action Note and Minutes from Previous Meeting (24 March 2015)

2.1 The updated cumulative action note had been previously circulated.

2.2 The minutes from the meeting held on 27 January 2015 were approved as a correct record.

3. Matters Arising

3.1 eHealth Strategy and Electronic Prescribing Update

3.1.1 Professor McMahon advised that he, along with the Medical Director, the Director of Pharmacy and the Head of eHealth had met with the Scottish Government to discuss the national Hospital Electronic Prescribing and Medicines Administration programme. The procurement process was currently in progress with aim of having a system in place in NHS Lothian in 2018/19. Project scoping would begin soon, and some work on systems that could connect to share information had already been completed.

3.1.2 Dr Williams welcomed the update, and noted that the Area Drug and Therapeutics Committee was concerned that the lack of an electronic prescribing system was a risk to patient safety, but felt that the timescale for this was long. Professor McMahon noted that no other Board had a full live system, and a culture change as well as a systems change would be required to implement this, and that engagement was starting immediately in preparation for the system being ready.

3.1.3 Professor McMahon advised that the national eHealth strategy had been launched by the Scottish Government, but that the accompanying finance plan was not yet available. The Lothian eHealth strategy was in draft form and would be submitted to the Healthcare Governance Committee for consultation at the next meeting.

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3.1.4 In response to a question from Ms Gormley, Professor McMahon agreed that there could also be consultation on the strategy with the public as well as within the organisation.

3.2 Pressure Ulcer Standards and Evidence Review

3.2.1 Ms Bennett advised that a review would take place within the UK to gather evidence on successful reduction of pressure ulcers. Ms Johnson would lead a group to work on an improvement plan, coordinating with Healthcare Associated Infection work to gain a more coherent view. Dr Bryce noted that an international review might be beneficial as expected improvement had not been seen in Scotland. The action plan would include different interventions in different areas, including dressings, early intervention, education, and appropriate equipment. Further work may be required in primary care and in nursing homes.

3.2.2 It was noted that gathering data was difficult due to the number of areas involved, including private care, but that this was an important step. Data on the initial review would be reported at the next meeting. Ms Allan suggested that a pilot of information gathering could be carried out in Edinburgh CHP to determine parameters.

3.2.3 Dr Bryce noted that it would be beneficial if an information analyst sat on the Healthcare Governance Committee or had input. Mr Houston agreed that there was ongoing work on the better use of information, and this could be included.

4. Emerging Issues

4.1 Healthcare Environment Inspection, Royal Infirmary of Edinburgh

4.1.1 Dr Farquharson advised that there had been an unannounced inspection by the Healthcare Environment Inspectorate on 29 April 2015, looking at 13 areas. The formal report had not yet been received, but initial feedback was that the area inspected was clean and well maintained overall, there was good compliance with standard infection control precautions in the handling of skips, and IV canula management was good. There were concerns about some contaminated mattresses; this had already been actioned.

4.1.2 It was also noted that there was a view following discussion with the bed contractors Huntleigh that some of the assessment on mattresses was not correct; and mattresses which had been declared fit for use by infection control specialists were then described as 'contaminated' by HEI inspectors. There had been discussion with NHS Glasgow and NHS Tayside on an approach for determining a set of criteria for what constituted a Healthcare Associated Infection risk in mattresses.

4.1.3 Mr Crombie advised that the Healthcare Environment Inspectorate had arrived unannounced at the Western General Hospital that morning, and the inspection was in progress.

4.2 GP Practice Closures and Reallocations

4.2.1 Dr White spoke to a draft update for MSPs which had been previously circulated for information. He noted that a problem with GP recruitment and a shortage of locums had made GP capacity inadequate, and that newly graduated doctors were not opting to become GPs. The population of Edinburgh was also growing by 5,000 per year, and this was expected to continue for the next 20 years. A further problem was inadequate IT systems which meant that GP clinical time was lost due to system crashes and problems.

4.2.2 Some work was in progress in putting together a number of initiatives into a clear strategy for improvement; it was felt that funding was required for long term improvements to be implemented. Some of the initiatives included: better use of flexible roles such as advance nurse practitioners; employee retention; back to practice funding; IT improvements; social prescribing initiatives; centralised responsibility for care homes; management of public expectations.

4.2.3 Mr Joyce noted that Alison MacDonald, Chief Nurse of East Lothian CHP, had presented a paper on advanced nurse practitioners to the Board, and that the Board had agreed to fund eight new posts. Ms Cowie noted that there were already advanced nurse practitioners working in community nursing and health visiting rather than in GP practices.

- 4.2.4 Dr Williams felt that primary care was in crisis and the primary care strategy should be revisited to cover recruitment of GPs in addition to redesign of services and premises. A returner scheme should also be considered as the average age of trained GPs leaving practice was 35 years, often women leaving to have a family, and there was no way to encourage them to return. Dr Williams advised that universities were reducing places for medical students and there was a reduction in numbers of students wanting to train as GPs.
- 4.2.5 Ms Harris advised that the press had taken up this problem, and that some work would be done with the local press to promote the positive aspects of being a GP, but that GPs also needed to make their workplaces more attractive to prospective trainees.
- 4.2.6 Mr Houston agreed that the primary care strategy was now inadequate to cover this problem, but felt that there was now more interest from the Cabinet Secretary for health on this issue, and that coming up with a solution to the GP problem was fundamental to the integration of Health and Social Care. This presented an opportunity for positive change. Mr Houston also noted that he sat on the Education Committee along with the Chairs of the medical school colleges and had raised with the Cabinet Secretary the fact that this Committee had a focus on acute rather than primary care.
- 4.2.7 Ms Bennett noted that the problem with GP recruitment was not on the Board Risk Register separate to medical recruitment, but that the case for this would be discussed at the next Risk Management Steering Group.
- 4.2.8 Ms Gormley felt that more could be done on social media to advise patients when to go to pharmacy or NHS 24 rather than see a GP.
- 4.2.9 Dr Bryce suggested that a more complete paper should be presented to the Board articulating what interventions would be required. It was noted that no-one in the Scottish Government was working on this particular issue currently.

5. Corporate Risk Register

- 5.1 A paper had been previously circulated. Dr Farquharson noted that the risk register had been reviewed recently and approved by the Audit and Risk Committee. The four outstanding risks were for Healthcare Associated infection, finance, access charges and delayed discharge, and would be reviewed by the Audit and Risk Committee.

6. Person Centred Culture

Involving People Update

- 6.1.1 The Chair welcomed Ms Baxter and Ms Harris to the meeting. Ms Harris spoke to the previously circulated update on the actions taken as part of the Involving People Framework, and advised that this would be an annual update. The paper currently reported on areas where the Communications Team were directly involved, future reports would also try to capture further work that was going on at the clinical level.

- 6.1.2 Ms Baxter noted that feedback on whether the report contained information that was useful to the Committee would be welcome. The highlights of the report were; increasingly proactive engagement with elected members with the help of the new Parliamentary Liaison Officer post rather than responding reactively to problems; ensuring involvement and engagement from the beginning of work like capital planning; carrying out engagement work in clinics where patients are to find out what is important to them, rather than asking people to attend workshops.
- 6.1.3 In response to a question from Ms Meiklejohn, Ms Baxter advised that feedback to patients about how NHS Lothian had responded to their suggestions was not returned on an individual basis but would be communicated using posters, social media and the website through the Communications Team. Issues raised by patients need to be addressed as part of planning and development of services.
- 6.1.4 Ms Gormley was pleased to see work going into this area and noted that a flexible approach was needed so that changes could be taken into account easily. She also suggested that the Framework could be communicated with more of a link to the organisational values.
- 6.1.5 Ms Allan noted that the bronchiectasis website was developed by patients, showing the level of engagement between patients and their clinicians.

6.1.6 Members noted the recommendations made in the paper.

6.2 Patient Experience and Feedback

- 6.2.1 A paper had been previously circulated. Ms Bennett noted that the survey results so far, both in depth and 'tell us ten things' had been positive. Common issues highlighted were: food; understanding new medicines prescribed; and noise at night in certain areas. This feedback had been taken back to relevant areas. The 'tell us ten things' questionnaire had been revised and now included a question on medicines management.
- 6.2.2 Ms Bennett advised that feedback to staff on the results of surveys would continue with as much information as possible, as feedback alone was an important improvement intervention.
- 6.2.3 Part of this work is being reviewed following the first responses, to ensure priorities match the information that had been gathered.

7. **Safe Care**

7.1 Healthcare Associated Infection Update

- 7.1.1 A paper had been previously circulated. Dr Farquharson advised that the *Clostridium difficile* Infection and *Staphylococcus aureus* Bacteraemia HEAT targets, and that there had been no improvement. Healthcare Associated Infection was now 'red' on the risk register. Work was ongoing: the new Lead Infection Prevention and Control Nurse had been appointed; there was regular contact with

the Scottish Government on what more could be done to make improvements; and there was a fortnightly report to the patient experience safety group.

7.1.2 Early indications were that the successful change in the antibiotic prescribing policy had not had the expected effect on reducing the incidence of CDI. Ms Bennett that the first quarterly report showed that compliance with the new policy was good with a reduction in the prescription of antibiotics known to increase the risk of *Clostridium difficile*, and an increase in the prescription of gentamicin as an alternative. No incidences of gentamicin toxicity had been reported so far; an increase in Datix entries was not associated with an increase in harm.

7.1.3 Ms Bennett noted that investment in the education resource to increase education of staff on safe insertion of lines and on pressure ulcers was part of the improvement plan, which would be part of the report at the next meeting.

7.1.4 Dr Bryce noted that the problem was not being resolved in spite of interventions, and that from a governance perspective it was unacceptable that reports showed no improvement on reducing potentially preventable infections.

7.1.5 Dr Williams expressed concern that the improvement focus was on secondary care when there was also room for improvement in primary care, where more resources were required. Dr Farquharson understood that the additional antimicrobial pharmacy resources supported by the Committee had been approved by the Director of Finance, but agreed to confirm that this was the case. **DF / MJ**

7.2 Public Protection Update

7.2.1 The previously circulated paper was noted by Members, and there were no comments.

7.3 Improving Management of Adverse Events

7.3.1 A paper had been previously circulated. Ms Bennett noted that at the last Committee there had been discussion about compliance with the requirement to complete all reviews of significant adverse events within 66 days. Work was in progress to complete the backlog of cases in areas such as Maternity Services and Mental Health. Guidance on which areas to focus on during reviews, and the importance of multi-disciplinary reviews was being developed and given to relevant areas.

8. **Effective Care**

8.1 Coronary Heart Disease Programme

8.1.1 A paper had been previously circulated. The chair welcomed Drs Bickler and Northridge to the meeting. It was noted that the indicators used in the paper to measure progress were what had been agreed by Healthcare Improvement Scotland, but were not necessarily what NHS Lothian would prioritise; these indicators were being reviewed. Against the indicators used, NHS Lothian was comparable to the national average or better in all instances.

- 8.1.2 It was noted that figure 4 in the paper showed NHS Lothian as an outlier compared to Scottish Health Boards in the length of stay following elective admission for angioplasty PCI, but Dr Northridge advised that this was because day cases were excluded in NSD figures, and as Lothian had a high number of day cases for geographical reasons, the figures included in the measure only covered about 20% of Lothian patients. The average door to balloon time for patients arriving at hospital having had a heart attack was 28 minutes in NHS Lothian, which was high against international standards, although average in Scotland. 70% of these patients in Scotland were treated by NHS Lothian or the Golden Jubilee National Hospital.
- 8.1.3 Dr Bickler advised that there had been no improvement in heart disease rates deprived areas in Lothian or elsewhere. A number of audits had been done and services were in place in these areas; work was ongoing.
- 8.1.4 Ms Allan noted that the paper highlighted the potential risk of inequity between areas due to the differing approaches of the new Integrated Health and Social Care Boards, but felt that this may also be an opportunity to make improvements and work more closely with social care services. Dr Bickler agreed, but this would be monitored. Professor McMahon noted that a pan-Lothian approach was planned and there would be discussions as to whether existing structures might be better used and how to mitigate the risk of divergence.
- 8.2 Maternity Service Update
- 8.2.1 A paper had been previously circulated. The chair welcomed Ms Wilson, Dr Love, and Ms Mitchell to the meeting. Ms Wilson noted that there had been a focus on the key issues in the recommendations from the Morecombe Bay investigation, particularly on openness and response to problems. Training on openness and risk had been very successful in moving forwards. NHS Lothian measured well against the other recommendations from the investigation.
- 8.2.2 Progress on actions in response to the Royal College of Obstetricians and Gynaecologists review of Women's Services in NHS Lothian was detailed in the paper. There had been some objectives, and also acknowledgement that some problems had been recognised and work was in progress to achieve improvements.
- 8.2.3 NHS Lothian reported well in the Maternity and Morbidity Audit, including on haemorrhage, which gave reassurance that improvements had been made. This was also part of the patient safety programme.
- 8.2.4 Ms Mitchell noted that the Scottish Government had recently announced its plans to carry out a national review of maternity services, specifically looking at the themes of patient choice and sustainability.
- 8.2.5 Dr Farquharson felt that the report that there had been good improvements and that NHS Lothian was up to date with progress nationally. He felt that more investment was required in the 'perceived status difference between the St John's Hospital and Royal Infirmary of Edinburgh units' noted in the paper to ensure that a Lothian service was provided from both units. Ms Mitchell advised that a meeting

with clinicians representing both units had taken place, at which it was agreed that there should be an overarching vision for the whole service, but that the units provided different services and the St John's unit needed to be able to develop its own identity and not be overwhelmed by the volume of activity at the Royal Infirmary unit. Ms Wilson noted that many of the previous problems in the unit had been due to capacity issues at the Royal Infirmary unit, and that without the support of the St John's team for transfer of patients, the service would have experienced worse problems.

8.2.6 Ms Allan welcomed the news that there was no problem in recruiting midwives, noting that this was not the case with all services. Ms Wilson agreed that there was a good experience and opportunities for midwives in NHS Lothian and that CPD was often better than elsewhere.

8.2.7 Dr Williams was reassured by the paper that there was a team approach to addressing problems and asked what improvement had been made in capacity and patient flow. Ms Wilson advised that there had been a reduction in number of transfers from the Royal Infirmary to St John's over the last year, but that more work was required on managing bookings. There had been no transfers outwith Lothian, but it was noted that patient inflow was very unpredictable with an average of 19 births per day but a high of 27 or more at the top of the range. This was the case in all units across Scotland.

8.2.8 In response to a question from Dr Bryce, Ms Wilson advised that there two consultant midwives had previously been employed at St John's and at the Royal Infirmary; one had been temporarily funded by the Scottish Government, and one post holder had gone on secondment and the money was used for a research project. There was one 0.5 WTE consultant midwife in research. Dr Love noted that advanced midwife practitioners had also been considered, but that other areas had found that these post holders moved on quickly after training. An alternative was to consider extended duties for more existing members of staff.

8.2.9 Updates on the action plan outlined in the paper would be reported to the Maternity Services Programme Board monthly.

8.3 Quality Report – Quarter 4

8.3.1 A paper had been previously circulated. Dr Farquharson noted that the areas covered in this paper had been previously discussed as part of the Committee's work, including the highest three adverse events with harm on pressure ulcers, healthcare associated infection, and medicines reconciliation.

8.3.2 Mr Crombie noted that the data showed improvement in some stroke indicators but intermittent compliance and non-compliance on other indicators. There was a programme of work in progress to improve capacity and some interim work for more short term improvements. An update on stroke care would be submitted to the Committee later in 2015. Dr Williams noted that indicators and measures needed to be interpreted with care and in conjunction with a focus on outcomes. The stroke survival rate was high in Lothian.

9. **Committee Effectiveness**

9.1 Healthcare Governance Committee Annual Report

- 9.1.1 The Annual Report had been previously circulated. Ms Bennett noted that there had been feedback from some Members requesting more opportunities for development and education, and that discussion was required on which areas to focus on. It was noted that any questions from patient representatives or non-executive directors could be answered by email prior to meetings by Dr Bryce and Dr Williams as Chair and Vice Chair of the Committee.

10. **Exception Reporting**

10.1 Out of Area Placements Monitoring Team Annual Update

- 10.1.1 The paper had been previously circulated. The Chair welcomed Dr Tomlinson to the meeting. Dr Tomlinson advised that there were 20 patients looked after out of Lothian across the UK as their needs could not be met in Lothian. Due to difficulties in engaging with clinicians regarding review of these patients' needs and their placements over time, a group had been set up to give an overview of these cases, and was chaired by the Medical Director. Inspection reports from areas where the patients were placed were scrutinised to minimise any risk of placing these patients out of area.

- 10.1.2 The budget for this service was currently with Public Health, but this was not thought to be appropriate; the Director of Finance had nominally agreed that the budget be transferred to Mental Health Services, as this area was better placed to consider the proper design of services.

- 10.1.3 A change in legislation soon to be implemented would mean that patients could ask not to be treated in areas which were excessively secure; this could result in more patients currently placed in psychiatric intensive care needing to be placed out of area in a more appropriate unit.

- 10.1.4 Members noted the recommendations in the paper and that their support with better negotiation with care providers and resolution of the Finance issue would be helpful.

10.2 Members noted the following previously circulated items for information:

- 10.2.1 Voluntary Services Annual Report;
- 10.2.2 Occupational Health Clinical Governance Annual Report;
- 10.2.3 Renal Registry Report;
- 10.2.4 Report of the Penrose Inquiry into Hepatitis C / HIV Acquired Infection;
- 10.2.5 Healthcare Environment Inspection, Ellen's Glen, 11 March 2015;
- 10.2.6 Letter to Mental Welfare Commission regarding Glenlee Ward, MCH;
- 10.2.7 Carers (Scotland) Bill Consultation Response;
- 10.2.8 Equality Outcome Framework.

11. **Other Minutes: Exception Reporting**

Members noted the previously circulated minutes from the following meetings:

- 11.1 Area Drug and Therapeutics Committee, 10 April 2015;
- 11.2 Clinical Management Group, 10 February, 10 March 2015;
- 11.3 Lothian Infection Control Advisory Committee, 3 March 2015.

12. Date of Next Meeting

- 12.1 The next meeting of the Healthcare Governance Committee would take place at **9.00 am on Tuesday 28 July 2015 in Meeting Room 7, Second Floor, Waverley Gate.**
- 12.2 Further meetings in 2015 would take place on the following dates:
 - 22 September 2015;
 - 24 November 2015.

The draft minutes of the meeting held on 11 June 2015 are attached.

Key issues discussed included:

- An update on GP practice capacity and workforce challenges and actions underway around people, premises and IT, including primary care out of hours services
- An update on actions underway to embed the House of Care model and approach particularly to meet the needs of Hannah, the exemplar patient with multi-morbidity
- An update on implementation planning for the Health Inequalities Strategy
- Details of the work underway to develop plans for improving older people's care in Edinburgh, with focus on the needs of Scott, the exemplar frail elderly patient with dementia
- A report on the site masterplanning undertaken for the St John's Hospital Campus.

Key issues on the horizon are:

- Further progress report on plans for improving older people's care in Edinburgh
- Consultation on draft IJB Strategic Plans
- Implementation plans for the Children and Young People's strategy, including pathway redesign to meet the needs of Sophie, the exemplar child with healthcare needs.

Brian Houston/ Alex McMahon

Chair/Executive Lead

DRAFT

NHS Lothian

Strategic Planning Committee

Minutes of the Strategic Planning Committee Meeting held at 9.30am on Thursday 11 June 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Professor J Iredale (Chair); Mrs J Anderson; Mr M Ash; Dr M Bryce; Mrs A Meiklejohn and Mrs A Mitchell.

In Attendance: Mr T Davison; Dr D Farquharson; Mr M Hill; Mrs C Harris; Mr A McCreadie; Ms D Milne; Professor A McMahon; Mr D A Small; Mrs L Tait and Mr D Weir.

Also attending was Dr M Douglas (for item 14); Mr I Graham (for item 16); Dr R Hardie (for item 13); Dr C Morton (for item 12) and Dr S Tucker (for item 12).

Apologies for absence were received from Mrs K Blair, Mr A Boyter, Mr J Crombie, Mr J Forrest, Mrs S Goldsmith, Mr B Houston, Mr P Johnston, Ms M Johnson, Mr A Joyce, Professor A K McCallum, Ms E McHugh and Mr G Walker.

9. Declaration of Financial and Non Financial Interest

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

10. Minutes of the Previous Meeting held in 9 April 2015

10.1 The minutes of the previous meeting held in 9 April 2015 were approved as a correct record.

11. Matters Arising

11.1 Work Programme – A copy of the work programme approved by the Corporate Management Team was tabled with it being noted this represented a busy programme of work.

11.2 Learning Disabilities – Integration Joint Boards had been written to asking them to include learning disabilities on their agenda. It was noted because of scheduling considerations that this issue would be discussed in principle at the East Lothian Shadow Board on 18 June. Formal proposals would be discussed at a later date. An update report would be provided at the next meeting of the Strategic Planning Committee.

AMcM

12. Primary Care and Lothian Unscheduled Care Services

- 12.1 The Chairman welcomed Dr Morton, Dr Tucker and Mr Small to the meeting advising that they would present a report in advance of the Board meeting on progress and proposals to progress the Primary Care Strategic Plan propositions.
- 12.2 The committee noted that the circulated paper was intended to be submitted to the Board in June although it might change slightly. It was reported the paper had been prepared following on from the January Board Development Session and represented the baseline actions to start developing better options around capacity and the need to develop the narrative around staffing and workforce issues.
- 12.3 Dr Morton, Dr Tucker and Mr Small provided the committee with a detailed presentation copies of which was provided to committee members immediately following the meeting. The broad thrust of the presentation was around the 2020 Vision; focus for clinical teams in the community; frail elderly; workforce; workload – for quality and safety; IT; working conditions; 2020 Vision – our new community hospital; the care home stay; the hospital stay; new models of care; care in nursing homes and new care home models; hospital at home; Hannah; the new simplicity model; community nursing review; Lothian Unscheduled Care Service and the national review and an update on progress in relation to stages 1-3 of the process.
- 12.4 It was noted that a number of the issues raised would be discussed under the paper later in the agenda on the frail elderly pathway. The Chair asked whether it would be appropriate to address issues such as feminisation of the workforce, by enhancing the number of salaried GPs, and whether the model pursued in at least one large English Foundation Trust in which the Trust started to incorporate local practices would be a useful model to observe/learn from. In Scotland a recent survey had reported that 80% of current GPs wanted to remain as independent contractors as this was seen as the most efficient model. The point was made however that there was a need to consider what healthcare would look like in 10 years time and this would probably result in a move to more salaried GPs.
- 12.5 The committee agreed that the fundamental issue facing the service was that care would need to be provided with less doctors whilst demand was increasing and financial resources reducing. Even if more doctors were appointed less hours would be available because of changes in shift patterns. In future there would in all likelihood be a move to more direct patient access to services like physiotherapy and podiatry etc.
- 12.6 The Chief Executive reminded the committee that the Board was already in financial deficit and there was therefore no discretionary spend. £1m had been allocated to the financial plan for primary care although this had as yet no identified funding source. In 2015/16 it was predicted there would be an £8.5m overspend in primary care prescribing. It was anticipated that the national element of what was contained within the 2017 GP contract would be the catalyst for primary care investment through the national group. It was not felt that the Health Board could take unilateral decisions around issues like end of life drugs.
- 12.7 It was reported that the Healthcare Governance Committee had been concerned about the huge impact on the quality of delivery including the risk that up to 25,000

people would be unable to register with a GP and had asked for this to be moved up the corporate risk register.

