BOARD MEETING

DATE: **WEDNESDAY 7 OCTOBER 2015**

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

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

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

AGENDA

Agenda Item		Lead Member	
	Welcome to Members of the Public and the Press		
	Apologies for Absence		
1.	**Items for Approval**		
1.1.	Minutes of the Previous Board Meeting held on 5 August 2015	**BH**	*
1.2.	Running Action Note	**BH**	*
1.3.	Performance Management	**AMcM**	*
1.4.	Healthcare Associated Infection Update	**MJ**	*
1.5.	NHS Lothian Performance Delivery 2015/16	**AMcM**	*
1.6.	Audit & Risk Committee Minutes of 7 September 2015	**JMcD**	*
1.7.	Finance & Resources Committee - Minutes of 9 September 2015	**GW**	*
1.8.	Healthcare Governance Committee - Minutes of 28 July 2015	**MB**	*
1.9.	Strategic Planning Committee - Minutes of 13 August 2015	**BH**	*
1.10.	East Lothian Integration Joint Board - Minutes of 1 July 2015	**DG**	*
1.11.	Edinburgh Integration Joint Board - Minutes of 17 July 2015	**GW**	*
1.12.	Midlothian Shadow Integration Joint Board - Minutes of 18 June 2015	**CJ**	*
1.13.	West Lothian Shadow Integration Joint Board - Minutes of 2 June and 25 August 2015	**FT**	*
2.	**Items for Discussion** (subject to review of the items for approval) *(9:35am - 12:00pm)*		
2.1.	Review of Medical Paediatric Inpatient Services	**JC**	*
2.2.	Winter Plan 2015-16	**JC**	*
2.3.	Person-Centred Culture	**MJ**	*
2.4.	Acute Services Performance Update	**JC**	*
2.5.	Financial Position to August 2015	**SG**	*

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

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

2.6.	Workforce Risk Assessment	**DF/MJ**	*
2.7.	Quality Report	**DF/MJ**	*
2.8.	Corporate Risk Register	**DF**	*
2.9.	Transforming Older People's Services in Edinburgh	**AMcM**	*
2.10.	NHS Lothian Clinical Quality Approach	**TD**	*

3. **Next Development Session:** Tuesday 3 November 2015 at 9:30 a.m. in the Boardroom, Waverley Gate.

4. **Next Board Meeting:** Wednesday 2 December 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.	Quality Improvement	**TD**	v
9.	Any Other Competent Business		

Board Meetings in 2015	**Development Sessions in 2015**
	3 November 2015
2 December 2015	

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

DRAFT **1.1**

LOTHIAN NHS BOARD

Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 5 August 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; Mrs K Blair; Dr M Bryce; Councillor D Grant; Mr M Hill; Ms C Hirst; Professor J Iredale; Mr P Johnston; Mr A Joyce; Mrs J McDowell; Mrs A Meiklejohn; Mrs A Mitchell; Councillor F Toner; Mr G Walker 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: Ms F Ireland (Assistant Director - Nursing Workforce & Business Support) and Mr P Reith (Secretariat Manager).

Apologies for absence were received from Councillor R Henderson, Ms M Johnson, Councillor C Johnstone and Mr J Oates.

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.

30. Welcome and Introduction

30.1 The Chairman welcomed members of the public to the meeting. He introduced Mr M Hill and Ms C Hirst, both new Non Executive Board members appointed from 1 August 2015. Mr Ash asked that clarification be sought on whether members of Integration Joint Boards would require to declare an interest at Board and Integration Joint Board meetings.

31. Items for Approval

31.1 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.

31.2 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.

31.3 Minutes of the Board meeting held on 24 June 2015 – Approved.

31.4 Running Action Note – Approved.

31.5 Performance Management – The Board received the update on the existing performance against HEAT targets and other relevant standards.

31.6 Corporate Risk Register – The Board 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 of the circulated paper to inform assurance requirements. It was agreed to reflect on the current position that NHS Lothian remained outwith its risk appetite on corporate objectives where low risk appetite had been set. The Board noted that the June Audit and Risk Committee had approved the risk review findings and improvement plan.

31.7 Healthcare Associated Infection Update – The Board acknowledged receipt of the Healthcare Associated Infection reporting template for July 2015 and noted that NHS Lothian's staphylococcus aureus bacteraemia target was to achieve a rate of 0.24 per 1000 bed days (≤ 184 incidences) by March 2016 with a current rate of 0.40. The Board further noted NHS Lothian's clostridium difficile infection target was to achieve a rate of 0.32 per 100 bed days (≤ 262 incidences by March 2016 with a current rate of 0.35). The Board acknowledged receipt of draft Healthcare Associated Infection Standards Strategy and approval matrix. The Board also acknowledged and supported ongoing actions to address gaps identified within the response to the Vale of Leven enquiry recommendations.

31.8 Local Delivery Plan 2015/16 – The Board agreed to note the risks against delivery of the local delivery plan, particularly in relation to very high and high risk areas relating to delivery of local reinvestment plan savings and performance as set out in section 4.1 of the report. The Board also noted that a Quarter 1 review had taken place on 27 July in advance of the Annual Review on 3 August 2015.

31.9 Acute Hospitals Committee – Minutes of 8 June 2015 – Adopted.

31.10 Audit & Risk Committee – Minutes of 22 June 2015 – Adopted.

31.11 Finance & Resources Committee – Minutes of 8 July 2015 – Adopted.

31.12 Healthcare Governance Committee – Minutes of 26 May 2015 – Adopted.

31.13 Strategic Planning Committee – Minutes of 11 June 2015 – Adopted.

31.14 East Lothian Shadow Integration Joint Board – Minutes of 2 April and 18 June 2015 – Adopted.

31.15 Edinburgh Community Health Care Partnership – Minutes of 17 June 2015 – Adopted. The Board noted that East Lothian and Edinburgh Community Health Partnerships had now disbanded following the formal establishment of their Integration Joint Boards.

31.16 West Lothian Shadow Integration Joint Board – Action Note of 2 June 2015 – Adopted.

32. Delayed Discharges

32.1 Professor McMahon introduced a circulated report outlining the current position in relation to delayed discharges across the four Health and Social Care Partnerships. He explained that performance levels in the Edinburgh, and to a lesser extent East Lothian, Partnerships were having a significant impact on the number of patients being discharged from hospital who were waiting for a care home placement, care package or other form of community support, and therefore in turn on other key aspects of acute hospital performance. The paper highlighted the actions being taken and it was noted that the remodelling by Edinburgh and NHS Lothian of a previous private care home to provide 30 beds had eased pressure and reduced the number of patients waiting for residential care.

32.2 The paper also highlighted the actions being taken to provide a minimum of around 15 hours care at home. The rate of pay in Edinburgh had been increased but this was not translating into steady recruitment and short and medium options were being put forward.

32.3 Mrs Blair commented that the bridging finance from the Scottish Government was a short term fix and emphasised the importance of developing plans to deal with patients due to undergo elective procedures.

32.4 Professor McMahon emphasised that it was hoped to change the model of care over the next three years and that step down beds were helping to keep beds clear and patient flow moving. A paper was being commissioned to review the current options available to NHS Lothian, the City of Edinburgh Council and the Edinburgh Integration Joint Board. This would be discussed initially at the Edinburgh Leadership Group but would be aligned with proposals from the Midlothian and East Lothian Partnerships. A number of options detailed in the paper were under consideration and these needed to be clearly and explicitly tied together with the imperative to vacate Liberton Hospital and the Royal Victoria Hospital as rapidly as possible as well as the need to have in place long term sustainable models for consistent delivery.

32.5 Mr Crombie advised the Board that elective lists were populated up to 4 weeks ahead and were assessed on the basis of clinical priority. If another slot could be offered to patients in order to comply with the treatment time guarantee this would be done but the work involved in balancing this was quite difficult.

32.6 Mr Johnston asked if more detail could be provided on the lack of availability of care packages, particularly identifying if the problem was a recruitment or a budget issue.

32.7 Mrs Meiklejohn asked if details could be provided on how services were being remodelled on the House of Care model in order to reduce admissions. Councillor Grant commented that East Lothian had seen a 26% increase in demand for packages of care.

32.8 Professor McMahon advised that the career aspect was being discussed as well as how NHS Lothian could work with care home providers. Options for packages of care were being examined but there was some difficulty in finding providers. Professor Iredale commented that it would be necessary to examine the way in which patients were admitted and not just discharges.

32.9 Mr Hill commented there was a need to revisit the rest of the system and its bureaucratic processes in order to make it more responsive. Professor McMahon advised that the Integration Joint Boards had a firm position on working with NHS Lothian and the Leadership Group continued to examine these issues.

32.10 Mr Davison commented that three issues, supply, demand and budget, were important. The additional supply had been giving additional hours of care to some people and Edinburgh had added an extra 5000 hours per week over the past three years. In 2015/16 the council could not provide that extra supply and this had placed a greater stress on extra admissions to hospital. The winter plan would be coming to the October Board meeting and a decision would need to be taken on whether elective beds should be protected over the winter.

32.11 The Board noted the current performance based on the July information and statistics division census; noted that the Edinburgh performance reflected the highest number of people delayed in hospitals since 2007 and agreed to support the direction of travel being put forward in relation to actions that might be taken to improve performance in Edinburgh and East Lothian.

33. Inpatient Paediatrics Service at St John's Hospital

33.1 The Chair advised Board members that the report on inpatient paediatrics at St John's Hospital had been issued very late because its content had been awaiting the outcome of the meeting with the Cabinet Secretary for Health, Wellbeing and Sport on Monday 3 August.

33.2 Mr Crombie introduced a circulated report and advised that it was an amalgamation of a number of pieces of information of which members were already aware. NHS Lothian had continued to look at all options to cover the rotas for inpatient paediatric services and had been the subject of regular briefings to the Board over the past 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 from both medical and advanced nurse practitioner staff, the middle grade out of hours rota had remained fragile and was only covered on a month to month basis.

33.3 The rota supported the paediatric ward and the neonatal service overnight and at weekends. Around 2700 babies were born every year and whilst the paediatric inpatient service could be safely transferred to the Royal Hospital for Sick Children 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.

33.4 The Board noted that the rota had 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 waivers, to allow them to provide this cover on top of their fulltime day

jobs. Over the past 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.

33.5 The impact of the substantial reliance on a small workforce persistently working additional hours over the past few years was a cause for concern in terms of staff well being. On 3 separate occasions in June, the service had experienced a short notice out of hours rota gap with gave rise to significant concern.

33.6 Mr Crombie emphasised that the proposed review of paediatric services would not simply concentrate on the service at St John's Hospital but would encompass all of Lothian and would need to be carried out as quickly as possible.

33.7 Councillor Toner welcomed the previously announced reopening of the paediatric ward on 17 August and expressed his concerns over the service's long term future in West Lothian. He asked if it would be possible to enhance the services at St John's Hospital by transferring staff and services from the Royal Hospital for Sick Children.

33.8 Mr Crombie advised that the review would have to come up with a safe paediatric service across Lothian. The original estimate was that such a review would take about a year but he did not believe that this was now viable and considered that the report would need to be delivered as quickly as possible.

33.9 Councillor Toner asked if the new Royal Hospital for Sick Children would be detrimental to West Lothian and asked if specialist services could be moved from the Royal Hospital for Sick Children to St John's Hospital.

33.10 Dr Bryce commented that paediatric services would not be the only service that would require to be examined on a Lothian wide basis and the process for doing this would need to be clear. It would not be possible to determine the results of such a review in advance and there would need to be full engagement with all stake holders.

33.11 Mr Johnston questioned whether the figures were an accurate reflection of the numbers of patients treated at St John's and transferred from West Lothian. He welcomed the return of the 24 hours 7 days a week service at St John's Hospital and asserted that this provision was essential to meet local need. In welcoming the review he felt that this required to be clinician led, to take account of general practitioners and lay people as well as a pan Lothian voice. He felt it was important that this was a robust review in which everyone could have confidence and that to achieve this it was vital for the remit of the review to be agreed with lead clinicians.

33.12 Mrs Blair expressed her support for an independent and concise review and the obtaining of external advice. She expressed her concern about staff having to work excessive hours in order to maintain the present service.

33.13 Mr Walker supported the proposed review and emphasised that it could not simply look at St John's Hospital and should also examine incentives and how jobs at St John's Hospital could be made more attractive.

33.14 Councillor Toner moved the following amendment to the recommendations contained in the report:

"1.1 Acknowledge that there is still not a sustainable staffing model for the St John's Hospital paediatric service and that the out of hour's rota remains fragile.

1.2 Agree that a comprehensive review of Lothian's acute paediatric services should take place to determine how a sustainable model of working can be secured which would delivery a full paediatric service at St John's Hospital.

1.3 Agree that this review needs to be concluded as quickly as possible.

1.4 Agree that the scope, remit, membership and timescales for the review will be developed and agreed by the Boards Acute Hospitals Committee and Health and 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 and that membership should include the West Lothian Council stakeholder member.

1.5 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 3 years since the temporary closure in the summer if 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 the their normal daytime roles, and that the Board will continue to seek to recruit permanent paediatric staff for vacancies at St John's Children's Ward.

1.6 The Board gives an undertaking that there will be no downgrading of the paediatric service at St John's Hospital.

1.7 The Board thanks the staff at St John's and further afield for the commitment to providing a service at St John's Children's Ward."

33.15 The motion was seconded by Councillor D Grant.

33.16 There were 2 votes in favour of the amendment which was declared to be not carried and the Board therefore agreed the circulated recommendations to:

- Acknowledge that despite best efforts, there was 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.

- Agree that a comprehensive review of Lothian's Acute Paediatric Services needed to take place to determine how a sustainable model of working could be secured which balanced 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.

- Agree that this review needed 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.

34. Acute Services Performance Update

34.1 Mr Crombie introduced the circulated report giving an update on the performance of acute services.

34.2 Professor Iredale left the meeting.

34.3 Mr Crombie advised the Board that at the end of June, 349 patients were waiting beyond the 12 week treatment time guarantee and 389 were treated in month beyond the guarantee. Mr Crombie advised that a formal review of cancer services had been requested, especially tracking and moving forward of patients as quickly as possible.

34.4 The Board noted that a significant clinical resource in respect of consultant and nurse specialist would be starting and increased pressures on the front door in July were being encountered. Performance was currently at 96.5% indicating that the Board had recovered its earlier position.

34.5 Councillor Toner commented on the use of private sector work, particularly in endoscopy and Mr Crombie advised that it was a major objective to step back from the increased use of the private sector and with the addition of new staff it was hoped to reduce this as quickly as possible.

34.6 Mr Crombie advised that there was robust monitoring of the treatment time guarantee compliant and an oversight review of non treatment time guarantee specialties had been instructed as whilst these were not categorised as treatment time guarantee they were necessary. There had been no changes in categorisation since January 2014.

34.7 Mrs Allan congratulated Mr Crombie and the acute hospital staff on the targets achieved.

34.8 Mr Crombie commented that the results had been achieved through improvements in management and advised that the tagging of patients suspected to have cancer required to be improved. Some tracking elements had been lost in the process and in some rarer conditions just one person missed cold represent a high percentage.

34.9 Mr Hill commented that the figure for outpatients was up whilst he was aware that efforts were being made to reduce the number of unnecessary appointments.

34.10 Mr Crombie advised that the position was currently being reviewed but a spike in the number of referrals had been encountered. Sustained growth was being observed and there was a need to confirm that the pathway being used was evidence based. It was intended to update the GP referral system and a test that would help reduce the number of referrals to the gastrointestinal service was being examined as was the therapeutic value of a number of referrals.

34.11 Professor McCallum commented that work was underway to look at the possibility of flexing the flow of patients to match the availability of staff across the year.

34.12 Mr Davison advised that assurance was required that unavailability was not masking demand and it would be helpful If future reports could pick up the demand profiles

detailing how many patients had been added to the list in the first week of the reporting cycle.

34.13 The Board agreed to note the update on the acute services performance.

35. Workforce Risk Assessment

35.1 Dr Farquharson introduced the circulated report giving an update on the actions currently underway to ameliorate risks to service sustainability within specialties where high levels of risk had been identified. The scope of the paper had been widened to consider workforce risk within the wider workforce. It was noted that given the relatively short time interval between Board meetings, this paper only provided an update on areas where there had been significant change within this period.

35.2 The Board noted that, whilst obstetrics and gynaecology and paediatrics were experiencing significant difficulties in filling vacant posts and recruiting competent locums appointed for training, progress had been made appointing to a number of unfilled consultants and specialty doctor posts in medicine of the elderly and appointing to a number of unfilled consultant and specialty doctor posts in anaesthetics.

35.3 Increasing difficulty in filling consultant posts in psychiatry was widespread across Scotland and there were continuing difficulties in recruitment to the regional perinatal service in the Mother and Baby Unit and the Regional Eating Disorders at St John's Hospital.

35.4 It was noted that challenges were also being experienced in recruiting General Practitioners within primary care and GP practices and a paper would be brought to the next Board meeting to provide further details on practices that were facing workforce challenges and the work that was underway to support sustainability.

35.5 The implementation of the national nursing and midwifery workload and workforce planning tools, the development of health visiting workforce capacity, increased investment in advanced practice and the introduction of revalidation would be discussed further as part of the September Board Development Session. Dr Farquharson emphasised that although NHS Lothian were experiencing problems it was in a much better position than many other Health Boards.

35.6 Councillor Toner commented that he could not see details of the advertisement for a paediatrician at St John's Hospital on the NHS Lothian or Show website and Mr Boyter undertook to check this out.

35.7 Mr Boyter advised the Board that a full recruitment programme was ongoing and details of this would be shared with Board members.

35.8 Dr Farquharson emphasised that although a number of consultant posts were vacant, cover was being maintained and the Mother and Baby Unit East Lothian, the Royal Edinburgh Hospital and NHS Borders were all helping to provide cover and discussions were ongoing with Greater Glasgow and Clyde to provide mutual support.

35.9 Councillor Grant welcomed the report and commented that a Consultant appointment had recently been made at Roodlands Hospital.

35.10 Mr Davison commented that the situation in respect of the Mother and Baby Unit was still serious with only a few specialists in this field in the United Kingdom. Scotland only had 2 Consultants 1 of which was the vacancy in NHS Lothian.

35.11 Mrs Meiklejohn commented that it would be helpful to see information on other professions such as healthcare scientists where there were also key risks and Dr Williams asked if information on GP recruitment could also be included.

35.12 Professor McMahon advised that a paper would be discussed at the Strategic Planning Committee on 13 August.

35.13 Mrs Mitchell commented that the report did not contain timelines in terms of when vacancies might occur as retirement etc could be anticipated.

35.14 Dr Farquharson advised that most of the current turnover was as a result of maternity leave and the medical staffing position was much more fluid than it had previously been.

35.15 In response to a question from Mrs Blair, Dr Farquharson confirmed that staff who were leaving did have exit interviews but these had not revealed any overarching issue. One of the main reasons for moving was that the individual's partner had obtained another job somewhere else in the United Kingdom.

35.16 The Board agreed to recognise the steps that were being taken to both sustain the trained obstetrics medical workforce in the medium term and enhance patient safety with 24/7 resident Consultant cover. It acknowledged the workforce pressures that existed in relation to the provision of paediatric services at St John's Hospital and the need to introduce contingency arrangements in June and July.

35.17 The Board acknowledged that substantial gaps in the substantive work consultant workforce remained and there was heavy reliance on temporary staffing measures which had led to Roodlands Hospital having to close to admissions on recent occasions when gaps could not be filled.

35.18 The significant recruitment difficulties within both the Regional Eating Disorder Unit and the Regional Perinatal Mental Health Unit and the contingency arrangements that were in place whilst recruitment was underway and the ongoing discussion with regional partners was also noted. The Board also noted the increasing workforce pressures that were being faced by the hospital at night service and supported the development of contingency arrangements to ensure sustainability.

35.19 The Board noted the positive findings of the annual GMC trainee survey results and the work that would take place to address areas of concern that had been identified.

36. Quality Report

36.1 Dr Farquharson introduced the circulated quality report for July 2015 providing assurance on the quality of care NHS Lothian provided.

36.2 It was noted that whilst the data presented as part of the hospital scorecard indicated that NHS Lothian was an outlier for 28 day surgical and medical readmissions, the trend data provided by the Information Services Division suggested that this was normal cause variation illustrated by previous quarters' data not showing NHS Lothian as an outlier.

36.3 The number of formal complaints (excluding prisons) remained fairly stable and staff absence levels were over 4% with significant variation across NHS Lothian.

36.4 It was noted that the HEAT targets for reduction in C-difficile and staphylococcus aureus bacteraemia were not being achieved and a separate paper on the prevention and management of healthcare associated infection had been received earlier in the meeting.

36.5 It was noted that achieving the stroke standards for both admission to unit within one day and swallow screen on day of admission remained a challenge and a stroke review was taking place which was due to report to the Healthcare Governance Committee in November.

36.6 NHS Lothian had aligned its reporting of pressure ulcers into the Scottish Patient Safety Programme Measurement Framework and a pressure ulcer management review paper had been discussed at the Healthcare Governance Committee in July proposing a reporting framework inline with Scottish Patient Safety Programme goals.

36.7 Dr Farquharson advised that in respect of healthcare associated infection, 58 of the recommendations in the Scottish Government report had already been implemented in Lothian.

36.8 It was noted that a target of 50% reduction of pressure ulcers had been set and the increase in numbers reported was likely to have been as a cause of the previous under reporting of pressure ulcers. Approximately ¾ of the pressure ulcers appeared to be coming from the community.

36.9 Mr Boyter reported that a lot of work was going into staff absence levels and he reminded the Board that NHS Lothian had an aging workforce. A paper on this had recently gone to the Staff Governance Committee and it was agreed that this should be circulated to Board members for the September development day.

36.10 Ms Hirst advised that she had an interest in the area of complaints and would be asking questions on feedback and complaints. She commented that the best performing organisations amongst housing associations also received the most complaints.

36.11 Dr Wilson commented that the Healthcare Governance Committee had agreed an additional post in healthcare associated infection but this had not yet been recruited. It was noted that Ms Johnson would be reporting back on this.

36.12 The Board noted the quality dashboard and exception reporting informing of the assurance requirements.

37. Financial Position to June 2015

37.1 Mrs Goldsmith introduced a circulated report providing an overview of the financial position for the 3 months to June 2015.

37.2 Mrs Goldsmith commented that this subject had been well rehearsed with a number of the risks identified in the financial plan now materialising. The deterioration of the financial position was more significant than in previous years as there had been an emphasis on trying to take pressure off clinical areas. In order to achieve the objectives of the financial plan the previously identified efficiency savings would have to be achieved. A first quarter review with the Scottish Government had been held and meetings were being arranged with all parts of the service with proposals for action to be finalised by the end of August. A number of areas were being looked at and a number of actions to ensure the achievement of financial balance that had already been identified would be implemented. A number of other actions would be pursued by the management team to deliver financial balance which might require engagement with and support from the Scottish Government.

37.3 Mr Ash commented that 2 of the 4 Integration Joint Boards were now in place and they would have responsibility for seeing how budgets were applied. He asked if Mrs Goldsmith could liaise with council colleagues in order that these could be debated with the Integration Joint Boards.

37.4 Mrs Goldsmith advised that the figures relating to the areas of responsibility covered by the Integration Joint Boards would have to be extracted and she would give presentations to the Integration Joint Boards when this had been done.

37.5 Mrs Goldsmith advised the Board that financial planning was increasingly moving to business units and there had been feedback received that clinicians were happy to discuss resource in the context of quality but not LRP in isolation. There had been a useful discussion on this at the recent Finance & Resources Committee.

37.6 Councillor Toner asked when the detail of this would be available and Mrs Goldsmith advised that she would be happy to provide details of the Local Reinvestment Plan schemes behind the proposals.

37.7 Mr Davison commented that overspending in prescribing and nurse staffing in particular had contributed to the problem and it would be important to take a Board-wide approach in addressing these issues. NHS Lothian was now in the higher range of GP prescribing and these areas required to be addressed.

37.8 The Board agreed to note that the financial position at June 2015 showed an overspend of £6.3m across all services with implications for the achievement of a breakeven year end position and agreed the proposed actions to support the achievement of year end financial balance.

38. Legionnaires Outbreak in Edinburgh 2012

38.1 Professor McCallum advised the Board that a report on the outbreak of Legionnaires' disease in Edinburgh in 2012 had just been finalised and would be released to the public the following day having been made available to the families of those affected.

38.2 The Board noted that an investigation by the Health and Safety Executive and Lothian and Borders Police into the circumstances of the four Legionnaires' deaths was undertaken under the direction of the specialist Health and Safety Division of the Crown Office and Procurator Fiscal Service. As it has not been possible to identify the precise source of the Legionella bacteria which resulted in the death of four people, Crown Counsel has concluded that there is insufficient evidence to prosecute any person or organisation for the deaths.

39. Quality Improvement Academy

39.1 Mrs Blair asked how the Board would be given more information around the objectives, make-up, intended outcomes and likely spend of the proposed Quality Improvement Academy.

39.2 Mr Davison advised the Board that a business case for the Quality Improvement Academy would have to be produced and considered by the Board. He was chairing a steering group which would bring forward a business case to the October Board meeting.

39.3 The Board noted that the principle aim would be to improve the quality of the service and reduce costs. In order to achieve this more and better data and analytics would be required and the Quality Improvement Academy would help departments achieve this by training staff in the skills necessary to improve the service.

39.4 Mrs Blair stressed the importance of the way in which the Quality Improvement Academy was communicated to staff and emphasised the importance of dynamic leadership to achieve the desired results.

40. Consent Agenda

40.1 Mr Walker suggested that the operation of the consent agenda, which had been in place for over a year, should be reviewed, particularly with regard to the evolution of Integration Joint Boards which would now require more substantial reports.

40.2 The Chair agreed with Mr Walker's suggestion and undertook to come up with a specific proposal.

41. Date and Time of Next Meeting

41.1 The next meeting of the Board would be held between 9.30am and 12.30pm on the 7 October 2015, in the Board room, Waverley Gate, 2-5 Waterloo Place, Edinburgh, EH1 3EG.

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LOTHIAN NHS BOARD MEETING

RUNNING ACTION NOTE

1.2

Action Required	Lead	Due Date	Action Taken	Outcome
Scottish Public Services Ombudsman Case 201200092 (23/10/13)				
• Report to a future Board meeting on how NHS Lothian now deals with complaints and demonstrate the benefits in terms of improved performance.	**MJ**	Ongoing	*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 Relations and Feedback Team. A report on the options available will be produced by the end of January 2015.*	**In progress**
Workforce Risk Assessment				
• 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 Medical Director would consider how best to bring a paper to the Board to address the fundamental capacity issue in primary care.	**AB/DF** **DF**		*A paper on recruitment will be discussed at the Staff Governance Committee and then taken to the Board* *The Board Development Day on 14/1/15 highlighted the challenges on recruitment and retention in General Practice and the need to look at alternative models of care.*	**In progress** **Now addressed by the Corporate Risk Register and Workforce Risk Assessment papers**

Action Required	Lead	Due Date	Action Taken	Outcome
Improving Older People's Care in Edinburgh - 2015/2017 (24/06/2015)				
• A definitive strategy and costed action plan to be developed by September and presented to the Board in October 2015.	**AMcM**	September 2015		
Delayed Discharges (05/08/2015)				
• Provide more detail on the lack of availability of care packages, particularly identifying if the problem was a recruitment or a budget issue	**AMcM**	September 2015		
Workforce Risk Assessment(05/08/2015)				
• provide further details on practices that were facing workforce challenges and the work that was underway to support sustainability as well as information on other professions such as healthcare scientists and GP recruitment.	**DF**	September 2015	*Now addressed in the current report.*	
Consent Agenda (05/08/2015)				
• Bring forward proposals for a review of the Consent Agenda process.	**BH**	September 2015		

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NHS LOTHIAN

Board Meeting
7 October 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - PERFORMANCE MANAGEMENT

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

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

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

Andrew Jackson
Information Services
18 September 2015
andrew.c.jackson@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 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 on 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	Section 4.5
Reduction in Emergency Bed Days	Red	JC/DF/PG/ EM/DS	Section 4.6
Clostridium difficile Infection (CDI) and Staphylococcus aureus Bacteraemia (SAB)	Red	MJ	Board Healthcare Acquired Infection Update
4 Hour Unscheduled Care performance	Red	JC	Board Acute Services Performance Update
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	Board Acute Services Performance Update
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 available from ISD on Smoking Cessation covers up to 31/03/2015 and shows that the Board's performance was 1104 successful quits against a target of 1765, a shortfall of 37.5%.

4.2 Early Access to Antenatal Care

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

The latest data available from ISD covers up to 31/03/2014 and shows that the Board's performance was 85.4% ahead of the target of 77%.

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

4.3 Carbon Emissions and Energy Efficiency

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

Over 2014/5, reduction of CO_2 is 5.67% worse than target at 27,755 tonnes of reported emissions against a target of 26,666 tonnes.

Reduction of energy was 4.84% better than the target of 868,531 GJ at 849,930 GJ for 2014/5.

4.4 Child and Adolescent Mental Health Services and Psychological Therapies

(Responsible Director: Joint Director, West Lothian)

The waiting times performance trends and trajectories for CAMHS and Psychological Therapies are detailed in the following tables. In July 67% of children and young people were seen within 18 weeks for first treatment whilst in psychological therapies, performance was 45%. Both areas have a 90% standard and an action plan to progress improvement was recently discussed with the Health Minister.

CAMHS Performance Trend

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Percentage seen within 18 weeks	67%	63%	69%	57%	52%	53%	51%	50%	62%	58%	57%	60%	67%
Trajectory for seen within 18 weeks	88%	88%	88%	90%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Total waiting at end of month	1,553	1,565	1724	1,680	1,678	1,784	1,651	1,699	1,704	1,687	1,709	1,708	1,716
Those waiting more than 18 weeks	514	601	623	526	492	494	428	446	445	478	472	509	646

Psychological Therapies Performance Trend

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Percentage seen within 18 weeks	52%	32%	52%	40%	36%	36%	44%	34%	41%	39%	44%	40%	45%
Initial Trajectory for seen within 18 weeks	82%	83%	86%	88%	90%	90%	90%	90%	90%	90%	90%	90%	90%
Total waiting at end of month	2442	2542	2645	2911	3010	3113	3095	3105	3176	3190	3341	3261	3314
Those waiting more than 18 weeks	802	814	859	910	1018	1144	1201	1167	1237	1254	1257	1173	1232

4.5 Delayed Discharges

Responsible Directors: Chief Officer and Joint Directors

Overall delays in NHS Lothian, outwith the monthly (ISD criteria) census rules, have averaged around 420 patients recorded since the start of 2014/5 compared to 380 across 2013/4. A recent reduction is however evident, as shown in the figure and table below.

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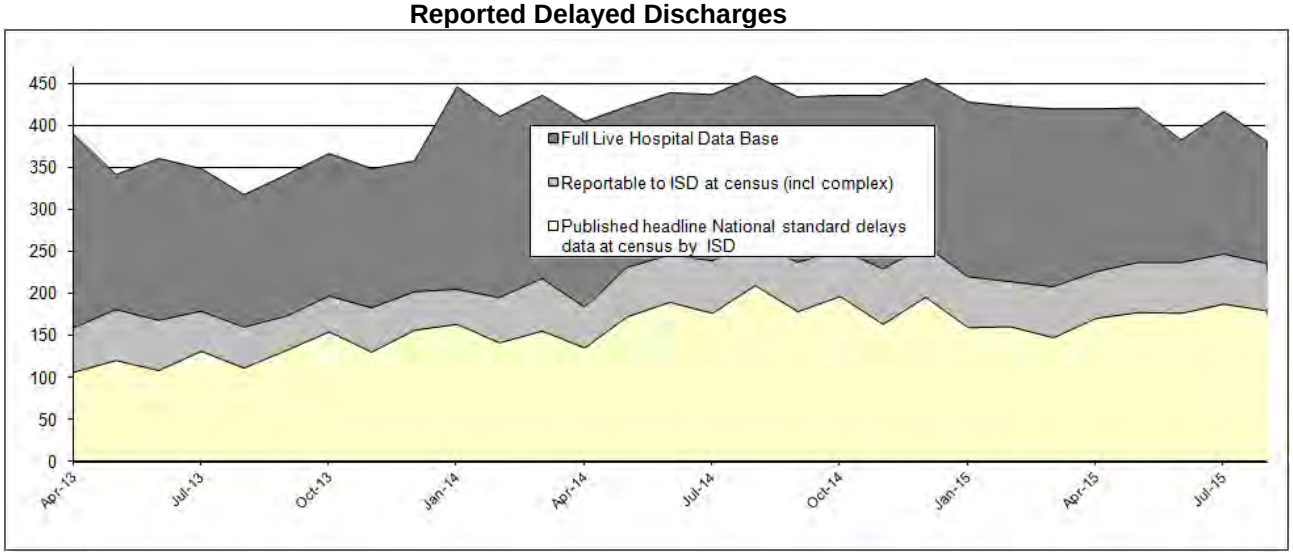
Reported Delayed Discharges



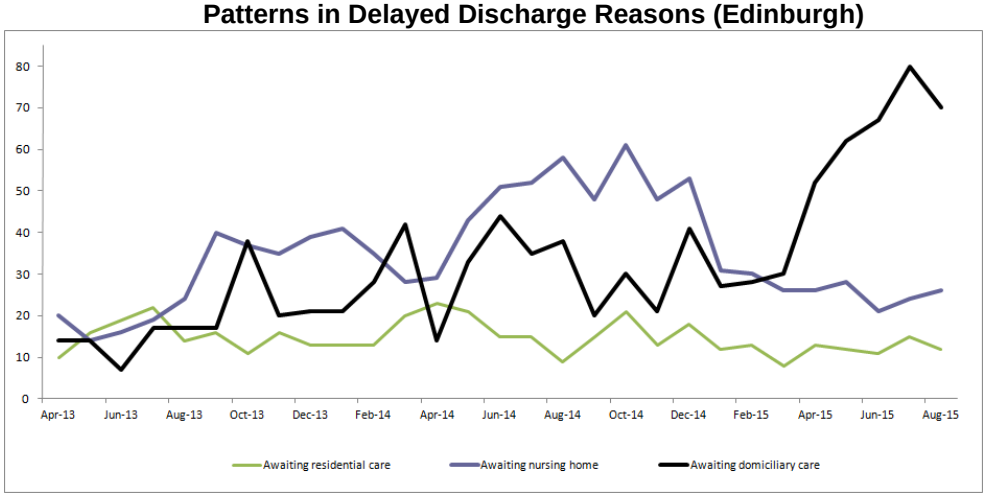
Breakdown of Delayed Discharge Numbers

	May	June	July	August
All Delays Recorded	421	403	403	382
All ISD Reportable Delays	238	238	248	237
ISD Delays excluding X codes	178	177	188	180
• hose over 2 weeks	105	99	104	85
• hose over 4 weeks	70	63	69	57

From the local authority perspective, East Lothian have improved their position roughly halving the number of delays from between 35-40 delays earlier this year, while Midlothian and West Lothian have been able to maintain low numbers. Edinburgh however remains a challenge with 133 of the 180 delays reported excluded X (complex) codes. Home care packages

continue to be the single biggest reason for delay in the city, a change evident from around the turn of the financial year as shown in the following graph.

Patterns in Delayed Discharge Reasons (Edinburgh)



4.6 **4.5 Reduction in Emergency Bed Days**
(Responsible Directors: Chief Officer and Joint Directors)

The latest data provided by ISD on rate of occupied bed days per 1,000 population (75+) covers up to 31/03/2015. The Board's performance is 4,978 against a target of 4,709 (5.7% worse than target).

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.

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.

Andrew Jackson
Information Services
18 September 2015
andrew.c.jackson@nhslothian.scot.nhs.uk

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NHS LOTHIAN

1.4

Board Meeting
7 October 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.

• Progress against Health Efficiency Access Treatment Targets	3.1
• *Staphylococcus aureus* Bacteraemia: NHS Lothian's *Staphylococcus aureus* Bacteraemia target is to achieve a rate of 0.24 per 1000 bed days (≤184 incidences) by March 2016 with a current rate of 0.33.	3.2
• *Clostridium difficile* Infection: NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days (≤262 incidences by March 2016 with a current rate of 0.40.	3.3
• Mandatory Surgical Site Infections**:** during April to June 2015 there were 1130 procedures performed and 8 Surgical Site Infections detected with a rate of 0.7%.	3.4
• *Escherichia coli* Bacteraemia: implementation phase of the data collection for the National Surveillance commenced 1 September 2015. Mandatory surveillance will commence on 1 April 2016.	3.5
• Meticillin Resistant *Staphylococcus aureus* Screening Programme: for 2014-15 NHS Lothian indicated an overall Clinical Risk Assessment compliance of 64% and compliance with swabbing 78%.	3.6
• Antibiotic Prescribing Guidelines: revised prescribing indicators were implemented from July 2015.	3.7
• Decontamination: building of the two new centralised endoscopy decontamination units at the Royal Infirmary of Edinburgh and Western General Hospital has commenced and progressing well.	3.8
• Healthcare Environmental Inspectorate: the 16 week action plan update following the unannounced inspection at the Royal Infirmary of Edinburgh on 28-29 April 2015, was returned by the deadline of 2 September 2015. A request to update the Inspectorate on the 2 partially met requirements following the inspection on 26-27 May 2015 has been received with a submission date of 29 September 2015.	3.9

Fiona Cameron
Head of Infection Prevention and Control Services
17 September 2015
fiona.cameron@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 2015

Executive Nurse Director

HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Committee 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 Monthly 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 Committee is recommended to:

- 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 0.33.
- 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 0.40.

3 Discussion of Key Issues

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

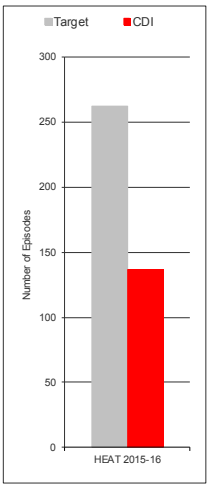


Figure 1: No. of CDI Episodes 2015-16

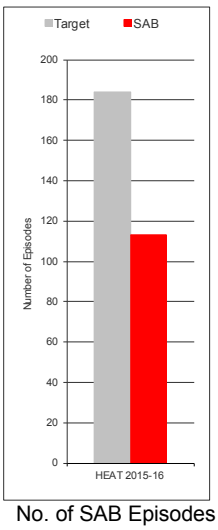


Figure 2: No. of SAB Episodes 2015-16

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 0.33 (Appendix 1, figure 3.2).

There were 16 episodes of *Staphylococcus aureus* Bacteraemia in August 2015 (1 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus*

aureus), compared to 17 in July 2015 (2 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*). Incidence rates in NHS Lothian continue to show natural variation. Appendix 1, figure 2.1 shows between June 2014 and April 2015 NHS Lothian has seen an upward shift in the numbers reported. In the last 4 months this shift is beginning to show signs of reversal. There was an outlying data point in April 2015 where the data was out with the warning limit.

Target Date	Target	Actual
Year Ending 31/3/2013	213	255
Year Ending 31/3/2014	219	243
Year Ending 31/3/2015	184	282
Year Ending 31/3/2016	184	113*

* Cumulative to date

Key Messages:

- It is proposed peripheral venous catheter related *Staphylococcus aureus* Bacteraemia to be treated as severe adverse event utilising DATIX incident reporting system. A draft process has been developed in conjunction with Clinical Governance, to be tabled at Clinical Management Group meeting in September for approval.
- One Year fixed term Education Facilitator and Quality Improvement Facilitator posts to commence from October 2015. Part of these roles will be to support review of procedures and practice, and develop a 90 day improvement cycle in relation to Peripheral venous catheter related *Staphylococcus aureus* Bacteraemia.

3.3 *Clostridium difficile* Infection: NHS Lothian's *Clostridium difficile* Infection target is to achieve a rate of 0.32 per 1000 bed days (≤262 incidences) by March 2016 with a current rate of 0.40. (Appendix 1, figure 3.1).

There were 36 episodes of *Clostridium difficile* Infection in patients aged 15 or over in August 2015, compared to 26 in July 2015. Incidence rates in NHS Lothian for age 15-64 continue to show natural variation. Appendix 1, figure 1.1 shows the incidence rate in NHS Lothian for age group 15-64 years indicates the process is showing random variation, however there are a few significant data points which are out with the warning limit. Appendix 1, figure 1.2 shows Incidence rates in NHS Lothian for age 65 years showing a shift in process, six or more data points in a run below the mean.

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	137*

* Cumulative to date

Key Messages:

- Health Protection Scotland, HAI Executive lead for NHS Lothian and key members of Infection Prevention and Control reviewed NHS Lothian data to interrogate data further. Increased incidence in Quarter 3 in 2013/14 and 2014/15 is being investigated further.

- Since the revision of UHS Antibiotic Prescribing Guidelines which promote use of narrow spectrum antibiotics for empirical treatment of infection, a reduction in the use of broad spectrum "4C" antibiotics and an increase in Gentamicin use has been observed. Possible adverse effects of increased Gentamicin prescribing are being closely monitored.

3.4 Mandatory Surgical Site Infections (SSIs)**:** Infection rate remains below national average across the mandatory surveillance streams (Hip Arthroplasty and Caesarean Section). During April to June 2015 there were 1130 procedures performed and 8 Surgical Site Infections detected with a rate of 0.7%.
The Surgical Site Infection rate for caesarean section (inpatient and post-discharge surveillance to day 10) for NHS Lothian is marginally down this quarter from 1.0% to 0.8%. 6 Surgical Site Infections reported were post-discharge caesarean section infections and classified as superficial infections.
The remaining 2 Surgical Site Infections were reported for hip arthroplasty this quarter. Both the Surgical Site Infections were re-admission up to day 30, one was a superficial infection the other an organ space infection.

3.5 *Escherichia coli* Bacteraemia: implementation phase of the data collection for the National Surveillance commenced 1 September 2015. As part of this project, Health Protection Scotland have provided Boards with a surveillance protocol and data entry sheet for the submission of the data. Mandatory surveillance will commence on 1 April 2016.

3.6 Meticillin Resistant *Staphylococcus aureus* Screening Programme: the annual report for 2014-15 for NHS Lothian indicated an overall Clinical Risk Assessment compliance of 64% and compliance with swabbing 78%.

3.7 Antibiotic Prescribing Indicators: revised prescribing indicators were implemented from July 2015 and are as follows:

- All prescribed doses are administered or the reason for omitting dose(s) is documented on the medicine chart.
- The indication for antibiotic treatment is documented in the medical notes.
- Anticipated duration for oral treatment is documented on the medical chart.
- Anticipated duration IV antibiotics are documented or review of treatment within 72 hours of starting is documented on the medicine chart.
- Antibiotic treatment is compliant with local prescribing protocol or the reason for deviation is documented in the medical notes.

Twenty patient cases/kardexes are reviewed on one medical and one surgical ward each month at the Royal Infirmary of Edinburgh, Western General Hospital and St Johns Hospital. The most recent set of results show that compliance is at or above target at >95% of cases reviewed for all three acute sites for all of the indicators except for antibiotic duration which was below target level at 40-60% of cases audited in all the sites.

3.8 Decontamination: decontamination is overseen by the Decontamination Project Board. This group has responsibility for taking forward major projects to allow NHS Lothian to meet and maintain compliance with current extant decontamination standards and guidance.

Key Messages:

- Building of the two new centralised endoscopy decontamination units at the Royal Infirmary of Edinburgh and Western General Hospital has commenced and progressing well, including procurement of endoscope washer disinfectors.
- A specification for a NHS Lothian Tracking and Traceability system has been developed and funding has been approved.
- The dental local decontamination unit at St John's is now in use. This gives NHS Lothian five complaint 2-room local decontamination units, compliant with Scottish Health Planning Note (SHPN) 13 part 2.
- A decision on the way forward with podiatry decontamination is still under discussion. A mixed model of using compliant dental local decontamination units and single-use instruments is the likely outcome.

3.9 Healthcare Environment Inspectorate: the 16 week action plan update following the unannounced inspection at the Royal Infirmary of Edinburgh on 28-29 April 2015, was returned by the deadline of 2 September 2015. A request to update the Inspectorate on the 2 partially met requirements following the inspection on 26-27 May 2015 has been received with a submission date of 29 September 2015.

The Inspectorate have written to all NHS Scotland Boards on 10 July 2015 to advise of changes to the inspection methodology. These changes will take effect in October 2015 and will include:

- Updating key tools and templates
- Two week delay in publishing report/action plan. This will allow one extra week immediately following inspection to engage with Boards and an extra week for Boards to develop their action plans.

4 Key Risks

4.1 The key risks associated with the recommendations are:

- *Staphylococcus aureus* Bacteraemia increases the burden of illness, the risk of additional treatment and an extended stay in hospital.
- Factors influencing exceedance of the Health Efficiency Access Treatment Target for *Clostridium difficile* Infection are actively being investigated. Compliance with antimicrobial prescribing guidelines continues to be promoted.
- Based on current data for both *Clostridium difficile* Infection and *Staphylococcus aureus* Bacteraemia NHS Lothian is currently reporting amber for progress against the Health Efficiency Access Treatment Target.

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
17 September 2015
fiona.cameron@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Clinical Management Group Quarterly Infection Report July 2015
Appendix 2: Healthcare Associated Infection Reporting Template for July 2015

APPENDIX 1

NHS Lothian Monthly Infection and Antimicrobial Report - September 2015

Date produced: 7th September 2015

This report is in development. The intial focus for development has been the acute sites.
A more comprehensive report is available quarterly. Brief commentary is provided alongside each figure.

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

Contacts

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

Antimicrobial data barbara.moore@nhslothian.scot.nhs.uk

Primary Data sources

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

Activity data: TRAK oracle

Infections data: Apex labs system

Please see individual sheets for other data sources

Abbreviations

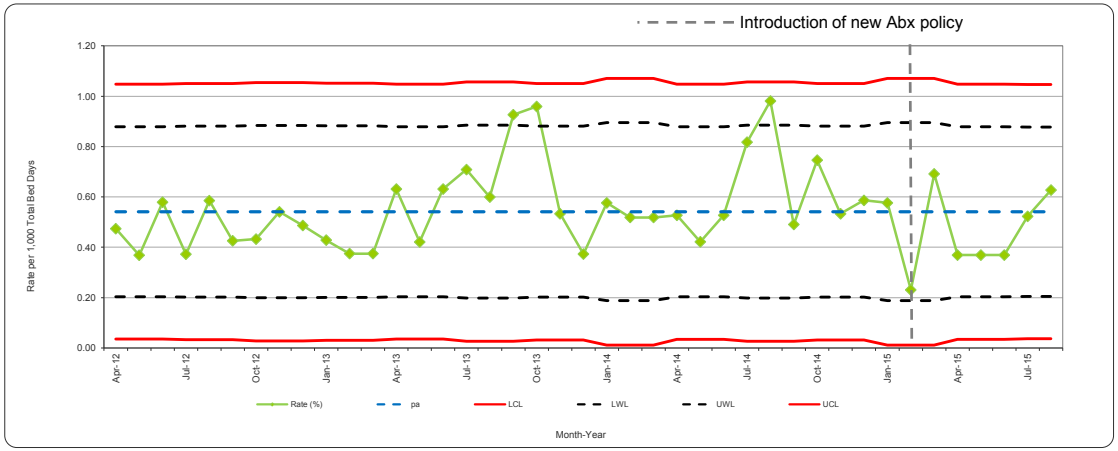
DDD - Defined Daily Dose
The DDD is the assumed average maintenance dose per day for a drug used for its main indication in adults.

OBD - Midnight Occupied Bed Days

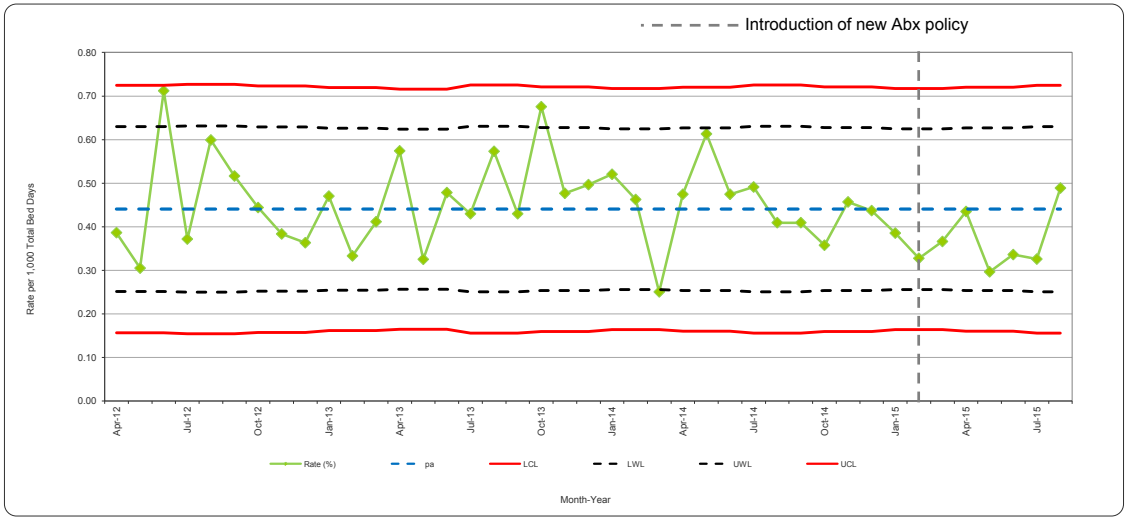
CDI - Clostridium difficile infection

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

1.1 u-chart - NHS Lothian CDI rate per 1,000 bed days for15-64 year age group (Apr 2012-Aug 2015)



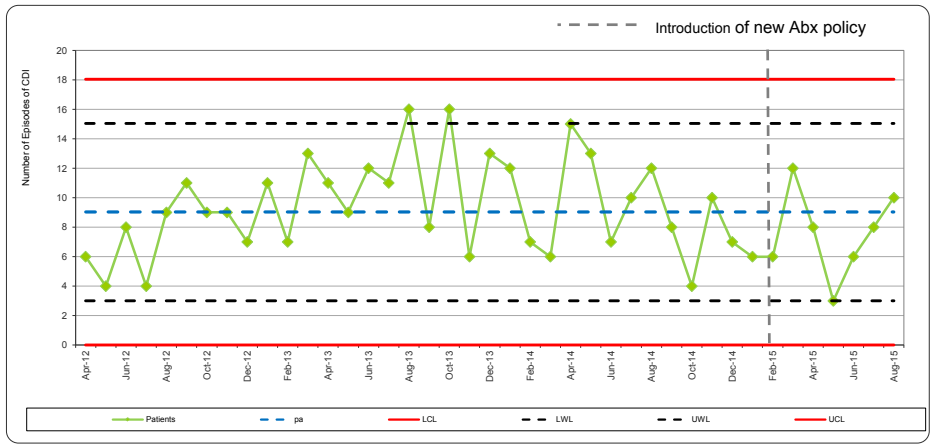
1.2 u-chart - NHS Lothian CDI rate per 1000 OBDs for 65 year and over age group (Apr 2012-Aug 2015)



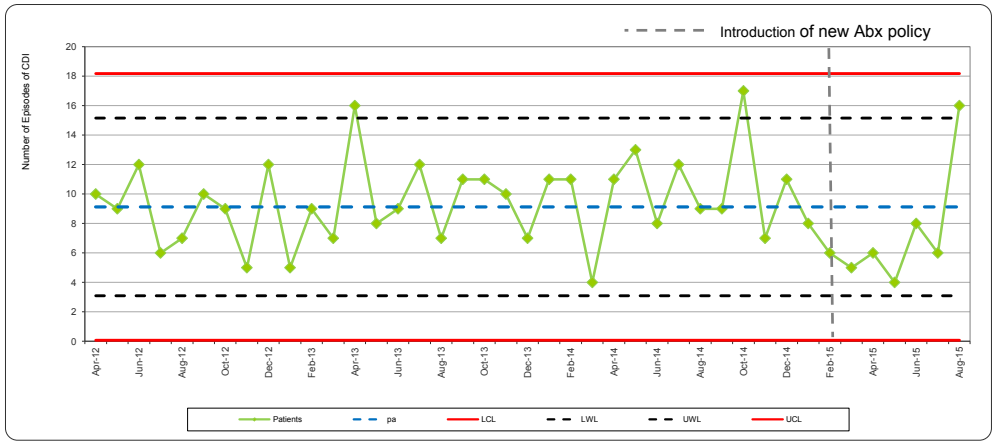
Source: IPCT
All data
Figure 1.1 shows the incidence rate in NHS Lothian for age group 15-64 years indicates the process is showing random variation.

Figure 1.2 shows incidence rates in NHS Lothian for age 65 years and over showing a shift in process, six or more data points in a run below the mean. However this shift has not been sustained.

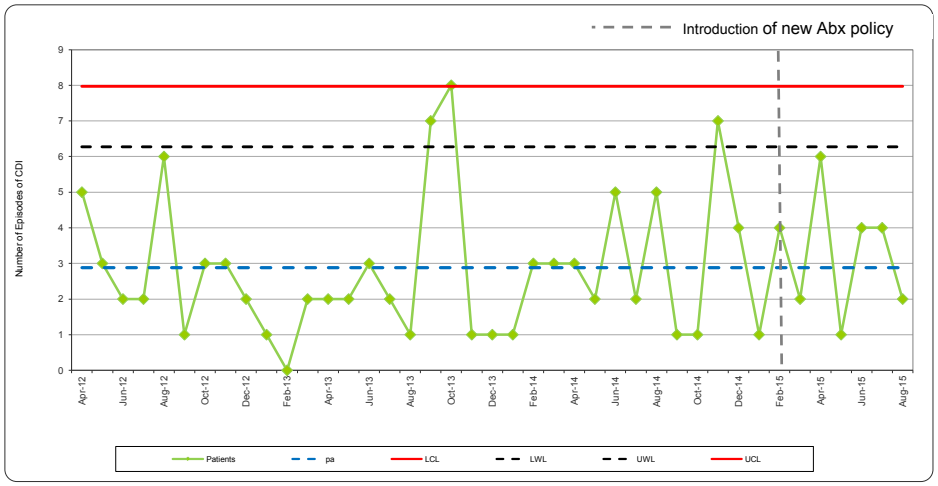
1.3 c-chart of number of episodes of CDI per month in RIE in pts aged 15+ (Apr 2012-Aug 2015)



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



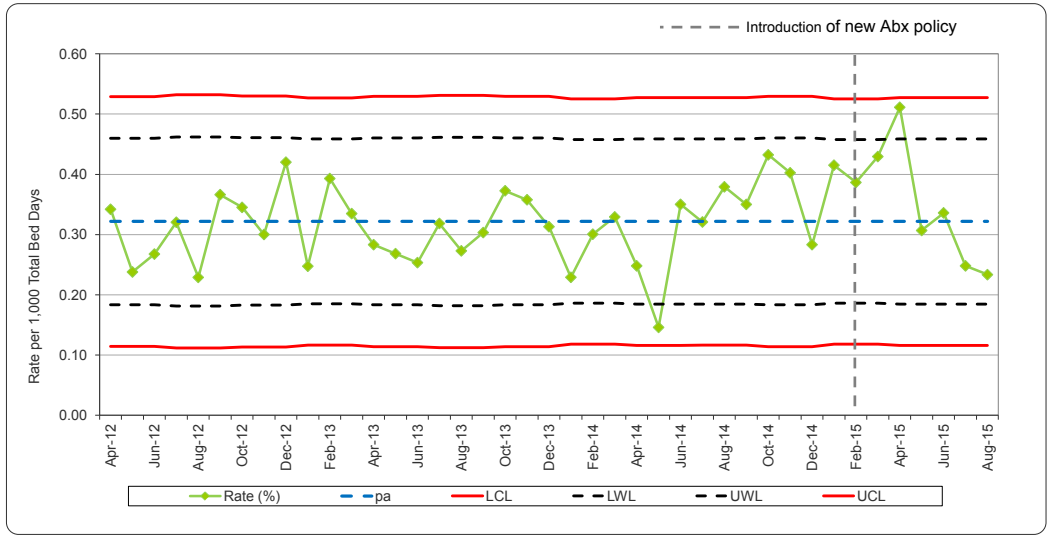
1.5 c-chart of number of episodes of CDI per month in SJH in pts aged 15+ (Apr 2012-Aug 2015)



Source: IPCT
All data
Incidences for RIE and SJH indicate the process is showing random variation.

Incidence for WGH showed a shift in process, six or more data points in a run below the mean for the period January to July 2015. However there was a significant data point which was out with the upper lcontrol imit in August 2015. Detailed investigation of each case has been undertaken buy Consultant Microbiologist and Infection Prevention & Control Team. There appears to be nothing to suggest that these cases are linked as a result of cross transmission within any particular clinical area.

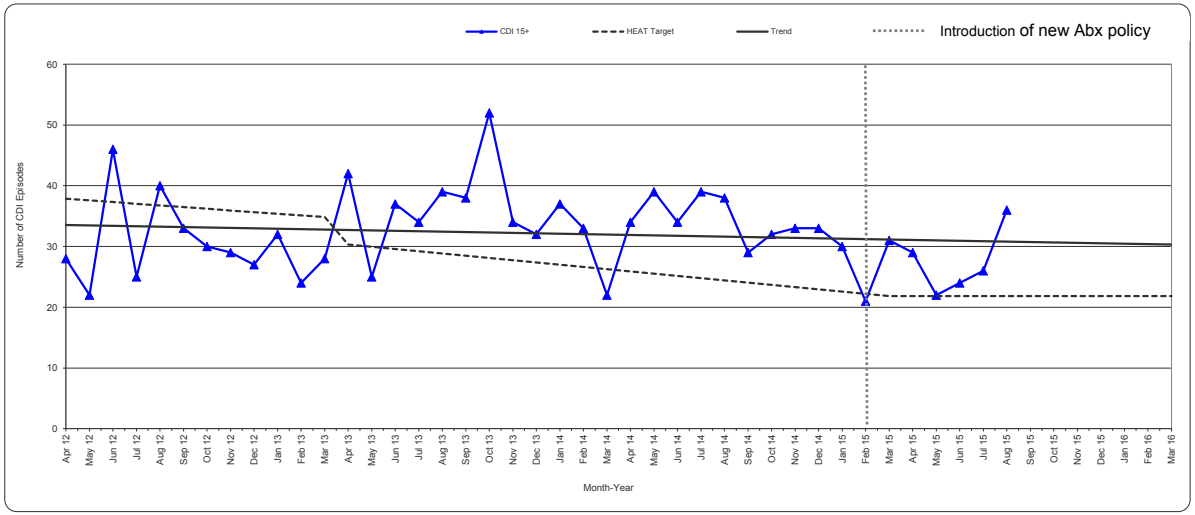
2.1 u-chart - NHS Lothian *Staphylococcus aureus* Bacteraemia rate per 1000 OBDs (Apr 2012-Aug 2015)



Source: IPCT
All data

Figure 2.1 shows between June 2014 and April 2015 NHS Lothian has seen an upward shift in the numbers reported, however this shift has not been sustained. In the last 4 months this shift is beginning to show signs of reversal.

3.1 CDI Progress against HEAT target - NHS Lothian

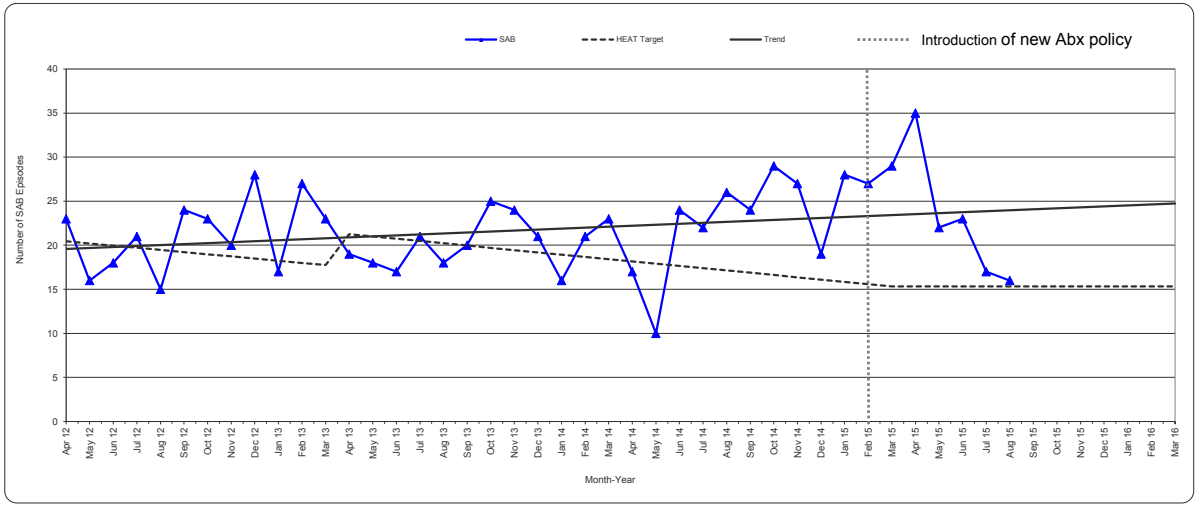


Source: IPCT
All data

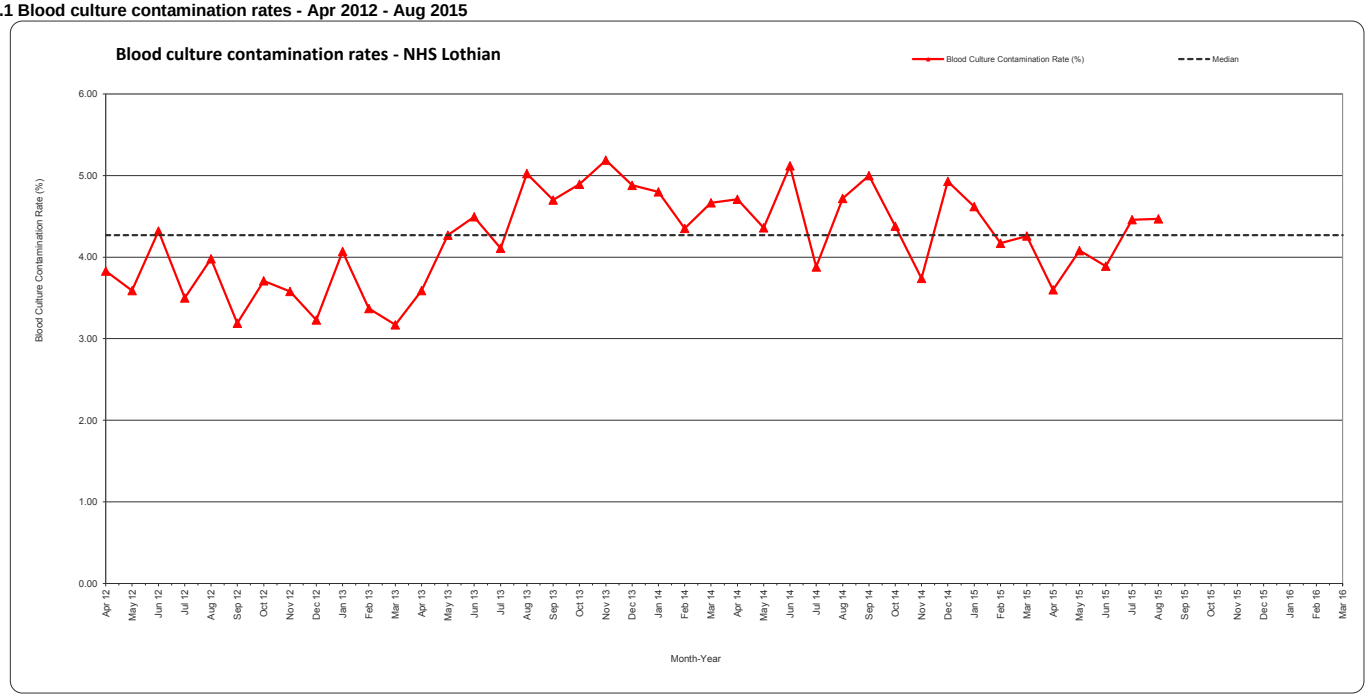
NHS Lothian's *Clostridium difficile* Infection Health Efficiency Access Treatment Target is to achieve a rate of 0.32 cases or fewer per 1000 total occupied bed days (<262 incidences) by March 2016 in patients aged 15 and over, with a current rate of 0.40 (137 incidences). NHS Lothian not achieving the HEAT target for *Clostridium difficile* Infection. Seasonal variation has been observed in previous years for the period July to September and the reasons for this are not yet fully understood. Continuing to see this trend this year.

NHS Lothian's *Staphylococcus aureus* Bacteraemia Health Efficiency Access Treatment Target is to achieve a rate of 0.24 cases or fewer per 1000 acute occupied bed days (<184 incidences) by March 2016 with a current rate of 0.33 (113 incidences). NHS Lothian not achieving the HEAT target for *Staphylococcus aureus* Bacteraemia.

3.2 SABs progress against HEAT target - NHS Lothian



4.1 Blood culture contamination rates - Apr 2012 - Aug 2015



Source: IPCT
All data
No change in rate over last year.

Notes:

During August 2015 there were 3,442 sets of blood cultures taken in NHS Lothian. Of these, 154 (4.47%) of the blood culture was considered to be contaminated.
During the previous 12-month period, there were a total of 45,070 blood cultures collected of which 4.31% were considered to be contaminants.

4.2 Ward closures

No up to date aggregate data are currently available.

4.3 Number of wards that have exceeded CDI trigger levels (Sep 2014 to Aug 2015)

LocationDescription	2014-09	2014-10	2014-11	2014-12	2015-01	2015-02	2015-03	2015-04	2015-05	2015-06	2015-07	2015-08	Grand Total
RIE Ward 107	1	1	2	1	2	0	0	1	0	1	2	0	11
RIE Ward 206	1	1	2	2	0	0	0	2	2	0	1	0	11
WGH ARAU Beds	0	2	0	1	1	1	0	2	0	1	0	2	10
RIE Ward 207	0	1	2	0	0	1	0	1	0	1	1	0	7
SJH Ward 8	0	1	1	1	0	1	0	2	0	0	0	0	6
WGH Ward 53	1	2	0	1	0	0	0	0	0	0	0	2	6
AAH Charles Bell Pavilion 1	0	0	1	1	2	0	1	0	0	0	0	0	5
RIE Ward 105	0	0	2	1	0	0	1	0	0	0	1	0	5
SJH Ward 9	0	0	1	1	0	0	0	0	0	3	0	0	5
WGH Ward 56	2	0	0	1	1	0	1	0	0	0	0	0	5
WGH Ward 8	0	0	1	0	1	0	0	0	1	0	2	0	5
GP: Tranent Medical Practice	2	0	0	1	0	0	1	0	0	0	0	0	4
GP: University Health Service	0	0	0	0	1	0	0	0	1	0	2	0	4
RIE Ward 104	0	0	1	1	0	0	0	0	0	0	0	2	4
RIE Ward 118 ITU	0	0	0	0	0	1	3	0	0	0	0	0	4
RIE Ward 206 Transplant	1	0	0	0	0	0	0	0	0	1	0	2	4
RIE Ward 208	0	0	0	0	1	0	2	0	0	0	1	0	4
SJH Medical Assessment Unit	0	0	0	1	0	2	0	1	0	0	0	0	4
WGH Ward 24	0	2	0	0	0	0	0	1	0	1	0	0	4
WGH Ward 52	0	0	0	0	0	0	1	0	0	2	0	1	4
WGH Ward 8 Unit	0	2	0	0	0	0	1	0	0	0	0	1	4
RIE Combined Assessment Area 6	1	0	0	0	0	0	2	0	0	0	0	0	3
RIE Ward 120	2	0	0	0	0	0	0	1	0	0	0	0	3
WGH ARAU Bed Area 2	0	0	0	0	0	0	0	0	0	0	0	3	3
WGH Ward 2	0	2	0	1	0	0	0	0	0	0	0	0	3

Source: IPCT
All data
These represent clinical areas where there have been > 2 CDI in the given time period - the highlighting illustrating how many CDIs there have been in the given time period.

5.1 Monthly medication error Datix reports - all NHS Lothian sites

	Financial year 2014/15							2015/16				
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Number of medication error reports	219	261	215	213	221	190	273	262	270	203	226	203
Number related to gentamicin	0	1	0	1	0	2	6	6	3	3	2	2
% related to gentamicin	-	0.4%	-	0.5%	-	1.1%	2.2%	2.3%	1.1%	1.5%	0.9%	1.0%

Source: Datix, All data
The antimicrobial policy changed in Feb 2015. Following an apparent decline in medication Datix reports in February, the number of medication error Datix reports increased in March, April and May in NHS Lothian, driven by the increase in the RIE and WGH (see below). Please use the gentamicin figures for the most recent month with caution and see the notes below . Due to small numbers this data needs to be considered with caution.

5.2 Monthly medication error Datix reports - Royal Infirmary of Edinburgh

	Financial year 2014/15							2015/16				
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Number of medication error reports	68	73	55	51	54	43	66	83	68	44	64	60
Number related to gentamicin	0	0	0	1	0	1	2	3	1	2	0	0
% related to gentamicin	-	-	-	2.0%	-	2.3%	3.0%	3.6%	1.5%	4.5%	-	-

Chart 5.1 NHS Lothian Medication error Datix reports

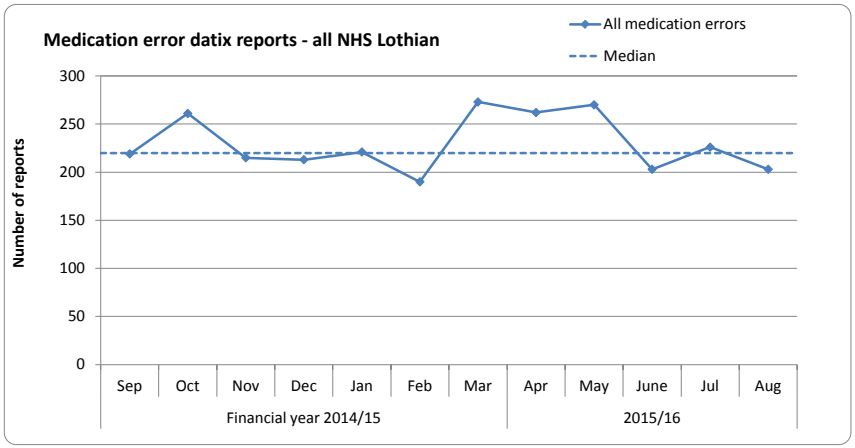
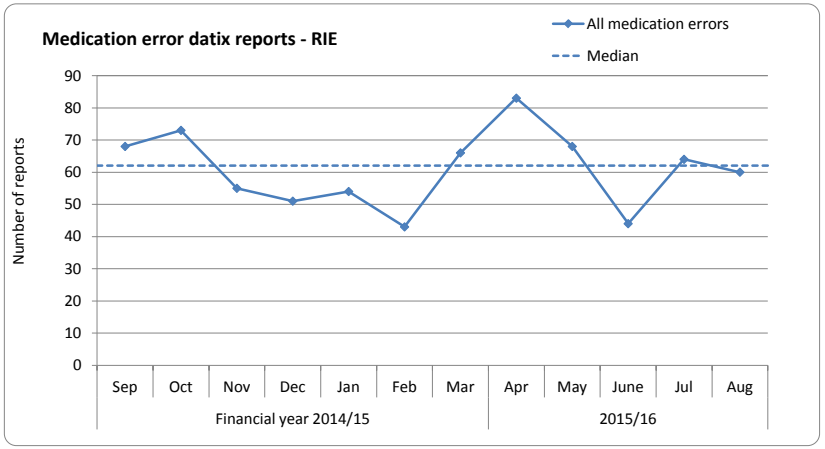


Chart 5.2 RIE Medication error Datix reports



5.3 Monthly medication error Datix reports - Western General Hospital

	Financial year 2014/15							2015/16				
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Number of medication error reports	61	59	57	59	63	49	82	49	77	54	50	54
Number related to gentamicin	0	0	0	0	0	0	3	2	1	1	0	1
% related to gentamicin	-	-	-	-	-	-	3.7%	4.1%	1.3%	1.9%	-	1.9%

Source: Datix, All data
The antimicrobial policy changed in Feb 2015. Following an apparent decline in medication Datix reports in February, the number of medication error Datix reports increased in March and May in WGH, but only a small percentage have been attributed to gentamicin. Figures for SJH have remained relatively stable. Please use the gentamicin figures for the most recent month with caution and see the notes below . Due to small numbers

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

	Financial year 2014/15							2015/16				
	Sep	**Oct**	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**
Number of medication error reports	18	27	16	22	23	20	20	17	22	16	13	17
Number related to gentamicin	0	0	0	0	0	0	1	0	0	0	2	0
% related to gentamicin	-	-	-	-	-	-	5.0%	-	-	-	15.4%	-

Chart 5.3 WGH Monthly medication error Datix reports

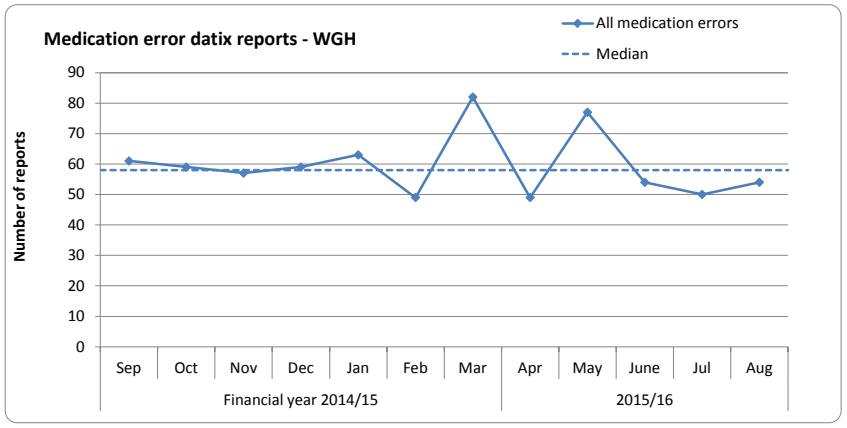
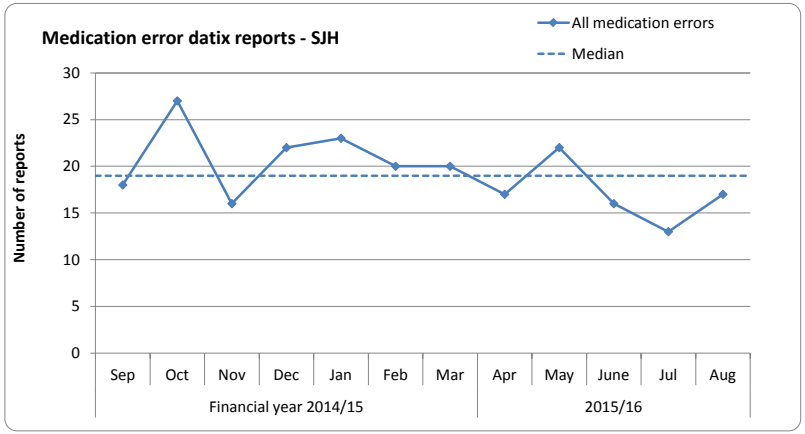


Chart 5.4 SJH Monthly medication error Datix reports



Adverse events - medication adverse events in and number related to gentamicin

Source: DATIX; data extracted 01/09/2015
Notes:
1: Data as at 01/09/2015.
2: Adverse events are recorded in 'real-time', therefore the total number of medication error reports for August (to date) are assumed to be accurate. However, it is not mandatory to record the drug involved when initally recording a medication adverse event and this is often only added to the database once the adverse event has been investigated.
For this reason, please use the gentamicin adverse events figures for August with caution.

NHS LOTHIAN

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
MRSA	4	3	4	1	3	1	2	6	1	3	2	1
MSSA	20	26	23	18	25	26	27	29	21	20	15	15
Total	24	29	27	19	28	27	29	35	22	23	17	16

Clostridium difficile Infection **Monthly Case Numbers**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Age 15-64	9	14	10	11	10	4	12	7	7	7	10	12
Age 65 plus	20	18	23	22	20	17	19	22	15	17	16	24
Total	29	32	33	33	30	21	31	29	22	24	26	36

Hand Hygiene Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
AHP	96.74	93.92	94.86	95.49	95.29	95.74	96.53	94.56	98.35	94.21	96.34	-
Ancillary	90.77	94.70	91.58	93.19	89.34	92.33	92.52	88.89	90.11	94.44	94.79	-
Medical	93.69	94.39	93.45	90.91	94.04	92.81	93.61	93.57	94.44	92.24	94.77	-
Nurse	98.23	98.20	98.19	98.09	98.55	98.57	98.27	98.38	98.82	98.25	97.90	-
Board Total	96.70	96.65	96.37	95.97	96.66	96.66	96.81	96.39	97.36	96.39	96.93	-

Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	95.60	96.10	95.70	95.10	94.95	95.40	94.55	94.25	95.55	95.25	95.48	95.48

Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	96.80	96.40	97.20	97.10	96.65	96.60	94.75	95.85	96.40	96.15	95.45	95.45

ROYAL INFIRMARY OF EDINBURGH

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
MRSA	2	0	2	0	2	0	0	4	1	0	1	0
MSSA	12	9	13	11	14	15	16	11	10	9	10	7
Total	14	9	15	11	16	15	16	15	11	9	11	7

Clostridium difficile Infection **Monthly Case Numbers**

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

Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	96.60	97.01	96.63	96.72	96.27	96.55	96.62	96.92	96.61	96.53	97.26	97.12

Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	95.82	96.33	97.98	96.10	95.45	95.47	95.99	96.45	95.87	95.94	97.24	94.42

WESTERN GENERAL HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
MRSA	0	2	1	1	0	1	2	1	0	0	0	1
MSSA	6	7	6	6	2	7	6	12	7	7	4	8
Total	6	9	7	7	2	8	8	13	7	7	4	9

Clostridium difficile Infection **Monthly Case Numbers**

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Age 15-64	2	7	2	2	4	3	3	3	2	3	1	7
Age 65 plus	7	10	5	9	4	3	2	3	2	5	5	9
Total	9	17	7	11	8	6	5	6	4	8	6	16

Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	95.01	96.33	94.02	93.55	92.89	93.42	93.22	94.53	94.65	94.17	94.01	94.02

Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	97.86	98.24	97.75	97.73	98.17	97.83	96.50	95.36	96.07	95.33	94.84	94.87

ST JOHNS HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

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

Clostridium difficile Infection **Monthly Case Numbers**

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

Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	93.83	95.43	95.38	95.02	95.76	95.92	94.51	94.52	95.79	94.75	94.92	95.65

Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	94.75	95.29	95.63	95.43	95.53	95.01	94.97	95.97	95.45	95.16	93.97	94.56

LIBERTON HOSPITAL

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

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

Clostridium difficile Infection **Monthly Case Numbers**

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

Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	96.83	97.70	97.02	96.71	96.87	96.77	96.23	96.96	97.87	96.63	97.39	97.92

Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	93.66	95.12	97.43	98.11	98.04	97.99	98.61	97.37	97.52	97.84	97.73	98.06

ROYAL HOSPITAL FOR SICK CHILDREN

Staphylococcus aureus **Bacteraemia Monthly Case Numbers**

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

Clostridium difficile Infection **Monthly Case Numbers**

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

Cleaning Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	93.67	94.21	95.13	95.83	94.11	94.47	91.83	92.61	94.22	93.47	94.11	94.90

Estates Monitoring Compliance (%)

	Sep 2014	Oct 2014	Nov 2014	Dec 2014	Jan 2015	Feb 2015	Mar 2015	Apr 2015	May 2015	Jun 2015	Jul 2015	Aug 2015
Board Total	97.59	97.21	98.29	99.00	96.61	97.91	95.15	95.82	97.77	95.83	93.99	95.73

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**

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

Clostridium difficile Infection **Monthly Case Numbers**

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

OUT OF HOSPITAL INFECTIONS

Clostridium difficile Infection **Monthly Case Numbers**

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

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NHS LOTHIAN

1.5

Board Meeting
7 October 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - NHS LOTHIAN PEFORMANCE DELIVERY

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

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

• To provide an update on 2015-16 Local Delivery Plan and Corporate Objectives approved by NHS Lothian Board on 1 April 2015	1.1
• An update associated with the Local Delivery Plan is outlined in Appendix 1	1.2
• Agreed at the Board meeting on 1 April 2015, responsibility of monitoring and governance arrangements for the Corporate Objectives should be delegated to appropriate Lothian Committees. A draft reporting template is outlined in Appendix 2.	1.3
• Note progress made with the integration agenda, children's agenda, developing plans for primary care, health inequalities and cancer care and treatment.	1.4
• Progress associated with LDP standards (previously HEAT targets) particularly in relation to delayed discharge, CAMHS and psychological therapies and stroke performance is not as we would want and is reported to the Board via separate performance reports.	1.5
• Key risks associated with delivery of the LDP and Corporate Objectives are predicated on NHS Lothian's ability to deliver local reinvestment plan assumptions.	4.1

Alyson Cumming
Strategic Programme Manager
24 September 2015
alyson.cumming@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 2015

Director of Strategic Planning, Performance Reporting & Information

NHS LOTHIAN PERFORMANCE DELIVERY 2015/16

1 Purpose of the Report

1.1 The purpose of this report is to provide a progress update associated with the delivery of the 2015-16 Local Delivery Plan (LDP) actions and the arrangements being put in place to monitor performance and progress associated with the 2015-16 Corporate Objectives. The LDP and Corporate Objectives were approved by NHS Lothian Board on 1 April 2015.