- 12.8 The point was made if more GPs were employed then there was a need for a better understanding of what future models of care might look like with there being a need for more discussion about what was common across Lothian. It was suggested there would be benefit in creating a 'think tank' although not a committee to come up with models of care.
- 12.9 The committee noted that a number of the papers before the current meeting laid down the foundations for new models of care as well as the scale and pace on which the Integration Joint Boards would need to take the lead. It was agreed that progress around primary care models of care should not await the release of the anticipated primary care funding from the Scottish Government and should be developed to a state of readiness should funding become available. There would be a need for this work to progress on a pan Lothian basis in conjunction with the GP Sub-committee and the Lothian Area Medical Committee. It was suggested clear models were already available and needed to be discussed at locality level. Whilst there was no current discretionary funding available it would be important that the system was clear about what it needed to invest in if and when resources became available. Further discussion about meeting the needs of the frail elderly in the community would be held at a scheduled meeting on 16 June with outcomes being brought forward to a future meeting of the Board.
- 12.10 The importance of using people already in the system and supporting them through a test of change process as part of the solution was stressed. It was agreed that the pace of change would be critical. Concern was raised about GP retiral statistics as a consequence in part of the impacts of the revalidation process and pension considerations. It was pointed out that there were opportunities to make progress though the creation of multidisciplinary teams albeit that there would be a lead in time for staff obtaining the necessary skills.
- 12.11 The Chairman commented that this was a key action area for the Board with a lot of work yet to be done with the achievement of new models of care requiring investment both in time and finances. The presenters at the meeting were thanked for their input into the proposed solutions.
- 12.12 The committee agreed the recommendations contained in the circulated paper.

13. Hannah and the House of Care Approach

- 13.1 The Chairman welcomed Dr Hardie to the meeting.
- 13.2 The committee were advised by Professor McMahon in his introductory comments that there were common threads running through the presentations at the meeting and these would be reflected in the forthcoming Integration Joint Board commissioning plans. It was noted that the proposals were philosophical rather than structural and should be complementary to any new models of care.
- 13.3 Dr Hardie provided the Board with a presentation, a copy of which was sent to committee members immediately following the meeting, updating on developments around the house of care model since the Board meeting in

October 2014. It was reported that the virtual patient Hannah needed to be informed, enabled and supported with a trained workforce who were committed to this type of approach. This approach would require a change in working practices and the 3 dimensional house model had been developed as a useful model for integration and the integrated model of care.

- 13.4 NHS Lothian and the Thistle Foundation had established a Steering Group to identify, support and learn from early adopters as well as identifying strategic synergies and work towards spread and sustainability. The house of care model would be used to inform the way in which the Integrated Care Fund was allocated. The house of care provided a framework for the actions identified within the Scottish Government's Many Conditions, One Life Action Plan. It was agreed that the third sector would be crucial to the success of the approach especially around supported self management. Work was already underway in respect of the Clinical Change Cabinet 'choosing wisely' message with further discussions planned with Dr Caroline Whitworth. The point was made that each Integration Joint Board would need to consider specific areas where the house of care approach would be most helpful.
- 13.5 The committee noted that partnership working was starting to emerge through the concept being embedded in strategic thinking. It was agreed that a version of the current paper should be provided to each of the Integration Joint Boards.
- 13.6 The committee agreed the recommendations contained in the circulated paper.

14. Health Inequality Strategy

- 14.1 The Chairman welcomed Dr Douglas to the meeting.
- 14.2 Dr Douglas advised that she would update the committee and seek their endorsement of progress as well as acknowledging risk. It was noted that an implementation group had been set up to take forward proposals and identify outcomes. The Steering Group were also looking at communications and training. The committee noted development of a tool to aid scrutiny of papers and proposals going to the NHS Board and committees for approval, to help assess where they were likely to increase or reduce health inequality. It was noted that not all papers would be capable of this scrutiny although it was suggested the proposal represented a good starting point. A revised version of the tool would be produced for use in and training provided for Non Executive Board members.
- 14.3 The committee noted that decisions to disinvest in areas with the least impact on health inequalities would be difficult with no answer having yet been reached although a literature review was underway. The point was made that there was a risk of stopping thinking about health inequalities when other issues were being considered.
- 14.4 The Chief Executive advised of the successful preventative model adopted by the Scottish Fire and Rescue Service in identifying and targeting vulnerable groups of people. It was noted that a small percentage of the population used a large percentage of the service. There was therefore a need to think out of the box.

- 14.5 It was reported that within East Lothian there had been investment in data capturing which had demonstrated that 2% of clients used 50% of the NHS budget. The position in Edinburgh was 1.7% using 50% of the budget. It was felt there was a need to improve the use of data and information sharing protocols. The Chairman commented that information was already available on patients who required 5 or more drugs.
- 14.6 The committee noted that the lack of personal income was a significant issue for a number of people with reference being made to the findings of a recent Joseph Rowntree Foundation Report in this area. The question was raised about how the Health Board could influence the payment of the living wage by contractors as this would have a significant impact on health inequality. The point was made that whilst it would not be possible to require contractors to pay the living wage that the principle was a good one which had already been explored jointly by NHS Lothian and the City of Edinburgh Council for some aspects of service provision. It was agreed that the expansion of apprenticeship schemes would also be a positive step forward.
- 14.7 The point was made in terms of employability issues if there was a lack of uptake in some areas then resource should be diverted to areas where people were being put forward for employment and accepting opportunities.
- 14.8 The committee noted that some aspects of the action plan required further focus to ensure they remained on target. It was important to remember however that the data reported in the paper reflected only on the first quarter and for that reason had not included red / amber / green performance indicators.
- 14.9 Dr Douglas advised she would be happy to spend time with Integration Joint Boards to talk about the importance of addressing health inequalities. It was suggested a more immediate focus should be through the Community Planning Partnerships with this engagement filtering down to the Strategic Planning Groups in the Integration Joint Boards.
- 14.10 The committee agreed the recommendations contained in the circulated paper.

15. Improving Older People's Care in Edinburgh: 2015-17 and the Frail Elderly Pathways – Scott

- 15.1 It was agreed to consider agenda items 6 'Improving Older People's Care in Edinburgh 2015-17' and agenda item 7 'The Frail Elderly Pathway – Scott' at the same time.
- 15.2 It was noted that this represented a complex area of work and currently lacked a critical path with further work on this being reported back to the Strategic Planning Group and the Board by October in order to show how to deliver on some of the efficiencies and propositions. A Programme Board would be established to bring that degree of focus to the workstream.
- 15.3 The committee noted that there was a requirement for multi-partnership working to make things happen and allow the desired outcomes to occur i.e. around the Astley Ainslie Hospital, Liberton Hospital and the development of community hospitals as well as appropriate repatriation of patients. It was noted for example

that a sequence of events would need to occur to make the Liberton Hospital proposals happen. The risks associated with the various proposals as well as the financial impacts were detailed.

- 15.4 The committee noted that the programme scope would in a matter of weeks become the domain of Integration Joint Boards to take forward through their lead commissioning role. It was important to recognise that the process was about improving the quality and safety of services as well as vacating premises. The committee were advised work was already underway in West Lothian in respect of virtual patient Scott with services at St Michael's Hospital having been redefined to improve activity.
- 15.5 The point was made in terms of engagement and consultation there was a need to build and improve on this with staff, relatives and patients as the magnitude of changes would be unsettling as would the sequencing of moves. There would also be a need to consider how to make better use of the Gylemuir facility.
- 15.6 Mrs Anderson advised she had met with colleagues from planning and had raised partnership concerns about the proposals. She commented whilst the strategy was understood the level of detail was not. Particular concerns were raised around the Royal Victoria Hospital ward closures from a staff and patient perspective. Partnership felt the further proposals represented a huge risk given that they were dependant on adequate primary care, community and Lothian unscheduled care capacity proposals. Currently staff and patients did not see and understand the transition pathway between the current and new model. It was noted although the paper before the committee indicated dates for ward closures these had not been communicated nor had assurances been provided to patients about their future care and this was a concern.
- 15.7 The point was made that although the direction of travel in the paper was appropriate this transitional work would be undertaken at a time when NHS Lothian was off trajectory on a number HEAT (Health Improvement, Efficiency, Access and Treatment) targets and there would therefore be a need to consider the impact on services like stroke bundles, hospital associated infection and complaints. This would represent a significant public relations challenge. Dr Bryce commented during a Non Executive Board member walk around that she saw evidence of facilities that were not fit for purpose.
- 15.8 The committee were advised that part of the challenge was that in some instances performance would be adversely affected in the short term whilst improvements were made and there would be a need for the Board to consider its risk tolerance around such a scenario. A major part of the communication strategy would therefore be to explain the longer term benefits to the service and patient care.
- 15.9 The committee were advised that a range of different individuals and groups were undertaking work and it had therefore been felt there would be benefit in pulling together all of the individual strands into a single document. It was noted that the proposed Programme Board would take an overview with there being a need to understand the impact of proposals on the overall strategic plan. It was noted therefore that recommendation 2.3 'to request that the definitive costed programme plan be provided in October for consideration by the Health Board and the Integration Joint Boards' would be crucial.

- 15.10 The committee were reminded that the paper before them was for discussion only at this stage and not for decision. It was noted in terms of the timescale for the Programme Board that this would be discussed outwith the meeting with Mr Crombie as he had been leading on this along with Mr Gabbitas. The Chief Executive advised there were 2 elements around inpatients services at the Royal Victoria Hospital. The first was around delayed discharges where individual plans and funding had been provided and with there being a very clear understanding that the beds would close. He was surprised therefore to hear that this message had not been understood or had been lost in translation and agreed on that basis that further work was needed around communications. The Chairman commented that what appeared to be lacking was a clear consistent message on the ground.
- 15.11 It was anticipated that recent leadership changes would lead to a different approach being adopted moving forward.
- 15.12 The committee were advised that the second component of inpatient services at the Royal Victoria Hospital was around IPCC (inpatient complex care) beds where an interim move from Corstorphine and Astley Ainslie Hospitals site into better accommodation at the Royal Victoria Hospital had been agreed until a longer term plan was developed. The development of the Royal Victoria Hospital site to provide an Integrated Care Facility allowed for the IPCC beds to be replaced more flexibly was noted. The Chief Executive stressed to the committee that the reality of life was that people had to cope with uncertainty although he heard the concerns about consistent messages and this had been one of the reasons for pulling together the composite paper in order to provide a route map of future direction of travel.
- 15.13 The point was made that the communications plan would be critical as would the process for supporting staff to build their resilience for the future by training them to take up their new roles. A future focus on dementia services would be important given the demographics around the patient population. Mrs Anderson commented that she would like to congratulate the local management team for their work in supporting staff through the anxious lead in period to this transition.
- 15.14 The recommendations in both papers 6 and 7 'Improving Older peoples Care in Edinburgh, 2015 – 2017' and 'Frail Elderly Patient – Scott' were approved with the caveat that the comments about communications in general and staff engagement were taken on board.
- 15.15 A progress report would be provided at the August meeting of the Strategic Planning Committee in advance of the production of the costed action plan for consideration at the October meeting.

16. St John's Hospital Master Plan

- 16.1 The committee noted that 2015 was the 25th anniversary of St John's Hospital. The masterplan would be submitted to the Finance and Resources Committee. It was noted that proposals around ward 20 represented a specific project to increase theatre capacity although the clinical strategy requirements would be critical to allow the project to be further defined. The key risks associated with the proposal were around availability of capital and revenue and the affordability of

buildings and service expectation. In terms of the physical estate this would require local authority planning input as the site currently had some constraints that needed to be addressed in terms of historical land, car parking and access. It was suggested that the St John's Stakeholder Group would be an appropriate vehicle to seek support to influence the planning process through the local authority.

- 16.2 The Chief Executive provided an update on discussions he and the committee Chair had held around the Bioquarter and how this might influence the St John's Hospital Masterplan. It was noted that over the next few months there would be a need to firm up on proposals.
- 16.3 The committee noted the progress being made by the St John's Hospital Master-planning Group.

17. Corporate Objectives 2014-15

- 17.1 The committee noted that not all the HEAT targets were being achieved and that issues around stroke, hospital associated infection, Child and Adolescent Mental Health Services (CAMHS) and psychological therapies would be addressed at the June Board. Work was in progress within primary care to develop capacity.
- 17.2 The Chairman commented that the position in respect of psychological therapies was worrying. He also felt that the table of recommendations around the Vale of Leven report were at too high a level and more detail was needed. Professor McMahon would pick this up with Dr Farquharson and Ms Johnson. The committee noted that the Vale of Leven report and progress against the recommendations had been discussed in detail at the Healthcare Governance Committee. **AMcM**
- 17.3 The committee noted that mitigating actions were in place for those objectives with red performance status reports.

18. NHS Lothian Annual Planning Cycle 2015-2016

- 18.1 The committee noted the NHS Lothian annual planning cycle. It was agreed that that a short, simple half page summary with diagrams on how the planning process worked would be produced in conjunction with the communications team. **AMcM/CH**

19. Terms of Reference and Membership

- 19.1 Professor McMahon advised he would produce for the next meeting further revised terms of reference around the Non Executive membership of the committee to also reflect the introduction of the Integration Joint Boards. It was noted that all Non Executive Board members with the exception of council elected members would be invited to be members of the committee and would count toward the quorum. This would provide an opportunity for NHS Lothian to consider what strategic matters it wanted to take to the Integration Joint Boards. It

was noted that either the NHS Lothian Chair or Vice Chair of each Integration Joint Board would be a key member of the Strategic Planning Committee. **AMcM**

20. Date and Time of Next Meeting

- 20.1 The next meeting of the Strategic Planning Committee would be held at 9.30am on Thursday 13 August 2015 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

EAST LOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP SHADOW BOARD

The minutes of the meeting held on 2 April 2015 are attached.

Key issues discussed included:

- **Scheme of Integration Update / Implementation Plan** – Integration Scheme has been submitted to the Scottish Government and comments are awaited. First and second meeting of IJB and Strategic Planning Group discussed.
- **Strategic Plan** – Plan is being redrafted based on the consultation and following issues were raised: -
 - Managing care capacity in a balanced way
 - Making the plan more balanced between health and social care.
 - Featuring the needs of client groups more clearly.
 - The need to have a focus on deliverables in the second version.
 - The need to have a matching financial plan.
- **Integrated Care Fund** – The paper proposed some initial investments from the ICF. Agreed that all other proposals should be considered to be new programmes under development which require future agreement.
- **Joint Financial Planning** – Agreed that transparency and clarity is key to the financial model and that future reports will cover this and the due diligence process.
- **Organisational Arrangements in Health and Social Care - Consultation** – The outcome of the consultation process will be presented to the Council and NHS Board in May. Noted that it is proposed that Children's Wellbeing should be part of the management structures however this will not be a delegated function to the IJB initially. All other services in the structure would be delegated functions. Members were requested to submit any further comments by 17th April 2015.

Key issues on the horizon are:

- **Scheme of Integration Update / Implementation Plan**
- **Strategic Plan**
- **Integrated Care Fund**
- **Joint Financial Planning**
- **Organisational Arrangements in Health and Social Care - Consultation**

Mike Ash

Chair/Executive Lead

East Lothian H&SCP



MINUTES OF SHADOW BOARD

2nd APRIL 2015

1400 – 1600

Saltire Room 2, John Muir House, Haddington

Present:	Michael Ash (Chair) (MA) Donald Grant, Vice Chair (DG) Shamin Akhtar (SA) Stuart Currie (SC) Jim Goodfellow (JG) Professor John Iredale (JI) Alex Joyce (AS) David King (DK) Angela Leitch (AL) Alison MacDonald (AMac) Joanne McCabe (JM) Margaret McKay (MMcK) Alison Meiklejohn (AM) Thomas Miller (TM) David Small (DAS) Eliot Stark (ES)
Apologies:	Maureen Allan (MAI) Alastair Clubb (AC) Carol Lumsden (CL) Keith Maloney (KM) Jon Turvill (JT) Graeme Warner (GW)
Scribe:	Miriam Anderson

1. **Welcome and Apologies**

MA welcomed Professor John Iredale, Dean of Clinical Medicine Edinburgh University, to his first meeting as an NHS Board member. Dr Alastair Clubb has resigned from membership.

2. **Minutes of Previous Meeting**

Agreed as accurate record.

3. **Matters Arising**

Nil.

4. **Standing Items**

4.1 Chair's Report – MA reported that the NHs Board had approved its budgets on 1st April. The three Ayrshire IJBs were now established. MA recommended that members should look at papers etc on line.

4.2 Director's Report – DAS highlighted delayed discharge performance which is improving. There has been an improvement in access to care homes. The Delayed Discharge Taskforce Group meets weekly to review progress. Discussions were still underway on how to increase capacity for care at home and to support access to care homes.

MMcK asked if the number of delays includes interim moves. DAS clarified that if people were in an appropriate interim place e.g. step down beds they were not in the validated number, but were on EDISON.

SC noted this is a national priority and and that the partnership should be working to meet the proposed 72 hour deadline. SC asked what the cost of bed blocking is. SC suggested that the partnership should invest to head off this problem and address capacity and resource.

DAS reported that there are ongoing problems with recruitment and retention in home care and some vulnerabilities in the care home sector.

DG enquired whether patient flow is being maintained Step Down beds in Crookston. AMac replied that it is currently working well. Weekly meetings and daily huddles are being held to monitor and manage the situation.

DAS reported that the East Lothian Community Hospital consultation on the PAN would start soon. It was agreed that the Shadow Board should be updated on feedback from the consultation.

Joint Inspection of Adult Services – An Inspection Steering Group has been established. A start date for this inspection has not been confirmed yet.

5. **Items for Discussion**

5.1 Scheme of Integration Update / Implementation Plan – JM reported that the Integration Scheme has been submitted to the Scottish Government. Comments are awaited.

JM briefed the shadow board on the implementation plan for the IJB. JM stressed that these actions depend upon the date the government agrees the

scheme and agreement on “start date” for the strategic plan. It was noted that these need not be the same date.

Before first meeting of IJB.

NHS and Council agree voting members.
Develop a process for appointment of non-voting members.
Develop a process for appointment of Chief Officer.
Develop a process for appointment of Chief Finance Officer.
Develop IJB’s standing orders and scheme of administration.
Develop the style of Direction documentation.

At first meeting of IJB

Note voting members.
Formal appointment of Chairperson and Vice-Chairperson as per Integration Scheme.
Appointment of non-voting members.
Appointment of Chief Officer and Chief Finance Officer.
Formal appointment of the Strategic Planning Group membership.
Adoption of Standing Orders and Scheme of Administration.

At first meeting of Strategic Planning Group

Approval of draft Strategic Plan and consultation process for recommendation for the IJB to approve the Strategic Plan.

At second meeting of IJB

Approval of Strategic Plan.
Set Relevant Date (the date services are delegated from Council/NHS Lothian to IJB).
Approval of Directions to Council and NHS Lothian for the delivery of services after the Relevant Date.
Decision on whether to join CNORIS from Relevant Date.
Work is ongoing and JM will continue to progress and update.
SC highlighted concerns regarding the timelines which may be difficult for the Council due to recess. It was agreed to continue discussions with a view to avoiding timing issues.
MMcK suggested that the first IJB would be public and therefore some thought should be given to the agenda to engage and gain the interest of the public.
JI also suggested local media should be kept engaged.
SA suggested a good item for the agenda would be the East Lothian Community Hospital.

5.2 Strategic Plan – DAS reported that the plan is being redrafted based on the consultation. The issues that were raised included:

Managing care capacity in a balanced way. Making the plan more balanced between health and social care. Featuring the needs of client groups more clearly. The need to have a focus on deliverables in the second version. The need to have a matching financial plan.

5.3 Integrated Care Fund – DAS reported that the paper proposed some initial investments from the ICF.

The meeting supported four items for immediate funding as continuation of Change Fund projects supported by the Change Fund evaluation process.

RVS Community Health Transport	49,934
Workforce Development	118,100
Supported Discharge Social Work Posts	79,000
Emergency Care Service	69,850

The meeting agreed that all other proposals should be considered to be new programmes under development which require future agreement.

It was noted that some of these proposals had existing commitments and it was agreed that DAS should progress discussions on interim funding with The CMTs.

AM requested that the process focus on innovations and changes in service models.

MMcK stressed that her concern was the governance of ICF to ensure best value and scrutiny and it was not the intention to delay processes.

The meeting discussed how such decisions should be made in future. It was noted that, till the IJB had delegated functions and a start date for the strategic plan, it might not have sole authority on such decisions.

MA asked DAS to review the situation, liaise with Chief Executives on the process for decision and to report back to the Shadow Board.

5.4 Joint Financial Planning – DK presented a paper that covered two issues :-

1. An indicative budget in 2015/16 for the IJB
2. A financial plan (based on the agreed plans from East Lothian Council and NHS Lothian) for those services managed by the Integrated Joint Management Team.

It was noted that the IJB's budget includes services that are not managed by the Joint Management Team e.g. set aside and hosted. The paper aims to fully inform Shadow Board members as to the resources to be allocated to them and the risks and issues that are to be managed.

A full process of financial assurance will be undertaken on the budget and presented to the IJB. Internal Audit will provide assurance on the process. Part of this will be a clear understanding of the efficiency schemes of both the Council and the Health Board and how these schemes will impact on the resources available to the IJB. MA asked for a note of the CHP's 15/16 schemes

ACTION: AMacD

There was a discussion about the ability of the IJB to make changes by moving budgets. The principle behind the allocation of resources to the IJB is that the IJB can direct the use of these resources. This will mean that the IJB can, in effect, move resources from one part of the overall system into another as part of its strategic plan.

It was agreed that transparency and clarity is key to the financial model. It was noted that future reports will cover this and the due diligence process.

ACTION: DK

5.5 Organisational Arrangements in Health and Social Care – Consultation

DAS reported that the attached paper sets out proposals for joint management arrangements for health and social care. The shadow board discussion is part of the consultation process.

DAS summarised the process followed and the options set out in the paper. The outcome of the consultation process will be presented to the Council and NHS Board in May.

It was noted that although the paper proposed that Childrens Wellbeing should be part of the management structures, this will not be a delegated function to the IJB initially. All other services in the structure would be delegated functions.

AM enquired how the aspirations in the paper would be achieved at local and team level. JI expressed concern that cultural development was as important as structures. DAS reported that there was an organisational development plan that address leadership and team development in joint services.

MMcK asked how third sector relationships would be managed, supported and considered. DAS advised that a number of responses had suggested the need for one senior leader across all care groups for specific roles e.g. carers and this would be considered.

DAS invited members to submit any further comments by 17th April 2015.

6. Any Other Business

Nil.

7. Dates of Future Meetings

Development Session – 4 June 2015

0900 – 1200

Adam Room, John Muir House, Haddington

ACTION: BG to organise lunch

ACTION; MA / DAS to organise agenda

Next Meeting – 18 June 2015

1000 – 1200

Council Chamber, Town House, Haddington

EAST LOTHIAN HEALTH AND SOCIAL CARE PARTNERSHIP SHADOW BOARD

The minutes of the meeting held on 18 June 2015 are attached.

Key issues discussed included:

- **Voting and Non Voting Membership of IJB** – Discussion took place regarding proposed membership of the Integration Joint Board and it was highlighted that although many members were appointed it was likely that not all non voting members would be in place at the first meeting on 1st July 2015.
- **Implementation Plan for IJB** – Proposed agenda for the first Integration Joint Board Meeting was discussed which would include papers on membership, governance arrangements, appointment of Chair/Vice Chair, Chief Officer, members of Strategic Planning Group and an update on the process for appointing a Chief Finance Officer.
- **Finance Report** – Audit Committee of the IJB required further discussion for 2015/16 but a committee would be required early in 2016/17.
- **Update on Joint Inspection** – Position statements are being drafted. Inspection is due to commence on 24th August 2015 with file reading, 14th September initial feedback on file reading, week of 21st September Inspectors will be in East Lothian visiting users, carers and teams, week of 5th October will involve meeting staff and 16th November initial feedback is expected.

Key issues on the horizon are:

- **Voting and Non Voting Membership of IJB**
- **Implementation Plan for IJB**
- **Finance Report**
- **Update on Joint Inspection**

Mike Ash

Chair/Executive Lead

East Lothian H&SCP



MINUTES OF SHADOW BOARD

18 June 2015

1030 - 1200

Council Chamber, Town House, Haddington

Present:	Mike Ash, Chairman (MA) Donald Grant, Vice Chairman (DG) Maureen Allan (MAL) Fiona Duncan (FD) Alex Joyce (AJ) David King (DK) Angela Leitch (AL) Alison MacDonald (AMac) Keith Maloney (KM) Joanne McCabe (JM) Margaret McKay (MMcK) Thomas Miller (TM) David Small (DAS) Eliot Stark (ES) Jon Turvill (JT)
Apologies:	Shamin Akhtar (SA) Alastair Clubb (AC) Stuart Currie (SC) Jim Goodfellow (JG) John Iredale (JI) Carol Lumsden (CL) Alison Meiklejohn (AM) Graeme Warner (GW)
Scribe:	Miriam Anderson

1. **Welcome and Apologies**

MA welcomed everybody to the meeting and highlighted to all that this is the last meeting of the Shadow Board. He thanked all personally for their contributions to date. The Integrated Joint Board meets formally for the first time on 1st July 2015.

MA noted that this meeting was not quorate and any decisions would require to be homologated at the IJB meeting.

2. **Minutes of Previous Meeting**

Agreed as accurate record.

3. **Matters Arising**

DS reported that the Organisational Arrangements in Health and Social Care proposals were agreed by NHS Board and Council. The first stage would be complete by end June 2015. Second stage proposals to be developed by autumn 2015 but avoiding inspection activity periods.

DS reported that the integrated Care Fund proposals for April to June 2015 had been agreed by CMT. A further report would be considered by the end of June. MA requested that the ICF to should be monitored by the IJB albeit the CMT will retain the delegated authority.

4. **Standing Items**

4.1 Chair's Report – MA reported this is his last report to the Shadow Board. He indicated that there had been much progress made to get to the current position and thanked all members for their work.

MA indicated he had some concerns regarding clarity in the NHS budget for the IJB. The ELC budget position was clearer. MA acknowledged that the NHS budget process was more complex.

MA reported that he had met with ELC Section 95 Officer and NHS Director of Finance who had recommended treating the second half of 2015/16 as a development period. This would involve the IJB going live on 1st July 2015 but setting a start date for the plan of 1st April 2016. MA suggested that the meeting discuss the implications of going live on 1st July 2015 but not having delegated functions and budgets till April 2016.

DK suggested that the IJB would have the opportunity to influence the budget setting process for 2016/17 in this proposal and therefore should work together as a Board to do so.

AL noted she would have liked to have been in a position to set the start date

for 1st July, however a further year to resolve financial issues by April 2016 would be useful.

KM asked is this the case for all IJB's. DS replied that the Ayrshire IJBs had adopted their plans in April 2015 since they had a full year ahead of them. East Lothian would be the first in Scotland to go live mid year. DS had canvassed Joint Directors across Scotland and most were aiming for April 2016 to have the delegated functions.

MA requested that proposals for how the IJB would monitor and be involved in financial performance and planning during 2015/16 be brought to the second meeting of the IJB in August 2015. This was agreed.

Action: DK

4.2 Director's Report

Delayed discharges have shown an improvement in May 2015 and overall a significant improvement over the last six months. The Task Group has prioritised the £530,000 Scottish Government allocation to Hospital to Home, Additional Domiciliary Care Capacity, Care Home Support, Additional Assessment Capacity and Support for Business Processes.

Public consultation on East Lothian Community Hospital has been very positive. The Initial Agreement should come forward in September 2015. Bed requirement modelling in respect of Hospitals, Care Homes and Housing has been reworked. This has shown that hospital and care home bed numbers planned are reasonable, but are dependent on assumptions such as no delayed discharges, 35% of new care home demand being met by housing and no loss of care home capacity.

AL asked if Herdmanflat site could be an opportunity for care and housing and that the IJB should support and consider this if that were practical. DS replied that this is being considered.

MMcK asked for more information on "care home support". AMacD and FD reported that training and development for Care Home staff is a key element in maintaining care home capacity. The proposal is to increase nursing input from the NHS for this purpose. This included supporting nurses with revalidation and care staff with SSSC registration.

MMcK asked what was happening with supporting 7 day discharge. AMacD indicated that seven day discharge was supported by the Emergency Care Service, but work was underway to provide 7 clinical support for admission avoidance and discharge through ELSIE and District Nursing.

MAL reported that home care capacity is not available at weekends due to process issues with approving packages at weekends. DAS agreed to look

into this.

Action: DAS

DAS reported that a start date of 24th August 2015 has been received in respect of the Joint Inspection of Adult Services and the team will be on site in East Lothian until September 2015. Preparation work is underway.

DAS highlighted that NHS Lothian has led work with the 4 Councils on Learning Disabilities. There is a proposal for a Lothian service of 12 places in a domestic setting to replace current out of Lothian placements which are very costly. Herdmanflat has been cited as a possibility. DAS proposed that the management team and CMT should consider this as it may require to be hosted by East Lothian. This was agreed and DAS will bring back to IJB for discussion.

Action: DAS

5. Items for Discussion

5.1 Voting and Non Voting Membership of IJB

DAS talked to the attached paper detailing proposed membership of the Integration Joint Board and highlighted that although many members were appointed it was likely that not all non-voting members would be in place in place at the 1st July meeting. The paper to the IJB will propose that some non-voting members places would be held till April 2016 and the IJB should run a process of selection for them during 2015/16.

KM suggested that the IJB should consider how it supports patient/client representation possibly through an additional member.

5.2 Implementation Plan for IJB

JM reported on the proposed agenda for the first Integration Joint Board Meeting which will include includes papers on membership, governance arrangements, appointment of Chair/Vice-chair; Chief Officer; members of Strategic Planning Group and an update on the process for appointing a chief finance officer. MA thanked JM for all of her hard work interpreting legislation and guidance and developing proposals.

AL enquired on progress with government performance targets and measures. DAS reported these were still not finalised.

MMcK asked if the first meeting would be public and suggested that there was an opportunity to make the meeting interesting and informative. DG agreed to consider this. AL suggested that the best opportunity would be around the second draft of the strategic plan.

5.3 Finance Report

DK reported that the overall financial position at Month 12 for the CHP was an overspend of £1.5m. The biggest element was £1m on e GP Prescribing,

some underachievement of the efficiency (LRP) schemes in year and a range of operational pressures largely within Medical Staffing. DK reported that the Adult Wellbeing position would not be reported till August 2015.

DG enquired how quickly the audit committee of the IJB requires to be set up. DK reported that this required further discussion for 2015/16 but a committee would definitely be required early in 2016/17.

5.4 Update on Joint Inspection

AMacD and FD reported that position statements are being drafted. The Inspection is due to commence on 24th August 2015 with file reading. 14 September initial feedback on file reading. Week of 21 September Inspectors will be in East Lothian visiting users, carers and teams. Week of 5th October will involve meeting staff. 16 November initial feedback is expected.

6. Any Other Business

MA thanked everybody for their time and commitment and DG thanked MA for his commitment, capacity, attendance, enthusiasm and leadership qualities over his term as Chair.

MA invited members to stay behind for a buffet lunch.

8. Date of First Meeting of IJB

1st July 2015 – 1400 - 1600

Council Chambers, Town House, Haddington

The minutes of the meeting held on 17 June 2015 are attached.

Key issues discussed included:

Integration; Strategic Plan, Management structure / localities and Children's Partnership
NHS Board Arrangements Following Disestablishment of CHPs
Infrastructure and Capital Reports
Challenges around primary care capacity and potential solutions
Finance Update
QIT Activities
IPCC Update
Completion of Living It Up Programme

Key issues on the horizon are:

- ❖ Financial positions facing the IJB when established.
- ❖ Primary Care growing instability.
- ❖ Momentum with support to Primary Care Infrastructure Development.
- ❖ Combination of vacancies/sickness/vacancy freeze/national shortages causing problems in several service areas.

Chair of the CHP – Shulah Allan

EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB COMMITTEE MEETING

DATE: Wednesday 17th June at 1pm
VENUE: PMR / Ainslie Room, SMART Centre, AAH

Present

Shulah Allan, Chair, ECHP and Non-Executive Director, NHS Lothian
David White, Assistant General Manager, Edinburgh CHP
Sheena Muir, Assistant General Manager, Astley Ainslie & Associated Hospitals
Dr Ramon McDermott, GP Sub/Lothian LMC
Maureen Reid, Primary Care Pharmacist, South West LHP
Christine Farquhar, Member, Shadow Integrated Joint Board
Dr Ian MacKay, Clinical Director, Edinburgh CHP
Maggie Gray, Project Manager, Edinburgh CHP
Aleisha Hunter, Development Manager, ECHP (Minutes)
Lynda Cowie, Chief Nurse, Edinburgh CHP
Angela Lindsay, AHP Manager, Edinburgh CHP
Sally Arnison, Community Pharmacist
Mandy Mackinnon, Health Inequalities Manager, Edinburgh CHP
Melanie Johnson, Nurse Director, NHS Lothian
Sylvia Boal, Member, ECHP QIT

Apologies

Bob Martin, Finance Partner, Edinburgh CHP
Wanda Fairgrieve, Lead Partnership Representative, Edinburgh CHP
Lyn McDonald, Director of Operations & Medical Associated Services, RIE

Action

1. Welcome & Introductions

Apologies were noted as above. SA (Chair) welcomed those present.

Melanie Johnson has taken over operational management responsibility for the CHP.
Sylvia Boal is a member of the QIT and previously the Public Partnership Forum.

2. Minutes of previous meeting of 15th April 2015

The minutes from 15th April were accepted as an accurate record.

3. Matters arising

Living It Up

The Living It Up programme has now completed and will be reinvented as a digital self management hub. A further three years funding has been secured from the Scottish Government.

Primary Care Capacity

A briefing for MSPs on Primary Care Capacity was circulated for information.

The current challenge is to move from managing short term crisis's to redesigning primary care in order to deal with the ageing population, population increase etc. Work is underway to stabilise a number of practices due to issues around GP recruitment, locum availability, an ageing workforce and difficulty in attracting GP partnerships. District nursing and health visiting are facing similar workforce issues and ongoing difficulties with IT performance are also having an impact. It was

highlighted that the model of primary care has not changed for several years. We are currently in a very challenging position with 20 practices in the city reporting closed lists.

A number of potential solutions are being explored. West Lothian has approached GPs who are set to retire to ask if they wish to stay on for a few sessions per week. This could be explored in Lothian, with payment being made via the staff bank. We now have a better handle on infrastructure with various solutions being explored and timescale / affordability being considered. IT improvements are being worked on at the moment and should be in place soon. Workforce redesign is also being explored. It is important for these things to gain traction quickly in order to stabilise things in order to then move forward and redesign primary care. There is the possibility of a new GP contract in 2017 and there have been very encouraging discussions with the Scottish Government on this. It is hoped that there will be greater recognition of deprivation on GP workload and that funding will be allocated appropriately.

District nursing have significantly changed their method of delivery in the past three years due to efficiency savings etc and have moved to a model of cluster working which ensures greater skill mix and increased support for nurses. The nursing workforce has not grown in pace with the population increase and with increasing frailty of patients etc the work itself has changed. We are moving towards patient self managing their conditions and now have a small team trained in long term conditions, frail elderly etc. Main concerns are around premises and an ageing staff group. The current cohort of nurses over 50 can retire at 55 if they wish, with over 40% of the workforce currently in this position. Many are choosing to stay on but workforce planning is crucial. The nursing workforce is being looked at across NHS Lothian.

Information is currently being gathered on patients self management and the JSNA and locality model will assist with this. Digital solutions are being explored e.g. patients taking their own blood pressure and submitting the information digitally. Prescription for Excellence has been taken up by a few practices and there are several Advanced Nurse Practitioner places available from September.

Work on infrastructure has been carried out in partnership with the Council but lack of capital funds is an issue, with very little capital available this year and next year. Gilmerton was discussed as an example due to the major house building underway across the area. Edinburgh and Midlothian have an agreement in place over which authority will take certain areas. These issues are being raised at Board level.

Concern was expressed over the increased primary care workload due to more work coming from secondary care, public health messages urging people to see their GP and increased admin workload.

A paper has been written for the Board noting the need for an additional £1 million funding for primary care. Caution was urged over this as nothing has been agreed yet and we are in a very challenging position. A brief example was given of a GP practice expanding into a local community centre, illustrating that effective solutions are being sought.

4. Integration

SA reported that a group has been established to take forward the work to develop the Strategic Plan for the Edinburgh IJB. There is wide representation on the group and it is progressing in a timely fashion and moving forward well.

The IJB will be live in July as the Integration Plan for Edinburgh has been agreed by the Scottish Government. The governance and members are all in place. The Chief Officer post will be advertised and the appointment will be made by the IJB. The

Chief Executives of NHS and CEC will be advising on that appointment. The senior management structure that had been agreed for the IJB has been paused at the moment and appointments have been put on hold. This is to enable the new Chief Officer to have input. The locality structure is still progressing. Although certain things are paused under the current circumstances, details can be discussed to ensure that business is progressing as required.

The Children's Services Partnership for Edinburgh had their first meeting last week. It is in the exciting early stages of development and priorities have been identified. The first thing to be explored will be how things can be improved for young people with mental health issues.

5. Update on QIT Activities

LC and IM delivered a very informative presentation on QIT Activities.

Brief discussion took place around complaints. All complaints are analysed in order to identify themes and main areas are documentation, care planning and staff. It was recognised that it can be beneficial for complaints to be dealt with locally as it can be very challenging pulling all the strands together for multifaceted complaints. A new system is being introduced where there are complaints cutting across several local teams. These will be managed centrally to ensure good co-ordination. It is important to keep sight of the fact that a very high number of compliments are submitted in comparison to the number of complaints. This positive feedback is fed back to the staff.

Moving forward with Health and Social Care, both NHS and CEC will retain their own performance and quality systems initially, which may mean duplication but there are issues to be resolved e.g. the organisations having different IT systems. In time the organisations will work together, evolve, share ideas and will potentially merge at some point down the line. NHS Lothian internal structures will provide assurance to the IJB on performance management within healthcare and SA will raise this when the Chairs of all Committees meet next week.

6. Report on Capital Schemes

MG gave an update on Capital Schemes.

We are waiting on decisions from the Capital and Investment Group meeting to clarify how much progress can be made with the following:

- Bundle project – The National issue around risk transfer and tax is ongoing and our projects cannot proceed until this has been resolved. No timescale has been given for this and project boards have been advised. Contract prices are being maintained until the end of June but this delay will go beyond that which means a financial penalty will be incurred. Advice is being sought on this.
- Ratho – The planning application was submitted and CEC Transport raised concerns over parking. This has resulted in an extension to the planning application. Revised parking plans have now been submitted and a decision is due back at the end of June.
- Leith Walk – The business case was approved and detailed discussions are being taken forward.
- Small Grant Scheme – We await a decision from the Capital Steering Group

on whether the application was approved for a similar amount of funding to last year.

- Liberton Extension Request – This will be taken forward in July and will provide 3 additional consulting rooms in the practice. This will be very helpful due to the new housing in the area.
- Edinburgh Access Practice – The current premises at the Cowgate have been sold by CEC and the practice must vacate in April. A potential solution is Argyle House, which could be used to house several services e.g. Spittal Street etc. It is likely that we will need to relocate the Access Practice before this is in place and options are being explored.
- Homebase at St Leonards – The original planning application was turned down but the appeal against this has been successful.
- Meadowbank Stadium Site – Things are progressing with this site.

7. IPCC

Main issues are the closure of wards 1 & 2 at RVH. Ward 2 is now completely closed and ward 1 is closing as beds become available. Wards 5 and 6 are also closing at this time as beds become available and wards 3 & 4 will be retained for IPCC patients. This is challenging from a staff perspective but all ward 1 & 2 staff have now been matched to posts. Staffing in IPCC has increased which has improved the ratio of non registered / registered staff and will result in reduced staff bank and agency costs. Recognition was given to the staff in this area who have been through a very difficult situation.

8. Finance Update

The CHP is in a very challenging position with a current overspend of £1.6 million, with significant pressures around drugs and nursing. This is a very adverse position to be in at this stage in the year and across Lothian there have been very poor month 2 results. Bridging money is being explored and we need significant redesign and recovery plans to release savings. The LRP saving required is £9.5 million. This will be a major challenge.

9. Transition Arrangements for CHP

This was intended to be the last meeting of the CHP Sub Committee. SA will confirm this with the Chairman of NHS Lothian and the Chairman of the Edinburgh IJB next week and members will be notified.

10. AOCB

No items were raised.



West Lothian
Council

**West Lothian Shadow Integration Joint Board
2 June 2015**

ACTION NOTE

A meeting of the West Lothian Shadow Integration Joint Board was held on 2 June 2015. The items for action and the allocation of that action are listed below.

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

If you have any comments or questions, please contact as soon as possible on .

Item	Title	Decision	Action
001	Apologies for Absence	<p><u>Present</u> – Frank Toner (Chair), David Farquharson, Alex Joyce, Danny Logue, Brian Houston (substitute for Julie McDowell), Anne McMillan, John McGinty, Alison Meiklejohn</p> <p><u>Apologies</u> - Julie McDowell</p> <p><u>In Attendance</u> – Jim Forrest, Rhona Anderson, Alan Bell, Marion Christie, James Millar</p>	N/a
002	Order of Business, including notice of urgent business	N/a	N/a
003	Declarations of Interest - Members should declare any financial and non-financial interests they have in the items of business for consideration at the meeting, identifying the relevant agenda item and the nature of their interest.	<p>Councillor Danny Logue declared an interest as an employee of NHS Lothian.</p> <p>Councillor Frank Toner declared a non-financial interest as a council appointee to the Board of NHS Lothian as Non-Executive Director.</p>	James Millar
004	Confirm Minute of Meeting of West Lothian Community Health and Care Partnership Board held on Tuesday 07 April 2015 (herewith)	Minute approved	N/a

005	Membership Arrangements for Appointment of Voting Members and Non-Voting Members - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To note that West Lothian Council and NHS Lothian had confirmed the eight voting IJB members as undernoted:- WLC - Frank Toner, Anne McMillan, John McGinty and Danny Logue. NHS Lothian – Julie McDowell, David Farquharson, Alex Joyce, Alison Meiklejohn 2. To agree the process to recruit non-voting members for consideration at the next meeting of the shadow IJB and to note, in particular, that the process would include the recruitment of two Staff-side representatives 	Jim Forrest
006	IJB Governance and Decision-Making - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To note the legislative requirements for the Board's governance and decision-making processes and procedures, and the advice in relation to good practice in governance terms. 2. To note that officers would develop and prepare for approval a set of Standing Orders for Board Meetings. 3. To agree that those Standing Orders should include a proposal for a committee to deal with risk, audit and governance; roles and responsibilities of Board members; and roles and responsibilities for the Board's Director and Finance Officer. 4. To note and agree the proposed meeting arrangements for the shadow Board and then for the Board when formally established, as set out in Appendix 1. 	Jim Forrest/James Millar
007	Strategic Planning Group - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To agree that a Strategic Planning Group be established in shadow form until approved by the full IJB. 2. To agree the terms of reference for the group as outlined in Appendix 1. 3. To agree to consider representation on the Strategic Planning Group from Staff-side Representatives once the Board had been formally established and Staff-side Representatives had been confirmed. 	Jim Forrest/Alan Bell
008	Provision of Support Services and Proposed Report Template - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To agree the process for developing arrangements for the provision of support services as outlined in the report. 2. To approve the draft report template as attached as Appendix 1 to the report. 	Jim Forrest

009	Organisational Development and Training Session for Members of the West Lothian Integration Joint Board - Report by Head of Health Services (herewith)	<ol style="list-style-type: none"> 1. To note the report providing information on organisational development for IJB members. 2. To note that, in relation to the central programme, information concerning dates/times was now available and this would be circulated to Board members by the Clerk. 3. To note that, in addition to the central programme, members would be asked to attend a local West Lothian away-day to be held in August 2015. 	Jim Forrest/ Marion Christie
010	JIT Readiness for Integration Tool - Report by Director (herewith)	<ol style="list-style-type: none"> 1. To note the report concerning a new self-evaluation tool produced by the Joint Improvement team for IJBs. 2. To agree that the self-evaluation tool be used as outlined in the report, with the results of the evaluation being brought back to the IJB at regular intervals. 	Jim Forrest

Board Meeting
5 August 2015

Director of Strategic Planning, Performance Reporting & Information/Chief Officer

DELAYED DISCHARGES

1 Purpose of the Report

- 1.1 The purpose of this report is to recommend that the Board note the current position in relation to delayed discharges across the four Health and Social Care Partnerships
- 1.2 Currently performance levels in the Edinburgh, and to a lesser extent, East Lothian partnerships are having a significant impact on the number of patients being discharged from hospital who are waiting for a care home placement, a care package or other form of community support, and therefore in turn on other key aspects of acute hospital performance.
- 1.3 The paper also covers a programme of actions which are being discussed across the Edinburgh, East Lothian, and Midlothian Partnerships and with the Scottish Government, which would be intended to form the bedrock of a short, medium, and long-term programme to transform older people's services.
- 1.4 Board members are reminded that from the 1st April 2015 the nationally agreed standard is that no patients should be delayed more than 2 weeks at the point at which they are ready for discharge, although the ambition from Government is that no patient should wait more than 72 hours to be discharged once ready to move on.
- 1.5 Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

- 2.1 Note current performance based on the July Information and Statistics Division (ISD) census;
- 2.2 Note that the Edinburgh performance reflects the highest number of people delayed in hospitals since 2007.
- 2.3 Discuss and support the direction of travel being put forward in section 3 in relation to actions that may be taken to improve performance in Edinburgh and in East Lothian.