1.2 Appendix 1 sets out the agreed actions in the LDP and the progress that has been made against these in year. Progress has been reported through use of narrative as many of the targets that need to be achieved are reported to the Board, Corporate Management Team and other committees of the Board on a regular basis for example in the performance 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 agreed in April 2015 the responsibility of monitoring and governance arrangements for the 2015-16 Corporate Objectives should be delegated to the appropriate NHS Lothian Committees. To support monitoring arrangements, it was suggested a standardised template process was developed to ensure consistency in reporting.

A draft template has been developed, and was submitted for review and discussion at the Corporate Management Team meeting on 10 August 2015. The draft reporting template requires further revision as the Terms of Reference for NHS Lothian Committees is currently being reviewed following the establishment of Integration Joint Boards, the update Terms of Reference require to be reflected in the template. Once finalised, the draft reporting template will be circulated to NHS Lothian committees for discussion and agreement. The current draft reporting template is outlined in Appendix 2.

1.4 Much progress has been made in the year to date to progress the integration agenda; the children's agenda as well as developing our plans for primary care, 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.

1.5 It is important to note however that progress in relation to a number of the LDP targets and standards, particularly the 2 week delayed discharge target; delivery of the target for CAMHS and psychological therapies and stroke performance are not as we would want and these are reported under cover of separate reports but do require to be highlighted.

1.6 The Board and Corporate Management Team have been appraised of its financial position in year and actions to address this but this alongside workforce planning are key elements of the LDP for this year.

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

2 Recommendations

2.1 To seek Board members comment or questions relating to progress against the priorities outlined in the LDP report (appendix 1)

2.2 The Board notes the risks against delivery of the LDP, particularly in relation to very high and high risk areas relating to delivery of LRP and performance as set out in section 4.1

2.3 That the Board also notes that a Quarter 1 review took place on the 27th July 2015 in advance of the NHS Lothian Annual Review on the 3rd August 2015 to discuss performance and the financial position.

2.4 The Board notes a draft reporting template has been developed to support monitoring of the 2015-16 Corporate Objectives. The template will be piloted during 2015-16 to ensure processes are embedded to support monitoring of 2016-17 Corporate Objectives (appendix 2).

3 Discussion of Key Issues

3.1 The Scottish Government have outlined six improvement priorities for focus within the 2015-16 LDP relating to:

- Health inequalities and prevention
- Antenatal and early years
- Person Centred Care
- Safe Care
- Primary Care
- Integration

The 2015-16 Corporate Objectives have also been structured to mirror the six key strategic improvement priorities set out in the LDP.

3.2 The LDP also outlines how NHS Lothian will support delivery of:

- LDP Standards (previously HEAT standards and targets)
- Financial Planning
- Workforce
- Community Planning

3.3 There are four overarching Corporate Objectives which relate to:

- Protect and improve the health of the population
- Improve the quality and safety of health care
- Secure value and financial sustainability
- Delivery actions to enable change

3.4 In addition to this report, NHS Lothian Board and Committees also receive regular reports associated with financial plans, workforce plans, performance, integration and community planning.

3.5 An update on delivery of the 2015-16 LDP is outlined in Appendix 1.

3.6 The Corporate Objective monitoring template is structured to provide the following information:

- Responsible Committee
- Linkage of Committee Terms of Reference and Assurance Need to Corporate Objective
- 2015-16 Overarching Corporate Objectives
- 2015-16 LDP Planning and Improvement Priorities
- Key Actions
- Risk Analysis and Dependencies
- Lead Executive
- Risk Management : Datix Risk ID Number and Risk Register
- Performance Measure : Target, Current Position and Date of Last Update
- Status of Action : Completed / Not Completed / Not Yet Due

4 Key Risks

4.1 The key risks associated with delivery of the LDP and Corporate Objectives are predicated on NHS Lothian's ability to delivery local investment plans assumptions and have been identified as:

- Very High Risk – Bed reductions, income assumptions, deficit in social care investment
- High Risk – Local reinvestment programme/financial balance, delivery of scheduled care treatment time guarantees, unscheduled care, Edinburgh and East Lothian delayed discharge position, changes to Individual Patient Treatment Review process, introduction of parental and adoption leave, Hepatitis C Drugs cost, SGHD Allocations, Capital Programme and Equal Pay
- Medium Risk – Pay(Terms and Conditions), prescribing, rebates and property sales

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

8.2 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
Strategic Programme Manager Corporate Planning and Public Records
24 September 2015
Alyson.cumming@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: 2015-16 Local Delivery Plan Progress Report
Appendix 2: Corporate Objectives Draft Reporting Template

APPENDIX 1

NHS Lothian 2015-16 Local Delivery Plan Progress Report September 2015

Improvement Priority	LDP Milestones	Progress Update
Health Inequalities and Prevention	Health Inequalities Strategy 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)	• 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 have been / will be presented 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
	Health Promoting Hospital Services (HPHS) Development of HPHS Priorities Action Plan	• 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
	Tobacco Smoke free grounds by 1 April 2015	• NHS Lothian grounds became smoke free on 1 April 2015.
Antenatal and Early Years	Health Visitor Population	• Challenges remain in recruitment and retention of Health Visitors to support delivery of a named person associated with the Children and Young People (Scotland) Act 2014. An additional 61 WTE Health Visitors are required to meet the named person legislation based on national SIMD quintiles by 2018. A paper outlining key actions and risks was considered by the Corporate Management Team in May 2015. • There were 22.5WTE Band 6 Health Visitor vacancies at 31 August 2015

Antenatal and Early Years	Health Visitor Population	• 15 student Health Visitors will have completed training at the end of September 2015. All have been offered posts based on risk stratification of vacant caseloads. • The vacancy rate is expected to reduce to 7.5 WTE plus 2 expected 2 WTE resignations during October 2015. Simultaneously Scottish Government is expecting NHS Lothian to evidence the creation of an additional 14 posts, this being the 2015/16 pro rata of the requirement of 61 WTE requirements. Recruitment is being progressed for these 14 additional posts. • 26 student health visitors will be trained during 2015/16 using Scottish Government Health Visitor increased allocation of £860,000. • Recruitment for administrative support for Health Visitors is being progressed, job descriptions were submitted for grading on 10 September 2015, the outcome is awaited. • 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. A paper has been prepared on behalf of SEAT Directors of Nursing proposing adoption of a SEAT wide approach to delivery of health visiting services. Proposals will be discussed within SEAT by the end of 2015. • A new national universal Health Visitor Pathway will be published in October 2015 and will be communicated through Executive Nurse Directors for dissemination with NHS Boards for implementation.
	Implementation of NHS Lothian Children and Young People's Strategy	• Good progress is being made and a progress report will be submitted to the Strategic Planning Committee and Corporate Management Team in October 2015.
	Family Nurse Partnership - 4th team in place by July 2015	• A fourth Family Nurse Partnership Team is now in place and will begin to recruit clients from 1 August 2015. This is a hybrid team with six nurse supporting Lothian and two nurses support in the Borders. • 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	• Work is underway to develop an NHS Lothian Maternity Services Strategy 2016- 2021. It is expected a first draft will be taken to the Strategic Planning Committee in March

		2016.
Person Centred Care	Tell Us Ten Thing –Local Patient Experience Survey Programme	• A patient experience survey (183 returns) undertaken in all wards at the Royal Infirmary of Edinburgh in March 2015 indicates out of a possible maximum weighted score of 10, responses to 8 of the 10 questions asked scored over 8. The highest scores related to 'treated with kindness and compassion' by the staff looking after you (score 9.48) and 'staff did everything they could to help control your pain' (score 9.13). The results below 8 related to patients being bothered by noise at night from the hospital staff (score 6.66) and happy with the food / meals I received (score 7.25) • In order to realise the aim of 90% of patients using our services have a positive experience of care and get the outcomes they expect, a Patient Experience Quality Improvement Plan has been developed, key aspects to the plan include: - NHS Lothian organisational culture and leadership improves patent, family and staff experience - Direct care delivery is reliable and is delivered in acute collaboration and partnership with patients and staff including the physical environment - Staff are engaged with the organisation to deliver services centred on the needs of people including the physical environment - Staff are open when dealing with people raising concerns or complaint - That there is an infrastructure in place to support system change underpinned by measurement
	Feedback and Complaints	• A draft Annual Feedback and Complaints Report 2014-15 has been produced which outlines improvements undertaken to consult with the public about planned changes in NHS Lothian to ensure a conscious effort is made to keep the person as the centre of all that NHS Lothian does. The draft plan was submitted to the Scottish Government and Scottish Health Council on 30 June 2015 for review and feedback has been sought from members of the public. The report was presented to the Healthcare Governance Committee in July 2015. • Following the external review of the complaint process undertaken earlier this year by Dorothy Armstrong – Listening and Learning from Complaints and Complaints, this report was fully supported by NHS Lothian Board in January 2015 and supports a devolved approach to complaints and feedback. The current Customer Relations and Feedback Team are going through organisational change, the Head of Patient Experience has been appointed and we are working with colleagues in HR and

Person Centred Care	Feedback and Complaints	Partnership to support the staff to establish the Patient Experience Team. • The Patient Experience Team will have two main functions – complaints and feedback and the proactive approach to patient experience through the use of patient stories and surveys. The complaints and feedback devolved approach is being tested in 3 areas: the Western General Hospital, Royal Edinburgh and Associated Services and Edinburgh CHP. This is going well and we are now looking for others to be part of phased 2 which we are planning will be begin in October 2015. The learning and reflections from the 3 tests areas will be incorporated into phase 2. • The Healthcare Governance Committee has received progress reports at the January, March, May and July meetings and there was a presentation given by the Executive Nurse Director at the private session on the 24 June 2015 at the NHS Lothian Board.
	Lothian House of Care	• NHS Lothian continues to 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	• NHS Lothian remains committed to the Scottish Patient Safety Programme. Priorities for action during 2015-16 include spread and sustainability set within a Quality Improvement infrastructure. An annual report associated with the Scottish Patient Safety Programme will be available towards the end of 2015. • A policy relating to 'Choosing Wisely' is being developed to understand the risks of over diagnosis and over treatment, acknowledge the wishes and goals of patients and to recognise the limits of treatments when considering harm, costs and the potential outcomes which might be achieved. • An NHS Lothian Quality Improvement Academy is also in the process of being developed aligned with the work undertaken to date regarding the establishment of the Clinical Change Cabinet and the 'Choosing Wisely' work outline above. A paper outlining NHS Lothian's Clinical Quality Approach will be discussed at the meeting of NHS Lothian Board on 7 October 2015.
	Hospital Associated Infections	• Delivery of LDP standards associated with healthcare associated infections (CDifficile and MRSA / MSSA) continues to be challenging. A review of environmental cleaning and standards will be undertaken in 2015-16 with the aim of reducing CDifficile.
Primary Care	Take forward work to support the priority areas outlined within the Strategic Plan	• 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, it is understood NHS Boards will be invited to submit funding proposals associated the national primary investment monies.

Integration	Establishment of Health and Social Care Partnerships and Integration Joint Boards	• 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, Edinburgh and Midlothian IJBs have taken place. The first meeting of the West Lothian IBJ will take place in October 2015. • The Integration Joint Boards are drafting their Strategic Commissioning Plans and Needs Assessments. The Edinburgh draft strategic plan is currently subject to a consultation period from 4 August to 31 October 2015. It is expected the draft Midlothian Strategic Plan will be published for consultation in early October 2015. The East Lothian draft Strategic Plan is being updated and will be circulated for comment at the end of September 2015. A final East Lothian plan will be published for consultation following the outcome of the Adult Joint Inspection which will influence the final plan. Draft plans are submitted to the NHS Lothian Strategic Planning Committee for review and discussion. • The Partnerships in Midlothian, Edinburgh and West Lothian are developing management structures and recruitment to key posts is progressing. • East Lothian, Midlothian and West Lothian have now appointed their Chief Officers. Recruitment to the Edinburgh Chief Officer position is underway, interviews will beheld in October 2015.
	Support for the Care of Older People	• 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	• Delivering for Patients, an appendix to Our Health, Our Care, Our Future: NHS Lothian Strategic Plan 2014 - 2024 outlines NHS Lothian's commitment to meet and sustain

		treatment time guarantees and outpatient standards. Implementation of Delivering for Patients is supported through a Programme and Priority Leadership Group to ensure delivery of the national waiting times standards in Lothian. This group oversees the progress of the Clinical Management Teams reviewing and managing performance and to ensure associated risks are managed. • NHS Lothian continues to be challenged in the delivery of the LDP Standards (previously HEAT targets), regular performance reports are submitted to the Corporate Management Team and NHS Lothian Board. The Board should note that progress is not cited within this update, the most up to date position will be provided at the 7 October 2015 NHS Lothian Board meeting through the standard Board reports on elective and unscheduled care waiting times; the performance paper and Quality and HAI papers.
Financial Planning	Deliver Financial Balance	• A 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 Clinical Quality 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. • NHS Lothian and City of Edinburgh Council have worked 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. Initial bridging finance of £2-3m has been secured to support developments in 2015-16 to support 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	• 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, an initial report was submitted to the CMT in September 2015, a further report is expected in October 2015
	Effective Leadership and Management	• A Clinical Change Cabinet which brings together clinicians from across NHS Lothian has been established to support development of the new strategic direction around organisational culture and behaviours. The Cabinet will focus on how we work together to improve quality while using the resources to create sustainability.
Community Planning Partnerships	Continue to work with partner organisations to support engagement in community planning	• A NHS Lothian Board Director and Non Executive Director have been appointed to each of the four CPP's • The Edinburgh Community Plan was taken to the April 2015 NHS Lothian Board meeting. The other three plans are expected to be taken to Board or Committees as appropriate. • NHS Lothian and the four community planning partnerships have been actively engaged in the development of the legislation around the Community Empowerment • Key relationships between the CPP's and the development of the four IJB's strategic commissioning plans will be important during this initial year. • The Edinburgh Joint Board of Governance for Children's Services has been established.

APPENDIX 2

	COMMITTEE	Link to Committee Terms of Reference (ToR) or Assurance Need (AN)	CORPORATE OBJECTIVE	2015/16 LDP Planning & Improvement Priorities	Action	Risk Analysis/ Dependencies	Lead Executive	RISK MANAGEMENT: DATIX Risk ID Number and the register(s) the risk sits on	Performance Measure for the Action			Status of Action (as approved by the Committee) - Completed/ Not Completed/ Not Yet Due
									TARGET	CURRENT POSITION	Date of Last Update	
1	Healthcare Governance	(**AN)** The Board complies with all relevant legislation to do with child protection, e.g.Children (Scotland) Act 1995, Protection of Children and Young People (Scotland) Act 2003	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	ensure that all children aged 0-5 will have access to a Named Person as required by the Children and Young People (Scotland) Act 2014;	Recruitment, retention and training of sufficient Health visiting staff	Nurse Director		Proportion of children under 5 within Lothian with a Named Person-target 100% by August 2016.			
2	Staff Governance Committee	(**AN**) A comprehensive workforce plan, based on these developments and changes is developed in partnership.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	increase capacity of the Health Visiting workforce	Recruitment, retention and training of sufficient Health visiting staff	Nurse Director		Additional 26 nurses to undertake Health Visitor training for 2015/16 . **AP Comment: Need to confirm what the baseline number and date is to support monitoring.**			
3	Staff Governance Committee	**(AN)** Resources including time and funding, are appropriately allocated to meet local training and development needs taking into account the current priorities of both the service and service users.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Train and support health visiting and maternity staff to deliver GIRFEC pathways	Recruitment, retention and training of sufficient Health visiting staff	Nurse Director		**No measure identified**			

	COMMITTEE	Link to Committee Terms of Reference (ToR) or Assurance Need (AN)	CORPORATE OBJECTIVE	2015/16 LDP Planning & Improvement Priorities	Action	Risk Analysis/ Dependencies	Lead Executive	RISK MANAGEMENT: DATIX Risk ID Number and the register(s) the risk sits on	Performance Measure for the Action			Status of Action (as approved by the Committee) - Completed/ Not Completed/ Not Yet Due
									TARGET	CURRENT POSITION	Date of Last Update	
4	Healthcare Governance	**(AN)** The Board complies with all relevant legislation to do with child protection, e.g.Children (Scotland) Act 1995, Protection of Children and Young People (Scotland) Act 2003	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	develop a local protocol on joint planning during the antenatal care pathway to support implementation and transition of the Named Person role after birth;	Recruitment, retention and training of sufficient Health visiting staff	Nurse Director		**No measure identified**			
5	Healthcare Governance	*(AN)* "The HCG Committee's remit is addressed in a systematic and documented manner through clear policies and procedures, and adequate and effective systems of internal control."	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Roll out information to staff throughout NHS Lothian regarding our duties under the Children and Young People (Scotland) Act 2014 and establishing any additional support required to enable staff to fulfil these duties;	Recruitment, retention and training of sufficient Health visiting staff			**No measure identified**			
6	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Use Early Years Collaborative (EYC) methodology to work towards: - "stretch aims" on stillbirth, infant mortality and child development - Improvements in each of the key change areas of EYC, including health and wellbeing, and income maximisation (e.g. through work on Healthy Start and referral of pregnant women and children for welfare rights advice)	Recruitment and retention of sufficient midwives			EYC1) Reduce still birth and infant mortality by 15% by end 2015.			

	COMMITTEE	Link to Committee Terms of Reference (ToR) or Assurance Need (AN)	CORPORATE OBJECTIVE	2015/16 LDP Planning & Improvement Priorities	Action	Risk Analysis/ Dependencies	Lead Executive	RISK MANAGEMENT: DATIX Risk ID Number and the register(s) the risk sits on	Performance Measure for the Action			Status of Action (as approved by the Committee) - Completed/ Not Completed/ Not Yet Due
									TARGET	CURRENT POSITION	Date of Last Update	
7	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Use Early Years Collaborative (EYC) methodology to work towards: - “stretch aims” on stillbirth, infant mortality and child development - Improvements in each of the key change areas of EYC, including health and wellbeing, and income maximisation (e.g. through work on Healthy Start and referral of pregnant women and children for welfare rights advice)	Recruitment and retention of sufficient midwives			EYC2) Increase % children achieving all developmental milestones at 27-30 months to 85% by end 2016.			
8	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Use Early Years Collaborative (EYC) methodology to work towards: - “stretch aims” on stillbirth, infant mortality and child development - Improvements in each of the key change areas of EYC, including health and wellbeing, and income maximisation (e.g. through work on Healthy Start and referral of pregnant women and children for welfare rights advice)	Recruitment and retention of sufficient midwives			EYC3) Increase % children achieving all developmental milestones to 90% by end 2017. 27-30 month review aim has bundle of measures including parenting/ early education prior to review, coverage, documentation, onward referral and more.			
9	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Use Early Years Collaborative (EYC) methodology to work towards: - “stretch aims” on stillbirth, infant mortality and child development - Improvements in each of the key change areas of EYC, including health and wellbeing, and income maximisation (e.g. through work on Healthy Start and referral of pregnant women and children for welfare rights advice)	Recruitment and retention of sufficient midwives			Other EYC) 80% eligible women and children in receipt of Healthy Start vouchers by end 2016			

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10	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Use Early Years Collaborative (EYC) methodology to work towards: - “stretch aims” on stillbirth, infant mortality and child development - Improvements in each of the key change areas of EYC, including health and wellbeing, and income maximisation (e.g. through work on Healthy Start and referral of pregnant women and children for welfare rights advice)	Recruitment and retention of sufficient midwives			Other EYC) Leith and West Lothian Scottish Legal Aid Board funded projects will provide more information on the expected level of referral, uptake and outcomes of welfare rights advice. **AP Comment: I am not clear what this is: is it commentary, or is there meant to be some objective measure?**			
11	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Implement maternity services action plan to improve patient flow in maternity services across Lothian.	Recruitment and retention of sufficient midwives			**No measure identified**			
12	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Ensure expectant mothers have access to timely antenatal care through continuing to exceed the antenatal care target;	Recruitment and retention of sufficient midwives			At least 80% of women in each SIMD percentile will be booked for antenatal care by 12th week of gestation. **(AP Comment - by when?)**			

	COMMITTEE	Link to Committee Terms of Reference (ToR) or Assurance Need (AN)	CORPORATE OBJECTIVE	2015/16 LDP Planning & Improvement Priorities	Action	Risk Analysis/ Dependencies	Lead Executive	RISK MANAGEMENT: DATIX Risk ID Number and the register(s) the risk sits on	Performance Measure for the Action			Status of Action (as approved by the Committee) - Completed/ Not Completed/ Not Yet Due
									TARGET	CURRENT POSITION	Date of Last Update	
13	Healthcare Governance	(ToR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Maintain comprehensive health assessment for all newly notified Looked After Children carried out within four weeks;	Recruitment and retention of sufficient midwives			No. assessed within 4 week timescale (**AP Comment: Should the target not say that e.g. 100% assessed within 4 weeks**)			
14	Healthcare Governance	(**AN)** The Board complies with all relevant legislation to do with child protection, e.g.Children (Scotland) Act 1995, Protection of Children and Young People (Scotland) Act 2003	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Respond to forthcoming NHS Delivery Plan to support the Children and Young People Act (2014) Parts 4, 5 and 18 relating to named person, child's plan and assessment of wellbeing;	Recruitment and retention of sufficient midwives			Delivery Plan metrics to be confirmed (A**P Comment: This needs to be updated now the LDP is approved. I am also not clear how this differs from the actions already on the schedule for named persons**)			
15	Healthcare Governance	(ToR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Consider the findings from the national review of school nursing, and develop a NHS Lothian response;	Recruitment and retention of sufficient midwives			Increased school nurse hours spent in schools- target to be confirmed (**AP Comment: The target needs to be confirmed. I am also not clear how the action relates to the target. Should the action actually be in the corporate objectives?**)			

	COMMITTEE	Link to Committee Terms of Reference (ToR) or Assurance Need (AN)	CORPORATE OBJECTIVE	2015/16 LDP Planning & Improvement Priorities	Action	Risk Analysis/ Dependencies	Lead Executive	RISK MANAGEMENT: DATIX Risk ID Number and the register(s) the risk sits on	Performance Measure for the Action			Status of Action (as approved by the Committee) - Completed/ Not Completed/ Not Yet Due
									TARGET	CURRENT POSITION	Date of Last Update	
16	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Extend Family Nurse Partnership service to East Lothian	Recruitment and retention of sufficient midwives			East Lothian FNP service operational by October 15			
17	Healthcare Governance	(TOR): "Monitoring and reviewing outcomes and processes across NHS Lothian, and taking action to ensure that the appropriate structures, processes and controls are in place and operating effectively.	One: Protect and Improve the Health of the Population	1.1: Ante Natal and Early Years	Test hybrid FNP service with NHS Borders	Recruitment and retention of sufficient midwives			NHS Borders test commences August 15 FNP available to all expectant teenage mothers by March 16. **AP Comment: Why is this in NHS Lothian Corporate Objectives?**			

	COMMITTEE	Link to Committee Terms of Reference (ToR) or Assurance Need (AN)	CORPORATE OBJECTIVE	2015/16 LDP Planning & Improvement Priorities	Action	Risk Analysis/ Dependencies	Lead Executive	RISK MANAGEMENT: DATIX Risk ID Number and the register(s) the risk sits on	Performance Measure for the Action			Status of Action (as approved by the Committee) - Completed/ Not Completed/ Not Yet Due
									TARGET	CURRENT POSITION	Date of Last Update	
18	Finance & Resources	(**ToR**) To be assured that NHS Lothian has robust arrangements in place to deliver effective Procurement, and that associated policies and procedures are fully implemented.	One: Protect and Improve the Health of the Population	1.2: Health Inequalities	Implement the NHS Lothian Health Inequalities Strategy action plan in relation to: Procurement- Develop use of community benefit clauses in contract specifications and procurement strategies	Alignment to four Community Planning Partnership Single Outcome Agreements			Agreed increase in targeted community benefits in project specifications – as new projects specified, review November 2015. Numbers of apprenticeships Spend in Supported Businesses Numbers of training opportunities **AP Comment: The baseline is not specified, therefore impossible to measure any change as a result of the action taken. I see two different measures - % of new contracts with a community benefit clause, as well as some quantification of the actual community benefits arising from**			
19	Finance & Resources	(**ToR**) To be assured that NHS Lothian has robust arrangements in place to deliver effective Procurement, and that associated policies and procedures are fully implemented.	One: Protect and Improve the Health of the Population	1.2: Health Inequalities	Implement the NHS Lothian Health Inequalities Strategy action plan in relation to: Procurement - implement contracts and SLAs that encourage use by suppliers of the living wage.	Alignment to four Community Planning Partnership Single Outcome Agreements			Increased number of contracts and SLAs held with organisations who pay a living wage or are registered and working towards it. **AP Comment: The baseline is not specified, therefore impossible to measure any change as a result of the action taken.**			

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NHS LOTHIAN

AUDIT & RISK COMMITTEE

Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 7 September 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); Mrs H Berry (Interim Chief Internal Auditor); Mr A Boyter (Director of Human Resources & Organisational Development); Mr J Crombie (Chief Officer: NHS Lothian University Hospitals & Support Services Division); Mr T Davison (Chief Executive); Mrs S Goldsmith (Director of Finance); Mrs C Grant (Audit Scotland); Ms D Howard (Head of Financial Control); Ms A Langsley (Programme Lead Safety and Compliance Education); Mr C Marriott (Deputy Director of Finance); Mr J Old (Financial Controller); Mr A Payne (Corporate Governance & VFM Manager); Mr M Smith (Internal Audit Manager); Professor A Timoney (Director of Pharmacy); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Ms Johnson.

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

19. Internal Audit – Pharmacy Stores (August 2015)

19.1 Mr Smith introduced the report. He described the background to the report, and highlighted that the significant issues related to the control objectives concerning stock movement and stock levels.

19.2 Professor Timoney described the significant work undertaken to implement the new JAC system, and advised the committee that it was the largest implementation ever done by JAC. She acknowledged the recommendations and assured the Committee that they would be taken forward within the designated timescales.

19.3 The Committee agreed to accept the report and the management actions detailed therein.

Professor Timoney left the meeting.

20 Minutes of the Previous Meeting

20.1 Minutes of the previous meeting held on 22 June 2015– The Committee approved the circulated minutes as a correct record.

21 Matters Arising

21.1 Matters Arising from the Meeting of 22 June 2015 – The Committee accepted the update on the actions detailed within the Running Action Note.

21.2 Output from Workshop on "Ensuring the Right Thing Happens in Practice Every Time" – The Committee considered the report that detailed the results from an intelligence gathering session on how to address the broad challenge of achieving compliance with policies and procedures whilst effectively managing risk.

21.2.1 Members agreed that the approach taken should be appropriate to what the policy was trying to achieve. For example people do not need to refer to human resources policies on a daily basis, but they should be immediately accessible when required. However clinical policies will be actively used on a daily basis, will require the exercise of professional judgement and need to be owned within the clinical setting.

21.2.2 Members agreed that the approach needed to consider human factors issues, so that it was clear to employees what they are being asked to do. It was agreed that there should be a clear irreducible core of policies and then this should be disseminated to staff for completion. The committee was advised that there is a suite of mandatory policy packages in place, and the selected policies were determined after a robust consultation process.

21.2.3 The Committee accepted the report and the direction of travel, and agreed that there should be alignment with the development of the NHS Lothian clinical quality management system. The committee noted that work was underway however it agreed that it could not take assurance at this time that the systems of control have improved.

Mr Crombie entered the meeting.

21.3 Mandatory Training Compliance – Mr Boyter introduced the report. He highlighted that the target of 80% compliance had been derived from the fact that at any given time NHS Lothian experience 10% staff turnover, 4.5% sickness absence and 5.5% for other types of leave. He highlighted that the recent move towards paid parental leave had increased the uptake of it. Given this context it was considered that 100% was not achievable. If compliance of 80% is achieved, then management can then revisit the target to see what further progress can be made. Management considered it to be important to set an initial target to focus efforts to improve on the current low levels of compliance.

21.3.1 The Chair questioned the logic of setting a target of only 80% compliance for policies deemed mandatory. In particular she queried the suitability of the 80% target for training in areas associated with the risks identified in the risk register as currently outwith risk appetite, e.g. HAI is one of the top 4 risks, its current status is outwith risk appetite but the compliance target is the same 80% target as for all other areas. In response Ms Langsley advised that employees were in practice prioritising areas of mandatory training

themselves. She noted that more work to move to a structured and aligned process of prioritisation for individual roles was required.

21.3.1a The Chair referred to recent developments in behavioural economics and the Behavioural Insights Team as potentially useful sources and suggested that they be consulted for ideas on how to improve compliance.

21.3.2 NHS Lothian is currently the only Board within NHS Scotland to have a clear picture on its uptake of mandatory training. The Scottish Government is leading to develop a national perspective.

21.3.3 Mr Boyter advised that mandatory training would remain a priority for the Staff Governance Committee. Discussions had taken place with the executive lead for each mandatory field, and he advised the committee that it would be a significant piece of work to improve performance.

21.3.4 Ms Bennett advised the committee that training is the weakest form of improvement opportunity. She advised the committee that more improvement is secured through designing out opportunities for error within processes, as well as standardising operational practice. The Committee acknowledged this.

21.3.4 The Committee agreed to note the progress made to date and endorse the improvement action plan. Recognising that the Staff Governance Committee is leading on this issue, Mr Payne would liaise with Mr Boyter to determine when a further update should be brought to the Audit & Risk Committee. **AB/AP**

Mr Boyter and Ms Langsley left the meeting.

22. Risk Management

Mr Davison entered the meeting.

22.1 <u>NHS Lothian Corporate Risk Register Update</u>

22.1.1 Ms Bennett gave a detailed overview of the report. She advised that the Board would be sighted on three emerging risks at their October meeting; General Practice Sustainability, Nursing Work Force Sustainability and Facilities fit for purpose.

22.1.2 The Chair posed the question of the Committee's responsibility to monitor and follow up when it receives a report indicating that NHS Lothian is outwith risk appetite on corporate objectives where low risk appetite has been set. The Committee noted that the Board receives papers at every meeting on subjects that are covered by the risk appetite, but the risk management report is commonly placed in the consent agenda of Board meetings. Therefore whilst the Board may be discussing papers on the subjects that are measured by risk tolerances, the Board is not explicitly discussing whether or not any actions will return performance to within the risk appetite and associated tolerances. The Committee further noted that other committees have oversight of risks relating to their remit and that the Audit & Risk Committee receives the annual reports of other committees.

22.1.3 The Committee agreed that it should take a more active role throughout the year to monitor management actions to address situations in which performance has breached the risk appetite. The committee agreed it was important to strike the right balance between appropriate governance oversight and scrutiny, and allowing management adequate time and space to work through issues.

22.1.4 The discussion illustrated that any actions to attend to breaches of risk appetite needed to be carefully thought through. Measures taken to address one area in the short term (e.g. immediate financial pressure) can compromise the delivery of performance in other areas of the risk appetite. There will be a point where the Board needs to make an explicit decision as to what it wants executive management to do in these circumstances. It was agreed that the audit & risk committee was a good place to consider such issues.

22.1.5 It was agreed that some development work should be undertaken to improve the focus of the Board, Audit & Risk Committee, and executive management on the risk appetite and tolerances. Part of this work will involve developing a programme of reporting to the Audit & Risk Committee on areas of the risk appetite, which will inform the committee's review of the Governance Statement at the year-end. **AP/JM/JB/SG**

22.1.7 The Committee agreed to accept the report and the recommendations detailed therein.

23 Internal Audit & Counter Fraud Reports

23.1 Internal Audit - Cardiac Perfusion Service August 2015

23.1.1 Mrs Berry advised the Committee that the review of the Cardiac Perfusion Service had been requested following the receipt of some whistleblowing allegations. The audit was not carried out to prove or disprove the allegations. The audit did identify definite opportunities to improve the systems of internal control, but it did not find evidence to support the allegations that were made.

23.1.2 Mr Crombie advised members of the robust and rigorous actions to address concerns raised. He confirmed that agreed management actions would be complete within 3 months. Mr Crombie provided the committee with further background on the current training programme for trainee perfusionists in Lothian, the risks associated with a highly competitive market for these employees, and the significant challenge to recruit and retain perfusionists.

23.1.3 The Committee agreed to accept the report.

Mr Crombie left the meeting.

23.2 Internal Audit – Progress Report September 2015

23.2.1 Mrs Berry gave a detailed overview of the report. She highlighted that although three additional audits had been added to the plan, Internal Audit remained on track to complete the planned schedule of work.

23.2.2 Mrs Berry assured the Committee that if further requests for additional audits were received Internal Audit would have capacity to accommodate these.

23.2.3 Mrs Berry reported that she would bring forward a draft report regarding the appointment of internal auditors to the Integration Joint Boards to the Section 95 officers group. She had sought advice from both local authority and NHS colleagues on the report and Mrs Berry and Mr Marriot agreed to bring forward the report to the Committee if appropriate. **CM/HB**

23.2.4 The Committee accepted the report.

23.3 Internal Audit – Reports with Green Ratings August 2015 (Annual Stock-Taking; Health & Social Care Integration

23.3.1 The Committee agreed to accept the Report with Green Ratings – August 2015.

23.4 Internal Audit – Workforce Planning

23.4.1 Mrs Berry gave a detailed overview of the report and background to the Audit.

23.4.2 Mr Davison advised the Committee that they could take assurance from the recent Board Development sessions that considered workforce planning, and the significant development and benefit that could be achieved through the use of e-Rostering in ensuring that the right staff were in the right place at the right time.

23.4.3 Members agreed that it would be appropriate for Ms Johnson to bring forward an update to the December meeting. **MJ**

23.4.4 The Committee accepted the report.

23.5 Counter Fraud Activity

23.5.1 Mr Old gave a brief overview of the report. He advised that at present there were 3 open referrals and 7 open operations.

23.5.2 Mr Old advised that NHS Lothian had referred the outcome of operation Iona to the Professional Standards Authority, however at present the GDP in question remained fit to practice within NHS Lothian.

25.3.3 The Committee agreed to accept the report.

26. General Corporate Governance

26.1 Payment Verification Protocols in Primary Care

26.1.1 The Committee noted the Director's Letter DL (2015) 18 and the assurances that the payment verification protocols will be considered by the Finance and Resource Committee.

26.2 Write Off of Overseas Debts

26.2.1 Ms Howard gave a brief overview of the report.

26.2.2 The Committee reviewed appendix 1 and confirmed that the Director of Finance may approach the SGHSCD for its approval to write off the loss.

27. Date of Next Meeting

27.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 7 December 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.

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NHS LOTHIAN

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 9:00 a.m. on Wednesday 9 September 2015 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr P Johnstone (Vice Chair); Dr D Farquharson; Mrs S Goldsmith; Councillor D Grant; Mr B Houston and Professor J Iredale.

In Attendance: Ms M Anderson (Programme Manager for East Lothian Capital Planning and Projects); Mr G Curley (Director of Facilities); Mr I Graham (Director of Capital Planning & Projects); Mr G Luke (Finance Trainee); Professor A McMahon (Director of Strategic Planning, Performance Reporting & Information); Mr C Marriott (Deputy Director of Finance); Mr A Milne (Project Director East Lothian Community Hospital); Mr P Reith (Secretariat Manager); Mr D Ridd (Communications Manager); Mr A Short (Head of Health, Midlothian) and Mr D White (Assistant General Manager, Edinburgh Community Health).

Apologies for absence were received from Mr G Walker, Mrs Kay Blair, Mr T Davison, Councillor R Henderson and Ms M Johnson.

Declaration of Financial and Non-Financial Interest

The Vice 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.

30. Minutes of the Previous Meeting

30.1 The minutes of the previous meeting held on 8 July 2015 were approved as a correct record.

31. Running Action Note

31.1 The Committee received the previously circulated running action note detailing outstanding matters arising, together with the action taken and the outcomes.

32. Matters Arising

32.1 ESA 10 Update - Mrs Goldsmith advised that she was concerned at the time being taken for this issue to be resolved. If the projects concerned were required to go onto the Government's balance sheet there would be a significant problem for Health Boards. The possibility of establishing a charity to handle this was being explored.

The Committee noted the position and agreed to express its concern to the Scottish Futures Trust that NHS Lothian's decision to go ahead with the project had been made on the basis of a specific Government financial contribution. **SG**

32.2 East Lothian Community Hospital Update - a circulated report from Mr Milne was received and he advised the Committee that number of key issues had arisen which might have a varying impact on the progress and outcome of the programme of work and were discussed in detail in the body of the paper. The Outline Business Case was being prepared based on a capital scheme of c£72m for net construction costs, based on a New Project Request affordability cap agreed with Scottish Futures Trust. This was higher than the upper limit of the original estimate for the Initial Agreement Preferred Option of £66m. The proposed model of care had been costed and comparison with existing budgets had identified a recurring revenue gap of c£3.5m. This was largely in line with the Initial Agreement and work was ongoing to refine these costs for the Outline Business Case. It was likely that modular accommodation would have to be brought in for decanting purposes.

It was noted that the paper had been to the Acute Hospitals Committee which had approved it but that support from the Chief Officer and his team was still awaited. Dr Farquharson reminded the Committee of the ongoing challenges with recruiting medical staffing and advised that the hospital could either be a General Practitioner or Consultant staffed unit. Councillor Grant supported the report and advised that East Lothian had waited for this Hospital for a number of years and East Lothian Council was working in partnership with NHS Lothian to mitigate the risks. Professor Iredale commented that recruiting General Practitioner staffing in East Lothian would not be a major problem and that it would be necessary to look at the model of care to identify the staffing needs.

Mrs Goldsmith reminded the Committee that the East Lothian Integration Joint Board had only just been established and the new hospital was a long-standing commitment. The Integration Joint Board would need to make a contribution.

The Committee agreed:

- To note the current financial position for the ELCH
- The submission of planning and building warrant applications based on the projects current form.
- To acknowledge the financial implications and work underway to address these related risks

33. Quarter 1 Financial Review and Financial Position to July 2015

33.1 Mr Marriott introduced a 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.

33.2 Mr Marriott advised that the main problem areas were GP prescribing, nursing and medical supplies. Whilst month 5 was showing an underspend, this was only because of the correction achieved by the release of some reserves. The Finance Team would

be picking up on recovery plans in the areas of recruitment and volumes in prescribing.

33.3 Mrs Goldsmith commented that there had been a significant dip in the first part of the year and the Chief Executive was currently at a meeting with other Board Chief Executives and the Director General Health and Social Care and Chief Executive of NHS Scotland to discuss the financial position. As a result of this dip the anticipated overspend was almost £28m. The current overspend of just over £11m had already been reduced and it was hoped to be able to use some capital arising from sales in order to reduce this further. It was also noted that there were significant issues with acute services and homecare places in Edinburgh and East Lothian.

33.4 The Committee noted that there were still risks around income, the achievement of Local Reinvestment Plans and operational costs. In respect of nursing costs, eRostering was not yet sufficiently rolled out to generate significant savings in the current financial year, although the roll-out was being expedited.

33.5 Mr Johnston asked if there were risks in terms of the quality of services and Mr Marriott advised that the risks were financial as quality was being maintained. Mr Houston commented that the identified risks would only become risks if improvements were not implemented.

33.6 Mr Marriott explained the process and advised that the budgets had been discussed with Business Units who had confirmed that the required services could be delivered within these constraints.

33.7 Mrs Goldsmith reminded the Committee that if circumstances changed, for example if there was a particularly bad winter, then this could have an impact as there was not the same level of confidence as there had been in earlier years. In response to a question from Mr Houston she advised that controlling the types of drug prescribed had minimal benefits but that repeat prescribing was a significant issue as most General Practitioners did not have the resources to review these in detail. The possibility of providing some pharmacy support to practices to assist in this was worth consideration and Professor McMahon advised that he and the Director of Finance would be attending the General Practitioners Sub-Committee to discuss this issue. Mrs Goldsmith confirmed that the best that could be done was to continue the dialogue with General Practitioners and Pharmacists.

33.8 Mrs Goldsmith outlined the intended approach to the development of the Board's financial plan for 2016/17 by seeking to strengthen the link between Business Unit plans and the delivery of financial balance by requiring the development of individual forecasts and specific action plans at Business Unit level. It also sought to recognise the Board's changing role in relation to the preparation of budgets for Integration Joint Boards.

33.9 Mr Johnston commented that this seemed an eminently sensible approach and wondered why it had not been tried before. Mrs Goldsmith advised that Local Authorities were required to deliver a balanced budget whilst the NHS was required to break even by the end of the Financial Year. The NHS was therefore learning from the Local Authority model.

33.10 Mr Houston commented that this was a fundamentally different approach and the management of the delivery of this model would be important as it would be up to local management to decide how to deliver services to a balanced budget.

33.11 The Committee agreed to:

- Note that the financial position at period 4 showed an overspend of £6.9m across all services, after the release of corporately held flexibility of £3.5m;
- Note that the Quarter 1 year end position and forecast did not yet give sufficient confidence that year end balance was achievable;
- Support the implementation of identified actions to deliver a breakeven position, noting that this compromised future flexibility;
- Endorse proposals to develop the financial planning process for financial year 2016/17.

34. 2014/15 QOF Prepayment Verification

34.1 The Committee noted the contents of a circulated paper together with the minutes of the QOF Payment Verification Group meeting on 28 May 2015, reviewing the 2014/15 QOF outcome data. In particular the continuing high level of achievement by Lothian GP practices in what is a voluntary scheme and the special arrangements applied to practices participating in the Section 17C Redesign Programme and Restructured Practices, together with the special arrangements for specific indicators were noted.

35. Property and Asset Management Investment Programme 2015-16

35.1 Mrs Goldsmith introduced a circulated report on an update on the property and asset investment programme for 2015/16.

35.2 Mr Graham reminded members that the programme was partly driven by the availability of capital and could be lower than anticipated. The Scottish Government was endeavouring to use the asset management system to enable all capital projects to be approved in a single document.

35.3 Mrs Goldsmith advised that the Corporate Management Team had approved a Lothian Capital Investment Group prioritisation process in July. As a result, the in-year over commitment had been reduced to £3m. This related to expenditure to develop business cases for schemes over £5m, and support for these costs had been sought from the Scottish Government.

35.4 It was noted that future years of the programme remained overcommitted and would be subject to the same process of prioritisation, in line with organisational priorities and would require consideration by the Strategic Planning Committee.

35.5 The Committee noted updates on the major projects and recognised the financial performance to date and the highlighted key risks and issues from this programme of work. The requirement to prioritise major infrastructure developments in the context of the strategic plan and limited financial resources was also noted.

36. Western General Hospital Masterplan

36.1 Mr Graham delivered a presentation covering masterplanning across Lothian, governance and risk, the Western General Hospital masterplanning process completed to date, delivering for service strategies and projects with an indication of the next steps.

36.2 In response to a question from Mr Houston, Mr Graham confirmed that there was no interdependence of the Western General Hospital project with the Royal Victoria Hospital. Professor Iredale advised that the University of Edinburgh and NHS Lothian met regularly to discuss overlapping issues.

36.3 The Committee noted the update on the position of the Western General Hospital Campus.

37. Initial Agreement: St John's Hospital Boiler Replacement for CEF Project

37.1 Mr Curley introduced a circulated report together with an Outline Business Case for the proposed boiler replacement at St John's Hospital.

37.2 The Committee noted that, taking into account the significantly overcommitted capital programme, as well as existing risks including backlog maintenance and medical equipment, the Outline Business Case identified the preferred solution as a revenue funded scheme in conjunction with the Carbon Energy Fund. Under this arrangement, prospective bidders would design, build, finance and maintain the assets for the duration of an agreed lease period of 15 years).

37.3 Mr Curley explained that a unitary charge was payable for the duration of the lease but that this payment would be covered by savings from reduced energy consumption that were contractually guaranteed by the supplier for the 15 year duration of the contract. Annual net savings, after payment of the unitary charge, were estimated at £0.17m. Savings would be measured by Carbon Energy Fund throughout the duration of the contract and should they exceed those predicted, these additional savings would be shared between NHS Lothian and the supplier.

37.4 It was noted that following approval of a preferred bidder, a full design process would be undertaken which would clarify the extent of the capital enabling works required. Following approval of a preferred bidder, should the final contract be for the same or better price and guaranteed savings, NHS Lothian would be liable for the bidder's costs subject to an agreed cap (currently estimated at £0.16m). If the project reached the point where a contract with the supplier was signed, these costs would be rolled into the unitary charge.

37.5 The Committee agreed to:

- Note and approve the Outline Business Case for submission to the Scottish Government Capital Investment Group;
- Note the preferred option of a revenue funded scheme in conjunction with the Carbon Energy Fund;

- Approve the appointment of Vital Energi as the preferred supplier;
- Note the estimated capital enabling works of £0.35m that would require funding in the 5 Year Property and Asset Management Investment Programme.

38. Initial Agreement: Cockenzie, and SBC: Prestonpans

38.1 Ms Anderson introduced a circulated report seeking approval for business cases for primary care in East Lothian. These cases had been given support at the Lothian Capital Investment Group on 25 August 2015 and the East Lothian Integration Joint Board on 27 August.

38.2 Ms Anderson confirmed that the current premises were not fit for purpose and it was proposed to increase the services provided in the new premises as well as re-patriating some services currently provided elsewhere.

38.3 Councillor Grant advised the Committee that that the population in the areas served by these premises had increased and current projections suggested that a further increase in population was predicted.

38.4 The Committee agreed to approve the:

- Initial Agreement for Cockenzie Health Centre;
- Standard Business Case for Prestonpans Health Centre

39. Initial Agreement: Edinburgh Inclusive Services

39.1 Mr White introduced the circulated report on the Initial Agreement for a project to re-provide the Edinburgh Access Practice from the Cowgate Centre and in doing so contribute to, and reinforce, a major re-design of the services delivered to the complex needs population of Edinburgh.

39.2 It was noted that the Cowgate Clinic would no longer be available from April 2016 and the previously identified alternative premises comprising the former offices of the Edinburgh Military Tattoo were no longer available as they were being purchased by the University of Edinburgh. It was therefore being proposed that the Cowgate Clinic and Leith Street premises be moved into a single property.

39.3 Professor Iredale commented that he was highly supportive of the initiative to provide a central hub for services to this element of the population which was over-represented as users of acute care. Whilst he understood the need for a timely solution to the closure of the Cowgate Centre it was also a timely opportunity to expand the project and he suggested that properties at Chalmers and Spittal Street could be considered.

39.4 Mr White agreed that moving the services delivered to the complex needs population of Edinburgh into a single property was desirable but at the moment an urgent replacement was required for the Cowgate Centre. He confirmed that there was an ongoing dialogue with the Community Planning Partnership to develop a holistic approach to the problem.

39.5 The Committee agreed to:

- Note that the Edinburgh Access Practice would be required to vacate its existing surgery in the Cowgate, at some point next year and that this was most likely to take place by April 2016.
- Note that any preferred long term re-provision of the Edinburgh Access Practice should take into account the review of city centre services for the complex needs population that was now underway and which was conducted jointly by Edinburgh City Council and NHS Lothian, under the leadership of "Inclusive Edinburgh".
- Note that co-location with other relevant services, delivered by both Edinburgh Council and voluntary sector partners might present an opportunity to deliver more positive treatment outcomes for patients of the Edinburgh Access Practice.
- Agree that as part of this exercise, consideration should be given to the long term accommodation requirements of other NHS Lothian community health services, based at Spittal St and Cambridge St in Edinburgh city centre.
- Approve the accompanying Initial Agreement and invite the submission of a Standard Business Case by the end of 2016 which will identify the preferred solution. In order to support the development of the Business Case enabling funding of £15K is requested to develop initial designs and costings for each of the options.

40. Standard Business Case: Loanhead

40.1 Mr Short introduced a circulated report seeking approval for the Business Case to re-provide the premises for Loanhead Medical Practice and Loanhead Clinic working in partnership with and delivered through Midlothian Council. He advised that the current premises were no longer suitable. The catchment population in the area was expanding as there that been considerable housebuilding in Loanhead. The proposals allowed for the facilities to be fit for the future.

40.2 The **Committee agreed to:**

- Note that following local agreement within the CHP and Shadow Board, the Initial Agreement was approved by the Finance & Resources Committee on 12 November 2014.
- Note that the practice premises were originally built as a satellite location to one of the Bonnyrigg practices, with the split to a separate practice taking place in 2010. It was now evident that these facilities were not sufficient as a stand-alone practice, with no room for visiting services, current or additional work-load and manpower.
- Note that the Loanhead Clinic premises, built in the 1960's, was some distance from the current practice premises, was in an isolated position and accommodated Health Visitors, Podiatry and the Sure Start (children's) services.
- Note the opportunity that has arisen for a partnership project with Midlothian Council and the resulting economies of scale realised by sharing a common foot-print with MLC services.

- Note that the Practice has made a commitment to increase their practice list capacity by 2,800 as a result of these proposals, which also addresses the immediate capacity constraints within the Practice.
- To approve the preferred option (Option 5) at a cost of £2,691k, to be paid to Midlothian Council in the form of a Capital Grant. This figure currently includes VAT, discussions are ongoing with council colleagues and our VAT advisers and it was hoped that the VAT burden would be reduced as the project progressed.

41. Property and Asset Management Investment Programme 2015/16 Capital Business Case Monitor

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

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

42. Date of Next Meeting

42.1 It was noted that the next meeting of the Finance & Resources Committee would be held on Wednesday 25 November 2015 at the Royal Infirmary of Edinburgh.

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HEALTHCARE GOVERNANCE COMMITTEE **1.8**

The draft minutes of the meeting held on 28 July 2015 are attached.

1. Key issues discussed included:

1.1 Acute Prescribing Processes

Members received a comprehensive report on improved acute prescribing processes including project work which projected significant anticipated savings and increased efficiencies.

1.2 Suspension of Inpatient Services at St John's Children's Ward

A verbal report updated members on the quality and safety issues related to the temporary closure of St John's Paediatrics inpatient services. Members received assurance that the service had been delivering safe care, but that the ongoing fragility of middle grade medical staff rota was the reason for the temporary reduction of services.

1.3 Person Centred Culture

Members were update on progress in the person centred culture work and the developments in the complaints and feedback service.

1.4 Improvement Plans for Pressure Ulcers and Healthcare Associated Infection

These two significant improvement plans were resented, providing reassurance that the Committee would see further data and supporting evidence of improvements in rates of pressure ulcers, *Clostridium difficile* and *Staphylococcus aureus* Bacteraemia.

1.5 External Reviews on Vascular Surgery and the Regional Eating Disorder Unit

Recommendations and improvements following the two external reviews of areas of clinical practice identified as problematic were considered.

Dr Morag Bryce
Chair of the Healthcare Governance Committee
17 August 2015

NHS LOTHIAN

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the Meeting of the Healthcare Governance Committee held at 9.00 am on Tuesday 28 July 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 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; Mr A. Sharp, Patient and Public Representative; Cllr F. Toner, Non-Executive Board Member.

In Attendance: Ms J. Bennett, Clinical Governance Manager; Dr B. Cook, Medical Director, Acute Services; Mr J. Crombie, Chief Officer, University Hospitals Services; Dr D. Farquharson, Medical Director; Mr J. Forrest, West Lothian CHCP Manager; Mr D. Gillan, Head of Soft Facilities Management (item 20.3); Ms J. Heslop, Chief Nurse, Royal Edinburgh Hospital (item 19.1); Mr B. Houston, Board Chairman; Ms M. Johnson, Director of Nursing; Professor A. McCallum, Director of Public Health and Health Policy; Professor A. McMahon, Director of Strategic Planning; Ms M. Monan, CAMHS Nurse Manager (item 19.1); Ms J. Morrison, Head of Patient Experience; Ms B. Pillath, Committee Administrator (minutes); Professor A. Timoney, Director of Pharmacy; Mr S. Young, Head of Spiritual Care and Bereavement (item 18.2).

Apologies: Ms S. Ballard-Smith, Deputy Nurse Director, Acute Services; Mr T. Davison, Chief Executive Ms P. Eccles, Partnership Representative; Ms W. Fairgrieve, Partnership Representative; Ms E. McHugh, Joint Accountable Officer, Midlothian Community Health Partnership; Mr D. Small, Joint Integration Manager, East Lothian; Dr R. Williams, 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.

13. Patient Story

13.1 Ms Johnson read out a letter from the family of a patient which was complimentary about the care received in ward 204 at the Royal Infirmary of Edinburgh, and wanted to thank all staff for being caring and attentive, friendly, genuinely going out of their way to provide help and support, and being a credit to the NHS.

14. Committee Cumulative Action Note and Minutes from Previous Meeting (26 May 2015)

14.1 The updated cumulative action note had been previously circulated.

14.2 The minutes from the meeting held on 26 May 2015 were approved as a correct record.

15. Matters Arising

15.1 Acute Prescribing Processes

15.1.1 A paper had been previously circulated. Professor Timoney noted that work was being done to ensure that prescribing efficiency was in line with prescribing quality, advising that medicines constituted 10% of the overall budget. The paper laid out systems being set up for closer management of acute prescribing. This included the establishment of an Acute Prescribing Committee jointly chaired by Dr Cook and Professor Timoney which sought engagement from clinicians representing different services either where specialist medicines were required or where problems had been identified.

15.1.2 NHS Lothian had a recognised and efficient Formulary but there was disconnect between Board level efficiency strategies and awareness of prescribing clinicians of the need to save money. Efficiencies were being considered item by item and work was currently in progress to review Hepatitis C including benefits for patients and the service. A proposed set up where patients would receive drugs through community pharmacy instead of in hospital could make an expected saving of £800,000.

15.1.3 The Homecare Medicines Team about which a paper had been previously submitted to the Committee had also come out of a project overseen by the Acute Prescribing Committee which was projected to make significant savings. These projects had achieved quality and efficiency improvements and had involved positive engagement with clinicians. Dr Cook noted that clinicians also welcomed the increased clarity around the use of expensive drugs.

15.2 Draft Lothian eHealth Strategy

15.2.1 The draft eHealth strategy had been previously circulated. Mr McMahon noted that it included a lot of technical detail and that priorities had been based on feedback from staff and clinicians both in Lothian and across Scotland. All of the top priorities in the strategy were already in progress. The strategy would be discussed at the Strategic Planning Committee, including any gaps and how it could be financed, and then would be submitted to the Board for approval.

15.2.2 Work on the problems with GP computer systems and servers was in progress, and a long term strategy laid out in the paper. A primary care eHealth forum had been set up. More work was needed on information sharing between the Integrated Joint Boards and NHS Lothian, although some work had commenced.

15.2.3 Professor McCallum noted that she was responsible for the parts of the strategy that were relevant to information governance.

15.2.4 Ms Meiklejohn supported the strategy and noted that the Area Clinical Forum recognised that the eHealth strategy was crucial for carrying out patient care.

15.2.5 Mr Houston noted that he would like to see eHealth looking at the Board strategy and coming up with innovative ideas about how eHealth could help drive strategy to ensure the Board met its objectives. He would discuss this further at the Strategic Planning Committee.

15.3 Update on Nursing Revalidation

15.3.1 An update paper had been previously circulated. Ms Johnson noted that the new revalidation system was expected to be implemented in April 2016 following the pilots currently underway. Awareness raising among staff was in progress in Lothian to mitigate the risk of staff not revalidating and therefore being unable to work. A further report would be submitted to the Committee following the completion of the pilots.

16. Emerging Issues

16.1 St John's Hospital Paediatrics

16.1.1 Mr Crombie advised that at the last Board meeting concerns were highlighted about the sustainability of paediatrics service at St John's Hospital due to staff shortages from sickness absence, maternity leave, annual leave and vacancies, and advised that the 24 hour paediatrics service be temporarily suspended. On 3 July the paediatrics inpatient service at St John's Hospital was changed to a day case service open 8am to 8pm daily, to ensure patient safety.

16.1.2 The situation had been monitored since by daily safety huddles and weekly meetings between stakeholders. A weekly situation report was also being circulated in Lothian and to the Scottish Government. Feedback was being sought from families of patients affected and data was being gathered on the number of patients transferred. There was assurance that safe and effective care was taking place and the situation was being reviewed. An update paper would be submitted to the August Board meeting.

16.1.3 This situation had come about following a period of time where 20-30 extra shifts per month were being covered voluntarily by existing staff from St John's Hospital, the Royal Hospital of Sick Children and through agencies. European Working Directive approval had been sought to allow these staff to work extra hours. There was a chronic inability to recruit paediatricians nationally and the vacancies at St John's Hospital had not been filled following international recruitment.

16.1.4 Cllr Toner asked whether the plan was to re-open the inpatient unit to a 24 hour service in the future. Mr Crombie advised that he was not ready to make this recommendation, and would make a statement following a staff meeting in the next week and discussions with the clinical director of Women's and Children's Services, and based on the data collected.

16.1.5 Cllr Toner asked whether children were being admitted to adult wards because of the suspension of 24 hour services. Ms Johnson advised that children over the age of 14 were routinely placed in adult wards in order to access specialist services. Mr

Crombie advised that any admission would be considered on an individual basis, and agreed to check the data for numbers.

16.1.6 Cllr Toner asked whether the service had been safe for the period before the suspension of 24 hour services. Mr Crombie advised that the service had been safe before the available hours were reduced further, but that there had always been a risk of short notice closures, which impacted on clinical care.

16.1.7 Dr Bryce noted that at the St John's Stakeholder group it had been agreed that an options appraisal and immediate review of the situation would take place. This would be followed by a comprehensive review of Paediatrics services as a whole which would include stakeholder involvement and was anticipated to take a number of months to ensure all areas were reviewed and options considered.

16.1.8 A further update would be given at the next meeting. **JC**

16.2 Healthcare Improvement Scotland (HIS) Reviewing the Quality of Care – Consultation

16.2.1 A link to the report had been previously circulated. Ms Bennett noted that following on from a number of reports on quality of care in particular areas of the country, Healthcare Improvement Scotland had produced this paper which focussed on key aspects of person centred culture identified in these reports. There was also a paper on how the recommendations would be assessed. The paper is out for consultation. The NHS Lothian response would suggest that the assessment and the recommendations should be more innovative and less mechanical. The closing date would be 30 September 2015 and individual responses were also encouraged.

16.3 Healthcare Improvement Scotland (HIS) West Lothian Mental Health Validation

16.3.1 Dr Farquharson advised that concerns from members of the public about the culture, complaints management, staff competencies, training and development had resulted in a validation visit by Healthcare Improvement Scotland to the West Lothian Mental Health Services. The visit included an inspection by a team of 6 HIS staff, during which they interviewed approximately 70 members of staff.

16.3.2 The report was very positive, finding that staff reporting a very good culture where any problems were quickly resolved, and finding that complaints and concerns were appropriately investigated. Recommendations made were regarding outside space for staff and some staff shortages, and these would be resolved by the end of the year. The full report with progress against actions would be submitted to the Committee in November 2015 or January 2016. **DF**

16.3.3 In response to a question from Ms Allan, Dr Farquharson advised that this inspection was separate to the Mental Welfare Commission, but that it did also take the views of patients and carers into account.

16.3.4 Mr Forrest noted that extra staff had been brought in on the day of the inspection to ensure availability to meet with inspectors, and that the reception was positive, some staff coming in on their own time as they wanted to take part. A very broad range of staff participated. The full report from the inspection had been shared with

staff, and management had also thanked staff for their participation. Healthcare Improvement Scotland had also provided the report to the initial complainants.

17. Corporate Risk Register

17.1 The updated Corporate Risk Register had been previously circulated. No points were raised.

18. Person Centred Culture

18.1 Person Centred Care

18.1.1 A paper had been previously circulated. Ms Johnson introduced Ms Morrison, Head of Patient Experience, who would now regularly attend meetings. Ms Morrison advised that in response to the recent review of the complaints process, the current members of the Complaints Team were working with Human Resources to dissolve the team so that staff could be considered for the new Patient Experience Team.

18.1.2 The devolved scheme for management of complaints was as recommended in the Dorothy Armstrong report was being trialled at the Royal Edinburgh Hospital. The new scheme gave clinical staff more opportunity to be involved in resolving complaints. The specifics of which function would be devolved to clinical teams and which would be retained by the central team were still being considered.

18.1.3 The current team had been chronically under resourced due vacancies and sick leave, and use of bank staff was considered to be less efficient as time was required for training. Activity was currently busier than usual – in May there had been 405 contacts, of which 250 where complaints.

18.1.4 Dr Bryce suggested that it would be helpful if non-executive directors could be asked what data they wanted to see on patient experience for informing decision making at Board and Committees, and if this could be included on Complaints reports. Ms Morrison noted that a lot of categorised data was collected, and certain figures were submitted regularly to the Scottish Government; it was planned that the new central team would have much more communication with clinical teams to support understanding of the data collected.

18.1.5 Cllr Toner noted that a third party website 'Patient Opinion' was being used for members of the public to sign in and make comments. He suggested that an NHS Lothian app could be developed to remind patients about appointments and prompt feedback. Ms Johnson advised that 'Patient Opinion was funded by the Scottish Government and had facilitated many positive responses; comments and results were available to all. She agreed that an app as described would be ideal and hoped something like this could be developed in the future.

18.1.6 Ms Morrison agreed that she would like to make it easier for patient to give feedback and make complaints, but noted that the initial focus would be on making the process for managing complaints fit for purpose.

18.1.7 Mr Houston noted an apparent seasonal variation in numbers of complaints, with more complaints in summer than winter. Ms Johnson noted that a number of

factors influenced the trend including one off events such as GP list movements, car parking changes, drug searches in prisons, etc.

18.2 Spiritual Care and Bereavement Update

18.2.1 The Chair welcomed Mr Young to the meeting and Mr Young spoke to the previously circulated paper. He noted that the bereavement service was in a period of transition; it was no longer advisory but was taking on referrals of both individual cases and project work with particular services and across NHS Lothian. An example was the work with Women's and Children's Services on the protocol for the death of infants and the Mortonhall report from the Scottish Government.

18.2.2 Mr Young noted that how we care for the bereaved and look after the deceased had become an important part of society and was a matter for discussion in the public forum more than before.

18.2.3 In response to a question from the Chair, Mr Young noted that staff were doing overtime to sustain the service. There had been some pressure as the balance of funding had shifted from spiritual care to the bereavement service but this was currently sustainable.

18.2.4 Ms Johnson noted that there had been some discussion nationally about changes to services in the community as part of health and social care integration but advised that this was a small resource which was already focussed on the most important areas. There were also good relations between bereavement services and other agencies and religious organisations, but spiritual care was traditionally focused in hospitals. Specific work was ongoing and would try to transcend traditional chaplaincy roles.

18.2.5 Mr Young advised that most referrals were of patients and families not already affiliated to religious organisations and were situation driven rather than based on religious needs.

18.2.6 In response to a question from Ms Meiklejohn about whether risks were being managed, Mr Young noted that at busy times some smaller areas may only receive basic cover, but advised that the primary spiritual care providers are the ward and clinical staff, with the spiritual care and bereavement team providing secondary care in more difficult areas.

19. Safe Care

19.1 Mental Welfare Commission Report – Unannounced Visit to Child and Adolescent Mental Health Service (CAMHS)

19.1.1 The Chair welcomes Ms Heslop and Ms Monan to the meeting and they spoke to the previously circulated paper. Ms Monan noted that there had been a staff shortage in the CAMHS inpatient unit due to a higher referral rate and increased activity. It was noted that this increase was due to the successful management of patients in this service; patients were received from all over Scotland. Costings had been carried out for the requirements to regain safe staffing levels; in the meantime bank and agency staff were being employed. This was safe but the impact was of

lack of continuity for patients and staff, as bank and agency staff may not be trained or experienced in this area, and only work in the unit for a short period of time.

19.1.2 In response to a question from Cllr Toner, Ms Heslop advised that there were staff available to recruit in this area as training was carried out in house.

19.1.3 Professor McMahon noted that additional funding from Scottish Government money available had been requested at a recent meeting with the Chief Executive about the CAMHS and psychological therapies service.

19.1.4 Professor McCallum noted that there had previously been a delay in patients being repatriated to their home Board. Ms Heslop advised that this had now improved since a unit in Dundee had opened. It was noted that the Lothian model was focussed on working with local agencies and communities to ensure that the inpatient period was as short as possible; and other Boards used a model with a longer inpatient period so had a lower turnover of patients. This meant that patients from other Boards stayed longer in Lothian than Lothian patients, but this was being worked on.

19.1.5 Professor McCallum noted that one of the recommendations of the Mental Welfare Commission report was to increase administrative support so that nursing staff could focus on nursing duties. Ms Heslop noted that some work had been done to free staff for nursing duties, for example the new Housekeeper role which had been very successful. These roles would be considered in the future.

19.2 Review of Pressure Ulcer Management and Improvement Plan

19.2.1 A paper had been previously circulated. Ms Bennett noted that the majority of pressure ulcers were acquired in the community, including at home and at nursing homes. Hospital acquired pressure ulcers were fewer and less advanced, but the likelihood of community acquired pressure ulcers developing to grade 3 and 4 could be reduced by early intervention. The improvement plan recognised that different interventions would be relevant in different service areas and needed to take into account the causes of ulcers, including food and fluid, continence and care at home.

19.2.2 The improvement plan included the need for a better review process following adverse events, with some guiding principles. Tissue Viability nurses would also be working with reviewers to identify contributing factors. There were also plans to work more closely with patients and carers on safe care and what was expected of carers.

19.2.3 The use of the reward system to reduce incidents had been successful and the target of 50% of wards going 300 days without a pressure ulcer had been exceeded at 68%. This was also being used to highlight good work and give support to areas not meeting their target, and for raising awareness.

19.3 Healthcare Associated Infection Report and Improvement Plan

19.3.1 A paper had been previously circulated. Ms Johnson noted that the HEAT targets for Healthcare Associated Infection were not being met for the year 2015-16. This

was expected as work was required and there would be a time gap between implementation of new measures and resulting change.

19.3.2 Work on the Healthcare Associated Infection Standards was in early draft form. The key issues identified for improvement were the antibiotics guideline, the cleaning regime pilot at the Western General Hospital to stop using actichlor for routine cleaning, and adherence to standard infection control precautions and transmission based precautions.

19.3.3 There was currently no Infection Control Doctor and consideration was being given to better ways of covering this need due to issues around the amount of time needed to carry out the role.

19.4 Public Protection Update

19.4.1 A paper had been previously circulated. Ms Johnson noted that the Adult Support and Protection Conference would take place on 26 November 2015 and would focus on important issues including female genital mutilation and human trafficking; all were welcome to attend.

19.4.2 In response to a question from Dr Bryce about changes as a result of the creation of the Integrated Joint Boards, Ms Johnson advised that the Public Protection Team was already totally integrated with local authorities and the Police and this arrangement would not be changed. Chief Officers Group meetings for each local authority area were attended by the chief executive of each council.

19.4.3 In response to a question from Ms Allan, Ms Johnson advised that child and adult protection services were available 24 hours as paediatric and forensic consultants were always available, the Police were always available, and Social Work had on-call arrangements.

19.5 Update on Governance of Independent Healthcare Providers

19.5.1 A paper had been previously circulated. Mr Crombie advised that this paper concerned the process of having proper governance arrangements for use of private healthcare. An update paper would also be brought in 6 months' time. **JC**

20. Effective Care

20.1 Vascular Surgery Review

20.1.1 A paper had been previously circulated. Dr Cook noted that problems with the functioning of the vascular surgery team due to differences in clinical opinion had been brought to the attention of senior clinical managers, who had asked for a review of the service by the Vascular Society of Great Britain and Ireland. This also allowed the performance of Lothian's vascular service to be compared to other UK services. Some recommendations from the review were already being met, for example concerning staff training.

20.1.2 Dr Bryce noted that this issue had been in the press, and wanted to know what happened to reassure patients waiting for operations who read this. The

Communications Team would be asked to comment. Ms Morrison noted that the complaints team had been aware of this but had received no complaints. Staff in the day unit had also been aware but there were no issues.

20.1.3 In response to questions about whether there was awareness of the issue before it reached this critical stage, and how any similar issues elsewhere would be identified, Mr Cook advised that the some work had been done on the issue previously but events overtook this so that the review was requested. Mr Crombie noted that these were difficult areas and that the initial concerns raised were around staff competence; steps were taken to ensure this before the complexities of the situation became clear. Mr Crombie wanted to reassure Members that the acute team had taken responsibility for looking into similar problems previously.

20.1.4 Professor McCallum noted that sometimes not enough support was given to services undergoing changes such as population change and new technologies or methods, and that if this could be anticipated such situations could be checked.

20.1.5 Dr Farquharson noted that a system had recently been put in place so that all external reviews would be requested through the Medical Directors so that they would have an overview of activity.

20.2 Regional Eating Disorders Unit Update

20.2.1 A paper had been previously circulated. Dr Farquharson advised that following concerns and complaints raised about the unit, an external review had been commissioned from the Royal College of Psychiatrists. The recommendations coming from the review were complex and included local, site wide and Lothian wide actions. An action group had been set up to oversee implementation of these.

20.2.2 The resignation of the lead clinician of the unit had caused some problems with cover, but robust arrangements were now in place for the next 3 months before the appointment of a new clinical lead.

20.2.3 In response to a question from Ms Allan, Dr Farquharson noted that the papers included a letter which identified the clinician involved, and stated that the clinician had been happy for this information to be made public.

20.3 Catering Strategy

20.3.1 The Chair welcomed Mr Gillan to the meeting and Mr Gillan spoke to the previously circulated paper. He asked for endorsement from the Committee of the strategy and the proposed next steps of developing a business case to deliver the strategy and carry out a review on recipes and processes. Mr Gillan noted that it was an obligation to have a catering strategy to improve quality and efficiency of services and that good quality food was directly linked to patients getting better and reducing length of stay. A person centred approach was being used to ensure the right food would be available at the right time. Food was currently produced in 5 main hospital kitchens, but that more capacity was required as well as update of facilities to remove food hygiene and safety risks.

20.3.2 A public engagement had been completed on the strategy which had been updated in response to views raised. There had also been consultation with staff and stakeholders and a Soil Association representative had sat on the planning group. Ms Allan noted that the response level to the public engagement was low but responses received had been useful. Focus groups were also planned as part of the impact assessment for the strategy.

20.3.3 Ms Allan noted that the strategy covered property, sites and wellbeing and covered the full process from sourcing ingredients to serving food. Mr Houston felt that the strategy was an exemplary piece of work which was thorough, related to existing polices, and was important as a response to patient feedback received through the Complaints Team noting dissatisfaction with hospital food. Ms Morrison noted that feedback from patients about food could be contradictory, with positive comments as well as negative, as individual tastes and expectations were influential in this area.

20.3.4 Cllr Toner noted that if patients were not happy with the food provided then vending machines and shops in the hospitals sold sweets and fizzy drinks, and asked whether these could be regulated as part of the strategy. Mr Gillan advised that there was work ongoing to seek engagement with contractors to ensure that products available in shops and vending machines met with healthy living standards. Professor McCallum noted that the availability of healthier products would also be of benefit to staff.

20.3.5 Ms Gormley suggested that the success of the strategy should be monitored following implementation to ensure that any problems were identified. She noted that at the Royal Hospital for Sick Children food was taken onto the site by parents. The more flexibility and the better food at home could be replicated the more positive the response. Mr Gillan noted that family engagement, including the support of children, while in hospital was central to the strategy, which included plans to have a member of catering staff in wards discussing nutritional needs with the family.

20.3.6 Ms Johnson felt that the strategy covered too wide an area and the food and nutrition part should be separated from the technical and facilities part. Food and nutrition should also cover patients that need help with eating, tube feeding and food, fluid and nutrition monitoring. She also had expected there to be more detail about kitchen facilities, staff and cost savings, and felt that work in other areas covered in the strategy would be ongoing. Ms Allan suggested that this would be part of the business case which would be the next step. Mr Gillan felt that the two areas complemented one another and neither would be possible without the other in place.

20.3.7 The strategy was endorsed by the majority of the Committee but Ms Johnson requested further discussion with Ms Allan and Mr Gillan before agreement, and this was agreed. **MJ / SA**

20.4 Quality Report

20.4.1 A paper had been previously circulated. Ms Bennett advised that most items of interest had already been covered as part of the agenda.

20.4.2 There was discussion about the link between patient experience and staff experience and how a better indication of staff experience could be gained. Currently the only indicator on the Quality report was staff absence and sickness. It was suggested that work on this could be taken forward through Mr Joyce and Mr Boyter.

21. Exception Reporting

Members noted the previously circulated papers for information:

21.1 Information Governance Annual Report;
21.2 LHSA Accreditation;
21.3 Edinburgh Transplant Unit Annual Report;
21.4 Diabetic Retinopathy Screening Annual Report;
21.5 Homecare Medicines Service Review;
21.6 Research and Development Report.

22. Other Minutes: Exception Reporting

Members noted the previously circulated minutes from the following meetings:

22.1 Area Drug and Therapeutics Committee, 12 June 2015;
22.2 Clinical Management Group, 14 April 2015, 12 May 2015;
22.3 Lothian Infection Control Advisory Committee, 17 June 2015;
22.4 Organ Donation Sub Group, 28 May 2015;
22.5 Public Protection Action Group, 20 May 2015;
22.6 Acute Hospitals Committee, 2 February 2015, 7 April 2015.

23. Date of Next Meeting

23.1 The next meeting of the Healthcare Governance Committee would take place at **9.00 am** on **Tuesday 22 September 2015** in **Meeting Room 7, Second Floor, Waverley Gate**.

23.2 A further meetings in 2015 would take place on the following date:
- 24 November 2015

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STRATEGIC PLANNING COMMITTEE **1.9**

The draft minutes of the meeting held on 13 August 2015 are attached.

Key issues discussed included:

- Edinburgh Bioquarter masterplan including proposed re-provision of Princess Alexandra Eye Pavilion
- Western General Hospital site masterplan including options for Cancer Services development and shorter term radiotherapy expansion requirements
- Progress with reprovision planning for Edinburgh Cancer Centre on a regional basis
- Update on plans for improving older people's services in Edinburgh, East and Midlothian
- Update on the development and delivery of 3 phases of primary care strategic priorities, including LUCS GP out of hours service
- Consultation on the refreshed E-Health strategy
- Edinburgh IJB Strategic Plan received for consultation
- Progress with Midlothian IJB Strategic Plan
- Update on East Lothian Community Planning Partnership key developments
- Update on West Lothian Partnership and IJB planning process
- An Invitation for NHS Lothian to participate in two EU funded innovation projects
- NHS Lothian Performance Delivery Reporting in 2015/16

Key issues on the horizon are:

- Final proposals for learning disability service redesign including autism unit
- St John's Hospital site masterplan

Brian Houston
Chair

Alex McMahon
Executive Lead

DRAFT

NHS LOTHIAN

STRATEGIC PLANNING COMMITTEE

Minutes of the Strategic Planning Committee Meeting held at 9.30am on Thursday 13 August 2015 in Meeting Room 5.4, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mrs A Meiklejohn (Chair); Mrs J Anderson; Mr M Ash; Professor J Iredale; Mr P Johnston; Mr A Joyce and Councillor F Toner.

In Attendance: Mr A Boyter; Mr C Briggs; Mr J Crombie; Mr T Davison; Mr I Graham (for item 24); Mrs S Goldsmith; Mrs C Harris; Dr T Keogh (for item 24); Ms F Ireland; Ms D Milne; Professor A McMahon and Mr D A Small and Mr D Weir.

Apologies for absence were received from Mr B Houston, Mrs K Blair, Ms M Johnson, Professor A K McCallum and Mr G Walker.

21. Declaration of Financial and Non Financial Interest

21.1 The Chair 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.

22. Minutes of the Previous Meeting held in 11 June 2015

22.1 The minutes of the previous meeting held in 11 June 2015 were approved as a correct record.

23. Matters Arising

23.1 Learning Disabilities – The Chair questioned when the final proposals would come forward to the Strategic Planning Committee. It was noted in respect of East Lothian that the proposals had not gone to the Shadow Integration Joint Board in June although they had been discussed at the East Lothian Health & Social Care Joint Management Team where they had been supported in principle. Further consideration was needed around the higher needs unit for autism with discussions being required around the potential risks for the East Lothian Partnership.

23.2 Mr Ash commented it had been hoped learning disabilities would have been discussed during June / July and this was an area where care would need to be taken around the process. He stressed if the unit were to exist then all IJB's would need to be in agreement and reflect this in their strategic commissioning

plans in April 2016. This would allow a few months for agreement or otherwise to be reached. Mr Ash felt that the proposals would probably also involve all 4 local authorities and in that regard Directors needed to come up with final proposals in the very near future. Mr Small commented that the availability of capital was also an issue and East Lothian Council did not have a budget for this and in that regard an alternative funding source might be required.

23.3 Professor McMahon advised proposals supported by all 4 IJB's needed to be brought forward to cover all appropriate linkages. It was noted that this was a delegated function that needed to be led by the IJB's with NHS Lothian playing into the proposals in particular in respect to Royal Edinburgh Hospital capital issues. It was noted that the learning disabilities collaborative chaired by Ms Eibhlin McHugh was due to meet in the near future.

23.4 The Committee noted that a time line of October was being worked to for the production of final proposals.

23.5 Bioquarter – It was noted that the Princess Alexandra Eye Pavilion (PAEP) would be the first significant project in respect of Bioquarter progress. The Committee were advised a meeting had been held with Scottish Enterprise and the University of Edinburgh in order to consider how the capital plan could be enhanced. It was reported that the business case was being updated and was well on track. The business case would be progressed through the Acute Hospitals Committee prior to being submitted to the Board.

23.6 It was noted that NHS Lothian, Scottish Enterprise and the University of Edinburgh were in the process of producing a mini masterplan for the PAEP as well as outpatient services at the Bioquarter which once open would allow the existing ward at the Royal Infirmary of Edinburgh to be redeveloped with additional beds. The business case would open up a more cost effective approach for the Royal Infirmary of Edinburgh as opposed to providing a new build proposal for either the Royal Infirmary of Edinburgh or the Western General Hospital to bring back orthopaedic services from the private sector.

23.7 The point was made that there was a need to clarify the role of the Western General Hospital in relation to acute medicine. If funding was available to develop outpatients at the Bioquarter this would free up the option to move acute medicine to the Royal Infirmary of Edinburgh to set the service scene for the next 10-20 years.

23.8 An update report would be provided to the next meeting of the Strategic Planning Committee.

23.9 Terms of Reference and Remit of the Strategic Planning Committee - Professor McMahon would circulate to members of the Committee details of the terms of reference and remit at the earliest opportunity.

24. Western General Hospital Masterplan Presentation

24.1 The Committee received a detailed presentation on the Western General Masterplan from Mr Graham (Director of Capital Planning & Projects) a colour copy of which was circulated to Committee members following the meeting. It was noted that the presentation was limited to how the Edinburgh Cancer Centre would be delivered and the LINACC option for the interim period.

24.2 The timing pressures around cancer services were explained with it being noted that regional work was progressing well with a view to providing a pathway approach to cancer reprovisioning during a period of increasing clinical demand. It was felt to be important that the Committee were sighted in the progress being made. It was noted a key issue was around radiotherapy capacity in terms of both staff and machine availability. SEAT funding had been obtained and issues around the LINACC machines represented the most pressing part of the timeline. The operational requirements in respect of energy rooms and space bundles for medium and high energy machines was discussed in detail in terms of increasing workload and the increasing length of the working day. The next medium energy machine would be required by 2017 with the replacement of the high energy machine being required in 2024.

24.3 The Committee noted a team visit had been made to an English facility where valuable lessons had been learned. It was reported that national radiotherapy capacity was an issue with the Scottish Government having work in progress around this. In terms of the 2024 deadline there were 3 options under consideration - a modular build, a permanent facility with a £12m sunk cost or to develop a Beatson style model.

24.4 The Committee discussed the need to maximise the efficiency of the service and the machines during any transitional period in order to avoid the creation of 3 separate radiology services.

24.5 The Committee was reassured of the importance of the continuation of cancer services on the Western General Hospital site and Mr Crombie advised a significant piece of work was in place to move forward a suitable structure. It was noted in terms of national procurement that a 10 year programme was in place and once Lothian had clarity around the transitional period appropriate discussions would be held with the Scottish Government. It was reported that the cost of additional LINACC's would fall on host Boards with replacement thereafter being funded.

24.6 The point was made that partnership working in cancer services was a success story and this had resulted in ongoing investment in Edinburgh. In terms of the Western General Hospital it was noted that this was not a brown-field site and it would be important to consider the impact on the site of the proposed development. It would be important therefore when strategic decisions were being made to future proof the site.

24.7 The Chief Executive suggested there would be merit in waiting until DCN moved and was demolished and then move straight to a 10 bunker solution rather than

adopt an interim position which was in danger of creating 3 radiotherapy sites. He questioned whether the bunkers could be fast-tracked as this was a similar approach to what happened at the Beatson Clinic. This would have the added advantage of protecting capital investment for the permanent solution.

24.8 Councillor Toner commented that he felt it was curious that St John's Hospital which had scope for development had not been considered to take services from the Western General Hospital. He commented that he was concerned about the Chief Executive's earlier comments about orthopaedics moving to the Royal Infirmary of Edinburgh when Edinburgh hospitals were not performing well and that there had been no mention of new services at St John's. The Chair stressed there was still an organisational commitment to developing St John's Hospital. The St John's Hospital site masterplan would be discussed at the October meeting of the Committee.

24.9 Mr Crombie commented that proposals were currently being pulled together and reviewed. Thereafter an evaluation would be brought back which would set the vision for the next 10-20 years. It was noted that this process would take until the end of the year.

25. Reprovisioning of Edinburgh Cancer Centre

25.1 The Committee noted that this paper linked directly with the previous Western General Hospital masterplanning presentation. It was noted the development of the quality agenda in NHS Lothian's cancer care and treatment had featured heavily as part of the discussions in respect of pathways and service developments that might fall under the emerging 'NHS Lothian Quality Improvement Academy' and also the 'choosing wisely' agenda.