3 Discussion of Key Issues

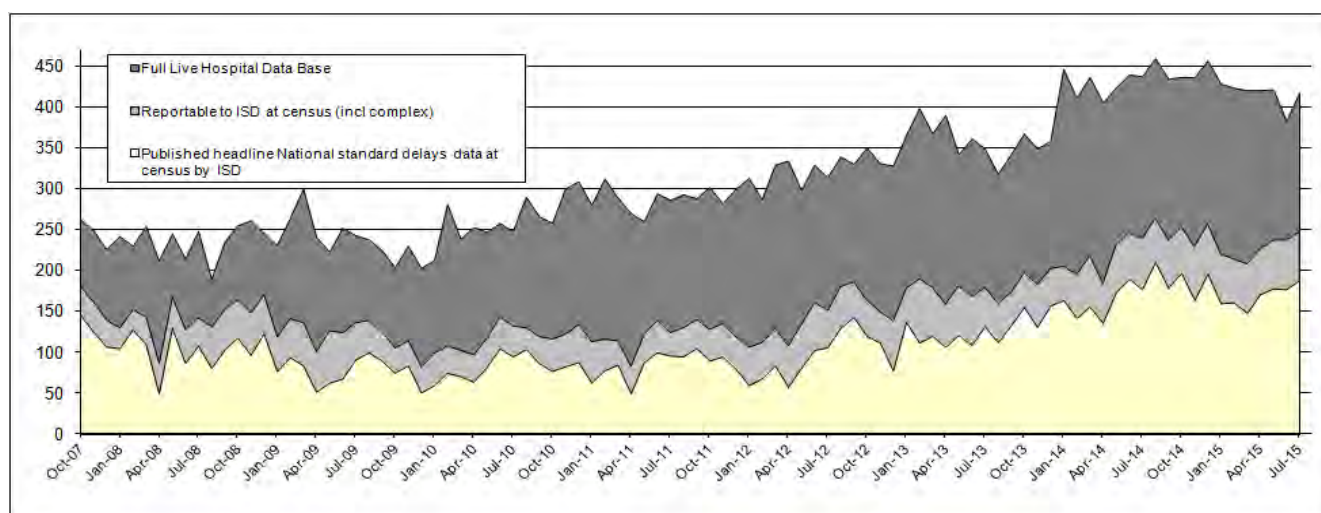
- 3.1 Based on the ISD Delayed Discharges Census of 15th July 2015;
 - There were 420 patients recorded as delayed in hospitals on the "live" hospital database, which is broadly in line with the average for the last 18 months;

- 248 of these were reportable to ISD;
- Of this figure of 248, 60 were “x-coded”, and therefore removed from the published figure. ISD therefore published a figure of 188;
- 69 of these 188 patients were delayed over 4 weeks;
- 104 of these 188 patients were delayed over 2 weeks;
- The average delay was 32 days;

Currently, between 14 and 16% of all NHS hospital beds are occupied by patients delayed in their discharge.

3.2 Table 1, below, shows the trend for NHSL hospitals dating back to October 2007;

Table 1 – showing delayed discharge numbers, NHS Lothian hospitals, all local authority areas, October 2007 to July 2015



3.2 Both Midlothian and West Lothian Partnerships continue to have low numbers of delayed discharges.

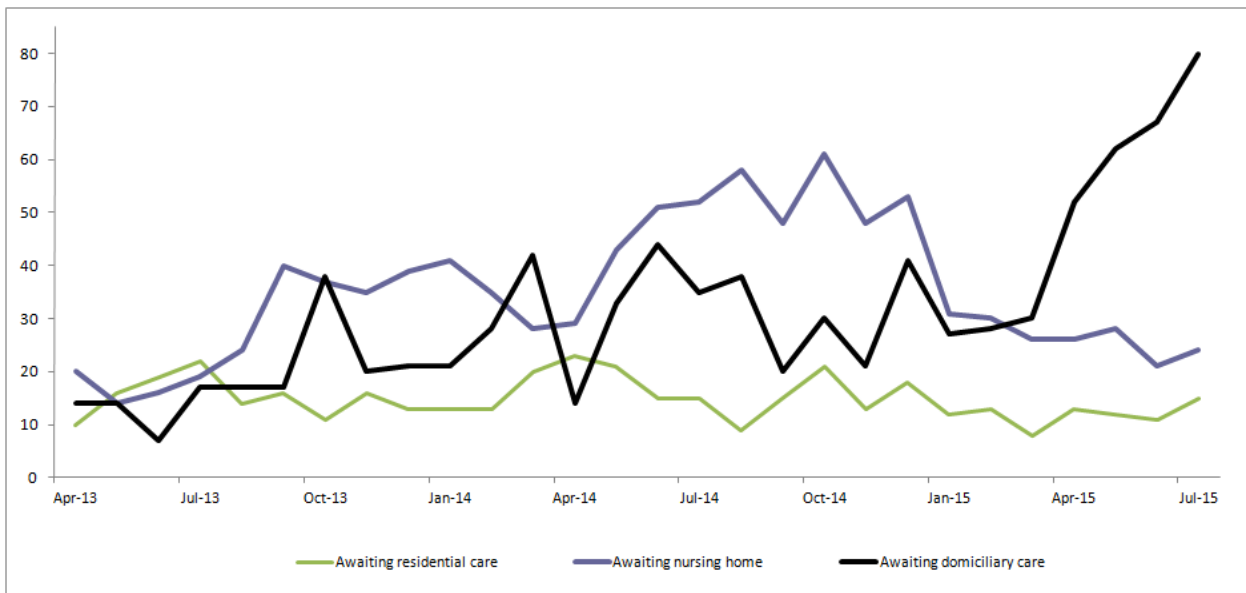
3.3 East Lothian have had rising numbers and performed relatively poorly across 2014/15. However, the last three months have seen improvement. This is in part due to the introduction of the 20 bedded step down unit within one of the Tranent care homes. This has been a contribution factor in the recent improvement by providing alternative capacity for patients waiting for residential care.

3.4 The City of Edinburgh continues to experience a challenge in enabling timely discharge from hospital. The remodelling by Edinburgh and NHS Lothian of a previous private care home (Gylemuir), by using 30 beds, has eased pressure and reduced the number of patients waiting for residential care.

3.5 Across all four partnership areas there are significant constraints on the ability to provide packages of care for patients in their own homes, and this is the single biggest reason for hospital delays. Board members will be aware of the UK-wide shortage of sufficient, appropriately-trained and qualified care staff able to undertake these roles

3.6 Within Edinburgh there has been change in the type of support required by patients on discharge. Table 2 shows what the assessed need was for Edinburgh delayed discharge patients at the various census points across the last two years. This, in part, reflects the progress Edinburgh has made in shifting the balance of care, but also the acuity of the difficulties in accessing appropriate support for care in the patient's own home. As a "full employment" city, recruitment into these roles is particularly challenging within Edinburgh

Table 2 – showing changes in numbers of delayed discharge patients, by category, City of Edinburgh residents, 2013-2015



3.7 There has been a significant growth, since April 2013, in the number of domiciliary care hours funded by the City of Edinburgh Council (CEC) from 56,292 hours per week to 86,494. This has been accompanied by a growth in the average package size from 12.2 hours to 14.5.

3.8 This growth has now ceased, due to financial constraints within CEC. CEC is open about the total pressure of some £16.6m within its Health and Social Care budget, which is clearly closely aligned to the Integrated Joint Board for the city.

3.9 These challenges are exacerbated by the current model of care for older people provided by our health services, which tend to be reactive. *Our Health, Our Care, Our Future* outlines how NHSL intends to transform these services.

3.10 In particular, NHSL needs to move services from the facilities currently provided in outdated facilities such as Liberton hospital and the re-opened Royal Victoria Hospital. NHSL has a commitment to vacate these facilities, and so proposals to improve the delayed discharge position need to be clearly linked to these plans. These plans include strengthened primary care infrastructure and new integrated care facilities within the city.

3.11 A paper is being commissioned to review the current options that are available to NHS Lothian, the City of Edinburgh council and the Edinburgh IJB. This paper will be discussed initially at the Edinburgh Leadership Group but this will be aligned with

proposals from the Midlothian and East Lothian Partnerships. Under consideration, currently, are the following options;

- Commissioning an additional 30 beds within Gylemuir House to provide additional alternative capacity for those patients waiting on residential care;
- Commissioning of an additional 7 beds of capacity for patients with challenging behavior and dementia;
- Expansions of the CEC reablement and intermediate care services;
- Investment in Third-Sector led preventative measures;
- The possible bringing forward of the repatriation of patients from Midlothian Community Hospital to East Lothian;
- Revised options for the use of Midlothian Community Hospital

Again, all of these options need to be clearly and explicitly tied together with the imperative to vacate Liberton and RVH as rapidly as possible, and the need to have long-term sustainable models for consistent delivery.

- 3.12 In order to make these transformational changes sustainable, there will be a need for us to reimagine the use of our financial resources within IJBs. To this extent the IJB Board is in the process of establishing a series of development sessions to review the current and future models of care within the known growth in demography and the financial envelope available from both parent bodies.

4 Key Risks

- 4.1 That the delayed discharge position continues to worsen and more patients are delayed in NHS Lothian beds whilst waiting for a package of care or a nursing or residential care home place.
- 4.2 That the inability to effect rapid change further reduces the number of inpatient beds available to acute services, with consequent significant impacts on both unscheduled and scheduled care services, with deteriorations in both 4-hour standard and elective performance would suffer as a consequence.
- 4.3 In the short term the inability to resolve the current position means that we have little additional capacity for 'winter' demand spikes. The proposals set out above, if funded and implemented, should begin to release some capacity from October 2015 onwards. That the proposals being developed are insufficiently based on rigorous analysis of the problems within the system and insufficiently robust project planning and implementation.

5 Risk Register

- 5.1 Delayed Discharges is already on the risk register as a high corporate risk.

6 Impact on Inequality, Including Health Inequalities

- 6.1 An impact assessment has not been carried out in the production of this report but we do know that delays in hospital have a negative impact on people and their ability to function.

7 Involving People

7.1 Not appropriate at the time of writing this paper for the NHS Lothian Board.

8 Resource Implications

8.1 The resource implications are significant. The City of Edinburgh Council is significantly under resourced for meeting the current demand for services in health and social care of circa £16.6m in 15/16. At the same time the NHS Lothian financial position to date is forecasting an overspend of circa £26m for the year 15/16 unless significant actions can be taken and these have and are being discussed with the Board.

8.2 NHS Lothian and the City of Edinburgh Council, through the Edinburgh Leadership Group are working with Scottish Government to explore options around 'bridging' finance to assist with current performance pressures and also to deliver the longer term strategic changes that we wish to see happen across the City and also within Mid and East Lothian..

Professor Alex McMahon

Director, Strategic Planning, Performance Reporting and Information

28 July 2015

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INPATIENT PAEDIATRIC SERVICE AT ST JOHN'S HOSPITAL

1 Purpose of the Report

1.1 The purpose of this report is to:

- update the Board on the paediatric service at St John's Hospital following the temporary closure of the overnight and weekend service for a six week period during the height of the summer holiday period;
- report on the patient activity to date during the temporary closure (3 July to 3 August)
- highlight the need for a comprehensive service review to be carried out in the next few months to determine how a sustainable model of care can be achieved for the future; and to
- note the planned reinstatement of 24/7 working for the ward from Monday 17 August 2015, pending the outcome of the review.

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

2 Recommendations

The Board is recommended to:

- 2.1 Acknowledge that despite best efforts, there is still not a sustainable staffing model for the St John's Hospital paediatric service and that the Out of Hours rota remains fragile, with the associated risk of an unplanned short notice closure of the ward which would require the transfer of patients to the Royal Hospital for Sick Children in Edinburgh.
- 2.2 Agree that a comprehensive Review of Lothian's acute paediatric services needs to take place to determine how a sustainable model of working can be secured which balances the Board's responsibilities to ensure safety and quality of care, access, the best outcomes for patients and the best use of available public resources.
- 2.3 Agree that this Review needs to be concluded as quickly as possible because of the detrimental impact of the ongoing uncertainty about a sustainable model of service for St John's on recruitment, retention and staff and patient safety.

- 2.4 Agree that the scope, remit, membership and timescales for the Review will be developed and agreed by the Board's Acute Hospitals Committee and Health Care Governance Committee following dialogue with internal clinical staff and Scottish Government colleagues and these details will be reported to the full Board meeting in October 2015.
- 2.5 Note that in the meantime, the ward will revert to 24/7 working from Monday 17 August 2015 on the same workforce model which has operated over the last three years since the temporary closure in the summer of 2012, supported by the small group of internal NHS Lothian staff who remain willing to volunteer to cover vacant Out of Hours shifts on a month to month basis in addition to their normal day time roles.

3 Discussion of Key Issues

Background – Paediatric Workforce issues, St John's

- 3.1 There have been long standing challenges with the Paediatric Medical workforce at St John's Hospital and this has been the subject of regular briefings to the Board over the last 5 years, as well as an externally commissioned Review by the Scottish Government (the TWIST Report published in April 2013). In spite of extensive and repeated annual recruitment campaigns, including International recruitment drives for both medical and Advanced Nurse Practitioner staff, the middle grade Out of Hours rota has remained fragile and is only covered on a month to month basis.
- 3.2 This rota supports the paediatric ward and the neonatal service overnight and at weekends. Around 2,700 babies are born every year and while the paediatric in patient service could be safely transferred to RHSC in the event of an unplanned collapse, the maternity and neonatal services could not be accommodated in Edinburgh, making it critical to avoid any unplanned disruption to services for West Lothian mothers and babies.
- 3.3 The rota has continued to rely heavily on locum cover at triple time rates of pay from a small pool of people, some with European Working Time Regulation (EWTR) waivers, to allow them to provide this cover on top of their full time day jobs. Over the last 12 months, the rota has become harder to manage due to a Consultant vacancy which could not be recruited to and more recently a Consultant going on Maternity Leave. Both of these Consultants were job planned to do Out of Hours resident middle grade shifts.
- 3.4 In spite of these difficulties, the team at St John's have maintained a safe and high quality service over the last few years, however, over recent months, the Out of Hours rota has become increasingly difficult to fill robustly, with only 3 of the 9 Out of Hours shifts required each week having staffed cover, the rest requiring locums. The rota is usually only available a few days before the start of each month and often contains unfilled shifts which have yet to be covered. The impact of this sustained reliance on a small workforce persistently working additional hours over the past few

years should not be underestimated and is a cause for concern in terms of staff wellbeing.

- 3.5 Additional pressures on medical and nurse staffing arose in June caused by sickness absence and on the junior rota, further gaps due to maternity leaves which compounded the existing pressures on the service. On 3 separate occasions in June, the service experienced a short notice Out of Hours rota gap which gave rise to significant concern.
- 3.6 When looking ahead to July, with 25 out of 39 Out of Hours shifts reliant on locum cover and with the wider pool of staff across Lothian who might be called on in a crisis being reduced because of the summer holiday period, the decision was made to close the inpatient part of the service for a 6 week period, due to concerns about patient safety and the heightened risk of a service collapse.
- 3.7 The inpatient service in the Paediatric Ward at St John's closed temporarily on 3 July and long standing contingency plans to manage the assessment and transfer to the Royal Hospital for Sick Children (RHSC) of children who need admission to hospital have been put in place and have been working effectively. These plans were first activated during a similar in patient service closure in 2012.

Current temporary Paediatric service provision at St John's

- 3.8 Since the temporary closure of the overnight service, the Paediatric Ward has been open and functioning from 08:00 to 20:00 Monday to Friday. It has provided an Acute Medical Paediatric Assessment service during this time as well as taking Day Surgery patients and patients for Planned Investigation/follow up.
- 3.9 Neonatal services have been running as normal. Paediatric outpatient clinics have been running as normal.
- 3.10 The Emergency Department at St John's has continued to provide emergency services for children and adults. This has included enhanced paediatric nursing care out-of-hours and at weekends from staff who had previously worked in the ward out of hours which has led to a model of working which will help to inform the Review of the long term options for the service.
- 3.11 The LUCS service based at St John's (Lothian GP Out of Hours service) has continued to provide the Out of Hours Primary Care service for children.

Activity impact of the changes to the inpatient ward

- 3.12 Since the ward closed to inpatients on 03 July, 59 West Lothian children have been transferred and admitted to RHSC, 8 of whom would have been transferred anyway for specialist care, leaving a true total of 51 transfers over 31 days.

Average daily transferred admissions: 1.6 children per day. On six of these days, there have been zero transferred admissions.

- 3.13 This is a very similar level of activity to that seen during the 2012 closure to inpatients. Although July is a quieter month generally, only 20% of the children normally admitted to the St John's Ward each year are true inpatients ie require to stay for more than 24 hours. In 2014/15, 680 patients required a stay of more than 24 hours, the majority were short stay assessment patients and this ambulatory/assessment workload has been increasing year on year.
- 3.14 There have been twice weekly reviews of the situation since the service changed, involving paediatric medical and nursing staff from both sites, Emergency Medicine, Maternity and the Scottish Ambulance Service. There have been no significant issues on either site and any problems have been worked through by the clinical teams.
- 3.15 It was agreed at the outset that there should be a case by case approach in relation to any teenagers requiring ENT, Maxillo-facial or Plastic surgery who would normally have been seen at St John's, to decide whether they would be best transferred in to RHSC or whether they should be treated and admitted to adult services at St John's. To date, 6 teenagers aged between 14- 16 years have been admitted either to the Day Surgery Unit at St John's or to an adult surgical ward.

Options for the future

- 3.16 Following the temporary closure of the inpatient service in 2012, which was precipitated by similar staffing and patient safety problems as this year, the Scottish Government set up an External review, the 'Tailored Workforce Intensive Support Team' (TWIST), which reported in April 2013.
- 3.17 This review considered potential service and workforce models for the paediatric and neonatal service at St John's in the light of the workforce challenges at that time. The current issue of excessive reliance on a small number of staff and the fragile short term nature of the rota were identified as key issues at that time. The medical team at St John's considered then that their model was short term and were keen to establish a more sustainable service model and staffing solution.
- 3.18 The comprehensive Review of the Lothian acute paediatric service will draw upon the detailed work reflected in the TWIST report in concluding the scope, remit and timescales of the review
- 3.19 The options identified by the TWIST Report were:
1. To maintain the current model with a 24/7 inpatient service
To maintain the current model with a 24/7 inpatient service in the expectation that the major recruitment initiative underway and wider

workforce development strategies would produce the staff needed to deliver this in a sustainable manner.

This option was the preferred option of the Board at that time, although, despite best efforts, the required level of staffing to support this option has not been able to be achieved.

2. To move to a day time Ambulatory Care model.

This would remove the need for overnight resident middle grade paediatric cover (neonatal cover would be provided from the Royal Infirmary of Edinburgh) but would still meet the needs of most of the patient population who present largely before the Out of Hours period. All paediatric trauma cases or those requiring surgical or specialist radiological intervention would be taken directly by ambulance to the RHSC.

This model is the one which has been in place during the temporary overnight and weekend closure.

3. To move to a 24 hour Ambulatory Care model.

This would be largely nurse led, remove the need for overnight resident middle grade paediatric (neonatal cover would be provided from RIE).

The recruitment of Advanced Nurse Practitioners to deliver this model has not thus far been successful.

Summary of Recruitment and staffing options

- 3.20 An International recruitment campaign was launched following the 2012 closure with a specialist Recruitment agency employed to assist and there have been ongoing major recruitment drives each year for Consultants, Speciality doctors, and Advanced Nurse Practitioners.
- 3.21 In spite of all these efforts, the paediatric staffing position Out of Hours has not seen any consistent improvement and the rota has continued to be available only on a month to month basis. Since early 2015, over two thirds of the overnight and weekend shifts have relied on locum cover.
- 3.22 A new Clinical Fellow role was also created as part of the effort to stabilise the paediatric workforce at St John's and two Clinical Fellows were recruited from abroad in 2013, however these roles have not been successful in addressing the middle grade Out of Hours rota gaps.
- 3.23 The most recent recruitment drive for International Medical Training fellows resulted in one job offer to one candidate who subsequently declined to take up post.
- 3.24 Recruitment to enhance neonatal staffing flexibility has been more successful. This gives a wider range of potential options for covering the maternity and neonatal service separate from the paediatric service as there

is now a significant pool of neonatal staff able to work between the Royal Infirmary of Edinburgh and St John's.

3.25 The TWIST team reviewed all the other staffing options in relation to the existing Paediatric Trainee and Neonatal and Paediatric Consultant/Career grade workforce in Lothian and the South East of Scotland. The position now is still the same as in 2012/13:

- Given the numbers available across the South East, removing Trainees from Fife or Borders would leave their services without adequate cover, which would endanger their Maternity and Neonatal services as well as their Paediatric services
- The Royal College of Paediatrics and Child Health review in 2012 led to the decision by the Post Graduate Dean to withdraw Trainees from Out of Hours work at St John's hospital because the low level of activity was not of training value
- The availability of Trainees to cover both RHSC and the Neonatal unit at the RIE fluctuates and both services already have to cope with gaps in their rotas. In February 2016, the number of available Paediatric Trainees in Lothian is expected to be at an all time low due to the usual range of factors including Maternity Leave, less than full time working, out of programme training and Trainees leaving the training programme. There are currently 19 wte Trainees at RHSC, at ST3+ level working across all the specialist services, including Intensive Care, Acute and Emergency Medicine etc.
- There are the equivalent of 10 Consultant Paediatricians at St John's, 2 Specialty doctors and 2 Clinical Fellows. At RHSC there are 7 Consultant General Paediatricians with a further 22 wte specialists in Oncology, Emergency Medicine, GI, Diabetes, Neurology, Intensive care etc. These Consultants are required to staff the specialist paediatric services provided at RHSC for the whole of Lothian and for the South East Scotland region as well as national services. It would not be possible to reallocate these staff to cover the St John's service and maintain the specialist services – and most of these Consultants have no recent Neonatal experience so could not cover the rota at St John's which supports both the Neonatal and Maternity service as well as the Paediatric ward. There are also 4.4 wte Specialty doctors at RHSC, 3.34wte of whom support the subspecialties and the other 1 has no recent neonatal experience.

Recommended next steps

3.26 It is recommended that a comprehensive Review of the acute paediatric service across NHS Lothian is conducted over the course of the next few months. The remit, scope and timescales of the review will be agreed by the Board's Acute Hospitals Committee and Healthcare Governance Committee following dialogue with internal clinical staff and colleagues from the Scottish Government Health Directorates.

3.27 Now that the peak holiday period is coming to its end, the willingness of local clinical staff to continue to work additional shifts to provide out of hours cover means that the temporary closure of the ward can be lifted and the ward can revert to 24/7 working, on the same basis as it has operated since the last temporary closure in 2012, pending the outcome of the review.

4 Key Risks

4.1 As the Out of Hours service relies heavily on locum cover, there remains a risk of a short notice inability to staff the paediatric resident Out of Hours middle grade rota, which could lead to an unplanned service closure.

5 Risk Register

5.1 The risks associated with the fragile staffing situation at St John's and the potential risk to other related services are on the Board's Risk Register.

6 Impact on Health Inequalities

6.1 A Health Inequalities impact assessment will be undertaken once the Review is completed.

7 Impact on Inequalities

7.1 An Equality and Diversity impact assessment will be undertaken once the Review is completed.

8 Involving People

8.1 There will be appropriate stakeholder involvement in the Review process and depending on the outcome of the Review, appropriate public and patient involvement.

9 Resource Implications

9.1 As much of this middle grade locum cover is provided by existing consultants who are paid at a premium rate, the annual cost of covering the rota, including the cost of the extra staff employed substantively to help cover it, is c £1 million per annum. This remains a real and continued challenge to NHS Lothian in delivering a sustainable financial and workforce model.

Jim Crombie

Chief Officer: NHS Lothian University Hospitals & Support Services Division

4 August 2015

Board meeting
5 August 2015

Chief Officer

ACUTE SERVICES PERFORMANCE UPDATE

SUMMARY PAPER

The key points of the paper are summarised here.

At the end of June, 349 patients were waiting beyond the 12 week treatment time guarantee. 389 patients were treated in month beyond the guarantee	3
4,192 outpatients were waiting over 12 weeks; this is a slight improvement on May's position of 4,261 outpatients waiting more than the 12 week TTG	4
18 week performance from referral to treatment remains stable at 86.0%	5
Performance against the 31 cancer standard in June was 95.8%, which exceeds the 95% expected standard. At 92.3%, performance against the 62 day cancer standard was below the expected standard.	6
1,852 diagnostic endoscopy patients were waiting longer than the 6 week standard and 142 radiology patients were also waiting longer than the standard	7
25 patients were waiting beyond audiology standards at the end of June 2015	9
NHS Lothian continues to perform well against the IVF standard of 90% of patients commencing IVF treatment within 12 months	10
NHS Lothian's overall performance against the 4 hour standard for the month of June was 94.7%.	11

NHS Lothian

Board meeting
5 August 2015

Chief Officer

ACUTE SERVICES PERFORMANCE UPDATE

1 Purpose of the Report

- 1.1 The purpose of this report is to provide the Board with an update on the performance of Acute Services.
- 1.2 Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

- 2.1 It is recommended that the Board receives this update.

3 Inpatients and Daycases

- 3.1 At the end of June, 349 patients were waiting beyond the 12 week treatment time guarantee (Table 1). 389 patients were treated in month beyond the guarantee (Table 2).

Table 1 – Treatment Time Guarantee Patients waiting beyond standard at month end.

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Urology	134	138	140	134	122	109	68	63	108	97	137	123	92
Plastic Surgery	122	150	191	188	162	181	195	255	212	139	111	101	89
Orthopaedic Surgery	32	20	42	34	51	64	49	89	107	53	88	86	60
Maxillofacial	22	28	34	37	39	35	30	41	52	42	42	46	34
Paediatric ENT	12	13	16	19	21	15	14	16	21	9	14	25	21
Colorectal/General	57	70	76	55	35	39	18	14	27	22	48	39	18
ENT	19	11	20	34	33	34	48	74	81	37	25	13	12
Ophthalmology	31	24	32	16	15	10	11	22	10	4	1	2	4
Others	63	46	17	15	8	11	14	18	31	23	34	41	19
TOTAL	492	500	568	532	486	498	447	592	649	426	500	476	349

Table 2 – Treatment Time Guarantee Patients seen beyond 12 weeks.

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
TTG Seen	476	388	402	467	448	397	427	406	564	692	476	463	389

- 3.2 Figures on list size and unavailability are shown in the following table. The use of unavailability and choice codes in Lothian remains low (14%)

Table 3 – List Size and Unavailability

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Total List Size (TTG)	9252	9307	9534	9842	9841	9832	9961	9600	9481	9140	8941	8692	8642
Available	7891	8000	8322	8697	8810	8733	8784	8714	8576	8174	7911	7644	7453
Unavailable	1361	1307	1212	1145	1031	1099	1177	886	905	966	1030	1048	1189
Percentage Unavailable	15%	14%	13%	12%	10%	11%	12%	9%	10%	11%	12%	12%	14%
non-TTG	631	564	574	551	606	572	620	1069	1144	1197	1180	1244	1246

4 Outpatients

4.1 Across NHS Lothian, 4,192 outpatients were waiting more than the 12 week TTG at the end of June; figures in key specialties are shown in the table below.

Table 4 – Trend in Outpatients over 12 weeks – Key Specialties

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Gastroenterology	350	339	328	259	288	263	198	210	252	323	477	671	902
Colorectal/General Surgery	176	152	256	226	305	352	288	506	596	342	454	583	632
Orthopaedic Surgery	29	84	169	152	223	408	459	647	775	517	515	665	558
ENT	314	305	551	447	446	292	295	272	269	320	431	504	541
Ophthalmology	361	425	395	407	362	288	285	335	481	296	336	378	326
Urology	54	41	28	121	248	339	358	378	339	315	398	438	321
Gynaecology	75	110	123	74	71	98	112	341	284	97	256	266	216
Community Child Health	12	9	8	22	36	24	66	115	144	122	137	111	92
Neurology	218	224	203	284	340	380	455	355	261	113	124	125	72
Vascular Surgery	2	3	8	3	7	6	6	49	65	23	21	23	21
Dental Institute	253	n/a	n/a	114	7	32	17	39	20	8	11	13	119
Others	1038	888	676	426	383	220	133	144	135	206	307	484	392
Total exc EDI	3679	3477	3429	2847	3092	2890	2788	3496	3736	2674	3456	4248	4073
TOTAL (inc EDI)	3932	3477	3429	2961	3099	2922	2805	3535	3756	2682	3467	4261	4192

4.2 Figures on outpatient list size and unavailability are shown in the following table.

Table 5 – List Size and Unavailability¹

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Total List Size	42480	43738	43091	42624	43955	43004	42639	41721	42861	43694	46547	46672	50243
Available	41169	42320	41854	41441	42808	42085	41527	41000	41987	42878	45843	47951	49004
Unavailable	1311	1418	1237	1183	1147	919	1112	721	694	816	704	721	1239
Percentage Unavailable	3%	3%	3%	3%	3%	2%	3%	2%	2%	2%	2%	1%	2%

5 18 Weeks Referral to Treatment Standard

5.1 Performance against the 18 week referral to treatment standard remains stable at 86.0% during June; however NHS Lothian is still below the expected 90% compliance. Table 6 shows the trend for combined performance for admitted and non-admitted pathways against the 18 week referral to treatment standard.

Table 6 -Trend in 18 Week Performance and Measurement

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Patient journeys within 18 weeks (%)	85.9	86.1	86.0	86.1	87.3	85.9	86.3	85.1	85.6	88.0	86.1	87.0	85.9
Number of patient journeys within 18 weeks	13,178	12,947	12,573	13,415	13,877	13,042	11,811	12,044	11,838	13,626	12,446	12,417	13,795
Number of patient journeys over 18 weeks	2,164	2,098	2,044	2,163	2,014	2,137	1,873	2,103	1,996	1,861	2,001	1,849	2,265
Patient journeys that could be fully measured (%)	86.6	86.6	86.5	86.3	85.9	86.0	83.4	85.5	85.6	85.8	85.1	85.7	86.0

6 Cancer

6.1 Performance over the last six months is set out by tumour site in the two tables below. Overall in June, 31 day performance met the expected standard of 95% (95.8%) whilst 62 performance fell below the standard (92.3%). Those pathways falling below required levels are highlight. Some, such as urology, feature consistently in the period covered.²

¹ Figures may differ from those previously reported. These were drawn from national data warehouse to ensure comparability throughout.

² June figures are provisional.

Table 7 - Trend in Cancer Performance (31 days from diagnosis to treatment)

Cancer Type	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	June 15
Cancer Type	Percentage that started treatment within 31 days						
All Cancer types [1]	97.4%	93.3%	94.1%	96.2%	97.2%	96.2%	95.8%
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%
Cervical (screened excluded)	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%
Colorectal (screened excluded)	93.6%	86.4%	94.4%	96.0%	95.2%	88.9%	100.0%
Colorectal (screened only)	87.5%	75.0%	80.0%	100.0%	100.0%	100.0%	75.0%
Head & Neck	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lung	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	100.0%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Melanoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurological - Brain and CNS	n/a	100.0%	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper GI	100.0%	95.8%	100.0%	95.8%	95.2%	100.0%	95.2%
Urological	90.7%	75.9%	73.1%	82.4%	89.5%	85.5%	84.6%

Table 7 – Trend in Cancer Performance (62 days from urgent referral to treatment)

Cancer Type	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	June 15
Cancer Type	Percentage that started treatment within 31 days						
All Cancer types [1]	96.5	94.5	93.1	95.6	96.1	93.4	92.3%
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened excluded)	50.0%	66.7	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%
Colorectal (screened excluded)	93.3%	78.6%	85.7%	87.5%	91.7%	100.0%	84.2%
Colorectal (screened only)	71.4%	100.0%	66.7%	100.0%	100.0%	100.0%	71.4%
Head & Neck	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	87.5%
Lung	100.0%	100.0%	94.4%	94.1%	93.3%	93.3%	100.0%
Lymphoma	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	71.4%
Melanoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%
Neurological - Brain and CNS	n/a	100.0%	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	100.0%	n/a	100.0%	100.0%	100.0%	100.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper GI	100.0%	100.0%	90.9%	100.0%	100.0%	83.3%	83.3%
Urological	94.4%	87.0%	80.0%	82.6%	85.2%	78.6%	92.3%

7 Diagnostics waiting times performance

- 7.1 Provisional information on diagnostic waiting times shows that 1,852 diagnostic endoscopy patients were waiting longer than the 6 week standard. This performance is in line with our capacity analysis and will improve from late August following additional clinical staff joining the team.
- 7.2 The number of radiology patients waiting beyond the 6 week standard was 142 in June; as outlined in our previous paper to the Board, there have been changes to the way in which we record radiology information and this has affected the trend data.³

Table 9– Numbers over 6 week standard for Key Diagnostic Tests (Radiology)

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
CT	0	1	0	0	0	0	0	0	2	3	15	8	6
MRI	1	4	2	0	1	0	1	1	0	2	108	123	106
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0
Ultrasound	0	0	0	1	7	21	67	90	40	15	23	13	30
Total	1	5	2	1	8	21	68	91	42	20	146	144	142

8 Surveillance Endoscopy

- 8.1 End of June's surveillance endoscopy position saw 1,344 patients waiting beyond their due date. As outlined in our previous update paper to the Board in June, we have a recovery plan in place to improve our performance. A recovery trajectory to the end of 2015 has been formulated using Demand Capacity Activity Queue (DCAQ) information sees this position improving from late August following additional clinical staff joining the team.

9 Audiology waiting times

- 9.1 An overall 18 week standard applies to audiology patients and such journeys are included with the 18 week figures covered earlier in the paper. In addition to this pathway standard, audiology services are expected to also meet stage of treatment targets for assessment and both treatment and hearing aid fitting.
- 9.2 These standards are set locally within an overall 18 week timeframe. Adult services elected to adopt 9 weeks for both elements, while paediatric services selected timeframes of 12 and 6 weeks. Across adult and paediatric audiology services, these standards were met at the end of May, however 25 patients were waiting beyond the standards at the end of June 2015.

Table 8 – Adult Audiology – Performance against Standard

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
Patients waiting for audiology assessment (first contact)													
Number waiting 9 weeks and over	38	11	3	0	0	0	111	174	5	0	1	0	0
Total number waiting	1599	1735	1516	1608	1464	1662	1939	1710	1683	1810	1756	1161	908
Patients waiting for fitting of hearing aid													
Number waiting 9 weeks and over	108	45	3	1	0	26	215	177	2	0	1	0	2
Total number waiting	1051	931	983	995	1007	1024	978	886	789	616	736	796	748
Patients waiting for other treatment (excl. hearing aids)													
Number waiting 9 weeks and over	2	4	4	4	0	8	15	27	6	0	1	0	0
Total number waiting	92	126	96	67	84	116	121	115	117	90	119	137	146

³ In April, the clock for radiology tests stopped with verification of report rather than attendance date. This change in data recording accounts for most of the cases reported over 6 weeks, apart from ultrasound where delays are continuing in the vascular lab.

Table 9 – Paediatric Audiology – Performance against Standard

	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15
<i>Patients waiting for audiology assessment (first contact)</i>													
Number waiting 12 weeks and over	0	0	0	0	0	0	0	0	0	0	0	0	0
Total number waiting	216	142	144	101	168	238	189	161	229	362	429	435	343
<i>Patients waiting for other treatment (excl. hearing aids)</i>													
Number waiting 6 weeks and over	0	0	0	0	0	1	0	17	29	22	16	0	23
Total number waiting	7	12	6	8	7	38	47	50	71	69	56	38	27

10 IVF waiting times

- 10.1 NHS Lothian continues to perform well against the IVF standard of 90% of patients commencing IVF treatment within 12 months. At the end of June 2015, there were no patients waiting over 12 months. Publication of this provisional information has now commenced nationally.
- 10.2 NHS Lothian is using capacity in its centre at the Royal Infirmary to assist reducing IVF waiting times elsewhere in Scotland. The numbers waiting at month-end since July 2014 are outlined below; figures exclude those patients waiting to be seen on behalf of other centres.

Table 10 – IVF Waiting List

	Jul 14	Aug 14	Sept 14	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	June 15
Numbers waiting	296	277	252	242	196	192	192	190	194	178	191	202
Numbers over 12 months	2	2	2	2	3	2	0	0	0	0	0	0

11 Accident and Emergency 4 hour standard

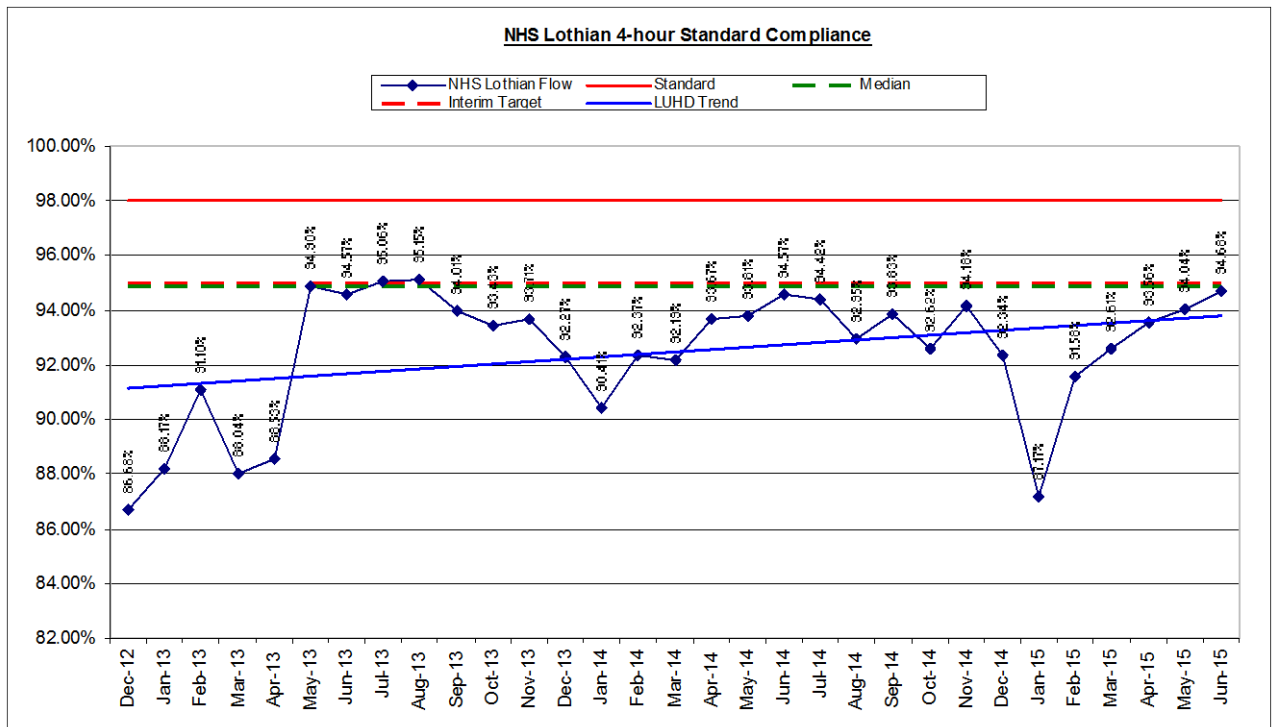
- 11.1 NHS Lothian's overall performance against the 4 hour standard for month of June 2015 was 94.7%, (93.3% as at 27th July).⁴
- 11.2 The performance across individual sites for June 2015 was as follows and overall trend in performance is shown in graph below.⁵

- RIE **94.4%** (93.6%)
- WGH **90.6%** (86.9%)
- StJ **94.7%** (94.1%)
- RHSC **99.1%** (98.7%)

⁴ The national target is to achieve a minimal compliance rate of 95% as at September 2014 and 98% thereafter.

⁵ Bracketed figures are up to 27th July.

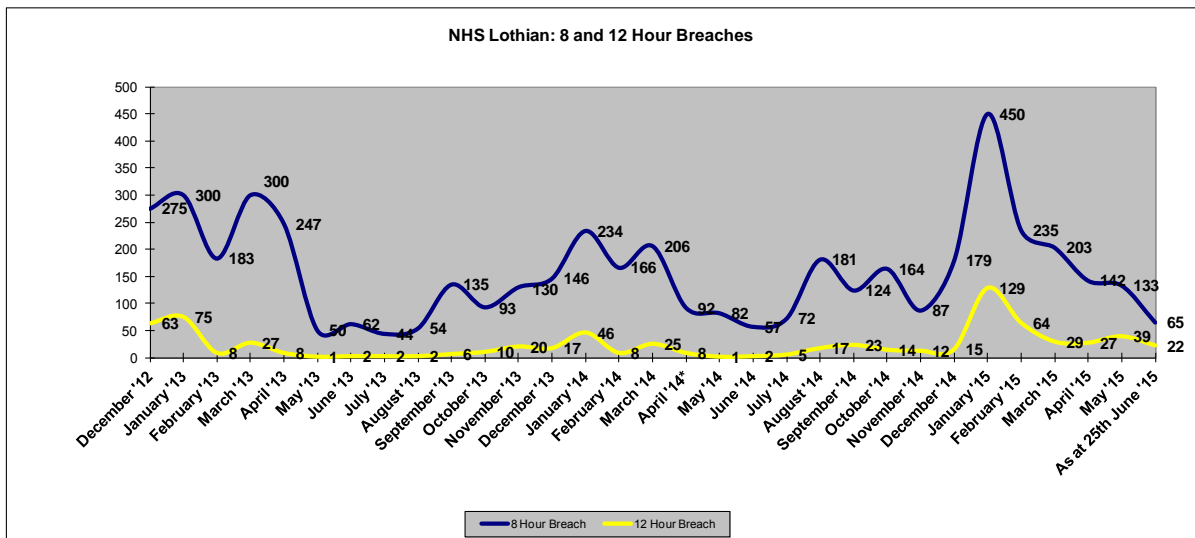
Trend in A&E performance



8 and 12 hour breaches

11.3 We are striving to continually improve the quality and safety of patient care which includes reducing the number of patients waiting long periods in A&E. There has been significant improvement in the number of patients who waited longer than 8 and 12 hours across NHS Lothian's hospitals since January 2015.

The number of patients who waited longer than 8 hours and 12 hours, Dec 2012 – 25th June 2015



12 Winter planning

- 12.1 The newly establish Winter Planning Project Board, chaired by the Chief Officer had its initial meeting early July to plan robust arrangements for Winter 2015/16. We will provide an update on the Project Board's progress in our next board paper.

13 Delayed discharges

- 13.1 Using the latest Monthly Census data, the overall number of delayed discharges across NHS Lothian was 248.⁶ Further information on Delayed discharges and the actions we are taking to tackle delays are covered in agenda item 2.1.

Jim Crombie
Chief Officer; NHS Lothian
University Hospitals & Support Services
28 July 2015

⁶ Monthly census at 15 July 2015.

Board Meeting
5 August 2015

Medical Director/Director of Human Resources & Organisational Development

SUMMARY PAPER - WORKFORCE RISK ASSESSMENT

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

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

<ul style="list-style-type: none"> Obstetrics & Gynaecology – Attempts to recruit two fixed term clinical fellows making use of the Scottish Government International Medical Training Fellowship initiative) were unsuccessful. One appointment has recently been made via our normal recruitment processes. Within elective gynaecology services sickness absence and two resignations have presented challenges for planned outpatient and inpatient work this year. A locum consultant was appointed from December 2014 for one year and two consultant posts in gynaecology have been advertised with an interview date in late August. 	3.21
<ul style="list-style-type: none"> Paediatrics – The situation at SJH previously detailed remains unchanged, with only four of the nine out of hours slots filled on a substantive basis. The ability to fill slots deteriorated in June due to maternity leave and sickness absence and a decision to close the inpatient ward to overnight admissions for six weeks was taken. 	3.22
<ul style="list-style-type: none"> Medicine of the Elderly - Recent consultant recruitment did not fill a post based at Roodlands Hospital which now has only 1wte of an establishment of 4wte filled substantively and is almost entirely reliant on RIE staff working additional shifts, staff bank and agency staffing. There have been recent instances where it has been necessary to stop admissions due to workforce gaps. The vacancy job profiles have been reviewed and are again under recruitment. The site will remain vulnerable until such time as substantive appointments can be made 	3.2.3
<ul style="list-style-type: none"> Anaesthesia - Following recent recruitment to 4 out of 5 vacancies the consultant workforce is now close to full capacity. A further 4 new posts are under recruitment as part of the Head and Neck Capacity plan. 	3.2.4
<ul style="list-style-type: none"> The Regional Perinatal and Eating Disorder Units have had to implement contingency arrangements as due to unsuccessful recruitment to consultant vacancies. These interim arrangements include cover from the Royal Edinburgh, St John's Psychiatry Service and support from other Boards in the South East. 	3.2.51 & 3.2.5.2
<ul style="list-style-type: none"> H@N Contingency plans are being drawn up for Hospital at Night services on each site to cover for any short term gaps in registrar availability to ensure robustness. 	3.2.6
<ul style="list-style-type: none"> The findings of the GMC medical trainee experience survey results have been published. 	3.5

Nick McAlister
Head of Workforce Planning
27 July 2015

5 August 2015

Medical Director/Director of Human Resources & Organisational Development

WORKFORCE RISK ASSESSMENT

1 Purpose of the Report

The purpose of this report is to update the Board on the actions currently underway to ameliorate risks to service sustainability within specialties where high levels of risk have been identified. The scope of the paper has been widened to consider workforce risk within the wider workforce.