25.2 Professor McMahon commented the main purpose of the paper was to bring the Committee up to speed on developments. He advised a Cancer Reprovisioning Group was looking at pathways to reflect increasing patient demands. Smaller tumour issues were being addressed nationally. Regional work was underway within the national context with the current option under consideration being a modular solution although further debate was needed about this as well as further information around costs.

25.3 The point was raised about how much it would cost to build a new state of the art facility somewhere other than the Western General Hospital site. Mr Crombie advised that at a point in time there would be a need to look at the future of the Western General Hospital and what the flow of acute care would be like for individual specialties. This would include the need to be clear about what each campus would deliver and the associated cost. These plans would need to be phased over a number of years. It was noted that the University of Edinburgh was not factored into the paper and it would be vital this was seen in the round.

25.4 Professor McMahon commented that the masterplan would need to come back to the Strategic Planning Committee. It was noted that the radiotherapy group would meet later in the month and would play into SEAT Group discussions. Mrs Goldsmith advised one of the reasons for undertaking the masterplanning process

was to provide an indication of what NHS Lothian's requirements would be in respect of the comprehensive spending review.

25.5 The Strategic Planning Committee supported the recommendations contained in the circulated paper.

26. Improving Older Peoples Care – Edinburgh, East Lothian and Midlothian

26.1 The Committee was reminded at the previous meeting and at the Board it had been agreed that an update report would be provided on the reprovisioning work in Edinburgh and connectivity with East and Midlothian. Professor McMahon provided an update report on progress since the Committee paper had been written. It was noted in terms of the bid for bridging finance that the Cabinet Secretary had received the requested paper on 31 July 2015. The bridging finance had been referenced at the annual review meeting and since then meetings had been held with the Scottish Government where they had advised they felt that neither NHS Lothian nor the City of Edinburgh Council were doing enough work to address the extant issues. A request had been made for a further paper to be produced for the Cabinet Secretary.

26.2 Professor McMahon provided an update on the recruitment process for the Edinburgh Chief Officer and Chief Finance Officer posts. It was noted that the structure would be locality based (north and south). An IJB development session specifically on older people's services and finances was in the diary. The Scottish Government had requested timelines around closures, care home provision and when progress was anticipated. An extension to their initial deadline for the supply of this information had been granted. At the Leadership Group meeting held earlier in the morning progress had been made around Royal Victoria Hospital and Liberton Hospital issues.

26.3 The Cabinet Secretary had asked through the Scottish Government what NHS Lothian and the City of Edinburgh Council were doing to address the financial deficit. In response the City of Edinburgh had detailed what they were doing to address the £16m with it being advised that NHS Lothian was looking at issues around prescribing, REAS and the Royal Victoria Hospital. It was noted that aspects of this would be predicated on work around the development of work around the Midlothian Community Hospital and the repatriation of patients. The Committee were advised however that there were unprecedented levels of delayed discharges in Edinburgh which had not been seen since 2007. It was advised that individual packages of patient care could not be met by the private sector. Discussions were being held with the City of Edinburgh Council about whether some degree of social care capacity could be brought back in-house. It was noted a plan around older peoples care needed to be submitted to the Board in October.

26.4 The Committee were advised that the provision of a further 30 beds at Gylemuir could be secured and this would improve flow in the system as well as being a key message in demonstrating progress to the Scottish Government.

26.5 It was suggested in terms of moving capacity back in-house to the City of Edinburgh Council that this might be difficult because of recruitment issues both internally and externally. Mr Ash commented that previous experience elsewhere around delayed discharges suggested that taking services back in-house would not resolve the problem and the key requirement was around the need to build capacity. It was stressed however that the intention was not to seek to bring all of the capacity back in-house but only a proportion of it.

26.6 The point was raised that the interdigitation of closing Liberton Hospital was not just an Edinburgh issue. It was noted that when resources from this exercise were released it would be important to be clear about where they would go. Mr Small advised that the outline business case for East Lothian Community Hospital in terms of rehabilitation activity currently had a revenue gap and this was being worked through. In terms of key timelines it was reported there might be a need for temporary accommodation to address some of these issues. Mrs Goldsmith advised this would require a separate proposal in terms of public sector / private sector financial classification.

26.7 Mrs Anderson felt futuristic plans needed to put in place in respect of the models of care needed to sustain the community hospital particularly in terms of hospital to home models of care of which there were already good examples in East Lothian. She suggested investment was needed around advanced nurse practitioners as this would translate into a reduction in front door pressure albeit the training process for such staff took a few years. Ms Ireland advised that 14 people had started in general practice and that consideration was being given to looking at the district nursing and frailty models that kept people out of hospital in the first place. The Committee noted that the solution was not only around band 6 nurses nor about increasing numbers of district nurses per se with there being a need to look at other professions and how they could be engaged as part of the solution.

26.8 It was suggested that care at home and the Edinburgh position was over spilling into other issues and areas. It was noted that Midlothian care home services were being retendered to ensure payment of the living wage which it was hoped would assist in recruitment terms. COSLA and the Scottish Government were looking at introducing the living wage into care homes in the current year. The suggestion was made that there would be benefit in investing in reablement services to keep people out of the acute sector.

26.9 The Committee was advised in Edinburgh some patients were awaiting care home places and although Edinburgh had increased the rate of pay to the private sector this had not addressed issues around travel time costs. It was noted that the City of Edinburgh Council were looking at the East Lothian model and that all other available solutions were being explored including reablement and care home capacity. It was noted that whilst recruitment issues were largely for IJB's to resolve the position in Edinburgh appeared to be fundamentally different in terms of the recruitment market.

26.10 The Chief Executive advised he had discussed with Ms Eibhlin McHugh and colleagues a process of discharge to assess for low level home care needs with patients being assessed at home. The suggestion had been made that other

parts of Lothian could in-reach into Edinburgh to provide assistance with home care services. Councillor Toner commented that West Lothian could not afford to undertake such an approach and commented that he welcomed the fact that Edinburgh was looking to move some services back in-house as the vagrancies of the private sector were alarming. He suggested there was a requirement for the Scottish Government to provide additional funding to local authorities.

26.11 Mr Ash commented whilst in a few years it would be fair to say this would be an IJB issue to resolve he felt at the moment there was a need for a focussed look and assessment to include a view on how other IJB's would be affected. It was noted a KPMG presentation had been given to East Lothian IJB which had focussed on a near neighbourhood scheme. In terms of IJB governance assurance it was noted these issues would be discussed at the Corporate Management Team (CMT) and that there would also be a requirement for each part of the organisation to comment on the others joint commissioning plan. The point was made that it would be important not to underestimate the detrimental impact on patients of the current position and there was therefore a need for an urgent solution.

26.12 The Committee noted the recommendations contained in the circulated paper and that a paper would be submitted to the October Board meeting.

27. Primary Care and Lothian Unscheduled Care Services

27.1 The Committee received an update report on the development and delivery of the primary care strategic propositions outlined in Our Health, Our Care, Our Future – NHS Lothian Strategic Plan 2014-2024. In terms of stage 1 progress was noted in relation to the initial investment of £1m for GP practices. Stage 2 funding still required to be identified to support a special measured package to meet the needs of practices at significant risk of service disruption and to deliver initiatives to alleviate difficulties associated with general practitioner recruitment and retention and increasing workloads which negatively impacted on access for patients. In terms of stage 3 work was being taken forward within the 4 Health and Social Care Partnerships to support development of models of care to support the frail elderly in the community.

27.2 The Committee noted that on 25 June 2015 the Scottish Government had announced details of how the primary care fund would be used to support the primary care workforce, including GPs and improved patient access to these services. It was reported that £50m was to be invested to address immediate workload and recruitment issues, as well as putting in place long term sustainable change within primary care. In addition £10m would be invested in primary care mental health services to encourage innovative ways of encouraging better identification and management of patients with mental heath needs in the community.

27.3 The Committee was advised in terms of the out of hours service a number of proposals had been taken forward. Rota coverage over the summer period had been less problematic than anticipated with flexibility around rates of pay having been helpful. A proposal had been put forward in respect of study leave for

salaried doctors and annual leave for bank and agency staff. The Corporate Management Team had considered proposals around the out of hours services and whilst recognising the real issues had been unable at this point to sign-off the proposals because of the financial position.

27.4 The Chair advised that Forth Valley had used pharmacists and advanced nurse practitioners to positive effect and she would encourage NHS Lothian and the IJB's to adopt a similar approach around the use of other professionals. It was noted phase 2 and 3 discussions with the GP Sub-committee would consider different pathways of care.

27.5 Professor McMahon commented that strong dialogue continued with the practitioner community with a central IT service about to be piloted in 12 practices with it being hoped that 4 hours per GP practice would be freed up by not dealing with IT issues. The point was made that in terms of the establishment of IJB's that there was a need for a real time IT infrastructure. The Committee was advised that Dr John Steyn who was an experienced GP was supporting the IT agenda. Currently all GP practices had their own servers and the NHS Lothian IT department did not have the capacity to respond timeously to their needs. A secondary issue was the disparity of different systems used. The Committee noted significant work was being undertaken nationally and internally around the IT agenda. The possibility of a single IT system across Lothian was being considered and the pilot project would be useful in this regard. The full rollout of a pan Lothian system would require capital investment to move it forward.

27.6 Mr Small confirmed that East Calder Health Service was on the long list of the GP premises capital programme with progress being dependant upon timing issues and the availability of capital. It was noted that the paper before the Committee focussed on revenue issues.

27.7 The Chief Executive suggested the next step should be to ask the GP Sub-committee to write to the Scottish Government suggesting that they allocate the primary care fund to match locally identified priorities. Professor McMahon and Mr Small would progress.

28. Refreshed e-Health Strategic Plan Consultation

28.1 Professor McMahon commented that the circulated paper represented a list of issues addressed and those still in the pipeline to be done. He commented that the plan did not go far enough in respect of being a statement of innovation. He advised in terms of the consultation process that he had no fear about the nature of responses that might come back in terms of suggested improvement. It was noted that the plan had been considered by the Healthcare Governance Committee. It was reported that consultation road shows were being undertaken and would include IJB's. The issue of IT had been touched upon at the annual review with the Cabinet Secretary.

28.2 The Committee noted that a meeting was scheduled between e-health and communications to discuss issues around the internet and supporting software in order to allow information to continue to be provided.

28.3 In terms of the hospital electronic prescribing service further work was still needed and would require investment from both the Board and IJB's. It was agreed there was a need to encourage people to do self management plans prior to accessing other services.

28.4 The Chief Executive updated on work with Intermountain and Dr Brent James where the need for triangulated data that tracked activity, outcomes and finances had been stressed. He advised that the Quality Academy would target 4 or 5 areas to improve outcomes and costs. He commented that the information strategy would need to be able to triangulate data whilst recognising that it might take around 3 years to move to a full e-system. In the meantime a paper based costing system that linked activity and outcomes was needed. It was noted that funding discussions had been held with the Foundation Trustees around the need for a step change from what was currently undertaken. The Chief Executive commented that internal analytical capacity would probably require to be enhanced.

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

29. Edinburgh Integration Joint Boards Strategic Plan

29.1 The Committee noted that all 4 partnerships were developing strategic plans which included needs assessment. It was noted that the strategic plans represented a significant opportunity to influence the shape and content of commissioning plans. It was noted there was a need to submit an NHS response to the plans. The need to translate the circulated paper into a commissioning plan capable of going live on 1 April 2016 was noted. An Edinburgh IJB development session would be held focussing on older people and finances. It was noted that a final plan would be submitted to the Committee in October.

29.2 Professor McMahon detailed the approval process for respective plans to the Committee. The Chief Executive stressed this was a new process for all involved and that the strategic commissioning plans for 2016/17 would need to based around financial assumptions and budget setting and that for September there would be a need to set out core assumptions for IJB budgets even if on an indicative basis to reflect their statutory status and the need to develop strategic commissioning plans.

29.3 Mr Small commented there needed to be an iterative process in place leading from respective development sessions before an agreed position was reached. It was noted that NHS Lothian would provide an IJB budget on which the IJB's would have a view. It was noted that IJB Chairs would sit on the NHS Board when the budget discussions were being held and it would be important therefore that at each meeting they should reflect on their respective roles.

29.4 It was noted that the IJB process was complicated and needed to dovetail into the NHS Lothian strategic plan.

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

30. Midlothian Integration Joint Boards Strategic Plan

30.1 In the absence of Ms McHugh the circulated paper was presented by Professor McMahon. It was reported that the paper would be submitted to the first IJB meeting on 20 August 2015. It was noted that the paper was before the Committee for comment and noting.

30.2 The point was made in terms of locality working the financial data needed to be worked upon and reflected in the needs assessment. It was stressed that the paper was still in draft format and was being consulted upon with the deadline for approval by IJB's being December 2015 for subsequent approval by the parent Board. It was noted plans were in place around how to use the funds known to be available to the IJB for use in the community. As in other partnership plans the House of Care Pathway was echoed in the development process.

30.3 Councillor Toner updated on progress being made in West Lothian in the absence of the IJB not yet having been formally constituted. He assured the Committee that positive work was progressing.

30.4 The Chief Executive reminded colleagues that the Strategic Planning Committee was an NHS Lothian Board Committee and IJB's required to consult the Board on their plans. He commented that the 2 areas where assurance was needed were around alternatives to admission / reducing the rate of admission and reducing delayed discharges.

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

31. East Lothian Partnership Key Developments

31.1 Mr Small advised that the report updated the Committee on the partnership developments underway through the East Lothian Community Planning Partnerships advising that the rationale was to dock this overview into the statutory organisation.

31.2 It was noted that within East Lothian that the Resilient People's Partnership was chaired by Mr Ash and this provided a better focus with single outcome agreements produced as detailed in the appendix to the paper. It was noted that these were all areas where other partners could contribute to and sat within the IJB agenda.

31.3 The Committee noted that the key measurements were not clear from the paper. It was reported that a new measurement was being developed around emergency admissions which would bring together all existing ones into a single measure which would capture a wider sweep of data through a single indicator. Details of this would appear in the next iteration of the strategic plan.

31.4 Professor McMahon commented that formal agreement had been secured for a lead director and Non Executive Board member to serve on the Community

Planning Partnerships and this would provide a richer NHS Lothian contribution and would address previous criticisms about NHS Lothian being a poor attender at these meetings.

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

32. West Lothian Community Partnership and Integration Joint Board Planning Process

32.1 Councillor Toner commented the Parliamentary recess had impacted on the formal process of establishing the Strategic Planning Group in order to prepare the strategic commissioning plan. He stressed however that the West Lothian Community Health Partnership was well established and joint working continued through the process. In the meantime service delivery and formal meetings continued. The formal West Lothian plan would come forward in October 2015.

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

33. NHS Lothian Innovation Programme Invitation to Participate in 2 European Union Funded Innovation Projects

33.1 The Committee agreed that NHS Lothian should confirm with the Digital Health and Care Institute of Scotland its formal agreement to participate in 2 European Union funded collaborative projects linked to the development of Health and Social Care 'Eco systems'.

33.2 It was noted a more detailed update on the wider NHS Lothian Innovation Programme would be presented to the Committee at its October 2015 meeting.

34. NHS Lothian Performance Delivery 2015/16

34.1 It was noted although this item had been marked for information on the agenda it was agreed that it should in fact be discussed as the paper's contents reflected a key result area for the Strategic Planning Committee to monitor.

34.2 It was noted that the Corporate Management Team had agreed that there was a need for a different way of reporting and reporting format to involve using the Committees of the Board to track and monitor progress and to produce assurance to the Board that actions were in place supported by appropriate narrative in the papers to the Board. It was noted this was probably an initiative for progressing in 2016/17. It was noted that work done in advance of the annual review had been important as it recognised progress in areas outwith the corporate objectives and HEAT targets.

34.3 The Chair commented that the paper did not provide enough supporting detail to give assurance and she was not sure where to access the individual reports to obtain such comfort. Professor McMahon advised a lot of the supporting data was duplicated to various Board Committees. The idea was to move to a position of

providing exception reports to the Board. Mr Ash commented that it would be important to ensure such reports were not provided at the end of a busy Board meeting and that IJB reports were appropriately linked.

34.4 The Committee agreed the recommendations contained in the circulated paper subject to the comments made by Mr Ash.

35. Date and Time of Next Meeting

35.1 The next meeting of the Strategic Planning Committee would be held at 9.30am on Thursday 8 October 2015 in meeting room 7, Waverley Gate, Edinburgh.

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EAST LOTHIAN INTEGRATION JOINT BOARD **1.10**

The draft minutes of the 1st meeting held on 1 July 2015 are attached.

Key issues discussed included:

- Membership of East Lothian IJB.
- Governance of East Lothian IJB.
- Appointment of Chair and Vice-Chair
- Appointment of Chief Officer.
- Membership of the Strategic Planning Group.
- Proposed Meeting Dates 2015/16

Key issues on the horizon are:

- Appointment of Chief Finance Officer
- Addressing vacancies on the Strategic Planning Group

Councillor Donald Grant
Chair

MINUTES OF THE MEETING OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

WEDNESDAY 1 JULY 2015
COUNCIL CHAMBER, TOWN HOUSE, HADDINGTON

Voting Members Present:
Councillor S Akhtar
Mr M Ash
Councillor S Currie
Councillor D Grant
Professor J Iredale
Mr A Joyce
Ms A Meiklejohn

Non-voting Members Present:
Ms F Duncan
Dr R Fairclough
Ms A MacDonald
Mr K Maloney
Mrs M McKay
Mr D Small
Mr E Stark
Dr J Turvil
Mr A Wilson

Other Officers Present:
Mr J Ferry
Mr D King
Mr J Lamond
Ms C Lumsden
Ms J McCabe
Mr P Ritchie

Clerk:
Ms A Smith

Apologies:
Councillor J Goodfellow
Dr A Flapan

Declarations of Interest:
None

Jim Lamond, Head of Council Resources, ELC, welcomed everyone to the inaugural meeting of the East Lothian Integration Joint Board. He would be chairing the meeting for the initial agenda items until the appointment of the Chair.

1. MEMBERSHIP OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

A report was submitted by the Depute Chief Executive (Resources and People Services), ELC, regarding membership of the East Lothian Integration Joint Board (the 'IJB').

Joanne McCabe, Senior Solicitor, ELC, presented the report. She outlined the arrangements for membership, drawing attention to the composition of voting and non-voting members, as set out by legislation. She referred to the appendix which detailed the categories of membership, posts and proposed members. She informed the IJB of the following amendments since preparation of the report:

Section B(2)
Alison MacDonald had been promoted to the Head of Older People and Access; she would continue to be the Registered Nurse advisor member

Section C
Local GP representative – Dr Richard Fairclough
Staff representative – Andrew Wilson had replaced John Nisbet

Decision

The IJB agreed:

i. to note the prescribed members being the:
   - voting members at Section A of the appendix to the report, and
   - minimum non-voting members at Sections B1 and B2 of Appendix 1; and

ii. to approve the stakeholder members at Sections B3 and C of Appendix 1.

2. GOVERNANCE OF THE EAST LOTHIAN INTEGRATION JOINT BOARD

A report was submitted by the Depute Chief Executive (Resources and People Services), ELC, seeking approval of the governance arrangements of the IJB.

Ms McCabe presented the report, informing members that the report and the 3 appendices, the Integration Scheme, the Order and the Standing Orders, set out in detail the governance arrangements for the IJB. She advised that the Code of Conduct was currently being developed and would be brought to the IJB for formal adoption in due course.

Councillor Akhtar thanked Ms McCabe for all her work in the preparation of these governance arrangements and expressed her support.

Margaret McKay mentioned, as a point of clarification, that only voting members could approve report recommendations; non-voting members could make comments and raise questions but could not approve recommendations. Mr Lamond asked all members to be aware of this.

Decision

The IJB agreed:

i. to note the contents of the Integration Scheme (attached at Appendix 1 to the report);

ii. to approve the Standing Orders for the IJB (attached at Appendix 3 to the report); and

iii. to note the progress in developing the draft Code of Conduct.

3. APPOINTMENT OF CHAIR AND VICE-CHAIR

Mr Lamond outlined the requirements for the appointment of Chair and Vice-Chair of the IJB. He advised that these appointments would rotate between East Lothian Council and NHS Lothian as set out in the Integration Scheme and the ELC Chair would be effective until 31 March 2017.

He invited nominations for the Chair from the East Lothian Council voting members.
Nomination – Donald Grant, proposed by Shamin Akhtar, seconded by Stuart Currie.

He invited nominations for Vice-Chair from the NHS Lothian voting members.
Nomination – Mike Ash, proposed by Alex Joyce, seconded by John Iredale.

Decision

The IJB agreed to approve the nomination of Donald Grant as Chair of the IJB and Mike Ash as Vice-chair of the IJB.

Councillor Grant took the Chair. He stated this was an historic day for East Lothian. The Health and Social Care Partnership, guided by the IJB, was the fourth partnership established in Scotland and the first in Lothian. The focus would be to drive forward the delivery of integrated health and adult social care services. The delivery of a new community hospital in East Lothian was a key priority. He thanked Mike Ash for all his work as Chair of the Shadow Board.

4. APPOINTMENT OF CHIEF OFFICER

A report was submitted by the Director of Human Resources, NHS Lothian, seeking approval of the appointment of the Chief Officer of the IJB.

Sederunt: David Small left the Chamber

The Chair outlined the appointment process. He advised that the Appointment Committee had met on 24 June 2015; the unanimous recommendation was that David Small be appointed Chief Officer of the IJB.

Decision

The IJB agreed:

i. to note the process for the appointment of the Chief Officer; and

ii. to approve the recommendation made by the Appointments Committee to appoint David Small as the Chief Officer of the IJB.

Sederunt: David Small returned to the Chamber

5. APPOINTMENT OF CHIEF FINANCE OFFICER

A report was submitted by the Director of Health and Social Care updating the IJB on the proposals for the appointment of the Section 95 (Chief Finance) Officer.

Mr Small presented the report, informing members that a job description was being developed jointly by ELC, Midlothian Council and NHS Lothian. The post of Section 95 Officer would be shared between East Lothian and Midlothian IJBs as it was not anticipated that full time support would be required to either IJB. Once the job description had been finalised the post would be advertised across the 3 organisations. He hoped to report the outcome to the next meeting in August.

Councillor Currie queried the necessity for this new post; questioning costs and level of input. Mr Small indicated this had been raised during earlier discussions. Clarification was required prior to the interview stage as to whether the successful candidate would continue to be operational in their current role in their organisation. Councillor Currie remarked that the Chief Social Work Officer was a dual role so perhaps, for an initial period, that could apply to this post.

Mr Ash added that this was a very significant due diligence process for the IJB, as well as for ELC and the NHS; it was important to ensure the correct appointment was made.

Decision

The IJB agreed to approve the proposals for the appointment of the Section 95 (Chief Finance) Officer.

6. MEMBERSHIP OF THE STRATEGIC PLANNING GROUP

A report was submitted by the Director of Health and Social Care advising the IJB of the legislative requirements as to the membership and proceedings of the Strategic Planning Group (SPG).

Carol Lumsden, Transformation and Integration Manager, NHS Lothian, presented the report. She referred to the duty to establish a SPG and outlined the required representation as prescribed by the legislation and supporting regulations. The SPG would be the forum for defining and developing the Strategic Plan. The SPG had been operating in shadow form since November 2013 and although there was broad representation a few members had still to be appointed. The current members and recommendations moving forward were detailed in Appendix 1a. Drawing attention to Appendix 1b, additional proposed membership, Ms Lumsden outlined each proposal. The proposed remit and terms of reference for the SPG was attached at Appendix 2.

In relation to proposals for future membership Keith Maloney asked about the possibility of adding members from the users' side, which seemed under represented; Ms Lumsden confirmed this would be possible.

Mr Ash drew attention to the NHS Board's nomination of Professor Alex McMahon. He gave thanks to Alison MacDonald, Donald Grant and Carol Lumsden for their work on the shadow SPG.

In response to a question from Councillor Currie about the SPG's role and remit, specifically accountability to the IJB and the process for this, Ms Lumsden agreed this was important; she advised that this was a working draft, the details would be clarified in due course.

Professor John Iredale referred to vacancies in the key professional areas. He highlighted the need to have the widest possible representation; a local pharmacist would be invaluable, as would a representative from a major charity. He stressed the need to think strategically about these appointments.

Alison Meiklejohn endorsed those comments. Membership was medicine and nursing dominate; groups that represented a variety of stakeholders should be encouraged.

Eliot Stark noted that the process for seeking nomination for a non-commercial health care provider linked into the TSI, this related to Mr Maloney's query; he added that some form of formalization of that process would be beneficial.

Mrs McKay remarked that the membership was perhaps unduly weighted towards health; she stressed the importance of having strong representation from the social care sector.

The Chair noted the points made regarding social care and the other membership representations.

Decision

The IJB agreed:

i. to approve the Strategic Planning Group membership proposals; and

ii. to approve the progression of appointments, as set out in the report.

7. MATTERS ARISING FROM THE MINUTES OF THE FINAL SHADOW BOARD MEETING

The minutes of the final meeting of the Shadow Health and Social Care Board were presented to the IJB.

Mr Ash indicated that in relation to item 4 of the minute, concerns expressed at the meeting regarding budget issues were not reflected; otherwise, the minute was presented for noting.

Mr Stark remarked that the emphasis on those concerns had come from several sources; further clarification was required. Mr Small referred to the need for a protocol for how the IJB received financial information and considered and dealt with financial planning for 2016/17; a report was perhaps required. Mr Ash agreed and indicated he would take this forward for the next meeting of the IJB.

Councillor Currie referred to section 4.2 of the minute, specifically delayed discharges and suggested that a report on this be brought to the next IJB.

Decision

The IJB agreed that the following reports would be brought to the August meeting:

i. a report outlining the protocol for financial reporting/planning; and

ii. a report on delayed discharge.

8. PROPOSED MEETING DATES FOR 2015/16

A report was submitted by the Depute Chief Executive (Resources and People Services) of East Lothian Council advising of the proposed dates for meetings of the IJB for 2015/16.

The Chair indicated that for diary management purposes it was important to set these dates. Meetings were scheduled monthly; the venue would be the Council Chamber. He added that it may be the case however that every alternate meeting could be a development session.

Councillor Currie raised an issue regarding scheduling of these meetings. If the IJB was to try and engage the public then holding these meetings during the working day was probably not ideal; he suggested, for the next session, considering alternative times and perhaps venues. He also asked that having meetings accessible on-line, during the meeting and afterwards, be looked into.

Mr Small indicated these suggestions would be considered.

Decision

The IJB agreed to approve the dates for meetings of the IJB for 2015/16, as detailed:

- Thursday 27 August 2015, 2 pm
- Thursday 24 September 2015, 2 pm
- Thursday 29 October 2015, 2 pm
- Thursday 26 November 2015, 2 pm
- Thursday 28 January 2016, 2 pm
- Thursday 25 February 2016, 2 pm
- Thursday 24 March 2016, 2 pm
- Thursday 28 April 2016, 2 pm
- Thursday 26 May 2016, 2 pm
- Thursday 30 June 2016, 2 pm

Signed .....

Councillor Donald Grant
Chair of the East Lothian Integration Joint Board

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EDINBURGH INTEGRATION JOINT BOARD

1.11

The draft minutes of the first formal meeting of the Edinburgh IJB held on 17 July 2015 are attached.

Key issues discussed included:

- Confirmation of membership of the Board
- Standing Orders
- Draft Code of Conduct
- Indemnity for the IJB (CNORIS)
- Sign off of the draft strategic plan and the needs assessment
- Sign off of the IJB logo and branding
- Bridging request to Scottish Government

Key issues on the horizon are:

- Three year bridging funding from the Scottish Government to support the transformation plan for older people
- Recruitment of Chief Officer
- Appointment of the four locality manager posts
- Financial arrangement for the shadow period 2015-16 and due diligence process
- Development sessions on the financial plan; learning disabilities; primary care; information and ehealth systems
- Sign off the final Strategic Plan

George Walker
Chair

Alex McMahon
Executive Lead

Minutes

Edinburgh Integration Joint Board

9.30 am, Friday 17 July 2015

Present

Board Members: George Walker (Chair), Councillor Elaine Aitken, Carl Bickler, Kay Blair, Wanda Fairgrieve, Christine Farquhar, Councillor Ricky Henderson, Kirsten Hey, Councillor Sandy Howat, Alex Joyce, Beverley Marshall, Angus McCann, Michelle Miller, Gordon Scott, Ella Simpson, Richard Williams, Councillor Norman Work

Officers: Sue Bruce, Tim Davison, Monica Boyle, Wendy Dale, Hugh Dunn, Susan Goldsmith, Dorothy Hill and Gavin King.

1. Welcome and Apologies

The Chair welcomed everyone to the first meeting of the Edinburgh Integration Joint Board (Joint Board). He introduced Sue Bruce, Chief Executive of City of Edinburgh Council, and Tim Davison, Chief Executive of NHS Lothian. Tim Davison noted the challenges facing health and social care in Edinburgh and the opportunities presented by the formation of the Joint Board. Sue Bruce highlighted the increasing pressures facing services and the need to continue strengthening the relationship between the Council and NHS Lothian.

Apologies were noted from Shulah Allen, Councillor Joan Griffiths and Sandra Blake.

2. Note of meeting of the Edinburgh Shadow Health and Social Care Partnership

Decision

To note the minute of the meeting, including apologies from Richard Williams.

(Reference – Note of the meeting of the Edinburgh Shadow Health and Social Care Partnership - 12 June 2015, submitted.)

3. Matters Arising

3.1 Joint Board development session: August 2015

Decision

1) To agree pathways for the frail elderly and dementia, and learning disability services, as the topics for the development session in August.

2) To ask for a programme of suggested topics for future sessions to be provided to the next Joint Board meeting.

3.2 Induction programme

Decision

To agree to build in bespoke induction training within the development session programme.

3.3 Scottish Government Transition Fund: update

Decision

To note that final funding details had still to be established and that an update would be circulated to members.

3.4 Visits to establishments

Decision

To agree to retain the Shadow Board's practice of visiting services and request further information on the options.

4. Standing Orders

Gavin King provided an overview of the Standing Orders for the Joint Board, which had been developed in partnership between the Lothian local authorities and NHS Lothian.

It was noted that officers had recommended the removal of the second sentence of the Standing Orders, which referred to the Joint Board commonly being referred to as the Health and Social Care Partnership. However, it was agreed that this sentence provided useful context and that it should be left in the Standing Orders.

Ella Simpson noted that the deputations process at City of Edinburgh Council provided an opportunity for greater openness and transparency and Gavin King provided an overview of the process. It was noted that there might be challenges in respect to timescales of meetings and that such a process would need to dovetail with the consultation process.

Decision

1) To approve the Standing Orders to take effect immediately.

2) To add a reference to Committees and Sub-Committees in the first sentence of the Standing Orders.

3) To request a paper outlining the options for Deputations, including links with the wider consultation process.

4) To request a proposal on establishing an Audit Committee, including the scope and links to the audit committees in partner organisations.

(Reference – report by the Chief Operating Officer and Deputy Chief Executive – CEC, submitted.)

5. Members' Code of Conduct

Gavin King provided a summary of the proposed Members' Code of Conduct. The Board noted the procedure for declarations of interest, where it would be the decision of the Board whether a member who had declared an interest should take part in discussions for that item. There was no need to declare an interest for being a Councillor or NHS Board member, however if there was a particular involvement in an area of work where that person did not feel impartial, this would still be declared.

It was noted that the Code of Conduct would require to be provided to the Scottish Government for approval.

Decision

To approve the Members' Code of Conduct for submission to the Scottish Government.

(Reference – report by the Chief Operating Officer and Deputy Chief Executive – CEC, submitted.)

6. Membership

The proposed membership of the Joint Board was submitted. This took account of all relevant statutory requirements.

Ella Simpson asked that the reference to 'Third Sector Representative' was changed to 'Third Sector Interface' to reflect the language used by the Scottish Government and to provide greater clarity on the role.

Decision

1) To note the need to modify shadow arrangements to ensure the Joint Board was compliant with statute.

2) To note that the recruitment process was in progress for the Chief Officer and Chief Finance Officer.

3) To note that NHS Lothian had determined the health professionals to be appointed to the Joint Board.

4) To appoint the Chair and Vice Chair of the Professional Advisory Committee (PAC) as 'additional' non-voting members in the first instance.

5) To request a review the role and remit of the PAC.

6) To appoint two staff representatives, one from NHS Partnership and one from Council Trade Unions.

7) To appoint the services user and carer members from the shadow arrangements.

8) To request further details on the mechanism to support wider stakeholder engagement.

9) To not appoint any additional members (over and above those above) in the first instance.

10) To change 'Third Sector Representative' to 'Third Sector Interface'.

11) To ask the Interim Management Team to work with carer members and service user members to develop a framework for expenses.

(Reference – report by the Chief Social Work Officer, CEC and the Director of Strategic Planning, Performance and Information, NHS Lothian, submitted.)

7. Clinical Negligence and Other Risks Indemnity Scheme (CNoRIS)

It was noted that the CNoRIS scheme had been in place since 1999 and other integration joint boards in Scotland had undertaken to join. The risk to the Joint Board was very low as the risk mainly affected the partner organisations, however there was some risk remaining. The initial annual cost for the Joint Board to join was £3,000.

Decision

1) To note the report.

2) To agree to apply to Scottish Ministers to join the CNoRIS from April 2016.

3) To note that the Council could make its own application for operational delivery of social care functions.

4) To request further information on individual Joint Board members' liability.

(Reference – report by the Chief Social Work Officer, CEC and the Director of Strategic Planning, Performance and Information, NHS Lothian, submitted.)

8. Engagement, Communication and Branding

A presentation was provided on the development of the brand for the Joint Board. Details were provided and welcomed on the level of research and testing with service users. Information was also provided on wider communications and engagement.

The use of language was discussed, particularly in terms of what 'Integration Joint Board' and 'Health and Social Care Partnership' meant to service users and the need for a consistent approach.

The potential for the branding to be expanded in the future to include staff from partner organisations was discussed and a report on potential expansion was requested.

The requirement for a separate website was discussed and it was noted that the Council's website did not offer the responsive functionality required or the opportunity for the Joint Board to have its own identity. Proposals for the website would be brought to the next meeting.

Decision

1) To agree the delivery principles for communications and engagement up to April 2016, particularly in relation to the Strategic Planning and Joint Strategic Needs Assessment work, to the shift to a Locality Model of service delivery and in support of the Prevention Strategy for Edinburgh.

2) To agree that a range of communications methods would be adopted for use, while ensuring recipients' preferences are taken into account and attention would be paid to the need for accessibility.

3) To agree the development of a web presence and social media, including the resource requirements for the short term web site development work, and long term maintenance.

4) To agree that a report on the costs for the web site development would come back to the next meeting.

5) To agree the refreshed brand for the Joint Board.

6) To ask for proposals on extending the use of the brand.

(Reference – report by the Chief Social Work Officer - CEC and the Director of Strategic Planning, Performance and Information – NHS Lothian, submitted.)

9. Appointment of Chief Officer and Chief Financial Officer

George Walker provided an overview of the proposed recruitment arrangements for the Chief Officer and Chief Finance Officer. Ella Simpson noted that she, alongside other stakeholders, had been involved in the recruitment of the new Council Chief Executive and asked if a similar approach would be undertaken in the recruitment of these posts. George Walker noted that a stakeholders panel had been discussed and would be further considered.

The assessment approach was discussed and it was noted that the process had not been finalised but was likely to include testing and other forms of assessment and the recruitment panel would have an opportunity to provide their views on this.

Richard Williams noted that it was important to have the interim Chief Financial Officer in place as soon as possible and that they would require to have the confidence and competence to ask difficult questions of both NHS Lothian and City of Edinburgh Council. It was noted that both organisations would need to support this person in their role.

Decision

1) To approve the recruitment arrangements to appoint to the post of Chief Officer for the Edinburgh Integration Joint Board and agree the content of the draft recruitment pack that would support the recruitment process.

2) To approve the appointment of an interim Chief Finance Officer pending the introduction of the reporting structure to the Chief Officer and agree delegated authority to the Chair of the Joint Board to progress this interim appointment.

3) To note that details of the Chief Officer candidate assessment process would be shared with Joint Board members.

(Reference – report by the Chair of the Joint Board, submitted.)

10. Finance Arrangements Update

Hugh Dunn and Susan Goldsmith noted that there had been significant work undertaken by both organisations in developing the financial arrangements and this work was continuing. Susan Goldsmith noted that there continued to be uncertainty as a result of the spending review in autumn 2015 and the potential impact of 24/7 services. The recruitment of a Chief Financial Officer was essential to continue this work.

Susan Goldsmith added that there were challenges for NHS Lothian in how money was released throughout the year using different methodologies. Hugh Dunn noted that the Council's budgetary allocation for 2016/17 was currently unknown and would be confirmed in December 2015. It was agreed that further discussion on the best use of the combined resource was required and that radical ideas would need to be considered, potentially as part of a development session.

The internal audit functions in both partner organisations were undertaking due diligence on the work to date and the results of this would be reported to the Joint Board.

Decision

1) To note the developing financial arrangements for the shadow period 2015-16.

2) To note the current estimated values of the delegated resource (subject to due diligence).

3) To note ongoing work by both Internal Audit teams on the 2015/16 budget regarding due diligence, and that the outcome would be shared with Joint Board members.

4) To agree to examine the potential for remodelling services within the budgetary framework as part of the development session programme.

5) To agree to consider a budget consultation strategy as part of the 2016/17 budget process.

(Reference – report by the Head of Finance – CEC and the Director of Finance – NHS Lothian, submitted.)

11. Integrated Risk Management Strategy

Michelle Miller noted that the Joint Board was required to establish a risk management strategy, and gave further information on this process.

Decision

1) To note the work underway to develop an integrated risk management strategy and framework.

2) To approve the proposal for a risk management session to be arranged, which would build on the Joint Board Lothian-wide induction process. The session would help facilitate consideration of the risks associated with integration and the function of the Joint Board itself, articulation of a risk appetite statement for the Joint Board and support the Joint Board to explore and agree options for overseeing risk management for example, through a separate Joint Board Risk and Audit Committee or through the Joint Board itself.

(Reference – report by the Chief Social Work Officer - CEC and the Director of Strategic Planning, Performance and Information – NHS Lothian, submitted.)

12. Integrated Performance

A summary was provided of the current performance and activity across the partnership area using a set of key indicators. It was noted that some of the existing targets would not be met within the current financial package and that the Joint Board would be required to consider whether the targets or the financial package should be changed.

It was requested that a glossary of terms was included in the next performance report.

Decision

1) To note the overview of current performance and areas of concern.

2) To recognise that these trends were long standing and that many were inter-connected, reflecting system-wide pressures.

3) To consider the proposals for the membership, remit and frequency of the meetings of a sub-group of the Board which would consider performance.

4) To note the ongoing work to develop the performance framework, and agree a glossary of terms in future reports.

5) To recognise that effective implementation of the performance framework would require widespread and comprehensive engagement of staff as well as time for managers to engage effectively.

(Reference – report by the Chief Social Work Officer - CEC, submitted.)

13. Update on the development of the draft Health and Social Care Strategic Plan

A presentation was provided by Wendy Dale on the draft Strategic Plan. Kay Blair noted that there would have to be radical thinking in order to modernise services and asked if references to change could be incorporated into the consultation. The involvement of young people in the consultation was encouraged by the Board.

Decision

1) To note the first draft of the strategic plan attached as Appendix A to the report, together with the brief summary of the Joint Strategic Needs Assessment attached as Appendix B to the report.

2) To approves both documents as the basis for a period of three months public consultation.

3) To note that further work would be undertaken with a range of stakeholders in parallel with the public consultation to develop more detailed actions for the delivery of the key priorities within the plan.

4) To include reference to change, and specifically which services might be stopped, in the consultation questions.

(Reference – report by the Chief Social Work Officer - CEC, submitted.)

14. Localities

It was proposed to adopt a four locality model as the basis for the Joint Strategic Needs Assessment and the Joint Strategic Plan. Details were provided of these, and an updated localities map circulated.

Decision

1) To approve the proposed four localities for the purposes of completing work on the Strategic Plan.

2) To note that other community planning partners were committed to a 'best fit' approach to these localities across the city.

3) To note that, if approved, the operational management arrangements to be developed under the Chief Officer/Joint Director will adopt a 'best fit' approach to these localities to align planning and service delivery.

(Reference – report by the Chief Social Work Officer - CEC, submitted.)

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MINUTES of **MEETING** of the **MIDLOTHIAN HEALTH AND SOCIAL CARE**

PARTNERSHIP SHADOW BOARD held in the Committee Room, Midlothian House,

Dalkeith on Thursday 18 June 2015 at 2.00pm.

NHS Lothian:– P Johnston (Chair), M Bryce, M Johnson and A Joyce.

Midlothian Council:– Councillors B Constable, C Johnstone (Vice-Chair), D Milligan and B Pottinger.

In Attendance:-

User/Carer Representatives:– J Foster and M Gill.

Third Sector Representative:– R McCabe.

NHS Lothian:– H Reid (Clinical Director), and D King (Head of Finance).

Midlothian Council:– E McHugh (Joint Director, Health and Social Care), A Short (Head of Health), A White (Head of Adult and Social Care), T Welsh (Integration Manager), M Naylor (Organisational Development HR Manager) and M Broadway (Clerk).

Apologies:– K Lawrie (Chief Executive, Midlothian Council), J Cuthbert (User/Carer Representative), P Eccles (Staff Representative, NHS Lothian) and A MacDonald (Chief Nurse, NHS Lothian).

1. Order of business

The Chair, Peter Johnston advised that he had agreed to accept a report on the Appointment of Chief Officer to the Midlothian Integration Joint Board (paragraph 2 below refers), as urgent business in view of the Shadow Board's interest in the matter.

2. Appointment of Chief Officer to the Midlothian Integration Joint Board

With reference to paragraph 1 above, there was tabled report, dated 18 June 2015, by the Chief Executive proposing a process for the appointment of a Chief Officer to the Midlothian Integration Joint Board now that the Scottish Government had published the establishment order for East, Mid and Edinburgh IJBs, allowing these IJBs to be formally constituted after 27 June 2015.

The report outlined the recruitment process followed in appointing the current Joint Director, Health and Social Care and explained that other than requiring the IJB to consult with the constituent authorities, in this case Midlothian Council and NHS Lothian, the legislation did not prescribe the process for selecting the Chief Officer. Whilst the Chief Officer would be appointed by the IJB, he/she would be employed by Midlothian Council. In considering the appropriate selection process the IJB would therefore require to take into account the extant organisational change policies and recruitment procedures.

Marina Naylor, Organisational Development HR Manager, then proceeded to explain what this meant in practical terms. The Council's Organisational Change Policy involved a 75% evidence based job matching rule. It was, therefore, proposed that in the first instance a job summary comparison between the current Joint Director's post and the new Chief Officer's post be carried out. If there was found that there was sufficient matching between the posts, then the IJB would be asked to formally agree the appointment of the current Joint Director to the new Chief Officer's post. In the event that there was not a sufficient match then the existing post-holder would be displaced and a ring-fenced interview would be undertaken with a recommendation being brought to the IJB. In accordance with the policies and procedures of Midlothian Council and NHS Lothian, an Appointments Committee would be constituted to undertake this process, supported by an appropriate HR officer. If the Appointments Committee were unable reach a recommendation following the ring-fenced interviews then this would be reported to the IJB and the post of Chief Officer would then be advertised and an external recruitment and selection process would be put in place.

The Shadow Board, having considered the proposed procedures for the appointment of the Chief Officer, agreed that this was a sensible approach to adopt. With regards the appointment of the Section 95 Officer it was noted that this would be a joint appointment with the East Lothian IJB and that the recruitment process was currently underway.

Decision

(a) To approve the appointment process for the Chief Officer as set out in the report, and outline above; and

(b) To note that the recruitment process for the Section 95 Officer was underway and that it would be a joint appointment with East Lothian.

Sederunt

Upon the conclusion of the foregoing item of business, M Naylor left, and E McHugh and D King joined, the meeting (2.20pm).

3. Declaration of Interest

No declarations of interest were intimated.

4. Minutes of Meeting

The Minutes of Meeting of 30 April 2015 were submitted and approved as a correct record.

5. Establishment of Midlothian Integration Joint Board

With reference to paragraph 7 of the Minutes of 19 February 2015 and paragraph 6 of the Minutes of 30 April 2015, there was submitted report, dated 12 June 2015, by the Joint Director, Health and Social Care, outlining the key issues to be considered and agreed by the Midlothian Integration Joint Board and inviting comments from the Shadow Board on how this business should be managed over the coming months.

The report advised that consideration was now being given to the arrangements for the inaugural meeting of the Midlothian Integration Joint Board and amongst the matters that would require to be addressed by the new Midlothian Integration Joint Board at an early stage were:-

- Membership and Chairing of the IJB (previously considered by the Shadow Board on 30 April 2015)
- Consideration of Corporate Objectives of IJB as outlined in the Integration Scheme
- Appointment of Chief Officer, Section 95 Officer and possibly a Chief Internal Auditor
- Formal approval of Membership of the Strategic Planning Group (previously considered by the Shadow Board on 19 February 2015)
- Standing Orders
- Scheme of Delegation
- Code of Conduct.

The report proposed that the remaining meeting dates that had already been approved for meetings of the Shadow Board - 20th August, 29th October and 10th December 2015 – be utilise for the initial meetings of the Midlothian Integration Joint Board. A draft outline of potential agenda items for each of these meeting dates was appended to the report for information and comment. In addition, it was highlighted that the specific requirements for the preparation of the Strategic Plan, approval of which was integral to the IJB's ability to issue directions to the parent bodies, suggested that there was a need for an additional meeting being scheduled in late September to agree the 2nd Draft of the Plan prior to moving to formal consultation.

The Shadow Board, having heard from Tom Welsh, Integration Manager, discussed progress in appointing members to serve on the IJB and also the proposed arrangements for the initial meetings. Particular consideration was given to the style of reports and whether they could be annotated to show if they were for noting or required a decision.

Decision

(a) To note the report;

(b) To welcome the proposals for the initial meetings of the IJB and the use of the already approved meetings dates of 20th August, 29th October and 10th December 2015; and

(c) To agree that an additional meeting of the IJB be scheduled for late September to approve the draft Strategic Plan.

6. Financial Update

With reference to paragraph 3 of the Minutes of 30 April 2015, there was submitted report, dated 24 April 2015, by the Joint Director, Health and Social Care, providing an update on some of the financial governance issues that would have to be managed by the IJB once it was formally established, in particular the appointment of a Chief Internal Auditor and establishment of an Audit Committee.

The report also looked at the ongoing Due Diligence process that was being undertaken by both the Council and NHS Lothian to consider what resources would be formally offered to the IJB, the impact of these resources no longer being under their direct control and any other financial impacts of the creation of the IJB. The IJB would in turn require to consider the risks inherent in the resources that had been offered to it and what impact this would have on allowing the IJB to undertake the functions that had been delegated to it.

David King, Joint Interim Finance Lead for the Shadow Board, in speaking to the report, explained that the IJB would be required to issues directions to both the Council and the Health Board for all the functions that had been delegated and the Strategic Plan would be the provenance behind these directions. Work was underway to lay out a process and mechanism for directions and this would be considered as part of the preparation of the Strategic Plan.

The Shadow Board in considering the report discussed the likely impact of any already agreed efficiency savings and what might happen in the event of an overspend. It was acknowledged that these issues were being examined as part of the due diligence process.

Decision

(a) To note the requirement to appoint a Chief Internal Auditor and create an Audit Committee;

(b) To note the current position on the due diligence process; and

(c) To note the outline financial framework for the Strategic Plan.

7. Strategic Commissioning Plan

With reference to paragraph 10 of the Minutes of 30 April 2015, there was submitted report, dated 11 June 2015 by the Integration Manager, providing an update on the progress being made with the development of the Midlothian Strategic Commissioning Plan. A copy of the draft Plan was appended to the report.

The report explained that the draft Plan remained a working document and continued to be considered and commented upon by a wide range of stakeholders. A number of appendices were in preparation including the Joint Needs Assessment and a detailed financial plan. A summary of user and carer views had already been completed and a summary version of the draft Plan had been prepared to encourage wide-ranging consultation and engagement. It had originally been anticipated that the Plan would be completed for approval and implementation during 2015-16. However the regulations governing the preparation and consultation process now made this timetable very difficult to achieve in a meaningful way and a more realistic timescale for final approval would be December 2015. This timing worked well with the subsequent process of giving directions to the parent bodies regarding the delivery of services in 2016-17 as it would enable Midlothian Council and NHS Lothian to develop their service plans and utilisation of resources in good time for the start of the new financial year.

Having heard from Tom Welsh, Integration Manager, the Shadow Board discussed the importance of dialogue between partners to ensure that there was no duplication and also to ensure that services were provided by those best equipped to provide them.

Decision

(a) To note the progress with the development of the Strategic Commissioning Plan; and

(b) To agree the revised timetable for final approval of the Plan.

8. NHS Lothian Strategic Planning Committee - Learning Disability Services, Redesign, Modernisation and Integration

There was submitted report, dated 10 June 2015, by the Joint Director, Health and Social Care, concerning a report considered and approved by NHS Lothian's Strategic Planning Committee, at its meeting on 9 April 2015, providing details of progress towards a more sustainable solution to the design of Learning Disability Services responding to growing need and expectation; a copy of which was appended to the report.

The report, for the NHS Lothian Strategic Planning Committee, had detailed the continued progress towards transformational change in the model of care supporting people with Learning Disabilities both in hospital and community settings in Lothian and the further actions required to achieve these changes and deliver a more sustainable solution to the design of Learning Disability Services that could respond to growing need and expectations. These changes had been overseen by the Lothian Learning Disability Collaboration chaired by Midlothian Council's Joint Director, Health and Social Care.

The Shadow Board, having heard from Eibhlin McHugh, Joint Director, Health and Social Care, discussed the likely impact of changing population demographics on services in Midlothian, the need to ensure that people with a learning disability continued to receive the appropriate levels of care, and the importance of having regards to the impact of changes in way that services are provided.

Decision

(a) To note and approve the NHS Lothian Strategic Planning Committee Report of 9 April 2015 'Disability Services, Redesign, Modernisation and Integration';

(b) To support the model of care and the focus on successful community lives for people with a Learning Disability in Midlothian;

(c) To support the overarching programme of whole system change to deliver the range of services required; and

(d) To consider future reports on the progress of Learning Disability Services, Redesign, Modernisation and Integration.

9. Integrated Care Fund & Delayed Discharge Investments

With reference to paragraph 6 of the Minutes of 11 December 2014, there was submitted report, dated 10 June 2015, by the Head of Health providing an update on the agreed investments from the Integrated Care Fund and Delayed Discharge funding over the next three years.

The report explained that the initial funding made available to the Midlothian Partnership was for 12 months however this had since been increased to 3 years, which would total £5.76m over the 3 year period, split across the Integrated Care Fund (£4.32m) and Delayed Discharge (£1.44m). The planned investments were set out in the spreadsheet appended to the report. In line with the agreed direction of shifting the balance of care towards home or homely settings, the investments were weighted towards social and community care to ensure the necessary support services were in place from the outset.

The Shadow Board in considering the report, heard from Allister Short, Head of Health, who responded to Member's questions

Decision

(a) To note the agreed investments through the Integrated Care Fund and Delayed Discharge funding;

(b) To note the reallocation of a limited amount of year 1 funding to support the hospital discharge team; and

(c) To note that further work was ongoing in relation to the performance management framework.

10. Lothian Unscheduled Care Service Review Outcome

There was submitted report, dated 11 June 2015, by the Head of Health providing an update on the outcome of the Lothian Unscheduled Care Service Review as it related to the service within Midlothian.

The report explained that the Lothian Unscheduled Care Service (LUCS) was hosted on behalf of NHS Lothian by East Lothian Community Health Partnership. It had been agreed that a review of the Service should be undertaken and this was led by Patricia Dawson on behalf of NHS Lothian. The review was carried out in 2014, with a remit to ensure that LUCS was working in the most efficient and productive way to provide effective, holistic patient care and an efficient, productive environment for staff, whilst ensuring LUCS was fit for purpose now and in the future. Formal consultation on the review was carried out from January to March 2015 and there was a separate session for the Midlothian Shadow Board during their visit to Midlothian Community Hospital with the LUCS Clinical Director.

Whilst the vast majority of the recommendations in the review report concerned operational issues, in light of the feedback received and the developing national picture, the following proposals were made and agreed by East Lothian CHP Sub-Committee at their meeting on 30 April 2015:

- No reduction in the hours of opening in either of the East and Midlothian bases
- One car to cover East and Midlothian on weekday evenings but will be supplemented by the car at RIE if required – there will continue to be 2 cars on at the weekend
- Nurse staffing centralised to the 3 main bases within an outreach service to East and Midlothian
- One GP and one nurse based at each of the East and Midlothian bases

The changes to the initial review recommendations were viewed as a positive outcome for Midlothian and had been welcomed by the Clinical Director and Head of Health.

Having heard from Allister Short, Head of Health, Members of the Shadow Board discussed the timing of the review, and the potential implications for Midlothian. On the one hand, concerns were voiced about the potential impact that changes agreed as a result of the review could have on services in Midlothian and that their introduction should have been delayed until after the national review had concluded, so that account could be taken of its findings. There was also a feeling that if a review was necessary then it should have been conducted by the incoming Integration Joint Board rather than the outgoing Community Health Partnership. Whilst on the other hand, there was an acknowledgement that change had become necessary in order to ensure that the out of hours service remained fit for purpose. It was also noted that the local review had started before the national review had been conceived and that the national review would look at things at a strategic level.

Thereafter, Peter Johnston, seconded by Morag Bryce moved, that the Shadow Board:- (a) note the outcome of the review recommendations as agreed by East Lothian Community Health Partnership; (b) note the level of service being maintained in Midlothian following consultation on the initial review recommendations; and (c) remit to the Joint Director, in consultation with the Chair, to make appropriate representation on behalf of the Shadow Board to the national review.

Councillor Derek Milligan, seconded by Councillor Bryan Pottinger, moved as an amendment that no changes be implemented until such time as the outcome of the national review.

On a vote being, two Members vote for the amendment and six for the motion, which accordingly became the decision of the Shadow Board.

Decision

(a) To note the outcome of the review recommendations as agreed by East Lothian Community Health Partnership;

(b) To note the level of service being maintained in Midlothian following consultation on the initial review recommendations; and

(c) To remit to the Joint Director, in consultation with the Chair, to make appropriate representation on behalf of the Shadow Board to the national review.

11. Date of Next Meeting

The Shadow Board noted that the next meeting was due to take place on **Thursday 20 August 2015** at **2.00 pm** in **Midlothian House, Dalkeith**.

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West Lothian
Shadow Integration Joint Board

MEETING	KEY ISSUES	ACTION
West Lothian Shadow Integration Joint Board 2 June 2015	Membership – Arrangements for Appointment on Voting and Non-Voting Members	Prescribed membership noted. Process to approve discretionary members agreed and that this would include recruitment of two staff-side representatives.
	IJB Governance and Decision Making	Noted legislative requirements, noted that officers would develop and prepare for approval a set of Standing Orders for Board meetings, agreed that those SOs 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, and agreed proposed meeting arrangements.
	Strategic Planning Group	Approved establishment of shadow Strategic Planning Group.
	Provision of support services and proposed report template	Agreed process to develop arrangements for the provision of support services. Approved draft report template.
	OD and Training Session for IJB Members	Noted arrangements for local and Lothian induction, training and OD.
	JIT Readiness for Integration Tool	Agreed use of self-evaluation tool.

MINUTE of MEETING of the WEST LOTHIAN SHADOW INTEGRATION JOINT BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 2 JUNE 2015.

Present – Frank Toner (Chair), David Farquharson, Brian Houston (substitute for Julie McDowell), Alex Joyce, Danny Logue, John McGinty, Anne McMillan, and Alison Meiklejohn.

Apologies – Julie McDowell

In Attendance – Jim Forrest (CHCP Director), Rhona Anderson (CHCP Development), Alan Bell (Senior Manager, Communities and Information), Marion Christie (Head of Health) and James Millar (Committee Services Manager).

1. DECLARATIONS OF INTEREST

Councillor Danny Logue declared an interest as an employee of NHS Lothian.

Councillor Frank Toner declared a non-financial interest as a council appointee to the Board of NHS Lothian as a Non-Executive Director.

2. MINUTE

The shadow Board approved the minute of meeting of the West Lothian Community Health and Care Partnership Board held on Tuesday 7 April 2015.

3. MEMBERSHIP - ARRANGEMENTS FOR APPOINTMENT OF VOTING MEMBERS AND NON-VOTING MEMBERS

A report had been circulated by the CHCP Director inviting the Shadow Board to consider the membership requirements and arrangements of the Integration Joint Board.

The report explained that the requirements regarding the membership of the IJB was set out in the Public Bodies Joint Working (Integration Joint Boards) (Scotland) Order 2014. This included minimum prescribed members and provision for additional, discretionary members to be appointed.

The report went on to advise that West Lothian Council and NHS Lothian had confirmed the eight voting IJB members. These were:-

West Lothian Council	NHS Lothian
Frank Toner (Chair)	Julie McDowell
Anne McMillan	David Farquharson

John McGinty	Alex Joyce
Danny Logue	Alison Meiklejohn

The Order set out a minimum requirement for the non-voting advisory members and allowed flexibility to add additional nominations as the Parties saw fit (subject to those members not being a Health Board member or a Councillor). The minimum advisory membership required was outlined in the report.

The Shadow Board was informed that West Lothian Council and NHS Lothian had agreed that it would be appropriate for there to be two Board members appointed in respect of the combined staff of the Parties engaged in the provision of the delegated services covered by the scheme.

The Director recommended that the shadow IJB formally note its prescribed membership and agree the process to identify and approve the discretionary members.

Decision

To approve the terms of the report and to note, in particular, that the process would include the recruitment of two staff-side representatives.

4. IJB GOVERNANCE AND DECISION-MAKING

A report had been circulated by the CHCP Director setting out the structures and procedures which would be required of the Board in relation to governance and decision-making, both in terms of the relevant legislation and good practice.

The report explained that, under the Public Bodies (Joint Working) (Scotland) Act 2014, the Board was required to make Standing Orders regulating is proceedings.

The report provided a summary of the content required of Standing Orders, or related governance documents, by the 2014 Act and relevant subordinate legislation, both expressly and by implication.

In addition, there were a number of matters that were felt to be desirable in the interests of good decision-making and good governance, and these matters were listed in the report.

The Board was required to have in place an internal audit service, to conduct a periodic review of its system of internal control, to prepare an annual governance statement and to have in place a process for consideration and approval of its unaudited financial statements and governance statement and then its audit accounts and report by its eternal auditor.

Finally, the shadow Board was informed that the programme of proposed meeting dates, times and venues, attached as Appendix 1 to the report, could be adjusted at a later date.

The Director recommended that the Board:-

1. 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. note that officers would develop and prepare for approval a set of Standing Orders for Board Meetings.

3. 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. 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.

Decision

To approve the terms of the report.

5. STRATEGIC PLANNING GROUP

The shadow Board considered a report (copies of which had been circulated) by the CHCP Director setting out proposals for the establishment of a Strategic Planning Group in shadow form.

The report advised that, as set out in the regulations to the Public Bodies (Joint Working) (Scotland) Act, the Integration Joint Board was required to establish a strategic planning group which would be involved throughout the process of developing, consulting on and finalising a strategic plan.

Appendix 1 to the report outlined the terms of reference and members of the Strategic Planning Group. It was proposed that the group operate in a shadow mode only until such times as the Integrated Joint Board was fully established and had confirmed the terms of reference and membership of the group.

The CHCP Director recommended that the shadow Board approve the establishment of the Strategic Planning Group in shadow form until approved by the full Integration Joint Board.

In response to a question raised concerning membership of the Strategic Planning Group, the shadow Board was informed that it was open to the Integrated Joint Board to consider the inclusion of Staff-side Representatives.

Decision

1. To approve the terms of the report; and

2. 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.

6. PROVISION OF SUPPORT SERVICES AND PROPOSED REPORT TEMPLATE

The shadow Board considered a report (copies of which had been circulated) by the CHCP Director advising of the requirement to make arrangements for the provision of professional, technical, administrative and support services to the IJB.

The shadow Board was informed that, in the short term, the Parties would continue to use the arrangements that had already been put in place to provide professional, technical and administrative support to Community Health Partnerships and joint working more generally.

In order to develop a sustainable long term solution, it was proposed that a working party be convened, with membership from the Health Board and the four local authorities in Lothian. The working party would develop recommendations for approval by the Health Board, the four local authorities, and the four Partnerships. Once approved, a draft agreement would be prepared reflecting the agreed proposals. The report went on to outline a proposed process for an annual review of the support services required by the IJB.

Finally, it was noted that a report template had been drafted for use by the IJB, and this was attached as Appendix 1 to the report. The template would ensure that reports were presented in a consistent and comprehensive manner and that all relevant areas and implications were considered in the production of the report.

The Director recommended that the shadow IJB:-

- agree the process to develop arrangements for the provision of support services
- approve the draft report template.

Decision

To approve the terms of the report.

7. ORGANISATIONAL DEVELOPMENT AND TRAINING SESSION FOR MEMBERS OF THE WEST LOTHIAN INTEGRATION JOINT BOARD

The shadow Board considered a report (copies of which had been circulated) by the Head of Health Services providing information on organisational development for IJB members.

The report advised that a programme for induction and development for IJB members was being progressed within NHS Lothian through NES. It would be open to all members and relevant senior officers for all four Lothian IJBs. It would be available on several dates to that all the Lothian IJBs' members had the chance to attend and it would provide a good grounding for IJB members and senior officers in how things were to work in the new IJB regime.

The shadow Board then heard an update by the Head of Health Services. Dates and times for the induction and development sessions were now available and the information would be forwarded to the Clerk for circulation to Board members.

In addition to the central programme, it was proposed that a local West Lothian away-day be held in August, with a view to covering local aspects of integration, to add an understanding of local arrangements and services to the common ground being covered at the NES sessions.

It was strongly recommended that IJB members, as well as senior officers who would be involved in managing and delivering integrated functions, attend these sessions to ensure as full an understanding of all aspects of integration from the outset. The underpinning aims of a development programme were outlined in the report.

The Head of Health Services recommended that the shadow Board note the contents of the report and consider what arrangements should be made for induction, training and organisational development.

Decision

1. To note the terms of the report.

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.

8. JIT READINESS FOR INTEGRATION TOOL

The shadow Board considered a report (copies of which had been circulated) by the CHCP Director concerning a new self-evaluation tool produced by the Joint Improvement Team for IJBs to highlight actions needed to meet the requirements of the Public Bodies (Joint Working) (Scotland) Act 2014.

The report provided a link to the Readiness for Integration Tool which was available on the Joint Improvement Team website. It covered the key themes that partnerships had previously and continued to identify as important, for successful integration.

The shadow Board was informed that it was for health and social care partnerships to decide how to use the tool to best effect. This would include what sections to use, who to involve, how regularly, and how the

findings were reported and utilised.

Members were asked to note the JIT Readiness for Integration Tool and consider how it might be used in West Lothian.

Decision

1. To note the terms of the report.

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.

WEST LOTHIAN SHADOW INTEGRATION JOINT BOARD

MEETING	KEY ISSUES	ACTION
West Lothian Shadow Integration Joint Board 25 August 2015	Integration Scheme Update	Noted approval process.
	IJB Membership – Process to recruit non-voting members	Noted membership and approved process to recruit non-voting members.
	Standing Orders	Noted draft SOs and suggested approach to the preparation of Board minutes.
	Strategic Planning Group	Verbal update. Noted arrangements had been made for Strategic Planning Group to meet.
	IJB Induction	Noted pan Lothian and local induction programmes.
	Consultation and engagement	Action Plan approved.
	Performance Management Framework	Approved performance management approach and that a regular report would be brought to IJB and Strategic Planning Group.
	2015/16 Budget Update	Noted indicative resources and key financial issues and risks.
	Clinical Negligence and Other Risks Indemnity Scheme (CNORIS)	Noted cover provided by CNORIS and agreed to apply to become a member of CNORIS.

MINUTE of MEETING of the WEST LOTHIAN SHADOW INTEGRATION JOINT BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189 (A) WEST MAIN STREET, BROXBURN EH52 5LH, on 25 AUGUST 2015.

Present – Frank Toner (Chair), Julie McDowell (Vice Chair), David Farquharson, Alex Joyce, Danny Logue, John McGinty, Anne McMillan

Apologies – Alison Meiklejohn

In Attendance – Jim Forrest (Director), Jane Kellock (Chief Social Work Officer) Rhona Anderson (CHCP Development, West Lothian Council), Alan Bell (Senior Manager, Communities and Information, West Lothian Council), James Millar (Solicitor/Committee Services Manager, West Lothian Council), Carol Bebbington (NHS Lothian), Dr Elaine Duncan (Clinical Director, NHS Lothian) Carol Mitchell (Associate Director of Finance, NHS Lothian), Patrick Welsh (Group Accountant, West Lothian Council)

1. DECLARATIONS OF INTEREST

Councillor Danny Logue declared a non-financial interest as an employee of NHS Lothian.

Councillor Frank Toner declared a non-financial interest arising from his position as a council appointee to the Board of NHS Lothian as a Non-Executive Director.

2. MINUTE

The shadow Board approved the minute of meeting of the West Lothian Community Health and Care Partnership Board held on 2 June 2015.

3. RUNNING ACTION NOTE

A Running Action Note had been circulated for information.

Decision

To note and agree the Running Action Note.

4. INTEGRATION SCHEME UPDATE

A report had been circulated by the Director updating the Shadow Board on the status of the West Lothian Integration Scheme.

The Board was informed that an integration scheme for West Lothian had been submitted to Scottish Ministers for approval. The scheme had been approved on 16 June 2015 and subsequently the Order to establish the IJB was laid in the Scottish Parliament.

A copy of the letter of approval of the scheme was attached as Appendix 1 to the report and the West Lothian Integration Scheme was attached as Appendix 2.

It was noted that, allowing for summer recess, West Lothian IJB would be legally established from 21 September 2015. The first meeting of the legally constituted IJB would take place on 20 October 2015. All functions would be delegated on or before 1 April 2016.

It was recommended that the IJB note that the West Lothian Integration Scheme had been approved by Scottish Ministers.

Decision

To note the terms of the report.

5. IJB MEMBERSHIP - PROCESS TO RECRUIT NON-VOTING MEMBERS

A report had been circulated by the Director advising the Shadow Board of the process to recruit non-voting members.

Under the Public Bodies (Joint Working) (Integration Joint Boards) (Scotland) Order 2014, the IJB was required to have two categories of membership:-

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

2. Non-voting – appointed in accordance with article 3 of the Order.

The Director recalled that, at its meeting of 2 June 2015, the Shadow IJB had noted the confirmation of the eight voting members and had agreed that the process to recruit non-voting members be considered at its next meeting, noting in particular that the process would include the recruitment of two staff-side representatives, rather than the one required by legislation.

It was noted that the following professional advisors would be appointed as non-voting members:-

- Chief Social Work Officer
- Chief Officer of the IJB
- S95/Chief Financial Officer
- GP Representative
- Secondary Medical Care Practitioner
- Nurse Representative

The report also outlined a process for the recruitment of stakeholder members from the following categories:-

- Third sector
- Service User
- Carer

- Staff

It was recommended that the Shadow IJB approve the process to recruit non-voting members.

Decision

To note the terms of the report and to approve the process to recruit non-voting members.

6. STANDING ORDERS

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

The Solicitor/Committee Services Manager presented the report, informing Board members of the legislative requirement of the Board to make Standing Orders regulating its procedures.

At the meeting of the Shadow Board on 2 June 2015, it had been agreed that a draft set of Standing Orders would be brought to the next meeting for consideration and discussion, with a view to finalising a draft for submission to the Board at its first formal meeting after adoption. The draft Standing Orders were attached as Appendix 1 to the report, and a number of provisions had been highlighted in the report by the Solicitor/Committee Services Manager for discussion.

Appendix 2 to the report provided details of the statutory requirements of Board minutes. The paper also examined different approaches that could be taken within the statutory rules, together with an approach recommended by the Solicitor/Committee Services Manager.

The Director recommended that the Board:-

1. note the draft Standing Orders, as contained in Appendix 1 to the report, and to consider them and provide comment and suggestion for adoption or change.

2. note the suggested approach to the preparation and agreement of minutes of Board meetings, as contained in Appendix 2 to the report, and provide comment and suggestion for adoption or change.

3. note that both Standing Orders and the approach to minutes of Board meetings would require to be formally approved by the Board when constituted.

The Committee Services Manager then responded to questions raised by Board members in relation to:-.

- Requiring the Board to set its values

- Requiring the Board to define its risk appetite

- The number and frequency of meetings
- The Chair's powers in relation to urgent business, and adding items not already on the agenda
- The Chair's powers to change the date and time of meetings
- Defining or explaining "temporary vacancy"
- Attendance of the public as a deputation to speak at Board meetings

The Committee Services Manager gave advice in relation to his recommended approach for minutes. The paper contained a recommendation that "points made by members in the course of discussion or debate" would not be recorded unless it served the main purpose of recording a decision taken. During discussion, it was noted that there would be scope to include points made by members that were considered to be "significant".

Decision

1. To note the report providing draft Standing Orders.
2. To note the suggested approach to the preparation of minutes of Board meetings, as contained in Appendix 2 to the report.
3. To agree that the draft Standing Orders would be brought back to the Board for formal approval and that the Committee Services Manager would provide options in due course to address issues raised by Board members.

7. STRATEGIC PLANNING GROUP - VERBAL UPDATE

Alan Bell provided a verbal update, giving apologies to the Board that there had been no paper to consider at this time.

Arrangements had been made for the Strategic Planning Group to meet, with a report coming to the next meeting of the IJB.

Decision

To note the verbal update on progress.

8. INTEGRATION JOINT BOARD INDUCTION

A report had been circulated by the Head of Health providing an update on planned organisational development induction sessions for Integration Joint Board members.

The Board was informed that a programme for induction and development

was being progressed within NHS Lothian through NES. It was open to all IJB members and relevant senior officers for all four Lothian IJBs.

The pan Lothian induction would be provided in two phases. The Phase 1 session was available on several dates to ensure that all the Lothian IJBs' members had the chance to attend. The dates available for members to choose from were listed in the report. The aim was that the pan Lothian session would provide a good grounding for IJB members and senior officers in how things were to work in the new IJB regime.

Phase 2 was a tailored programme for each IJB base on the Scottish Government IJB Guide and discussions were currently underway as to what that might look like. In addition, a local West Lothian Induction had been held on 19 August 2015.

It was recommended that the Shadow Board consider the contents and note that events were programmed across Lothian in addition to the West Lothian session held on 19 August 2015.

Decision

To note the terms of the report.

9. CONSULTATION AND ENGAGEMENT

A report had been circulated by the Director inviting the Board to approve an approach to consultation and engagement to the Shadow Integration Joint Board.

The Board was informed that the Public Bodies (Joint Working) (Scotland) Act 2014 placed an increased emphasis on listening to and involving health and social care service users and carers in deciding upon the care they received.

There was an expectation that, alongside providers of health and social care, service users and carers would be active participants in how care and support was planned, designed and delivered.

The report contained proposals for planning and developing communications to support the IJB responsibilities for strategic planning, commissioning and operational oversight of delegated functions.

It was proposed that a range of communications tools and channels be employed, including: websites, email udpates and newsletters, events (workshops and road shows), social media, and press releases. Close attention would be paid to ensuring all communications materials and events were accessible, particularly in view of the service user audience.

Appendix 1 to the report provided an Action Plan showing the main stakeholders and providing details of the activities and methods proposed to ensure successful engagement as an integral part of the delivery of sustainable health and social care services for the future that were centred around the needs of patients and service users.

It was recommended that the Shadow Integration Joint Board approve the approach to consultation and engagements as outlined in Appendix 1 to the report.

Decision

To approve the terms of the report.

10. PERFORMANCE MANAGEMENT FRAMEWORK

A report had been circulated by the Director inviting the Board to approve an approach to consultation and engagement to the Shadow Integration Joint Board.

In presenting his report, the Senior Manager, Community Care Support and Services explained that the Board would be required to publish an annual performance report which would set out how they were improving the National Health and Wellbeing. The expectation was that the annual report would include performance against the core suite of outcome measures, supported by local measures and contextualising data to provide a broad picture of performance.

Appendix 1 to the report provided the national outcome measures aligned to a suite of performance indicators; some of these indicators were based on operational data, some were based on survey data. The annual performance report would require to report against all of these indicators. In addition to the need to report annually on performance to the Scottish Government, it was proposed that the performance framework outlined in Appendix 1 was used to provide a regular report on performance to the IJB.

The Board was informed that the CHCP performance framework had been based on the Covalent system to facilitate standard reporting. It was proposed that the performance framework for the IJB was also built on the Covalent system and that standard reports and scorecards be developed to allow regular reporting of performance to both the IJB and the Strategic Planning Group.

It was recommended:-

1. that the Shadow Integration Joint Board approve the approach to performance management as outlined in Appendix 1.

2. that a regular report on performance was provided to both the IJB and the Strategic Planning Group.

Decision

To approve the terms of the report.

11. 2015/16 BUDGET UPDATE

A report had been circulated by the Director setting out the indicative 2015/16 budget that related to Integration Joint Board functions in line with the agreed West Lothian Integration Scheme. The report also outlined summary information on the areas that had been included in the IJB budget resources and highlighted key financial issues and risks associated with the functions and budgets.

Table 1 within the report outlined the indicative budget resources associated with the IJB for 2015/16. This remained indicative until agreement of the exact elements of the budgets that constituted the delegated functions and the mechanism for sharing out the Pan Lothian budgets that represented the hosted and acute health functions that were delegated to the IJB.

Appendix 1 to the report showed the Pan Lothian Hosted Health Services and Appendix 2 provided a breakdown of indicative 2015/16 IJB budgets by service.

The Board was informed that, prior to budgets being allocated to the IJB for 2016/17, a process of due diligence would have to be undertaken on the resources proposed to be delegated by the parent bodies to the IJB. This due diligence process was referred to in Scottish Government guidance as Financial Assurance. The due diligence process would entail considering how the IJB's budget had been made up, to consider past financial performance against this budget and to reflect on what financial pressures exist and what provisions had been made and management actions taken to address those pressures.

It was recommended that the Board:-

- note the indicative 2015/16 resources associated with IJB functions.
- note the key financial issues and risks associated with the IJB functions.

Decision

To note the terms of the report.

12. CLINICAL NEGLIGENCE AND OTHER RISKS INDEMNITY SCHEME (CNORIS)

A report had been circulated by the Director proposing that the West Lothian Integrated Joint Board apply to become a member of the Clinical Negligence and Other Risks Indemnity Scheme (CNORIS).

The Group Accountant explained that the CNORIS was a risk transfer and financing scheme which had been established in 1999 for NHS organisations in Scotland. NHS National Services Scotland was the scheme manager and its primary objective was to provide effective risk pooling and claims management arrangements for Scotland's NHS

Boards and Special Health Boards.

There was provision under the Public Bodies (Joint Working) (Scotland) Act for the extension of CNORIS to Local Authorities and Integration Joint Boards. This allowed IJBs to apply to Scottish Minsters to become a member. This included cover in respect of health and social care functions were delegated to the IJB.

The report went on to provide details of the cover provided. The Board was asked to note that the risks associated with IJBs membership of CNORIS was considered low and therefore an annual contribution of £3,000 payable each financial year had been set, with notification of the contribution being confirmed in December of the preceding year.

Subject to agreement by the Board, it was intended that the application to join CNORIS would be submitted in advance of the next meeting of the IJB on 20 October 2015.

It was recommended that the Board:-

1. note that membership of CNORIS would provide cover in respect of any potential claim made against the West Lothian IJB in terms of Officers/Officials Indemnity.

2. agree that the West Lothian IJB apply to Scottish Ministers to become a member of CNORIS.

Decision

To agree the terms of the report.

Return to first page

NHS LOTHIAN

Board meeting
7 October 2015

Chief Officer

SUMMARY PAPER - REVIEW OF MEDICAL PAEDIATRIC INPATIENT SERVICES

The key points of the paper are summarised here.

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

Background to the Paediatric Workforce Issues	3.1 – 3.10
Progress in securing independent support to undertake the review of Acute Medical Paediatric Inpatient services in NHS Lothian	3.16
Acute Hospitals Committee and Healthcare Governance Committee strongly support the proposal to invite the Royal College of Paediatrics and Child Health (RCPCH) to carry out the review	3.23
Draft Terms of Reference for the Review have been developed	3.26
An initial meeting with the RCPCH will be undertaken late October 2015	3.29

Jim Crombie
Chief Officer; NHS Lothian
University Hospitals & Support Services
25 September 2015

NHS LOTHIAN

Board meeting
7 October 2015

Chief Officer

REVIEW OF MEDICAL PAEDIATRIC INPATIENT SERVICES

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress in securing independent support to undertake the review of acute medical paediatric inpatient services in NHS Lothian and to seek approval for the draft Terms of Reference for the review.

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

2 Recommendations

2.1 agree that the Royal College of Paediatrics and Child Health (RCPCH) should be appointed to lead this review

2.2 agree the proposed Terms of Reference for the review.

3 Discussion of Key Issues

Background - Paediatric Workforce issues, St John's

3.1 There have been long standing challenges in sustaining the Paediatric Medical workforce at St John's Hospital (SJH) 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).

3.2 In spite of extensive and repeated annual recruitment campaigns, including International recruitment drives for both medical and Advanced Nurse Practitioner staff, there has been a failure to recruit the numbers of clinical staff required. The middle grade Out of Hours rota has remained fragile and is only covered on a month to month basis.

3.3 This rota supports the SJH Paediatric ward and the Special Care Baby Unit (SCBU) 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.

3.4 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 by working additional hours.

3.5 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.

3.6 In spite of these difficulties, the team at SJH 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.

3.7 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.

3.8 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.

3.9 The inpatient service in the Paediatric Ward at SJH 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 were put in place and worked effectively. These plans were first activated during a similar inpatient service closure in 2012.

3.10 The inpatient service in the Paediatric Ward at SJH was re established on 17th August 2015.

3.11 It is important to note that the out of hours rota cover remains as it was prior to the inpatient closure. This provision model remains fragile and could be subject to short notice interruption.

Service provision during July and August 2015

3.12 During the temporary closure of the overnight service, the Paediatric Ward remained open and functioning from 08:00 to 20:00 Monday to Friday. It provided an Acute Medical Paediatric Assessment service during this time as well as taking Day Surgery patients and patients for Planned Investigation/follow up.

3.13 Neonatal services ran as normal. Paediatric outpatient clinics ran as normal.

3.14 Emergency Department at SJH continued to provide emergency services for children and adults. This 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.

3.15 The Lothian GP Out of Hours service (LUCS) based at SJH continued to provide the Out of Hours Primary Care service for children.

Independent review

3.16 At its August meeting, the NHS Lothian Board agreed that a detailed review of inpatient medical paediatric services across the whole of Lothian would be undertaken, with an emphasis on recommending a sustainable NHS Lothian model for the future.

3.17 The Board remitted the development and approval of the Terms of Reference to the Acute Hospitals Committee and Healthcare Governance Committee, but stressed the need for any such review to be credible and independently-led.

3.18 Following discussion and consultation with staff within NHS Lothian and colleagues within the Scottish Government Health Department, the Medical Director approached the Royal College of Paediatrics and Child Health to invite them to undertake this review.

3.19 The Royal College of Paediatrics and Child Health has extensive experience of undertaking such reviews, and is widely respected as a serious, credible, and independent body. It offers a range of review formats, designed in conjunction with the commissioning body. A brief introduction to the RCPCH invited review service is attached as appendix 1 and more is available at www.rcpch.ac.uk/invitedreviews.

3.20 RCPCH invited reviews fall into categories;

- Service reviews – which include investigations into safety, quality or sustainability concerns or an overall developmental 'healthcheck' of a service;
- Design reviews – where a more detailed analysis of whole-service provision may result in structural change to a service;
- Individual Performance reviews – which examine the clinical practice of an individual doctor or doctors within the context of the service in which they are working.

3.21 RCPCH has clarified that it does have capacity to undertake this Inpatient Medical Paediatric review for NHS Lothian before the end of this financial year. In addition, RCPCH has a wealth of experience in developing national clinical and professional standards within paediatric services.

3.22 A Design Review will be sought from RCPCH.

3.23 The Acute Hospitals Committee met on 1 September 2015 and discussed the proposal to invite the RCPCH to carry out the review and this recommendation was strongly supported. The Healthcare Governance Committee met on 22 September and also supported the recommendation to have the RCPCH lead this review.

Proposed Terms of Reference for review

3.24 As part of the commissioning process, the RCPCH will meet with NHS Lothian and work with it to clarify the Terms of Reference, the involvement of a wide range of stakeholders and consultation processes.

3.25 As this is a pan-Lothian review, there will be a requirement to engage with staff, stakeholders from across all areas of NHS Lothian, and service users in relation to the RHSC service as well as the SJH's paediatric service.

3.26 Following the discussion at the Acute Hospitals Committee on 1 September, the proposed Terms of Reference for the independent review are:

- To review NHS Lothian's Acute Medical Paediatric service at RHSC and at SJH in terms of current and projected demand, expected standards of care and current workforce arrangements;
- Given NHS Lothian's current and realistically projected clinical workforce, to recommend what the most reliable, sustainable and affordable model of service for the foreseeable future would be;
- If there are options about the best model, to advise NHS Lothian of the timescales within which each model could reasonably be implemented;
- To advise NHS Lothian on how associated Acute Medical Paediatric services such as ambulatory care and medical assessment could be enhanced to improve care and maximise local access;
- To advise NHS Lothian on outcome measures to provide transparent evidence of the effectiveness of service distribution;
- All five objectives should be with clear reference to RCPCH's published standards within its *Facing the Future* work stream.

3.27 The Review team will be advised that while there are certain elements of NHS Lothian's strategy for acute hospital services for Paediatrics which are fixed, for example, in relation to the new Children and Young People's Hospital which is currently being built, there may be parts of these wider hospital services which could be taken into consideration in recommending a sustainable service model for Medical Paediatrics.

3.28 The Review Team will also be advised of the paediatric surgical service component at SJH and asked to ensure that this is taken into consideration in any proposed service and workforce model.

3.29 Our aim would be to hold an initial meeting with the RCPCH late October 2015 to ensure optimum progress with this important Review.

4 Key Risks

4.1 The risks associated with the staffing situation at SJH will remain until implementation of review recommendations, and this includes the risk that the SJH

Children's Ward will have to be closed for Out of Hours periods, for clinical safety reasons, at short notice.

5 Risk Register

5.1 The risks associated with the fragile staffing situation at SJH 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 RCPCH have extensive experience in managing such processes and as part of preliminary discussions, the requirement for appropriate consultation to meet NHS Lothian standards has been explicitly discussed. The NHS Lothian team will facilitate access to key stakeholders including staff within the services involved, LUCS, the Lothian GP community, parents, patients, and local representatives, and staff-side colleagues

9 Resource Implications

9.1 There will be a cost to engaging RCPCH in this work, but this is to be finalised in discussion around the exact format and workload involved in the review.

Jim Crombie
Chief Officer; NHS Lothian
University Hospitals & Support Services
25 September 2015

List of Appendices

Appendix 1: Guide to Royal College of Paediatrics and Child Health Invited Review process

Offering expertise?

We welcome applications from experienced consultant paediatricians to join our panel of reviewers. For more about the skills we are looking for and the benefits of doing this work please send your contact details in confidence to **invited.reviews@rcpch.ac.uk** and we'll be in touch.

Benefits to reviewers of being part of the RCPCH process include:

- Administration, negotiation, QA and document control handled centrally
- Swift payment of fees and reimbursement of expenses
- Access to free training, review and professional development
- Clear procedures and templates to focus review and reporting
- Supporting the RCPCH in its development and 'reach'
- Data collection, briefings and specialist advice provided by RCPCH support team enabling best use of onsite time
- Compliance with confidentiality and data management regulations
- Indemnity and support for reviewers where cases are sensitive
- Backup of professional communications team and legal support should media/political handling be required

More information

You can find out more about the RCPCH Invited Reviews Service:

Web: www.rcpch.ac.uk/invitedreviews
Call: 020 7092 6091
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Invited Reviews Service

Supporting improvement in child health

RCPCH
Royal College of
Paediatrics and Child Health
Leading the way in Children's Health

The Royal College of Paediatrics and Child Health's (RCPCH) Invited Reviews Service aims to support healthcare organisations and clinical teams in resolving concerns about paediatric service provision, safety, training, compliance with standards, and proposals for paediatric reconfiguration or service design.

Using expert clinicians and in-depth knowledge of standards and service models, RCPCH's Invited Reviews can help employers, commissioners and managers work with clinical colleagues towards designing sustainable services that provide improved outcomes for children and young people and compliant, effective working arrangements for clinicians.

Our Invited Reviews fall into three main categories:

- **Service reviews** – which include investigations into safety, quality or sustainability concerns or an overall developmental 'healthcheck' of a service;
- **Design reviews** – where a more detailed analysis of whole-service provision may result in structural change to a service;
- **individual Performance reviews** – which examine the clinical practice of an individual doctor or doctors within the context of the service in which they are working

Seeking assistance?

We welcome enquiries from healthcare organisations (usually the Medical Director or Chief Executive) and would be happy to discuss in confidence, without obligation, how the service may be able to help.

Why use RCPCH for your Invited Reviews?

RCPCH is committed to developing standards for continuous improvement in children's health and medical care. Invited Reviews offer an independent but realistic perspective where concerns are raised over the care being provided by an individual paediatrician or a paediatric service. We are keen to be involved at an early stage and can advise on approaches to safety, reconfiguration, service design and workforce planning.

The benefits of involving the RCPCH early in resolving concerns include:

- Centrally managed liaison and communication
- Consistent approach but tailored to the individual situation
- At least two experienced/specialist reviewers providing assurance, perspective, and breadth of knowledge
- Clear timescales for report delivery
- QA and endorsement by the RCPCH
- Formal involvement of experienced clinicians from nursing, obstetrics, emergency medicine, etc if required
- Links to extensive data, information, expertise and advice held uniquely by the RCPCH, including policy and specialist clinical comment
- All-inclusive single costing covers fees, expenses and administration
- Professional communications and media team should it be required

Please contact **invited.reviews@rcpch.ac.uk** or call Sue Eardley, Head of Invited Reviews on 020 7092 6091.

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NHS LOTHIAN

2.2

Board Meeting
7 October 2015

Chief Officer

SUMMARY PAPER – WINTER PLAN 2015-16

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

• Between 1 January and 31 March 2015, the combined impact of winter saw NHSL's performance against the 4-hour emergency access standard decline to 90.5%, against a national standard of 95%.	4.1
• This year NHS Lothian has altered its approach to planning for winter with a developed structure led by a Winter Planning Board thus ensuring a whole-system, multi-level approach with an emphasis on "lessons learned".	5.1
• A policy shift is detailed which supports a more balanced priority to both scheduled & unscheduled care flows and supports reduced boarding and more priority focus on discharge of those patients with minimal care needs.	7.1
• Through joint working with Integrated Joint Board and Health and Social Care Partnerships we will promote primary care services and not allow hospital admission to be considered as the 'default' position.	8.1
• Part of the resource allocation made within this year's winter plan is to support matters of infection control including the staff seasonal flu vaccination programme.	9.1
• A co-ordinated approach to communication is planned to ensure effective understanding and engagement in winter planning and delivery. Targeted communications will be delivered to both internal and external audiences through existing channels such as the intranet, website and social media.	10.1
• A well rehearsed multi-agency Hogmanay Plan is designed each year lead by the City of Edinburgh Council and NHS Lothian.	11.1
• Our anticipated spend for winter 2015-16 amounts to £6.4 million. This compares to a total of £3.6 million outlined last year.	17.2
• A total of 46 additional acute beds will be opened over winter.	17.3

Neil Wilson
Unscheduled Care Manager
2 October 2015

NHS LOTHIAN

Board Meeting
7 October 2015

Chief Officer

WINTER PLAN 2015-16

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the NHS Lothian Winter Plan.

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

2 Recommendations

2.1 That the Board approve the contents of the appended winter plan.

2.2 That the Board note and approve the financial aspects of the plan and the additional capacity required for winter.

2.3 That the Board support the various measures being taken to support services over winter including inpatient elective flow.

2.4 That the Board support the policy change indicated regarding a joint focus on unscheduled and scheduled care flows particularly in reference to effective discharge processes for patients with minimal care needs.

2.5 That the Board notes the Performance and Escalation procedures established.

3 Challenges/ Context

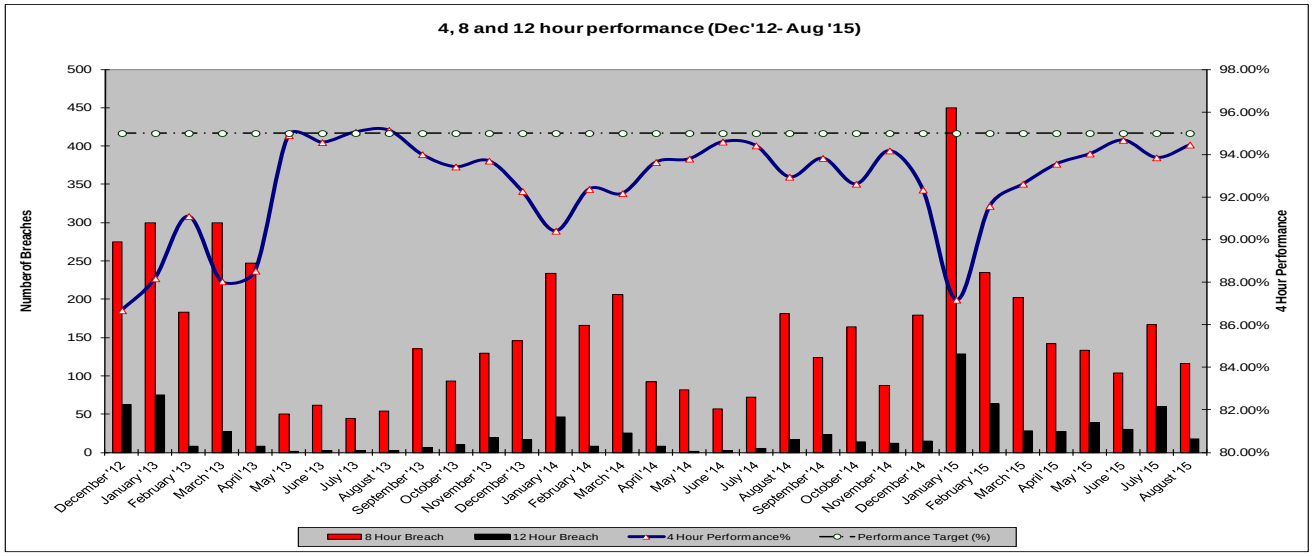
3.1 Disruption to NHS services is a common feature of every winter. Specific challenges include;

- Changed disease patterns with growth in infectious conditions such as influenza and norovirus;
- Changes in weather conditions having an adverse impact on circulatory conditions;
- An increase in falls and trips leading to increased demand for orthopaedic trauma services, in particular;
- Management of workforce leave patterns across the festive period.

4. Winter Performance

4.1 Between 1st January and 31st March 2015, the combined impact of the above saw NHSL's performance against the 4-hour emergency access standard decline to 90.5%, against a national standard of 95%. The period also saw an unacceptably high level of cancellation of elective operations and long waits in admissions units, and a significant level of social care delays in the system.

4.2 The following table outlines our performance against the 4 hours hour standard as well as against 8 and 12 hour breaches, noting performance dips during winter periods. It is self evident that we must learn from this experience and develop a more resilient plan for 2015/16.



4.3 Following a de-brief of our winter performance last year, NHS Lothian was able to identify a number of positive outcomes. However inevitably there were a number of issues that were of concern, including:

- Recruitment/ Capacity issues
- 24/7 service delivery/ access to services (winter/ weekends/festive period etc)
- Availability of portering and domestic support
- Effective Discharge
- Delays/ Bed days lost
- Dementia focus
- Deferral of elective procedures
- Boarding

5. A New Approach

5.1 This year NHS Lothian has altered its approach to planning for winter with a more structure approach led by a Winter Planning Board, under the chairmanship of the Chief Officer for University Hospitals and Support Services. This winter planning Board has so far taken a whole-system, multi-level approach with an emphasis on "lessons learned".

5.2 The NHSL Winter Planning Board has drawn its membership from across the organisation's component parts and beyond, with strong representation from each adult site, Women's and Children's Services, staff-side representatives, HSCP/IJBs, diagnostics, facilities, the Scottish Ambulance Service, Public Health, Infection Control and the Scottish Government.

5.3 The role of the Board is to lead and drive the winter planning process forward this time around. Our winter planning process this year has worked hand-in-glove with the Scottish Government's 6 Essential Actions for improving unscheduled care, namely;

- Essential Action 1 - Clinically Focussed and Empowered Hospital Management
- Essential Action 2 – Hospital Capacity and Patient Flow (Emergency and Elective) Realignment
- Essential Action 3 – Patient Rather Than Bed Management – Operational Performance Management of Patient Flow
- Essential Action 4 – Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway
- Essential Action 5 – Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working
- Essential Action 6 – Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting

5.4 SGHD has also issued clear guidance regarding preparing for winter and laid down milestones it expects each Board to meet in the iterative development of its winter plans, including clarity around financial allocations, detail on working across acute and integrated joint board boundaries, and specifically, plans to significantly reduce numbers of patients delayed in their discharge from hospital. Part of this SGHD guidance is the expectation that Boards will explicitly sign-off their winter plans and publish these.

6. Resource Allocation

6.1 Of particular note for the Board is the additional resource expected from SGHD in respect of improving older people's services within the Edinburgh IJB area. This programme of work has secured an additional £2m of resources to improve the delayed discharge position within NHSL, with the opening of an additional 30 transitional beds at Gylemuir House for patients awaiting residential care placements, and additional investment in domiciliary care capacity for the City.

6.2 The total indicative costs of supporting our services over winter 2015-16 amount to a total of £6.4 Million. These monies will support a range of initiatives including:

- An additional 46 acute hospital inpatient beds at the Western General and St John's Hospital;
- Additional nursing capacity to support Wards, including PICU, within the Royal Hospital for Sick Children;
- Additional consultant support for both general medicine and respiratory medicine across all sites;
- Additional pharmacy, therapy, diagnostic and facilities capacity;
- Dedicated leadership presence into the evenings and at weekends to support flow outside of "normal" working hours;

6.3 These investments complement the process redesign work ongoing to ensure discharging of patients occurs earlier in the day and more effectively during weekends and public holidays, that demand is effectively anticipated 24-48 hours in advance, and that escalation plans across sectors are effective and work when invoked. The winter plan also acts as an overlay onto the business continuity plans that every unit is required to have in place and to test regularly.

7. Ring-fenced Elective Capacity

7.1 This year's Winter Plan will herald a policy shift which supports a more balanced priority to both scheduled & unscheduled care flows, supports reduced boarding and has a more prioritised focus on discharge of those patients with minimal care needs.

7.2 To agree the 'ring-fenced' elective capacity we are conducting an analysis of activity data from last year (beds, patient numbers, lost activity etc) to support possible levels of demand going into this year's winter period. This is being developed in conjunction with Information and Statistics Division, using the national SystemWatch tool, to support individual sites in more effectively planning for both scheduled and unscheduled demand.

7.3 Other initiatives to protect our elective capacity in January includes a review of 'in-patient' elective programme on the weeks commencing 4th and 11th January as well as managing all flow activity on an 'anticipatory' basis.

7.4 Initiating this protocol may have a detrimental impact on front door performance but supports the recognition of the impact on individuals on the day of cancellations.

8. Avoiding Hospital Admission

8.1 We are also keen to promote primary care services and not for hospital admission to be considered as the 'default' position. Through joint working with Midlothian Health and Social Care Partnership, we are sponsoring investment to allow MERRIT to move to a 7 day service. This admission avoidance pathway will in turn relieve pressure from the Emergency Department front door.

8.2 A further example is the development of up to 20 virtual beds to support Frailty outreach including the new south Edinburgh model. This will have 2 key components, that is it will be able to identify suitable patients ahead of admission to hospitals, and secondly will also be able to 'pull' patients out of unnecessary hospital stays, thus supporting effective patient flow.

8.3 Within the respiratory pathway, we will continue with an integrated COPD pathway Consultant and we will also develop at home IV antibiotic delivery within Edinburgh to Bronchiectasis patients. Both are excellent models which will promote admissions avoidance and that support primary care delivery

9. Public Health/ Infection Control

9.1 There will also be a revised focus on prevention of infection, not just through ongoing work on acute hospital wards through the closer management of outbreaks, but through public education campaigns to support primary care services and staff vaccination campaigns supported by Occupational Health Services.

9.2 Part of the resource allocation made within this year's winter plan is to support the staff seasonal flu vaccination programme across Lothian

10 Communications

10.1 A co-ordinated approach to communication is planned to ensure effective understanding and engagement in winter planning and delivery. The **Winter Ready** communication plan includes key themes for each month:

October – Flu vaccinations and awareness
November – Norovirus and infection control
December – Where to go for care/festive period cover/know your limits
January – Where to go for care/healthy lifestyle

10.2 Targeted communications will be delivered to both internal and external audiences through existing channels such as the intranet, website and social media.

11. Hogmanay Plans

11.1 A well rehearsed multi-agency Medical Plan is designed each year through the Events Planning Organisational Group lead by the City of Edinburgh Council and NHS Lothian are represented on that group by Emergency Planning and Emergency Department colleagues.

11.2 The Hogmanay Plan will include additional support for the Royal Infirmary ED, Radiology, HAN and support services as required. This is a multi agency plan and will have the Resilience Committee support at NHS Lothian Board level.

11.3 All Health and Social Care Partnerships will contribute to the development of the Hogmanay Plan.

12. Winter Plan

12.1 We have altered our approach this year to ensure we have taken a whole-systems approach that is innovative and transparent. Our governance arrangements will allow us to monitor performance on an ongoing basis and to reach a decision on any remedial action that is necessary.

12.2 Our winter plan therefore reflects a collective vision for how patients and services will be supported more effectively during the coming winter months.

12.3 The final version as signed off by the Board will be shared more widely and will be considered a live document subject to alteration and sharing of learning throughout the winter months.

13 Key Risks

13.1 From our experience of the past we are aware of the challenges that winter can exert on our services. Some of the key risks to maintaining effective service delivery are noted below:

- The risk to elective capacity as front door pressures increase during the winter months
- The risk of poor patient experience for those being cared for in both the unscheduled and scheduled streams of acute services;
- The risk of failure to maintain performance against key measures such as the emergency access standard, cancer waiting times standards, and others;
- The risk of poor financial governance with unplanned expenditure to provide unplanned contingency measures.

13.2 It is therefore essential that we are able to effectively plan to counter additional activity and all-round pressures to services. This year's winter plan outlines, in detail, the key actions that we plan to take to mitigate any risks and how we plan to maintain effective service delivery during the winter months.

14 Risk Register

14.1 The winter period provides a heightened risk to many elements of the NHS Lothian Risk Register, but this is included in risk assessments.

15 Impact on Inequality, Including Health Inequalities

15.1 An impact assessment will be carried out in each component part of the organisation as part of their winter plans.

16 Involving People

16.1 We have adopted a more structured approach to our winter planning arrangements this year. Following our winter de-brief and report earlier in the year it became clear that we need to develop a more integrated and transparent approach. With the formation of Integrated Joint Boards and their maturation, it was important that we were able to work more closely in planning our future service, including the development of our winter plans

16.2 As a result the Winter Planning Board has allowed for a multi-agency/ multi-professional approach to help plan and drive our winter services this time around. This has proved very effective in supporting the delivery of our final winter plan.

17 Resource Implications

17.1 As part of our winter planning arrangements, we invited bids for winter monies from a range of hospital sites, and services as well as from Integrated Joint Boards / Health and Social Care Partnerships. Having reviewed all bids to date, the following table outlines our anticipated spend for winter this year.

17.2 Our anticipated spend for winter 2015-16 amounts to £6.4 million. This compares to a total of £3.6 million outlined last year. Of this amount, £2.9 million is set aside for acute care costs (including facilities and transport) while a total of £3.5 million is set aside to support primary and social care services.

17.3 A total of 46 additional acute beds will be opened over winter.

17.4 Much of the work ongoing builds on extant work within the organisation, and the specific allocations made by SGHD to support work around delayed discharges (approximately £2m) and unscheduled care (approximately £1.1m).

17.5 Finally, it is anticipated that there will be a further resource (circa £870k) allocated by SGHD to support improvements in services for older people within Edinburgh specifically. The specific resource implications for this year's winter plan are set out in the following table.

Area	Site/ Service	14/15 Actual	15/16 Allocation	Movement from 14/15
Acute Costs	RIE	78	**520**	442
	WGH	385	**450**	65
	SJH	402	**355**	-47
	RHSC	150	**261**	111
	Facilities	71	**84**	13
	Imaging	61	**300**	239
	AHPs	149	**130**	-19
	Pharmacy	8	**48**	40
	Transport	80	**129**	49
	Acute Service Support & Infrastructure	48	**579**	531
Acute Costs Sum		**1,431**	**2,856**	**1,425**
CHP Costs	East Lothian	6	**224**	219
	Edinburgh	604	**2,187**	1,583
	Midlothian	77	**44**	-34
	West Lothian	23	**120**	97
	RVH	1,402	**0**	-1,402
	Incremental Delayed Discharge Monies		**1,000**	1,000
CHP Costs Sum		2,112	**3,575**	**1,463**
Grand Total		**3,543**	**6,431**	**2,888**

18. Policy Shift

18.1 This year's Winter Plan will support a policy shift which supports a more balanced priority to both scheduled & unscheduled care flows and supports reduced boarding and has a more prioritised focus on discharge of those patients with minimal care needs.

Neil Wilson
Unscheduled Care Manager
2 October 2015
neil.wilson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Lothian's Winter Plan

APPENDIX 1

Lothian's Winter Plan:

2015-2016

Date: Final Submission

October 2015

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Executive Summary

I am very pleased to deliver this robust and evidence based Winter Plan to support effective and safe care across our whole system over this winter period.

The plan's foundations are person centred safe & effective care, collaborative planning & working, lessons learned from 2015/16, multi professional models of care and a focus to ensure not only unscheduled but scheduled care services are maintained by maximising the resources available to us from all parts of our system and its partners.

Last year, 'winter' had a marked and measurable impact on our service. This was evidenced in our performance against national standards as well as the disruptive effect on elective flow. Key indicators for this period;

- Our 4 hour performance over the winter period last year (Jan-Mar) averaged at 90.45% against a target of 95%.
- 8 and 12 hour breaches peaked during January 2015 with 450 and 129 reported respectively
- Increased levels of Boarding across sites was monitored to have a direct and detrimental impact on elective capacity with peak cumulative boarding of 905 reported across our system during the first week in January
- Significant level of our patients experiencing social care delays with 160, 161 and 148 reported in January, February and March respectively
- Significant disruption to our elective programme with circa 600 elective patients cancelled on the day of their surgery

It is self evident that we must learn from this experience and develop a more resilient plan for 2015/16.

This year we have taken a multi stakeholder & structured approach to the planning of our services across NHS Lothian during winter 2015-16.

The formation of our Winter Planning Board takes a whole-system, multi-agency approach to the planning and delivery of our services over winter that is transparent, timely and transformational.

Going forward we believe our winter planning process will allow us to prepare and manage more effectively for the challenges that winter can exert.

Our winter planning process this year has reflects the key principles detailed within the Scottish Government's 6 Essential Actions for improving unscheduled care and reflects the recent national guidance issued to Boards over the summer.

Our plan also take a 'lessons' learned approach – that is consolidating those elements that worked well last year as well as undertaking to improve upon those elements that were less than effective last time around.

The resource implications of this year's winter plan total £6.4m. These allocated funds will support a range of options which will not focus solely on bed capacity within acute hospitals but will, more appropriately, focus on targeted infrastructure initiatives within localities and communities to reduce admissions and improve safe and effective discharges.

This Winter Plan demonstrates our commitment to ensuring collaborative working across our sites to maximise our capacity and ensure resources are used effectively and efficiently to support quality experiences for our patients.

This can be evidenced in our developed cross-site support that promotes effective patient flow, such as the rebalancing of activity between the RIE and WGH sites, evolving whole system reparatory initiates and evolving real time data and analysis to support informed decision making.

We are working with our health and social care partners in each of the council areas to influence and support robust and effective discharge through the delivery of suitable and timely packages of care.

We have undertaken work to ensure we have maximised capacity to deal with winter. This has involved working with our partners to identify where additional capacity can have the most valued

impact. This elegant planning process has allowed us to identify where we can support services that prevent unnecessary hospital admission, where additional workforce capacity requirements will support performance (particularly over the festive period) as well as capacity in the form of 46 additional beds on acute sites.

We plan to invest in up to 20 virtual beds for frailty outreach, supported from additional capacity from within our intermediate care teams (COMPASS, ELSIE, MERIT and REACT).

We plan to invest in our AHP and imaging workforce to cover 7 day working in support of effective discharge. We are also planning to extend our pharmacy and technician capacity, notably within AMU/ ARAUT at weekends and over the public holidays

In addition to our clinical workforce, we are also investing in our portering and domestic workforce. These staff will support systems to work to their maximum through effective room cleans that minimise delays as well as to ensure physical patient flow, especially at weekends.

A central success factor is clearly ensuring we have effective focus on safe & effective discharges from admission. This will require all our teams to support transition through care pathways.

The plan characterises the importance of elective flow and recognisees the very real emotional and physical impact, on the day, cancellations of surgery can have on patients and their families. In recognising this fact the plan seeks to 'protect' elements of hospital capacity on each site to maintain a level of flow and throughput for this important group of patients.

Effective patient flow requires effective discharge from hospital, particularly when services are under in high demand. In collaboration with our health and social car partners we will deliver a range of measures that support our discharge profile including discharges earlier in the day and at weekends. We are also taking forward ‘criteria-led discharge’ planning aligned to 7 day service provision noting the additional AHP and imaging capacity required to support this.

Our respiratory pathways will be supported by dedicated respiratory teams in place on each acute site that will interface appropriately with Primary Care and Hospital at Home teams resilience and cross site cover arrangements will be in place to focus on need..

Additional support has been made in terms of on-call cover at weekends and a 7 day respiratory nurse specialist service at RIE and St Johns Hospital. Dedicated boarding teams on all sites will also support early discharge to home or to a virtual ward setting.

Working closely with the Scottish Ambulance Service, we have reviewed our transport arrangements, both in terms of procedural arrangements and in terms of available resources to maximise availability of the correct vehicles at the correct locations and to match patient dependency to vehicle type. Enhancing the functionality of our 'Transport Hub' enables this effective and flexible working initiative.

Matters of infection control are also central to our winter planning arrangements. We are mindful of the impact that Norovirus can have within our hospitals and also in care homes, and the impact this can have on our front door performance and overall patient flow. Infection Prevention and Control teams will contribute to contribute to any local contingency plans and support the wider services to manage the impact of the most common winter related infections.

We have also supported the roll out of our staff flu vaccine programme. Last year there were a number of respiratory pressures as a result of the flu vaccine mis-match. However we remain supportive of the programme. To ensure we build on the improvements made last year, a flu programme will be developed and in place across all sites.

Planning for winter takes considerable effort and commitment. We have altered our approach this year to ensure we have taken a whole-systems approach that is innovative and transparent. Our governance arrangements will allow us to monitor performance on an ongoing basis and to reach a decision on any remedial action that is necessary.

We are grateful for the efforts of many in developing this plan to this point but also to those who will ensure its compliance through the demanding winter months.

Our winter plan therefore reflects a collective vision for how patients and services will be supported more effectively during the coming winter months.

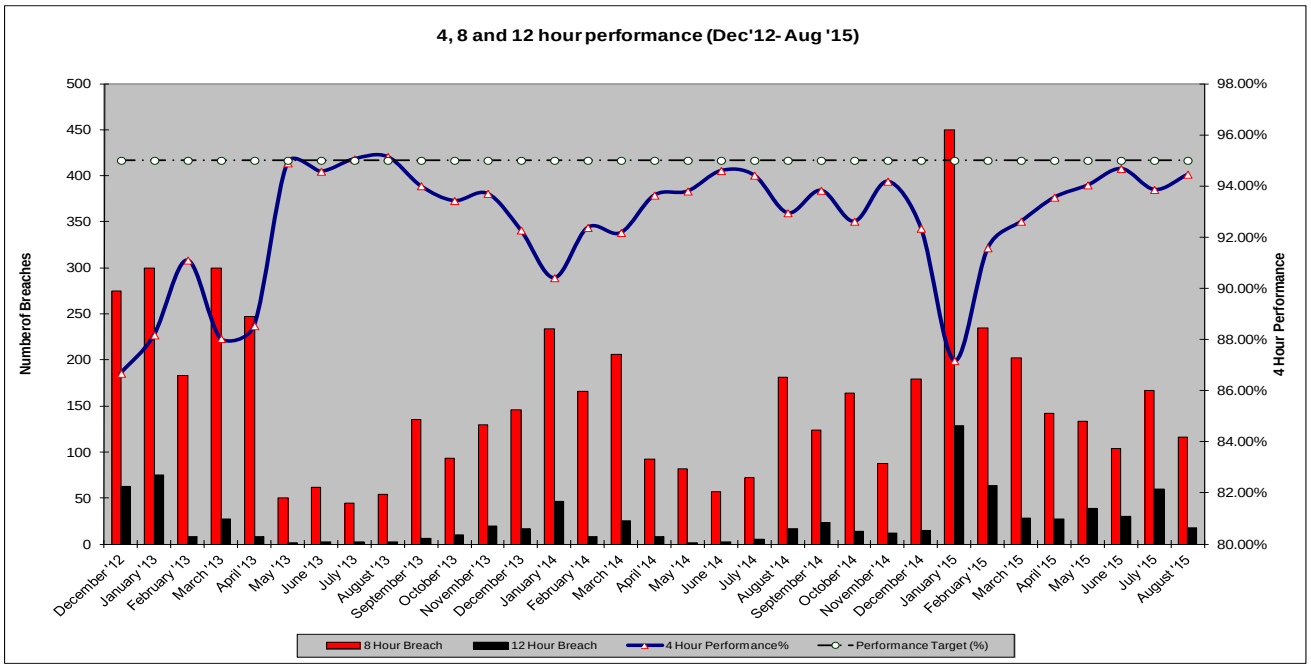
Jim Crombie

Chief Officer; NHS Lothian

University Hospitals & Support Services

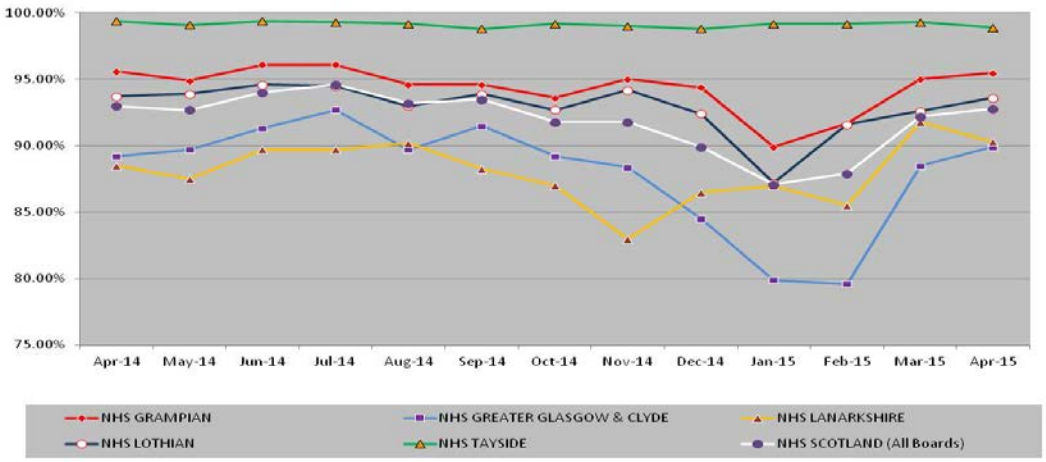
1. Last Year's Winter Performance

NHS Lothian's performance last year was challenging. Performance in January 2015 was 87.17% against a target of 95%. While performance improved in February and March (91.58% and 92.61% respectively) it remained below the national standard. Evidence of a system under pressure was also evidenced by the spike in the number of 8 and 12 hour delays. This can be clearly evidenced in the following graph.

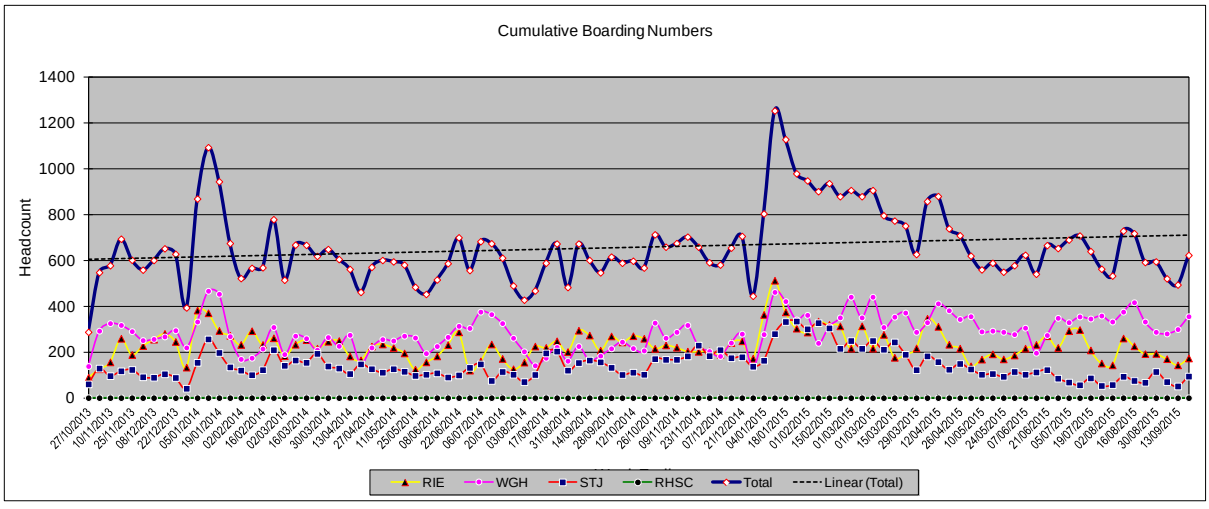


Last year's performance was not a 'one-off'. The above graph also highlights the annual dip in performance over the last 3 winter periods. However it was clear that other NHS Boards in Scotland were also under pressure as can be seen in the following graph.

Comparison of 4 Hour Performance: Teaching Boards (Apr '14 - Apr'15)



Due to the poor patient flow, we also witnessed an increase in the number of patients that were 'boarded out' across the system. The following graph highlights the cumulative weekly number of patients boarded out across NHS Lothian from October 2013 to September 2015.



At its peak, a cumulative total of 1200 patients were boarded out during week ending 11th January 2015. Such levels of boarding also raise issues of concern regarding the overall patient experience.

During the winter months of January to March 2015, there were also high levels of delays within the system which exacerbated the level of overall performance. According to monthly census data, there were 160, 161 and 148 delayed discharges within Lothian for the months of January, February and March 2015. However local intelligence would suggest that the overall number of delays was much higher.

2. Winter De-Brief

Following a debrief of our winter performance last year, NHS Lothian was able to identify a number of positive outcomes in spite of the pressures noted above. Feedback suggested that the following worked well:

- Good site team working and resilience
- Use of Safety Huddles
- Winter Ward function/ team
- Infection Control – Influenza A support
- New front door at WGH working well and appreciated by practices
- Discharge hub improving discharge from hospital to home
- Earlier in the day discharge
- More robust ward flow management and reduction in LOS in key specialties
- New hospital at home setups (eg compass +) which are anecdotally working well, though still on small scale.
- Better engagement between Board and GPs

However inevitably there were a number of issues that were of concern. The main issues noted included:

- Lack of effective focus on discharges
- Poor use of discharge lounges
- Recruitment/ Capacity issues

- 24/7 service delivery/ access to services (winter/ weekends/festive period etc)
- Weekend access to diagnostic Imaging
- Increasing demand for services
- Availability of portering/ domestic support
- Flu Outbreak and its impact
- Effective Discharge
- Delays/ Bed days lost
- Dementia focus
- Deferral of elective procedures
- Boarding
- Bank/ agency usage
- Interface between health care and social care
- Long SAS waits

The outcome from the winter de-brief has been used in attempting to take a 'lessons learned' approach to the development of this years winter plan – that is to continue with those aspects that worked well but to also plan how to mitigate against those issues that proved challenging last time around.

3. Winter Planning this Year

This year we have taken a more structured approach to the planning of our services across NHS Lothian during winter 2015-16.

In an effort to ensure robust planning mechanisms were in place for winter 2015/16, the 'Winter Planning Board' was established.

Our Winter Planning Board takes a whole-system multi-agency approach to the planning and delivery of our services over winter. The role of the Board is to lead and drive the winter planning process forward this time around. Membership includes representation from across acute, primary care and social care services and is outlined in Appendix B.

Our winter planning process this year has referenced the Scottish Government's 6 Essential Actions for improving unscheduled care. Our approach to planning our services this winter has also been aided by the development of national guidance issued by the Scottish Government earlier this year.

As a result of this programme of work we have detailed 'winter plans from all our partners and from each Acute Campus. Examples of these can be found in Appendix A. More detailed IJB/ H&SCP plans will become available in the coming weeks.

The Winter Planning Board has sponsored a series of strands of work in support of the wider winter planning agenda. For example in order to create a more robust performance reporting framework we are working with colleagues in collaboration with ISD to develop a winter dash-board. This will allow for up-to-date data and information to be available across the whole system in support of early and informed decision making for winter planning.

To date the Winter Planning Board has met sequentially since August and has supported the various actions required to develop this year's winter plan. The Winter Planning Board will continue to meet on a monthly basis over the winter months in order to appropriately monitor performance and to identify any necessary remedial action as required.

4. Key Risks

From our experience of the past we are aware of the challenges that winter can exert on our services. Some of these challenges are noted below:

- Safeguarding elective capacity as front door pressures increase during the winter months
- Poor patient experience for those being cared for in both the unscheduled and scheduled streams of acute services;
- Maintaining performance against key measures such as the emergency access standard, cancer waiting times standards, and others;
- Ensuring financial governance.

It is therefore essential that we are able to effectively plan to counter additional activity and all-round pressures to services. This year's winter plan outlines, in detail, the key actions that we plan to take to mitigate any risks and how we plan to maintain effective service delivery during the winter months. The following table highlights some of the key risks and details the mitigating actions we intend to take.

	RISKS	MITIGATION	Level
1	**Demand**	Use of forward planning data and predictor tools in support of site readiness. Effective and prioritised focus on site discharges will improve dail capacity to deal with spikes in demand	
2	**Compromised bed base linked to infection issues**	Enhanced Infection control, laboratory testing and additional cleaning services deployed as part of winter plan	
3	**Social Care Provision**	Significant additional resources deployed to Local Authority partners targeted at areas of biggest impact on flow and preventing admission	
4	**Lack of Performance Data**	Winter Dashboard agreed with 'real time' updates	
5	**Poor Discharge Profile**	Strong emphasis from each site on effective actions to increase medical & non medical discharge processes. Improved performance already being reported. Increased site focus on discharge lounge use. Standardised site huddles	
6	**Lack of inter site mutual aid**	Key and visible performance objective for newly appointed leadership teams. Daily formal site interactions and performance reviews. Ongoing dynamic monitoring of each site	
7	**Diagnostic tests available at weekends to support weekend discharging**	Increased site weekend provision of key diagnostic testing from November 2015	

5. Safe & Effective Admission/ Discharge

All flow activity by site will be monitored on a daily basis via the morning Safety Huddle chaired routinely by individual Site Directors. The format of these site huddles has been rationalised and through collaboration across our teams now demonstrate a consistency of format and approach.

Site huddles will be undertaken again at the 1pm and 4 pm focused on site calibration and reinforcing a focus on effective and safe discharging.

Looking ahead there will be robust attention given for the weekend start of 18th, 19th and 20th December for daily discharge quotas notably for those patients in the health and social care delays categories and for any admissions age 65 years and above, patients who have dedicated case management and any patient from care of residential type homes. Reasons for admission will be closely monitored by site teams.

From 15th December onwards, focused attention will be given to:

a. New package or care allocation;
b. Restart package of care;
c. Weekend starts for both Referrals to Intermediate Care and other community support teams including 'Hospital to Home' and 'Hospital at Home'. It is important that COMPASS +, REACT, MERIT, ELSIE all operate and pull out hospital discharges on Friday 18th December and 21, 22nd and 23rd December.

This will require close working arrangements between health service and social work teams.

Site Directors will be instrumental in overseeing any health delays and rebalance of the Royal Infirmary's activity as a priority from the 18th December through to Monday 4th January. This will be important as the WGH will be operating a 4 day LUCS service on both weeks of the festive period. The Hogmanay Plan will also be led via the Royal Infirmary site.

During this time, Orthopaedic Rehabilitation, Stroke and General Rehabilitation Flows to WGH and all other acute and downstream sites in Lothian will remain a priority.

Downstream hospitals will also have admission and discharge quotas and will be monitored in the same way as acute sites. Downstream wards will also have a focus on weekend discharge, for example Packages of Care restarts at weekend; new packages of care at weekends; families supporting gaps until commencement of new package of care on a Monday.

Delayed Discharge activity will be monitored and reported on a daily basis from each site Control Rooms including additions to the list and removals based on average POC number and wait. The top 10 delays on each site will be a focus. A Health Reablement Model will be considered to support discharge to assess from January 2016.

All patients will be monitored on an internal social work standard; that is 24 hours to allocation of social work and 3 days to assessment

Health and Social Care Partnerships will focus on monitoring Community Hospital capacity on a daily basis and to ensure TRAK is updated in real time to support effective decision making. Such actions will support effective patient flow through the hospital, including timely discharge from hospital.

Within Midlothian we are supporting increased capacity within the Assisted Discharge Service, currently delivered by the British Red Cross. The additional resource will support this service from January to March 2016

Other activities in support of safe and effective discharge include extending the working day over 7 days for pharmacy services (St Johns) that allow for early discharge planning and IDL preparation.

6. Workforce Capacity Plans & Rotas for Winter / Festive Period/ Out of Hours

Across MHS Lothian, medical consultant rotas for all specialities will be reviewed to ensure there is adequate festive period cover, including the 4 day breaks, weekends and the time in between when senior reviews are critical to expedite discharge.

There will be increased Emergency Department staffing during vulnerable periods, most notably from 25th December, Monday 28th December, Hogmanay and Monday 4th December. There will also be 24 hour consultant cover for Hogmanay, including 2 Consultants on overnight. There will also be enhanced nursing capacity within our Emergency Departments over the month of January.

Within respiratory medicine and medicine, additional consultant support will be implemented to cover the weekends of 26th and 27th December and 2nd and 3rd January.

The month of January should be given special consideration for consultant medical staff notably for the weekends. Respiratory Medicine will consider and deliver (with support from medicine colleagues) double weekend on call cover for this month.

Additional junior medical staff and nursing staff will be rostered to cover the Emergency Departments for the period 31st December to 4th January. Further support, as part of the Hogmanay plan will cover areas such as Radiology and Hospital at Night services

Senior Charge Nurse Cover for the festive weekends and January month will be reviewed to ensure adequate 5/7 rota cover at band 6 and 7 level and should include night duty or extended days where appropriate.

In addition, dedicated Management support will be delivered for the weekends from end of December onwards on all sites via the CNM and CSM Group and supported by a dedicated On Call Management Team.

7. Health and Social Care Capacity

In order to develop robust and integrated plans, our winter planning process takes into consideration the capacity available within health and social care settings over the festive and winter periods. The following is a short summary highlighting some of the key capacity and discharge issues from a health and social care perspective.

City of Edinburgh Council

- Home Care will continue to support individuals in their own homes throughout the winter period, including Christmas day and public holidays. This includes overnight visits. Over the entire festive period, Home Care will deploy 95% of its routine staffing levels to ensure it can meet demand.

- Intermediate Care - Normal staffing levels will continue throughout the winter period with the exception of there being no therapist on duty on 25 December and 1 January. Weekend services will continue as normal. There will be no therapy cover on the 25 December and 1 January; however, there will be public holiday cover for Community Therapy Assistants on these dates. Therapist cover at weekends will be increased (using existing resources) in the 3 weeks preceding and following the festive break to ensure timely assessment of urgent referrals.

- Increased capacity is being established at Gylemuir in October and in December.

- Sector teams will be operating a 'business as usual' service over the winter period and will ensure adequate levels of routine staffing levels over the festive period. However, they will

limit the scheduling of routine assessments over the festive period to ensure urgent cases are dealt with.

- Community Equipment Service – over the Christmas and New Year period CES will operate as normal except for 25-26 December and 1-2 January. On these public holidays, the out of hours service currently in operation for weekends and evenings will provide emergency cover.

- Care homes will be fully staffed over the entire winter and festive period.

- Disabilities day services will close from 24 December until 5 January. This is due to the fact that historically there has been little demand over that period. However, if a service user required day support over the festive period, 1:1 support arrangements would be put in place.

- Disabilities respite services will close from 24 December until 5 January.

Midlothian

- An Assisted Discharge service with British Red Cross has been established which will increase support for early discharge. Further discussions are ongoing re how this might be expanded to include South Edinburgh.

- The Hospital Discharge Team within Reablement will continue to be funded to ensure discharges within 48hours for those waiting for Packages of Care (up to 10hrs)

- *Discharge to Assess* has been within Liberton and is now rolling out across RIE to support more rehab in the community

- A single point of contact for discharge planning has been established within Midlothian. Work is being progressed with the RIE Discharge Hub

- The Hospital at Home team has been expanded with additional staff (Clinical Support Worker and OT) with a view to moving to a 7 day service and longer operating hours during weekdays

- The Hospital In-reach team has also been expanded with additional staff (Community Care Assistant and Band 6 Nurse) which will increase capacity for referrals

- Support within Care Homes is also being increased to review pathways and reduce hospital admissions through improved local care and decision making

- Increased assessment and rehabilitation capacity within Highbank (intermediate care facility) along with increased GP input to support local care management

West Lothian

- Across West Lothian, Community Hospital capacity will be monitored on a daily basis and TRAK kept up to date to ensure accurate reporting of bed status. Information will be relayed for site safety huddle and planning meetings.

- Actions will focus on ensuring effective patient flow and that planned discharges happen in a timely manner aiming for pre 12 mid-day discharge where possible including
    - Ordering of Discharge Medication
    - Notifying Care Providers 48 hours prior to discharge.
    - Ensuring transport arrangements are in place to support morning discharge

- Community Hospital duty rosters will be completed for Festive period by October 2015. It is anticipated that the peak demand periods will fall just before and after the festive public holidays all staffing has been enhanced to cope with additional activity. Community Nursing teams are reviewing public holiday arrangements to support cluster working to enhance patient care and integration of OOH and generic DN teams.

- The Rapid Elderly Assessment Care Team (REACT) service will concentrate on supporting acute discharges and review patients attending A & E where appropriate thus relieving pressure on in patient areas if safe to do so. REACT will be available throughout festive period with exception of Christmas Day and New Year Day.

- The Crisis Care service will be operational 24/7 to support patients at home, carer issues and rapid access to falls and personal care
- There will be continued close liaison with reablement and interim care team to ensure that capacity is identified and appropriate patients signposted to community services

- Discharge to Assess will be available through REACT/reablement where appropriate.

- Additional nursing capacity will be available through OOH Nursing Team from November to March.

- ROTAS will continue to offer rapid assessment and discharge in the Observation ward and A/E

East Lothian

- Delayed discharge funding has been used to increase capacity within the Hospital to Home team to support effective and timely discharge from hospital where packages of care are required.

- The Hospital to Home Team now consists of Band 6 Co-ordinator, 9 X Band 3 support workers and recent addition of 4 X Band 2 support workers will increase ability to support discharge where 2 care workers are required for visits.

- The team work very closely with social work colleagues and will support gaps in capacity as required.

- The carers also add capacity to the Elsie Hospital to home team by supporting this active caseload with additional visits if time available and appropriate.

8. Whole System Activity Plans for Winter: Post-Festive Surge

Across our acute hospital sites, a number of system-wide approaches are being developed for winter planning that tackle the post-festive surge in activity.

The January 'in patient' elective programme is to be reviewed for weeks commencing 4th and 11th January and only urgent cases and cancer cases will be progressed as required. The day case programme will continue as usual during this time and may be increased where appropriate.

All flow activity is to be managed in an 'anticipatory' way for 24/48 hours in advance across all adult sites, downstream sites and across the children's hospital. Those flow markers that indicate a sluggish system will be highlighted via the daily safety and planning meetings. These flow markers include:

- inadequate discharges to match admissions
- increased boarding activity across the site
- medical boarding into the surgical specialities
- increase in delayed discharges
- norovirus outbreaks

Community Rehabilitation Teams (CRT) and IMPACT teams will be available to support immediate and early discharge from hospital over the winter months (January to March). Foe example Hospital at Home Teams at WGH will also engage with East and Midlothian patients

Additional Ambulatory Care and Day Medicine capacity will also support front door activity, for example Lumbar Punctures will be available via the Front Door at the WGH.

The RIE will work closely with Integrated Joint Boards in support of a health 'reablement' model which can support hospital to home for immediate or early supported discharge. Support will also

be offered for effective rehabilitation and discharge of trauma patients, in line with agreed Trauma plans

Within Health and Social Care, a number of actions have been identified to deal with anticipated surge including additional nursing capacity, use of step down beds as well as piloting emerging programmes such as Discharge to Assess.

Specific capacity in support of respiratory pathways has been identified and agreed. This includes an additional integrated COPD pathway Consultant to support admission avoidance and primary care, enhanced RIE respiratory Nursing capacity that focuses on discharge across a 7 day window as well as additional respiratory cover for WGH (double on-call each weekend for month of January)

9. Whole System Activity Plans: Respiratory

As part of an overview of our respiratory pathways the following support has been identified and will be introduced over the winter period.

There is to be a dedicated respiratory team on each site who can management 5/7 day's activity and outreach as a boarding support to all areas across the adult sites. This team can act as an interface with Primary Care and Hospital at Home teams. This will require an additional support for respiratory on call on the last weekend of December and the 4 weekends in January. The Respiratory Nurse Specialist Service at the Royal Infirmary and St John's should operate on a 7 day service in ED/AMU.

Further support in the form of additional respiratory on call capacity will also be made available on the last weekend of December and the 4 weekends in January.

RIE Respiratory Hot Clinics will also be available via the PAA Front Door model and all sites are to ensure there is capacity on all clinics for urgent respiratory care

Community Rehabilitation Teams (CRT) and IMPACT teams will be available to support immediate and early discharge from hospital over the winter months (January to March). Additional Ambulatory Care and Day Medicine capacity will also support front door activity.

REACT along with a community respiratory facilitator will work closely with inpatient wards to identify respiratory patients who can have their care needs met at home and facilitate supported discharge for those patients.

10. Strategies for Additional Winter Beds and Surge Capacity

As is typical during winter, we are required to consider the additional capacity required to deal with the volume of activity over the winter months. This needs to be planned carefully and in line with the agreed financial envelope.

This year we plan to augment our bed capacity using a number of options available to us. The following list outlines the anticipated bed capacity that will be required across NHS Lothian to help support our services over winter.

We have agreed to continue with the 30 beds at Gylemuir from November onwards and to have clear criteria for referral for those beds for a quick turnaround over the winter period. The MOE Lead Consultant/AMD will have input into this criteria.

In additional to Gylemuir and the Hospital at Home Models, surge plans will be planned and made available. Current options include:

- Open 28 additional acute beds at WGH within Ward 15 to accommodate delayed discharges and to support patient flow.

- Ward 22 at WGH to remain open at weekends to support flow during winter

- Open Ward 15 at St Johns Hospital to 18 beds with 7/7 AHP cover

- Options to open up additional beds and cubicles at the Royal Hospital for Sick Children

- Convert PAA area at RIE to a 10 bedded inpatient area and open separate Enhanced Ambulatory Care/Ambulant PAA area protected from the bedding down that occurs in the

current PAA area. This protected area will remove some of the pressure from ED where PAA patients are currently seen when PAA is bedded down

- Open 10-20 virtual ward beds for Frailty Outreach including a new South Edinburgh Model. This should be supported via additional capacity in ELSIE, REACT, MERIT and COMPASS+.

To support these additional beds and oversee patient flow, dedicated boarding teams on all sites will focus on expediting tests and investigations to ensure early supported discharge to home or to a virtual ward area. This team will be consultant led.

In light of this additional bed capacity, we will augment our workforce capacity to the end of March 2016. This will cover a range of staff groups including medical, nursing, AHPs, Pharmacy, Imaging and facilities.

11. Minimising the Risk of Patients being Delayed on their Pathway

In order to reduce the risk of unnecessary patient delays during the winter period, a number of measures will be put in place.

Daily flow activity will continue to be monitored on all adult and children's sites and reported to the Chief Officer via Control Room.

The markers here include:

- admission and discharges by noon
- front door attendances & admissions
- discharge hub effectiveness

Downstream Hospitals will have admission and discharge quotas agreed and monitored in the same way as adult acute. This includes Liberton, Roodlands, Astley Ainslie, and RVB.

Effective weekend discharge will also require downstream hospitals to have a focus on Packages of Care restarts at the weekend, new package of care restarts at the weekends as well as liaising with families in support of 'gapping' until package of care become available from Monday.

It is essential that we are able to reduce bottle necks in the system, the symptoms of which are often seen in the level of patient boarding across sites. To counter this hospital site teams are considering a variety of models that will reduce the level of boarding. These include

- criteria led discharge pilots at St Johns Hospital
- Enhanced cover for Day Bed Suite at WGH that protects elective capacity and frees up in-patient beds
- Re-balancing of weekend 'health delays' from the Royal Infirmary to all sites allowing for more appropriate use of beds.
- All boarding processes will also reflect identification of those patients who have an estimated date of discharge of less than 24 hours.

Another example includes extending the Hospital to Home team in across East Lothian by introducing a third team to target delayed discharges. Through working in more remote areas this team will be able to deliver certain packages of care not currently being delivered via social care. By meeting this demand we will be able to support quicker and effective discharge and maintain patient flow

12. Discharges at Weekends & Public Holidays

To support effective discharge at weekends and during public holidays, all adult sites, including the children's hospital, are to ensure that adequate support services are in place (notably the second week of festive period) to ensure effective numbers of discharges are delivered. Examples include:

- Diagnostic support through radiology (mainly CT and Ultrasound), laboratories and endoscopy is to be made available. A 'wait for test' BOXI report to be set up to highlight any waiting patients at any one time waiting on investigation to support discharge decision-making. This should start 20th December onwards.

- Transport hub to support any additional transport carriers as required.

- Pharmacy support not only in pharmacy dept but to consider pharmacy and technician support in ward areas, notably AMU/ARUAT. This will support junior medical staff.

- Appropriate therapy support will be available at front door areas over the festive period (notably the public holidays on the second week) as well as increased support at the weekends to the roaming teams especially during January.

- To ensure adequate weekend 'hospital' social work support to ensure timely assessments for patients admitted on Friday. Any additional support for the Public Holidays on the second week is to be seriously considered.

- Every wards on all sites, acute and downstream, to evidence a 'Friday morning board ward round' led by a consultant, SCN and MDT who can plan and anticipate Saturday,

Sunday and Monday discharge decisions and expedite tests/investigations as required. CSMs and CNMs to be involved in every directorate and this should be reported at the 1pm Weekend Planning Meeting.

- A 'twice weekly delayed discharge board round' to be undertaken to ensure discharge decisions are being taken which consider potential patients for 'Hospital to Home/Reablement Health model' – POC under 6 hours. This should be led by the General Manager and Clinical Service Manager for Medicine Services.

- Community OOH nursing teams will liaise closely with the discharge hub to ensure discharges can be supported into the community and that information regarding patient care is transferred to community teams in a timely manner.

Such actions will assist in ensuring that patients are discharged at weekend/ during public holidays, will avoid unnecessary stays within acute ward settings and in turn allows for effective patient flow through the system, particularly during busy periods.

13. Escalation Plans

It is important that access block is avoided at each Emergency Department. To ensure this each site will work towards a target operated model that is managed effectively via the individual site teams. As such all 4 front door Emergency Departments and receiving areas can evidence robust escalation processes including:

- Volume attending in the hour (escalation thresholds > than RIE 20 / STJ 10 / WGH 10 / RHSC 10
- Escalation of first assessment waits at 90 minutes and above
- Escalation of any patient waiting at 3 hours with no management plan
- Escalation of high resuscitation activity and Medic 1 & 2 calls outs
- All site flow teams, Senior Charge Nurses, CMT members to have clear understanding of roles in response to escalation.
- All sites to evidence a Daily UCC & Flow Debrief 'separate' to the safety huddle on the 'day before performance of 4 hours & elective cancellations'. This will raise issues and themes to be addressed in relation to capacity and flow and this should be documented and circulated to core site CMT members and form the basis of any informal report to the Chief Officer for Acute or to Scottish Government.

- Health and Social Care Partnership will ensure that local community hospitals have internal escalation procedures with clear trigger points and actions. A de-escalation process will be agreed likewise.

In leading the above all sites teams will demonstrate a clear understanding of their role on whole system escalation processes.

14. Business Continuity Plans

NHS Lothian have Business Continuity strategies and plans in place to deal with a range of challenges that might affect NHS Lothian's services and functions at any time e.g. staff shortages, denial of access, failure in technology, loss of utility, fuel shortages.

These enable a response to a disruptive challenge to take place in a co-ordinated manner including processes for recovery and restoration of essential functions and services.

Strategic and Tactical level Business Continuity modules have been established and must be read and applied in conjunction with Business Areas Operational Level plans for Essential services and functions.

Without appropriate BCM arrangements, NHS Lothian would not be considered adequately prepared if operational activities were adversely impacted. The lack of preparedness could mean areas of poor resilience are not identified and the opportunity to mitigate risk has not been addressed.

The following outlines some of the business continuity plans in place across Lothian

NHS Lothian

- Severe weather plans for NHS Lothian are in place and will be managed via local resilience site meetings.
- Norovirus outbreak plans will be refreshed and circulated appropriately.

West Lothian

- In West Lothian, all teams have reviewed their business continuity plans, and Business Continuity Exercises have been undertaken within services and with partners. Specific arrangements in place for severe weather to ensure continuity of service provision

CEC

- A City of Edinburgh Council-wide Business Continuity Plan has been produced, which includes plans for each department. In addition, a Severe Weather Contingency Plan has been produced for Health and Social Care.

Midlothian

- Across Midlothian, work is underway to review contingency planning in relation to adverse weather etc. across health and social care

East Lothian

- East Lothian community hospitals are developing close working links with acute hospitals - in particular agreement with the logistics department for both mail and specimens pick up during spells of severe weather. The Equipment Service is focused on discharges and terminal care with additional priority over festive and winter period.

- Business Continuity Operational Plans on shared drive for all essential services available to Senior Management and Clinical Managers.

15. Preparing Effectively for Norovirus

Infection Control and Surveillance are issues that will be raised at every site Safety Huddle by the nominated IC Nurse for the day and any concerns on any issues of IC including Norovirus will be raised at this time with appropriate and specific actions agreed.

Where outbreaks are noted, specific consideration will be give to these areas and a review by the Associate Nurse Director for the site to ensure local plans and approach are robust and in place. This includes HPS Guidance.

External communications from the site to other sites in the system will be robust and channelled via the Control Room. This will ensure any high risk patient transfers across the system are noted and precautions taken for any emergency admissions to any site via this route.

The Bed Bureau and St Johns ANP Services will raise with all referrers specific infection questions. Weekend Infection Control service will be reviewed to ensure on site support during the winter and especially where there are outbreaks to be managed.

Uniform Policy will be emphasised at every site safety huddle and a critical friend approach will be taken as usual for all uniformed and non uniformed staff. Hand Hygiene will also be emphasised at every opportunity.

Protocols and procedures are in place across Health and Social Care Partnerships for the management of norovirus outbreaks. All staff area aware of and will adhere to the standard precautions to reduce impact of outbreaks.

There remains ongoing liaison with Care Home Providers to ensure early recognition and appropriate action is taken to manage outbreaks

16. Seasonal Flu Vaccination

Effectiveness of flu vaccination in 2014/15

During December 2014, the UK experienced circulation of influenza A(H3N2) with a particular impact on the elderly. It soon became clear that there was a mismatch between the circulating H3N2 strain and the H3N2 vaccine component.

In NHS Lothian this mismatch was evident in the community. Within Care Homes, 22 outbreaks were reported despite average vaccine uptake of 82% in those areas. Most of the outbreaks occurred between 1 January and early February. Only two influenza outbreaks had been reported in Lothian in the previous ten years.

However although over 700 care home residents developed flu symptoms, there were only 21 hospital admissions recorded and 19 deaths. This would appear to be far fewer than might be expected for flu outbreaks of this size and probably shows some protection from the vaccine. However it is also a reminder of what flu can do, were we not to have such a high annual uptake in our flu vaccination programme.

Aim for 2015/16

This year we aim to increase the staff flu vaccination uptake from last year (2014). A total of 16,179 vaccines were used for the seasonal flu campaign which started on 1 October 2014. Vaccines given to staff totalled 13,242 with nearly 3,000 given to hospital patients.

In doing so, our main objectives this year will be:

- To promote the staff flu vaccination programme to all 24,000 staff across Lothian
- To increase the number of flu vaccinations undertaken last year by 10 per cent

- To incorporate lessons learnt from last year
- Identify minimum of six flu champions who can encourage staff at their site to take flu vaccinations
- To ensure flu messages are incorporated into our winter planning programme

Our target audience will be Hospital-based ward staff, GPs and nursing staff who administer the vaccinations, other healthcare professionals along with support and administrative staff.

Awareness of the staff flu vaccination campaign will be sustained via our communications plan. This will be managed and reviewed on a regular basis to ensure the plan is being properly implemented, developed and up-dated as required in support of our objectives.

Hospital Sites

All hospital sites will have a flu programmes in place by October and will be led by the Associate Nurse Director. This will be supported by a Healthy Working Lives Initiative to ensure all staff remain in good health during the winter period.

Across each of the Integrated Joint Boards/Health and Social Care Partnerships, a range of actions have been identified in support of this year's flu campaign. These include:

- All staff encouraged to uptake free flu vaccine to protect patients and themselves.

- GP practices will provide to all eligible patient groups and their own staff in accordance with National Enhanced Service.

- Carer vaccination to be encouraged by GP Practices and also offered to carers of the housebound patients.

- Co-ordinators identified to facilitate the delivery of vaccines to staff groups in the community including to partner agencies

- Effective outbreak policies and procedures are now in place.

- Care Home senior Nurse and NHSL education delivering training programme for care homes to support delivery of flu vaccine to vulnerable patients and also to staff in care homes sector.

- Specific plans to increase staff uptake of flu vaccination particularly within the social care sector (care homes/care at home)

17. Trauma Flow

We are reviewing options for Trauma rehab to ensure effective arrangements to support predicted trauma activity. We will plan for orthopaedic trauma service over the winter within the context of the winter planning for the RIE site and NHS Lothian.

The key principles underpinning the plans in Surgery and Trauma and Orthopaedics will be to:

- support interdepartmental working (e.g. ED and orthopaedics)
- maximise capacity
- ensure timely discharge
- proactively manage the bed base
- ensure multi-disciplinary staff availability
- proactively ensure downstream beds
- thresholds for escalating higher demand

Using the actual activity and performance data from last year, we will establish options to support effective rehab & discharge for Trauma patients in RIE.

In turn this should evidence projected activity for December through March 2016 and the optimal processes for existing services and flow pathways as well as redesign options to deliver a sustainable Trauma and Elective Ortho service over winter.

18. Critical Care/ PICU Provision

We are clear that early involvement of the Clinical Management Team is required to ensure adequate patient flow through critical care facilities to ensure access for our most dependant patients.

In the event of any Critical Care Unit in Edinburgh being full, the Duty Consultant for that Critical Care Unit is notified. Patients suitable for discharge to either the ward or HDU is identified and discharge organised. If the unit is full, there are delayed discharges and a patient requires admission to Critical Care immediate discharge of ward fit patients will be progressed with Site and Capacity team.

If a unit is full and discharge cannot be organised for ward fit patients within an hour then the duty consultant will liaise with the site and capacity team or senior manager on call.

If there are no suitable patients for transfer to the Ward or HDU then the possibility of transferring appropriate patients to another Critical Care Unit in Lothian should be explored. These patients will be stable for transfer and do not require specialist intervention at their hospital of origin. It is the responsibility of the critical care consultant on duty to make this decision.

The site specifics are laid out below:

No Critical Care Beds at SJH Critical Care Unit

- Duty Consultant should liaise with Consultant at WGH or RIE regarding transfer of suitable patients.

No Critical Care Beds at WGH Ward 20

- Duty Consultant should liaise with Consultant at SJH or RIE regarding transfer of suitable patients.
- Duty consultant should also liaise with Neurosurgery regarding diversion of non-Lothian Neurosurgical referrals.

No Critical Care Beds at RIE Ward 118

- Duty Consultant should liaise with Consultant at SJH or WGH regarding transfer of suitable patients. If no level 3 bed available in Lothian and Ward 118 is full then the following locations should be used (in order):

1. Ward 111 Cardiothoracic ICU under continued management of the Critical Care team, and only after discussion with the duty Cardiothoracic
1. Anaesthetist
2. Ward 116 HDU in Side rooms 1 and 2
3. Theatre Recovery

No Critical Care Beds at RIE Ward 116

1. Placement of HDU patients in 118 if beds available
2. Utilisation of further HDU beds in Ward 115 or 117 following discussion with the responsible SCN and Consultant
3. Utilisation of HDU beds in Ward 112 (Cardiothoracic HDU) only after discussion with the responsible Cardiothoracic Anaesthetist

Royal Hospital for Sick Children

- Within PICU, 2 additional beds will come online from December 2015, thus boosting our capacity for winter at the RHSC.

19. Ring-Fenced Elective Capacity

The anticipated increase in unscheduled activity across our sites during the winter period provides a significant challenge to managing our elective capacity. It is crucial that we effectively manage peaks of unscheduled care demand with our elective demand as this is crucial to ensuring the best care for our patients as well as ensuring efficient flow across our hospitals; ensuring performance against TTG, cancer waiting times targets. There is now clear evidence that boarding of patients to different specialties has an impact on optimal care and this plan is keen to minimise such instances.

This Winter Plan heralds a policy change focusing the site teams on a clinical decision model that moves away from boarding and elective cancellations to improve capacity to a more risk assessed discharge process that identifies patients ready for safe discharge with minimal care requirements.

It is evident that clinical staff will need to be supported in this policy shift and a number of communication processes will be established across sites to ensure clarity. A formal clinical guidance section will be developed in the coming weeks and launched within an augmented NHS Lothian discharge policy & procedure.

To further help us plan for and protect sufficient elective capacity for this year's winter, as well as undertaking analysis of data from last winter, we plan to use Information and Statistics Division's SystemWatch prediction tool. This will enable us to monitor and predict numbers of emergency and elective admissions and the number of occupied beds. Predictions are available one to three weeks ahead and are based on seasonal and weekly variation, current emergency admission activity and flu rates.

Operationally the January 'in-patient' elective programme will be reviewed on the weeks commencing 4th and 11th January. Only urgent and cancer cases will be progressed. During this period Day case activity will be augmented to further support elective throughput.

Additionally all flow activity will be managed on an 'anticipatory' basis 24/48 hours in advance across acute sites and the children's hospital. Dedicated 'boarding' teams on each site will also focus on expediting tests and investigations to ensure early discharge where possible.

20. Facilities Capacity

In line with the additional commitment made in terms of bed capacity and service provision throughout winter, additional facilities capacity has also been identified.

To support rapid room cleans and ensure optimal flow across Emergency Departments and assessment units, additional domestic and portering resource has been agreed for each acute site over the weekends of 2nd& 3rd January; 9th&10th January and 16th &17th January 2016.

This resource will be protected for the duration of the winter period and will act as a dedicated resource for the purposes of acute services during the winter period.

21. Transport Capacity

The winter plan for 2014/15 identified the need for a mid tier service to be utilised by front door services at the 3 main acute sites (RIE/WGH/STJ). Following analysis and review of this service the demand failed to meet the available transport capacity providing no direct value to front door services. The service was redirected to support repatriation of PCI patients from cardiology (RIE).

To support the requirement for increased bed availability supporting front door and inpatient demand it is proposed that NHSL/SAS provide an enhanced transport service, increasing available transport to support discharge, cross site movement and out of area discharge.

Transport will continue to be booked via the Transport Hub. As part of the winter proposal the opening times of the Hub will continue as above. However, to promote early and pre bookings the

service will be augmented by 2 call handlers Mon – Fri. This will support the increased call activity and support the areas in ensuring that the extra capacity is maximised during the winter period.

Across the City of Edinburgh Council, the resourcing and coordination of 4 wheel drive vehicles and the equipment for other vehicles (e.g. winter weather snow tyres) will be undertaken by Corporate Governance, based on an assessment of the needs of all departments. Health and Social Care will lease an additional two (TBC) 4x4s for the winter period.

Consideration is also being given to a Home from Hospital service – similar to that provided by the Red Cross for Midlothian Council.

22. AHP Capacity

As a result of our ongoing winter planning arrangements, the following key indicators have been identified for AHP staffing:

- OT and PT first assessments will be delivered within 24 hours of referral
- All ongoing therapeutic interventions delivered.
- Workforce capacity and rota's agreed by October
- Principles of 7 day working over festive period

From 1st October which will see more robust AMU and A&E rotas for OT/PT with no detriment to the Monday to Friday service.

As in previous years we will have OT/PT presence across the festive period on all days, with the exception of Christmas day, with staff doing full day shifts. Our Roving Team capacity will be increased at the weekends throughout the winter.

The Respiratory Out-Reach team on the RIE and WGH sites will be augmented with additional physiotherapist capacity (7.5 wte) to interface with the Community Respiratory Team. There is also increased respiratory capacity at the weekend throughout the winter.

Boarding Teams on the RIE and WGH sites now include occupational therapy and physiotherapy resource to ensure ongoing rehabilitation and discharge planning for boarded patients that supports effective patient flow.

There is also increased community capacity from the ELSIE (East Lothian Service for Integrated care for the Elderly) Team.

23. Radiology Capacity

It is imperative that we are able to offer an augmented imaging service over the winter period given the historical demands that winter will impose. As activity increases it will be important that we are able to support patient turnaround times and to maintain flow.

To this extent we are supporting a number of actions within radiology services, including:

- Additional Escort Nurse capacity for RIE and WGH radiology Journeys

- Additional Radiographers capacity for Accident & emergency and for reducing CT delays on each site.

- Additional Radiologist capacity to address the additional reporting required as a result of increase in activity.

- 24/7 radiographic support for the Emergency Department at St Johns Hospital, to help reduce waits for both emergency and outpatient activity

24. LUCs Capacity

As is established practice LUCS will tailor its service provision across the festive period to accommodate the anticipated levels of demand. This is especially so in years where the festive period involves a four-day break from normal in-hours services, as will happen at both Christmas and New Year within 2015/16. Activity trends are analysed from a well-established dataset for LUCS going back for a number of years, and from this the required service provision is designed in order to address adequately the predicted pattern of need.

In recent years, all of general practice has experienced significant difficulties in achieving adequate recruitment into the service, and this has had a concomitant impact within the provision of out-of-hours services such as LUCS and others throughout Scotland. In light of this, some additional investments are being proposed for the specific festive period in 2015/16 within LUCS in order to maximise the ability of the service to meet demand and to support those neighbouring services, chiefly those of front-door hospitals, at what is always a period of considerable pressure.

LUCS has requested support through winter funding for the provision of a protected GP triage function to assist with the anticipated demand. This function would be of significant benefit at points of peak demand, and it is LUCS's intention to provide this function at anticipated busy periods, including those relating to the festive period as well as throughout winter more generally.

In addition, LUCS is keen to resource clinical support graded staff into the service during winter to provide logistical and core clinical support duties. This resource will free up capacity within nursing and medical staffing that can be rededicated to meeting the demands arising from increased winter and festive activity.

25. Pharmacy Capacity/ Opening Hours

Opening hours for community pharmacies are covered by a core hours agreement which is an NHS service requirement but there are several pharmacies that open longer hours which is a business decision on their part. The opening hours are contained in the pharmaceutical list held by PCCO Contract Support who are currently engaged in collating the festive opening information.

Contractors have informed us that some will open on the Saturday of each week and those who do not will open on the Monday (PH) with reduced hours. They have agreed to work with the NHS Lothian to ensure there is good geographical pharmaceutical provision over both Saturday's and Monday's. Exact details have yet to be confirmed.

During this time community pharmacies are able to offer minor ailments service which allows treatment of self limiting illnesses, unscheduled care service for provision of medicines when a patient is not able to see their GP in addition to the traditional dispensing service and help with self care.

We have are also reviewing hospital pharmacy capacity to meet the demands of winter. Examples of specific resource commitment identified to date include:

- Additional Pharmacy Technicians to support medicines supply and discharge planning
- Additional Pharmacy capacity supporting discharge at weekends – pharmacy capacity will be increased in pharmacy departments but also within ward areas, notable AMU/ ARUAT
- Extended Pharmacy Department opening hours (eg to 7pm week days and 10-2pm at weekends – St Johns)
- A dedicated pharmacy porter resource at St Johns Hospital

26. Hogmanay Plans

A well rehearsed multi-agency Medical Plan is designed each year through the Events Planning Organisational Group lead by the City of Edinburgh Council and NHS Lothian are represented on that group by Emergency Planning and Emergency Department colleagues.

The Medical Plan includes Medical, Nursing, Paramedic and First Aiders at the event scene including a “sleep off” facility for those intoxicated who do not need medical intervention. This contingency negates and minimises the impact of the Hogmanay Street Party on our Emergency Departments.

In addition the UHS Hogmanay Plan has been adapted over many years and provides a robust framework for managing Unscheduled Care on the prior evidence of attendances, presentations and challenges. The basis of the plan is an increased medical and nursing presence within the RIE, Emergency Department to support predicted increases in activity on specified days and time spans over the Festive Holiday days. There is a further contingency to staff the Medical Day Case Unit, primarily for patients recovering from the effects of excessive alcohol consumption

The Hogmanay Plan will include additional support for the Royal Infirmary ED, Radiology, HAN and support services as required. This is a multi agency plan and will have the Resilience Committee support at NHS Lothian Board level.

All Health and Social Care Partnerships will contribute to the development of the Hogmanay Plan

In addition Festive On-Call rotas have been established to allow for appropriate escalation and support during the Christmas and New Year holiday period.

27. Communication Plans

A co-ordinated approach to communication is planned to ensure effective understanding and engagement in winter planning and delivery. The **Winter Ready** communication plan includes key themes for each month and targeted communications will be delivered to both internal and external audiences through existing channels such as the intranet, website and social media.

Internal communications

Daily inter site communications will be enhanced to ensure focused discussion on site activity, pressures and resilience planning for acute and downstream sites. The 9.30am teleconference is the key communication point and this will be chaired by the Service Manager for Flow and Capacity and a core member of site CMTs will be in attendance. For downstream sites, General Managers/Chief Nurses should be present to ensure timely and appropriate decision-making on flow issues.

A Winter Intranet site will be set up from October onwards and hold key plans and advice for staff. This will be led via the Royal Infirmary Control Room and updated for all sites as required.

Regular communication channels such as team brief and social media will be used to raise awareness of the winter plans and encourage staff to participate in flu vaccinations and hand hygiene awareness

Across Health and Social Care Partnerships, local winter plans are communicated to all health and social care teams. In addition Patient information includes advice on how to access services during festive periods

External Communications

A **Winter Ready** section will be created on the NHS Lothian website to provide advice and support for the general public. A programme of social media and media activity is planned to help the public understand what services are available when and what steps they can take to help ensure they and their families are ready for winter. This will support national campaigns around Flu, Norovirus and the NHS 24's Healthwise and will link into work on winter planning by the four local authorities.

A summary of our Winter Ready Programme is outlined in the table below.

The Winter Ready programme and sample of activities planned is included below

Month	Theme	External Communications Activity	Internal Communications Activity
October	Flu vaccinations and awareness	Dedicated Winter ready section on the NHS Lothian website set up. Support for Scottish Government flu campaign launch with local case studies. Features on how to look after yourself in winter/colds and flu in the Evening News and other local newspapers. Social media campaign – busting the myths around flu	Flu vaccination clinics promoted through: intranet payslips team brief site and IJB newsletters. Raising awareness of the winter plan and where to find supporting information: intranet team brief site newsletters
November	Norovirus and infection control	Support Scottish Government Norovirus campaign. Features on advice and hand hygiene in Evening News and local papers. Social media campaign – hand hygiene	Infection control management pack promoted through: intranet team brief site newsletters Handy hygiene campaign for staff Continued promotion of Flu clinics through: intranet payslips team brief site and IJB newsletters.
December	Where to go for care/festive period cover/know your limits	Support Scottish Government Healthwise campaign. Features on where to turn to, Minor Injuries and what services are available over the festive period in the Evening News and local papers. Social media campaign – where to	Continued promotion of: Flu vaccinations infection control hand hygiene Through: intranet payslips team brief

		go for care – minor injuries/NHS 24/Pharmacies Edinburgh Hogmanay advice on knowing your limits and where to go.	site and IJB newsletters.
January	Where to go for care/healthy lifestyle	Support Scottish Government Healthwise campaign. Social media campaign – where to go for care – minor injuries/NHS 24/Pharmacies Features on new year resolutions – healthy lifestyle/stop smoking	Continued promotion of: Flu vaccinations infection control hand hygiene Through: intranet payslips team brief site and IJB newsletters.

28. Finance

As part of our winter planning arrangements, we invited bids for winter monies from a range of hospital sites, and services as well as from Integrated Joint Boards / Health and Social Care Partnerships. Having reviewed all bids to date, the following table outlines our anticipated spend for winter this year.

Our anticipated spend for winter 2015-16 amounts to **£6.4 million**. This compares to a total of £3.6 million outlined last year. The following table outlines the various funding sources that make up our winter planning allocation this year.

WINTER INCOME SOURCES	Amount (000)
USC WINTER FUNDING (Beds/ Surg/ Flu)	£2,561
Additional SG Funding	£870
Delayed Discharge Funding	£2,000
Assumed Further Delayed discharge monies	£1,000
Grand Total	**£6,431**

Of this amount, £2.9 million is set aside for acute care costs (including facilities and transport) while a total of £3.5 million is set aside to support primary and social care services.

A detailed breakdown including a comparison with last year is outlined in the table below.

Area	Site/ Service	14/15 Actual	15/16 Allocation	Movement from 14/15
Acute Costs	RIE	78	**520**	442
	WGH	385	**450**	65
	SJH	402	**355**	-47
	RHSC	150	**261**	111
	Facilities	71	**84**	13
	Imaging	61	**300**	239
	AHPs	149	**130**	-19
	Pharmacy	8	**48**	40
	Transport	80	**129**	49
	Acute Service Support & Infrastructure	48	**579**	531
Acute Costs Sum		**1,431**	**2,856**	**1,425**
CHP Costs	East Lothian	6	**224**	219
	Edinburgh	604	**2,187**	1,583
	Midlothian	77	**44**	-34
	West Lothian	23	**120**	97
	RVH	1,402	**0**	-1,402
	Incremental Delayed Discharge Monies		**1,000**	1,000
CHP Costs Sum		2,112	**3,575**	**1,463**
Grand Total		**3,543**	**6,431**	**2,888**

A total of 46 additional acute beds will be opened over winter 2015-16.

29. Evidence of Changes to Working Arrangements

Over the winter period, and particularly during the festive period, it is imperative that we are able to review our working arrangements and workforce capacity in order to better deal with the anticipated demands placed upon our services at this time.

As a result there are a range of measures that we are planning to incorporate to support our winter planning process this year. The following highlights some of these measures that we will introduce over winter.

- Medical Consultant rotas for all specialties to be reviewed to ensure effective cover including the 4 day holiday periods over the festive season

- Respiratory Medicine and Medicine to have additional consultant support for 26th and 27th December as well as 2nd and 3rd January

- Senior Charge Nurse cover for the festive weekends and for January 2016 to ensure adequate 5/7 rota cover at Bands 6 and 7 (including night duty)

- Dedicated management support from the end of December for weekends (CNM/ CSM Groups and On-Call Management Teams)

- Increased nursing capacity during festive weekends for RHSC

- Additional Medical staff during vulnerable periods

- 24 hour consultant cover for Hogmanay including 2 on overnight

- Enhanced nursing capacity during January

- Additional Therapy Support at front door over festive period and increased support at weekends during January

- Pharmacy and technician support in ward areas, notable AMU/ ARUAT at weekends/ public holidays

- Additional Portering and domestic capacity over the first 3 weekends in January

- Health reablement model that will support discharge to assess from January 2016

30. Evidence of Admission Avoidance

In addition to supporting front door capacity to meet the anticipated hike in demand over winter as well as back door capacity that ensures appropriate patient flow, we are keen to develop services that support admission avoidance

For example, through joint working with Midlothian Health and Social Care Partnership, we are sponsoring investment to allow MERRIT to move to a 7 day service. Investment will cover additional nursing, AHP and GP resource that will increase our ability to refer more patients to virtual ward settings. This admission avoidance pathway will in turn relieve pressure from the Emergency Department front door.

A further example is the development of up to 20 virtual beds to support Frailty outreach including the new south Edinburgh model. This will have 2 key components, that is it will be able to identify suitable patients ahead of admission to hospitals, and secondly will also be able to 'pull' patients out of unnecessary hospital stays, thus supporting effective patient flow.

Within the respiratory pathway, we will continue with an integrated COPD pathway Consultant and we will also develop at home IV antibiotic delivery within Edinburgh to Bronchiectasis patients. Both are excellent models which will promote admissions avoidance and that support primary care delivery.

31. Adopting a Lessons Learned Approach

As part of our winter de-brief earlier in the year, we were able to highlight those aspects that worked well as well as those that fared less well. In developing this year's winter plan, it was important that lessons were learned form our approach last year that could support us going in to the winter of 2015-16.

The following lists some examples of where lessons have been learned and the implications this had for our planning process this year:

- A rapid response team for domestic services – this has been prioritised as part of our winter planning this year to ensure this essential support.

- Conducting small test of change initiatives now ahead of winter to test the portering requirements both in the ED and Discharge lounge.

- Increased portering capacity to speed up our discharge processes, to support patient flow to and from the discharge lounge and also to ensure timely discharge prescriptions are received to the main

- Increase efficiency of the discharge lounge – porter to support flow by pulling patients to the discharge lounge early and allow scope of patients within discharge lounge to increase (currently the CSW from the D/L does this duty meaning nursing resource is depleted)

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- Support a short term increase in nursing staff in the ED to ensure patient safety at times of overcrowding Jan-Mar.