2 Recommendations

- 2.1 Recognise the steps that are being taken to both sustain the trained obstetric medical workforce in the medium term and enhance patient safety with 24/7 resident consultant cover.
- 2.2 Acknowledge the workforce pressures that exist in relation to the provision of paediatric services at St John's Hospital (SJH) and the need to introduce contingency arrangements in June and July.
- 2.3 Acknowledge that substantial gaps in the substantive consultant workforce remain and there is heavy reliance on temporary staffing measures which has led to Roodlands Hospital having to close to admissions on recent occasions when gaps cannot be filled.
- 2.4 Note the significant recruitment difficulties within both the Regional Eating Disorder Unit and the Regional Perinatal Mental Health Unit and the contingency arrangements that are in place whilst recruitment is underway and the on-going discussion with regional partners.
- 2.5 Note the increasing workforce pressures that are being faced by the Hospital at Night Service and support the development of contingency arrangements to ensure sustainability.
- 2.6 Note the positive findings of the annual GMC Trainee survey results and the work that will take place to address areas of concern that have been identified.

3 Discussion of Key Issues

3.1 Background

The June Board paper contained significant detail in relation to workforce risks and challenges that are being faced and the actions that are underway to support sustainability at a local and national level.

Given the relatively short time interval between Board meetings this paper only provides an update on areas where there has been significant change within this period.

3.2 Progress in addressing key medical workforce risks

3.2.1 Obstetrics & Gynaecology

The South East Scotland O&G training programme experiences a high level of gaps due to trainees going Out of Programme (OOP) for research/experience, maternity leave and less than full time working. Recruitment of competent Locums Appointed for Training (LATs) to cover these gaps is often unsuccessful. There is an ongoing requirement for internal locum usage including consultants covering resident middle grade OOH shifts several times a month with a consequent impact on day time availability.

In 2012/13 the Board made funding available for eight new consultant posts to contribute to the resident middle grade rota at RIE and from February 2015 seven of these posts were filled substantively and one filled on a fixed term basis. However, recruitment has been difficult and ongoing turnover is anticipated. The service continues to look at options for increasing resident on-call consultant cover and where vacancies occur they will be filled on the basis of participation on the on-call rota. Without further expansion however it may take longer to increase the consultant presence on the labour ward. Where gaps arise these will be covered by internal locums.

Attempts to recruit two fixed term clinical fellows (making use of the Scottish Government International Medical Training Fellowship initiative) were unsuccessful. One appointment has recently been made via our normal recruitment processes.

Within elective gynaecology services sickness absence and two resignations have presented challenges for planned outpatient and inpatient work this year. A locum consultant was appointed from December 2014 for one year and two consultant posts in gynaecology have been advertised with an interview date in late August.

The findings and recommendation of a review of Women's services undertaken by the Royal College of Obstetricians in February at NHS Lothian's request have recently been considered by the healthcare governance group. The Maternity Services Programme Board will now consider the recommendations and take forward necessary actions that may be required.

3.2.2 Paediatrics

As detailed in previous papers there have been considerable efforts made to sustain paediatric and neonatal rotas across Lothian in the face of considerable gaps.

The situation at SJH detailed in previous Board papers however remains unchanged, with only four of the nine out of hours slots filled on a substantive basis. The staffing situation for the combined paediatric and neonatal service remains very difficult, heavily reliant on a small number of people doing additional night and weekend shifts (making use of a waiver from the EWTD) and prone to short notice collapse because of sickness or other unplanned absence.

The medical staffing situation deteriorated in June due to maternity leave and sickness absence and a decision to close the inpatient ward to overnight admissions for six weeks was taken. All other paediatric services at St John's Hospital (SJH) have continued including ambulatory assessment, programmed investigations, outpatients and day case surgery. The neonatal and maternity service has not been affected.

Long standing contingency plans have been put in place and are working well. The service is being provided with the small number of West Lothian children requiring inpatient treatment going to RHSC. Neonatology can now be covered by neonatal staff working across the RIE and St John's sites and is robust and there is no clinical urgency to reopen the inpatient paediatric unit until a sustainable rota is in place.

One clinical fellow was appointed making use of the International Medical Training Fellowship programme but subsequently withdrew.

At St John's for the last six months there are also gaps (currently two out of six) in the FY/GPST rota which further affect the service. These have been managed by a series of short term locums. Two junior clinical fellow posts were advertised recently to try and cover these gaps and one appointment made with a start date in August.

3.2.3 Medicine of the Elderly

The June board paper highlighted the positive progress that has been made appointing to a number of unfilled consultant and specialty doctor posts at both the RIE/Liberton and WGH. Posts that remained unfilled are once again under recruitment the outcome of which will be detailed in future papers.

There are also significant challenges associated with the recruitment of trained doctors and the following section provides detail on recent recruitment activity.

Roodlands Hospital

As detailed in the June paper only 1 wte of an establishment of 4 wte consultant posts is filled on a substantive basis. These gaps cannot fully be covered and there is a reliance on a range of ad-hoc staffing measures including Medicine of the Elderly (MOE) consultants from the RIE working additional shifts, staff bank shifts and external agency staffing. It has been increasingly difficult to fill even costly external agency locum shifts. Consequently there is the risk of short notice closure at Roodlands to admissions. This is likely to be an on-going issue until such time as gaps can be filled on a substantive basis. There is further recruitment underway for a consultant post which will combine RIE 'front door' session with sessions at Roodlands. There are also other measures around out of hours rotas and weekend on site staffing being reviewed.

The service remains very reliant on the one substantive member of staff and the temporary staffing measures and as such prone to having to close to all admissions.

These challenges come at a time when East Lothian Integrated Joint Board is establishing Hospital to Home as part of its delayed discharge planning and the East Lothian Service for Integrated care of the Elderly, which seeks to increase capacity to reduce emergency admissions.

3.2.4 Anaesthetics

The June board paper highlighted the positive progress that has been made appointing to a number of unfilled consultant and specialty doctor posts at both the RIE, WGH and St John's Hospital.

There are however 4 additional new consultant posts under recruitment at SJH as part of the Head and Neck capacity plan which aims to improve and sustain services to

meet treatment time guarantees on an on-going basis. The outcome of this recruitment will be detailed in the October board paper.

Within the trainee workforce however there remain however a significant number of gaps that emerge within the trainee workforce as a result of maternity leave and emerging gaps as trainees complete training. These posts as with other specialties continue to be very difficult to fill and as a consequence there is continuing reliance of supplementary staffing to cover gaps.

3.2.5 Psychiatry

The June board paper provided detail on the increasing difficulties that are being faced in filling consultant posts across Scotland and also the very poor fill rates in higher specialty training programmes. It also set out where NHS Lothian is facing in filling posts at SJH:

Mother and Baby Unit - Perinatal Psychiatry
General Adult Psychiatry
Rehabilitation Psychiatry

The following section provides further detail of these services and the actions that are underway to sustain services:

3.2.5.1 Regional Perinatal Service in Mother and Baby Unit at St John's Hospital

The specialist Perinatal Service is provided in the six bedded Mother and Baby Unit located at SJH. A consultant who has been with the unit since 2010 indicated in 2014 their intention to leave in December 2014. However in order to assist transition and recruitment the consultant subsequently agreed to continue until 31st July 2015 before taking up a new position. A staff grade post also become vacant during this period and has been used to create an additional 0.4wte consultant post. There has also been additional input provided by a Consultant from NHS Borders.

The vacant posts have been advertised widely however they did not attract any applicants. The job outlines were subsequently reviewed to offer a range of flexible contracts to attract as many interested and suitably qualified applicants as possible. A recruitment consultant has also been engaged to facilitate recruitment across the UK and Ireland and posts are currently advertised and interview panels organised.

The service also participated in a European Employment Service (EURES) international on-line recruitment event on 16th & 17th of July however this did not attract and applicants.

Discussions are also taking place at both Regional Planning level and between the senior clinical staff in the Greater Glasgow and Clyde and South East of Scotland service to further develop mutually supportive relationships.

However given that the existing consultant will leave on 31st July interims arrangements have been put in place. From the 1st August 2015 the consultant from NHS Borders will continue to work in the service and provide four clinical sessions. In addition a consultant from East Lothian, who has previously worked in the service, will provide five sessions; together they will provide the medical cover for the inpatient unit. The community service for Lothian will be covered by the Associate Medical

Director, who will provide 5 sessions of input plus also provide flexible telephone advice across the week.

These arrangements will be in place for a minimum of three months whilst we continue with our recruitment process. The medical staffing position will however continue to be fragile until substantive appointments can be made. These contingency arrangements are under close review to ensure service safety and sustainability.

3.2.5.2 Regional Eating Disorders Unit (REDU) at St John's Hospital

The Regional Eating Disorder Unit (REDU) is a 12 bedded inpatient unit located within St John's Hospital, Livingston. It aims to provide a therapeutic programme and re-feeding treatment for people with eating disorders aged over 18, from NHS Forth Valley, Lothian, Fife and Borders Health Board areas. The unit opened in February 2012. The multidisciplinary team in the unit is led by a part time consultant psychiatrist, and includes a specialty-grade psychiatrist, a consultant physician, nursing, dietetics, psychology, physiotherapy and administration staff. The unit is managed by the mental health management team working through the governance framework within West Lothian Health and Social Care Partnership.

NHS Lothian commissioned an external review of REDU services by the Royal College of Psychiatrists, as a result of concerns and complaints received from the regional partners. A detailed action plan to implement the review recommendations has been developed and a core group established to oversee delivery of the action plan which includes action to ensure appropriate medical input, clinical and operational leadership of the unit.

The part-time consultant however left the unit on the 3rd of July and further consideration of service requirements has resulted in the post being made full time to provide sufficient capacity and arrangements are currently being made to advertise the post nationally. A full-time specialty doctor post that had been working in another area on a temporary basis has now returned to the unit.

Given that the consultant post is not yet filled interim arrangements have been in place since 6th of July. From the 19th July 2015 consultant support and responsibility is being provided by a consultant psychiatrist from the Anorexia Nervosa Intensive Treatment Team, based at The Royal Edinburgh Hospital, who will work two additional sessions until a substantive appointment is made.

Out of hours cover, 5pm-9am and weekends, will continue to be provided by the psychiatry department at St John's Hospital.

Senior clinicians from the regional community teams in Lothian, Forth Valley and Fife have agreed to provide greater support to the REDU team for the treatment planning of patients from their locality, where they are able.

These arrangements will be in place for a 3 month period from 6th July to 9th October 2015 with the aim to ensure safe care and allow for senior clinical appointments to be made. The medical staffing position will however continue to be fragile until a substantive appointment is made. We will be keeping these arrangements under close review to ensure we are able to provide a safe service.

3.2.6 Hospital at Night

The Hospital at Night team is a multidisciplinary team consisting of registrars and experienced nurse practitioners who provide cover to each hospital site at night. The HaN medical rota consists of registrars from a range of specialties and has provided an excellent training since its inception and has provided improved medical cover to sites out of hours and improved patient safety as a consequence. Whilst committing a senior trainee has represented a loss of resource for contributing specialties it has been recognised to provide benefits to both the service and the trainee.

The ability however to recruit to a number of medical specialties within NHS Lothian, the South-east region and Scotland has decreased significantly. The difficulties are in part in filling training places through the national recruitment exercise although the SE region remains in a comparatively strong position. The most significant problem is actually filling gaps as result of trainees going out of programme due to maternity leave and take time out to undertake research/PhDs. These locum posts have become almost impossible to fill through recruitment in many specialties and there has been an increasing reliance on staff bank and agency staffing to fill gaps. It is now becoming difficult to fill gaps with staff supplied through agencies and in some cases trainee gaps cannot be filled. These gaps mean that it is becoming increasingly difficult for specialties to release trainees to support HaN. The successful appointment to Clinical Development Fellowships has been helpful in providing support for HaN they do not however have the same level of expertise as a HaN registrar and as such there is a risk of an experiential gap should there be a HaN registrar gap at short notice.

Consequently each site is developing detailed contingency plans to ensure that there are appropriate actions that can be taken at short notice to ensure continuity of service and ensure availability suitably trained staff.

3.3 National medical workforce planning

The June paper provided detail around workforce planning that is taking place at a national level in relation to the medical workforce. Given the relatively short period of time since this paper an update will not be provided until the October board paper.

3.4 General Practice

The June workforce board paper and separate Primary Care board paper highlighted the challenges that are being faced within primary care and GP practices. The workforce paper provided an example of the pressures within Leith Links Practice and the measures that are being taken to sustain the practice.

The challenges are clearly increasing within Lothian and Scotland as a whole, the October Board paper will provide further detail on practices that are facing workforce challenges and the work that is underway to support sustainability. This paper will also provide detail around work that is underway nationally in relation to the GP workforce.

The SGHD will be running the Primary Care Workforce Survey 2015 between August and October (subject to confirmation). This will ask all GP practices and OOH services to complete a survey looking at the workforce profile of both GPs and practices nurses including demography, retirements and vacancies.

3.5 GMC Survey of trainees

The purpose of the General Medical Council (GMC) is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The GMC has four main functions, of which two are particularly relevant in the context of workforce and NHS Lothian as a training environment:

- fostering good medical practice
- promoting high standards of medical education and training

In Scotland, NHS Education Scotland (NES) lead on ensuring that these GMC Standards for training and education are being met and that training programmes, trainee experience and educational support are of a sufficiently high quality.

The annual GMC National training survey of all trainees in Boards, Trusts and community settings is a rich source of data. It has been accepted as a valid early warning indicator of issues within a clinical unit, service or hospital as the “training” element of clinical practice tends to be the first aspect to deteriorate when other pressures are applied.

The results of the 2015 survey (in a Red/Amber/Green format) have recently been released and overall the training experience within the S.E. region and NHS Lothian in particular is reported as very positive with some excellent improvements in certain domains over the past 12-14 months. In particular:

- Induction of all trainees in Lothian to hospitals and clinical units
- Positive trends in the reporting of handover practices in all hospitals
- Excellent experiences reported in many of the medical subspecialties e.g. Respiratory, Endocrinology
- Positive trends in the supervision of trainees both in and out of hours as a marker of both safety and educational development.

The survey data (red & pink flags) do highlight and align with areas where there are challenges in acute care in particular increasing workload and unstable or depleted workforce:

- Acute medicine across all adult sites
- Obstetrics & Gynaecology in RIE
- Surgery [Colorectal, Urology, Neurosurgery] at WGH

These challenges are known to the clinical and educational management infrastructure, the solutions to the latter being very much entwined with a sustainable solution to the former.

3.6 Nursing and Midwifery Workforce

The June workforce paper provided detail around the implementation of the national nursing and midwifery workload and workforce planning tools, the development of Health visiting workforce capacity, increased investment in advance practice and the introduction of revalidation.

There will be further discussion of these issues as part of the September Board Development Session.

3.7 Workforce risk assessment update process

A programme for the review of medical workforce risk assessments has commenced, and will cover all areas covered previously as well as some community areas not specifically covered previously. These will be fed into the Lothian Medical Workforce Group as well as clinical/site management teams and key areas of risk will also be reflected within future board papers.

4 Risk Register

- 4.1 The NHS Lothian risk register contains a 'Medical Workforce Sustainability' risk, which relates the risk that workforce supply pressures in conjunction with activity pressures will impact on service sustainability and/or NHS Lothian's ability to achieve its corporate objectives. The multi-factorial risk assessments that have been carried out will be reviewed and updated where necessary on a 6 monthly basis or where there are significant changes.

5 Impact on Inequality, Including Health Inequalities

The introduction of the medical workforce risk assessment process has been subject to a rapid impact assessment for which a report has been prepared.

6 Involving People

Before any changes in service provision across any site in NHS Lothian are made, there would need to be engagement and consultation with appropriate audiences with the guidance of the Scottish Health Council.

7 Resource Implications

- 7.1 There are potential resource implications, which are identified as part of the planning process within specialties to reduce the level of workforce risk. These will be progressed through the appropriate local management structures to secure necessary support.

Nick McAlister
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27 July 2015

Board Meeting
5 August 2015

Medical Director / Nurse Director

SUMMARY PAPER – QUALITY REPORT

This paper summarise the key points in the full paper.

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

	Para
<ul style="list-style-type: none"> The data presented as part of the Hospital Scorecard (October-December 2014), would indicate that NHS Lothian is an outlier for this quarter for 28 Day Surgical and medical Readmissions. The trend data, however, provided by ISD would suggest it is normal cause variation which is illustrated by previous quarters data not showing NHS Lothian as an outlier. 	3.1.1
<ul style="list-style-type: none"> The number of formal complaints remains fairly stable (excluding prisons Graph 3). Achieving a sustained response rate at 20 days and 3 days remains a challenge (graphs 1 & 2). 	3.1.2 and Graphs 1-4
<ul style="list-style-type: none"> Staff absence levels (Graph 6) are over 4% (4.7%) which has been above 4% for a number of months with significant variation across NHS Lothian. 	3.1.3 and Graph 6
<ul style="list-style-type: none"> The HEAT targets for reduction in <i>C.Difficile</i> and Staph. aureus bacteraemias are not being achieved (see graphs 11&12). Healthcare Associated Infection is a separate agenda item and paper. 	3.1.4 and Graphs 11-12
<ul style="list-style-type: none"> A number of reports on the Board agenda examine in more detail delayed discharges, A&E 4 hour waits and Cancer 62 day waits. Compliance with stroke standards remains a challenge and a review is in progress which is due to report to Healthcare Governance Committee in November 2015. 	3.1.5 and Graphs 5,17,18 & 19-21

Jo Bennett
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30 July 2015
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QUALITY REPORT

1 Purpose of the Report

- 1.1 This report presents the Quality Report for July 2015, to provide assurance on the quality of care NHS Lothian provides.

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

2 Recommendations

- 2.1 Review the quality dashboard and exception reporting to inform assurance requirements, (context and technical appendix are set out in Appendix 1).

3 Discussion of Key Issues

3.1 Exception Reporting – Quality Dashboard

- 3.1.1 The data presented as part of the Hospital Scorecard (October-December 2014), would indicate that NHS Lothian is an outlier for 28 Day Surgical and Medical Readmissions. The trend data, however, provided by ISD would suggest it is normal cause variation which is illustrated by previous quarters data not showing NHS Lothian as an outlier.
- 3.1.2 The number of formal complaints remains fairly stable (excluding prisons Graph 3). Graph 4 shows a subset of these complaints which are prison complaints which account for a large number of the overall complaints. Achieving a sustained response rate at 20 days and 3 days remains a challenge (graphs 1 & 2).
- 3.1.3 Staff absence levels (Graph 6) are over 4% (4.7%) which has been above 4% for a number of months with significant variation across NHS Lothian.
- 3.1.4 The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (see graphs 11&12). A separate paper on the prevention and management of HAI is on this committee agenda.
- 3.1.5 Achieving the stroke standards for both admission to unit within 1 day and swallow screen on day of admission remains a challenge. A stroke review is taking place which is due to report to Healthcare Governance Committee in November 2015.
- 3.1.6 NHS Lothian has aligned its reporting of Pressure Ulcers into the Scottish Patient Safety Programme (SPSP) Measurement Framework. A Pressure Ulcer Management Review paper was discussed at Healthcare Governance Committee in July 2015 and proposed a reporting framework in line with Scottish Patient Safety Programme goals.

Quality Dashboard – July 2015 (dates for each data item stated in background charts)

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

If you have an electronic version of this report, links to each measure chart have been embedded in the headings below.