- Winter nursing staff must be prioritised and recruited to now to ensure flexing of capacity can be safely managed.

- A psychiatry review within the Emergency Department has supported a reduction in the number of breaches compared with last year – increased ACAST team has improved this.

- Greater understanding between health and social care in particular over the 2 week festive period.

32. Pre-Winter Planning (and through to April 2016)

We have adopted a structured approach to our winter planning arrangements this year. Following our winter de-brief and report earlier in the year it became clear that we need to develop a more integrated and transparent approach. With the formation of Integrated Joint Boards and their maturation, it was important that we were able to work more closely in planning our future service, including the development of our winter plans

As a result we formed the Winter Planning Board which allowed for a multi-agency/ multi-professional approach to help plan and drive our winter services this time around. This has proved very effective in supporting the delivery of our final winter plan.

The above approach has also allowed for Scottish Government Colleagues input, and this has been most valuable both in terms of rolling out national winter planning guidance, but also in developing strong relationships as we develop our winter plans under the overarching umbrella of the *6 Essential Actions* initiative for unscheduled care in Scotland, namely;

- Essential Action 1 - Clinically Focussed and Empowered Hospital Management
- Essential Action 2 – Hospital Capacity and Patient Flow (Emergency and Elective) Realignment
- Essential Action 3 – Patient Rather Than Bed Management – Operational Performance Management of Patient Flow
- Essential Action 4 – Medical and Surgical Processes Arranged to Improve Patient Flow through the Unscheduled Care Pathway
- Essential Action 5 – Seven Day Services Appropriately Targeted to Reduce Variation in Weekend and Out of Hours Working

- Essential Action 6 – Ensuring Patients are Optimally Cared for in their Own Homes or Homely Setting

So our approach this year has been cautious and deliberate yet far reaching. We will continue to rely on our Winter Planning Board to monitor and oversee our performance over winter. It will certainly prove invaluable as we look to help shape the necessary actions required over the winter months that deliver effective services to our patients in Lothian.

Looking ahead we anticipate that we will once again reflect on our experiences over winter and with the development of strong networks across health, primary and social care settings, we can look to build on our planning processes to date.

Appendix A

SITE PLANS

NHS Lothian University Services Winter Plan 2015/16

Royal Infirmary Edinburgh and Liberton Winter Plan 2015/16

2. Safe & effective admission/discharge continues in the lead-up and over festive period and also in to January			
Outcome: Emergency and elective patients are safely and effectively admitted and discharged over the Christmas – New Year holiday period. Over this period the numbers of patients receiving elective treatment reduces. NHS Boards should minimise the risk of boarding medical patients in surgical wards. This will help ensure that patients do not have unnecessary stays in hospital; and hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January		Indicators: • daily/ cumulative admissions/discharges over the festive period • levels of boarding (medical patients in surgical wards) • delayed discharges • bed occupancy • number of SW assessments including variances from planned levels	
Action	**Owner**	**Status**	**Complete?**
1. All flow activity <u>by site</u> will be monitored on a daily basis via the morning Safety Huddle chaired by the Site Director or nominated representative, and at the 1pm and 4 pm Planning Meetings. **Focused attention will be given from the weekend start 18th, 19th and 20th December to daily discharge quotas** notably for those patients in the health and social care delays categories and for any admissions age 65 years and above, patients who have dedicated case management and any patient from care of residential type homes. Reasons for admission will be closely monitored.	Lyn McDonald, Site Director	Safety Huddles established on each site	Partial
2. **From 15th December onwards, focused attention will be given to:** - **New package of care allocation;** - **Restart packed of care;** - **Weekend starts for both Referrals to Intermediate Care and other community support teams** including 'Hospital to Home' and 'Hospital at Home'. It is important that COMPASS +, REACT, MERIT, ELSIE all operate and pull out hospital discharges on Friday 18th December and 21, 22nd and 23rd December.	Billie Flynn, Clinical Service Manager		

3. **Health delays and rebalance of the Royal Infirmary's activity will be a priority from the 18th December onwards and right through to Monday 4th January**. This will be important as the WGH will be operating a 4 day LUCS services on both weeks of the festive weeks and also the Hogmanay Plan will be lead via the Royal site. Flows which will be priority to note will be Orthopaedic Rehabilitation, Stroke and General Rehabilitation to WGH and all other acute and downstream sites in Lothian.	Chris Stirling, Site Director		
4. **Delayed Discharge activity will be monitored and reported on a daily basis from each site Control Rooms** including additions to the list and removals based on average POC number and wait. The top 10 delays on each site will be a focus. A Health Reablement Model will be considered to support discharge to assess from January led by Lynne Douglas Director of Therapy.	Angela Tuohy, Site and Capacity Manager		
5. **All patients to be monitored on an internal social work standard**: 24 hours to allocation of social work and 3 days to assessment.	Mike Grey		
6. **AMU and ward 204 enhanced weekend Pharmacy service.** 4 hours Clinical Pharmacist and Pharmacy Technician on a Saturday and Sunday to support discharge. Pharmacy Winter Plan aimed at maximising current resource to support timely flow	Fiona McIntyre	Bidding for additional Technicians in Pharmacy to support processing and reduce delays in the provision of prescriptions. These roles will provide a more proactive Pharmacy service over the winter months. Pharmacy Winter Plan Written	

3. Workforce capacity plans & rotas for winter / festive period/ Out of Hours

Outcome: NHS 24; GP OOH; SAS emergency/PTS; and Hospital rotas as well as levels of community capacity (including community nursing/AHP/intermediate care/SW assessment/home care/care home) for the winter/festive period are agreed in October to underpin safe and effective admission and discharge of emergency and elective patients	Indicators: • Workforce capacity plans & rotas for winter (agreed by October) • Workforce Capacity Plans for Festive/ Hogmanay • Effective local escalation of any deviation from plan and actions to address these.

Action	Owner	Status	Complete?
1. **Medical consultant rotas for all specialities to be reviewed to ensure adequate festive period cover**, including the 4 day breaks, weekends and the time in between when senior reviews are critical to expedite discharge.	Clinical Service Managers		

2. **Respiratory Medicine and Medicine to implement additional consultant support for weekend 26th and 27th December and 2nd and 3rd January.**	Kim Dickson		
3. **The month of January should be given special consideration for consultant medical staff notably the weekends**. Respiratory Medicine should consider and deliver (with support from medicine colleagues) double weekend on call for this month.	Clinical Service Managers	Bids submitted to increase General Medicine, Toxicology, Stroke and MOE senior medical provision over winter weekends	
4. **Senior Charge Nurse Cover for the festive weekends and January month should be reviewed to ensure adequate 5/7 rota cover at band 6 and 7 level** and should include night duty or extended days where appropriate.	Clinical Nurse Managers	Plans underway to increase senior cover weekends: 2nd and 3rd 9th and 10th 16th and 17th 23rd and 24th 30th and 31st Medicine plans finalised	
5. **Hogmanay Plan to be delivered** which includes additional support for the Royal Infirmary ED, Radiology, HAN and support services as required. This is a multi agency plan and will have Resilience Committee support at NHS Lothian Board.	Gareth Clinkscale		
6. **Dedicated Management support to be delivered for weekends** from end of December onwards on all sites via the CNM and CSM Group and supported by a dedicated On Call Management Team.	General Managers		
7. **Increased ED staffing during vulnerable periods including** • Additional medical staffing Xmas day – Monday 28th December and Hogmanay – Monday 4th January • 24 hour consultant cover for Hogmanay including 2 on overnight • Enhanced nursing staffing for January	Gareth Clinkscale	Bid submitted for Hogmanay cover, additional medical cover for Christmas to 4th January and increased nursing resource for January to support bed pressures	
3. Whole system activity plans for winter			

Outcome: The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. The hospital models will include flows between front doors, receiving units, and downstream wards.		Indicators: • Daily number of cancelled elective procedures • Daily number of elective and emergency admissions and discharges • Number of respiratory admissions and variation from plan	
Action	**Owner**	**Status**	**Complete?**
1. **The January 'in patient' elective programme to be reviewed weeks 4th and 11th January and only urgent cases and cancer cases** to be progressed as required. The day case programme to continue as usual and indeed increased as appropriate.	Chris Myers		
2. **All flow activity to be managed in an 'anticipatory' way 24/48 hours in advance across all adult sites, downstream sites and the children's hospital**. Those flow markers that indicate a sluggish system should be highlighted via the daily safety and planning meetings including: - inadequate discharges to match admissions - increased boarding activity across the site - medical boarding into the surgical specialities - increase in delayed discharges - norovirus outbreaks	Site Directors		
3. **A health 'reablement' model which can support hospital to home for immediate or early supported discharge should be considered**.	IJBs		
4. **Priority will be given to support effective rehabilitation and discharge for trauma patients, in line with the agreed Trauma Winter plan**	Site Directors, General Managers		
4. Strategies for additional winter beds and surge capacity			
Outcome: The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans are for additional staffed medical beds and additional intermediate bed capacity for winter is agreed in October. The planned dates for introduction of additional staffed medical beds and intermediate beds in the community are agreed and the capacity is operational before the expected surge in admissions.		Indicators: • Planned number of additional staffed medical beds (incl date of introduction) • Planned number of additional intermediate beds in the community • Levels of boarding	
Action	**Owner**	**Status**	**Complete?**
1. Agree **Gyle Muir additional 30 beds from November** onwards and have clear criteria for referral for these beds to turnaround over	Edinburgh IJB		

the winter period. The MOE Lead Consultant/AMD should have input into this criteria			
2. In additional to Gyle Muir and the Hospital at Home Models, **2 surge plans** should be planned and available: - **10-20 virtual ward beds to be in place for Frailty Outreach including a new South Edinburgh Model**. This should be via additional capacity in ELSIE, REACT, MERIT and COMPASS+. - **Enhanced capacity in downstream hospitals where ward capacity has potential to expand**. Example, 4-12 beds in post acute care wards. - 20 acute hospital beds site/area to be considered at either WGH/STJ.	Billie Flynn Site Directors Chris Stirling	Funding bids submitted	
3. **Dedicated boarding teams on all sites** which can focus on expediting tests and investigations to ensure early supported discharge to home or to virtual ward. This team must be consultant led.	AMDs	RIE exploring test of new boarding model for January	
4. Create protected Enhanced Ambulatory Care space that protects PAA function from bedding in this area	Gareth Clinkscale	Options appraisal being drawn up for consideration at Emergency Access	
5. The risk of patients being delay on their pathway is minimised			
Outcome: Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital.		Indicators: • distributions of attendances / admissions • distribution of time to assessment • distribution of time between decision to transfer/discharge and actual time • % of discharges before noon • % of discharges through discharge lounge • % of discharges that are criteria led • levels of boarding medical patients in surgical wards	
Action	**Owner**	**Status**	**Complete?**

1. **Daily flow activity continues to be monitored on all adult and children's sites and reported to Chief Officer via Control Room**. The markers here includes: - admission and discharges - by noon discharges - boarding levels	Site Directors		
2. **Downstream Hospitals have admission and discharge quotas agreed and monitored in the same way as adult acute**. This includes Liberton, Roodlands, Astley Ainslie, and RVB.	Site Directors		
3. **Weekend discharge should also be a focus in the downstream hospital and focus must be on:** - Package of care restarts at the weekend - New package of care restarts at the weekends - Families 'gapping' POC until start on Monday	Site Directors		
4. **Weekend rebalancing of 'health delays' from the Infirmary to all sites is critical given the UCC activity being carried by this site**. This will ensure: - More appropriate use of beds and reduction of overall boarding numbers at the Infirmary site. This will allow the Infirmary to buffer Lothian UCC in the out of hour's periods. - Reduction of medical boarding in surgical wards - The Infirmary's resilience in carrying the bulk of UCC activity for Lothian	Site Directors		
5. **All boarding processes from main arc wards to reflect identification of those patients who have an estimated date of discharge within 24 hr.**	CNMs		
6. Discharges at weekend and bank holiday			
Outcome: Patients are discharged at weekend and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital.		Indicators: • % of discharges that are criteria led on weekend and bank holidays • Daily number of elective and emergency admissions and discharges.	

Action	Owner	Status	Complete?
1. **All adult sites and the children's hospital to have adequate support services in place at the weekend and at the festive period** (notably the second week of festive period) to ensure effective numbers of discharges are delivered this includes: a. **Diagnostic support through radiology** (mainly CT and Ultrasound), laboratories and endoscopy. A 'wait for test' BOXI report to be set up to highlight any waiting patients at any one time waiting on investigation to support discharge decision-making. This should start 20th December onwards. b. **Transport hub to support any additional transport carriers as required**. c. **Pharmacy support not only in pharmacy dept but to consider pharmacy and technician support in ward areas, notably AMU/ARUAT**. This will support junior medical staff. d. **Therapy support at front door areas over the festive period (**notably the public holidays on the second week) and increased support at the weekends to the roaming teams especially January. e. **Consider weekend 'hospital' social work support** to ensure timely assessments for patients admitted on Friday. Any additional support for the PH on the second week to be seriously considered.	Stephen Evans Joan Donnelly Fiona McIntyre Lynne Douglas Mike Stokes	Respective support services have submitted bids for Winter funding	
2. **Every ward on all sites, acute and downstream, to evidence a 'Friday morning board ward round' led by a consultant, SCN and MDT** who can plan and anticipate Saturday, Sunday and Monday discharge decisions and	CSMs		

expedite tests/investigations as required. CSMs and CNMs to be involved in every directorate and this should be reported at the 1pm Weekend Planning Meeting.			
3. **A 'twice weekly delayed discharge board round'** to be undertaken to ensure discharge decisions are being taken which consider potential patients for 'Hospital to Home/Reablement Health model' – POC under 6 hours. This should be led by the General Manager and Clinical Service Manager for Medicine Services.	CSMs		
4. **Open Discharge Lounge at weekend**	Billie Flynn	Funding bid submitted to open Lounge from 08:00am – 18:00	

7. Escalation plans tested with partners

Outcome:
Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.

Indicators:
- attendance profile by day of week / time of day managed against available capacity;
- % occupancy of ED
- utilisation of trolley/cubicle
- % patients waiting for admission over 4,8,12 hours

Action	Owner	Status	Complete?
1. All 4 front door **EDs and receiving areas to evidence robust escalation** processes including: f. Volume attending in the hour (escalation thresholds > than RIE 20 / STJ 10 / WGH 10 / RHSC 10) g. Escalation of first assessment waits at 90 minutes and above h. Escalation of any patient waiting at 3 hours with no management plan i. Escalation of high resuscitation activity and Medic 1 & 2 calls outs	Gareth Clinkscale		

2. **All site flow teams, Senior Charge Nurses, CMT members to have clear understanding of roles in response to escalation**. All sites to evidence a Daily UCC & Flow Debrief 'separate' to safety huddle on the 'day before performance of 4 hours & elective cancellations'. This will raise issues and themes to be addressed in relation to capacity and flow and this should be documented and circulated to core site CMT members and form the basis of any informal report to the Chief Officer for Acute or to Scottish Government.	GMs		

8. Business continuity plans tested with partners

Outcome: The board has business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.	**Indicators:** • Progress against any actions from the testing of business continuity plans.

Action	Owner	Status	Complete?
1. **Severe weather plans to be put in place** and managed via local resilience site meetings.	Suzanne Connell		
2. **Norovirus outbreak plans to be refreshed** and circulated via the same meeting.	Infection Control		

9. Preparing effectively for norovirus

Outcome: The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised. HPS Annual Guidance produces guidance on norovirus.	**Indicators:** • number of wards closed to norovirus • application of HPS norovirus guidance.

Action	Owner	Status	Complete?
1. **Infection Control and Surveillance should be raised at every site Safety Huddle** by the nominated IC Nurse for the day and any concerns on any issues of IC including Norovirus should be raised at this time with appropriate and specific actions agreed.	Lyn McDonald		
2. **Where outbreaks are noted,**	Claire Smith		

specific consideration will be give to these areas and a review by the Associate Nurse Director for the site to ensure local plans and approach are robust and in place. This includes HPS Guidance.			
3. **External communications from the site to other sites in the system will be robust and via the Control Room**. This will ensure any high risk patient transfers across the system are noted and precautions taken for any emergency admissions to any site via this route.	Angela Tuohy		
4. **Bed Bureau and St Johns ANP Service will raise with all referrers specific infection questions**.	Angela Tuohy		
5. **Weekend Infection Control service will be reviewed to ensure on site support during the winter and especially where there are outbreaks to be managed**	Infection Control		
6. **Uniform Policy will be emphasised at every site safety huddle and a critical friend approach will be taken** as usual for all uniformed and non uniformed staff.	Lyn McDonald		
7. **Hand Hygiene will be emphasised at every opportunity**.	All clinical team		

10. Delivering seasonal flu vaccination to staff and public

Outcome: The risk of staff spreading influenza infection to patients is minimised.	**Indicators:** • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

Action	Owner	Status	Complete?
1. **All sites will have a flu programme in place by October** and will be lead by the Associate Nurse Director. This will be	Claire Smith		

supported by a Healthy Working Lives Initiative to ensure staff remain in good health during the winter period.			

11. Communication Plans

Outcome: The public and patients are kept informed of winter pressures, their impact on services, and the actions being taken.	**Indicators:** • daily record of communications activity • early and wide promotion of winter plan

Action	Owner	Status	Complete?
1. **Daily inter site communications** will be enhanced to ensure focused discussion on site activity, pressures and resilience planning for acute and downstream sites.	Angela Tuohy		
2. The **9.30am teleconference is the key communication** point and this will be chaired by the Service Manager for Flow and Capacity and a core member of site CMTs will be in attendance. For downstream sites, General Managers/Chief Nurses should be present to ensure timely and appropriate decision-making on flow issues.	Angela Tuohy		
3. **A Winter Intranet site will be set up from October** onwards and hold key plans and advice for staff. This will be lead via the Royal Infirmary Control Room and updated for all sites as required.	Angela Tuohy		
4. **A dedicated festive period and winter period service booklet should be developed** with communications and each locality to ensure there is widespread understanding of what is available in and out of hours and which can help hospital staff to make more appropriate and supported discharge decisions.	Communications		

12. Other Areas for inclusion

a) Facilities Capacity

Action	Owner	Status	Complete?

1. **Additional domestic staff** will be available on the following weekends to ensure room cleans do not delay patient flow: 2nd and 3rd 9th and 10th 16th and 17th	Cofely		
2. **Additional portering staff** will be available on the following weekends and Mondays to ensure physical patient flow is maintained: 2nd and 3rd 9th and 10th 16th and 17th	James McNee		

WGH Winter Plan 2015/16

1. Safe & effective admission/discharge continues in the lead-up and over festive period and also in to January			
Outcome: Emergency and elective patients are safely and effectively admitted and discharged over the Christmas – New Year holiday period. Over this period the numbers of patients receiving elective treatment reduces. NHS Boards should minimise the risk of boarding medical patients in surgical wards. This will help ensure that patients do not have unnecessary stays in hospital; and hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January		Indicators: • Daily/ cumulative admissions/discharges over the festive period • levels of boarding (medical patients in surgical wards) • delayed discharges • bed occupancy • number of SW assessments including variances from planned levels	
Action	**Owner**	**Status**	**Complete?**
1. All flow activity by site will be monitored on a daily basis via the morning Safety Huddle chaired by the Site Director or nominated representative, and at the 1pm and 4 pm Planning Meetings. **Focused attention will be given from the weekend start 18th, 19th and 20th December to daily discharge quotas** notably for those patients in the health and social care delays categories and for any admissions age 65 years and above, patients who have dedicated case management and any patient from care of residential type homes. Reasons for admission will be closely monitored.	Chris Stirling, Site Director	Safety Huddle format under review with increased focus on identification of actions to support safe flow.	Partial
2. **From 15th December onwards, focused attention will be given to:** - **New package of care allocation;** - **Restart packed of care;** - **Weekend starts for both Referrals to Intermediate Care and other community support teams** including 'Hospital to Home' and 'Hospital at Home'. It is important that COMPASS +, REACT, MERIT, ELSIE all operate and pull out hospital discharges on Friday 18th December and 21, 22nd and 23rd December.	David Hood Marna Green Discharge Hub		

3. **Health delays and rebalance of the Royal Infirmary's activity will be a priority from the 18th December onwards and right through to Monday 4th January**. This will be important as the WGH will be operating a 4 day LUCS services on both weeks of the festive weeks and also the Hogmanay Plan will be lead via the Royal site. Flows which will be priority to note will be Orthopaedic Rehabilitation, Stroke and General Rehabilitation to WGH and all other acute and downstream sites in Lothian.	Chris Stirling, Site Director		
4. **Delayed Discharge activity will be monitored and reported on a daily basis from each site Control Rooms** including additions to the list and removals based on average POC number and wait. The top 10 delays on each site will be a focus. A Health Reablement Model will be considered for supported discharge from January led by Lynne Douglas Director of Therapy.	Angela Tuohy, Site and Capacity Manager	Supported discharge pilot will be for South East Edinburgh patients only so impact on WGH will be minimal.	
5. **All patients to be monitored on an internal social work standard**: 24 hours to allocation of social work and 3 days to assessment.	Marna Green		
6. **Pharmacy technician supporting medicines supply and discharge planning.** This role may also review new admissions and support care of patients on high risk medicines	Sheena Kerr	Addressograph labels with discharges to be provided at safety huddles to ensure that discharge scripts can be prioritised to aid flow	
2. Workforce capacity plans & rotas for winter / festive period/ Out of Hours			
Outcome: NHS 24; GP OOH; SAS emergency/PTS; and Hospital rotas as well as levels of community capacity (including community nursing/AHP/intermediate care/SW assessment/home care/care home) for the winter/festive period are agreed in October to underpin safe and effective admission and discharge of emergency and elective patients		Indicators: • Workforce capacity plans & rotas for winter (agreed by October) • Workforce Capacity Plans for Festive/ Hogmanay • Effective local escalation of any deviation from plan and actions to address these.	
Action	**Owner**	**Status**	**Complete?**
1. **Medical consultant rotas for all specialities to be reviewed to ensure adequate festive period cover**, including the 4 day breaks, weekends and the time in between when senior reviews are critical to expedite discharge.	Clinical Service Managers	Confirmed rota's to be provide at Emergency Access meeting by 9th October	

2. **The month of January should be given special consideration for consultant medical staff notably the weekends**. Respiratory Medicine should consider and deliver (with support from medicine colleagues) double weekend on call for this month.	Fiona Wilson	Weekend plans for Respiratory and Medicine for January to be confirmed by EA access meeting on 9th October	
3. **Senior Charge Nurse Cover for the festive weekends and January month should be reviewed to ensure adequate 5/7 rota cover at band 6 and 7 level** and should include night duty or extended days where appropriate.	Clinical Nurse Managers		
4. **Dedicated Management support to be delivered for all days over festive period** from Monday 21st December through to Monday 4th January with exception of Christmas Day	General Managers	Mon 21st to Thurs 24th Dec - normal working day Sat 26th / Sun 26th Dec – Ass Nurse Director and 1x CNM on site Mon 28th December – 1 CNM plus 1 CSM / GM Tues 29th – Thurs 31st – Normal working day Fri 1st – Mon 4th – 1 CNM plus 1 CSM / GM	

3. Whole system activity plans for winter: post-festive surge/respiratory pathway

Outcome: The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. The hospital models will include flows between front doors, receiving units, and downstream wards.		Indicators: • Daily number of cancelled elective procedures • Daily number of elective and emergency admissions and discharges • Number of respiratory admissions and variation from plan	
Action	**Owner**	**Status**	**Complete?**
1. **The January 'in patient' elective programme to be reviewed weeks 4th and 11th January and only urgent cases and cancer cases** to be progressed as required. The day case programme to be maximised and indeed increased as appropriate. All elective cases moved to day case pathway where possible (e.g. infusions)	Catherine Crombie / Gemma Couser/ Lyndsay Cameron		

2. **All flow activity to be managed in an <u>'anticipatory'</u> way 24/48 hours in advance across all adult sites, downstream sites and the children's hospital**. Those flow markers that indicate a sluggish system should be highlighted via the daily safety and planning meetings including: - inadequate discharges to match admissions - increased boarding activity across the site - medical boarding into the surgical specialities - increase in delayed discharges - norovirus outbreaks	Site Directors		
3. **Community Rehabilitation Team (CRT) and IMPACT Team should be a key link into this team and be available for immediate and early discharge support over January to March**. Hospital at Home Teams should also be considered for East and Midlothian patients	Fiona Wilson		
4. **Additional Ambulatory Care and Day Medicine capacity e.g. for Lumbar Punctures** should be available via the Front Door and testing of use of cubicles for additional procedures in ARU(T) between 0900 and 1600 to avoid admissions.	Fiona Wilson	Proposals to be developed and shared at Emergency Access meeting on 9th October	
5. Discharge Lounge to be extended to include ability to accommodate 2 stretchers and opening hours to be extended Monday-Friday until 8pm.	Richard MacKay	Finalised proposals to be shared at Emergency Access meeting on 25th September	
4. Strategies for additional winter beds and surge capacity			
Outcome: The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans are for additional staffed medical beds and additional intermediate bed capacity for winter is agreed in October. The planned dates for introduction of additional staffed medical beds and intermediate beds in the community are agreed and the capacity is operational before the expected surge in admissions.		Indicators: • Planned number of additional staffed medical beds (incl date of introduction) • Planned number of additional intermediate beds in the community • Levels of boarding	
Action	**Owner**	**Status**	**Complete?**

1. Agree **Gylemuir additional 30 beds from November** onwards and have clear criteria for referral for these beds to turnaround over the winter period. The MOE Lead Consultant/AMD should have input into this criteria	Connor Maguire		
2. In additional to Gylemuir and the Hospital at Home Models, **surge plans** should be planned and available: - 28 additional acute hospital beds to be provided within Ward 15 - Ward 22 to remain open into weekend as needed throughout Winter Period to support overall flows	Fiona Wilson / Catherine Crombie		
3. **Amended Boarding Model for January - Consider** - **SAU** footprint to be re-profiled to include x beds for short stay surgical patients < 12 hrs - **Enhanced cover for Day Bed Suite** at WGH to include extended working to maximise use and protect Elective capacity and free up Inpatient beds - **Cohort boarding patients** into identified area(s) - Appropriate parent specialties to take over management of boarding patients on wards.	Dave Caesar / Caroline Whitworth	Draft option to be considered at Emergency Access meeting on 2nd October.	
5. The risk of patients being delay on their pathway is minimised			
Outcome: Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital.		Indicators: • distributions of attendances / admissions • distribution of time to assessment • distribution of time between decision to transfer/discharge and actual time • % of discharges before noon • % of discharges through discharge lounge • % of discharges that are criteria led • levels of boarding medical patients in surgical wards	

Action	**Owner**	**Status**	**Complete?**
1. **Daily flow activity continues to be monitored on all adult and children's sites and reported to Chief Officer via Control Room**. The markers here includes: - admission and discharges - by noon discharges (with aim of 30 discharges pre noon per day) - boarding levels	Site Directors		
2. **Downstream Hospitals have admission and discharge quotas agreed and monitored in the same way as adult acute**. This includes Liberton, Roodlands, Astley Ainslie, and RVB.	Site Directors		
3. **Weekend discharge should also be a focus in the downstream hospital and focus must be on:** - Package of care restarts at the weekend - New package of care restarts at the weekends - Criteria led discharge - Families 'gapping' POC until start on Monday	Clinical Nurse Managers		
4. **Weekend rebalancing of 'health delays' from the Infirmary to all sites is critical given the UCC activity being carried by this site**. This will ensure: - More appropriate use of beds and reduction of overall boarding numbers at the Infirmary site. This will allow the Infirmary to buffer Lothian UCC in the out of hours periods. - Reduction of medical boarding in surgical wards - The Infirmary's resilience in carrying the bulk of UCC activity for Lothian	Site Directors		

5. **All boarding processes from Wards to reflect identification of those patients who have an estimated date of discharge within 24 hr.**	CNMs		

6. Discharges at weekend and bank holiday

Outcome:	Indicators:
Patients are discharged at weekend and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital.	• % of discharges that are criteria led on weekend and bank holidays • daily number of elective and emergency admissions and discharges.

Action	Owner	Status	Complete?
1. **All adult sites and the children's hospital to have adequate support services in place at the weekend and at the festive period** (notably the second week of festive period) to ensure effective numbers of discharges are delivered this includes:	Mike Conroy		
a. **Diagnostic support through radiology** (mainly CT and Ultrasound), laboratories and endoscopy. A 'wait for test' BOXI report to be set up to highlight any waiting patients at any one time waiting on investigation to support discharge decision-making. This should start 20th December onwards.	Joan Donnelly Fiona Wilson		
b. **Transport hub to support any additional transport carriers as required**.	Alison Hynd / Veronica McLeod / Janet Johnson		
c. Test use of scribes within ARU medical team to support input and increase time FY doctors can spend with patients			
d. **Therapy support at front door areas over the festive period (**notably the public holidays on the second week) and increased support at the weekends to the roaming teams especially January.	Marna Green		
e. **Implementation of 7 day AHP**			

working from October, with no expected impact on Monday – Friday flows especially through MOE/ORS/Stroke pathways f. **Adequate social work support** to ensure timely assessments for patients admitted over festive period and timely discharge. Any additional support for the PH on the second week to be seriously considered.			
2. **Every ward on all sites, acute and downstream, to evidence a 'Friday morning board ward round' led by a consultant, SCN and MDT** who can plan and anticipate Saturday, Sunday and Monday discharge decisions and expedite tests/investigations as required. CSMs and CNMs to be involved in every directorate and this should be reported at the 1pm Weekend Planning Meeting.	CSMs		
3. **A 'twice weekly delayed discharge board round'** to be undertaken to ensure discharge decisions are being taken which consider potential patients for 'Hospital to Home/Reablement Health model' – POC under 6 hours. This should be led by the General Manager and Clinical Service Manager for Medicine Services.	CSMs		

7. Escalation plans tested with partners

Outcome:
Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.

Indicators:
- attendance profile by day of week and time of day managed against available capacity;
- % occupancy of ED
- utilisation of trolley/cubicle
- % patients waiting for admission over 4,8,12 hours

Action	Owner	Status	Complete?
1. ARU and SAU front door **to evidence robust escalation** processes including: a. Volume attending in the hour	Richard MacKay / Anne Donaldson	Agreed escalation processes to be shared by week commencing 28th September	

(escalation thresholds > b. Escalation of first assessment waits at 90 minutes and above c. Escalation of any patient waiting at 3 hours with no management plan d. Escalation of high resuscitation activity, standby patients and acuity			
2. **All site flow teams, Senior Charge Nurses, CMT members to have clear understanding of roles in response to escalation**. All sites to evidence a Daily UCC & Flow Debrief 'separate' to safety huddle on the 'day before performance of 4 hours & elective cancellations'. This will raise issues and themes to be addressed in relation to capacity and flow and this should be documented and circulated to core site CMT members and form the basis of any informal report to the Chief Officer for Acute or to Scottish Government.	General Managers		
8. Business continuity plans tested with partners			
Outcome: The board has business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.		**Indicators:** • progress against any actions from the testing of business continuity plans.	
Action	**Owner**	**Status**	**Complete?**
1. **Severe weather plans to be put in place** and managed via local resilience site meetings and safety huddles	Chris Stirling		
2. **Norovirus outbreak plans to be refreshed** and circulated via the same meeting.	Infection Control / Carol Calder	Plans to be brought to Emergency Access meeting in November.	
9. Preparing effectively for norovirus			

Outcome: The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised. HPS Annual Guidance produces guidance on norovirus.		**Indicators:** • number of wards closed to norovirus • application of HPS norovirus guidance.	
Action	**Owner**	**Status**	**Complete?**
1. **Infection Control and Surveillance should be raised at every site Safety Huddle** by the nominated IC Nurse for the day and any concerns on any issues of IC including Norovirus should be raised at this time with appropriate and specific actions agreed.	Chris Stirling		
2. **Where outbreaks are noted, specific consideration will be give to these areas and a review by the Associate Nurse Director for the site to ensure local plans and approach are robust and in place**. This includes HPS Guidance.	Catriona Rostron		
3. **External communications from the site to other sites in the system will be robust and via the Control Room**. This will ensure any high risk patient transfers across the system are noted and precautions taken for any emergency admissions to any site via this route.	Angela Tuohy		
4. **Weekend Infection Control service will be reviewed to ensure on site support during the winter and especially where there are outbreaks to be managed**	Infection Control		
5. **Uniform Policy will be emphasised at every site safety huddle and a critical friend approach will be taken** as usual for all uniformed and non uniformed staff.	All Clinical teams		
6. **Hand Hygiene will be emphasised at every opportunity**.	All clinical team		

10. Delivering seasonal flu vaccination to staff and public

Outcome: The risk of staff spreading influenza infection to patients is minimised.	**Indicators:** • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

Action	Owner	Status	Complete?
1. **All sites will have a flu programme in place by October** and will be lead by the Associate Nurse Director. This will be supported by a Healthy Working Lives Initiative to ensure staff remain in good health during the winter period. **WGH site to aim exceed 50% staff vaccination rate**	Catriona Rostron		

11. Communication Plans

Outcome: The public and patients are kept informed of winter pressures, their impact on services, and the actions being taken.	**Indicators:** • daily record of communications activity • early and wide promotion of winter plan

Action	Owner	Status	Complete?
1. **Daily inter site communications** will be enhanced to ensure focused discussion on site activity, pressures and resilience planning for acute and downstream sites.	Angela Tuohy		
2. The **9.30am teleconference is the key communication** point and this will be chaired by the Service Manager for Flow and Capacity and a core member of site CMTs will be in attendance. For downstream sites, General Managers/Clinical Service Manager should be present to ensure timely and appropriate decision-making on flow issues.	Angela Tuohy		
3. **A Winter Update to be provided through Newsletters on monthly basis with updates for all staff**	Chris Stirling		

12. Other Areas for inclusion			
a) Facilities Capacity			
Action	**Owner**	**Status**	**Complete?**
1. **Additional domestic staff** will be available on the following weekends to ensure room cleans do not delay patient flow: 2nd and 3rd 9th and 10th 16th and 17th	Myra Keenan		
2. **Additional portering staff** will be available on the following weekend to ensure physical patient flow is maintained: 2nd and 3rd 9th and 10th 16th and 17th	Myra Keenan		

SJH Winter Plan 2015/16

1. Safe & effective admission/discharge continues in the lead-up and over festive period and also in to January	
Outcome: Emergency and elective patients are safely and effectively admitted and discharged over the Christmas – New Year holiday period. Over this period the numbers of patients receiving elective treatment reduces. NHS Boards should minimise the risk of boarding medical patients in surgical wards. This will help ensure that patients do not have unnecessary stays in hospital; and hospitals are in a good position to deal with the surge in patients normally admitted in the first week back in January	Indicators: • Daily/ cumulative admissions/discharges over the festive period • levels of boarding (medical patients in surgical wards) • delayed discharges • bed occupancy • number of SW assessments including variances from planned levels

Action	Owner	Status	Complete?
1. **All flow activity at SJH will be monitored on a daily basis via the morning Safety Huddle** chaired by the Site Director or nominated representative, and at the 1pm and 4 pm Planning Meetings. 2. **Focused attention will be given from the weekend start 18th, 19th and 20th December** to ensure daily discharge quotas are met. This will continue throughout the winter months with much more focus on discharges. 3. **The REACH nurse and Elderly care team will look to manage the frail elderly patients and provide support for the discharge hub** on reducing the number of delayed patients awaiting POC/NH 4. Reasons for admission will be closely monitored to ensure those patients that can remain in NH remain so and admission avoidance is prioritised.	Site Director	Safety Huddles established at SJH Daily debrief	Yes
5. **From 15th December onwards, focused attention will be given to:** - **New package of care allocation;** - **Restart package of care;** - **Weekend starts for both Referrals to Intermediate Care** and other community support teams including 'Hospital to Home' and 'Hospital at Home'. It is important that, REACT operate and pull out hospital discharges on Friday 18th December and 21, 22nd and 23rd December. - React looking to increase AHP service over Winter period to work a 7 day week. - Increased ROTAS service - Increased Case	Social Work Team REACT Discharge Hub CHCP CHCP/ Site Director	Newly procured POC tender on existing POC's New POC's – this remains to be seen how this will take off so some concern here but will be monitored closely. All being prepared by the CHCP SJH site to link into the CHCP winter plan – cross reference with Acute winter plan in joint working.	Partial Await funding confirmation.

Management to keep patients at home			
6. **Delays and rebalance of activity will be a priority from the 18th December onwards and right through to Monday 4th January.** 7. **Plan for additional winter beds on the SJH site** to support increased medical demand as a last resort 8. **Nursing staff will be placed within the SJH back door wards to enable a flex up approach** to deal with demand 9. **Elective activity for H&N surgical services to agree scheduled programme and agree flexible beds for medical patients**, being mindful of keeping boarding to a minimum. 10. **Use of DOSA as the norm**, prioritising urgent and cancer cases only. 11. **Work with Infection control colleagues to review 'clean' beds in the H&N wards** to allow flexible use of beds to support flow.	Social Work Team Discharge Hub Site Director Associate Nurse Director (AND) General Manager	Discharge Hub and SW teams to work closely to ensure delays are being proactively managed on the site. Link into Edinburgh plan for Edinburgh delays on the SJH site. Test Porter to pull patients to d/c lounge and measure impact on patient numbers/complexity. use porter also to support timely transfer from ED/MAU. Trial week of 28.9. Use winter bed nurse resource to test- nurse in x-ray department to stop MAU escorting and out of ward. Measure impact on nurse time within MAU. Need to recruit to this post ASAP to allow impact here. Test porter booked for 2 weeks following ED trial, again booked to cover period of peak activity. Audit will run alongside to test effectiveness of change. Winter beds for the SJH last resort- costs submitted to finance. Use winter bed nurse resource to work ED/Mau differently to create capacity and increase flow and allow flexible bed model.	Partial

12. **Delayed Discharge activity will be monitored and reported on a daily basis from SJH site Control Room** (with other acute sites) including additions to the list and removals based on average POC number and wait. The top 10 delays on each site will be a focus. • Discharge Hub will continue to micro-manage delays with help from community colleagues • Equipment store within CHP to prioritise for discharges and palliative care needs. – P Donald	AND Site and Capacity Manager Delayed Discharge team lead.	Strict monitoring by Discharge Hub AHP to closely monitor efficiency of community store and escalate delays affecting discharging.	complete
13. **All patients to be monitored on an internal social work standard**: 24 hours to allocation of social work and 3 days to assessment.	Delayed Discharge team lead.	Focus already on this.	Complete
14. **Pharmacy –** plan for extended working day 7/7. Still to be agreed. • Early discharge planning and IDL preparation is paramount. • Extend working day 7 days per week • Extend to 7pm Mon-Fri • Extend to 4pm Sat/Sun to support patient discharge and flow. • Audit efficiency of this extending working as part of lessons learned for next year winter planning. • Dedicated porter for pharmacy to enhance patient flow and discharges. Part of winter funding.	John Heggie	Costs submitted via winter funding plan. Audit of efficiency to be carried out for next year's planning.	Funding to be confirmed.

2. Workforce capacity plans & rotas for winter / festive period/ Out of Hours

Outcome: NHS 24; GP OOH; SAS emergency/PTS; and Hospital rotas as well as levels of community capacity (including community nursing/AHP/intermediate care/SW assessment/home care/care home) for the winter/festive period are agreed in October to underpin safe and effective admission and discharge of emergency and elective patients	Indicators: • Workforce capacity plans & rotas for winter (agreed by October) • Workforce Capacity Plans for Festive/ Hogmanay • Effective local escalation of any deviation from plan and actions to address these.

Action	Owner	Status	Complete?
1. **Medical consultant rotas for all specialities to be reviewed to ensure adequate festive period cover**, including the 4 day breaks, weekends and the time in between when senior reviews are critical to expedite discharge.	Clinical Service Managers	Rotas being collated. Double up on weekend working from Nov 15 ongoing to enhance patient safety and ensure discharges over the weekend. Increased n	Partial
2. **Respiratory Medicine – link into Lothian wide Respiratory cover plan.**	Lyn McDonald CNM/Resp team	RIE/WGH being asked for support for Respiratory service due	Await LMcD confirming support

3. **Use of Respiratory Nurse specialists to enhance support**		to current respiratory Consultant vacancies on the SJH site (2 vacancies). Request to support x 2 OP clinics and 1 EBUS list per week from beginning of December has been made.	
4. **Senior Charge Nurse Cover for the festive weekends and January month** should be reviewed to ensure adequate 7/7 rota cover at band 6 and 7 level and should include night duty or extended days where appropriate.	Clinical Nurse Managers	Festive rotas being finalised with Band 6 or 7 cover over weekends. Mon- Fri CNM cover in situ with senior management.	Complete
5. **Hogmanay Plan to be delivered** which includes additional junior medical and nursing staff rostered within the ED from 31st Jan – 4th Jan inc. • Need to see LUCS winter plan – Sian Tucker • Enhanced nursing staffing for January – March if supported via winter (x 3 additional Band 5's)	CSM/CNM/CD	Increased ED nursing and medical staff on duty each shift from 31st Dec through until 4th Jan inc. 31st Dec – x 1 extra Late shift, x 1 extra ND (medical) extra nurse on DD and ND. 1st-4th Jan inc – x 1 extra Day shift, x 1 extra Back shift (medical), x 1 extra Staff Nurse DD and ND>	Funding to be confirmed.

3. Whole system activity plans for winter: post-festive surge/respiratory pathway

Outcome:	Indicators:
The clinically focussed and empowered hospital management have a target operating model that sets out the expected range of daily emergency and elective admissions and discharges over the festive and winter period. The expected range takes account of the potential surge in emergency admissions in the first week of January and includes the potential surge in respiratory and circulatory admissions over the winter. The hospital models will include flows between front doors, receiving units, and downstream wards.	• Daily number of cancelled elective procedures • Daily number of elective and emergency admissions and discharges • Number of respiratory admissions and variation from plan

Action	Owner	Status	Complete?
1. **The January 'in patient' elective programme to be reviewed weeks 4th and 11th January and only urgent cases and cancer cases** to be progressed as required for the H&N specialities. The day case programme to continue as usual and indeed increased as appropriate.	CSM H&N General Manager	Plan under review. Day case to be the norm. Work with infection control re: clean beds for surgical flow with other beds for flexible use.	Partial

2. **All flow activity to be managed in an <u>'anticipatory'</u> way 24/48 hours in advance across all adult sites, downstream sites and the children's hospital**. Those flow markers that indicate a sluggish system should be highlighted via the daily safety and planning meetings including: - inadequate discharges to match admissions - increased boarding activity across the site - medical boarding into the surgical specialities - increase in delayed discharges - norovirus outbreaks	Site Director	Reviewed daily at Safety Huddle and frequently throughout the day thereafter as necessary. Daily debrief to review previous day's performance with action planning. Infection control integral at these meetings	
4. Strategies for additional winter beds and surge capacity			
Outcome: The risk of an increase in the levels of boarding medical patients in surgical wards in the first week of January is minimised. The staffing plans are for additional staffed medical beds and additional intermediate bed capacity for winter is agreed in October. The planned dates for introduction of additional staffed medical beds and intermediate beds in the community are agreed and the capacity is operational before the expected surge in admissions.		Indicators: • Planned number of additional staffed medical beds (incl date of introduction) • Planned number of additional intermediate beds in the community • Levels of boarding	
Action	**Owner**	**Status**	**Complete?**
1. **No plan to open winter ward or beds** 2. **Nurses will be recruited to allow a flex up** / flex down system for creating additional capacity at short notice. 3. **Ability to flex further on the site is an option** – Ward 14 x 6 beds, Ward 22 x 12 beds, Ward 15 up to 18 beds.	Site Director	Costs submitted for nursing manpower Nurses will be recruited to MAU/ED then pulled if flexible capacity is required. Ongoing review of further capacity will be discussed as and when as part of wider Lothian capacity overview.	Progressing.
2. **Link into CHCP community plan for winter**. • Increase REACT AHP service to 7 days (not cover Christmas nor New Year's Day) • Increase ROTAS team • Increase Case Management	Carol Bebbington	SJH to link into CHCP winter plan Membership from CHCP part of SJH winter planning team	Partial await funding outcome
5. The risk of patients being delay on their pathway is minimised			
Outcome: Patients receive timely assessments in A&E, Acute Assessment Units, Acute Receiving Units and downstream specialty wards. Delays between decision to transfer/discharge and actual transfer/discharge are minimised. The capacity in these units reflect the arrival patterns and potential waiting times for assessment and/or transfer/discharge. Patients in downstream wards are discharged earlier in the day to avoid unnecessary stays in hospital and to improve flow through the hospital.		Indicators: • distributions of attendances / admissions • distribution of time to assessment • distribution of time between decision to transfer/discharge and actual time • % of discharges before noon • % of discharges through discharge	

		lounge • % of discharges that are criteria led • levels of boarding medical patients in surgical wards	
Action	**Owner**	**Status**	**Complete?**
1. **Daily flow activity continues to be monitored on SJH site and reported to Chief Officer via Control Room**. The markers here includes: - admission and discharges - by noon discharges - boarding levels	Site Director	Focus remains here Daily debrief of performance indicators and actions taken to improve	Ongoing
2. **Downstream Hospitals have admission and discharge quotas agreed and monitored in the same way as adult acute**. - St Michael's and Tippethill. 3. Also SJH site need to be able to access Edinburgh downstream facilities due to number of Edinburgh delays.	Site Director/Delayed Discharge lead.	Increased focus will be on this in particular the Edinburgh delayed position on the SJH site. Impact of bed bureau will be a potential risk to the delayed position on the SJH Site.	Ongoing
4. **Weekend discharge should also be a focus in the downstream hospital and focus must be on:** - Package of care restarts at the weekend - New package of care restarts at the weekends - Families 'gapping' POC until start on Monday	Discharge Lead Social Work	Look to test weekend discharge hub working. As part of winter nursing recruitment look to see if potential to second another member of nursing staff with an interest in discharge planning to further support discharge in particular over the weekend.	Progressing
5. **All boarding processes from wards to reflect identification of those patients who have an estimated date of discharge within 24 hr** 6. **Nurse Practitioners key to management of boarding patients**	CNMs/Medical Staff	Nurse practitioners in wards 9, 21 and 25 are identifying borders early in the day. Criteria Led Discharge piloting in Ward 21 and 8. Once audited to be rolled out across all of medicine wards. Ensure boarding documentation is completed for all patients to ensure junior doctors in boarding wards are informed and be able to discharge safely.	Progressing
6. Discharges at weekend and bank holiday			
Outcome: Patients are discharged at weekend and bank holidays to avoid unnecessary stays in hospital and to improve flow through the hospital.		Indicators: • % of discharges that are criteria led on weekend and bank holidays • daily number of elective and emergency admissions and discharges.	

Action	Owner	Status	Complete?
1. **All adult sites to have adequate support services in place** at the weekend and at the festive period (notably the second week of festive period) to ensure effective numbers of discharges are delivered this includes: a. **Diagnostic support** through radiology (mainly CT and Ultrasound), laboratories and endoscopy. A 'wait for test' BOXI report to be set up to highlight any waiting patients at any one time waiting on investigation to support discharge decision-making. This should start 20th December onwards. b. **Transport hub** to support any additional transport carriers as required. c. **Therapy support** at front door areas over the festive period (notably the public holidays on the second week) and increased support at the weekends to the roaming teams especially January. d. **Consider weekend 'hospital' social work support** to ensure timely assessments for patients admitted on Friday. Any additional support for the PH on the second week to be seriously considered.	Site Director Aris Tyrothoulakis Joan Donnelly AHP team leads Social work lead.	Domestic and portering staff requested as per winter funding plan. Meeting with X-ray team at SJH to review some of the challenges that have flagged up lately. Link into transport winter plan ROTAS team – service asking to increase resource as part of winter funding plan. From 1st Oct 2015 full OT service working 7 days per week. PT 7/7 service progressing to this model also – still to agree start date. For discussion with Charles Swan.	Progressing
4. **A weekly delayed discharge round'** is undertaken to ensure discharge decisions are being taken which consider potential patients for 'Hospital to Home/Reablement Health model' – POC under 6 hours.	AND/Delayed Discharge Lead. Social Work	Currently once per week – may need to increase frequency over winter period if delays become an issue.	
7. Escalation plans tested with partners			
Outcome: Access block is avoided at each ED where there is a target operating model managed effectively by an empowered site management team with clear parameters on whole system escalation processes.		**Indicators:** • attendance profile by day of week and time of day managed against available capacity; • % occupancy of ED • utilisation of trolley/cubicle • % patients waiting for admission over 4,8,12 hours	

Action	**Owner**	**Status**	**Complete?**
1. SJH Front door **ED and MAU to evidence robust escalation** processes including: e. Volume attending in the hour (escalation thresholds > than RIE 20 / STJ 10 / WGH 10 / RHSC 10) f. Escalation of first assessment waits at 90 minutes and above g. Escalation of any patient waiting at 3 hours with no management plan h. Escalation of high resuscitation activity	CNM/CSM	In situ and working well in the ED since August 2015. **See appendix 1.** Plan for further escalation criteria to be added to support ED overcrowding (BLACK escalation). MAU escalation to be progressed.	Complete Ongoing
2. **SJH site flow teams, Senior Charge Nurses, CMT members to have clear understanding of roles in response to escalation**. All sites to evidence a Daily UCC & Flow Debrief 'separate' to safety huddle on the 'day before performance of 4 hours & elective cancellations'. This will raise issues and themes to be addressed in relation to capacity and flow and this should be documented and circulated to core site CMT members and form the basis of any informal report to the Chief Officer for Acute or to Scottish Government.	GM/AND	Daily site safety huddle Daily site debrief Action planning.	Complete and ongoing.
8. Business continuity plans tested with partners			
Outcome: The board has business continuity management arrangements in place to manage and mitigate all key disruptive risks including the impact of severe weather.		**Indicators:** • progress against any actions from the testing of business continuity plans.	
Action	**Owner**	**Status**	**Complete?**
1. **Severe weather plans to be put in place** and managed via local resilience site meetings.	Site Management team	In situ	
2. . **Norovirus outbreak plans to be refreshed** and circulated via the same meeting.	Infection Control/Site & Capacity/AND	Infection control a main focus at morning site safety huddle and at repeated times	Complete and ongoing

		throughout the day/week when outbreaks are reported.	
9. Preparing effectively for norovirus			
Outcome: The risk of norovirus outbreaks becoming widespread throughout a hospital is minimised. HPS Annual Guidance produces guidance on norovirus.		**Indicators:** • number of wards closed to norovirus • application of HPS norovirus guidance.	
Action	**Owner**	**Status**	**Complete?**
1. **Infection Control and Surveillance should be raised at every site Safety Huddle** by the nominated IC Nurse for the day and any concerns on any issues of IC including Norovirus should be raised at this time with appropriate and specific actions agreed.	Infection Control team	Already in situ.	ongoing
2. **Where outbreaks are noted, specific consideration will be give to these areas and a review by the Associate Nurse Director** for the site to ensure local plans and approach are robust and in place. This includes HPS Guidance.	Infection Control team	Already in situ.	ongoing
3. **External communications from the site to other sites in the system will be robust and via the Control Room**. This will ensure any high risk patient transfers across the system are noted and precautions taken for any emergency admissions to any site via this route.	Angela Tuohy	Site and Capacity teams already robust process here working very closely with Infection Control.	ongoing
4. **Bed Bureau and St John's ANP Service will raise with all referrers specific infection questions**.	Angela Tuohy		
5. **Weekend Infection Control service will be reviewed to ensure on site support** during the winter and especially where there are outbreaks to be managed	Infection Control	Need to see Infection control working rotas for festive period.	ongoing
6. **Uniform Policy will be emphasised at every site safety huddle** and a critical friend approach will be taken as usual for all uniformed and non uniformed staff.	GM/AND/CNM's	Ongoing vigilance	ongoing

7. **Hand Hygiene will be emphasised at every opportunity**.	All clinical teams		

10. Delivering seasonal flu vaccination to staff and public

Outcome: The risk of staff spreading influenza infection to patients is minimised.	**Indicators:** • % uptake of staff vaccine by site / speciality and variance from planned levels in line with CMO advice.

Action	Owner	Status	Complete?
1. **All sites will have a flu programme in place by October** and will be lead by the Associate Nurse Director. This will be supported by a Healthy Working Lives Initiative to ensure staff remains in good health during the winter period.	Agnes Ritchie	Plan progressing.	

11. Communication Plans

Outcome: The public and patients are kept informed of winter pressures, their impact on services, and the actions being taken.	**Indicators:** • daily record of communications activity • early and wide promotion of winter plan

Action	Owner	Status	Complete?
1. **Daily inter site communications will be enhanced to ensure focused discussion on site activity, pressures and resilience planning** for acute and downstream sites.	Angela Tuohy	SJH part of wider Lothian team.	ongoing
2. **The 9.30am teleconference is the key communication point and this will be chaired by the Service Manager for Flow and Capacity and a core member of site CMTs** will be in attendance. For downstream sites, General Managers/AND's should be present to ensure timely and appropriate decision-making on flow issues.	Angela Tuohy	SJH part of this communication	ongoing
3. **A Winter Intranet site will be set up from October onwards and hold key plans and advice for staff**. This will be lead via the Royal Infirmary Control Room and updated for all sites as required.	Lyn McDonald	SJH to review and add to this once up and running.	

5. **A dedicated festive period and winter period service booklet should be developed** with communications and each locality to ensure there is widespread understanding of what is available in and out of hours and which can help hospital staff to make more appropriate and supported discharge decisions. 6. **Review current patient/relative discharge documentation to ensure discharge planning is proactive from the onset of admission**	With central comms team CNM's/CSW	SJH to link into this. Progressing with this.	Partial
12. Other Areas for inclusion			
a) Facilities Capacity			
Action	**Owner**	**Status**	**Complete?**
1. **Additional domestic staff as per site winter plan will provide additional cover for rapid room cleans to support patient flow and prevent infection**.	Facilities	Await outcome of winter funding plan for SJH but this must be a priority for the site.	Await funding outcome
2. **Additional portering staff as per site winter plan to provide additional portering cover for MAU to protect flow**. 3. **Plan to pilot protected porter for ED** to support patient flow from the ED with a view to longer term porter for ED ongoing. 4. **Dedicated pharmacy porter** requested as per winter plan to speed up discharge planning and also protect flow.	Facilities	Test Porter to pull patients to d/c lounge and measure impact on patient numbers/complexity. use porter also to support timely transfer from ED/MAU. Trial week of 28.9. Use winter bed nurse resource to test- nurse in x-ray department to stop MAU escorting and out of ward. Measure impact on nurse time within MAU. Need to recruit to this post ASAP to allow impact here. Test porter booked for 2 weeks following ED trial, again booked to cover period of peak activity. Audit will run alongside to test effectiveness of	Partial Await funding outcome.

		change.	

RHSC Winter Plan 2015/16

Action	Owner	Status	Complete?
1. **Recruitment and Induction** • First wave of winter recruitment completed. Of the 17wte posts 16 offers have been made. 1.0 wte vacancy remains. Second advert has been posted. These are provisional offers at present and are awaiting confirmation of acceptance. Majority of posts are new graduates. • Planned start date for the beginning of November for the 10 permanent posts – registrations pending. If not registered by this point they will commence as B2's to allow for induction and familiarization of clinical area. • Approval for pharmacy winter staffing – awaiting outcome.	P Campbell	Advert out for remaining winter post and small number of vacancies within medical. Date for interviews to be set for mid October 2015. Awaiting approval for pharmacy winter bid approval.	
2. **Ability to open additional winter beds as per plan** (14 beds & 6 cubicles). • Date will depend on the start date for winter posts. Anticipated date for the beginning of November.	P Campbell	Plan in place to allow the increase from beginning of November 2015.	
3. **Senior Charge Nurse cover and off duties for the festive period** prepared in draft for agreement and sign off.	Lynda Cowie & CNM's	Prepared for sign off by the end of October 2015.	
4. **Increased Children's ED activity** • Increased staffing as per winter plan • Near patient RSV kits ordered • Enhanced cover during festive period	P Campbell	Kits to be ordered October 2015.	

Respiratory Winter Plan 2015/16

Action	Owner	Status	Complete?
1. **Continue Integrated COPD pathway consultant to support admission avoidance and primary care support**	Kim Dickson	Oct - March	
2. **Develop home IV antibiotic delivery in Edinburgh to Bronchiectasis patients**	Kim Dickson	Dec - March	
3. **Dedicated respiratory team on each site who can manage 5/7 day's activity and outreach as a boarding support to all areas across the adult sites**. This team can act as an interface with Primary Care and Hospital at Home teams.	CSMs/CDs	Bid submitted	
4. **Additional support for respiratory on call on the last weekend of December and the 4 weekends in January**.	CSMs/CDs	Bid submitted	
5. **The Respiratory Nurse Specialist Service at the Royal Infirmary and St John's should operate on a 7 day service in ED/AMU**.	CSMs	Bid submitted	
6. **The RIE Respiratory outreach team should be agreed by the adult site** and should include a senior doctor, a Respiratory Nurse Specialist, a junior doctor, a physiotherapist, and pharmacist	Kim Dickson		
7. **Community Rehabilitation Team (CRT) and IMPACT Team should be a key link into this team and be available for immediate and early discharge support over these weekends in January**. Hospital at Home Teams should also be considered.	EIJB		
8. **RIE Respiratory Hot Clinics** should be available via the PAA Front Door model and all sites to ensure there is capacity on all clinics for urgent	Kim Dickson		

respiratory care.			
9. **REACT team together with REACH nurse and MOE team be a key link to support immediate and early discharge support over these weekends in January**	REACT team lead Discharge team Lead REACH nurse	REACH nurse now commenced. Increase in REACT AHP service to cover weekends – part of winter funding.	Partial – await funding outcome
10. **Enhanced AHP service for Respiratory Boarders**	Lynne Douglas	Funding bid submitted	

Radiology Winter Plan 2015/16

Action	Owner	Status	Complete?
1. **Escort Nurse for RIE and WGH Radiology journeys & Additional Radiographers** 1 for Accident and Emergency and 1 for extending CT. An additional Radiologist to address the additional reporting required as a result of increase in activity	Aris Tyrothoulakis	Oct - March	
2. **Increased radiographer capacity to manage winter demand supporting ED and reducing delays for CT on each site**	Aris Tyrothoulakis	Oct - March	
3. **Increased radiologist capacity** to ensure timely reporting	Aris Tyrothoulakis	Oct - March	
4. **Additional portering** support to improve patient flow	Aris Tyrothoulakis	Oct- March	
5. **24/7 radiographic support to SJH ED** and reduce waits for both emergency and outpatient activity.	Aris Tyrothoulakis	Oct – March	

Transport Winter Plan 2015/16

Action	Owner	Status	Complete?
1. **Increase Transport Capacity** including: • Bus • Out of area • Car	Joan Donnelly	Funding bid submitted	
2. Increase Transport hub processing ability	Joan Donnelly	Funding bid for band 2 submitted	

Winter Planning Project Board – Membership 2015-16

Area/ Title	Name	Area/ Title	Name
Chief Officer, UHD	Jim Crombie	Transport	Joan Donnelly (Sheena Walter)
Site and Capacity Lead	Angela Tuohy	Facilities (Hard and Soft FM)	Robert Aitken (Michelle Finnie)
Asst. General Manager	Sheena Muir	Analytical Services	Nicola Rigglesford
LUCS	Sian Tucker (Jamie Hetherington)	Associate Medical Director/GP	James McCallum
Lead Clinician - ED	Dave Caesar (Sara Robinson)	Partnership Rep	Alex Joyce
Lead Clinician - MoE	Andrew Coull	CHCP Health Rep (Midlothian)	Allister Short
AHP Director	Lynne Douglas	CHCP Health Rep (CEC)	Monica Boyle Mike Stokes
Finance Rep	Jill Dempsey	CHCP Health Rep (West Lothian)	Marion Christie (Carol Bebbington)
Associate Nurse Director	Sarah Ballard-Smith	CHCP Health Rep (East Lothian)	Alison MacDonald
Scottish Ambulance Service	Ian Archibald	USC Manager/ Winter Lead	Neil Wilson
Infection Control	Lindsay Guthrie	Children's Services	Peter Campbell
Scottish Government	Helen Maitland	Nurse Bank	Fiona Ireland (Lisa Claire)
Site Director (St Johns)	Jacqui Campbell	Pan Lothian Services Director	Aris Tyrothoulakis
Site Director (WGH)	Chris Stirling	Site Director (RIE)	Lyn McDonald

Also request representation as required from areas such as:

- Public Health
- HR
- Communications Dept
- Pharmacy
- REAS

- Other

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NHS LOTHIAN

2.3

Board Meeting
7 October 2015

Executive Nurse Director

SUMMARY PAPER - PERSON-CENTRED CULTURE

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

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

• The Board is asked to note the ongoing progress with the complaints review.	2.1& 3.1.5
• Three operational units continue to test a devolved approach during July - Oct; ➢ Royal Edinburgh and Associated Services - 1 July ➢ Western General Hospital – 6 July ➢ Edinburgh Community Health Partnership – 13 July	3.1.6
• The 2 prisons (HMP Addiewell and HMP Edinburgh) will test the devolved complaints and feedback approach within the prison healthcare setting, linking this work to a number of recent Scottish Public Services Ombudsman recommendations.	3.1.8
• Review the most recent complaints and feedback activity and performance.	3.2 & Charts 1 - 6
• To note the positive feedback from the Scottish Health Council – Participation Standard.	3.2.9
• Discuss the Tell us Ten Things patient experience survey results (TTT) and Patient Opinion Report.	3.3.3
• Note the number of Patient Opinion posts up to the month of June.	3.3.8
• Note the conclusion of the national Person Centred Health & Care Collaborative	3.4
• To note that Sickness within the team remains a challenge is excessive of 40%. In addition to this there are a significant number of vacancies and both of these issues are impacting on performance but also staff morale within the team.	4.3
• To acknowledge that approximately 5000 phone calls were received 2014/5 that had not previously had a recognised resource associated. It is possible that as we review existing workload across all aspects of the patient experience activities this is likely to identify a resource shortfall that will need to be considered	8.1.2

Jeannette Morrison
Head of Patient Experience
24 September 2015
Jeannette.morrison@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 2015

Nurse Director

PERSON-CENTRED CULTURE

1 Purpose of the Report

1.1 The purpose of this report is to provide an update to the NHS Lothian Board on the person centred culture agenda that was discussed at the private session of the NHS Lothian Board June meeting and the September meeting of the Healthcare Governance Committee.

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

2 Recommendations

The Board is recommended to:

2.1 Note on the ongoing progress with the complaints review

2.2 Review the most recent complaints and feedback activity and performance, including the feedback from the Scottish Health Council – Participation Standard

2.3 Discuss the Tell us Ten Things patient experience survey results (TTT) and Patient Opinion Report

2.4 Note the conclusion of the national Person Centred Health & Care Collaborative

3 Discussion of Key Issues

3.1 Complaints Review

3.1.1 The implementation of the complaints review remains a work in progress. The Chairman is taking a close involvement to provide Non Executive Director support and scrutiny. There was strong support from the Board following the presentation given by the Executive Nurse Director at the June Board meeting.

3.1.2 The structure for the Patient Experience Team will be devolved (Appendix 1) to the operational teams. In addition, there will be a central team that will provide a triage and “specialist” function for those complaints that are complex or cross multiple management teams. This central team will also provide a co-ordinating function for all Scottish Public Services Ombudsman cases.

3.1.3 The outcome of the job evaluation process for new Patient Experience Team job descriptions has now been completed. The Head of Patient Experience is working with colleagues from Partnership and Human Resources to support the staff involved through the next stages of organisational change.

3.1.4 Work continues to be done to quantify the workload and resource to support the Patient Experience Team moving forward. A retrospective review of all feedback (Complaints, concerns, comments and compliments) that has been made to the existing Customer Relations & Feedback Team (CRaFT) and this also includes the number of telephone calls that are received on a weekly and monthly basis.

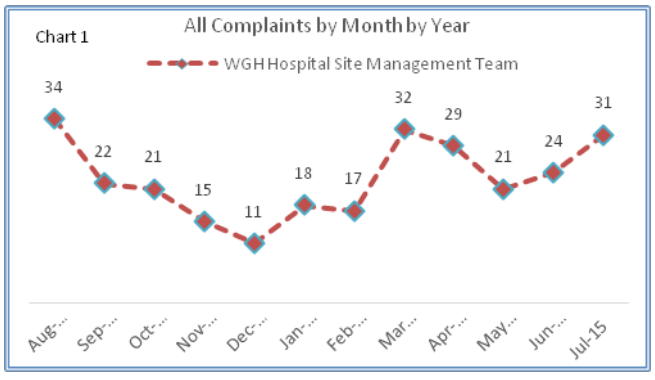
3.1.5 We remain in a transition period to the move to the Patient Experience Team and have implemented a number of changes within the team which include the following:

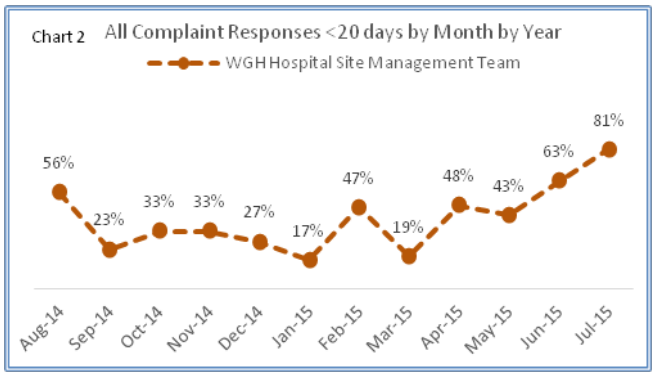
- Name change to Patient Experience Team
- Implemented a daily huddle to aid communication across the team
- Revised all the documentation / templates within DATIX
- Implemented a new email address – feedback@nhslothian.scot.nhs.uk
- Review our complaints and feedback data on a daily basis
- Process mapping the different elements of the complaints pathway
- Developed a complaints "dashboard" within DATIX
- Progressing with the recruitment to these posts
- Looking at new ways to support and train the staff in their new roles

3.1.6 Three operational units continue to test this devolved approach during July - Oct;

- Royal Edinburgh and Associated Services - 1 July
- Western General Hospital – 6 July
- Edinburgh Community Health Partnership – 13 July

Following the trial period we have reviewed the data and during the first month of the trial (July) there were 47 contacts received for the WGH, of which 31 were complaints. It can be seem that locally they were able to respond to 81% of the complaints within 20 working days.





3.1.7 Learning from these 3 areas will be key and the Head of Patient Experience is working with the Associate Nurse Directors for other services / sites as part of the wider implementation and a series of meetings have been arranged to discuss this with the operational teams.

3.1.8 There is a specific programme of work that will commence in September within the 2 prisons (HMP Addiewell and HMP Edinburgh) during the next few months. This will be to test the devolved complaints and feedback approach within the prison healthcare setting. In addition to this the Scottish Public Services Ombudsman has made a number of recommendations and this work is intended to meet these.

3.1.9 Work will commence to establish the Patient Experience Sub-committee. The Executive Nurse Director and Head of Patient Experience will work with Non-executive Directors to develop this committee's terms of reference and associated work plan. The focus of this work will be to scrutinise and provide assurance of our new complaints and feedback processes.

3.2 Complaints and Feedback Performance and Activity

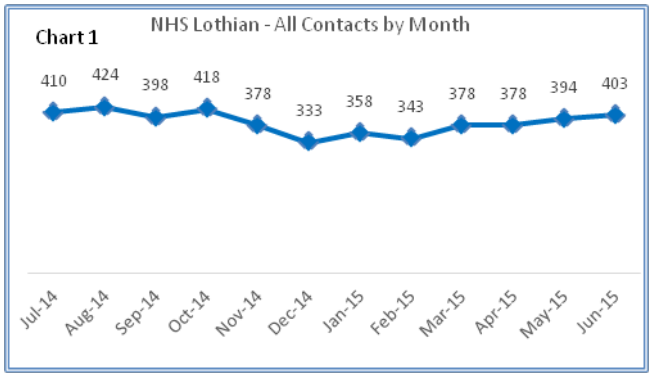
3.2.1 Chart 1 reflects all contacts received into the Patient Experience Team. In June there were 403 contacts (compliments, comments, concerns and complaints), which is an increase of 7 on the previous month. Complaints remain the largest category of feedback (n=210) and this is a fall of 25 from May.

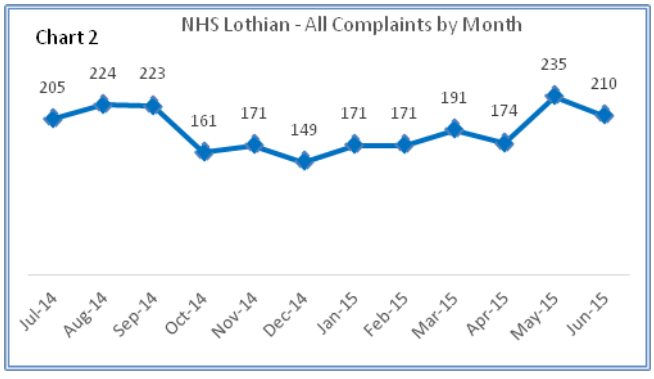
3.2.2 Chart 3 reflects the number of contacts that were acknowledged within 3 working days from receipt and performance is at 97%, which is a rise from May (88%).

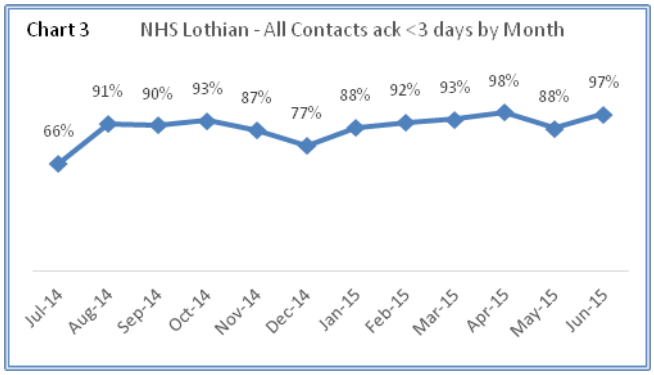
3.2.3 Chart 4 reflects the number of complaints that were acknowledged within 3 working days from receipt and performance is at 95%, which is a rise from May (86%)

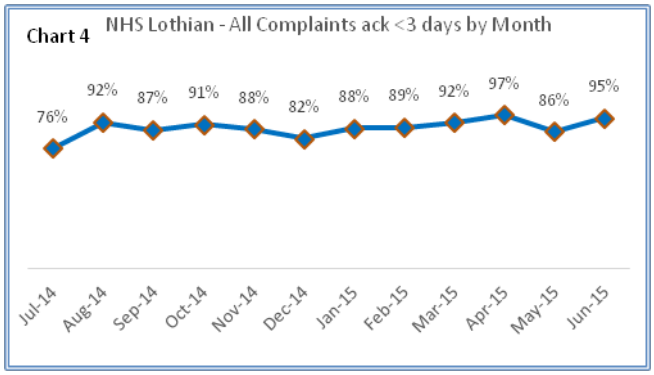
3.2.4 Chart 5 reflects all contacts responded to within 20 working days and the performance in June was 91%, which is improved on May (81%).

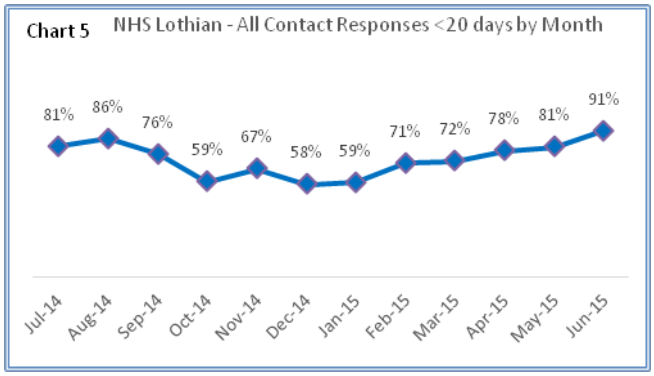
3.2.5 Chart 6 reflects the number of complaints responded to within 20 working days and the performance in June was 95%, which is improved on May (75%).

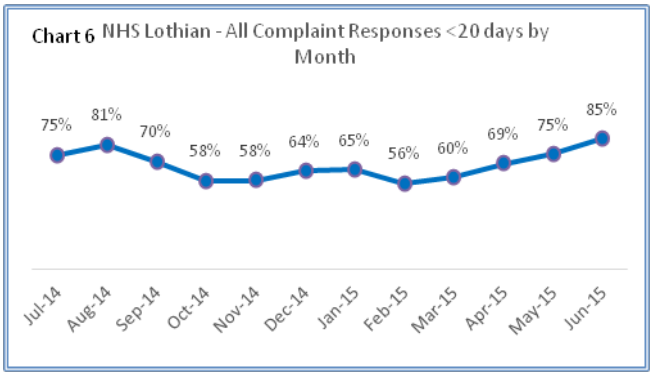






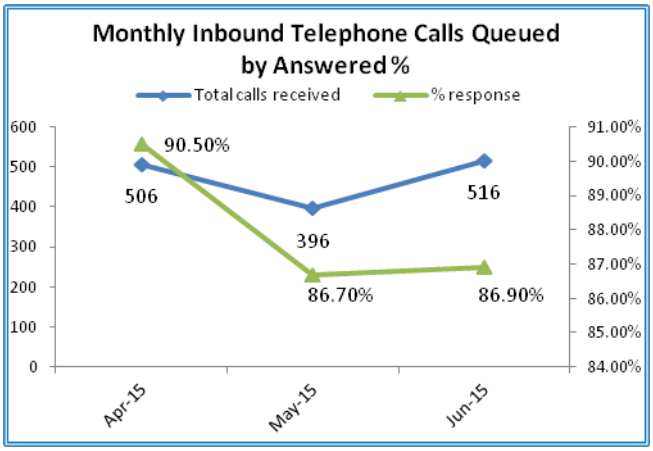






3.2.6 The number of telephone calls are now being reviewed on a monthly basis and Chart 7 shows the number of incoming calls received. During June, the team received 516 telephone calls and were able to respond to 86% of incoming calls.

Chart 7



3.2.7 NHS Lothian is required to produce an annual report on complaints and feedback annual report, which stems from The Patient Rights (Scotland) Directions 2012. There is also a requirement for NHS Boards to complete the Participation Standard Self Assessment. In order to streamline and align these requirements, NHS Boards annual reports will form the basis of Participation Standard 2014/15 and this was submitted to the July Healthcare Governance Committee before it was submitted to the Scottish Government.

3.2.8 NHS Lothian self assessed this submission as Level 1 - Developing our arrangements. Following analysis from the Scottish Health Council we have now received confirmation from the Scottish Health Council (SHC) as Level 1 and no further action is required at this time.

3.3 NHS Lothian Patient Experience Survey

Tell us Ten Things

3.3.1 Tell us Ten Things" (TTT) was a local patient survey programme which ran within the Universities Hospital Services. In November 2014 the questions were reviewed against best practice and aligned with the "5 must do elements" of the national Person Centred Health and Care Collaborative:-

- What matters to you?
- Who matters to you?
- What information do you need?
- Nothing about me without me
- Personalised contact

3.3.2 Following the testing of the TTT survey, this has now been extended to St John's Hospital (StJ) and the Western General Hospital. The surveys and staff posters have been delivered to all general in-patient ward and staff have been encouraged to offer this survey to patients. All wards now receive a local report.

3.3.3 NHS Lothian Aggregate TTT Results

Following the pilot at the Royal Infirmary of Edinburgh (RIE) all wards now receive their TTT monthly report. The results below cover an aggregate of 8 months (up to August 2015) and the report is included as Appendix 2. It is hoped that as the survey continues to be used, we will be able to present the results in a way which will show results over time, which will help staff to easily identify and focus their improvement activities.

How the results are calculated and presented

- The results are presented as an average score out of a possible maximum score of 10

- A score is given to each possible answer so that the most positive response scores 10. For example, Q9 asks about patients being happy with the food and scores 10 for patients who strongly agree that they were happy. In contrast, Q7 asks about patients being bothered by noise at night and scores 10 for patients who strongly disagree that they were bothered

- If a patient did not answer a question or said that it was not relevant, this has been excluded from the results summary

- More detailed results for each question are provided in bar charts showing percentage response rates for each question

- The last section of the report lists any comments made

August Results

The weighted average responses to the questions are as follows:	**Overall Weighted Average**
1. Do you feel that the staff took account of the things that matter to you?	**9.04**
2. Were the people that matter to you (family and friends) involved in decisions about your care and treatment as much as you wanted?	**7.81**
3. How much information about your care & treatment was given to you?	**8.58**
4. Were you involved, as much as you wanted to be, in decisions about your care & treatment?	**8.23**

5. Were you treated with kindness & compassion by the staff looking after you	**9.51**
6. In your opinion, how clean was the hospital room or ward you were in?	**9.11**
7. I was bothered by noise at night from the hospital staff:	**7.10**
8. Do you think the staff did everything they could to help control your pain?	**9.37**
9. I was happy with the food/meals I received:	**6.86**
10. Overall: I had a very poor/good experience:	**8.70**

3.3.5 As part of TTT there is a question at the end that asks 'Is there anything else we could have done to improve your experience of our care?'. The ward staff particularly value these comments and they are included in the monthly reports. These comments inform improvement plans and also highlight the positive experience of many patients.

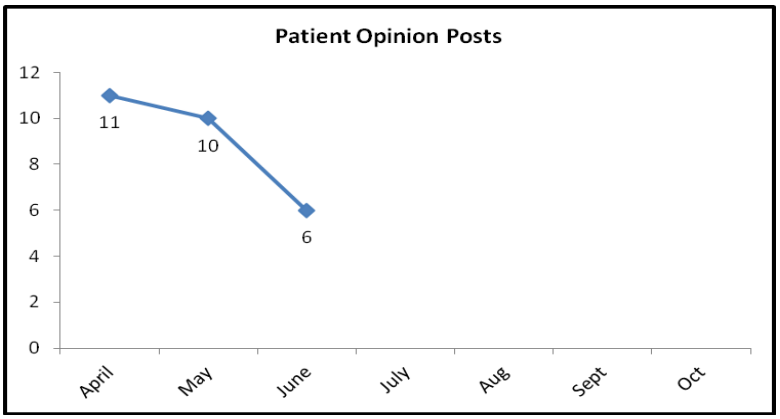
3.3.6 The team have also been working with colleagues from the Emergency Dept at the RIE and StJ and have developed a question set relevant to their patients which is being tested. It is anticipated that the first report will be available late August.

3.3.7 Moving forward TTT has now been rolled out to the three main hospital sites, however, further consideration and resource to find an effective method of data collection for the potential volume of returns is required.

Patient Opinion

3.3.8 Patient Opinion (PO) is a not for profit organisation that was founded in 2005 and allows people to share their experiences of healthcare via their website. There are a number of NHS Boards across Scotland who encourage people to feedback using this website. Chart 8 below identifies the stories that have been shared about NHS Lothian up to June 2015. In June there were 6 stories that were posted. We are working with Patient Opinion to improve the reporting and sharing of these stories. Appendix 3 is the June PO report for NHS Lothian.

Chart 8



3.3.9 Patient Opinion apply a "criticality" rating to each of the stories that are posted and these are identified by the PO team. The table below shows how these posts have been rated. It can be noted that the majority of these posts are not critical.

	Mildly critical	Minimally critical	Moderately critical	Not critical
April	5	0	1	5
May	3	1	0	6
June	1	1	1	3

3.3.10 The Executive Nurse Director with the Head of Patient Experience met with Gina Alexander from Patient Opinion to discuss how NHS Lothian can use this site as one element of our wider patient experience programme. Scottish Government are supporting Boards to engage with Patient Opinion and are providing funding for this. NHS Lothian is in the process of agreeing a "subscription" level. As a result Patient Opinion is supporting us with a range of support and resources to help us plan implementation and next steps. It is anticipated that with the devolved complaints and feedback function there will be the opportunity for site leads to be able to respond directly to their feedback.

3.3.11 NHS Boards that have embraced Patient Opinion include NHS Lanarkshire and Fife and we are in the process of contacting them to hear of their experiences of using this mechanism of real time patient feedback.

3.4 National Person Centred Health & Care Programme

3.4.1 Healthcare Improvement Scotland (HIS) recently met with the Person Centred Health and Care (PCHC) Programme Managers from across Scotland to inform NHS Boards that the PCHC Collaborative has now come to an end. However they have identified what remains as priority areas nationally:

- Continuous quality improvement of person centred care
- Gathering and using feedback to improve experiences of services
- Utilising the 5 must do with me elements of care
- Sharing and learning from good person centred practice

3.4.2 HIS have indicated that there will be three new work streams:

- Health and care experience
- Person centred health and care improvement programmes
- Connecting people and good practice

The committee will be updated as to when we receive any further updates from HIS on these activities.

3.8 Programme Governance

3.8.1 The Executive Lead for this work is Melanie Johnson, Executive Nurse Director. This work will report through the Quality Management Group on a monthly basis and to the Healthcare Governance Committee on a quarterly basis along with patient experience data being reported through the Quality Report.

4 Key Risks

4.1 This is an ambitious cultural programme and as such to achieve a person centred culture it needs to be woven into all aspects of NHS Lothian activity and measurement frameworks.

4.2 As we move forward with the transition to the new devolved service there is a risk that the performance of patient experience feedback (Complaints, concerns, comments and compliments) may deteriorate but this will be monitored.