QUALITY AMBITION

PERSON-CENTRED - Process Measures

[20-day Complaints Response Rate](#) *

[3-day Complaints Response Rate](#) *

[Delayed Discharges and Average Length of Stay](#) *

PERSON-CENTRED - Outcome Measures

[Number of Complaints \(excluding HMP Healthcare\)](#) *

[Number of Complaints for HMP Healthcare](#) *

[Staff Absence Levels](#) *

[Patient Experience](#)

[Staff Experience](#)

SAFE – Outcome Measures

[Hospital Standardised Mortality Ratios for RIE, WGH & St. John's](#)

[Incidents with harm](#) *

[C. Difficile Numbers](#) *

[Staph. Aureus Bacteraemia Numbers](#) *

[Number of Cardiac Arrests](#) *

[Rate of Cardiac Arrests](#) *

[Inpatient Falls with Harm](#) *

EFFECTIVE – Process Measures

[A&E 4 Hour Wait](#) *

[Cancer Waits 62 Days from Diagnosis to Treatment](#) *

[Admission to stroke unit on day or day after admission](#) *

[Stroke Treatment Measure: CT Scan](#) *

[Stroke Treatment Measure: Swallow Screen](#) *

Additional Quality Measures

Hospital Scorecard: October to December 2014 *

Indicator

	Lothian Rate	Scottish Rate
	(Per 1000 admissions)	
Standardised Surgical Readmission rate within 7 days	22.13	21.17
Standardised Surgical Readmission rate within 28 days	42.69	39.87
Standardised Medical Readmission rate within 7 days	53.02	53.17
Standardised Medical Readmission rate within 28 days	117.07	113.87
	Lothian	Scotland
Average Surgical Length of Stay – Adjusted	0.93	1.00
Average Medical Length of Stay – Adjusted	1.05	1.00

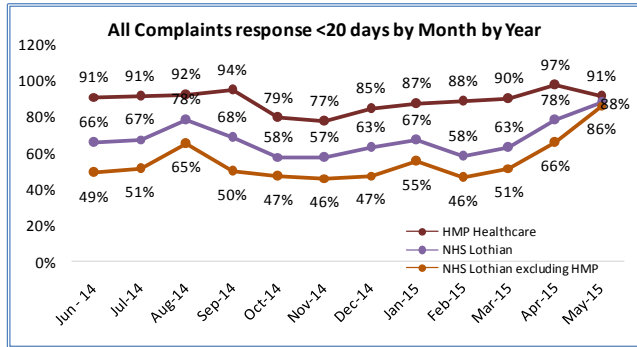
Person-Centred

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

Title:	20-day Complaints Response Rate (Graph 1)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	85% of complaints responded to within 20 days

Process Measure

20-Day Response Target across NHS Lothian

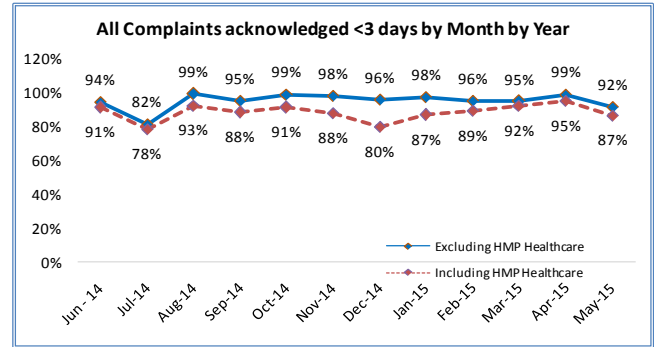


Data Source: Datix Exec Lead: Melanie Johnson

Title:	3-day Complaints Response Rate (Graph 2)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	100% formal acknowledgement within 3 working days

Process Measure

3-Day Response Target across NHS Lothian

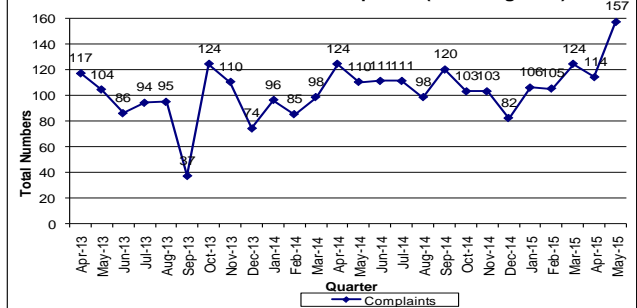


Data Source: Datix Exec Lead: Melanie Johnson

Title:	Number of Complaints (excluding Prison Complaints) (Graph 3)
Numerator:	Total number of complaints
Goal:	Reduction in number of formal complaints

Outcome Measure

NHS Lothian Formal Complaints (excluding HMP)

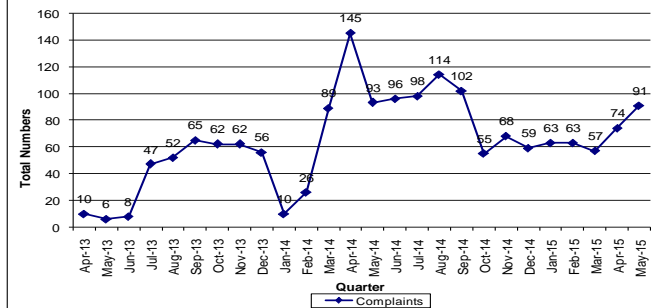


Data Source: Datix Exec Lead: Melanie Johnson

Title:	Number of Prison Complaints (Graph 4)
Numerator:	Total number of prison complaints
Goal:	Reduction in number of formal complaints

Outcome Measure

HMP Healthcare Formal Complaints

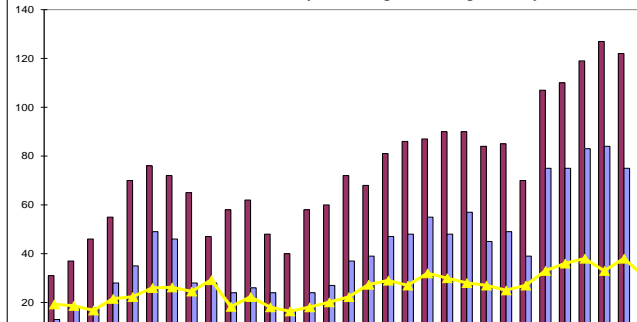


Data Source: Datix Exec Lead: Melanie Johnson

Title:	Delayed Discharges & Average Length of Stay (Graph 5)
Goal:	No patient waiting longer than 2 weeks for discharge

Process Measure

Delayed Discharge and Average LOS/days

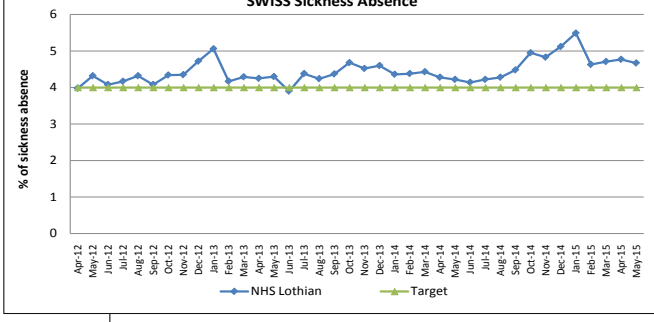


Data Source: Local data captured on EDISON shared data with Health & Social Care Exec Lead: Jim Crombie

Title:	Staff Absence Levels (Graph 6)
Numerator:	Total staff hours lost
Denominator:	Total staff hours available
Goal:	4% or less

Outcome Measure

SWISS Sickness Absence

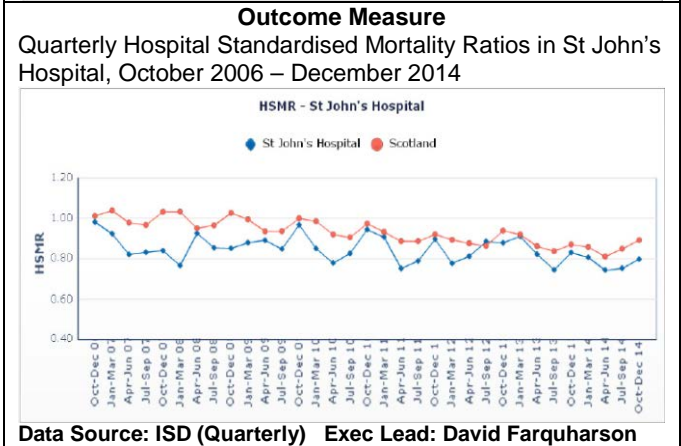
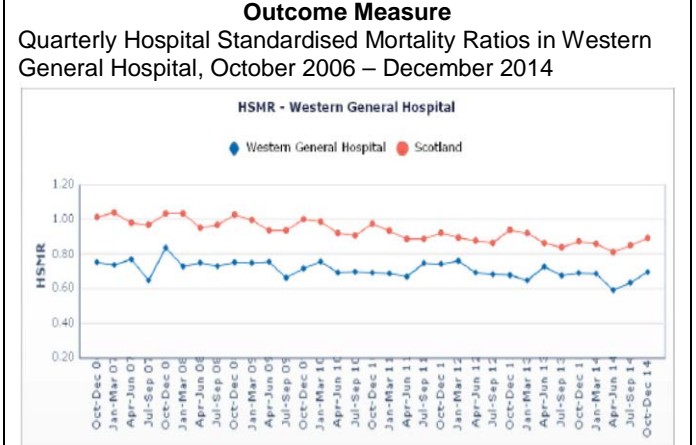
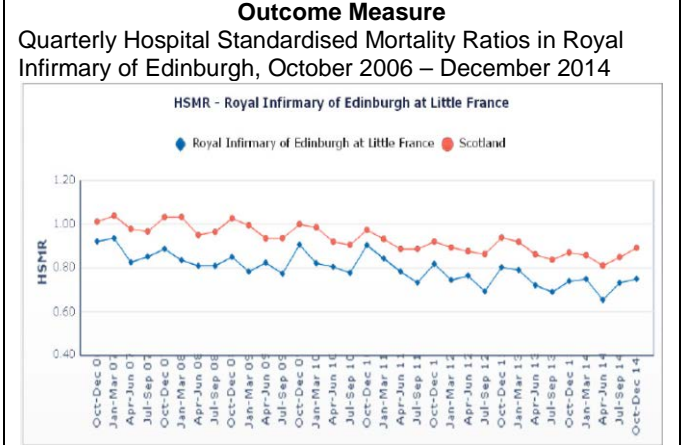


Data Source: Scottish Workforce Information Strategic Systems (SWISS) Exec Lead: Alan Boyter

Safe

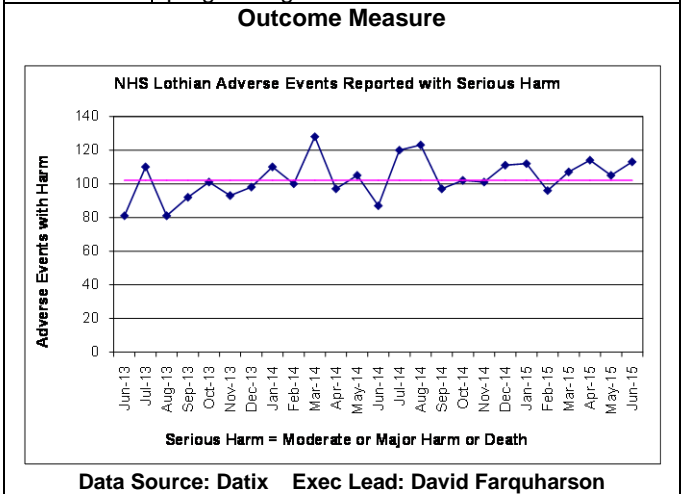
“There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.” Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, HAI indicators, arrest calls, falls with harm and pressure ulcers.

Title:	Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Graphs 7 – 9)
Numerator:	Total number of in-hospital deaths and deaths within 30 days of discharge from hospital
Denominator:	Predicted total number of deaths
Goal:	20% reduction against 2006/07 baseline by December 2015

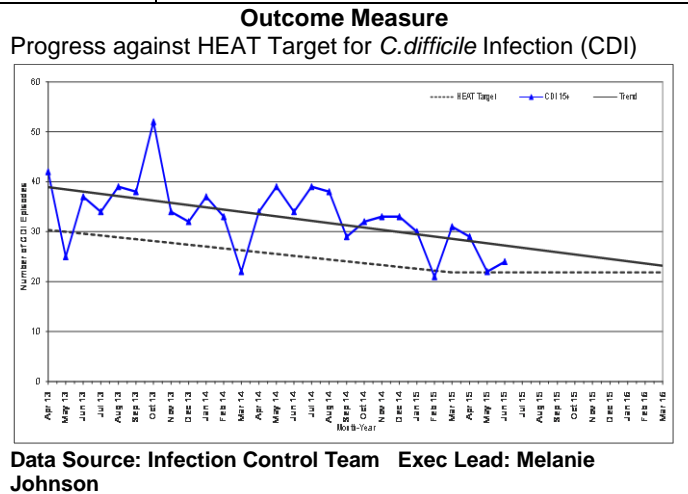


Data Source: ISD (Quarterly) Exec Lead: David Farquharson

Title:	Incidents with harm (Graph 10)
Numerator:	Number of incidents associated with serious harm reported per month in NHS Lothian
Goal:	There are specific goals for reductions in Falls & Pressure Ulcers. See separate graphs for progress against these.

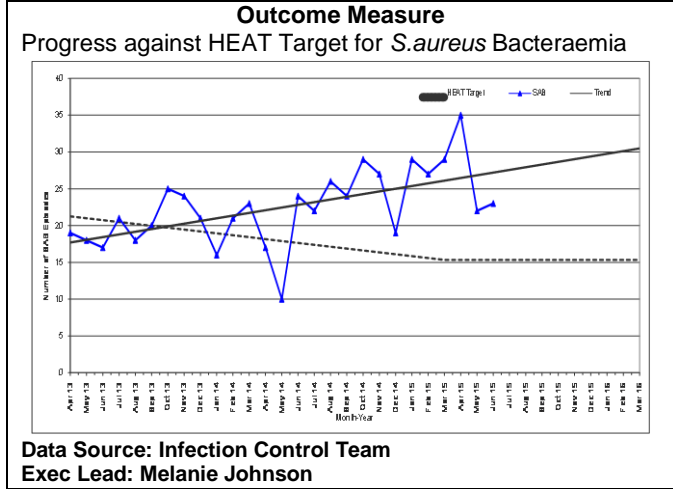


Title:	C. difficile associated disease against HEAT Target 2012-13 (Graph 11)
Numerator:	Total number of patients aged 15 and over with C.difficile toxin positive stool sample (CDI)
Goal:	NHS Lothian is to achieve 262 or fewer CDI by March 2015 as shown by trend line.

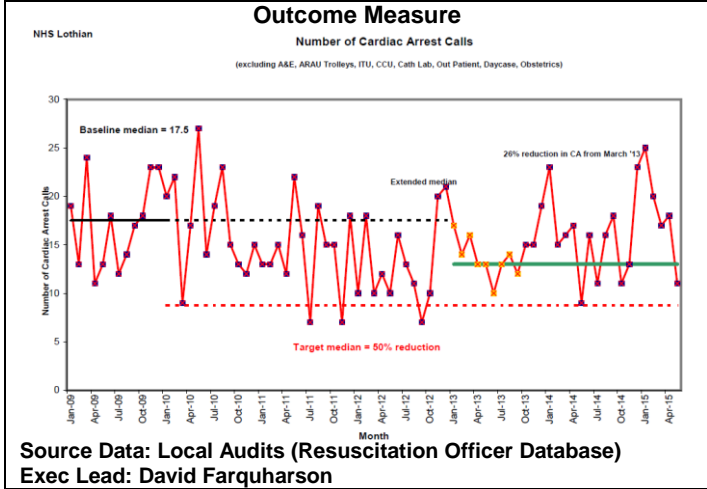


Safe (cont'd)

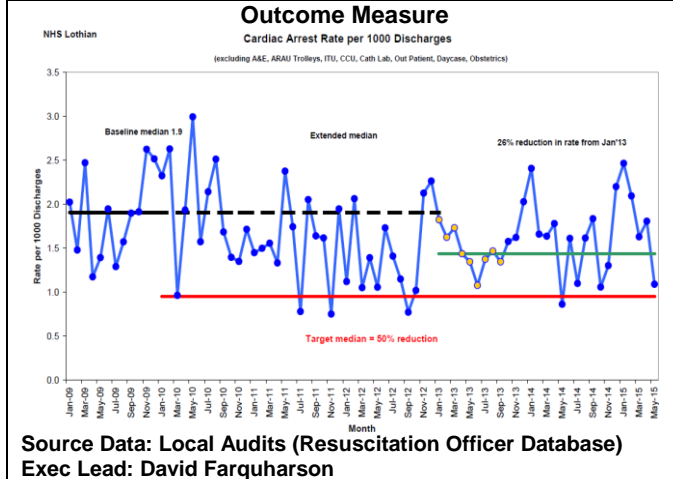
Title:	Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Graph 12)
Numerator:	The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)
Goal:	NHS Lothian is to achieve 184 or fewer SABs by March 2015 as shown by trend line.



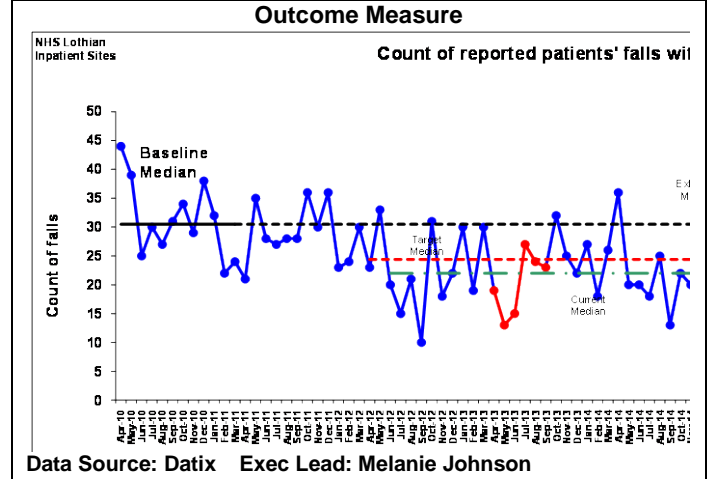
Title:	Number of Cardiac Arrests (Acute Wards) (Graph 13)
Numerator:	Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline



Title:	Rate of Cardiac Arrests (Acute Wards) (Graph 14)
Numerator:	Arrest – Rate of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline



Title:	Patient Falls with Harm (Graph 15)
Numerator:	Number of falls reported resulting in moderate or major harm or death (define moderate/major). Data for NHS Lothian inpatient sites
Goal:	20% reduction in inpatients falls and associated harm by December 2015

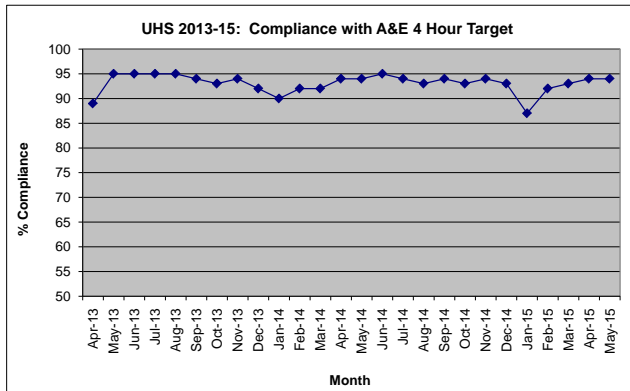


Effective

“The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.” Progress on this ambition is measured through clinical quality indicators and stroke care.

Title:	A&E 4 Hour Wait (Graph 17)
Numerator:	Number of patients waiting less than 4 hours from arrival to admission or discharge
Denominator:	Number of patients attending
Goal:	98% of patients waiting less than 4 hours from arrival to admission by March 2015

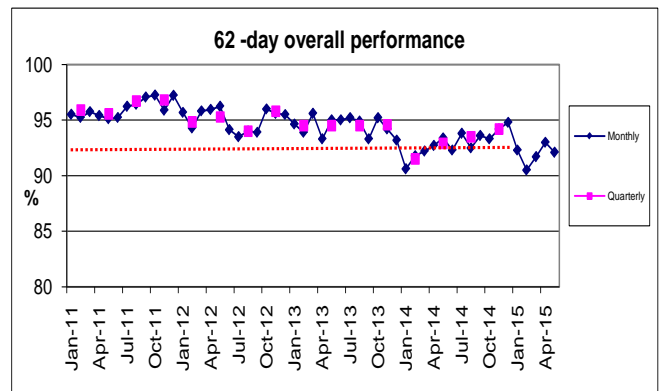
Process Measure



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

Title:	Cancer Waits 62 Days from Diagnosis to Treatment (Graph 18)
Numerator:	Number of patients waiting 62 days to treatment Please note the scale
Denominator:	Number of cancer patients
Goal:	95% of patients from diagnosis to treatment wait no longer than 62 days

Process Measure

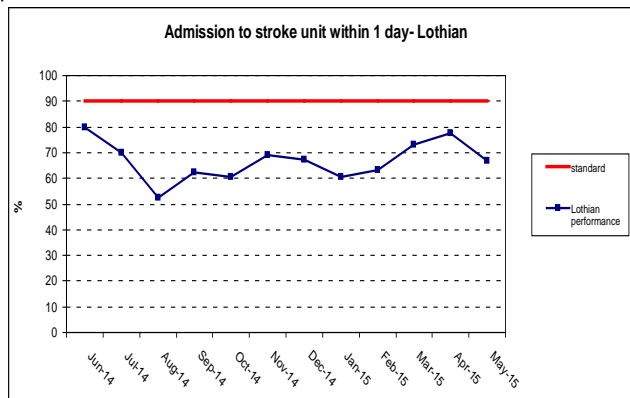


Data Source: SGHD Management Information
Exec Lead: Jim Crombie

Title:	Admission to Stroke Unit within 1 day of admission (Graph 19)
Numerator:	Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
Goal:	90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional

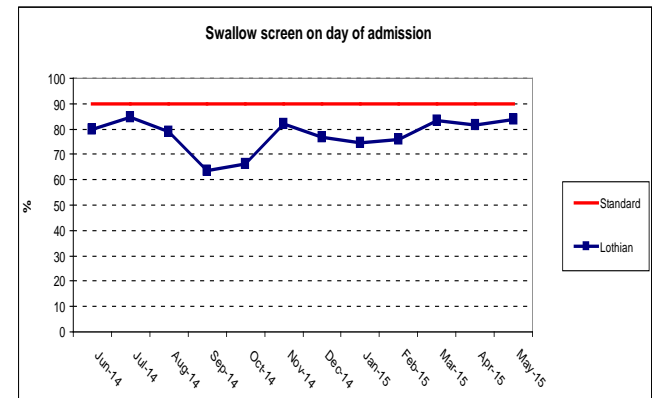


Lothian = 73.3% (63/86)
Data Source: ISD Exec Lead: Jim Crombie

Title:	Stroke Treatment Measures (Graph 20)
Numerator:	Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional



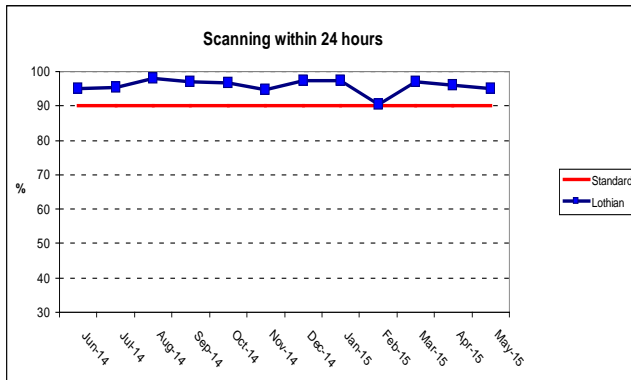
Lothian = 83.2% (84/101)
Data Source: ISD Exec Lead: Jim Crombie

Effective (cont'd)

Title:	Stroke Treatment Measures (Graph 21)
Numerator:	Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission

Process Measure

Note: 2015 data is not validated and should be treated as provisional



Lothian = 97% (98/101)

Data Source: ISD Exec Lead: Jim Crombie

4 Key Risks

- 4.1 Achieving the HAI HEAT target, complaints response times, stroke targets, delayed discharge target and cancer target.
- 4.2 This dashboard has been developed to ensure a range of measures that can be considered easily, all of which impact on the patient experience and outcome of care. These measures, however, do not reflect all aspects of care and need to be supplemented with condition-specific data, both qualitative and quantitative.
- 4.3 Failure to comply with national standards with potential impact on patient experience and outcomes of care, and external inspections.

5 Risk Register

- 5.1 Achieving HAI targets is also on the Corporate Risk Register (Risk 1076) and its risk grading has been increased to reflect that NHS Lothian is outwith HAI trajectory. Access to Acute Stroke Unit is on the University Hospital Services Risk Register – Medicine and Associated Services (Risk 2444). Compliance with stroke standards is captured in Unscheduled Care on the Corporate Risk Register. Complaints Management is also captured on the Corporate Risk Register.

6 Impact on Inequality, Including Health Inequalities

- 6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.
- 6.2 This paper combines elements of the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010) and the Scottish Patient Safety Programme (assessed in May 2009).
- 6.3 The findings of the Equality Diversity Impact Assessment in SPSP are that particular note must be made of the harm to patients with disabilities as part of the measurement of harm. The changes to the assessment documentation encourage systematic and standardised screening for all risks including screening of cognitive impairment.

7 Involving People

- 7.1 No service change.

8 Resource Implications

- 8.1 Work is ongoing to automate the production of this Dashboard, which is complex, as it uses data from a number of sources. This is within the Clinical Governance Workplan.

Jo Bennett

Associate Director for Quality Improvement & Safety

30 July 2015

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List of Appendices

Appendix 1: Supporting Context and Technical Appendix

Context and Technical Appendix

Quality Report Development

The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland's quality ambitions and across levels 1 to 3.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian's Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

Hospital Standardised Mortality Ratio (HSMR)

HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level 'warnings' for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

S.aureus Bacteraemia (SAB) rate

New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.

C.difficile Infection (CDI) rate

New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

Incidents associated with harm

Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.

Surgical readmissions within 7 days

This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011.

This measure has been standardised by age, sex and deprivation (SIMD 2009).

Surgical re-admissions within 28 days

As for 7 day readmissions.

Medical Re-admissions Within 7 Days

This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.