4.3 Sickness within the team remains a challenge and during May and June sickness was running in excessive of 40%. In addition to this there are a significant number of vacancies and both of these issues are impacting on performance but also staff morale within the team.

5 Risk Register

5.1 Enabling a person centred approach within all work streams including complaints management which is on the revised Corporate Risk Register.

6 Impact on Inequality, Including Health Inequalities

6.1 The principles of this agenda will see the person at the centre and therefore all aspects of inequalities will be embedded in the core values of the work programmes agreed.

7 Involving People

7.1 The agenda for person-centredness has at its core involving people and as this work progresses patients, carers and staff are central.

8 Resource Implications

8.1.1 This work brings together the previous person centred team and CRaFT. The Patient Experience Team is being remodelled on existing resources and is being delivered by Organisational Change process, supported by HR and partnership.

8.1.2 As this review continues it has identified that approximately 5000 phone calls are received into the team and this has not previously had a recognised resource associated with this. It is possible that as we review the existing workload across all aspects of the patient experience activities this is likely to identify a resource shortfall that will need to be considered.

Jeannette Morrison
Head of Patient Experience
16 September 2015
Jeannette.morrison@nhslothian.scot.nhs.uk

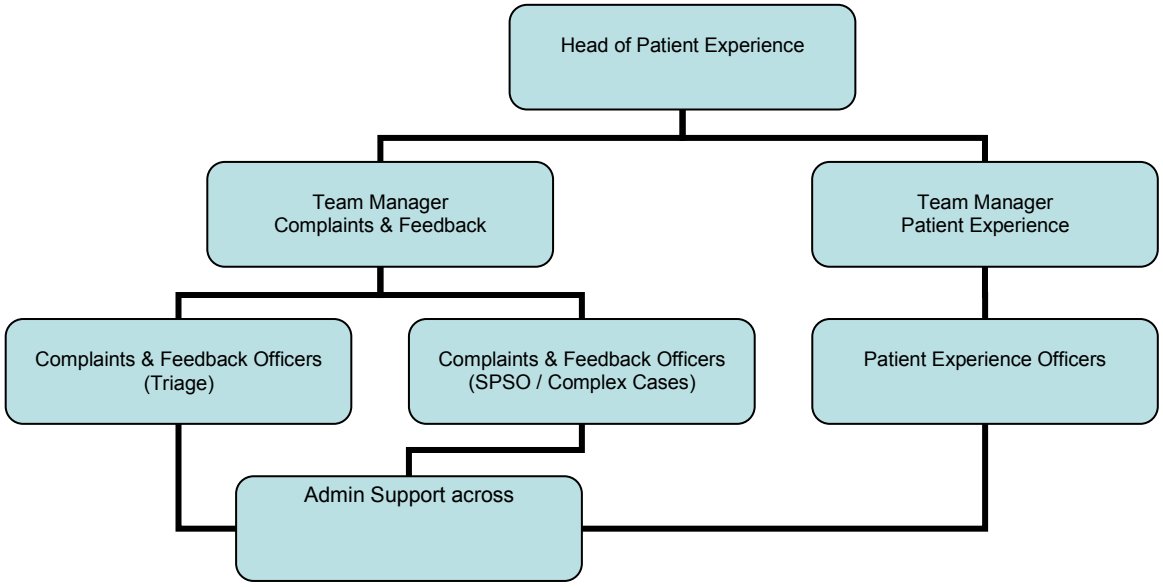
List of Appendices

Appendix 1: New Patient Experience Team Structure

Appendix 2: Tell us Ten Things - Aggregate Report (July 2015)
Appendix 3: Patient Opinion – Stories in summary (June 2015)

APPENDIX 1

Patient Experience Structure



Tell us ten things (TTT)

Patient Experience Survey Results

NHS Lothian

(August) 2015

The following pages contain the (August) report from the **Tell us ten things** patient experience survey. This survey is the organisation's tool to capture what patients think about the service we provide. It contains combined data for all sites presently using TTT surveys. Due to the phased introduction of this survey across the organisation results included in the report are as follows:-

from January 2015 to March 2015 - RIE results only

from April 2015 to June 2015 - SJH & RIE results

and from July 2015 - WGH, SJH & RIE

We previously reported 'snapshots' of results by period, but we have now progressed to reporting the results as 'data over time' and it is hope this will be extended to reports to the Wards, which will help staff to easily identify and focus their improvement activities.

How the results are calculated and presented

- The results in Table 1 are presented as a 'weighted average' score out of a possible max score of 10. Each response in every question carries a different weight or score. ie. 10, 5 & 0 and 'not applicable'. The 'not applicable' responses are treated as invalid for the purposes of the survey calculations. For example, Q9 asks about patients being happy with the food and scores 10 for patients who strongly agree that they were happy. In contrast, Q7 asks about patients being bothered by noise at night and scores 10 for patients who strongly disagree that they were bothered. If a patient did not answer a question or said that it was not relevant, this has been excluded from the results summary.

- The figures in the right hand column in Table 1 show the actual number of valid responses used to calculate the averages.

- More detailed aggregated results for each question are provided in run charts showing percentage response rates for each question over time for all participating NHS Lothian sites at that period.

- Discharge Figures – monthly discharge data is used to give corrected percentages using the number of valid surveys returned and the number of patients discharged from an area in the same period.

- The third section of the report lists a selection of both positive and negative comments from patients.

We are keen to ensure that the results are presented in a way that is useful to staff. We welcome any suggestions on how we could improve the format of the report or any additional information that you would find helpful.

The Tell us ten things team.

Tell us ten things

Survey Results August 2015

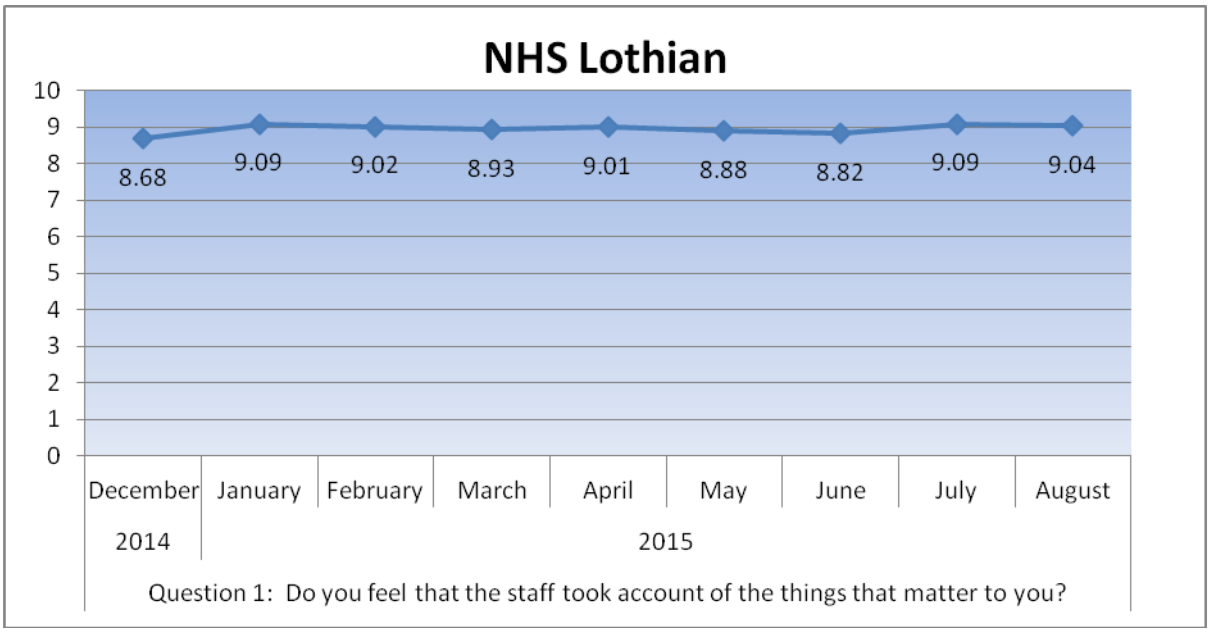
NHS Lothian Results

	Overall Average Score
Question 1: Do you feel that the staff took account of the things that matter to you?	9.04
Question 2: Were the people that matter to you (family and friends) involved in decisions about your care and treatment as much as you wanted?	7.81
Question 3: How much information about your care & treatment was given to you?	8.58
Question 4: Were you involved, as much as you wanted to be, in decisions about your care & treatment?	8.23
Question 5: Were you treated with kindness & compassion by the staff looking after you?	9.51
Question 6: In your opinion, how clean was the hospital room or ward you were in?	9.11
Question 7: I was bothered by noise at night from the hospital staff:	7.10
Question 8: Do you think the staff did everything they could to help control your pain?	9.37
Question 9: I was happy with the food/meals I received:	6.86
Question 10: Overall: I had a very poor/good experience:	**8.70**

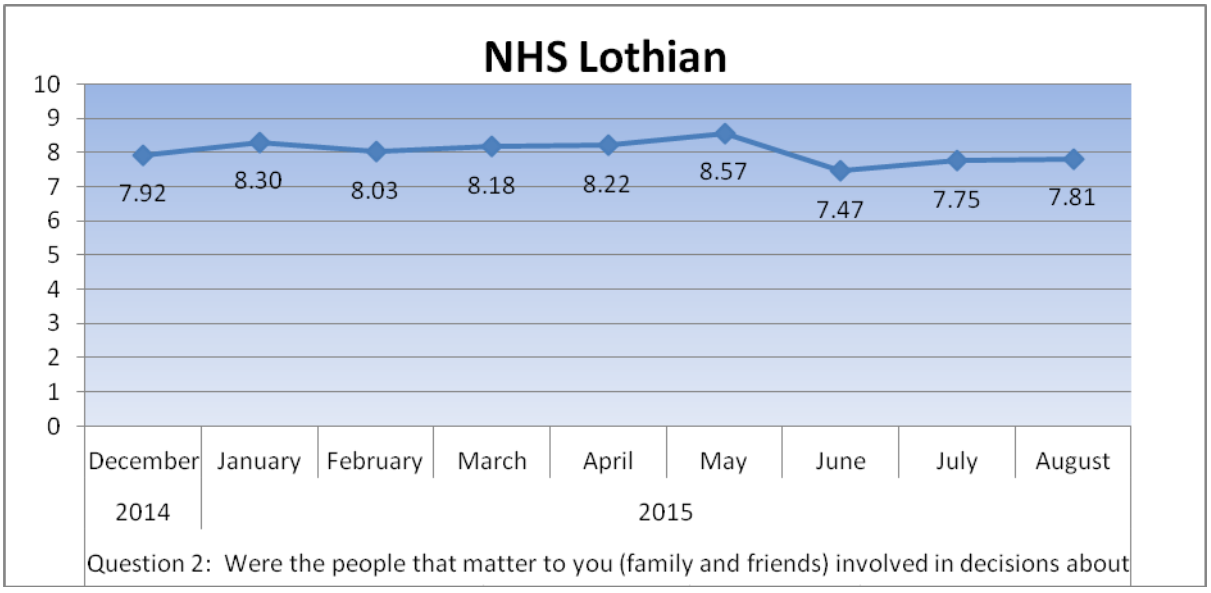
For an explanation of the weighting calculations please see last page.

The following graphs illustrate survey results data over time from December 2014 to August 2015 collected from all in-patient areas at RIE, WGH & SJH and are presented as average scores out of ten.

Q1 – Do you feel that the staff took account of the things that matter to you?

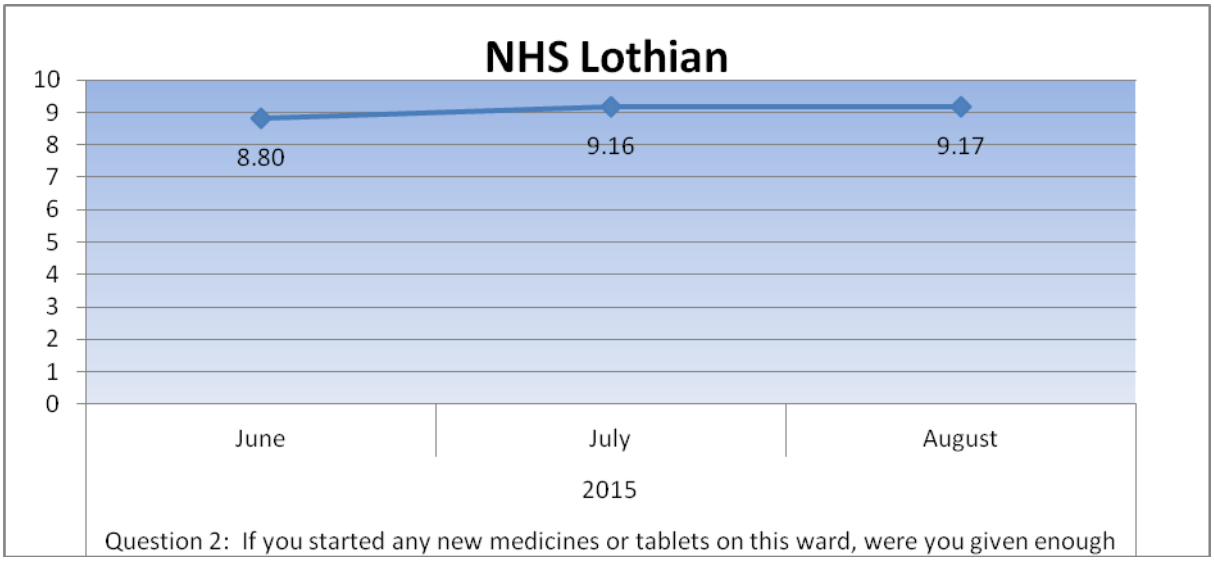


Q2- Were the people that matter to you (family and friends) involved in decisions about your care and treatment as much as you wanted?



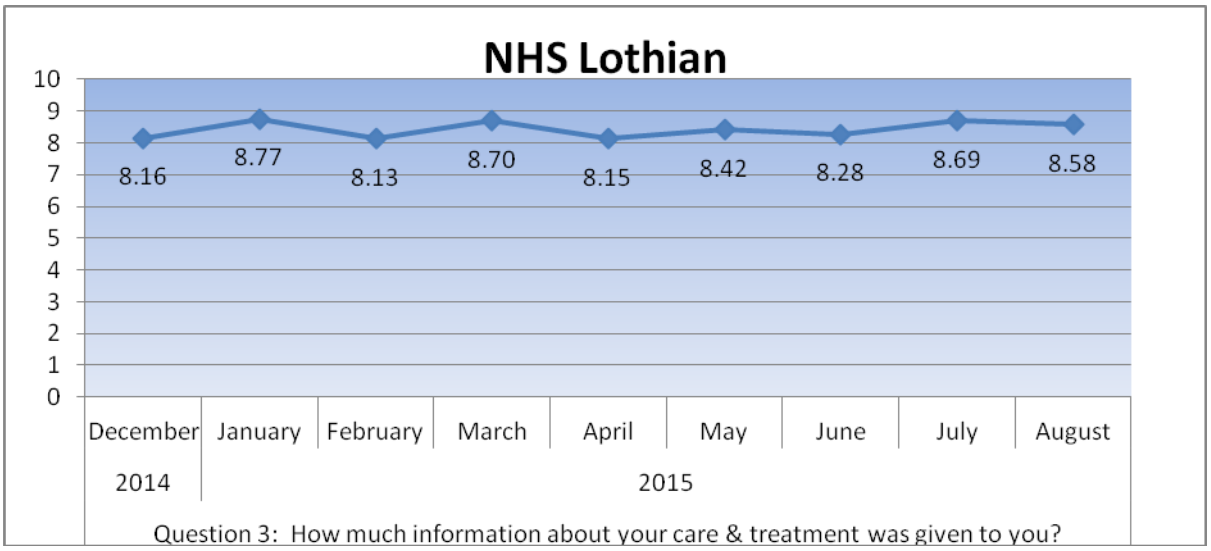
NB. Data for July and August is for St Johns site only.

NEW Q2 – If you started any new medicines or tablets on this ward, were you given enough explanation about what these were for?

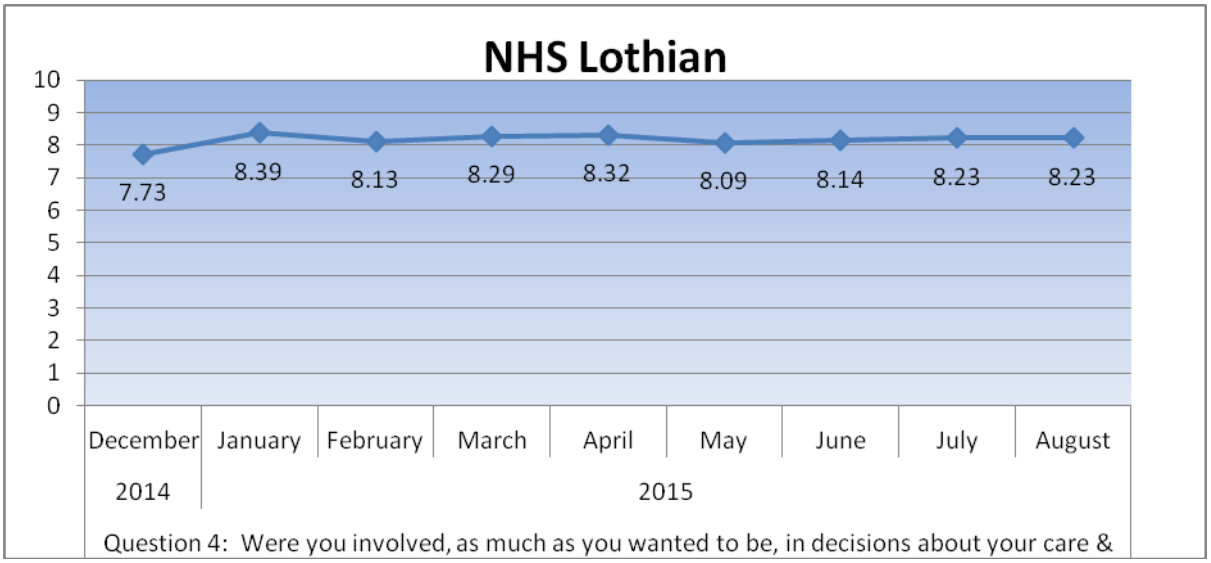


NB. Data for June, July & August is for RIE & WGH sites only.

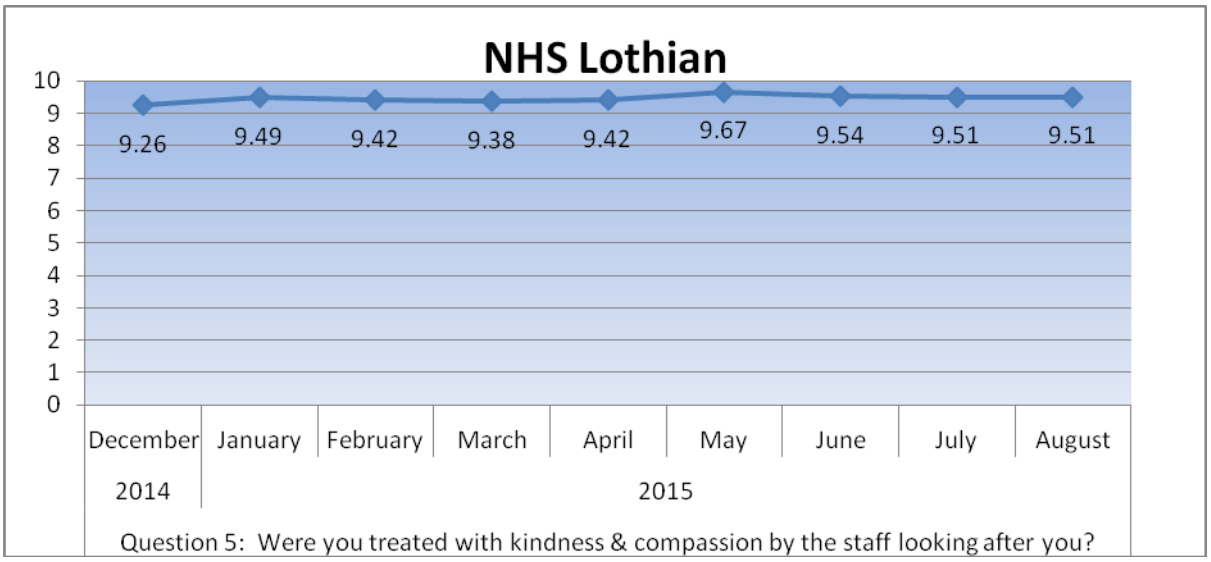
Q3 – How much information about your care and treatment were you given?



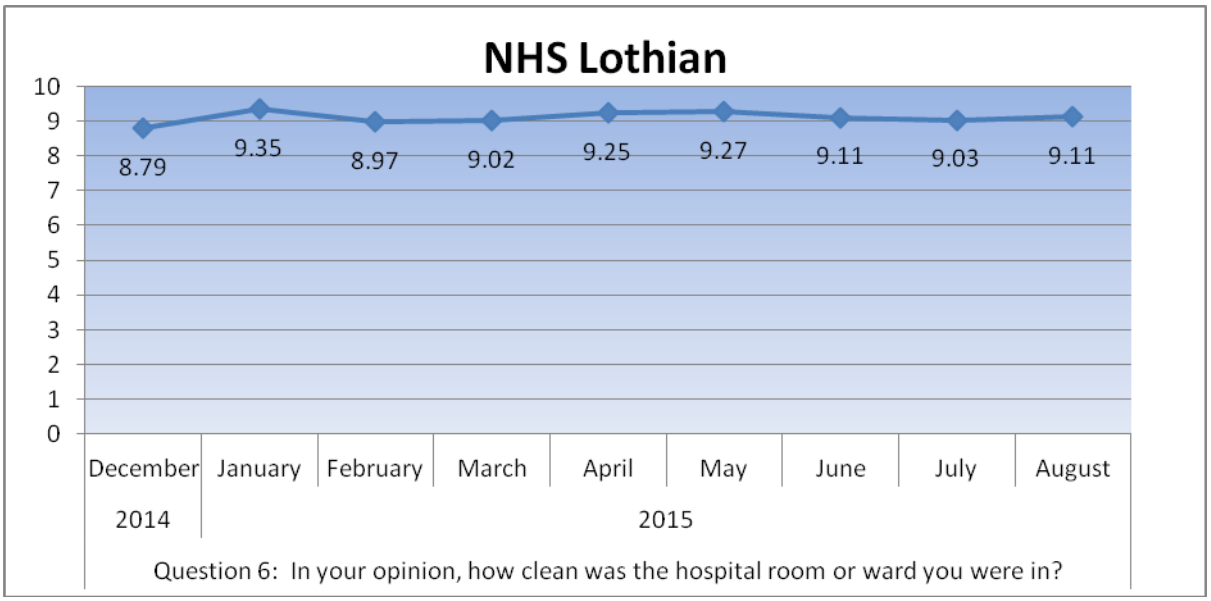
Q4 – Were you involved as much as you wanted to be, in decisions about your care and treatment?



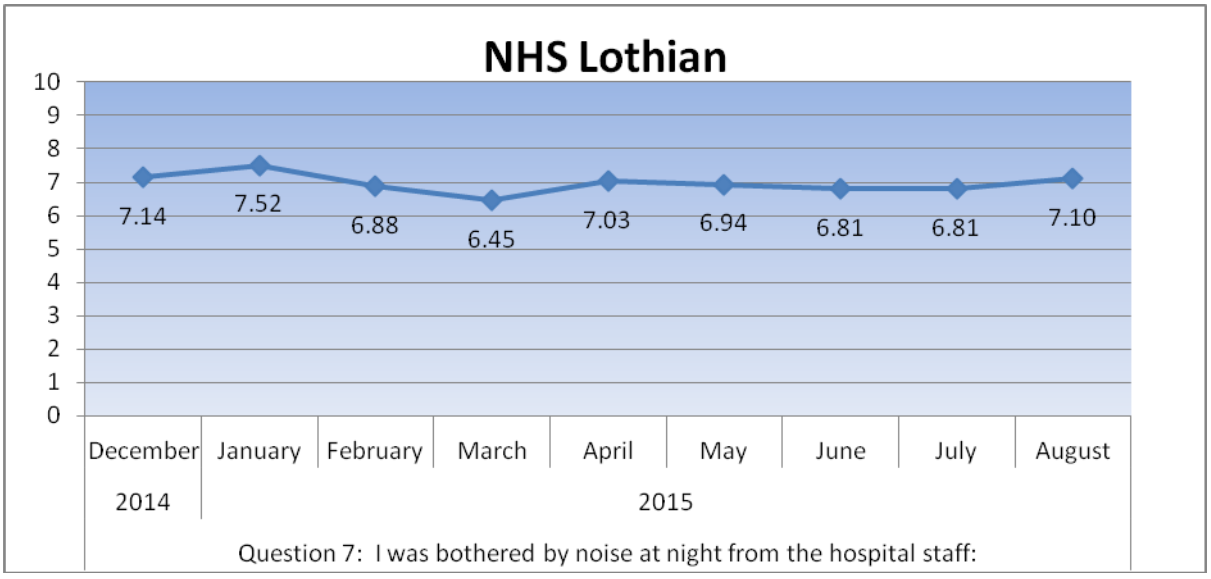
Q5 – Were you treated with kindness and compassion by the people looking after you?



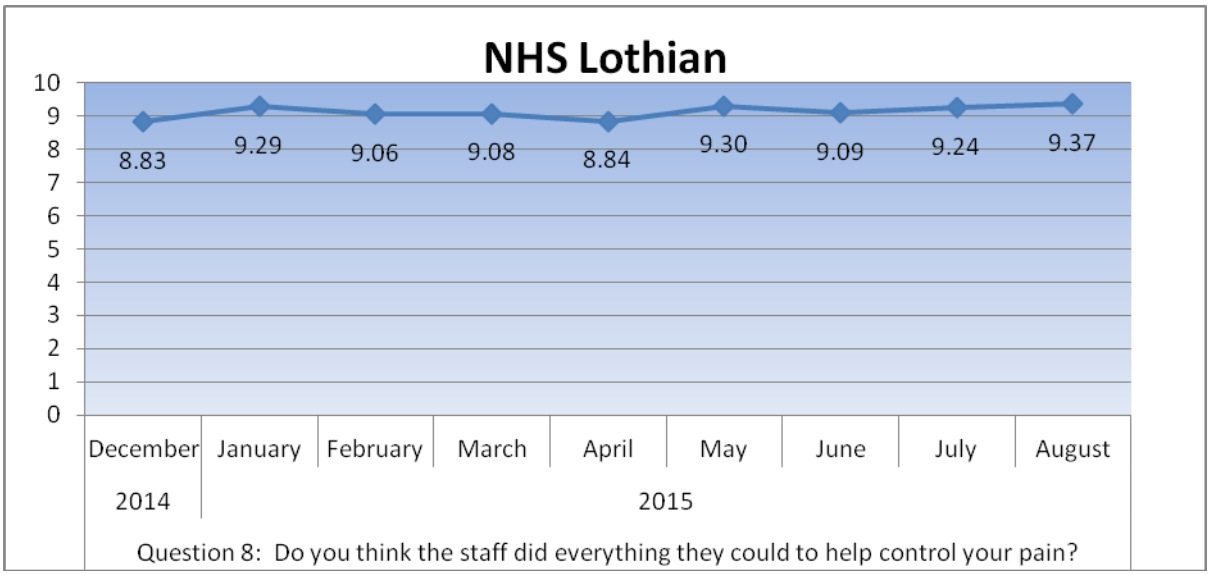
Q6 - In your opinion, how clean was the hospital room or ward you were in?



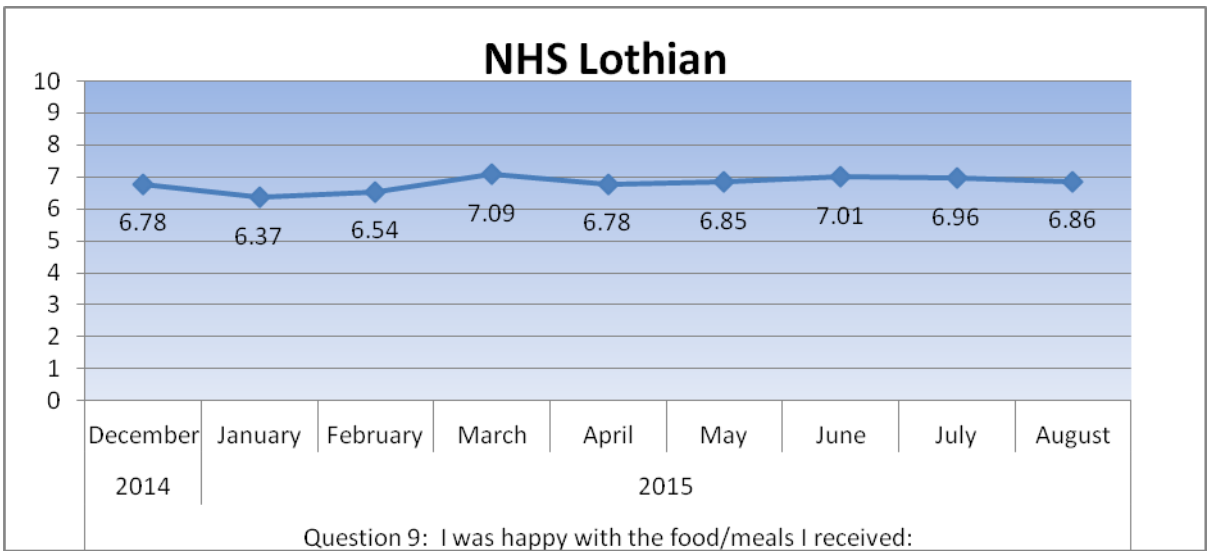
Q7 - I was bothered by noise at night from hospital staff?



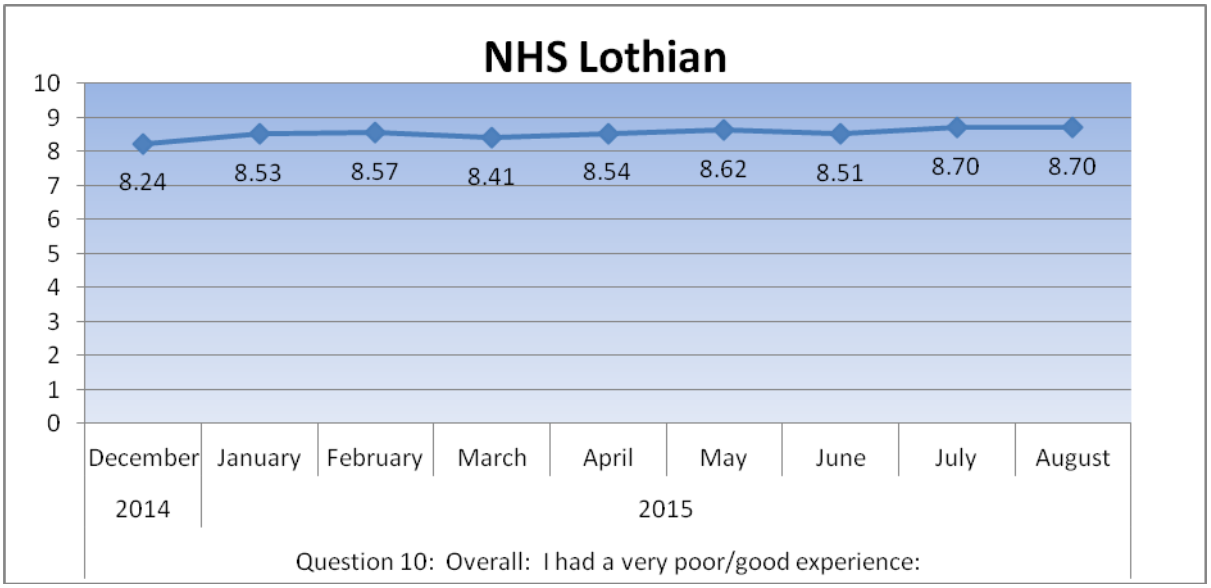
Q8 – Do you think the staff did everything they could to help control your pain?



Q9 – I was happy with the food/meals I received.



Q10- Overall I had a very poor/ experience good.



Is t**here anything else we could have done to improve your experience of our care?**	
Positive Feedback	**Negative Feedback**
Highly appreciative of excellent level of care received, thank you.	Improve the food, on many occasions I ate nothing. I was not offered an alternative. My family brought food in for me to eat.
No, I can't think of anything that was not done and could have been done. In particular, the staff were brilliant.	Don't allow large numbers of noisy visitors especially after 8pm. More ice for cold compress as machine could not supply enough for ward needs
I can't think of anything that was not done and could have been done.	The attitudes of some staff could be improved. Granny has felt she has "got into trouble" by some people.

A few points to note about the results and how the weighting is calculated:

The results are shown as a weighted average score out of a possible maximum 10.

A score is given to each valid response so that the most positive response scores 10. For example, Q9 which asks about patients being happy with the food, scores 10 for patients who 'strongly' agree that they were happy and scores 5 for patients who 'agree' and so on.

In contrast, Q7 asks about patients being bothered by noise at night and scores 10 for patients who 'strongly disagree' that they were bothered.

Progressively negative responses are assigned progressively lower scores.

If a patient did not answer a question or answered 'Don't know'/ not applicable, it is not considered a valid response and is excluded from the calculations.

Stories in summary

About this report

This report shows summary information about a selection of stories published on Patient Opinion.

It was created on **06 July 2015.**

Which postings are included?

This report shows stories about NHS Lothian submitted between 01/04/2015 and 30/04/2015

Frequently asked questions

How is story criticality rated?

Story criticality is rated by our moderations at the time each story is moderated. It is a measure of how critical the most critical part of a story is, according to a criterion-based system. Criticality is rated in order to support our filtered email alerting system for staff, and is not intended for publication.

What do the story counts mean?

To the right of an organisation/service you will see a count. This tells you the number of stories listed in the report about that organisation or service (including any services run by that organisation/service).

What does "most popular" mean?

The most popular stories are those which have been read most often per day, since publication. This measure does produce a small bias towards more recent stories, but at least it is simple to understand.

Why might unexpected services appear in my report?

The services listed in the report depend on the stories that are included, and that depends on how you have filtered the report. So, for example, if you have filtered only according to where authors live, you may find they have used services some distance away.

Sharing and reuse

Contributors to Patient Opinion want their stories to get to those who can use them to make a difference, so we encourage you to share this information with others.

About Patient Opinion

Patient Opinion is a not-for-profit social enterprise which enables people to share the story of their care, and perhaps help care services make changes.
For more information, contact us via: https://www.patientopinion.org.uk

This report summarises **11** stories

To date, the stories in this report have been viewed on Patient Opinion **1,944** times in all

These are the three most popular stories, out of all the stories included in this report

You can click the story title to see the story online

I was treated with such dignity, respect and care

Posted by **Fee280** as the patient 2 months ago

I went to the Edinburgh Royal Infirmary three times over a few days with symptoms of nausea and sickness. Because of the severity of the symptoms I was given injections to stop the sickness on the first two occasions I went to the hospital – at that point I was unable to keep down any water which I was trying to drinking to counteract the dehydration caused by the sickness. After being given the injections I was sent home.
Unfortunately the...

I felt whatever I had to say would be disbelieved

Posted by **Mirabelle** as the patient 2 months ago

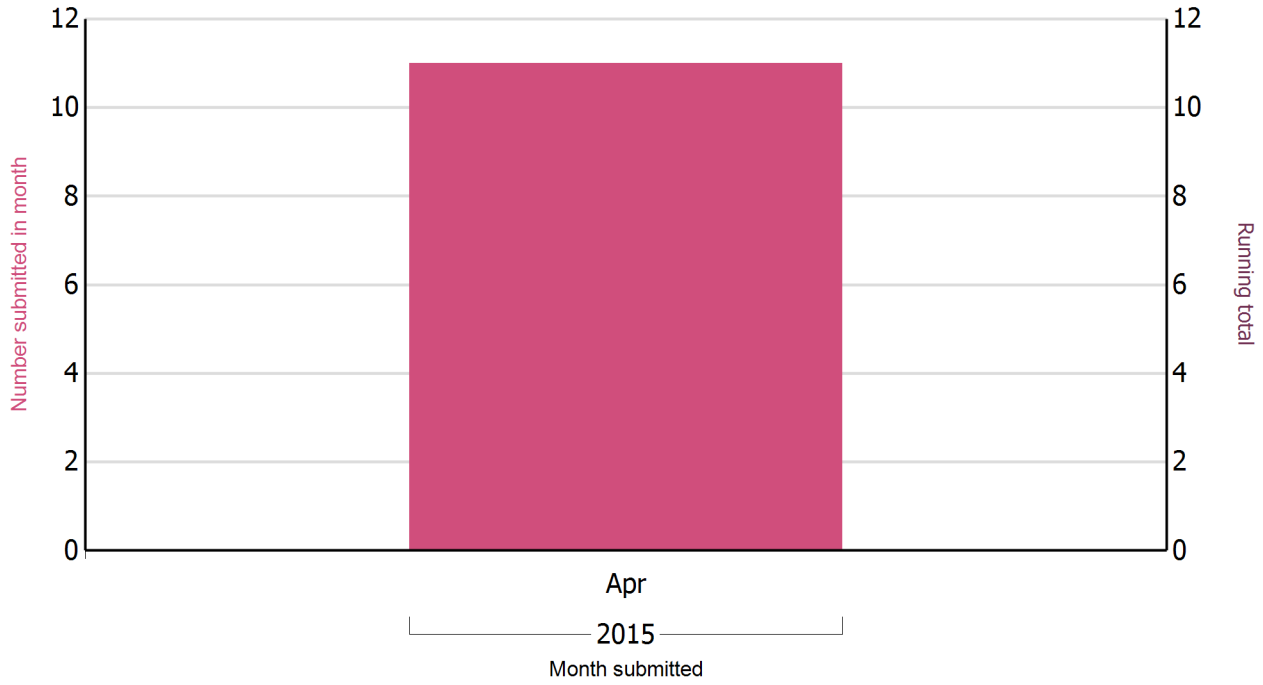
In January 2013, I had a bleed from my bowel – blood and mucus shot out of me when I was not near a toilet. During an appointment with a rheumatologist about another matter, amongst other things he asked me if I had any problems with my gut. I mentioned the blood and mucus. He asked me if I had reported it to my GP, and when I said that I had not, he said that he would include it in his report and that I must see my GP about it.
I rang the bowel...

Lack of empathy

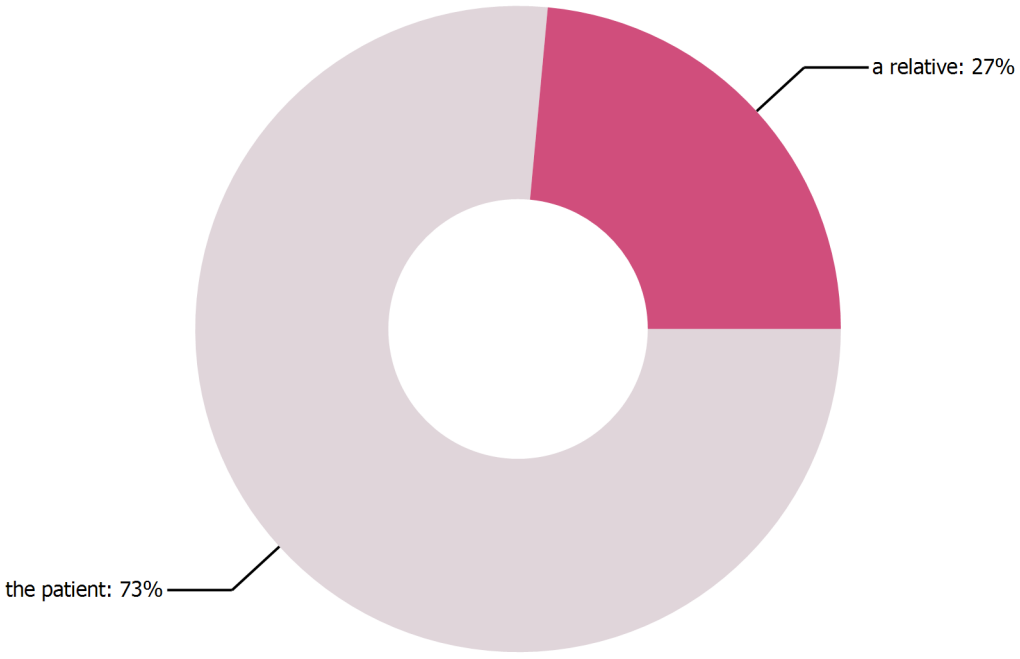
Posted by **Miktq2** as the patient 3 months ago

My father has been in hospital for four weeks. He has become very distressed, not about the treatment as such just that some staff, primarily nursing staff display so little empathy, some seem to just not care.
They are very good at doing the patient administration, not so good at communicating with patients and noticing when the are uncomfortable, in pain, distressed or have small needs like nail cutting or a shave.
Technical training seems to...

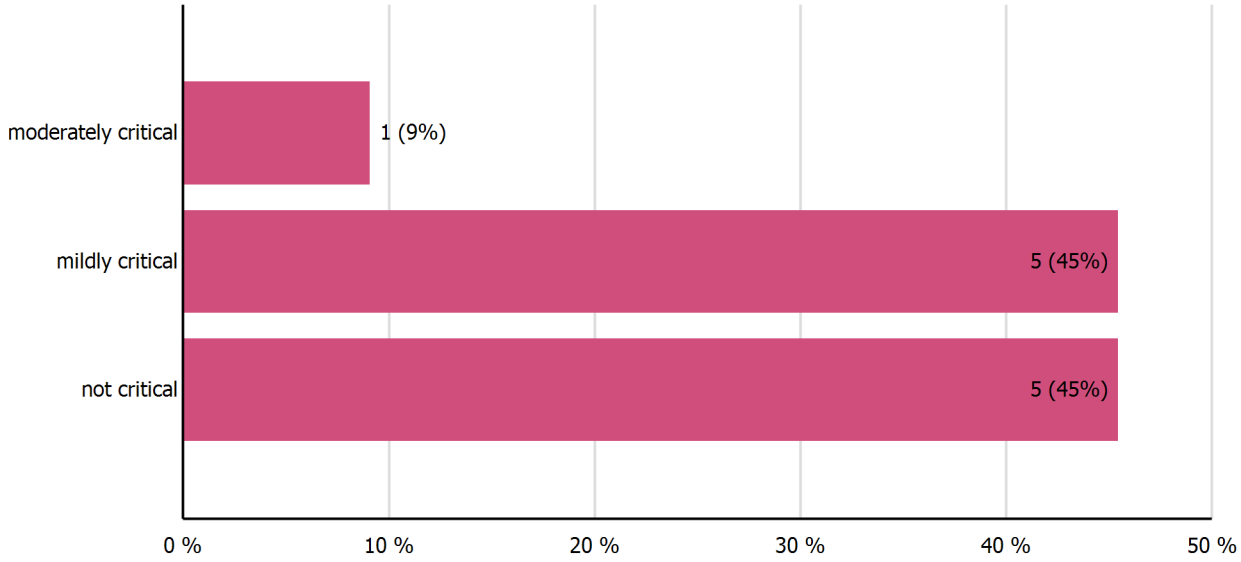
When these stories were told



How the authors of these stories identify themselves



How moderators have rated the criticality of these stories



NB: criticality scores are assigned by moderators (not the public) to stories to support our alerting service. They are assigned *per story* not *per service*, so may reflect criticism of services other than your own. We provide them here purely for information, with these caveats in mind.

Where these stories have come from

NHS Lothian	**10**
NHS East Lancashire CCG	**1**

Most common tags added by authors to these stories

What's good?	
GP	2
after care	1
ambulance	1
calm	1
Care	1
caring	1
clean ward	1
cleanliness	1
communication	1
Dignity	1
doctor	1
doctors	1
efficient staff	1
electrophysiologist	1
empathy	1
environment	1

What could be improved?	
communication	2
annoyed	1
appointment wait	1
caring	1
communcation	1
Communication between professionals	1
communication between staff	1
continuity	1
doctor care	1
doctor knowledge	1
empathy	1
frustrated	1
hygiene	1
insect	1

Initial feelings	
disappointed	2
brilliant	1
cared for	1
compassionate	1
confidence	1
feel at ease	1
grateful	1
patience	1
worried	1
annoyed	1
frustrated	1
sad	1
shocked	1
Dignity	1
happy	1
relaxed	1

happy	1	sad	1
most staff	1	shocked	1
NURSES ATTITUDE	1	some staff	1
nurses professionalism	1	treatment	1
patients	1	waiting time	1
professional	1	cancer care	1
referral	1		
relaxed	1		
skilled	1		
staff	1		
staff attitudes	1		
surgery	1		
treatment	1		

Services the stories are about	Number of stories	Latest story
NHS Lothian	**11**	27/04/2015
Ellen's Glen House	1	26/04/2015
Leith Community Treatment Centre	1	04/04/2015
Royal Hospital for Sick Children (Edinburgh)	1	27/04/2015
Ear, Nose & Throat	1	27/04/2015
Royal Infirmary of Edinburgh at Little France	6	09/04/2015
Accident & Emergency	2	09/04/2015
Cardiology	2	07/04/2015
General Medicine	3	09/04/2015
General Surgery	1	02/04/2015
St John's Hospital	3	22/04/2015
Ear, Nose & Throat	1	02/04/2015
General Medicine	2	22/04/2015
Western General Hospital	2	08/04/2015
General Surgery	1	08/04/2015
Medical Oncology	1	07/04/2015

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NHS LOTHIAN

Board meeting
7 October 2015

Chief Officer

SUMMARY PAPER - ACUTE SERVICES PERFORMANCE UPDATE

The key points of the paper are summarised here.

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

At the end of August, 398 patients were waiting beyond the 12 week treatment time guarantee. 314 patients were treated in month beyond the guarantee.	3
6,933 outpatients were waiting over 12 weeks; this is an increase on July's position of 6,087.	4
Performance against the 31 cancer standard in July was 96.7%, which exceeds the 95% expected standard. At 95.7%, performance against the 62 day cancer standard also exceeded the standard.	7
Published Stroke Care Bundle performance data for July show 52.3% against our local target of 70%. Recent local data show an improvement; the 70% target was achieved at the start of September.	8
17 patients were waiting beyond audiology standards at the end of August 2015.	11
NHS Lothian continues to perform well against the IVF standard of 90% of patients commencing IVF treatment within 12 months.	12
NHS Lothian's overall performance against the 4 hour standard for the month of August was 94.46%.	13

NHS LOTHIAN

Board meeting
7 October 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 August, 398 patients were waiting beyond the 12 week treatment time guarantee (Table 1). 314 patients were treated in month beyond the guarantee (Table 2).

Table 1 – Treatment Time Guarantee Patients waiting beyond standard at month end.

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Urology	140	134	122	109	68	63	108	97	137	123	92	104	133
Plastic Surgery	191	188	162	181	195	255	212	139	111	101	89	86	86
Orthopaedic Surgery	42	34	51	64	49	89	107	53	88	86	60	55	62
Maxillofacial	34	37	39	35	30	41	52	42	42	46	34	31	30
Colorectal/General	76	55	35	39	18	14	27	22	48	39	18	29	21
Paediatric ENT	16	19	21	15	14	16	21	9	14	25	21	6	20
ENT	20	34	33	34	48	74	81	37	25	13	12	7	8
Ophthalmology	32	16	15	10	11	22	10	4	1	2	4	5	0
Others	17	15	8	11	14	18	31	23	34	41	19	24	38
TOTAL	**568**	**532**	**486**	**498**	**447**	**592**	**649**	**426**	**500**	**476**	**349**	**347**	**398**

Table 2 – Treatment Time Guarantee Patients seen beyond 12 weeks.

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
TTG Seen	402	467	448	397	427	406	564	692	476	463	389	314	314

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 (12% in August 2015.)

Table 3 – List Size and Unavailability

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Total List Size (TTG)	9534	9842	9841	9832	9961	9600	9481	9140	8941	8692	8642	8421	8599
Available	8322	8697	8810	8733	8784	8714	8576	8174	7911	7644	7453	7264	7543
Unavailable	1212	1145	1031	1099	1177	886	905	966	1030	1048	1189	1157	1056
Percentage Unavailable	13%	12%	10%	11%	12%	9%	10%	11%	12%	12%	14%	14%	12%
non-TTG	574	551	606	572	620	1069	1144	1197	1180	1244	1246	1187	1048

4 Outpatients

4.1 Across NHS Lothian, 6,933 outpatients were waiting more than the 12 week standard at the end of August; trend data in key specialties are shown in the table below.

Table 4 – Trend in Outpatients over 12 weeks – Key Specialties

	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
TRAUMA AND ORTHOPAEDIC SURGERY	408	459	647	775	517	515	665	558	912	1291
GASTROENTEROLOGY	263	198	210	252	323	477	671	902	1208	1334
EAR, NOSE & THROAT (ENT)	292	295	272	269	320	431	504	541	872	1093
GENERAL SURGERY (EXCL VASCULAR)	352	288	506	596	342	454	583	632	854	1036
UROLOGY	339	358	378	339	315	398	438	321	606	648
OPHTHALMOLOGY	288	285	335	481	296	336	378	326	475	395
GYNAECOLOGY	98	112	341	284	97	256	266	216	283	379
COMMUNITY CHILD HEALTH	24	66	115	144	122	137	111	92	87	109
NEUROLOGY	380	455	355	261	113	124	125	72	100	107
OTHER SPECIALTIES	226	139	193	200	229	328	507	413	549	384
EDINBURGH DENTAL INSTITUTE	32	17	39	20	8	11	13	119	141	157
TOTAL OVER 12 WEEKS	**2702**	**2672**	**3391**	**3621**	**2682**	**3467**	**4261**	**4192**	**6087**	**6933**

4.2 Figures on outpatient list size and unavailability are shown in the following table.

Table 5 – List Size and Unavailability[1]

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Total List Size	43091	42624	43955	43004	42639	41721	42861	43694	46547	48672	50243	53046	52040
Available	41854	41441	42808	42085	41527	41000	41987	42878	45843	47951	49004	51930	50867
Unavailable	1237	1183	1147	919	1112	721	694	816	704	721	1239	1116	1173
Percentage Unavailable	3%	3%	3%	2%	3%	2%	2%	2%	2%	1%	2%	2%	2%

5 Tackling the challenging outpatient position

5.1 As the trend data in table 4 above demonstrate, there has been a significant increase in the number of outpatients waiting beyond the 12 week standard – 6,933 outpatients waited longer than 12 weeks in July. Analysis to explore the reasons for this show that there are two contributing factors; the majority can be attributed to an increase in demand for some of the specialties affected for example, general surgery, ENT and urology have seen a significant increase in demand. The second factor, although to a lesser extent, has been our loss of capacity due to reducing our use of the external provider Medinet.

5.2 Extensive investigation and analysis has been undertaken to establish drivers for this increase and to support recovery strategies. The tables below show movements in general surgery, ENT and urology over a specific period, including the increase in waiting list size, the increase in additions to the waiting list, increase in internal activity and reduction in external capacity.

[1] Figures may differ from those previously reported. These were drawn from national data warehouse to ensure comparability throughout.

Table 6 – Movement in general surgery (April to August 2014 and 2015)

		Prior Period in Analysis	30/04/14 29/04/15	28/05/14 27/05/15	25/06/14 24/06/15	23/07/14 22/07/15	20/08/14 19/08/15	Overall Change
Week Number			18	22	26	30	34	
WL Size	2014	1168	1037	1107	1169	1258	1251	+83
	2015	1212	1497	1596	1689	1901	1995	+783
		+44	+460	+489	+520	+643	+744	+700
Breaches	2014	47	19	18	20	27	62	+15
	2015	36	182	262	355	479	532	+496
		-11	+163	+244	+335	+452	+470	+481
Additions	2014	1873	512	622	573	562	548	
	2015	2411	663	774	742	780	739	
		+538	+151	+152	+169	+218	+191	+1419
Internal Activity	2014	1526	413	418	388	363	439	
	2015	1799	472	547	519	451	506	
		+273	+59	+129	+131	+88	+67	+747
Medinet Activity	2014	55	36	1	1	0	0	
	2015	0	0	0	0	0	0	
		-55	-36	-1	-1	0	0	-93
Other EP Activity	2014	0	0	0	0	0	0	
	2015	0	17	26	16	1	27	
		0	+17	+26	+16	+1	+27	+87
Prior Period is position as at week 2 for size and breaches, with totals provided for week 2-14 in other rows								

Table 7 Movement in ENT (April to August 2014 and 2015)

		Prior Period in Analysis	30/04/14 29/04/15	28/05/14 27/05/15	25/06/14 24/06/15	23/07/14 22/07/15	20/08/14 19/08/15	Overall Change
Week Number			18	22	26	30	34	
WL Size	2014	3144	2892	3214	2963	2935	2835	-309
	2015	2339	3134	3420	3457	3634	3631	+1292
		-805	+242	+206	+494	+699	+796	+1601
Breaches	2014	291	43	139	194	277	280	-11
	2015	69	117	221	236	465	724	+655
		-222	+74	+82	+42	+188	+444	+666
Additions	2014	4751	1413	1546	1407	1424	1399	
	2015	5180	1584	1772	1678	1531	1376	
		+429	+171	+226	+271	+107	-23	+1181
Internal Activity	2014	3782	1039	864	1220	953	933	
	2015	3721	1013	1166	1346	1064	1038	
		-61	-26	+302	+126	+111	+105	+557
Medinet Activity	2014	302	100	86	81	200	199	
	2015	5	1	0	0	0	0	
		-297	-99	-86	-81	-200	-199	-962
Other EP Activity	2014	0	0	0	0	0	0	
	2015	0	0	0	0	0	0	
		0	0	0	0	0	0	0
Prior Period is position as at week 2 for size and breaches, with totals provided for week 2-14 in other rows								

Table 8 Movement in Urology (April to August 2014 and 2015)

		Prior Period in Analysis	30/04/14 29/04/15	28/05/14 27/05/15	25/06/14 24/06/15	23/07/14 22/07/15	20/08/14 19/08/15	Overall Change
Week Number			18	22	26	30	34	
WL Size	2014	1311	1234	1221	1326	1452	1385	+74
	2015	1817	1881	1980	1957	1928	1946	+129
		+506	+647	+759	+631	+476	+561	+55
Breaches	2014	241	46	56	66	57	67	-174
	2015	296	451	469	416	491	630	+334
		+55	+405	+413	+350	+434	+563	+508
Additions	2014	2104	637	613	695	665	654	
	2015	2125	741	796	748	658	680	
		+21	+104	+183	+53	-7	+26	+380
Internal Activity	2014	1445	480	443	416	348	494	
	2015	1576	410	485	523	458	457	
		+131	-70	+42	+107	+110	-37	+283
Medinet Activity	2014	118	8	0	2	1	37	
	2015	5	0	0	0	0	0	
		-113	-8	0	-2	-1	-37	-161
Other EP Activity	2014	38	44	22	67	45	53	
	2015	110	44	53	61	47	29	
		+72	0	+31	-6	+2	-24	+75
Prior Period is position as at week 2 for size and breaches, with totals provided for week 2-14 in other rows								

5.3 The intelligence to date indicates a sustained change in our list additions and clearly this impacts on our conversion numbers to Inpatient & Day case lists. As part of the refresh of our Demand Capacity Activity Queue (DCAQ) methodology, we are

undertaking detailed analysis which includes examining demand for services per GP practice and reasons for referral as well as the subsequent conversion to treatment lists. Details of our updated DCAQ work will be presented to the Acute Hospitals Committee and then to board in a future Acute Services Performance Update report.

6 18 Weeks Referral to Treatment Standard

6.1 Unfortunately due to technical issues, the figures for July and August are not yet available. Trend data up to June 2015 is shown in Table 9.

Table 9 -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

7 Cancer performance

7.1 Performance over the last six months is set out by tumour site in the two tables below. Table 10 and 11 show that, in July, provisional information suggests NHS Lothian met both 95% standards, although some difficulties persist at tumour site level.

Table 10 - Trend in Cancer Performance (31 days from diagnosis to treatment)

	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15
Cancer Type	arted treatment within 31 days									
All Cancer types	**98.2%**	**95.3%**	**97.4%**	**93.3%**	**94.1%**	**96.2%**	**97.2%**	**96.2%**	**95.8%**	**96.7%**
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.7%	100.0%
Cervical (screened excluded)	100.0%	100.0%	100.0%	88.9%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened only)	100.0%	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%
Colorectal (screened excluded)	96.9%	96.4%	96.3%	86.4%	94.4%	96.0%	95.2%	88.9%	100.0%	96.2%
Colorectal (screened only)	100.0%	100.0%	87.5%	75.0%	80.0%	100.0%	100.0%	100.0%	75.0%	100.0%
Head & Neck	100.0%	92.3%	94.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Lung	100.0%	98.4%	100.0%	100.0%	98.6%	98.6%	100.0%	100.0%	100.0%	100.0%
Lymphoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Melanoma	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Neurological - Brain and CNS	n/a	n/a	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	83.3%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Sarcoma	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Upper GI	100.0%	100.0%	100.0%	95.8%	100.0%	95.8%	95.2%	100.0%	95.2%	100.0%
Urological	90.4%	84.6%	90.7%	75.9%	73.1%	82.4%	89.5%	85.5%	84.6%	85.5%

Table 11 – Trend in Cancer Performance (62 days from urgent referral to treatment)

Cancer Type	Oct 14	Nov 14	Dec 14	Jan 15	Feb 15	Mar 15	Apr 15	May 15	Jun 15	Jul 15
	arted treatment within 62 days									
All Cancer types	**96.8%**	**92.9%**	**96.5%**	**94.5%**	**93.1%**	**95.6%**	**96.1%**	**93.4%**	**92.3%**	**95.7%**
Breast (screened excluded)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	96.8%	100.0%
Breast (screened only)	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
Cervical (screened excluded)	100.0%	100.0%	50.0%	66.7%	100.0%	100.0%	n/a	100.0%	100.0%	100.0%
Cervical (screened only)	n/a	n/a	100.0%	100.0%	100.0%	100.0%	100.0%	n/a	100.0%	100.0%
Colorectal (screened excluded)	81.3%	93.8%	93.3%	78.6%	85.7%	87.5%	91.7%	100.0%	84.2%	93.8%
Colorectal (screened only)	100.0%	100.0%	71.4%	100.0%	66.7%	100.0%	100.0%	100.0%	71.4%	100.0%
Head & Neck	100.0%	66.7%	100.0%	100.0%	100.0%	100.0%	100.0%	66.7%	87.5%	66.7%
Lung	100.0%	100.0%	100.0%	100.0%	94.4%	94.1%	93.3%	93.3%	100.0%	100.0%
Lymphoma	80.0%	71.4%	100.0%	80.0%	100.0%	100.0%	100.0%	100.0%	71.4%	100.0%
Melanoma	100.0%	50.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	83.3%	100.0%
Neurological - Brain and CNS	n/a	n/a	n/a	100.0%	n/a	n/a	n/a	n/a	n/a	n/a
Ovarian	100.0%	50.0%	100.0%	100.0%	n/a	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	n/a	n/a	n/a
Upper GI	100.0%	91.7%	100.0%	100.0%	90.9%	100.0%	100.0%	83.3%	83.3%	92.9%
Urological	95.2%	87.5%	94.4%	87.0%	80.0%	82.6%	85.2%	78.6%	92.3%	73.7%

8 Stroke performance

8.1 The four key inpatient Scottish Stroke Care Standards are as follows:

- Admission to stroke unit - 90% by day after admission
- CT scanning - 90% within 24 hours
- Swallow screening - 90% on day of admission
- Aspirin administration - 95% by day after admission

8.2 The Stroke Care Bundle measures performance against these key elements. NHS Lothian's 2015/16 local target for the Stroke Care Bundle has been set at 70%. Monthly performance against the overall bundle varies: May 57.4%, June 57.4%, July 52.3%. As shown in Table 12, performance against each of the four elements of the Stroke Care bundle also varies.

Table 12 Performance against 4 elements of stroke bundle May – July 2015

Elements of Stroke bundle	May-15	Jun-15	Jul-15
Admission to stroke unit on day of admission	66.7%	66.3%	50.8%
CT scanning within 24 hours	95.1%	95.7%	98.9%
Swallow screening on day of admission	83.6%	83.0%	83.0%
Aspirin administration by day after admission	85.9%	91.8%	90.0%

8.3 However, more recent unpublished local data show an improvement in performance against the bundle. For the week 31st August to 6th September 2105, NHS Lothian achieved the Stroke Care Bundle for 70% of patients with an initial diagnosis of stroke - achieving the local delivery plan target.[2] All three sites delivering Stroke provision are continuously striving to improve performance rates against the Stroke Care Bundle targets with a focus on reaching beyond the local delivery plan target of 70%.

[2] This is local provisional data.

9 Diagnostics waiting times performance

9.1 There has been an increase in the number of diagnostic endoscopy patients waiting longer than the 6 week standard is improving with an estimated 1670 patients being > 6 weeks at end September.

9.2 The number of radiology patients waiting beyond the 6 week standard has improved; 52 patients waited longer than 6 weeks in August compared with 142 patients in June 2015. (Table 14)

Table 14 – Numbers over 6 week standard for Key Diagnostic Tests (Radiology)

	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
CT	0	0	0	0	0	0	2	3	15	8	6	12	9
MRI	2	0	1	0	1	1	0	2	108	123	106	60	38
Barium Studies	0	0	0	0	0	0	0	0	0	0	0	0	0
Ultrasound	0	1	7	21	67	90	40	15	23	13	30	4	5
Total	**2**	**1**	**8**	**21**	**68**	**91**	**42**	**20**	**146**	**144**	**142**	**76**	**52**

10 Surveillance Endoscopy

10.1 End of August surveillance endoscopy position saw 1,598 patients waiting beyond their due). As outlined in a previous update paper to the Board, 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 and this position should improve from late August following additional clinical staff joining the team and the focus use of the Regional Unit in Fide for Surveillance patients.

11 Audiology waiting times

11.1 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.

11.2 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, a small numbers of patients exceeded these standards August; 17 patients in both areas, as shown in the tables below.

Table 16 – Adult Audiology – Performance against standard

		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Patients waiting for audiology assessment ***(first contact)***														
	Number waiting 9 weeks and over	**3**	**0**	**0**	**0**	**111**	**174**	**5**	**0**	**1**	**0**	**0**	**0**	**1**
	Total number waiting	1516	1608	1464	1662	1939	1710	1683	1810	1756	1161	908	1247	1180
Patients waiting for fitting of hearing aid														
	Number waiting 9 weeks and over	**3**	**1**	**0**	**26**	**215**	**177**	**2**	**0**	**1**	**0**	**2**	**2**	**0**
	Total number waiting	983	995	1007	1024	978	886	789	616	736	796	748	723	761
Patients waiting for other treatment ***(excl. hearing aids)***														
	Number waiting 9 weeks and over	**4**	**4**	**0**	**8**	**15**	**27**	**6**	**0**	**1**	**0**	**0**	**1**	**1**
	Total number waiting	96	67	84	116	121	115	117	90	119	137	146	126	142

Table 17– Paediatric Audiology – Performance against standard

		Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15	Aug-15
Patients waiting for audiology assessment ***(first contact)***														
	Number waiting 12 weeks and ove	**0**	**0**	**0**	**0**	**0**	**0**	0	0	0	0	0	0	0
	Total number waiting	144	101	168	238	189	161	229	362	429	435	343	289	180
Patients waiting for other treatment ***(excl. hearing aids)***														
	Number waiting 6 weeks and over	**0**	**0**	**0**	**1**	**0**	**17**	29	22	16	0	23	11	15
	Total number waiting	6	8	7	38	47	50	71	69	56	38	27	60	67

12 IVF waiting times

12.1 NHS Lothian continues to perform well against the IVF standard of 90% of patients commencing IVF treatment within 12 months. At the end of July 2015, there were no patients waiting over 12 months. Publication of this provisional information has now commenced nationally.

12.2 NHS Lothian is using capacity in its centre at the Royal Infirmary to assist reducing IVF waiting times elsewhere in Scotland.[3] The figure for August 2015 is currently being prepared.

Table 18 – IVF Waiting List

	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Jan-15	Feb-15	Mar-15	Apr-15	May-15	Jun-15	Jul-15
Numbers Waiting	296	277	252	242	196	192	192	190	194	178	191	202	194
Numbers over 12 Months	2	2	2	2	3	2	0	0	0	0	0	0	0

13 Accident and Emergency 4 hour standard

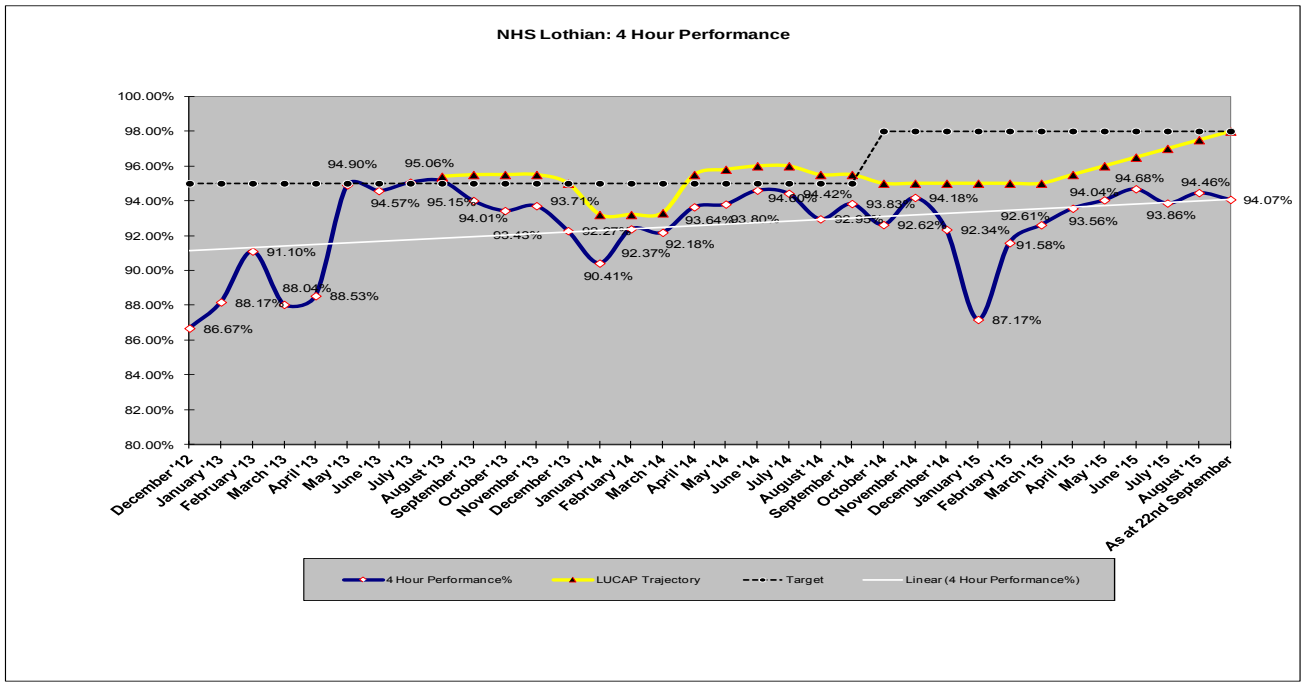
13.1 NHS Lothian's overall performance against the 4 hour standard for the month of August 2015 was **94.46**% (94.07% MtD as at 22nd September). Although July saw a slight decrease in performance (93.86%), there has been a general upward trend in performance since January 2015.

13.2 The performance across hospital sites for August 2015 was as follows (MtD as at 22 September figures are shown in brackets) and overall trend in performance is shown in graph below.

- RIE **93.96%** (94.36%)
- WGH **90.61%** (85.02%)
- StJ **95.28%** (96.98%)
- RHSC **99.01**% (98.64%)

Trend in A&E performance December 2012 – 22 September 2015

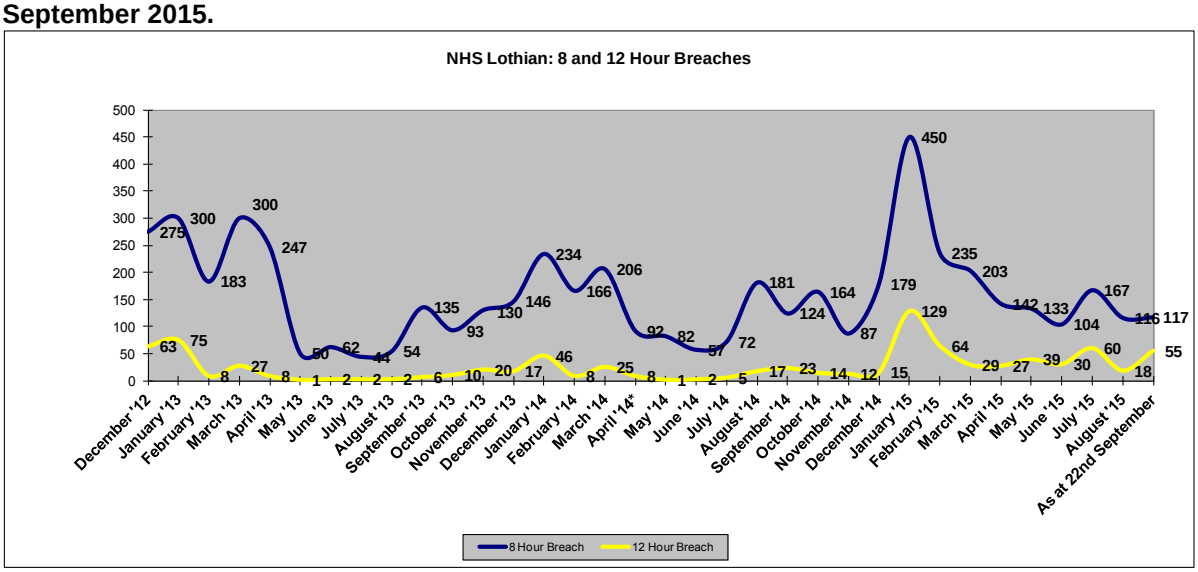
[3] Figures exclude those patients waiting to be seen on behalf of other centres.



8 and 12 hour breaches

13.3 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. In August 116 patients waited longer than 8 hours and 18 patients waited longer than 12 hours. However these figures have already been surpassed in the month to 22nd September.

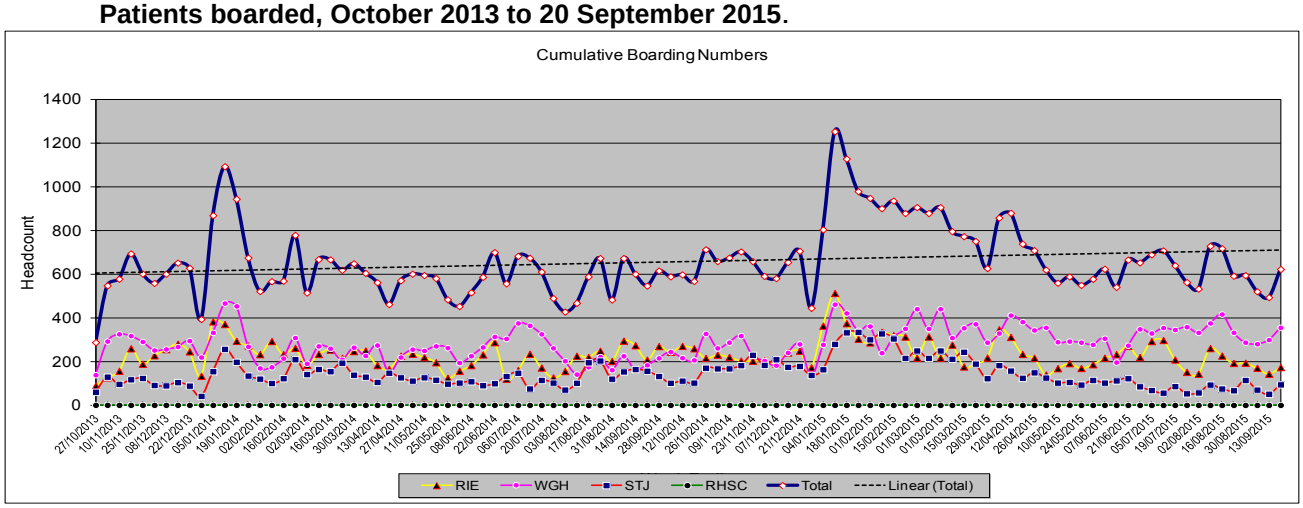
The number of patients who waited longer than 8 hours and 12 hours, Dec 2012 – 22 September 2015.



Boarding of patients

13.4 The following graph shows the number of patients 'boarded out' across the system on a weekly basis since October 2013. From a high of 1,252 at week ending 11 January 2015, the cumulative boarding number has reduced to 493 at week ending 13 September 2015. This increased again to 622 at week ending 20 September 2015.

Patients boarded, October 2013 to 20 September 2015.



14 Delayed discharges

14.1 Delayed discharges is covered in the paper on Performance Management, agenda item 1.3 Using the latest Monthly Census data, the overall number of delayed discharges across NHS Lothian was 237 (248 reported in July). [4]

Jim Crombie
Chief Officer; NHS Lothian
University Hospitals & Support Services
25 September 2015

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[4] ISD reportable delays - monthly census at 15 August 2015.

NHS LOTHIAN

Board Meeting
7 October 2015

Director of Finance

FINANCIAL POSITION TO AUGUST 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 5 months to August. The paper also gives consideration of the year-to-date position, 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 cumulative financial position at period 5 shows an overspend of £6.2m across all services, with an in-month improvement in financial performance showing an underspend of £0.7m in August;
- **Consider** the year end forecast position which does not yet give complete confidence that year end balance is achievable;
- **Support** the implementation of actions by Business Units to allow the deliver of a breakeven position;

3 Discussion of Key Issues

3.1 At period 5 of this financial year, NHS Lothian underspent by £687k, bringing the year to date position to £6,166k overspend against the Revenue Resource Limit. This position includes £3,890k of unachieved efficiency savings as well as the release of reserves flexibility of £4,323k reflecting a pro-rata share of total available reserves identified following the Quarter 1 review.

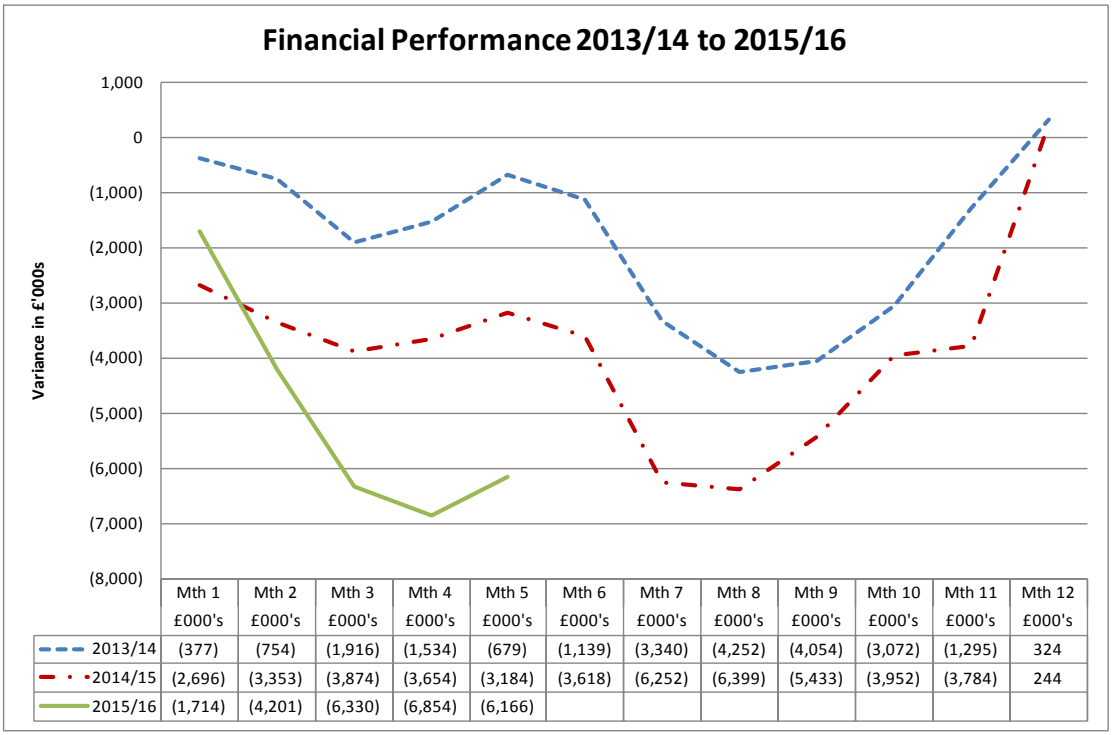
3.2 Table 1 shows a summary of the monthly trend and year to date position. A detailed analysis by expenditure type and business unit is shown in Appendix 1 and by operational unit in Appendix 2.

Table 1: Financial Position to 31 August 2015

	Mth 1 £000's	Mth 2 £000's	Mth 3 £000's	Mth 4 £000's	Mth 5 £000's	YTD £000's
Pay	(1,468)	(89)	(266)	(823)	571	**(2,075)**
Non Pay (including GP Prescribing)	846	(1,754)	(1,800)	(3,008)	55	**(5,661)**
Income	(48)	(169)	351	800	204	**1,138**
Efficiency Savings	(1,044)	(475)	(414)	(949)	(1,008)	**(3,890)**
Operational Position	**(1,714)**	**(2,487)**	**(2,130)**	**(3,980)**	**(178)**	**(10,489)**
Reserves Flexibility	0	0	0	3,458	865	**4,323**
Total Financial Position	**(1,714)**	**(2,487)**	**(2,130)**	**(522)**	**687**	**(6,166)**

3.3 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



	Mth 1 £000's	Mth 2 £000's	Mth 3 £000's	Mth 4 £000's	Mth 5 £000's	Mth 6 £000's	Mth 7 £000's	Mth 8 £000's	Mth 9 £000's	Mth 10 £000's	Mth 11 £000's	Mth 12 £000's
2013/14	(377)	(754)	(1,916)	(1,534)	(679)	(1,139)	(3,340)	(4,252)	(4,054)	(3,072)	(1,295)	324
2014/15	(2,696)	(3,353)	(3,874)	(3,654)	(3,184)	(3,618)	(6,252)	(6,399)	(5,433)	(3,952)	(3,784)	244
2015/16	(1,714)	(4,201)	(6,330)	(6,854)	(6,166)							

3.4 NHS Lothian is currently failing to deliver financial balance against its core budget, with some of the risks highlighted within the 15/16 financial plan materialising. In addition, cost pressures which were expected to be managed as part of the financial planning process continue to overspend.

The main areas reflecting ongoing pressure against budget are as follows:-

- **GP Prescribing** is reporting an overspend to date of **£3.8m** and is currently the single largest adverse variance. The year to date position is based on extrapolated data received to date on volumes and average prices. Although the latest volume information is lower than planned, average price remains higher than initially estimated at the start of the year. Despite the in month

performance, based on projected growth and future price changes, there is no significant improvement on the year-end forecast.

- The pay overspend is driven predominantly by **Nursing** costs, reporting an adverse variance to date of **£2.3m** (1.4%). The main areas contributing to this pressure sit within Edinburgh CHP and Acute Services.

- Acute services are reporting a £1.7m pressure in Nursing to date with the level of reliance on supplementary staffing continuing to be a significant factor contributing to the level of overspend. Ongoing bank and agency usage to cover high levels of sickness and other absence, provision of 1:1 care as a result of increased acuity and increased level of occupancy are the drivers for significant levels of supplementary staffing expenditure in excess of budget available from vacancies. Directorates have proposed recovery plans that involve a significant reduction in the use of supplementary staffing in order to recover the overall forecast position. Based on the month 5 positions, these plans appear to be having an impact, with Acute nursing costs in the month £182k better then the trend of the previous months.

- Within Edinburgh CHP the continued high use of supplementary staffing in Rehab, Older People and REAS services is driving the £908k overspend against the nursing budget. Work continues within these areas to assess 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. CAMHS patient acuity is beginning to improve and Older People's IPCC costs are expected to reduce as a result of the reconfiguration of Psycho-geriatric and IPCC Wards, therefore supplementary costs are not expected to continue at the same rate. As in Acute, the month 5 position on nursing has improved in the month with a reduction of £112k on the monthly trend to date.

- Whilst pay expenditure in month 5 is showing an improvement, non pay costs continue to run at levels significantly higher than budget available. Acute Services is reporting a £1.9m pressure; Edinburgh CHP is reporting a £748k overspend to date. The main drivers across these business units is medical supplies (£1.8m) and acute medicines (£1m). There are recovery plans being implemented following the Q1 review to bring the monthly spend back into balance through closer review and monitoring of high cost activity and use of high cost drugs.

Efficiency and Productivity

3.5 The total efficiency savings required to be delivered in 2015/16 to fund the planned investments within the Financial Plan is £31.3m. As at the end of August only £29.3m of plans have been identified by the Business Units, leaving an in year gap of £2.0m against target.

3.6 Of the £29.3m plans identified, £8.3m were targeted to be achieved by the end of month 5. With only £5.3m being achieved, a shortfall against plans of £3m is reported. A further £859k slippage gap arises due to a shortfall against the total target required, bringing the total year to date efficiency slippage to £3.9m. Of

this slippage, £3m relates to the Acute Services efficiency programme. Appendix 3 out sets the efficiency savings achieved to date in further detail.

3.7 Failure to make efficiency savings to the required £31.3m value presents the health board with a major challenge to deliver breakeven; therefore a significant focus is required to ensure both delivery of the agreed plans and the development of additional schemes to ensure the target is delivered in full both in-year and on a recurrent basis

4 Year end forecast – Quarter 1 Review

4.1 NHS Lothian has a statutory requirement to breakeven and following the first quarter of the financial year a detailed year-end forecast was undertaken to establish the projected year end outturn based on current information, and any subsequent actions required to ensure delivery of breakeven. A detailed paper on the Quarter 1 forecast was presented and considered at the August Finance and Resources Committee.

4.2 The Quarter 1 review process indicated that the Financial Plan target of breakeven is not currently achievable without the delivery of a number of high and medium risk actions to reduce expenditure, and reducing any flexibility for future years.

4.3 At the start of the Quarter 1 review process an initial assessment of the year-end outturn projected an overspend of £13.693m. This included:

- An overspend of £27.88m within the Business Units, including a £9.6m shortfall in efficiency savings;
- An estimated £5m of additional costs not included in the operational position, including the impact of parental leave on operational budgets;
- Non-recurrent flexibility of £23.3m to offset the overspend position;
- Non-achievement of funding streams assumed within the financial plan totalling £4.121m.

4.4 Following the initial forecast assessment and subsequent meetings with Business Unit leads actions were agreed to reduce expenditure. From this, a total of £8.858m of management actions were identified and risk assessed, and within this £2.677m were classified as low risk. At this stage, only the low risk actions are included within the updated forecast, bringing the revised projected outturn to £11.016m overspent.

Table 3 : NHS Lothian Quarter 1 Forecast

	£k	£k
Initial Operational Q1 Forecast	**(27,880)**	
Further potential commitments	(5,000)	
Reserves & N/R Flexibility	23,308	
Non-delivery of Financial Plan funding assumptions	(4,121)	
Initial Q1 Forecast		**(13,693)**
Local Management actions -		
Low Risk		2,677
Revised Q1 Forecast		**(11,016)**
Additional actions in support of achieving financial balance		
High Risk Management actions	3,702	
Medium Risk Management actions	2,479	
Additional potential flexibility Primary Care Investment	1,000	
PPRS funding	1,432	
Proposed capital brokerage	2,689	
Total additional actions		**11,302**
Potential Q1 Forecast Outturn		**286**

4.5 A number of additional actions have been identified to reduce this projected deficit. Inclusion of high and medium risk management actions as shown above would provide a benefit of £3.702m and £2.479m respectively. In addition, there remains further potential to utilise additional Primary Care funding due but not yet received to support pre-existing financial plan commitments, although this opportunity is recognised as high risk. Further, the realisation of financial plan funding that is not currently assumed and which is also considered a high risk opportunity has also been shown as a potential source to reduce the projected overspend. This includes funding of £1.432m and Capital to Revenue funding of £2.689m, although the latter is presented as brokerage in anticipation of asset sales in the next financial year. Assurance that these asset sales will be completed in 2016/17 is essential.

4.6 Delivery of these actions at this level would allow the achievement of financial balance, with the board able to deliver a moderate underspend of £286k at the year-end. However, the level of risk associated with these actions require that these are shown as 'below-the-line' opportunities with further work required to crystallise these savings.

4.7 The Period 5 in-month underspend of £688k does indicate that there are some signs of improvement in financial performance across all areas and the year to date position is broadly in line with projections laid out as part of the Quarter 1 review process. The progress against Business Unit projections is shown in Table 4.

Table 4 – Period 5 comparison to Q1 projections

	M05 YTD VARIANCE £k	Q1 FORECAST VARIANCE £k
University Hosp Support Serv	(4,730)	(10,981)
Edinburgh Chp	(3,893)	(5,583)
East Lothian Chp	(521)	0
Midlothian Chp	(120)	0
West Lothian Chp	(558)	(132)
Primary Care Other	(12)	0
Facilities And Consort	202	(109)
Strategic Services	101	1,819
Corporate Services	189	462
Inc + Assoc Hlthcare Purchases	(1,939)	(4,498)
Total Operational Position	**(11,280)**	**(19,022)**
Reserves & N/R Flexibility	5,114	23,308
Additional potential flexibility		1,000
Further anticipated commitments		(5,000)
TOTAL NHS LOTHIAN	**(6,166)**	**286**

5 Risks and Assumptions

5.1 At this stage, elements of the Financial Plan funding still require to be confirmed. There is £33m assumed Scottish Government allocations included within the annual budget which has not yet been received or confirmed. Just over £4m remains an elevated risk, including assumptions around the delivery of capital to revenue resource which is dependent on asset sales.

5.2 In addition, the ability for the board to deliver against other operational targets, including waiting times and delayed discharges as well as the unknown impact of winter may yet impact adversely on the outturn position.

5.3 The risks in relation to the agreed financial plan were originally set out with some risks now materialising and contributing to the current projected overspend. A detailed list of these risks was considered at Finance and Resources Committee in August. In addition there are now further risks associated with the delivery of Business Unit financial recovery plans and are highlighted in this paper, and will be set out in further detail for the next Finance and Resources committee in November.

6 Risk Register

6.1 The Risk register will be considered and any changes will be made based on the outcome of this.

7 Health and Other Inequalities

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

8 Involving People

8.1 The financial results and position of the Board is published annually on the FOI publications pages. The Board also shares the monthly financial position with local partnership forums and makes its monthly monitoring returns available under non routine FOI requests from other stakeholders.

9 Resource Implications

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

Susan Goldsmith
Director of Finance
25 Sept 2015
Susan.goldsmith@nhslothian.scot.nhs.uk

Appendix 1: NHS Lothian Income & Expenditure Summary 31 Aug 2015
Appendix 2: NHS Lothian Summary by Operational Unit to 31 Aug 2015
Appendix 3: NHS Lothian Efficiency & Productivity Summary at 31 Aug 2015

APPENDIX 1

NHS Lothian Income & Expenditure Summary to August 2015

Description	Annual Budget (£k)	YTD Budget (£k)	YTD Actuals (£k)	YTD Variance (£k)	Period Variance (£k)
Medical & Dental	227,067	96,426	96,830	(403)	506
Nursing	376,712	156,866	159,139	(2,273)	(276)
Administrative Services	82,532	34,019	33,524	494	264
Allied Health Professionals	60,304	25,410	24,698	711	259
Health Science Services	36,322	15,041	14,792	249	(35)
Management	10,098	4,279	4,002	277	16
Support Services	50,360	21,216	22,258	(1,042)	(170)
Medical & Dental Support	6,205	2,585	2,518	67	14
Other Therapeutic	23,765	10,124	10,221	(98)	(3)
Personal & Social Care	2,902	1,181	1,147	34	(2)
Other Pay	(3,729)	(4,398)	(4,312)	(86)	(1)
Emergency Services	15	7	13	(6)	0
Pay	**872,555**	**362,755**	**364,831**	**(2,075)**	**571**
Drugs	115,643	47,547	48,577	(1,031)	(174)
Medical Supplies	83,339	35,438	37,202	(1,764)	(266)
Maintenance Costs	5,681	2,322	2,812	(490)	(271)
Property Costs	40,393	16,213	15,156	1,057	264
Equipment Costs	20,551	8,771	9,342	(571)	(417)
Transport Costs	9,844	4,278	4,614	(336)	(65)
Administration Costs	159,358	31,185	30,015	1,170	464
Ancillary Costs	14,870	6,229	6,129	100	23
Other	19,064	(5,652)	(6,088)	436	177
Service Agreement Patient Serv	85,989	39,930	40,784	(854)	(114)
Non-Pay	**554,731**	**186,260**	**188,543**	**(2,283)**	**(380)**
Gms2 Expenditure	114,259	46,206	45,720	486	74
Ncl Expenditure	3	1	(34)	36	(0)
Other Primary Care Expenditure	0	0	54	(54)	(10)
Pharmaceuticals	134,032	58,075	61,919	(3,844)	374
Primary Care	**248,294**	**104,282**	**107,658**	**(3,376)**	**437**
Fhs Non Discret Allocation	(2,177)	(1,267)	(1,259)	(8)	(2)
Bad Debts	0	0	4	(4)	0
Other	**(2,177)**	**(1,267)**	**(1,256)**	**(11)**	**(1)**
Income	(1,699,957)	(111,719)	(112,856)	1,138	204
Income	**(1,699,957)**	**(111,719)**	**(112,856)**	**1,138**	**204**
Rrl	0	(24)	(32)	9	0
Revenue Resource Limit	**0**	**(24)**	**(32)**	**9**	**0**
CORE POSITION	**(26,556)**	**540,289**	**546,888**	**(6,599)**	**832**
Savings Target Non-Pay	(3,889)	(3,889)	0	(3,889)	(1,008)
Additional Reserves Flexibility	4,323	4,323	0	4,323	865
TOTAL	**(41,864)**	**540,722**	**546,888**	**(6,166)**	**688**

NB. The above table relates to Core Services only. There is £41.864m of Non Core Budget not shown above that balances the Annual Budget to zero.

APPENDIX 2

NHS Lothian Summary by Operational Unit to August 2015

Description	University Hosp Support Serv (£k)	Edinburgh Chp (£k)	East Lothian Chp (£k)	Midlothian Chp (£k)	West Lothian Chp (£k)	Corporate Services (£k)	Facilities And Consort (£k)	Strategic Services (£k)	Inc + Assoc Hlthcare Purchases (£k)	Primary Care Other (£k)	Reserves (£k)	Total (£k)
Annual Budget	**647,467**	**305,296**	**86,886**	**53,209**	**114,538**	**87,624**	**137,765**	**9,648**	**(1,551,777)**	**0**	**67,480**	**(41,864)**
Medical & Dental	581	84	(74)	36	(160)	(712)	(6)	(152)	0	0	(0)	**(403)**
Nursing	(1,737)	(908)	269	141	(152)	149	(15)	(20)	0	0	0	**(2,273)**
Administrative Services	74	58	(12)	(15)	(109)	565	(38)	(25)	0	(3)	0	**494**
Allied Health Professionals	(127)	124	11	144	56	(72)	(0)	(1)	0	(6)	583	**711**
Health Science Services	129	124	6	(9)	37	(23)	0	(16)	0	0	0	**249**
Management	127	96	(1)	30	1	58	(38)	4	0	0	0	**277**
Support Services	(131)	18	(27)	0	(18)	(408)	(475)	(1)	0	0	0	**(1,042)**
Medical & Dental Support	(25)	(1)	0	0	64	29	0	0	0	0	0	**67**
Other Therapeutic	49	17	25	(8)	(178)	2	0	(5)	0	0	0	**(98)**
Personal & Social Care	(27)	(16)	(6)	0	0	84	(0)	0	0	0	0	**34**
Other Pay	(23)	(22)	(4)	(4)	0	(17)	(15)	0	0	0	0	**(86)**
Emergency Services	0	0	0	0	3	(9)	0	0	0	0	0	**(6)**
Pay	**(1,111)**	**(425)**	**186**	**316**	**(457)**	**(354)**	**(587)**	**(217)**	**0**	**(9)**	**582**	**(2,075)**
Drugs	(886)	(51)	(100)	(19)	(60)	94	(1)	(217)	0	0	209	**(1,031)**
Medical Supplies	(1,131)	(459)	(93)	(33)	(55)	28	(32)	12	0	0	0	**(1,764)**
Maintenance Costs	(251)	(77)	(11)	(1)	(24)	(74)	(47)	(5)	0	0	0	**(490)**
Property Costs	(11)	0	(2)	(7)	29	17	1,036	(6)	0	0	0	**1,057**
Equipment Costs	(394)	(70)	(66)	(23)	27	206	(166)	(71)	(14)	0	0	**(571)**
Transport Costs	(163)	(29)	(26)	10	47	(53)	(122)	6	(6)	0	0	**(336)**
Administration Costs	760	7	(29)	3	42	(206)	105	489	1	(2)	(0)	**1,170**
Ancillary Costs	63	(4)	8	20	9	(13)	19	(0)	0	(0)	0	**100**
Other	117	30	(52)	0	10	345	(13)	0	0	0	0	**436**
Service Agreement Patient Serv	(42)	(94)	140	0	(30)	269	0	444	(1,542)	0	0	**(854)**
Non-Pay	**(1,939)**	**(748)**	**(232)**	**(49)**	**(5)**	**613**	**779**	**653**	**(1,561)**	**(2)**	**209**	**(2,283)**
Gms2 Expenditure	(6)	255	44	3	194	(2)	(1)	0	0	0	0	**486**
Ncl Expenditure	35	(0)	1	0	0	(1)	0	0	0	0	0	**36**
Other Primary Care Expenditure	(54)	0	0	0	0	0	0	0	0	0	0	**(54)**
Pharmaceuticals	(1)	(1,965)	(520)	(458)	(901)	0	0	0	0	0	0	**(3,844)**
Primary Care	**(26)**	**(1,710)**	**(475)**	**(455)**	**(707)**	**(3)**	**(1)**	**0**	**0**	**0**	**0**	**(3,376)**
Fhs Non Discret Allocation	0	(8)	0	0	(1)	1	0	0	0	0	0	**(8)**
Bad Debts	(5)	(0)	0	0	(0)	(0)	0	2	0	0	0	**(4)**
Other	**(5)**	**(8)**	**0**	**0**	**(1)**	**1**	**0**	**2**	**0**	**0**	**0**	**(11)**
Income	1,301	(84)	(1)	10	184	44	124	(62)	(378)	0	0	**1,138**
Income	**1,301**	**(84)**	**(1)**	**10**	**184**	**44**	**124**	**(62)**	**(378)**	**0**	**0**	**1,138**
Rrl	0	0	0	0	0	9	0	0	0	0	0	**9**
Revenue Resource Limit	**0**	**0**	**0**	**0**	**0**	**9**	**0**	**0**	**0**	**0**	**0**	**9**
CORE POSITION	**(1,781)**	**(2,975)**	**(521)**	**(179)**	**(986)**	**310**	**315**	**375**	**(1,939)**	**(12)**	**791**	**(6,599)**
Savings Target Non-Pay	(2,949)	(917)	(1)	59	428	(121)	(113)	(274)	0	0	0	**(3,889)**
Additional Reserves Flexibility	0	0	0	0	0	0	0	0	0	0	4,323	**4,323**
TOTAL	**(4,730)**	**(3,893)**	**(521)**	**(120)**	**(558)**	**189**	**202**	**101**	**(1,939)**	**(12)**	**5,114**	**(6,166)**

NB. The above table relates to Core Services only. There is £41.864m of Non Core Budget not shown above that balances the Annual budget to Zero.

APPENDIX 3

NHS Lothian Efficiency and Productivity Summary as at Month 5 2015/16

Business Unit	Total Recurring Target	Current Year Plans	Gap on In Year Plans	Year to Date Position April - August					Full Year Position		
				Plans Phased to Date	Actual Delivery	Slippage on Plan	Gap Phased to Date	Total Slippage	Total Recurring Target	Full Year Plans Identified	Gap on Recurring Plans
	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k	£k
East Lothian Chp	465	1,203	(738)	355	29	326	(307)	18	465	1,402	(937)
Midlothian Chp	447	724	(277)	156	83	73	(115)	(42)	447	996	(549)
Edinburgh Chp	4,658	3,761	897	1,370	747	623	374	996	4,658	4,131	527
West Lothian Chp	377	1,334	(957)	410	408	2	(399)	(396)	377	1,342	(965)
Prescribing	1,298	3,325	(2,027)	1,090	390	700	(845)	(145)	1,298	3,325	(2,027)
Acute Hospital Services	15,846	11,223	4,622	3,515	2,492	1,023	1,926	2,949	15,846	12,469	3,376
Facilities & Consort	3,208	3,242	(34)	326	198	127	(14)	113	3,208	4,089	(881)
Total Business Units	**26,298**	**24,812**	**1,486**	**7,222**	**4,347**	**2,874**	**619**	**3,495**	**26,298**	**27,754**	**(1,455)**
Corporate Services & Strategic Programmes											
eHealth	1,355	912	443	199	143	56	185	241	1,355	943	412
Finance	408	1,411	(1,003)	171	336	(165)	(418)	(583)	408	411	(3)
Human Resources & Communications	593	611	(18)	236	142	94	(8)	86	593	653	(60)
Medical Director	121	122	(1)	51	51	0	(1)	(1)	121	122	(1)
Nursing	226	227	(1)	85	94	(9)	(0)	(9)	226	245	(19)
Pharmacy	1,012	390	622	162	53	109	259	369	1,012	390	622
Planning	178	150	28	58	54	4	12	16	178	158	20
Public Health	498	501	(3)	53	49	4	(1)	2	498	501	(3)
Strategic Programmes	552	124	428	62	0	62	178	240	552	124	428
Strategic - Other	82	0	82	0	0	0	34	34	82	0	82
Total Corporate Depts & Strategic Programmes	**5,024**	**4,448**	**577**	**1,078**	**922**	**155**	**240**	**395**	**5,024**	**3,546**	**1,478**
Total	**31,323**	**29,260**	**2,063**	**8,299**	**5,270**	**3,029**	**859**	**3,890**	**31,323**	**31,300**	**23**

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NHS LOTHIAN

2.6

Board Meeting
7 October 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 available to Board members at the meeting.

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

• National Medical Training Overview – within Scotland only 48% of entrants to medical schools are from Scotland. • More doctors complete foundation training than there is core/specialty training places, however 34% in Scotland (41% in Lothian) choose not to immediately enter. • Up to 40% of doctors in CT2 training posts are choosing not to progress immediately to ST3 and are either not in UK training or are completing other Higher Specialty Training such as clinical development fellows. • Maternity leave represents the largest proportion of gaps in higher specialty training – 204 across Scotland per year. • Of the 19,977 doctors currently on the GMC register who graduated from Scottish medical schools, 11,716 (59%) are working in Scotland, and 8,261 (41%) are working elsewhere in the UK	3.21
• Out of 64wte consultant posts for which the recruitment process has concluded in this financial year only 52.5% were filled with 26% receiving no applications and the remainder either applications that were unsuitable or where candidates withdrew.	3.2.3
• Interim arrangements remain in place to cover the Peri-natal Mental Health Unit until December. Current extensive recruitment campaign will remain open until 30th October to allow for a wide range of recruitment options to be progressed.	3.2.5.1
• Interim arrangements remain in place to sustain the Regional Eating Disorder until current consultant recruitment in complete.	3.2.5.2
• In addition to the £1.1m invested in General Practice through the financial planning process a further £836k of local funding has been proposed to address difficulties associated with GP recruitment and retention and increasing workloads in primary care. Each Health and Social Care Partnership is developing risk registers for their practices and the Primary Care Joint Management Team is currently considering a more formalised framework of support for practices in difficulty.	3.3
• GMC Survey - The quality of training experience was considered by 88% of trainees to be either excellent or good. When asked to describe their post to a friend thinking of applying 96% described it as either excellent or good.	3.4

Nick McAlister
Head of Workforce Planning
18 September 2015

NHS LOTHIAN

7 October 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 Note the national training overview which details the progression rates between various stages in medical training and associated pressures this has for services in Scotland and Lothian.

2.2 Acknowledge the challenges that remain with the recruitment of trained doctors and the potential financial impact this can have in relation to workforce alternatives.

2.3 Acknowledge that whilst comprehensive recruitment measures have not yet concluded within Perinatal Mental Health service and the Regional Eating Disorder Unit robust contingency arrangements are in place.

2.4 Note the national and local pressures that exist within general practice associated with availability and reducing training programme fill rates and acknowledge the support being provided to practices by NHS Lothian including the development of framework of support measures.

2.5 Note the very positive feedback from trainees around both their service and training experiences and the establishment of a quality control team to support clinical teams through proactive intelligence gathering.

3 Discussion of Key Issues

3.1 Background

Since April 2013 a paper has been brought to the Board to provide members with an understanding of where NHS Lothian faces pressures within the medical workforce. Many of the pressures that NHS Lothian faces are national and in some cases UK-wide.

In February 2015 NHS Lothian introduced a Clinical Change Forum which brings together clinicians from across NHS Lothian to discuss the issues and ensure clinical engagement and leadership. It aims to change practice, improve outcomes, reduce waste and variation by developing our approach to individual patient care and driving quality. Following three further meetings and input from Dr Brent James a leading expert in healthcare quality improvement from Intermountain Healthcare in the USA there is a clear need to focus on a total Clinical Quality Approach to deliver ‘high quality, safe and person centred care at the most affordable cost’.

In keeping with this approach there will be an increased focus on appraising members of the performance of our recruitment processes and highlighting the financial impact associated with measures required to support service sustainability.

3.2 Progress in addressing key medical workforce risks

3.2.1 National Medical Training Overview

Medical school entrants and progression to foundation training

Within Scotland only 48% of entrants into medical schools are from Scotland, with 26% from the rest of UK, 6% from other EU countries and 20% from the rest of the world. There is currently an oversupply of leavers from Medical School and consequently there are 80 temporary training places across both foundation years (FY). Approximately 80% of foundation trainees are from the UK and 20% from overseas.

Transition from foundation training to core training (CT)/specialty training (ST) year 1

The output from foundation programmes in both the UK and Scotland is insufficient to meet the UK requirement for training places at CT1/ST1 level.

In 2014 in Scotland 790 doctors completed FY2 and were therefore eligible to apply for a CT/ST training place. In Scotland there were 752 CT1/ST1 posts (Source NES) which is less than the number of eligible trainees and therefore represents a relatively balanced position. However a large proportion (34%) of trainees from Scottish schools who complete FY2 do not go straight into CT1 or ST1 and within Edinburgh the level is 41.1%, the highest level in Scotland.

Whilst the 55% (148) of these FY2 graduates enter CT/ST 1 training within 3 years 45% (121) do not, leaving an annual deficit of 80 CT1/ST1 doctors.

Transition from CT2 to ST3

Up to 40% of doctors in CT2 training posts are choosing not to progress immediately to ST3 and are either not in UK training or are completing other Higher Specialty Training such as clinical development fellows. This is similar to the pattern before Modernising Medical Careers was introduced, however the numbers leaving UK training appear to be increasing.

Recruitment into Specialty Training Programmes

Despite the high proportion of trainees choosing to take time out from training there remains a high fill rate - the 2015 recruitment round has so far filled 2542 of 2754 (92%) of vacant posts, and the overall fill rate of the establishment of training posts is currently 5524 of 5755 (96%). This is partly because whilst significant numbers do leave training the majority do rejoin training and approximately 30% of successful applicants for ST3 posts have come from trainees have been out of a formal training programme in the preceding 12 months. Whilst intelligence around what out of programme trainees have been doing is limited it is clear that individuals are choosing their own personalised training pathway which does not reflect the current ‘official’ training programmes albeit they have been employed in roles such as clinical

development fellow posts which have provided them with high quality training and experience.

Whilst overall specialty fill rates are on the whole high in Scotland 92% this still represents 230 unfilled posts, with over half (134) located within the following areas:

	NHS Scotland
Acute Medicine	4/21 (19%)
Emergency Medicine	5/21 (23%)
GP	216/305 (71%)
Psychiatry	42/54 (78%)

Within these specialties however the SE region Deanery has a significantly better fill rate then the rest of Scotland. The SE region along with other Boards is however heavily affected by the loss of trainees to out of programme is far more significant as detailed below:

Unfilled Posts	Acting Up	Career Break	OOP Experience	Maternity/ Paternity	OOP Research	Sick	OOP Training	Total
230	22	14	22	204	176	13	39	720
32%	3.05%	1.9%	3.05%	28.3%	24.4%	1.8%	5.4%	100%

NHS Scotland Gaps – NES May 15

The increase in trainees going out of programme has increased overall substantially from 195 in 2010/11 to 430 in 2014/15, within this maternity leave increasing from 120 to 223 within this time period.

Maternity/Paternity represents the largest proportion of gaps and impacts most heavily in those specialties with the highest proportion of female trainees such as O&G and paediatrics. It is however becoming increasingly difficult to fill gaps other than by agency locums upon which there is a heavy reliance on in a number of specialties. Leaving training to undertake research also represents a significant cause of gaps, however it also represents a good quality training opportunity which helps make the SE region attractive when filling HST posts.

Cross border flows

Whilst it is difficult to accurately scope the extent of cross borders flow of doctors currently the GMC register shows of the 19,977 doctors with a primary medical qualification currently on the GMC register and who graduated from Scottish medical schools, 11,716 (59%) are working in Scotland, and 8,261 (41%) are working elsewhere in the UK. In contrast, of the 106,455 who graduated from an English medical school, 100,731 (95%) are working in England. Of those doctors on the specialist register, 52% of Scottish graduates are working in Scotland, and 45% of Scottish graduates are working in England. Whilst this data is not current it points to a need to consider recruiting a higher proportion of Scottish applicants into medical schools and ensuring that in implementing new training programmes they should incorporate flexibility reflecting the needs of individuals.

One of the biggest difficulties both nationally and locally is that the areas where there are most capacity pressures associated with a growing and ageing population (acute

medicine, emergency medicine, general practice, medicine for the elderly and Psychiatry) are the areas with the highest proportion of gaps and lowest fill rates.

3.2.2 NHS Lothian Medical Workforce Establishment

As with other job families there is an overall medical workforce baseline budget establishment, the following table details how this is distributed across the medical workforce.

Row Labels	2015/16 Establishment	YTD WTE Average	Month 4 WTE in-post
Junior Medical			
Foundation Yr1	134.00	141.56	138.00
Foundation Yr2	143.00	162.92	172.25
Locum Fy1	5.00	1.70	1.01
Locum Fy2	0.00	11.96	14.35
Specialty Registrar (Str)	781.53	680.01	676.02
Students	0.00	2.00	2.00
Junior Medical Total	**1063.53**	**1000.14**	**1003.63**
Medical - Dental			
Senior Medical - Dental	43.87	44.34	43.62
Medical - Dental Total	**43.87**	**44.34**	**43.62**
Senior Medical			
Appraisal Advisor	0.50	0.35	0.35
Appraiser	4.61	4.25	4.25
Associate Specialist	54.90	56.46	56.65
Asst Clin Director	3.61	2.69	2.00
Clinical Director	1.00	1.00	1.00
Consultant	961.62	904.80	905.01
Locum Consultant	22.02	28.02	26.20
General Practitioners	38.96	38.11	38.26
Practitioners	24.11	33.98	37.75
Specialty Doctors	138.16	117.43	116.90
Staff Doctor	2.43	0.20	0.20
Senior Medical Total	**1251.92**	**1187.27**	**1188.57**
Grand Total	**2359.32**	**2231.75**	**2235.82**

These establishments represent the baseline funded staffing budgets within each service area. It is clear that in a number of instances as has been detailed within previous Board papers there remain areas where it is not possible to recruit.

Within the training grade workforce where a post cannot be filled Boards are able to use the unspent salaries to pay for alternative staffing to cover rota gaps. This may represent posts such as Clinical Development Fellows which are not established posts, they are however employed to provide cover for a range of areas and reduce reliance on short term forms of supplementary staffing. This funding is also used for short term supplementary staffing to cover gaps in rotas or posts where it is not possible to fill on a substantive basis. Where trainee posts are filled as part of the annual recruitment process on a less than full-time basis the unspent funding remains with NES and may be used to fund new specialty training posts at a national level. This however potentially leaves a funding pressure for Boards to pick up.

3.2.3 Vacancies under recruitment

As highlighted in the previous section NHS Lothian seeks to recruit to vacancies when they arise and where it is not possible alternatives are used to sustain services. The following table details trained doctor recruitment in the period April 2015 to the end of August 2015 where the recruitment process has concluded detailing both whole time equivalent and specialty.

Speciality	Fully Filled	Partially filled 1 of 2	Partially filled 1 of 3	Partially filled 2 of 4	0 applicants	Not filled	Pending	Candidate Withdrew	Grand Total
Acute Medicine					1.0			1.0	2.0
Acute Medicine & Stroke Medicine	1.0								1.0
Anaesthesia				2.0 from 4.0	2.0				4.0
CAMHS	0.5								0.5
Community Child Health						1.0			1.0
Dental	0.1								0.1
Dental (Paediatric)	0.9								0.9
Dermatology	1.0								1.0
Forensic Psychiatry	0.8								0.8
Gastroenterology							1.0		1.0
General Adult Psychiatry	2.0				1.0				3.0
General and Upper GI Surgery x 2		2.0 from 4.0							2.0
General Medicine	1.0							1.0	2.0
GP	1.4								1.4
GP Performers list					0.0				0.0
Haematology	1.0								1.0
Histopathology					1.0				1.0
IPCU Psychiatry	0.5								0.5
Medicine of the Elderly			1.0 from 3.0		3.0				4.0
Microbiology	1.0								1.0
Obs and Gynae	1.0								1.0
OHS Sessions					0.0				0.0
Old Age Psychiatry	1.0				2.0				3.0
Ophthalmology (DMO)					1.0				1.0
Ophthalmology (Glaucoma)	1.0								1.0
Ophthalmology (Paediatric)	1.0								1.0
Oral Medicine					1.0				1.0
Paedatric A&E	1.0								1.0
Paediatric Anaesthesia						1.0			1.0
Paediatric Intensive Care					1.0				1.0
Perinatal Psychiatry					1.4				1.4
Plastic Surgery	2.0							1.0	3.0
Psychiatry LD	2.6				1.0				3.6
Public Dental (Special Care)	0.9								0.9
Radiologist	2.0								2.0
Radiology/Breast Screening	0.8								0.8
Rehab Psychiatry					1.0				1.0
Rheumatology	1.0								1.0
Salaried GP with Special Interest in Addictions	1.0								1.0
Transplant	2.0								2.0
Transplantation / Renal Medicine						1.0			1.0
Vascular surgery	1.0								1.0
Grand Total	29.6	4.0	3.0	4.0	16.4	3.0	1.0	3.0	64.0

During this period total of 64 wte of posts were advertised for recruitment, 46% were fully filled, with 11wte only partially filled by 4 wte, providing a combined fill rate of 52.5%. Of the 47.5% that were unfilled 16.4 wte (26% of total) received no applicants with the reminder receiving applicants that were either not suitable or withdrew prior to commencement. Where posts are not filled areas may seek to recommence recruitment immediately or delay recruitment until there are likely to be individuals completing their specialty training and therefore eligible to apply for a consultant post.

Supplementary Staffing Expenditure

One of the key means for filling gaps is through utilising staff bank and agency alternatives. The following table details expenditure on both elements between April 15 and August 15.

Service Area	April to August 15 Agency Expenditure	April to August 15 Bank Expenditure
Acute Divisional Management	128,532	644,609
Diagnostics, A+T, Crit Care	12,304	383,715
E/L Chp - Community Services	67,541	480
Edinburgh Chp - Core Services	8,460	3,186
Facilities Management	5,991	34,668
M/L Chp - Community Services	2,605	541
Pharmacy	5,906	1,860
Reas	65,983	108,481
Reas Hosted Services	5,360	106,861
Royal Infirmary Edinburgh Site	71,088	33,377
St Johns Hospital Site	338,543	6,530
W/L Chp - Community	407,565	44,203
Western General Hospital Site	245,005	21,234
Women + Children Services	102,827	315,879
Grand Total	**1,467,709**	**1,705,623**

There are also other forms of supplementary staffing that are used including waiting list initiative payments where NHS Lothian staff are paid for undertaking additional activity over and above their contracted hours to help meet and sustain treatment time guarantees and reduce reliance on the external capacity. Expenditure in April to August is detailed in the following table.

Row Labels	April to August Waiting List Initiative payments
Anaesthetics & Theatres	4,821
Children	64,594
Critical Care	1,179
Director Of Nursing	262,321
Imaging - Radiology	78,354
Laboratories	8,248
Ophthalmology	27,015
Rie Medicine	9,446
Rie Surgery	62,223
Sjh Medicine	3,721
Sjh Surgery	217,218
Wgh Medicine	81,715
Wgh Surgery	182,761
Women	43,808
Grand Total	**1,047,424**

As part of the clinical quality work services will be supported to their review service models in areas of high pressure and expenditure. This pathway work will be supported by the Clinical Quality Management Leads supported by appropriate expertise from the Quality Program support team and reporting within the new corporate management structure.

3.2.4 Roodlands Hospital

The previous Board paper set out the pressures that were being faced in filling consultant posts at Roodlands and the various measures in place to try sustain services in the interim. This further recruitment effort has not yet concluded and details will provided in the next Board paper of the outcome.

3.2.5 Psychiatry

The June and August Board papers provided detail on the increasing difficulties that are being faced in filling consultant posts across Scotland and also the very poor fill rates in higher specialty training programmes. It also set out where NHS Lothian is facing difficulty in filling posts at St John's Hospital:

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

As detailed in the previous Board paper the service has been unsuccessful in recruiting to vacant consultant posts which have subsequently been reviewed to attract as many interested and suitably qualified applicants as possible.

These vacancies covering General Adult, Rehabilitation and Perinatal have been re advertised. The General Adult post has been interviewed and an offer has been made subject to completion of pre-employment checks. The other posts have been advertised with an extended closing date through to 31 October to cover the wider promotional events. This includes:

- Targeted advertising campaign and recruitment event in Ireland
- Participation in a BMJ recruitment event in London
- Targeted on-line advertising and promotion

To date there has been a small level of interest shown, it is hoped however that these additional measures will help attract increased awareness and interest.

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.

The interim consultant arrangements are now fully active. There are 3 Consultant Psychiatrists covering the 1.4 sessions across both in-patient Mother and Baby Unit and the Lothian Community Perinatal Service. This includes a consultant from NHS

Borders who 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 continues to be fragile until we are able to make substantive appointments. We will be keeping these arrangements under close review to ensure we are able to provide a safe service.

Plans are in place to maintain interim cover to the end of December 2015 to support the active recruitment process.

3.2.5.2 Regional Eating Disorders Unit (REDU) at St John's Hospital

The previous Board paper set out the measures that are being taken by the service to implement the recommendations from a review of the service undertaken the Royal College of Psychiatrists.

Following the review a part-time vacancy has been converted to full time to provide enhanced capacity. This post will both lead the clinical team and also the development of a psychological model. The job description of the post has been finalised and the recruitment process is now underway with the establishment of an interview panel and date.

To provide safe and sustainable consultant psychiatric cover whilst a replacement is recruited the following interim arrangements have been put in place from the 6th July 2015:

- Consultant support and responsibility is currently being provided by a consultant psychiatrist from the Anorexia Nervosa Intensive Treatment Team, based at The Royal Edinburgh Hospital, who is working two additional sessions. This cover arrangement is in place and is proving effective in ensuring appropriate senior medical cover for the unit. The full time specialty-grade psychiatrist is also in place providing medical cover.

- Consultant physician support for the unit has been agreed with the medical team at St John's Hospital

- Out of hours cover, 5pm-9am and weekends, will continue to be provided by the psychiatry department at St John's Hospital.

Partner Boards are being kept fully informed through the SEAT Regional Planning Group. A Regional Clinical Governance Group has been established to review local and regional governance systems and processes.

3.3 General Practice

The June and August Board papers and separate primary care Board paper highlighted the challenges that are being faced within primary care and GP practices.

The challenges are clearly increasing within Lothian and Scotland as a whole and there are increasing numbers of practices that require some support and in some cases special measures are required which may include the practice being taken on by the health Board. As detailed in previous papers one of the most significant issues for practices is the lack of GP workforce availability, which is likely to be a continuing trend as only c78% of GP training places were filled in both Scotland and the UK during the most recent recruitment exercise. This represents a 10% reduction on 2014.

When these pressures are taken together with the demographic changes that are emerging in terms of a growing and ageing population there a clear need for a framework of support that can be provided for practices that are experiencing difficulties. Currently 10 practices are being provided with support to varying degrees, with a 25 practices out of a total of 125 having to apply restrictions to their list size to protect the quality of service provided to existing patients.

An initial investment of circa £1.1m in revenue for primary care and community health services was included in NHS Lothian's 2015-16 financial plan in the following areas:

Strategic Priority Investment	Investment
Domiciliary Phlebotomy	£300k
Type 2 Diabetes Enhanced Service	£350k
Very Long Acting Contraception	£100k
LEGUp/Initial Practice allowance	£200k
Advance nurse practitioner training	£130k
Access pilots	£30k
	£1,100k

To address difficulties associated with GP recruitment and retention and increasing workloads in primary care, a number of local funding schemes are proposed to ameliorate the situation though it should be noted these initiatives will not resolve the current position.

These actions will also address issues of patient safety and quality of care. Four initial proposals are being developed, supported by the Primary Care Joint Management Group.

Local Scheme	**Description**	Investment
Local GP Returner Scheme	Three locally funded places in 2015-16 to encourage back to work doctors who leave the Performers List at a young age and encourage doctors going on maternity leave to apply for a retainer scheme to facilitate return to work and avoid loss of skill and confidence. NES is developing a national scheme to support four full time returners per annum across Scotland.	£105,000 (estimate) 3 trainer grants £23,000
Primary Care Clinical Development Fellows	Newly qualified GPs are in a unique position in terms of career choices, geographical location and being medically competent but wishing to gain further experience. These posts will offer successful applicants an opportunity to develop their clinical and professional competence in a purposeful and supervised manner. The posts will comprise of 4 sessions in general practice,	Investment £75,000 for 3 Fellows (2015) LUCS and practices will fund sessions within their areas

	weekly out-of hour's sessions and development time.	
Locum Pool of Recently Retired GPs	West Lothian CHCP will pilot a locum pool of retired GPs with agreed terms and conditions attractive to older GPs (no house calls, no duty sessions, set surgeries, £200 session rate, 1 paid CPD session for 8 or more sessions per month)	Investment of £60,000 for CPD sessions (up to 5 locums working 8 sessions per Month (£12,000 x 5 locums) West Lothian Practices funding £96,000 to support the locum sessions
Practice Emergency Care Fund	The Lothian GP Sub Committee has developed recommendations to support delivery of services to support Care of the Frail Elderly and 2020 Vision.	£500,000

As part of developing a systematic approach managing difficulties each Health and Social Care Partnership is developing risk registers for their practices and the Primary Care Joint Management Team is currently considering a more formalised framework of support for practices in difficulty. The measures will be temporary and aimed at helping the practice return to a sustainable position, which enables them to fulfil normal contractual obligations on an on-going basis.

The SGHD are running the Primary Care Workforce Survey 2015 between August and the end of October. This will ask all GP practices and OOH services to complete a survey looking at the workforce profile of both GPs and practices nurses including demography, retirals and vacancies. This will provide the Scottish Government with intelligence with which to develop the New GP Contract and also plan GP training programmes. Further work is also underway nationally to understand the push and pull factors for individuals considering entering GP training and what can be done to widen and enhance GP careers.

3.4 GMC Survey of trainees

The results of the 2015 GMC national trainee survey (in a Red/Amber/Green format) (Appendix 1) 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.

When asked to rate the quality of teaching (informal and bedside teaching as well as formal and organised sessions) in their current post 69% of trainees rated their experience as either excellent or good. The quality of training experience was

considered by 88% of trainees to be either excellent or good. When asked to describe their post to a friend thinking of applying 96% described it as either excellent or good.

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. In all such instances the Director of Medical Education is working with areas/specialties to understand the context and agree actions to address.

The establishment of a quality control team within medical education means enhanced awareness of issues and the ablity to support clinical teams through proactive intelligence gathering rather than relying on Deanery or GMC visits. This applies equally to examples of best practice as well as areas of concern in NHSL with respect to Clinical Education and training.

3.5 Healthcare science

The healthcare science workforce provides a diverse range of essential specialist clinical support services a number of which include small workforces and associated challenges with succession planning. The next Board paper will provide detail on these areas and work that is underway to respond to these challenges.

3.6 Nursing workforce

The previous Board paper set out in detail work that was underway in the nursing workforce to address workforce pressures and was the subject of further detailed discussion as part of the Board Development day in September. Further updates will be provided in subsequent 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
Head of Workforce Planning
nick.mcalister@nhslothian.scot.nhs.uk
22 September 2015

List of Appendices

Appendix 1: GMC Trainee Survey Results

GMC Trainee Survey Results

NHS Education for Scotland

2015 Postgraduate Training Overview: Lothian

NATIONAL TRAINING SURVEY

		Overall Satisfaction	Clinical Supervision	Clinical Supervision out of hours	Handover	Induction	Adequate Experience	Supportive environment	Work Load	Educational Supervision	Educational Resources	Feedback	Local Teaching	Regional Teaching	Study Leave	Number of Respondents
Ashgrove Health Centre - S301B	General Practice															1
Astley Ainslie Hospital - S201H	Geriatric medicine															1
Astley Ainslie Hospital - S201H	Rehabilitation medicine	-	▲		-	-	▲		-	-	▲	-	-	-	-	8
Baronscourt Surgery - S317B	General Practice															1
Bathgate Primary Care Centre - S324B	General Practice															1
Beaufort Road Surgery - S074B	General Practice															2
Bellevue Medical Centre - S316B	General Practice															1
Bonnyrigg Health Centre - S203B	General Practice															1
Braids Medical Practice - S079B	General Practice															1
Bruntsfield Health Centre - S207B	General Practice															1
Carmondean Health Centre - S309B	General Practice															1
Chalmers Hospital - S203H	Community Sexual and Reproduct															1
Craiglockhart Surgery - S014B	General Practice															1
Craigmillar Medical Centre - S321B	General Practice															1
Craigshill Health Centre - S304B	General Practice															1
Cramond Medical Centre - S052B	General Practice															1
Crewe Medical Centre - S055B	General Practice															1
Dedridge Health Centre - S313B	General Practice															1
Dr R Wd Langlands & Partners - S76071	General Practice															1
East Craigs Medical Centre - S010B	General Practice															2
Eastfield Medical Centre - S037B	General Practice															2
Edinburgh University Practice - S068B	General Practice															2
Eskbridge Medical Centre - S033B	General Practice															1
Eyre Medical Practice - S039B	General Practice															1

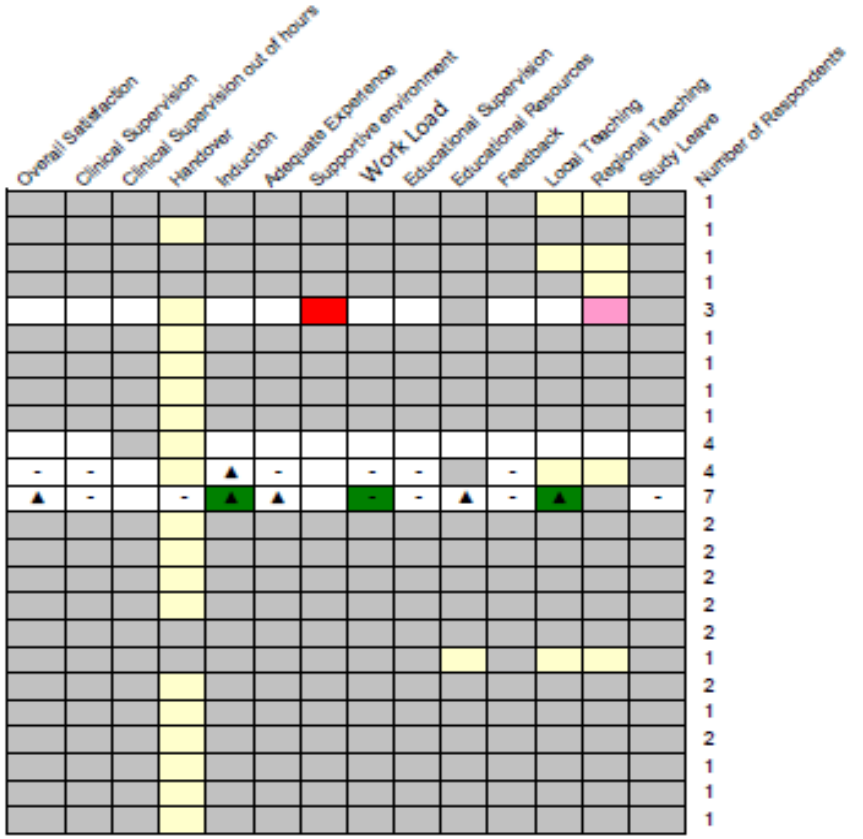
Postgraduate

- Results are below the national mean and in the bottom quartile nationally
- Results in the bottom quartile but not outside 95% confidence limits of the mean
- No flag: not falling in any other category
- Results in the top quartile but not outside 95% confidence limits of the mean

Notes

This report utilises the GMC National Training survey *Post Specialty by site by Trust/board* reports. *"Number of respondents"* is the total responses received: the number of responses received for some questions may be significantly fewer. No postgraduate results are available where fewer than 3 responses were received. Trend data: ▲ indicates an improvement in the flag from the previous year. ▼ a deterioration and - no change. If no prior data is available the cell is blank.
The undermining indicator has been removed

2015 Postgraduate Training Overview: Lothian



Fairmile Marie Curie Centre - S203K	Palliative medicine	1
Firrhill Medical Centre - S012B	General Practice	1
Herdmanflat Hospital - S109H	General psychiatry	1
Herdmanflat Hospital - S109H	Old age psychiatry	1
Howden Health Centre - S305B	General Practice	3
Inchpark Surgery - S027B	General Practice	1
Ladywell Medical Centre - East Wing - S319B	General Practice	1
Ladywell Medical Centre - West Wing - S009B	General Practice	1
Leith Mount Surgery - S329B	General Practice	1
Leith Walk Surgery - S002B	General Practice	4
Liberton Hospital - S209H	General Practice	4
Liberton Hospital - S209H	Geriatric medicine	7
Liberton Medical Group - S025B	General Practice	2
Links Medical Centre - S062B	General Practice	2
Linlithgow Health Centre - S314B	General Practice	2
Mackenzie Medical Centre - S069B	General Practice	2
Midlothian Community Hospital - S318H	General psychiatry	2
Midlothian Community Hospital - S318H	Old age psychiatry	1
Mountcastle Primary Care Centre - S125C	General Practice	2
Muirhouse Medical Group - S050B	General Practice	1
Newbattle Medical Group Practice - S036B	General Practice	2
Newton Port Surgery - S315B	General Practice	1
North Berwick Health Centre - S104B	General Practice	1
Pathhead Medical Centre - S048B	General Practice	1

Postgraduate

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Results in the bottom quartile but not outside 95% confidence limits of the mean

No flag: not failing in any other category

Results in the top quartile but not outside 95% confidence limits of the mean

Notes

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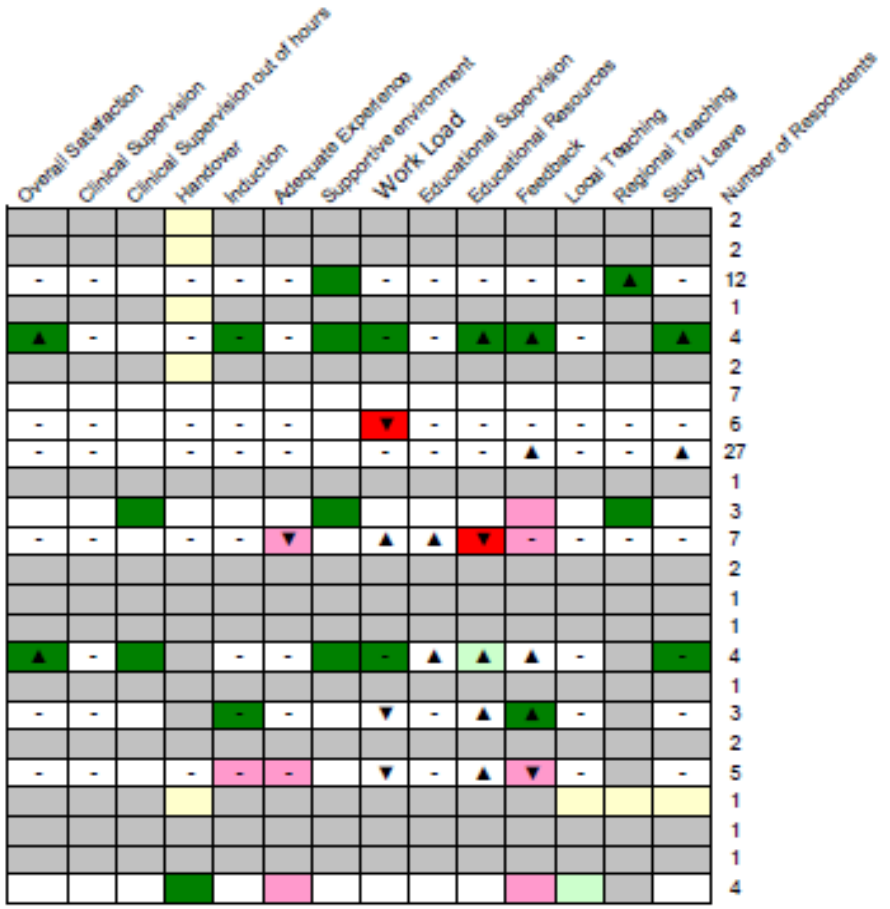
NHS Education for Scotland

2015 Postgraduate Training Overview: Lothian

NATIONAL TRAINING SURVEY



Penicuik Health Centre - S206B	General Practice	2
Portobello Health Centre - S021B	General Practice	2
Princess Alexandra Eye Pavilion - S316H	Ophthalmology	12
Restalrig Park Medical Centre - S322B	General Practice	1
Roodlands General Hospital - S113H	Geriatric medicine	4
Roslin Health Centre - S208B	General Practice	2
Royal Edinburgh Hospital - S217H	Child and adolescent psychiatry	7
Royal Edinburgh Hospital - S217H	Forensic psychiatry	6
Royal Edinburgh Hospital - S217H	General psychiatry	27
Royal Edinburgh Hospital - S217H	Liaison Psychiatry	1
Royal Edinburgh Hospital - S217H	Medical psychotherapy	3
Royal Edinburgh Hospital - S217H	Old age psychiatry	7
Royal Edinburgh Hospital - S217H	Psychiatry of learning disability	2
Royal Edinburgh Hospital - S217H	Rehabilitation Psychiatry	1
Royal Edinburgh Hospital - S217H	Substance Misuse Psychiatry	1
Royal Hospital for Sick Children (Edinburgh) - S225H	Anaesthetics	4
Royal Hospital for Sick Children (Edinburgh) - S225H	Child and adolescent psychiatry	1
Royal Hospital for Sick Children (Edinburgh) - S225H	Clinical radiology	3
Royal Hospital for Sick Children (Edinburgh) - S225H	Community Child Health	2
Royal Hospital for Sick Children (Edinburgh) - S225H	Emergency Medicine	5
Royal Hospital for Sick Children (Edinburgh) - S225H	General surgery	1
Royal Hospital for Sick Children (Edinburgh) - S225H	Haematology	1
Royal Hospital for Sick Children (Edinburgh) - S225H	Paediatric Gastroenterology, Hepa	1
Royal Hospital for Sick Children (Edinburgh) - S225H	Paediatric Intensive Care Medicine	4

Postgraduate

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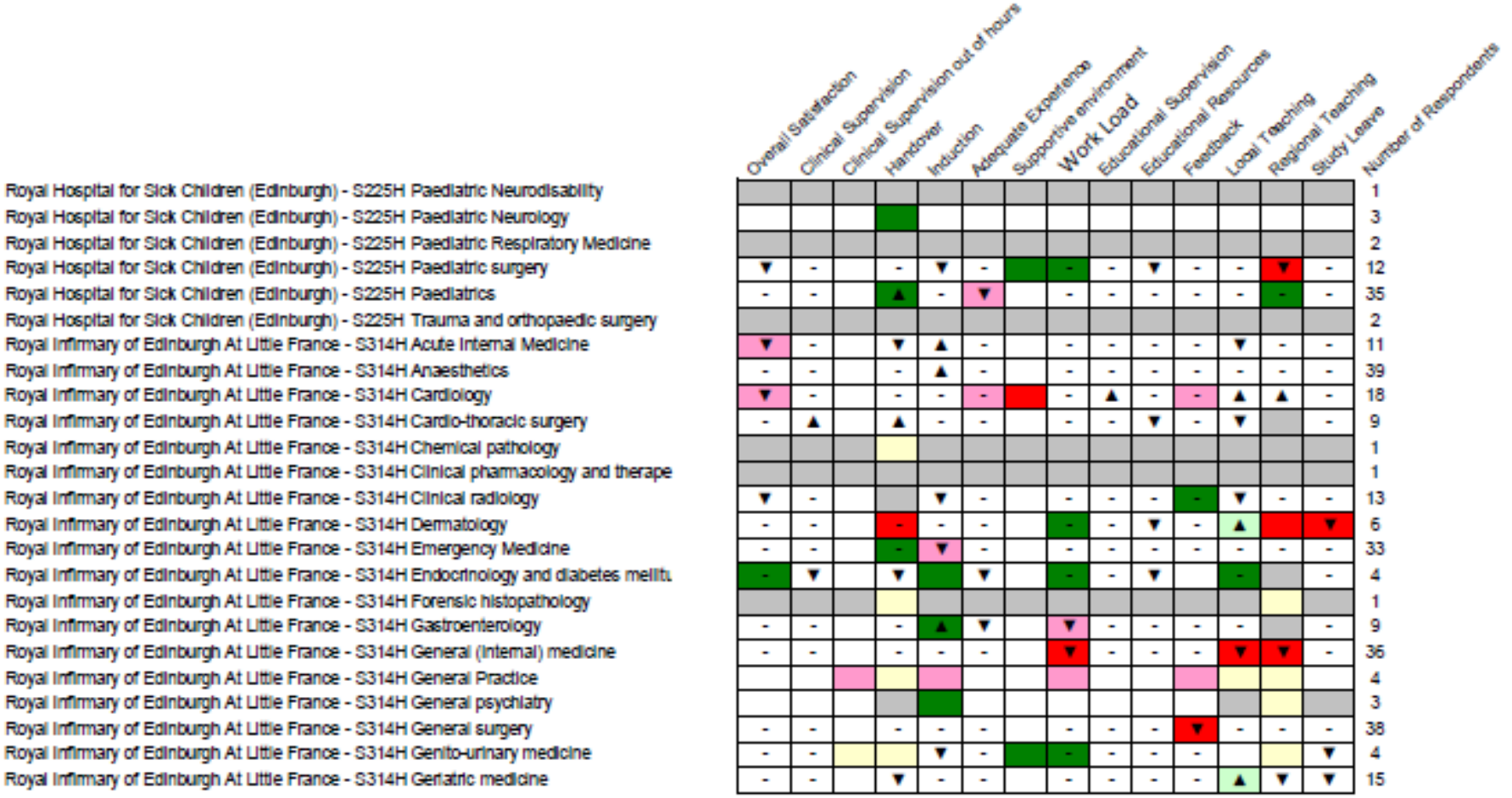
NHS Education for Scotland

NATIONAL TRAINING SURVEY

2015 Postgraduate Training Overview: Lothian



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NHS Education for Scotland

2015 Postgraduate Training Overview: Lothian

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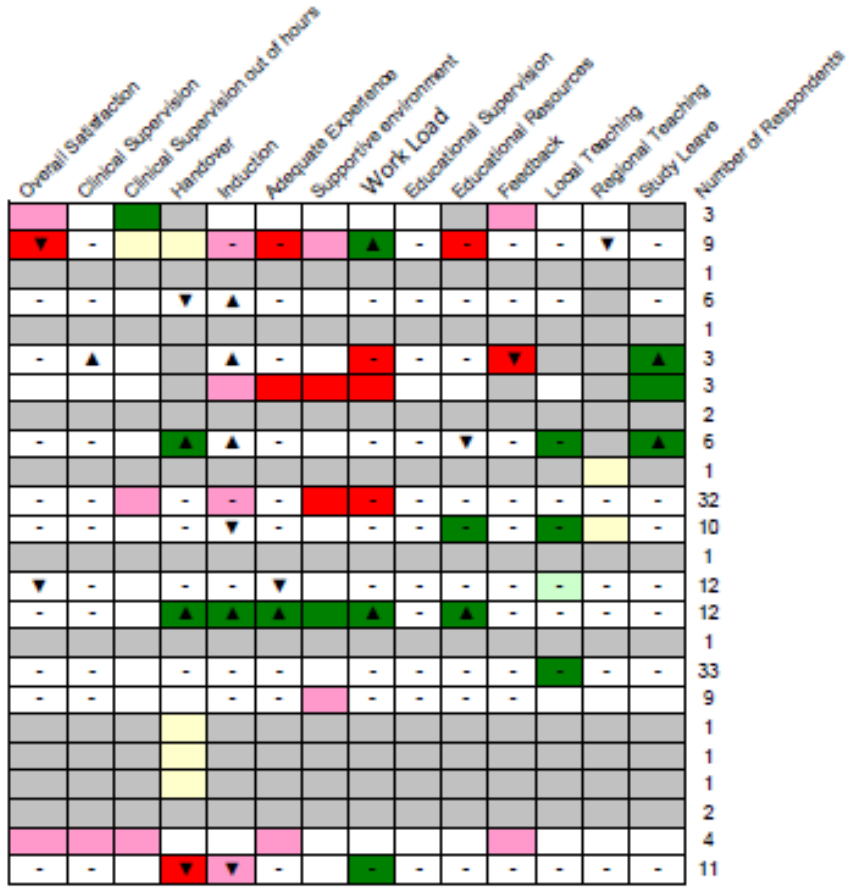

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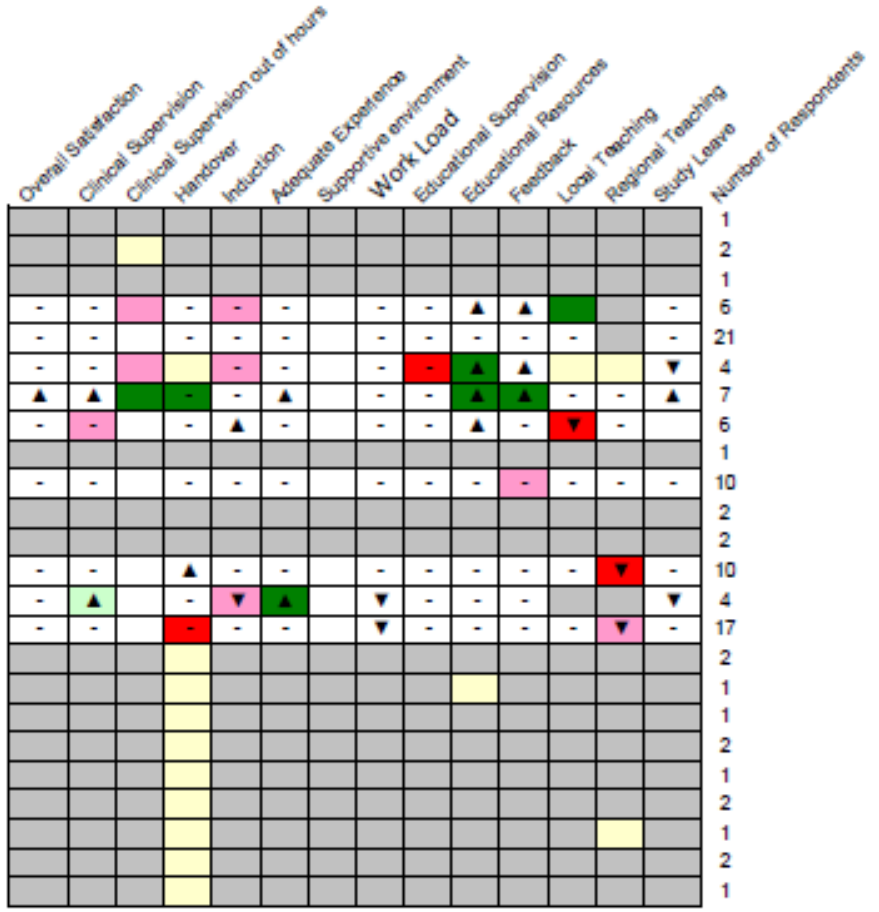
NHS Education for Scotland

2015 Postgraduate Training Overview: Lothian

NATIONAL TRAINING SURVEY



St John's Hospital - S308H	Child and adolescent psychiatry	1
St John's Hospital - S308H	Clinical radiology	2
St John's Hospital - S308H	Community Child Health	1
St John's Hospital - S308H	Emergency Medicine	6
St John's Hospital - S308H	General (internal) medicine	21
St John's Hospital - S308H	General Practice	4
St John's Hospital - S308H	General psychiatry	7
St John's Hospital - S308H	Geriatric medicine	6
St John's Hospital - S308H	Haematology	1
St John's Hospital - S308H	Obstetrics and gynaecology	10
St John's Hospital - S308H	Old age psychiatry	2
St John's Hospital - S308H	Oral and maxillo-facial surgery	2
St John's Hospital - S308H	Otolaryngology	10
St John's Hospital - S308H	Paediatrics	4
St John's Hospital - S308H	Plastic surgery	17
St Triduanas Medical Practice - S065B	General Practice	2
Stockbridge Blue - 70408	General Practice	1
Stockbridge Green - 70094	General Practice	1
Strathbrock Partnership Centre - S303B	General Practice	2
Summerside Medical Centre - S060B	General Practice	1
The Long House - S057B	General Practice	2
The Wood Medical Practice - 78306	General Practice	1
Toilcross Health Centre - S323B	General Practice	2
West End Medical Practice - 70319	General Practice	1

Postgraduate

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NHS Education for Scotland

2015 Postgraduate Training Overview: Lothian

NATIONAL TRAINING SURVEY

Western General Hospital - S116H	Acute Internal Medicine	4
Western General Hospital - S116H	Anaesthetics	19
Western General Hospital - S116H	Cardiology	1
Western General Hospital - S116H	Chemical pathology	1
Western General Hospital - S116H	Clinical oncology	7
Western General Hospital - S116H	Clinical radiology	9
Western General Hospital - S116H	Dermatology	1
Western General Hospital - S116H	Endocrinology and diabetes mellitu	4
Western General Hospital - S116H	Gastroenterology	4
Western General Hospital - S116H	General (internal) medicine	17
Western General Hospital - S116H	General Practice	6
Western General Hospital - S116H	General psychiatry	2
Western General Hospital - S116H	General surgery	28
Western General Hospital - S116H	Geriatric medicine	23
Western General Hospital - S116H	Haematology	8
Western General Hospital - S116H	Infectious diseases	9
Western General Hospital - S116H	Intensive care medicine	5
Western General Hospital - S116H	Liaison Psychiatry	1
Western General Hospital - S116H	Medical oncology	15
Western General Hospital - S116H	Neurology	6
Western General Hospital - S116H	Neurosurgery	11
Western General Hospital - S116H	Respiratory Medicine	7
Western General Hospital - S116H	Rheumatology	4
Western General Hospital - S116H	Urology	12

Postgraduate

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Return to first page

NHS LOTHIAN

2.7

Board Meeting
7 October 2015

Medical Director

SUMMARY PAPER – QUALITY REPORT

This paper summarise the key points in the full paper.

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

	Para
• There is now regular reporting of patient experience across the three acute inpatient sites on patient experience and as such the patient experience outcome measure has now been included in the Quality Report (Chart 1). The person-centred culture paper on the Board agenda and highlights that this data is still in a developmental stage, with respect to establishing a reliable process that offers all patients the opportunity to complete the patient experience questionnaire, Tell us Ten Things (TTT).	3.1.2
• The HSMR publication in August 2015 is for the period January to March 2015 and shows none of the three acute adult hospitals is a statistical outlier.	3.1.3
• The number of formal complaints remains fairly stable. Chart 2 shows an improvement in responses to complaints in 20 days in NHS Lothian.	3.1.5
• Staff absence levels (chart 6) are over 4% (4.9%) which has been above 4% for a number of months with significant variation across NHS Lothian.	3.1.6 & chart 6
• The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (charts 11&12). Healthcare Associated Infection is a separate agenda item and paper.	3.1.7 & charts 11-12

Jo Bennett
Associate Director for Quality Improvement & Safety
14 September 2015
Jo.bennett@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 2015

Medical Director/Nurse Director

QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for September 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. This was previously presented to the August Board and there has been no update as the data is published on a quarterly basis.

3.1.2 There is now regular reporting of patient experience across the three acute inpatient sites and as such the patient experience outcome measure has now been included in the Quality Report (Chart 1). The person-centred culture paper on this agenda highlights that this data is still in a developmental stage, with respect to establishing a reliable process that offers all patients the opportunity to complete the patient experience questionnaire, Tell us Ten Things (TTT).

3.1.3 Since December 2009, Information Services Division (ISD) has produced quarterly hospital standardised mortality ratios (HSMR) for all Scottish hospitals participating in the Scottish Patient Safety Programme (SPSP). The aim of the Scottish Patient Safety Programme is to reduce hospital mortality by 20% by December 2015 compared to the baseline of 2007. The publication in August 2015 is for the period January to March 2015.

The HSMR is based on all acute inpatient and day case patients admitted to all specialties (medical and surgical). The calculation takes account of patients who died within 30 days from admission; that is, it includes deaths that occurred in the community (out of hospital deaths) as well as those occurring in-hospital. It

excludes deaths that occur more than 30 days after admission whether in hospital or not.

Hospital Standardised Mortality Ratio (HSMR) = Observed Deaths / Predicted Deaths. The prediction is based on data from SMR01 returns. The purpose is to adjust observed mortality for the underlying risk of death at the time of admission (Charts 7-9).

Key Points:

- The current values and change from baseline are in Table 1 below
- None of the three acute adult hospitals is a statistical outlier and all are below 1.

Table 1

	HSMR Oct-Dec 2007	**HSMR Jan-Mar 2015**	**Change from baseline**
Scotland	1.03	0.90	-15.7%
RIE	0.89	0.70	-18.3%
St John's	0.84	0.83	-9.1%
WGH	0.84	0.70	-10.6%

3.1.4 The number of adverse events with harm has seen an increase in the last three months (chart 10). The data has been examined and shows that pressure ulcers and maternity adverse events are contributing to this increase. The rise in pressure ulcer adverse events is due to increased awareness of reporting and appropriate grading of pressure ulcers. The Pressure Ulcer Improvement Plan went to Healthcare Governance Committee (HCG) in July 2015 and highlighted actions being undertaken to improve reporting and accuracy of reporting.

Maternity adverse events are reviewed by a multi-disciplinary team which has been recognised by the Royal College of Obstetrics & Gynaecology as good practice when recently reviewed. The reviews have not highlighted any care or service delivery issues, however, there is always learning from these reviews which is fed into the Maternity & Children Quality Improvement Collaborative (MCQIC) SPSP programme.

3.1.5 The number of formal complaints remains fairly stable. Chart 2 shows an improvement in responses to complaints in 20 days in NHS Lothian. Achieving a sustained response rate at 20 days and 3 days remains a challenge (charts 2 & 3).

3.1.6 Staff absence levels (Chart 6) are over 4% (4.9%) which has been above 4% for a number of months with significant variation across NHS Lothian.

3.1.7 The HEAT targets for reduction in *C.Difficile* and Staph. aureus bacteraemias are not being achieved (see charts 11&12). A separate paper on the prevention and management of HAI is on this Board agenda.

3.1.8 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 HCG in November 2015.

Quality Dashboard – September 2015 (dates for each data item stated in background charts)

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

QUALITY AMBITION

PERSON-CENTRED - Process Measures
20-day Complaints Response Rate *
3-day Complaints Response Rate *
Delayed Discharges and Average Length of Stay *

PERSON-CENTRED - Outcome Measures
Patient Experience *
Number of Complaints *
Staff Absence Levels *
Staff Experience

SAFE – Outcome Measures
Hospital Standardised Mortality Ratios for RIE, WGH & St. John's *
Incidents with harm *
C. Difficile Numbers *
Staph. Aureus Bacteraemia Numbers *
Number of Cardiac Arrests *
Rate of Cardiac Arrests *
Inpatient Falls with Harm *

EFFECTIVE – Process Measures
A&E 4 Hour Wait *
Cancer Waits 62 Days from Diagnosis to Treatment
Admission to stroke unit on day or day after admission *
Stroke Treatment Measure: CT Scan *
Stroke Treatment Measure: Swallow Screen *

Additional Quality Measures

Hospital Scorecard: October to December 2014

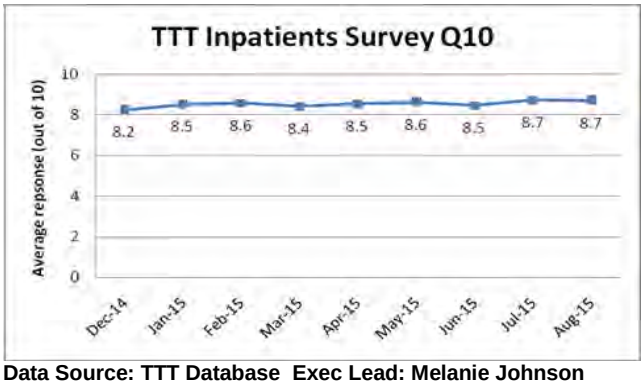
Indicator	Lothian Rate (Per 1000 admissions)	Scottish Rate
Standardised Surgical Readmission rate within 7 days	22.13	21.17
Standardised Surgical Readmission rate within 28 days	42.69	39.87
Standardised Medical Readmission rate within 7 days	53.02	53.17
Standardised Medical Readmission rate within 28 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:	Tell us ten things (TTT) Inpatient Survey Question 10 (Chart 1)
Numerator:	Average of Inpatient responses (out of 10) to Question 10 : Overall experience
Goal:	9.5 (out of 10)

Outcome Measure

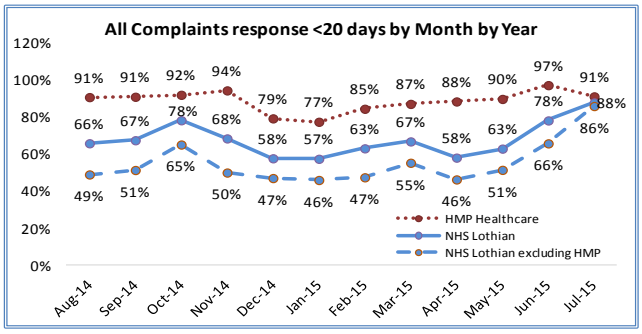


Data Source: TTT Database Exec Lead: Melanie Johnson

Title:	20-day Complaints Response Rate (Chart 2)
Numerator:	Number of complaints responded to within 20 days
Denominator:	Number of complaints
Goal:	85% of complaints responded to within 20 days

Process Measure

20-Day Response Target across NHS Lothian

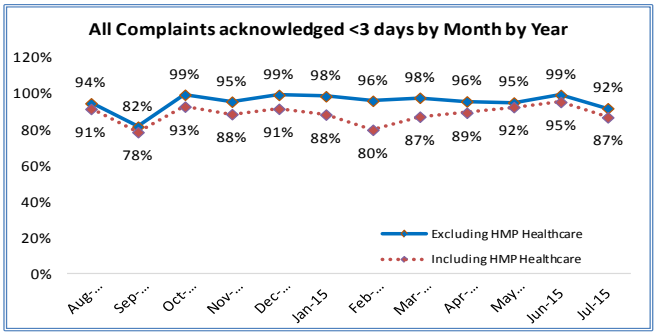


Data Source: Datix Exec Lead: Melanie Johnson

Title:	3-day Complaints Response Rate (Chart 3)
Numerator:	Number of complaints responded to within 3 days
Denominator:	Number of complaints
Goal:	100% formal acknowledgement within 3 working days

Process Measure

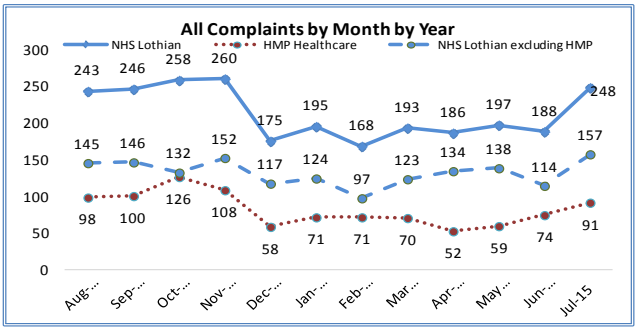
3-Day Response Target across NHS Lothian



Data Source: Datix Exec Lead: Melanie Johnson

Title:	Number of Complaints (including & excluding HMP) (Chart 4)
Numerator:	Total number of complaints
Goal:	Reduction in number of formal complaints

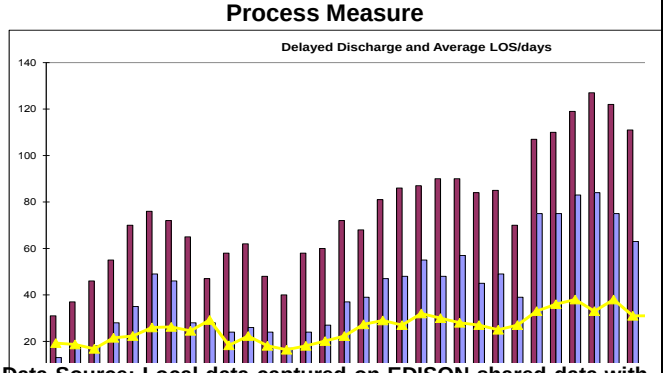
Outcome Measure



Data Source: Datix Exec Lead: Melanie Johnson

Title:	Delayed Discharges & Average Length of Stay (Chart 5)
Goal:	No patient waiting longer than 2 weeks for discharge

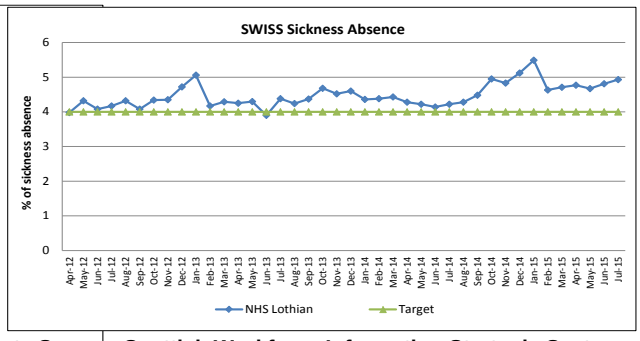
Process Measure



Data Source: Local data captured on EDISON shared data with Health & Social Care Exec Lead: Jim Crombie

Title:	Staff Absence Levels (Chart 6)
Numerator:	Total staff hours lost
Denominator:	Total staff hours available
Goal:	4% or less

Outcome Measure



Data Source: Scottish Workforce Information Strategic Systems (SWISS) Exec Lead: Alan Boyter

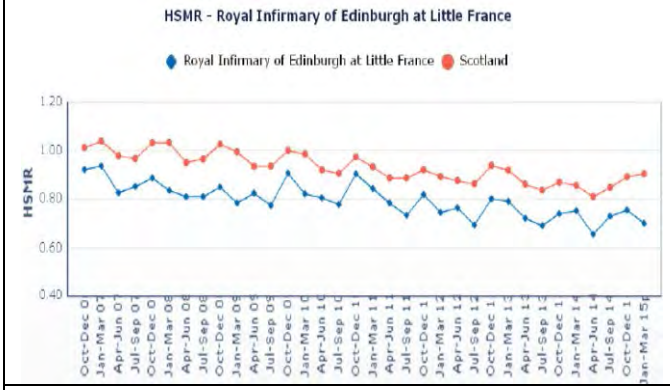
Safe

"There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times." Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, HAI indicators, arrest calls, falls with harm and pressure ulcers.