The data are presented for calendar year 2011.

This measure has been standardised by age, sex and deprivation (SIMD 2009).

Medical Re-admissions Within 28 Days

As for 7 day readmissions.

Average Length of Surgical Stay (Adjusted)

Ratio of 'observed' length of stay over 'expected' length of stay.

This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.

A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

Average Length of Medical Stay (Adjusted)

Ratio of observed length of stay over expected length of stay.

This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations.

NHS Lothian

Board Meeting
5 August 2015

Director of Finance

FINANCIAL POSITION TO JUNE 2015

1 Purpose of the Report

- 1.1 The purpose of this report is to provide the Board with an overview of the financial position for the 3 months to June. The paper also gives early consideration of the year-to-date position on the year end outturn and the mitigating actions identified in support of achieving year-end financial balance.
- 1.2 Any member wishing additional information on the detail of this paper should contact the Executive Lead prior to the meeting.

2 Recommendations

2.1 Members of the Board are asked to:

- Note that the financial position at period 3 shows an overspend of £6.3m across all services, with implications for the achievement of a breakeven year-end position.
- Consider actions proposed that will support the achievement of year-end financial balance.

3 Discussion of Key Issues

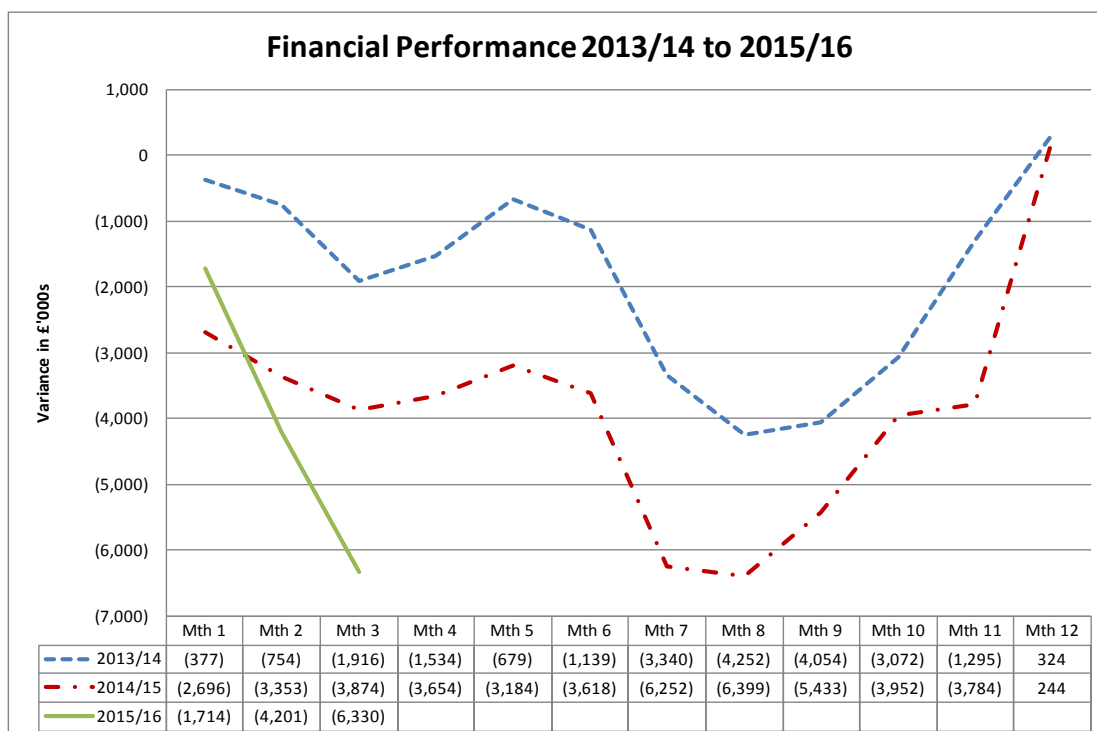
- 3.1 At period 3 of this financial year, NHS Lothian overspent by £6.3m for the year to date against the Revenue Resource Limit. Table 1 shows a summary of the monthly trend and year to date position. A detailed analysis by expenditure type and business unit is shown in Appendix 1 and by operational unit in Appendix 2.

Table 1: Financial Position to 30th June 2015

	Mth 1 £000's	Mth 2 £000's	Mth 3 £000's	YTD £000's
Pay	(1,468)	(89)	(266)	(1,823)
Non Pay	846	(1,754)	(1,800)	(2,708)
Income	(48)	(169)	351	134
Efficiency Savings	(1,044)	(475)	(414)	(1,933)
Total Financial Position	(1,714)	(2,487)	(2,130)	(6,330)

3.2 Table 2 below shows the cumulative run rate for the year of the total position compared to the last 2 financial years.

Table 2: Cumulative Run Rate



3.3 The 2015/16 Financial Plan presented to the Board on the 1st of April 2015 set out how financial balance could be achieved in this financial year, including a number of key risks and assumptions. At this stage of the year, NHS Lothian has not been able to deliver financial balance against its core budget, with some of the risks highlighted in the plan now materialising. An update was provided to the Finance and Resources Committee at its meeting of July 8th on these risks after two months of the financial year.

3.4 Within the Financial Plan, due recognition was given to pre-existing financial pressures and a total of £14.3m was allocated from within the plan to cover these. Additional recurrent cost pressures of approximately £10m incurred in the last financial year were not funded through the financial plan on the basis these costs would be managed through specific management actions.

3.5 The performance year to date shows little evidence that these pressures are being managed and as a result the year to date baseline is £6.3m overspent. The key drivers of the overspend are as follows:

- **GP Prescribing** is reporting an overspend to date of **£2.3m** and is currently the single largest adverse variance. This is despite uplift funding totalling £8m as part of the Financial Plan. The year to date position is based on extrapolated data from the last financial year into the start of this year. Based on current growth and price increases continuing, a year end overspend in the region of £6.6m is forecast.

- The pay overspend is driven predominantly by **Nursing** costs, reporting an adverse variance to date of **£1.8m** (2%). The main areas contributing to this pressure sit within Edinburgh CHP and Acute Services. The overspend reported in Corporate Services relates to bank costs worked within operational units which will be recharged out next month.
- Acute services contribute a £1m pressure in Nursing to date with supplementary staffing again contributing a significant element to the overspend. £0.5m of the pressure is reported against Theatres and Critical Care with Theatres using supplementary staffing to cover vacancies and extended theatre days in support of achieving waiting time guarantees. Nursing overspends also continue on both the RIE and WGH sites (£400k), with Medicine of the Elderly wards on the RIE site showing an ongoing overspend with staffing levels beyond budgeted establishment. Cancer services at the WGH site have staffing resource in excess of the budgeted levels following a reduction in the number of beds without a corresponding reduction in staffing levels. This is being reviewed and managed by the Clinical Nurse Managers currently in order to return this to balance. Actions are currently being introduced across NHS Lothian to reduce levels of supplementary staffing and eliminate agency nursing.
- Within Edinburgh CHP the continued high use of supplementary staffing in Rehab, Older People and REAS services is driving a significant overspend against budget. Work is underway within these areas to look at ways to manage spend on supplementary staffing and agreeing safe and appropriate nursing staffing levels, while taking account of issues of acuity, 1:1 observations and sickness levels.
- **Medical Supplies** is reporting an overspend of **£1m** to date. Acute Services is the main contributor to this overspend, with an adverse variance of £682k to date. The pressure on Cardiology supplies (£365k overspent) is driven by TAVI procedures, with Lothian activity ahead of plan. It is envisaged that the variance will reduce in future months as charges for non-Lothian patients increases and anticipated discounts are realised. The use of a new type of valve (Intuity Valve) in Cardiology which has contributed a £65k pressure to date has been paused while a business case is developed for its continued use. Another area reporting a significant variance currently is Edinburgh CHP, and is driven by an overspend within the Mobility Centre. The pressure was identified and supported through the financial plan, and this funding will reduce the current levels of overspend once expenditure profiles have been formalised.

Efficiency and Productivity

- 3.6 Further consideration has been given to the 2015/16 targets at business unit level. Targets totalling £49m had been set at the start of the year including a new 3% target for 2015/16 of approximately £31m, plus a further £18m for carry forward savings relating to non-delivery in 2014/15. However the board only requires delivery of £31m in-year to fund all the planned investments based on the Financial Plan. The reduction of £18m in the overall in year target has been spread over the clinical areas based on their in year target. The proposed revised targets are shown in Table 3 below.

- 3.7 Where targets have been reduced to a level lower than planned delivery this year, Business Units will still be expected to deliver the value against the plans in support of delivering overall financial balance.

Table 3: Revised Efficiency Targets by Business Unit

	2015/16 Target	Carry Forward from 14/15	Allocation of £18m based on in year target	Revised 2015/16 Target
	£k	£k	£k	£k
Acute	15,126	10,993	(10,702)	15,417
East Lothian CHP	1,043	160	(738)	465
Edinburgh CHP	3,593	3,895	(2,542)	4,946
Midlothian CHP	508	298	(359)	447
West Lothian CHCP	1,344	(16)	(951)	377
Prescribing	3,827	178	(2,707)	1,297
Facilities	2,652	556	0	3,208
Corporate Services	3,186	1,348	0	4,534
Strategic	481	151	0	632
Total	31,759	17,563	(18,000)	31,322

- 3.8 Efficiency plans totalling £28.8m have been identified at this stage leaving a shortfall against the financial plan target. Of the £28.8m plans identified, £4.2m were targeted to be achieved by the end of month 3. With only £2.9m achieved, a shortfall against plans of £1.3m is reported. A further £629k slippage gap arises due to a shortfall against the total target required, bringing the total year to date efficiency slippage to £1.9m. Appendix 3 sets the LRP achievement to date in further detail.
- 3.9 A new system of portfolio reporting involving the project leads has been introduced by the Efficiency and Productivity Team to give a robust assessment of the anticipated delivery against the submitted plans. The output from this process will be incorporated into the Quarter 1 Review; however it is clear that Business Units need to prioritise the development of further efficiency plans and the in year delivery of already agreed plans.
- 3.10 Failure to deliver LRP to the anticipated £31.3m value presents the health board with two challenges: Firstly, this will impact on the board's ability to deliver its statutory target of breakeven this year; Secondly, the financial plan requires efficiency savings as a funding source for investments in the plan, and failure to achieve the full quantum of savings means that the resources in the plan will no longer be available at this level.

4 Risks and Assumptions

- 4.1 At this stage, elements of the Financial Plan funding are still to be confirmed including the full receipt of £5m income for Waiting Times. In addition, the Plan assumed £12.5m from PPRS funding to support drug prescribing this year. Information recently received from the SG suggests that funding will be lower than expected, although the full impact of this is being worked through. Failure to receive this funding to the level anticipated will have a further adverse effect on achievement of year end balance.
- 4.2 As previously noted, the Finance and Resources Committee has been provided with an update on the risks identified in the Financial Plan. This update set out the current status of these risks, and the impact on financial performance at Period 2.
- 4.3 In addition to the above, the ability for the board to deliver against other operational targets, including waiting times and delayed discharges as well as the unknown impact of winter may yet impact adversely on the outturn position.

5 Year end forecast – Quarter 1 Review

- 5.1 A Quarter 1 review is currently being undertaken across the organisation and will be concluded and reported to the F&R Committee in September. However based on the evidence of the first three months it is clear that the conditions required to deliver a breakeven outturn position as set out in the financial plan are not being met. Therefore, robust management actions must now be identified to deliver month on month balance and ensure in year balance can be achieved.

6 Actions to ensure achievement of financial balance

- 6.1 NHS Lothian remains fully committed to achieving financial balance this year. In order to deliver this a number of actions have been introduced, or will be put in place, including:
- Quarterly financial performance meetings with the Chief Executive, Director of Finance and the Director of Strategic Planning and relevant leads of Business Units and Services to review year to date performance, including forecast outturn, to ensure plans are in place locally to deliver a breakeven outturn with renewed focus on delivery of efficiency savings in line with plans;
 - A review of all in-year flexibility to support breakeven is being undertaken as part of the Quarter 1 review including balance sheet provisions. The level of flexibility available this year is significantly lower than in prior years, and it will not be sufficient to achieve financial balance in isolation;
 - Continued actions to mitigate spend on supplementary staffing;
 - Actions on GP prescribing to control spend;
 - Review of independent sector investment that does not relate to Treatment Time Guarantee expenditure;
 - A review of opportunities to slow the introduction of financial plan investments;
 - A further review of Rates to establish further flexibility;

- Actioning of recommendations from the recent “Data Diagnostic” review;
- Development of plans through the IJB on avoiding admissions;
- Skill mixing opportunities across the workforce.

6.2 A number of other actions will be pursued by the management team to deliver financial balance which may require engagement with and support from the Scottish Government, including:

- NRAC funding parity – the plan assumed further benefit in 2016/17 which is subject to confirmation;
- PPRS flexibility released by the SG – the Centre is withholding £10m of national funding until December;
- Delayed discharges and options for the expansion of Gylemuir – Current challenges with delayed discharges in Edinburgh need resolution, and an opportunity may exist to use Gylemuir as a temporary facility for additional capacity;
- New Drugs approach – The SG is planning to change the current IPTR process with a new peer-based approach. There is a potential adverse financial implication to this for Boards;
- Determining any additional flexibility in terms of performance targets.

6.3 The actions above are intended to address the immediate financial challenges for 2015/16. However there are also a range of opportunities to support financial sustainability beyond this year being progressed that NHS Lothian is again looking for Scottish Government support on including:

- The impact of the Barnett consequentials for further funding support;
- Prioritising financial stability which would include not investing in new commitments;
- Early confirmation of planning assumptions for 2016/17;
- Clarifying position regarding new initiatives including National Trauma Centre, Seven day services, OOH Review and Robotic Surgery;
- Early conclusion on the consultation on National Clinical Services Strategy to enable planning for required changes.

7 Risk Register

7.1 The Risk register will be considered following the detailed Quarter 1 review and any changes will be made at this stage based on the outcome of this.

8 Health and Other Inequalities

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

9 Involving People

9.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local

partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

10 Resource Implications

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

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28 July 2015

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Appendix 1: NHS Lothian Income & Expenditure Summary 30 June 2015

Appendix 2: NHS Lothian Summary by Operational Unit to 30 June 2015

Appendix 3: NHS Lothian Efficiency & Productivity Summary as at Month 3

NHS Lothian Income & Expenditure Summary to June 2015

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)	Period Variance (£k)
Medical & Dental	225,653	57,466	58,063	(597)	(298)
Nursing	374,596	94,313	96,093	(1,781)	(674)
Administrative Services	79,955	20,302	20,130	172	175
Allied Health Professionals	59,540	15,197	14,885	312	206
Health Science Services	36,684	9,144	8,858	286	156
Management	9,806	2,648	2,451	197	71
Support Services	50,207	12,620	13,082	(462)	(55)
Medical & Dental Support	6,727	1,684	1,516	168	57
Other Therapeutic	23,270	6,051	6,113	(63)	104
Personal & Social Care	2,878	719	694	25	22
Other Pay	(3,726)	(4,482)	(4,407)	(76)	(29)
Emergency Services	15	4	9	(5)	(2)
Pay	865,606	215,665	217,488	(1,823)	(266)
Drugs	112,064	26,984	27,318	(334)	(334)
Medical Supplies	82,115	21,074	22,140	(1,065)	(608)
Maintenance Costs	5,671	1,387	1,622	(235)	(310)
Property Costs	40,575	10,233	9,606	628	96
Equipment Costs	20,249	5,238	5,696	(458)	(214)
Transport Costs	9,909	2,586	2,634	(48)	68
Administration Costs	170,393	16,554	15,585	970	(12)
Ancillary Costs	14,802	3,698	3,627	72	28
Other	22,573	(4,439)	(4,489)	50	17
Service Agreement Patient Serv	80,888	21,689	22,011	(322)	(62)
Non-Pay	559,240	105,006	105,749	(743)	(1,332)
Gms2 Expenditure	113,471	28,217	27,885	332	220
Ncl Expenditure	3	1	(23)	24	12
Other Primary Care Expenditure	0	0	32	(32)	(10)
Pharmaceuticals	134,016	34,265	36,552	(2,287)	(689)
Primary Care	247,489	62,483	64,446	(1,963)	(467)
Fhs Non Discret Allocation	(2,177)	(987)	(981)	(5)	(3)
Bad Debts	0	0	(2)	2	2
Other	(2,177)	(987)	(983)	(4)	(2)
Income	(1,687,968)	(69,230)	(69,365)	134	351
Income	(1,687,968)	(69,230)	(69,365)	134	351
CORE POSITION	(17,810)	312,937	317,335	(4,398)	(1,716)
Savings Target Non-Pay	(1,932)	(1,932)	0	(1,932)	1,086
N/R Corp Savings LRP	0	0	0	0	(1,500)
TOTAL	(40,808)	311,004	317,335	(6,330)	(2,130)

NB. The above table relates to Core Services only. There is £40.808m of Non Core Budget not shown above that balances Annual Budget to zero.

NHS Lothian Summary by Operational Unit to June 2015

Description	University Hosp Support Serv (£k)	East Lothian Chp (£k)	Edinburgh Chp (£k)	Midlothian Chp (£k)	West Lothian Chp (£k)	Facilities And Consort (£k)	Corporate Services (£k)	Strategic Services (£k)	Primary Care Other (£k)	Inc + Assoc Hlthcare Purchases (£k)	Reserves (£k)	Total (£k)
Annual Budget	635,604	85,494	310,525	52,833	113,869	137,339	78,179	9,437	0	(1,546,850)	82,764	(40,808)
Medical & Dental	207	(105)	(29)	19	(129)	0	(436)	(124)	0	0	(0)	(597)
Nursing	(964)	158	(360)	88	(61)	(11)	(620)	(11)	0	0	0	(1,781)
Administrative Services	(9)	(12)	37	(17)	(74)	(1)	261	(10)	(2)	0	0	172
Allied Health Professionals	(108)	5	23	96	27	(0)	(77)	0	(3)	0	350	312
Health Science Services	216	3	70	(5)	12	0	(11)	0	0	0	0	286
Management	99	(0)	52	18	1	(25)	45	6	0	0	0	197
Support Services	(101)	(20)	11	0	(6)	(337)	(6)	(1)	0	0	0	(462)
Medical & Dental Support	113	0	(1)	0	39	0	16	0	0	0	0	168
Other Therapeutic	31	14	(2)	(4)	(131)	0	31	(2)	0	0	0	(63)
Personal & Social Care	(20)	(3)	(10)	0	0	(0)	59	0	0	0	0	25
Other Pay	11	(2)	(13)	0	0	(17)	(54)	0	0	0	0	(76)
Emergency Services	0	0	0	0	0	0	(5)	0	0	0	0	(5)
Pay	(525)	37	(221)	195	(322)	(392)	(797)	(142)	(5)	0	349	(1,823)
Drugs	(276)	78	(3)	(9)	(46)	(0)	(112)	(174)	0	0	209	(334)
Medical Supplies	(682)	(99)	(212)	(23)	(42)	(27)	13	8	0	0	0	(1,065)
Maintenance Costs	(186)	(6)	(48)	(1)	(5)	47	(35)	(2)	0	0	0	(235)
Property Costs	0	(34)	27	(4)	20	611	10	(3)	0	0	0	628
Equipment Costs	(434)	(21)	(57)	(14)	27	(23)	90	(24)	0	(2)	0	(458)
Transport Costs	(32)	(27)	27	14	31	(37)	(26)	4	0	(1)	0	(48)
Administration Costs	621	87	84	(1)	99	21	(155)	213	(0)	2	(0)	970
Ancillary Costs	56	2	(18)	8	5	33	(13)	(0)	0	0	0	72
Other	68	(19)	0	0	6	2	(7)	0	0	0	0	50
Service Agreement Patient Serv	(47)	(33)	(74)	(0)	(17)	0	156	351	0	(658)	0	(322)
Non-Pay	(912)	(72)	(274)	(31)	77	627	(80)	372	(0)	(658)	209	(743)
Gms2 Expenditure	(0)	49	186	21	79	(1)	(1)	0	0	0	0	332
Ncl Expenditure	23	1	(0)	0	0	0	0	0	0	0	0	24
Other Primary Care Expenditure	(32)	0	0	0	0	0	0	0	0	0	0	(32)
Pharmaceuticals	0	(316)	(1,170)	(258)	(543)	0	0	0	0	0	0	(2,287)
Primary Care	(9)	(266)	(985)	(237)	(464)	(1)	(1)	0	0	0	0	(1,963)
Fhs Non Discret Allocation	0	0	(5)	0	(1)	0	0	0	0	0	0	(5)
Bad Debts	0	0	0	0	0	0	0	1	0	0	0	2
Other	0	0	(5)	0	(1)	0	0	1	0	0	0	(4)
Income	595	28	(102)	10	103	28	27	(3)	0	(552)	0	134
Income	595	28	(102)	10	103	28	27	(3)	0	(552)	0	134
CORE POSITION	(851)	(272)	(1,586)	(63)	(607)	261	(851)	228	(5)	(1,210)	558	(4,398)
Savings Target Non-Pay	(1,690)	83	(381)	58	307	(97)	(52)	(158)	0	0	0	(1,932)
N/R Corp Savings LRP	0	0	0	0	0	0	0	0	0	0	0	0
TOTAL	(2,541)	(189)	(1,968)	(5)	(300)	164	(904)	69	(5)	(1,210)	558	(6,330)

NB. The above table relates to Core Services only. There is £40.808m of Non Core Budget not shown above that balances Annual Budget to zero.

NHS Lothian Efficiency and Productivity Summary as at Month 3 2015/16

Business Unit	Total Recurring Target	Current Year Plans	Gap on In Year Plans	Year to Date Position					Full Year Position		
				April - June					Total Recurring Target	Full Year Plans Identified	Gap on Recurring Plans
				Plans Phased to Date	Actual Delivery	Slippage on Plans	Gap Phased to Date	Total Slippage			
£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	
East Lothian CHP	465	1,203	738	152	13	(139)	185	46	465	1,402	937
Midlothian CHP	447	724	277	85	39	(46)	69	23	447	986	539
Edinburgh CHP	4,944	4,011	(933)	828	522	(306)	(233)	(539)	4,944	3,885	(1,059)
West Lothian CHCP	377	1,333	956	165	166	1	239	240	377	1,331	954
Prescribing	1,298	3,325	2,027	601	390	(211)	507	296	1,298	3,325	2,027
Acute Hospital Services	15,559	11,048	(4,511)	1,726	1,164	(562)	(1,128)	(1,690)	15,559	11,933	(3,626)
Facilities & Consort	3,208	3,126	(82)	167	89	(78)	(20)	(98)	3,208	4,089	881
Corporate Services	4,390	3,911	(479)	484	551	67	(120)	(53)	4,390	2,979	(1,411)
Strategic	634	124	(510)	30	0	(30)	(128)	(158)	634	124	(510)
Total	31,322	28,805	(2,517)	4,237	2,934	(1,303)	(629)	(1,933)	31,322	30,054	(1,268)