Title:	Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Charts 7-9)
Numerator:	Total number of in-hospital deaths and deaths within 30 days of discharge from hospital
Denominator:	Predicted total number of deaths
Goal:	20% reduction against 2006/07 baseline by December 2015

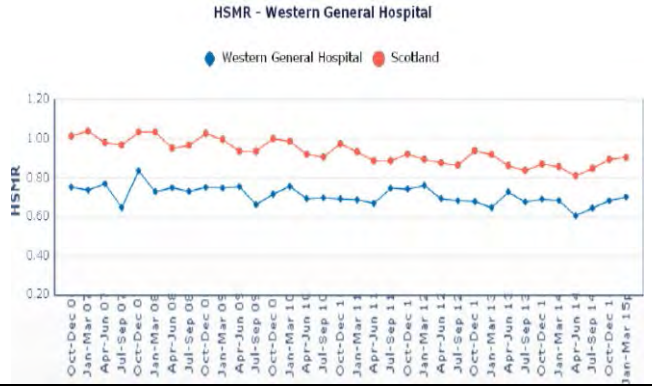
Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – March 2015



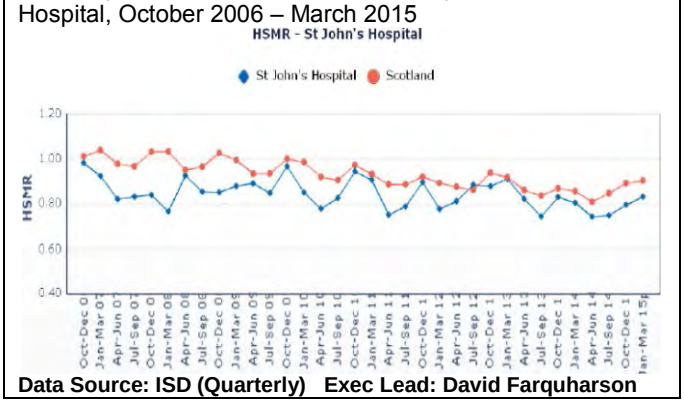
Outcome Measure

Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – March 2015



Outcome Measure

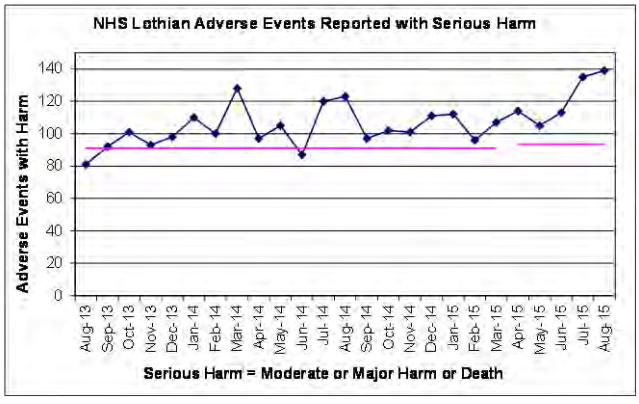
Quarterly Hospital Standardised Mortality Ratios in St John's Hospital, October 2006 – March 2015



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

Title:	Adverse Events with harm (Chart 10)
Numerator:	Number of adverse events associated with serious harm reported per month in NHS Lothian
Goal:	There are specific goals for reductions in Falls

Outcome Measure

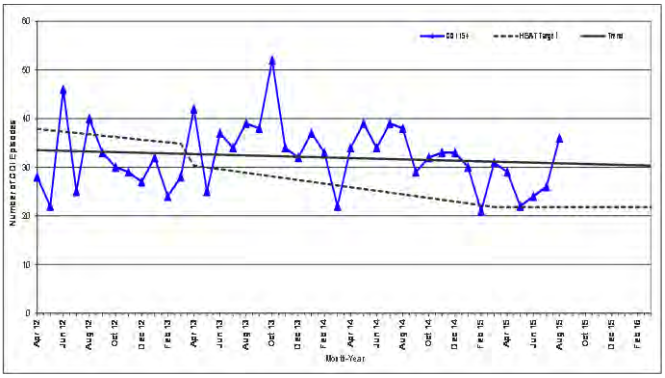


Data Source: Datix Exec Lead: David Farquharson

Title:	C. difficile associated disease against HEAT Target 2012-13 (Chart 11)
Numerator:	Total number of patients aged 15 and over with C.difficile toxin positive stool sample (CDI)
Goal:	NHS Lothian is to achieve a rate of 0.32 per 1000 bed days (<262 incidences) by March 2016

Outcome Measure

Progress against HEAT Target for *C.difficile* Infection (CDI)



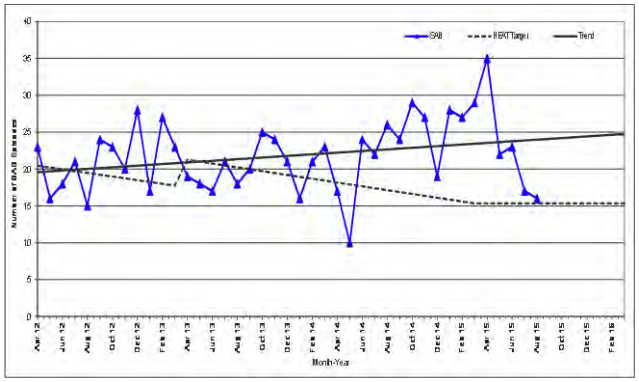
Data Source: Infection Control Team Exec Lead: Melanie Johnson

Safe (cont'd)

Title:	Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Chart 12)
Numerator:	The number of SAB patient episodes (i.e. both MRSA and MSSA blood stream infections)
Goal:	NHS Lothian is to achieve a rate of 0.24 per 1000 bed days (<184 incidences) by March 2016

Outcome Measure

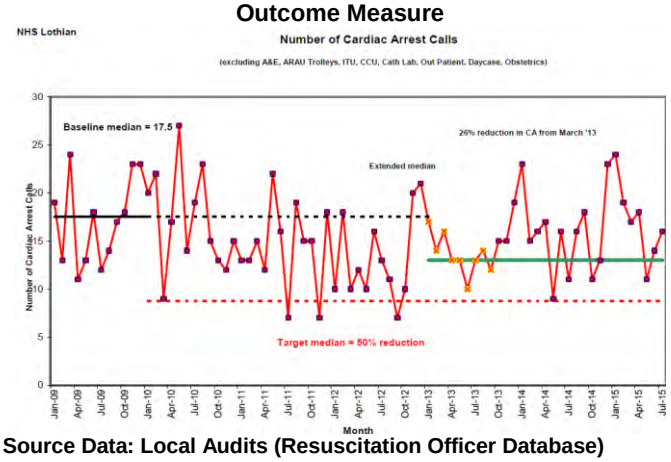
Progress against HEAT Target for *S.aureus* Bacteraemia



Data Source: Infection Control Team
Exec Lead: Melanie Johnson

Title:	Number of Cardiac Arrests (Acute Wards) (Chart 13)
Numerator:	Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

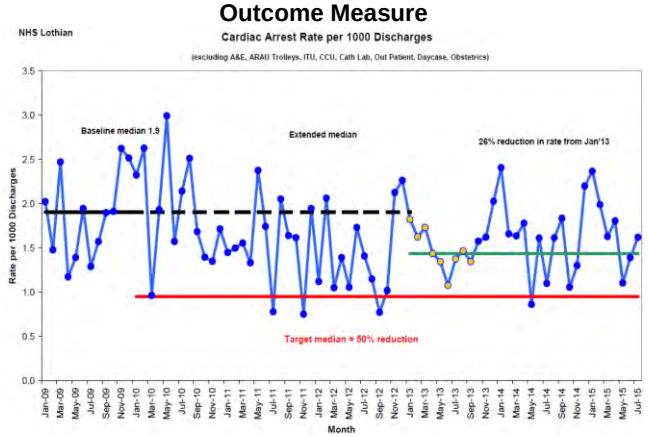
Outcome Measure



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

Title:	Rate of Cardiac Arrests (Acute Wards) (Chart 14)
Numerator:	Arrest – Rate of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ ITU/ day care procedures are excluded.
Goal:	50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

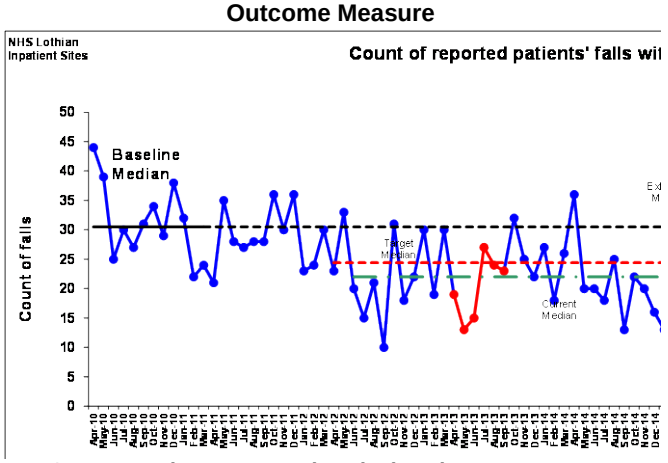
Outcome Measure



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

Title:	Patient Falls with Harm (Chart 15)
Numerator:	Number of falls reported resulting in moderate or major harm or death (define moderate/ major). Data for NHS Lothian inpatient sites
Goal:	20% reduction in inpatients falls and associated harm by December 2015

Outcome Measure



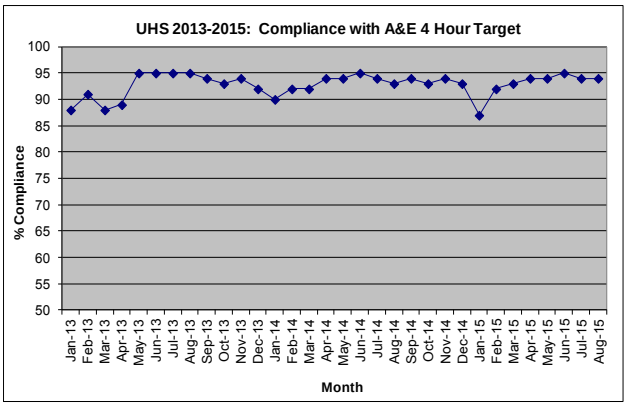
Data Source: Datix Exec Lead: Melanie Johnson

Effective

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

Title:	A&E 4 Hour Wait (Chart 16)
Numerator:	Number of patients waiting less than 4 hours from arrival to admission or discharge
Denominator:	Number of patients attending
Goal:	98% of patients waiting less than 4 hours from arrival to admission by March 2015

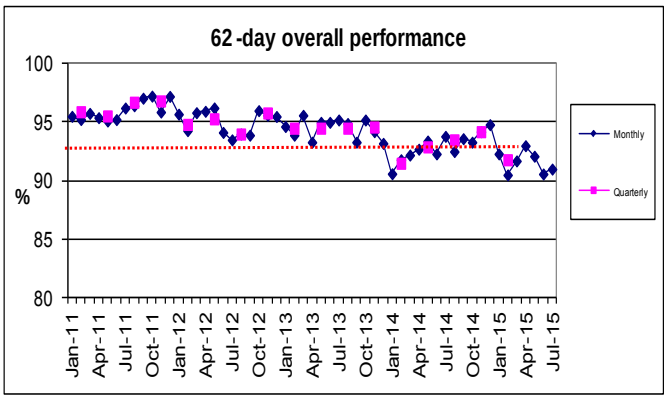
Process Measure



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

Title:	Cancer Waits 62 Days from Diagnosis to Treatment (Chart 17)
Numerator:	Number of patients waiting 62 days to treatment Please note the scale
Denominator:	Number of cancer patients
Goal:	95% of patients from diagnosis to treatment wait no longer than 62 days

Process Measure

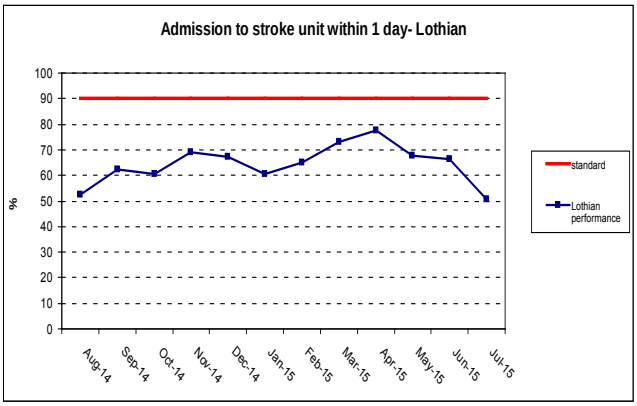


Data Source: SGHD Management Information
Exec Lead: Jim Crombie

Title:	Admission to Stroke Unit within 1 day of admission (Chart 18)
Numerator:	Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke excluding in-hospital strokes, patients discharged within 1 day and transfers in from another health board
Goal:	90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional

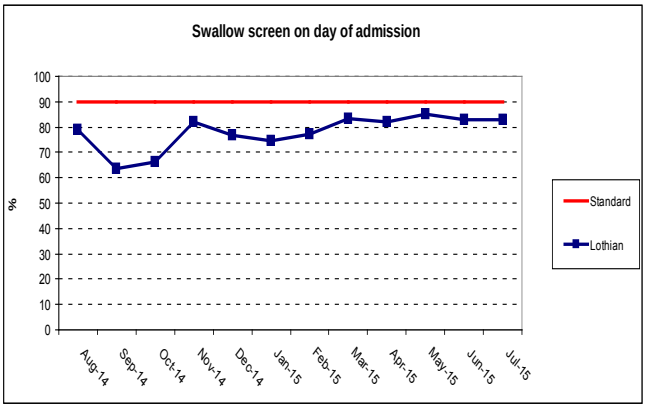


Lothian = 50.8% (32/63)
Data Source: ISD Exec Lead: Jim Crombie

Title:	Stroke Treatment Measures (Chart 19)
Numerator:	Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission

Process Measure

Note: 2014 data is not validated and should be treated as provisional



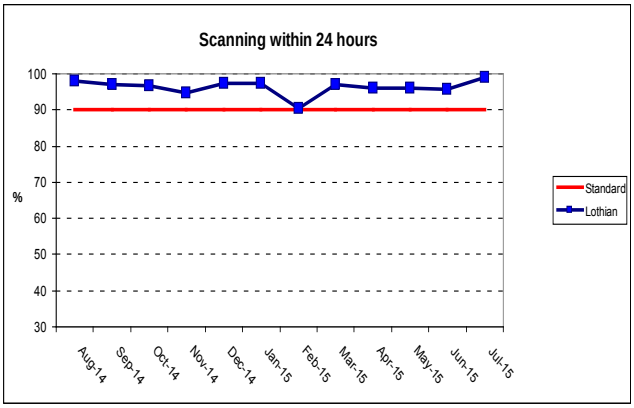
Lothian = 83% (73/88)
Data Source: ISD Exec Lead: Jim Crombie

Effective (cont'd)

Title:	Stroke Treatment Measures (Chart 20)
Numerator:	Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival
Denominator:	Number of patients admitted with initial diagnosis of stroke
Goal:	90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission

Process Measure

Note: 2015 data is not validated and should be treated as provisional



Lothian = 98.9% (87/88)
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
14 September 2015
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Supporting Context and Technical Appendix

APPENDIX 1

Context and Technical Appendix

Quality Report Development

The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland's quality ambitions and across levels 1 to 3.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian's Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

Hospital Standardised Mortality Ratio (HSMR)

HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level 'warnings' for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

S.aureus Bacteraemia (SAB) rate

New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.

C.difficile Infection (CDI) rate
New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

Incidents associated with harm
Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.

Surgical readmissions within 7 days
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Surgical re-admissions within 28 days
As for 7 day readmissions.

Medical Re-admissions Within 7 Days
This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.
The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

Medical Re-admissions Within 28 Days
As for 7 day readmissions.

Average Length of Surgical Stay (Adjusted)
Ratio of 'observed' length of stay over 'expected' length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

Average Length of Medical Stay (Adjusted)
Ratio of observed length of stay over expected length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations.

Return to first page

NHS LOTHIAN

2.8

Board Meeting
7 October 2015

Medical Director

SUMMARY PAPER – CORPORATE RISK REGISTER

This paper summarise the key points in the full paper.

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

	Para
• The top 4 risks at Very High 20 are:- o Healthcare Associated Infection o Achieving the 4-Hour Emergency Care standard o Achieving the Delayed Discharge targets at 2 and 4 weeks o The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	3.2.1
• Table 1 sets out a Quarter 2 update of the NHS Lothian Corporate Risk Register.	3.2.2
• Three risks are proposed for inclusion on the Corporate Risk Register - General Practice Workforce Sustainability, Nursing Workforce Safe Staffing Levels and Facilities Fit for Purpose.	3.4
• NHS Lothian remains out with its Risk Appetite on corporate objectives where low and medium risk appetite has been set, with the exception of Scheduled care	3.5

Jo Bennett
Associate Director for Quality Improvement & Safety
9 September 2015
Jo.bennett@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 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 out with its Risk Appetite on corporate objectives where low and medium risk appetite has been set, with the exception of Scheduled care

2.3 Approve the three additional risks: General Practice Workforce Sustainability, Nursing Workforce - Safe Staffing Levels and Facilities Fit for Purpose for inclusion onto the NHS Lothian Corporate Risk Register, as set out in paragraph 3.4 and detailed in Appendix 2.

3 Discussion of Key Issues

3.1 As part of our systematic review process, the risk registers are updated on Datix on a quarterly basis at a corporate and an operational level. Risks are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used, is based on the same risk scoring matrix, remains unchanged.

3.2 This report sets out the Quarter 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 *.

* Outwith risk appetite as illustrated in Table 2 below.

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

Table 1

Datix ID	Risk Title	Initial Risk Level	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 Work streams. (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 and have also been discussed at Board governance committees. The Board is asked to consider for inclusion onto NHS Lothian's Corporate Risk Register, the following corporate risks which cannot be managed at executive level and require discussion and decision at Board level (see Appendix 2).

3.4.1 General Practice Workforce Sustainability

This risk was discussed at the January 2015 Board Development Session and plans were approved to mitigate this risk in June 2015. The risk, however, remains current and as such warrants consideration for inclusion onto the Corporate Risk Register. The proposed risk (see Appendix 2) is described as:-

'There is a risk that the Board will be unable to meets its duty to provide access to primary medical services for its population due to increasing population combined with difficulties in recruiting and retaining general practitioners, staffing, premises and IT difficulties. This may affect:

- ability of practices to accept new patients (restricted lists);
- patients not being able to register with the practice of their choice;
- ability to successfully fill practice vacancies;
- ability to cover planned or unplanned absence from practice;
- ability to safely cover care homes; and difficulties in one practice may impact on neighbouring practices/populations, occur at short notice with the result that practices are unable to provide services in their current form to existing patients.'

3.4.2 Nursing Workforce - Safe Staffing Levels

This topic and related risks were discussed at the September 2015 Board Development Session. The proposed risk (see Appendix 2) is described as:-

'There is a risk to the provision of safe care being delivered to patients across NHS Lothian where staffing levels are compromised as a consequence of increased activity, the acuity of the patients exceeding the nursing resource available to deliver care or in specialities where recruitment is challenging.

Although individual CMTs / Health and Social Care Partnerships will manage the local risks arising from specific issues within their business units there is a corporate responsibility to assure the Board of the capacity to deliver safe patient care across every care setting in line with corporate objective number two (2015/16).

The impact of any of these situations potentially compromise the safety of the patient care delivered with consequent impact on length of stay, patient experience and potential long term effects on the health and wellbeing of clients.

Service sustainability risks are high within theatres and anaesthetics, critical care and in health visiting owing to lower levels of workforce supply and increasing levels of demand, including legislative changes around the provision of care to children.

Risks may arise from the high use of supplementary staffing to counteract shortfalls, with the reduced continuity of care and unfamiliarity with the clinical area.

The risk that safe staffing levels are not maintained may arise from actions being taken to meet other targets (Treatment Time Guarantees, 4 hour Emergency Department wait etc.'

3.4.3 Facilities Fit for Purpose

This risk (see Appendix 2) was removed from the Corporate Risk Register in June 2015, for review at divisional level. The conclusion of the review was that this risk could not be fully managed at divisional or executive level and requires consideration by the Board for inclusion onto the Corporate Risk Register. The risk is described as:-

'Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk.'

A number of actions have taken place to mitigate this risk from closure to reprovision of property and securing additional funds to address the backlog. There are, however, significant and very high items on the maintenance backlog register which remain outstanding.

3.5 Risk Appetite Reporting Framework

NHS Lothian's Risk Appetite Statement is:-

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

Table 2

	Current Status	Current Position	Data Report
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.2 Deliver Safe Care) **Low Risk Appetite**			
• Scotland target to reduce acute hospital mortality by 20% (Scotland-14.4%) with a tolerance of 15-20% by Dec 2015 [1]	Green	15.7%	Quality Report (charts 7-9)
• Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015	Green	99.7%	Patient Safety Programme Annual Report (July)
• Achieve 184 or fewer SAB by March 2016 with a tolerance of 95% against target. n=193 to 184	Red	296 (as at Aug 2015)	Quality Report (chart 12) HAI report on Board Agenda
• Achieve 262 or fewer C.Diff by March 2016 with a tolerance of 95% against target. n=275 to 262	Red	342 (as at Aug 2015)	Quality Report (chart 11) HAI report on Board Agenda

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

	Current Status	Current Position	Data Report
• Reduce falls with harm by 20% with a tolerance of 15-20% by Dec 2015	Green	20%	Quality Report (chart 15)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.1 Deliver Person-centred Care) **Low Risk Appetite**			
• Patients would rate out of 10 their care experience as 9.5, with a tolerance of 9.3	Red	8.7	Quality Report (chart 1) Tell us Ten Things (TTT) Patient Questionnaire
• 90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%	Tbc	Tbc	To be collected
• Staff absence below 4% with a 5% tolerance (4-4.2%)	Red	4.9%	Quality Report (chart 6)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.4 Scheduled Care & Waiting Times) **Low Risk Appetite**			
• 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%	Green	86%	Scheduled Care Report
• 95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%	Green	92%	Quality Report (chart 17)
Corporate Objective 2 – Improve the Quality & Safety of Healthcare (LDP 2015-16 - 2.3 Appropriate Unscheduled Care) **Low Risk Appetite**			
• 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%	Green	94%	Quality Report (chart 16) Unscheduled Care report on Board Agenda
• 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	104	Quality Report (chart 5)
• 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	69	Quality Report (chart 5)
• 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	50.8%	Quality Report (chart 18)
Corporate Objective 1 – Protect & Improve the Health of the Population. **Medium Risk Appetite**			
• Sustain and embed successful smoking quits at 12 weeks post quit, in the 40% SIMD areas	Red	32.5% below target	Performance Report on Board Agenda
• 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**			
• In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%	Red	£522k overspend at period 4 (inc. unachieved	Period 4 Finance Report (July 2015)

	Current Status	Current Position	Data Report
		LRP), equating to 0.4%	
• For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%	Red	£6,853k overspend for the year-to-date (inc. unachieved LRP) equating to 1.6%	Period 4 Finance Report

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

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.

Jo Bennett
Associate Director for Quality Improvement & Safety
9 September 2015
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Summary of Corporate Risk Register
Appendix 2: Proposed emerging risks for inclusion on Corporate Risk Register

APPENDIX 1

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	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. 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.	Leadership and Governance: UHS and CHP Infection Prevention and Control Committees are well established and report to board through LICAC. In addition to LICAC and local committees, Infection Prevention and Control routinely report at a senior management level to CMG/Healthcare Governance and bi-monthly board papers. NHS Lothian has an Infection Prevention & Control team in place. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid & East and West Lothian) established with responsibility for both acute and community settings within their remits. Education: There is a HAI Education Strategy which defines the training and education requirements for staff of all disciplines across the organisation. 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. 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. 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).	Risk Reviewed: June 2015 Risk has been updated to reflect the HAI Standards released Feb 2015. Control measures have been reviewed and updated. 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 Risk Grade/Rating decreased High/12 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.	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Medium 4	Melanie Johnson	Fiona Cameron	Healthcare Governance Committee

1076	2: Improve the quality and safety of health care	Healthcare Associated Infection		Controls Continued: 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. 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. Invasive Devices: Clinical Teams monitor compliance with invasive devices care bundles and are supported in making improvements by the Scottish Patient Safety Programme Team. 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. 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. 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.	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

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3600	3: Secure Value & Financial Sustainability	The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.	NHS Scotland is operating in a strategic context of increasing challenges and a real term reduction in resources. Local authority partners also face similar challenges. All NHS Boards will need to re-design how they carry out their functions, so that there is no unacceptable drop in the standard of public services. The focus of attention should be on 100% of activity, not just the annual 3% efficiency target. On 2 April 2014 the Board considered its draft Strategic Plan - "Our Health, Our Care, Our Future". Within that there is a projection that £400m worth of efficiencies will need to be delivered over the next 10 years. The December 2014 Finance Board paper update the Board on the current financial challenge. If the Board and management fail to systematically and robustly respond to this challenge now it will simply store up significant problems for future years. This will limit the Board's options in the future with regard to what it can and cannot do.	The Board has already established a financial governance framework and systems of financial control. NHS Lothian is currently reliant on non-recurring efficiency savings. A detailed Action Plan, attached to this risk, is in place and is regularly reviewed by the Senior Finance Team. Rationale for Adequacy of Control: A combination of uncertainty about the level of resource availability in future years, combined with known demographic pressure which brings major potential service costs, requires a significant service redesign response. The extent of this is not yet known, nor tested.	Risk Reviewed: July 2015 Month 3 Finance report indicates the controls are not working. Detailed plan to review financial performance in each area to agree action for recovery. Quarter 1 review planned with Scottish Government. Longer term plan being prepared to align recovery with Quality Improvement. Risk Grade/Rating remains Very High/20	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	Very High 20	Medium 6	Susan Goldsmith	Craig Marriott	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3203	2: Improve the quality and safety of health care	Unscheduled Care: 4 hour Performance	There is a risk that patients are not seen in a timely manner who require emergency care as required by the Emergency Care standard of 98% resulting in sub optimal care experience and outcome.	A range of governance controls are in place for Unscheduled Care notably: - Bi monthly NHS Lothian Board oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area. -The bi-monthly Acute Hospitals Committee as well as formal SMT meetings. Both are chaired by the Director for Unscheduled Care. - The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis. - 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 A number of performance metrics are considered and reviewed, including: - 4 hour Emergency Care Standard and performance against trajectory - 8 and 12 hour breaches - Attendance and admissions - Delayed Discharge (see Corporate Risk ID 3726) - Boarding of Patients - Winter Planning - Length of Stay (LOS) - Cancellation of Elective Procedures - Finance Adherence to national guidance/ recommendations Plethora of work now focussed around the Scottish Government's *6 Essential Actions* initiative to support achievement of 98% target for 4 hour performance.	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: • 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 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	Adequate but partially effective; control is properly designed but not being implemented properly	Very High 20	Low 1	Jim Crombie	Neil Wilson	Finance & Resource Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3726	2: Improve the quality and safety of health care	Unscheduled Care: Delayed Discharge	There is a risk that patients are not being discharged in a timely manner resulting in sub optimal patient flow impacting on poor patient, staff experience and outcome of care.	A range of governance controls are in place for Unscheduled Care notably: NHS Lothian Board (bi monthly) oversee performance and the strategic direction for Delayed Discharges across the Lothian Board area. The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a fortnightly basis The bi-monthly Acute Hospitals Committee as well as formal SMT meetings. Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (data analysis from EDISON NHS Lothian's Winter Planning Project Board will be responsible for ensuring sustainable performance throughout the winter period A number of performance metrics are considered and reviewed, including: - Attendance and admissions - No. of Delayed Discharges (by Local Authority Area) - Length of Stay (LOS) - Bed Days Lost NHS Lothian strategy to improve unscheduled care performance and delayed discharge is being delivered under the umbrella of the Scottish Government's *6 Essential Actions* initiative.	Risk Reviewed: July 2015 Risk Grade/Rating remains Very High/20 Action to help tackle DD across NHS Lothian include: • 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 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 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: • 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. Monthly meetings in place through to November – the next meeting due to take place on 19th August 2015.	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	• 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.	Risk Reviewed June 2015: Improvements can be demonstrated but compliance with 10 Essentials is variable and priorities work at testing phase. Outcomes have shown improvements but not achieved all SPSP goals. Risk grade/rating to remain High/16	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Medium 6	Dr David Farquharson	Jo Bennett	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3211	2: Improve the quality and safety of health care	Achievement of National Waiting Times Targets	There is a risk of: Lack of management of national waiting times targets for a number of reasons due to lack of core capacity or appropriate use of what is available Overspends relating to not meeting waiting times targets e.g. through purchase of additional capacity from private providers; and risk of not achieving Value for Money. Lack of robust management process and staff capability to deliver consistent management of waiting lists. Risk of adverse publicity relating to failure to meet waiting times targets.	Monthly Access Performance and Government Group meeting chaired by Director of Planning, Performance Reporting and Information oversees this area. These are supplemented by weekly scheduled reviews between this Director and Directors of Operations. It considers: • Performance against trajectory across a range of measures (including waiting time standards) • Finance • Governance position, in terms of adherence to national guidance and local access policy/SOPs This meeting reports to the Acute Services Committee with a comprehensive overview on governance arrangements provided in September 2014. Papers on CAMHS and psychological therapies presented to the Board in April 2015 outlining difficulties in delivering standards of 18 weeks coming into force in December. Further investments were approved.	Risk Reviewed: July 2015 Controls updated. Risk Grade/Rating remains High/16	Satisfactory; controls adequately designed to manage risk and working as intended	High 16	Low 1	Jim Crombie	Andrew Jackson	NHS Lothian Board

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3527	3: Secure value and financial sustainability	Medical Workforce Sustainability	There is a risk that workforce supply pressures in conjunction with activity pressures will result in service sustainability and/or NHS Lothian's ability to achieve its corporate objectives, (i.e. Treatment Time Guarantees (TTG)). Risks occur across the medical workforce (trained and trainees) and non-medical elements of the workforce who could substitute for medical staff. Service sustainability risks are particularly high within Paediatrics, Emergency Medicine and Obstetrics & Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.	•In response to a request from the SEAT Planning Board, a medical workforce risk assessment tool has been developed and implemented across all specialties. The assessments are fed back to local Clinical Directors and their Clinical Management Teams. They use these to inform their own service/workforce plans to minimise risk. •For the risks that require a Board or Regional response the findings are fed back to the SEAT Regional Medical Workforce Group. This group will co-ordinate actions across Boards within SEAT and feed into the national medical workforce planning processes co-ordinated by NES/SG. •A report is taken to each Board meeting updating the actions taken to minimise medical workforce risks in order to support service sustainability and address capacity issues within priority areas. The main challenges have been in Paediatrics, Obstetrics and Gynaecology, Anaesthetics, Radiology and Medicine for the Elderly. •For those specialties at high risk, local workforce plans and solutions which minimise risk have been developed and are monitored closely through existing management structures. •A Medical Workforce Group has being established who are looking at medical workforce issues in Ophthalmology and Radiology. The group will also be looking at the Greenway Report on 'Shape of Training' and how this framework should support changes to the medical staffing model.	Reviewed August 2015 There has been successful recruitment to a numbers of anaesthetic posts at the RIE, WGH and STJ which has significantly improved capacity. Within Medicine for the Elderly there has been some improvement in consultant recruitment at the WGH and RIE. There remain however significant problems at Roodlands with only 1 of 4 posts filled on a substantive basis. There is reliance on ad-hoc staffing measures to remain open to admissions. There have been occasions where there has been a short term closure to admissions as a result. Vacancies have been reviewed to make more attractive and are under recruitment. There are difficulties in filling consultant psychiatrist posts within the Peri-natal Mental Health Unit and Regional Eating Disorder Unit at St John's hospital and as a consequence short term contingency arrangements have been put in place to ensure sustainability. Further recruitment is underway. The on-going difficulties in sustaining paediatric out of hours services at St John's hospital have resulted in the closure of the unit for a six week period in July/aug 2015 A review is underway looking at areas of high expenditure on locums, waiting list payments and private sector with a view to identifying areas where more sustainable solutions can be developed. Of the 14 International Medical Training Fellowships approved by the Scottish Government 12 have been advertised, with 5 appointments being made. There have been significant difficulties in recruitment for GP practices. Whilst most practices are independent providers there is a risk for the board as where the workforce is no longer sustainable then the Board requires to take over the practice to avoid closure. Risk Grade/Rating remains as High/16.	Adequate but partially effective; control is properly designed but not being implemented properly	High 16	Low 2	Dr David Farquharson	Nick McAlister	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3454	2: Improve the quality and safety of health care	Management of Complaints and Feedback	There is a risk that the quality of patient experience is compromised due to staff attitudes and lack of reliable engagement of patients/families in their care, leading to poor patient experience of care. It is also acknowledged that a number of other corporate risks impact on this risk such as unscheduled care, patient safety and waiting times.	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. 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 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 In June complaints and feedback reports have been sent to the operational management teams to identify those complaints that are over 50days The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care. • 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. The National Person Centred Health & Care Programme has been concluded and work is being undertaken nationally to embed patient experience into the existing quality improvement programmes. Tell us Ten Things questionnaire was reviewed in November 2014 and aligned to the "5 Must dos". This has now been rolled out to the three main adult hospitals and further discussions are required as to wider dissemination • Delivering Better Care commitments have been agreed and plans are now in place to deliver on the required actions from the HIS Older People's review and the updated vulnerable Patient's Quality Improvement Framework.This activity is reported to the Board through the Executive lead. These plans are informed by inspection reports produced by Healthcare Improvement Scotland, local audit and regular checks i.e. PQI, mock OPAH ,frailty bundle audit and via the Clinical manager ward assurance checklists. The tools in use have been adapted and updated to reflect the person centred agenda. HIS Older People in Acute Care had their initial Board Assessment day on 16th April 2014, an unannounced inspection is awaited. There has been intense work on each of the Adult Acute Sites to raise the profile of OPAH and each site has a nominated lead.. The new Older peoples Standards were published in June ; Board will be notified when they will be assessed against these new standards. The PQI tool is being amended and currently in the test phase.. • Quality of care is subject to Internal Audits and compliance with audit recommendations reported via Audit & Risk Committee and Healthcare Governance Committee • The Delivering Better Care established on 2012 as a resource for staff (primarily nursing) but where appropriate, other disciplines continue to deliver support to clinical areas on the key ambitions of harm reduction work is now on going to streamline programmes of work for 2015/16 working more closely with Clinical Goverance and using improvement methodology. • As part of the improving care to vulnerable patient's support manual with detailed information inclusive of a rapid patient essential care check sheet was implemented within acute and community In patient facilities during 2013 and has recently been reviewed and the e-version on all PC's has been updated. March 2015 the Vulnerable People Manual was refreshed and updated, there is ongoing work on the web page. Rationale for Adequacy of Controls is through the newly developed quality management group discussions are ongoing.	Risk Reviewed: July 2015 Risk reviewed and controls updated. Risk Grade/Rating remains High/16	Inadequate; control is not designed to manage the risk and further controls & measures required to manage the risk	High 16	Medium 6	Melanie Johnson	Jeannette Morrison	Healthcare Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
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.	•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. ROSPA QSA Audit complete and action plan in place. NHS Lothian Health and Safety Strategic Plan endorsed. Specific actions related to controlling violence & aggression risk are contained within these reports.	Risk Reviewed: June 2015 The “Description” and “Controls In Place” columns have been adapted to reflect a particular focus on Violence and Aggression Risks. Risk Grade/Rating remains High/15	Adequate but partially effective; control is properly designed but not being implemented properly	High 15	Medium 6	Alan Boyter	Ian Wilson	Staff Governance Committee

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Assurance
3567	2: Improve the quality and safety of health care	Health & Social Care Integration	There is a risk that the Board and its Partners fail to submit agreed integration plans that satisfy the Scottish Government requirements to agreed timescales resulting in a failure to meet its legal responsibilities (Public Bodies Joint Working Act)	•A leadership group with the NHS Lothian CEO and Chair has been in Edinburgh to oversee the development of that particular integration scheme •Integration of Health and Social Care Plan Lothian Leadership Group •Named leads for the writing of the Integration Schemes in each area •Nominated leads for the development of each key section •Common text produced for development in each Local Authority area •Structured engagement with senior staff in the Health Board and Local Authority in East, Mid and Edinburgh •First set of Regulations published in October. Integration Schemes developed in response. •Plans will be open to consideration by the three governance committees during the consultation. •The Board will adopt the "body corporate" integration model (Section 1(4)(a) of the Act) in all four integration schemes •The Board has agreed the functions that must be delegated as defined in the current version of the draft Regulations •Edinburgh Leadership Group established to oversee the Integration Scheme and establishment of the Integration Joint Board •Executives and officers from West Lothian Council and NHS Lothian working to produce an Integration Scheme agreeable to both organisations •The Board has approved the East and Midlothian Schemes for consultation •The Board will consider the Edinburgh and West Lothian Integration Schemes on January 14th. Rationale for Adequacy of Controls: The Scottish Government have issue the final regulations, guidance and orders in relation to health and social care integration. Integration Schemes drafted and all now expected to be out for consultation by January 15th.	Risk Reviewed: June 2015 Risk closed as all integration schemes have now been submitted to Scottish Government.	Adequate but partially effective; control is properly designed but not being implemented properly	Medium 9	Low 3	Alex McMahon	Jamie Megaw	NHS Lothian Baord

Proposed emerging risks for inclusion on Corporate Risk Register

APPENDIX 2

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Date Reviewed
New Risk	2.2 Deliver Safe Care	GP Workforce Sustainability	There is a risk that the Board will be unable to meets its duty to provide access to primary medical services for its population due to increasing population combined with difficulties in recruiting and retaining general practitioners, staffing, premises and IT difficulties. This may affect: - ability of practices to accept new patients (restricted lists); - patients not being able to register with the practice of their choice; - ability to successfully fill practice vacancies; - ability to cover planned or unplanned absence from practice; - ability to safely cover care homes. Difficulties in one practice may impact on neighbouring practices/populations, occur at short notice with the result that practices are unable to provide services in their current form to existing patients.	1. PCCO maintain a list of restrictions to identify potential and actual pressures on the system – this is shared with HSCPs and taken to PCJMG monthly. 2. Position with closure of lists set out in regulatory framework. 3. Ability to assign patients through PSD. 4. HSCP development of risk register for general practice. 5. "Buddy practices" through business continuity arrangements. 6. PCJMG review the position monthly with practices experiencing most difficulties. 7. Primary Care propositions in strategic plan – updates reported to Board and Strategic Planning Committee. Stage one of the primary care propositions are in place and are being implemented. HSCPs are implementing elements of phase 2 as required. 8. Primary Care IT Operational Board now established. Despite these measures the key issues of recruitment and retention of medical staff cannot be tackled only at a Lothian level. It is these issues which can lead to significant difficulties in individual practices which can have knock on effects on other practices.	21/08/13 – AMcN – remains an issue – should be on all CHP risk registers. 07/05/14 – AMcN – updated to add in pressures with lack of locums and in looking after care homes. As at 04/08/15 – general medical practitioners are mostly independent contractors and business continuity is not explicit in the contract. Proposals have been put forward and agreed at the NHS Board for additional support, eg an emergency measures package, clinical development fellows, local enhancement of the National Returner Programme, locum pools of recently retired practitioners, LEGUP/IPA, 2c. These are not yet all funded in the financial plan. 15/09/15 - all of phase 1 measures have been implemented, support measures for 15/16 funded within the plan have been prioritised and are being implemented. In addition Partnerships are putting in place and funding ad hoc support arrangements as problems arise. The PCCO is developing a standard "protocol" for discussions with practices in difficulties. There is still no clarity on the allocation of national primary care funds which would support further measures as set out in phases 2 and 3 of the strategy.	Inadequate; control is not designed to properly manage the risk and further controls and measures are required.	Very High 20	High 16	David Farquharson	David White	06/08/2015

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Notes	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Date Reviewed
New Risk	2.2 Deliver Safe Care	Nurse Workforce – Safe Staffing Levels	There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and / or inability to recruit. Risks occur across the nursing and midwifery workforce where additional capacity is opened to facilitate delivery of other corporate targets (e.g HEAT target 4 hour wait) or where patients have a greater level of acuity than the funded establishment is based upon. Service sustainability risks are high within theatres and anaesthetics, critical care and in health visiting owing to lower levels of workforce supply. Risks arise from the high use of supplementary staffing to counteract shortfalls. The impact of any of these situations potentially compromise the safety of the patient care delivered with consequent impact on length of stay, patient experience and long term	A Nursing and Midwifery Workforce Group has been long established to co-ordinate actions across the organisation. Nationally accredited tools to measure the nursing and midwifery workload by speciality are used on at least an annual basis. The findings from the tools are triangulated with the professional judgement, quality measures and with the local context. The findings from these exercises are used to inform local workforce plans to minimise risk and where appropriate escalated as priorities for additional funding via the financial planning process. eRostering and SafeCare are being rolled out to all nursing and midwifery wards, community teams and departments to provide real time information for local decision making around the deployment of the available staffing. Escalation procedures are in place to review the use of external agency suppliers. Datix reports are escalated on a weekly basis for all incidents with staffing issues identified as a major or contributory factor. In response to a request from SEAT Workforce Board a regional approach is being adopted to the Health Visiting workforce recruitment, training and deployment of staff.		The control is adequately designed to manage the risk, but it is not being implemented properly	Medium	Low	Melanie Johnson	Fiona ireland	

ID	NHS Lothian Corporate Objectives	Title	Description	Controls in place	Updates	Adequacy of controls	Risk level (current)	Risk level (Target)	Risk Owner	Risk Handler	Date Reviewed
Review of risk – previous number (3198)	3. Secure Value of Financial Sustainability	Facilities Fit for Purpose	Insufficient funding, difficulty in obtaining capital investment, continued deterioration of the fabric and infrastructure within identified sites, failure to maintain current standards and positive HEI reporting. Possible failure to comply with statutory legislation, reputation at risk.	•The reported backlog maintenance as at 1st May 2015 and reported in the Property Asset Management Strategy (PAMS) 2015 is now £67.4m which includes a 13% uplift for inflation which has been applied nationally. The PAMS describes the action which will be taken to reduce the figure, which includes estate rationalisation, capital investment and Re-provision projects.. •The financial plan for 2015/16 has allowed for a further £3m BLM allocation for 2015/16, thereafter the allocation has been reduced to £2.5m. Programmes of works are being confirmed for the next three financial years. •The capital plan for 2015/16 has a number of capital projects which will improve the physical condition of the estate and reduce backlog maintenance. •The programme of works will continue to address high and significant risks. The programme continues into the financial year 2015/116. The allocation for this financial £3m has been committed. •A procurement and implementation strategy was approved in early November 2012, which described how this funding would safely expended. •An update of the PAMS each year will log the affect upon the backlog maintenance and compliance figure. - Regular updates are provided to the Capital Steering Group and Capital Investment Group •A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance. •A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years.	Reviewed by A&R Committee June 2015 and it was agreed to reinstate this risk back on the risk register. Programme of works for 2015/16 has been prepared against an allocation of £3m. A review of the current risks and re-categorisation of the risks dependent on use of property is currently ongoing and as a result of this process and investment in the estate the total of high and significant works has fallen from 78% (of total blm) to 73%. The disposal programme for 2015 has reduced the BLM with the sale of Rosslynlee and Longstone clinic to date. Two other properties are due to be sold this financial year. Further properties have now declared surplus in line with the property rationalisation programme of works.	Adequate but partially effective; control is properly designed but not being implemented properly	High	Medium	Alan Boyter	George Curley	17/02/2015

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NHS LOTHIAN

2.9

Board Meeting
7 October 2015

Director of Strategic Planning, Performance Reporting & Information

SUMMARY PAPER - TRANSFORMING OLDER PEOPLE'S SERVICES IN EDINBURGH

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

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

• to update the Board on progress with funding the transformational plan which has been developed to reshape older people's services in Edinburgh	3.2
• The first steps and key components of the wider strategy are summarised	3.3
• Details are provided of the immediate steps now underway in relation to additional interim care home, care at home and reablement capacity	3.4,3.5
• Expected impact in terms of packages of care supporting discharge and reduction of delayed discharges are provided	3.6
• The vision for locality working in Edinburgh will develop locality hubs working with hospital discharge hubs to ensure patients who could benefit from reablement to receive this.	3.8
• A robust governance structure is being implemented to lead the strategic planning and decision making around integrated older people's services in Edinburgh.	3.9
• Key risks include internal and external workforce availability.	4
• While funding has been agreed in 15/16, agreement on future years will be dependent on discussions in December about progress made.	8

Libby Tait
Associate Director, Strategic Planning
25 September 2015
Libby.tait@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 2015

Director of Strategic Planning, Performance Reporting & Information

TRANSFORMING OLDER PEOPLE'S SERVICES IN EDINBURGH

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress with the transformation plan which has been developed to reshape older people's services in Edinburgh, led by Edinburgh Integration Joint Board (IJB) and with support from Scottish Government colleagues.

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

2 Recommendations

2.1 Welcome the progress with development and early implementation of a three year transformation plan to improve older people's services in Edinburgh, and the support funding secured from Scottish Government to date;

2.2 Note the anticipated impact on availability of community packages of care and on delayed discharges in the hospital division by the end of March 2016;

2.3 Agree to support and ensure wider system engagement with the robust governance framework for older people's services now planned

2.4 Recognise the risks associated with bridging funding and market capacity which will require to be resolved or mitigated to achieve sustainable improvement.

3 Discussion of Key Issues

3.1 The Edinburgh IJB has been established at a time when the demographic and financial challenges facing the partnership have never been greater. The partnership along with the parent bodies of NHS Lothian and City of Edinburgh Council have agreed an urgent priority is to take forward a three year transformation plan to improve the delivery of services which care for older people. In recognition of this the IJB focused its first full development session in August 2015 on discussing the steps needed to improve older people's services.

3.2 The challenges to the health and care system in Edinburgh which result in unacceptably high numbers of patients being delayed in hospital, and in increasing numbers of elderly people waiting for packages of care at home, are well known to the Board. The plan developed has recognised that essential first steps to reshape older people's services are to maximise the use of the re-ablement pathway, to expand and then release core capacity for care at home and to provide additional interim care home capacity and challenging behaviour care home places to reduce discharge delays. This resulted in a proposal for interim "bridging" funding which was submitted to the Scottish Government in late July 2015. In September agreement was reached that £2m would be allocated for

2015/16 with a potential further £1m in the current year, subject to review in December once the impact of the initial funding and actions is apparent.

3.3 The first steps in the strategy are the investment in additional capacity to unblock reablement and the expansion of Gylemuir with a further 30 interim care beds.

In order to sustain an ongoing improvement in delays the wider strategy will include:

- Cultural change including addressing risk averse culture
- Appointment to the four Interim Locality Manager Posts
- Focus on Prevention of Admission through Locality Working
- Building upon work with the Third Sector, EVOC, LOOP's etc. to signpost to alternative services
- Improvements in discharge flow with a requirement to deliver at least 80 discharges per week on a sustainable basis
- Greater emphasis on discharge home without a package where appropriate
- Whole system capacity planning and focus on the circa 2% of the population who make the greatest use of services

3.4 **Additional Beds at Gylemuir House**

It has been agreed that 30 additional interim care home beds will come on-stream at Gylemuir to provide interim care for those waiting in hospital for care home and complex care packages. These beds will become available over two phases in September and December with 7 residents able to be admitted per week, the first being admitted the week commencing 14 September.

3.5 **Additional domiciliary care capacity**

There are two mechanisms planned for achieving additional domiciliary capacity. The first, to free up capacity in reablement, is the expansion of mainstream domiciliary care by 1,100 hours. These purchased Care at Home hours are anticipated to become available in two phases; 550 hours in December and a further 550 hours in January.

Further capacity will be achieved by the current Home Care recruitment programme. It is anticipated that three groups of up 30 staff will complete the essential learning programme on 18 December 2015, 29 January 2016 and 18 March 2016. These staff will be split 5:1 between the Reablement Task Force (which will free up capacity in mainstream domiciliary care by working with people who previously did not receive reablement to reduce the volume of care they require),and increasing mainstream homecare capacity.

3.6 **Impact on delayed discharge**

The number of people delayed in Edinburgh at the August census was 150. There were 102 waiting for more than two weeks. It is assumed that this figure will remain the same at the September census. From September on the benefits of the initial investments should be seen assuming the anticipated benefits are fully realised.

The table below shows the estimated impact on overall delays and delays over two weeks of the additional interim beds and domiciliary care capacity:

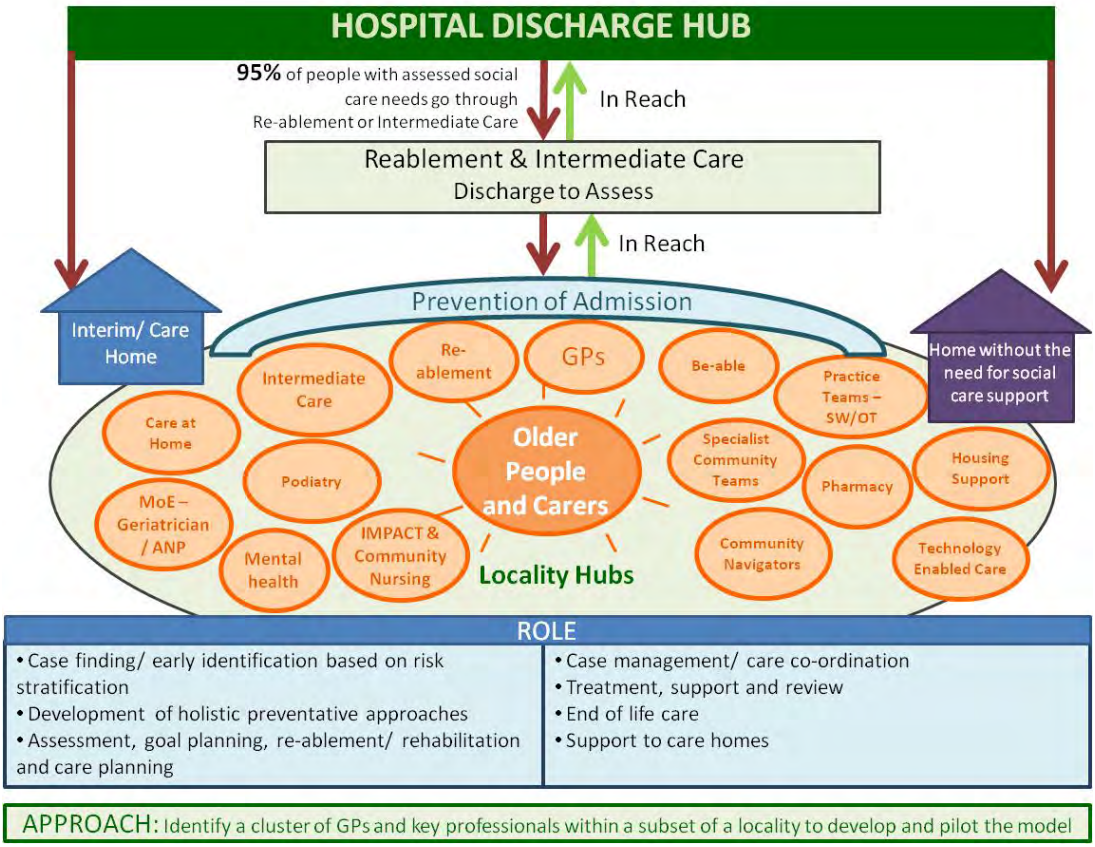
	Total No. of Delays	No. of Delays >2 weeks
August	150	102
September	150	102
October	135	87
November	123	75
December	98	50
January	82	34
February	48	0

The baseline level of packages of care and residential placements per week that need to be delivered to achieving this impact is between 80 and 90 supported discharges a week. Scottish Government colleagues are keen to see a faster trajectory of improvement than we have proposed and this is one aspect on which future funding will be decided. There needs to be a concerted effort from all stakeholders to achieve this weekly target as soon as possible.

3.7 **Winter planning**

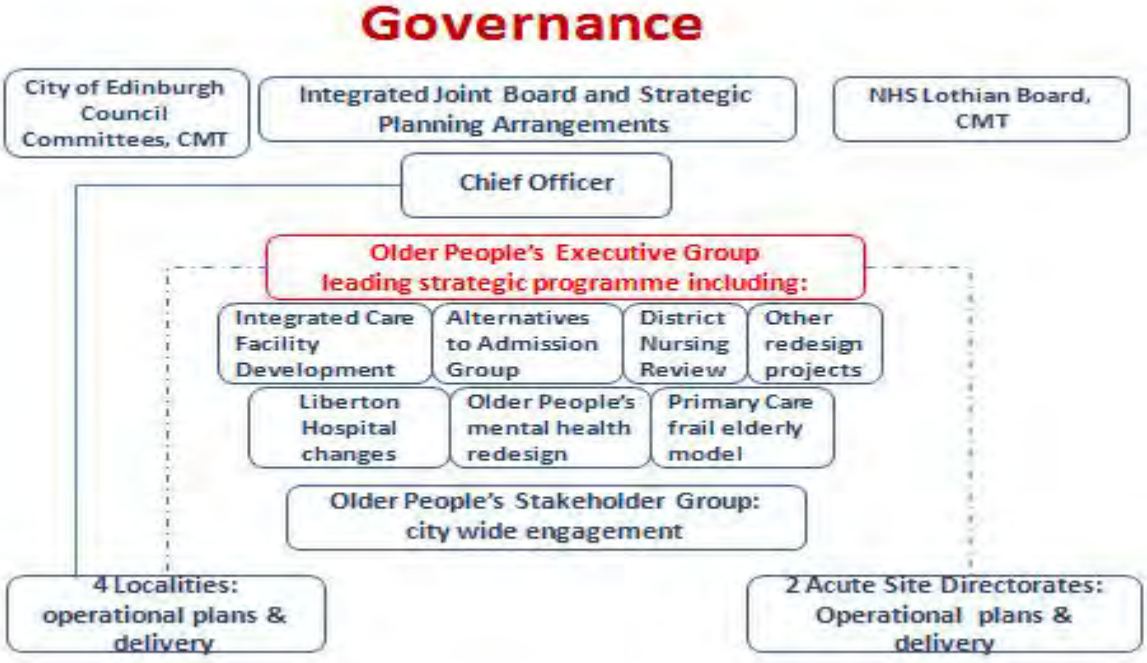
To ensure the health and care system can manage the usual peaks in demand in winter, the Edinburgh system will need to achieve and maintain the target number of discharges all through the festive and winter period. The Chief Operating Officer for the Acute System and his team have agreed to fully support engagement of hospital consultants and multidisciplinary teams alongside Edinburgh Health and Social Care staff teams to maintain forward momentum on our plans.

3.8 The diagram below illustrates the vision for locality working which is proposed to transform health and care services for older people in Edinburgh. It is essential that all patients who can benefit from reablement, intermediate care and discharge to assess on discharge from hospital follow this pathway, (circa 95% of those with assessed social care needs), so that individuals can be supported to live as independently as possible after an acute hospital admission.



3.9 Governance Arrangements around Older People's Agenda

As part of this work there is a need for tighter governance of service planning and clarity of interface with day to day management arrangements around this agenda in order that all are clear on decision making and responsibilities. Revised governance arrangements which anticipate the role of localities are highlighted below including the establishment of a key senior group leading service change, led by the Chief Officer shortly to be appointed.



The remit of the Older People's Executive Group is as follows:

- Lead the strategic planning and decision making of integrated older people's services in Edinburgh
- Oversee the development of a whole systems capacity plan for older people's services
- Develop, review and oversee the programme for older people's redesign projects, to include shifting the balance of care
- Oversee the development of transparent outcome information including finance, workforce, activity and quality
- Work with the emerging locality structures to progress plans for integrated locality working

Operational delivery of older people's services will be the responsibility of the 4 Locality Managers and the acute Site Directors, and their membership of this group will ensure full alignment between strategic direction and operational delivery.

4 Key Risks

There are a number of risks associated with achieving the reduction in delayed discharge levels as described in this paper, as follows:

- There are not enough staff available to fill the new posts to create additional capacity
- Packages of care are placed directly with mainstream providers by hospital staff and are not routed via reablement
- The anticipated reduction in care hours by the Reablement Task Force of 37% is achieved
- Care at Home providers will accept and support all allocated packages of care within their geographic area
- No other demands are made on the new staff, diverting them to address new emerging pressures
- Capacity freed up in hospital is not filled with more delayed discharge patients
- These levels can only be sustained assuming funding is available beyond March 2016
- There are further care home closures in the City which reduce overall capacity and require urgent prioritisation within remaining capacity.

5 Risk Register

There are no new implications for NHS Lothian's risk register. The plans described are expected to significantly mitigate the risks to the delivery of flow and capacity in the Lothian health system.

6 Impact on Inequality, Including Health Inequalities

This report is an update on progress with steps to improve existing care pathways and no policy change is proposed.

7 Involving People

The transformation plan draws on the engagement with a wide range of stakeholders including the Older People's workshop held in July, and the discussion at the IJB development workshop in August. The new governance arrangements include the re-designation of the Edinburgh Joint Older People's management group as a stakeholder engagement group to ensure ongoing wide engagement in the service transformation programme.

8 Resource Implications

8.1 The bridging submission to the Scottish Government requested funding as follows:

2015-16 (£)	2016-17 (£)	2017-18 (£)	2018-19 (£)	Total
3,137,108	6,301,109	4,567,982	508,421	14,514,620

The £2-3m available from the Scottish Government for 2015/16 will be used to fund 30 beds at Gylemuir and additional care at home and homecare. It should be noted that no commitment to funding at this point has been given for 2016/17. The 2016/17 full year costs of the additional beds at Gylemuir and additional cost of care at home is £5,218,530.

The funding position for 2016/17 will be discussed in December with Scottish Government, at which point an assessment of the need for the further £1m in 2015/16 will also take place. It is important to recognise that further bridging funding in 2016/17 will be essential to sustain improved performance.

Libby Tait
Associate Director, Strategic Planning
25 September 2015
libby.tait@nhslothian.scot.nhs.uk

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NHS LOTHIAN

2.10

Board Meeting
7 October 2015

Chief Executive

SUMMARY PAPER - NHS LOTHIAN CLINICAL QUALITY APPROACH

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

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

• The purpose of this report is to update the Board on the NHS Lothian Clinical Quality Approach which is under development, with the intention of achieving outcomes in line with the 6 dimensions of quality	1.1-1.3
• The clinical quality management system will include the Clinical Change Forum, a Clinical Quality Academy, and the Clinical Quality Programme	3.2.1
• The initial pathways will be selected for the clinical quality programme against agreed criteria	4.3
• Three initial phases of work are planned over a nine month period from October 15 – June 16	4.4
• It is anticipated that it will take 3-5 years for the programme to become embedded and sustainable	9.3
• Success will be evaluated by measureable quality, efficiency and cost outcomes, and the successful development of quality improvement capacity and capability in operational leaders.	9.3
• The Board is asked to endorse the need to secure strategic partnerships with public sector organisations and Intermountain Healthcare to drive this work forward.	4.1, 4.4.5
• A funding request is proposed via a business case to Edinburgh and Lothians Health Foundation to cover additional costs in the initial years	9

Libby Tait
Associate Director, Strategic Planning
25 September 2015
Libby.tait@nhslothian.scot.nhs.uk

NHS LOTHIAN

Board Meeting
7 October 2015

Chief Executive

NHS LOTHIAN CLINICAL QUALITY APPROACH

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on the NHS Lothian Clinical Quality Approach which is under development and to ask the Board to support the next steps in the development of a full business case.

1.2 The planning assumptions on which the approach is being developed are in relation to:

- challenges of integrating care across boundaries and designing services around patient voice and choice
- a global and local variation in healthcare practice leading to high rates of inappropriate or unwarranted care
- unacceptable rates of care-associated patient injury and death including HAI
- an inability to always “do what we know works" in relation to achieving nationally approved standards of care e.g. Stroke care bundle compliance
- large amounts of waste leading to excess process costs that limit access to care especially in the face of increasing demand and rapidly changing demography
- evidence from highly reliable healthcare organisations worldwide that a focus on improving the quality of healthcare controls cost of delivery

1.3 Our aspirational health care delivery model aims to deliver across all 6 recognised dimensions of quality:

- All the right care (no underuse)
- But only the right care (no overuse);
- Delivered free from injury (no misuse);
- At the lowest necessary cost (efficient);
- Coordinated along the full continuum of care (timely; "move upstream“);
- Under each patient's full knowledge and control (patient-centered; “nothing about me without me”).

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

2 Recommendations

2.1 The Board is asked to support the development and implementation of an NHS Lothian Clinical Quality Approach, and the realignment of existing improvement

support resources which will contribute to its delivery;

2.2 The Board is asked to endorse the need to secure strategic partnerships with public sector organisations (see 4.1) and Intermountain Healthcare to drive this work forward.

2.3 The Board is asked to support the submission of a business case for funding to support the Clinical Quality Approach to the next meeting of the Edinburgh and Lothians Health Foundation Trustees.

3 Discussion of Key Issues

3.1 Need for Change

The need for transformational change to ensure that the NHS delivers high quality care and improved outcomes is well documented[1]. The NHS is under increasing financial pressure to achieve year on year efficiency, with the focus on rationalising inputs to the system, which is proving increasingly difficult. Over a number of months members of the multi-professional Clinical Change Forum have discussed how NHS Lothian might develop a more sustainable approach to care, by radically changing our current practice while maintaining or improving clinical outcomes. The discussions have centred on the increasing challenge of developing and sustaining quality healthcare at an affordable cost in the face of the rapidly changing demography of the patients using our service. The attached Health Foundation report "Quality Improvement Made Simple" (appendix 2) provides useful background information for Boards on approaches, methodology and success factors.

In all highly reliable healthcare organisations, it is clear that senior leadership commitment to the importance of the work, the introduction of a consistent improvement methodology and creating improvement capability within the workforce, are key to the successful delivery of improvement strategies. It was to this end that our senior team engaged with Intermountain, a highly respected healthcare organisation in the USA and part of the High Value Healthcare Collaborative including Dartmouth health system and the Mayo Clinic.

Last month, hundreds of NHS Lothian staff attended workshops and sessions with Dr Brent James, the Chief Clinical Quality Officer with Intermountain Healthcare who shared with us aspects of their Clinical Quality Management System. He described how data in the form of clinical outcomes, financials and care experience are used to develop a clear understanding of clinical processes and eliminate inappropriate variation within services. This system of management and measurement focuses on front line value-adding clinical processes to underpin improvement and ensure affordability and sustainability of their integrated health system.

3.2 Transformational Change – Clinical Quality Management System

NHS Lothian is proposing a fundamental shift in the way we work, learning from high reliable organisations and building on the success of the patient safety programme in Lothian. We are seeking to move away from seeing improvement as one off projects to a way of working embedded into the management system in order to realise improvement in patient outcomes, reduction in clinical variation and improved resource utilisation. This Clinical Quality Management System requires collective and

[1] The Kings Fund – Reforming the NHS from within, June 2014, Chris Ham

dedicated leadership. It would be set within NHS Lothian's core values with skilled clinicians working with experienced managers developing, implementing and monitoring clinical care processes across primary, secondary and social care services.

This transformational Clinical Quality Management System will enable the delivery of NHS Scotland's 20/20 Vision and NHS Lothian's strategic plan (Our Health, Our Care, Our Future), mirroring the Intermountain system by focusing on frontline value-adding care processes that are integrated into the management system to improve patients outcome and improving reliable evidence-based care, whilst maximising resources by reducing waste, improving efficiency and reducing variations in care.

3.2.1 Key elements of this transformation will include:

- Using an open multi-professional and board wide **Clinical Change Forum** (CCF) to discuss with frontline staff how NHS Lothian develops a sustainable approach to care, by changing practice and improving outcomes. Discussions to date have centred on the increasing challenge of trying to provide quality healthcare at an affordable cost.
- The development of a **Clinical Quality Academy** that will deliver training to front line clinical teams, clinical and non-clinical managers and executive sponsors of the improvement activities, to build capacity and capability for quality improvement within the service.
- The development of a **Clinical Quality Programme** which will support service based clinical teams to identify key priorities for improvement, and support clinical teams with data driven clinical process mapping, testing and implementing improvements within their services supported by appropriate expertise from the Quality Improvement Support Team.
- Pathway improvement activity will be led by designated **Clinical Quality Management Leads**. The infrastructure to support this will evolve over the coming months as the Clinical Quality Steering Group, chaired by the Chief Executive, identifies the first clinical pathways to be redesigned through the Clinical Quality Programme. Implementation and sustainability of improvement will be monitored and supported by the current clinical management infrastructure leading eventually to a total **Clinical Quality Management system** for NHS Lothian.

3.2.2 It is the intention that over the coming months, multi-professional clinical teams within every service area will have the opportunity to identify key pathways or processes that would benefit from redesign or improvement through the Clinical Quality Programme. The criteria for pathway selection will rely heavily on the use of clinical process and outcomes data (see 4.3 below).

3.2.3 While an important component of understanding frontline processes and agreement of evidence based best practices involves standardisation, it is vital that this approach incorporates the patient voice and an ability to vary based on individual need i.e. the concept of mass customisation. Conversations in the CCF have also introduced the concepts of "Choosing Wisely". Although these principles will be an integral part of the Clinical Quality Approach, they may have a wider application to clinical decision making and are therefore being promoted in a parallel policy. The draft policy statement which will be tested out at the 30th September Forum is appended at appendix 1.

3.2.4 Central to this work of evolving an awareness of the reliability of our front line care processes is the consistency of our data entry, analysis and reporting. We recognise

that significant investment will also be required in developing our data and financial analytic capacity to support all of this work.

4 Initial Programme

4.1 Recognising the success of quality improvement strategies in other Health systems, including Intermountain Healthcare, Scottish Government colleagues have expressed support for NHS Lothian in developing and testing this approach as a pathfinder for Scotland. Discussions are also taking place with Health Improvement Scotland (HIS), NHS Education Scotland (NES) and the University of Edinburgh (the Farr Institute) as a wider strategic partnership, alongside, we hope the Edinburgh and Lothian Health Foundation.

4.2 NHS Lothian already invests heavily in both the national patient safety programme, our own internal quality and service improvement activity and in the development and support of high quality patient experience both in the acute and primary care settings. This new approach however will over time, result in a significant step change in NHS Lothian's organisational way of working. Thus our approach recognises the importance of testing and evaluating the impact on clinical outcomes, patient experience and resource utilisation. Growing and embedding capacity to support this approach to the management of clinical quality will also take time and learning.

4.3 Our initial focus in terms of clinical pathways will be based on criteria (listed below) and will focus on high volume, high cost services and areas where performance improvement is required. Allocation of pathways to the clinical quality programme will be made by the Clinical Quality Steering Group chaired by the Chief Executive and informed by the following criteria:

1. How do we know this pathway and/or aspect of the pathway requires improvement: What is our data / intelligence telling us?
2. What is the problem definition and from which perspective (patient, clinicians, managers).
3. Is it a high cost/volume system
4. Does it have within it intensive interventions (usually costly).
5. Does it provide opportunities to incorporate efficiency and productivity, choosing wisely (share decision making) and end of life care.
6. Is the team involved ready for change and able to identify a multi-disciplinary change team?
7. What other current improvement activity is already taking place across this pathway.

4.4 The initial programme of work to take place over the next 9 months will comprise the following:

Phase 1: Planning & Promotion (Sept-Dec '15)

4.4.1 As data is key to understanding and developing awareness of our clinical processes we will undertake an assessment of the quality of existing clinical and financial data. High reliability organisations undertaking similar transformations have found that their current dataset describes less than 50% of the care processes reliably. We will also require to establish a basic infrastructure to support data collection, analysis and

visualisation for the clinical teams involved in the initial pilot areas, building on our existing data systems.

4.4.2 This phase will also include awareness raising for all areas and staff groups to align the Board and steering group aspirations for this total quality approach to that of our clinical workforce including our patient groups.

Phase 2: Initial Preparation & Faculty Development (Oct – Dec '15)

4.4.3 This phase will focus on sharing the organisational vision, establishing a common vocabulary across existing improvement methodologies, and outlining a standard approach to focus on front line value adding clinical processes with those in the organisation who currently have aspiration or expertise in the area of clinical improvement.

4.4.4 We will also during this phase engage with the clinical and support teams identified around the first set of allocated pathways, providing preparatory information in readiness to commence supported and patient focused change programmes in the New Year.

4.4.5 Learning from other organisations that have embraced a similar total quality approach shows that early access to support materials for clinical teams with already well-established quality improvement activities, and those individuals and teams keen to engage in the programme is key to building momentum. We will engage with both the BMJ Quality platform and the Intermountain Healthcare 100% participation programme to support these individuals and teams.

Phase 3: Focused Training (Jan – June '16)

4.4.6 The Lothian Clinical Quality Academy will launch the first offering of its development programme focusing on members of the clinical teams identified in the first group of allocated pathways, along with clinical and non-clinical senior managers and members of the executive team. The programme will aim to support and develop confidence and capability in quality improvement using the methodologies identified in the Intermountain programme and in offerings from other members of the High Value Healthcare Collaborative.

4.4.7 During this phase we will also be supporting these front-line clinical teams to plan and implement quality improvement activities supported by data analysis and aligned financials.

5 Key Risks

5.1 This approach which has been tested in other health economies, took time and coherent organisational intent and leadership to achieve demonstrable improvements. There is a risk that if these key requirements are not sustained over a number of years we will not achieve improved outcomes for patients, staff and the organisation.

5.2 The development of internal capability and capacity to deliver this approach including informatics infrastructure could be compromised given the competing demands and priorities within and out with NHS Lothian.

5.3 Managing the transformation from the current clinical and managerial approach to an integrated clinical managerial system will be challenging especially in the current financial climate and transparency of alignment between the organisational clinical quality approach and achievement of organisational priorities will be essential.

6 Risk Register

6.1 This proposed approach seeks to positively contribute to the reduction of a number of risks on the current corporate risk register from improving patient experience to finance.

7 Impact on Inequality, Including Health Inequalities

7.1 The clinical quality approach is founded on the 6 dimensions of quality, including equity. Impact assessments will be undertaken as part of considering any changes to processes and protocols considered as part of the clinical quality programme.

8 Involving People

8.1 There has been wide engagement with the clinical community in NHS Lothian during the year through the clinical change forum. The clinical quality approach and programme of pathway transformation will include the perspectives of service users and carers as well as staff and stakeholders across the system.

9 Resource Implications

9.1 The NHS Board currently invests in a range of improvement support through its patient safety programme, the efficiency and productivity support, the modernisation team, and support for organisational development.

Table 1 – Current Investment in Improvement Support

	£k
Efficiency & Productivity Team	£316
Other Programme Management Resources	£503
Modernisation Team	£188
Quality Improvement and Safety Team	£445
Current Improvement Support Investment	**£1,452**

9.2 It is anticipated that this resource will, either in part or in full, form the initial quality improvement support team, with the extent of team input depending on support skills required and an assessment of current work programmes. However it is clear that there will be an immediate requirement for a stepped change in data and financial analytical capacity, programme management capacity and release of front-line clinical time and leadership. Access to external training and mentoring will also be required.

9.3 It is expected that over a 3 to 5 year period this approach will become the organisational way of working with NHS Lothian embedding this vision for quality i.e. moving from parallel structures of clinical management and quality improvement to a combined and focused total quality management approach. Success will be evaluated by the measureable quality, efficiency and cost outcomes within the allocated pathways, and the development of capacity and capability of operational leaders to deliver programmes to maintain and improve service quality.

9.4 The initial programme of activity to facilitate and achieve the phases outlined has the following resource implications, in addition to the existing internal capacity:

Table 2 - Initial Programme of Activity Estimated Costs

	Current Year Costs £k	Full Year Costs £k
Initial Training Module Event	£24	£47
Lothian Mini Advanced Training Programme	£82	£159
Other Ongoing Costs	£10	£16
Quality Academy Infrastructure	£100	£199
Quality Programme Infrastructure	£256	£414
Intermountain Advanced Training Programme & Fact Finding	£90	£90
Initial Programme and Academy Costs	**£562**	**£925**

9.5 Scottish Government colleagues have indicated willingness to contribute to support the programme in the initial years. Funding support will be also sought via a business case to be submitted to Edinburgh and Lothians Health Foundation for the initial phases, and potentially for 3-5 years. Longer term it is envisaged that the programme will be sustainable within core NHS Lothian resources.

Simon Edgar
Associate Medical Director

Nikki Maran
Associate Medical Director

Alex McMahon
Director of Strategic Planning ,Performance Reporting and Information
25 September 2015
Alex.McMahon@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Draft Choosing Wisely policy position
Appendix 2: The Health Foundation - Quality Improvement Made Simple

APPENDIX 1

NHS Lothian 'Choosing Wisely'

Background

- Participants in the NHS Lothian Clinical Change Forum wish to explore new ways of delivering clinical care in the context of limited financial resource but growing demand.

- Such demand stems from
    - changing patient demographics
    - increasing prevalence of multimorbidity and long-term conditions
    - increasing patient and political expectations
    - new technologies
    - increasing options for both drug and procedural interventions
    - the influence of pressure-groups
    - the practice of defensive medicine.

- We believe that many "disease-centred" care models require review to ensure delivery of high quality, timely and effective care which still meets patient wishes and expectations, but also ensures best use of NHS resources in a sustainable way.

- Individual patients present with varying co-morbidities, psychological and physical frailties, social challenges, coping strategies and support networks. Consequently the benefits, harms and the burden of treatment faced by individual patients will differ. However, Guidelines and 'Standards' are derived from analysis of large groups of patients and may therefore only partially help the clinician address the individual patient's problem.

- *Choosing Wisely* is an approach embraced by international health institutions and specialty-based organisations. It has invited practitioners and patients to re-evaluate the risk/benefit ratio and appropriateness of some investigations and treatments with the aim of encouraging practitioners to reduce or avoid the use of potentially harmful or wasteful practices.

- *Minimally Disruptive Medicine* (MDM) is another new concept that invites clinicians to take account of multi-morbidity and the overall burden of care faced by the individual patient, and consider treatment strategies that might minimise that burden. By providing 'more thoughtful care' in a holistic fashion, it is argued that patient outcomes and experience are improved and healthcare waste reduced.

Recommendation

- We propose that the core concepts behind *Choosing Wisely* and MDM are combined into a broader initiative, and invite NHS Lothian to support the introduction of this initiative into healthcare delivery in all areas.

- Introducing such an initiative will complement the *NHS Lothian Clinical Quality Approach* and *NHS Lothian Our Health Our Care, Our Future Strategic plan 2014-2024* to deliver the highest quality, safe and person centred care in the most cost effective and sustainable manner.

- The expected value of adopting *Choosing Wisely* in NHS Lothian would be improved patient experience, reduced avoidable harm, reduced waste from inappropriate use of healthcare resource and thereby improved capacity.

- If supported, there would be a need to engage both the clinical community and patient groups to ensure that there is an understanding and trust that the primary motivation for change is to provide sustainable, quality care to patients that best meets their individual needs.

Key Actions

- Clinicians should be encouraged to:
    - understand the overall burden faced by the patient.
    - ascertain patient preference i.e. "What matters to me".
    - question the applicability of evidence-based guidelines and standards for the individual patient and have the clinical confidence through peer and organisational support to deviate from guidelines when they judge that to be appropriate.
    - question the added value of proposed investigations, interventions or treatments in the individual patient in the light of knowledge of the 'whole patient' .
    - understand the impact of multi-morbidities, make some assessment of prognostic impact of these and judge whether that knowledge shifts the risk/benefit ratio for "usual" treatment strategies.
    - understand the burden of treatment and expected impact on the patient.
    - undertake shared decision making through explicit and open discussion of treatment options, expected benefits and risks of harm.

- Clinicians will need support to deliver the above. This may be provided by:
    - Education and training in communication strategies.
    - Provision of accessible information from data to help clinicians and patients understand impact of multi-morbidities on overall prognosis and understand the potential impact of treatment strategies.
    - Support and mentorship of clinicians who may be concerned about 'not doing something' in some cases. Development of local Ethics Committees, and supporting existing MDT meetings could prove useful to foster a culture where a Choosing wisely approach is actively considered.
    - Allowing sufficient time in clinical settings to 'stop and think', enable meaningful discussion, ensure medicines optimisation and ultimately enable delivery of the 'right care to the right patient the first time'.
    - Support to clinicians from the Organisation when there is a challenge to the recommendation not to offer a treatment/intervention: where there is insufficient clinical indication; or where there is no evidence of benefit for a treatment option; or where there is significant risk of increased harm such that the risk benefit ratio is adverse; or evidence that the benefit is not sufficient to warrant the cost.

- Patients should be encouraged to
    - Understand the complexity of clinical decision making , the absence of evidence for much practice and the uncertainty of outcome in some clinical situations.
    - Ask whether specific treatments or investigations will help them.
    - Ask whether specific investigations are actually necessary, particularly if they have been recently performed.
    - Express their preferences regarding proposed investigations or treatments.

Authors
Dr C Whitworth
Dr K Boyd
Dr A Elder

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APPENDIX 2

QUALITY IMPROVEMENT MADE SIMPLE

What every board should know about healthcare quality improvement.

Identify Innovate Demonstrate Encourage

ABOUT THE HEALTH FOUNDATION

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK. We want the UK to have a healthcare system of the highest possible quality – safe, effective, person centred, timely, efficient and equitable. We believe that in order to achieve this, health services need to continually improve the way they work.

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

CONTENTS

INTRODUCTION

1

Improving quality is about making healthcare more safe, effective, patient centred, timely, efficient and equitable. In the history of the NHS, there has never been such a focus on improving the quality of health services.

The economic downturn means an end to year-on-year financial increases, and boards are being challenged to respond not through indiscriminate cuts, but by driving up quality, reducing harm and improving efficiency.

Improving the quality of services is now a key requirement within the NHS, supported by initiatives such as the Commissioning for Quality and Innovation (CQIN) payment framework, and quality accounts. The board has a major role to play in ensuring that the organisation focuses on quality improvement approaches, applies them, and achieves the necessary outcomes.

This guide focuses on one important element of the quality agenda: quality improvement. It looks in particular at what are known as 'organisational' or 'industrial' approaches to quality improvement, which focus on bringing about a measurable improvement by applying specific methods within a healthcare setting.

This is not a 'how to' guide. Instead, it offers a clear explanation of some common methods and approaches used to improve quality, including where they have come from, and their efficacy and applicability within the healthcare arena.

WHY FOCUS ON QUALITY IMPROVEMENT?

The Health Foundation believes that there is a compelling case for applying organisational or industrial quality improvement approaches to healthcare. The evidence that applying these quality improvement approaches can reduce costs is patchy, although there are growing indications that some can be effective if used appropriately.[1]

But a focus on improvement is not just about reducing costs. It is also about ensuring that healthcare is as safe as it can possibly be. At present, the evidence is clear that healthcare is not always safe – one in 10 hospital inpatients is likely to suffer an adverse event during their stay. Given this, it is likely that even high-performing healthcare organisations can improve the quality of healthcare they deliver, resulting in improvements in patient outcomes, experience and efficiency.

Nevertheless, for some boards this is a challenging agenda. As the drive to improve quality has moved centre stage for NHS organisations, the role of the board in ensuring these approaches are being appropriately employed becomes pivotal. To take on this challenge, every board member needs to understand the characteristics that make success more likely in terms of impact, outcome and sustainability.

[1] Øvretveit J. *Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to health service providers*. London: Health Foundation, 2009.

WHO IS THIS GUIDE FOR?

This guide is written primarily for board members of NHS trusts, but it should prove helpful for any leader in a healthcare organisation who has an interest in approaches to quality improvement.

The guide provides an overview of organisational or industrial approaches to quality improvement. It is intended for those who need to understand approaches to quality improvement but who are not directly involved in the day-to-day work of a quality improvement programme. Having read the guide, you should be in a position to ask the right questions of those who are tasked with leading this work – including the chief executive, who has ultimate responsibility for improving the quality of services offered to patients.

KEY LEARNING

Improving the quality of services is now a key requirement within the NHS. The board has a major role to play in ensuring that the organisation focuses on quality improvement approaches, applies them, and achieves the necessary outcomes.

WHAT ARE 'QUALITY' AND 'QUALITY IMPROVEMENT'?

2

The terms 'quality' and 'quality improvement' mean different things to different people in different circumstances.

This can be confusing. This section looks at common definitions of both terms, and summarises how they are broadly understood.

WHAT IS QUALITY?

Within healthcare, there is no universally accepted definition of 'quality'. However, the following definition, from the US Institute of Medicine (IoM), is often used:

> the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge.[2]

The IoM has identified six dimensions through which quality is expressed.[3] They are:

- safety
- effectiveness
- patient centeredness
- timeliness
- efficiency
- equity.

[2] Institute of Medicine. *Crossing the quality chasm: a new health system for the 21st century.* Washington DC: National Academy Press, 1990, p244.

[3] *Ibid.*

The Health Foundation regards quality as the degree of excellence in healthcare. Excellence is multi-dimensional. For example, drawing on the Institute of Medicine definition, it is widely accepted that healthcare should be safe, effective, person centred, timely, efficient and equitable.

So, boards need to actively consider these six dimensions when setting their priorities for improvement. Often the dimensions are complementary, and work together. However, there are tensions among them that need to be balanced – for example, person-centredness may not always go hand-in-hand with efficiency. Meanwhile, it is important to take into account the different views of stakeholders about what they feel matters, and what the priority areas of focus should be within the organisation.

The dimensions of quality

Safe
Avoiding harm to patients from care that is intended to help them.

Effective
Providing services based on scientific knowledge and which produce a clear benefit.

Person-centred
Providing care that is respectful or responsive to individuals' needs and values.

Timely
Reducing waits and sometimes harmful delays.

Efficient
Avoiding waste.

Equitable
Providing care that does not vary in quality because of a person's characteristics.

WHAT IS QUALITY IMPROVEMENT?

There is no single definition of quality improvement, and no one approach appears to be more successful than another. However, there are a number of definitions that describe quality improvement as a systematic approach that uses specific techniques to improve quality. The most important ingredient in successful and sustained improvement is the way in which the change is introduced and implemented.

This guide draws its definition of quality improvement from that provided by Dr John Øvretveit, a leading expert on quality in healthcare, in his report *Does improving quality save money?*, which states:

> The conception of improvement finally reached as a result of the review was to define improvement as better patient experience and outcomes achieved through changing provider behaviour and organisation through using a systematic change method and strategies.[4]

For us, the key elements in this definition are the combination of a 'change' (improvement) combined with a 'method' (an approach or specific tools) to attain a superior outcome.

[4] Øvretveit J. *Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to health service providers.* London: Health Foundation, 2009, p8.

HOW CAN WE IMPROVE QUALITY?

When it comes to improving quality, Dr John Øvretveit identifies two types of approach available: extrinsic, and intrinsic. The extrinsic approaches include centralised government initiatives, economic drivers and professional requirements, while the intrinsic approaches incorporate a range of models and methods that can be put in place by individual organisations. These are known as organisational or industrial approaches because they were originally developed within an organisational or industrial context.

The Health Foundation believes that a combination of extrinsic and intrinsic approaches is needed to ensure sustained improvement. External reward and incentive systems, such as the Commissioning Quality and Innovation (CQUIN) framework, are important, but individual organisations can usefully complement these by adopting internal approaches, which involve developing and setting their own goals, with full staff engagement.

Once the goals are set, quality improvement approaches offer organisations a systematic way of implementing change and monitoring progress. The focus of this guide is on organisational or industrial approaches to quality improvement because we believe they have the power to transform services and drive up quality and safety.

What would improve quality?

The Health Foundation's *Our theory of change,*[5] identifies a number of solutions that have the greatest potential to make lasting and widespread change. They are set out below.

- A sustained focus on the continuous improvement in the quality of health services is needed.
- Emphasise the importance of internal motivators (for example, professionalism, skills development, organisational development and leadership), alongside external ones (for example, regulation, economic incentives and performance management).
- Align quality at every level to make sure that all levels of the system relate to each other in supporting quality.
- Redefine the nature of the relationship between people who use services and those who provide them.
- Build knowledge, skills and new practices, including learning from other sectors that have improved their performance and reliability in highly complex areas.

[5] The Health Foundation. *Our theory of change. Why we do what we do.* London: Health Foundation, 2010.

Quality improvement draws on a wide variety of methodologies, approaches and tools. Many of these share some simple underlying principles, including a focus on:

- understanding the problem with a particular emphasis on what the data tell you
- understanding the processes and systems within the organisation – particularly the patient pathway – and whether these can be simplified
- analysing the demand, capacity and flows of the service
- choosing the tools to bring about change, including leadership and clinical engagement, plus staff and patient participation
- evaluating and measuring the impact of a change (see section 4).

There are a number of specific approaches to quality improvement, such as Lean and Six Sigma, (see pp21–22), but there is no clear evidence that any one approach is more effective than the others in terms of its applicability or impact in healthcare settings. What is vital, however, is how the change is implemented – including factors such as leadership, clinical involvement, focus, and resources to facilitate the change. How the implementation is managed depends very much on the context of the particular organisation making the change, and requires careful consideration.

Quality improvement approaches and sustainable change

Only around two-thirds of healthcare improvements go on to result in ongoing, sustainable change that achieves the planned objective, so leaders need to think about how they can embed that change.

The NHS Institute for Innovation and Improvement's Sustainability Model and Guide[6] is a tool designed to help predict, and increase the likelihood of, sustainability. There is evidence that sustainable change is more likely to result from a model that involves patients and staff in developing, designing and implementing changes than from a 'command and control' model.

Quality improvement in commissioning

There is growing awareness among healthcare providers of how industrial quality improvement approaches can benefit healthcare providers. But it is also important that commissioners have an understanding of these methods. Commissioners have a specific role to play in contracting for quality and ensuring that quality improvement approaches are being used to improve services.

This includes:

- putting the emphasis on assuring quality and safety in evaluating current and potential providers

[6] NHS Institute for Innovation and Improvement. *NHS Sustainability Guide*. Coventry: NHS Institute for Innovation and Improvement. Available at: www.institute.nhs.uk/sustainability_model/general/welcome_to_sustainability.html

– looking at governance and leadership on these issues, rather than merely policies and procedures

– building measures of quality and safety into commissioning specifications and, where appropriate, penalties for significant breaches

– putting in place performance management regimes that assess quality and patient safety processes

– assessing for themselves how care is provided on the ground, and how the culture and values of the organisation are expressed in behaviour

– using CQUIN as a route to reward providers for quality improvement.

At the heart of every commissioner-provider interaction should be discussions about what is being done to improve quality. By developing a better understanding of quality improvement approaches, commissioners will be better placed to ask the right questions about providers' focus on improvement and the progress they are making. This will help commissioners ensure that quality is the driving factor in their relations with providers.

KEY LEARNING

There is no single definition of quality improvement, and no one method appears to be more successful than another. The most important ingredient in successful and sustained improvement is the way in which the change is introduced and implemented.

THE ROOTS OF QUALITY IMPROVEMENT

3

Most of today's quality improvement methods were developed in industry, and have been adapted for use in the service sectors such as health. These industrial approaches have been used within healthcare for the past 20 years, but their use has not yet been embedded throughout healthcare organisations. Perhaps because of this, the evidence base for their effectiveness is relatively limited, although it is expanding.

The roots of many quality improvement approaches can be traced back to the thinking about production quality control that emerged in the early 1920s. During the 1940s and 1950s, quality improvement techniques were further developed in Japan, pioneered there by the US experts Feigenbaum, Juran and Deming, and Ishikawa from Japan. In healthcare, Donald M Berwick is known for his work in the US, leading the pioneering work of the Institute for Healthcare Improvement.

Leaders in quality improvement approaches

Armand V Feigenbaum was the originator of 'total quality control', which he defined as:

> an effective system for integrating quality development, quality maintenance and quality improvement efforts of the various groups within an organisation, so as to enable production and service at the most economical levels that allow full customer satisfaction.

He saw this as a business method, and proposed three steps to quality: quality leadership, modern quality technology, and organisational commitment.[7]

Kaoru Ishikawa made many contributions to the field of quality improvement, including a range of tools and techniques. Techniques such as his cause and effect 'fishbone' tool.[8] His emphasis was on the human side of quality. The concept of quality improvement as a fundamental responsibility of every member of staff became a key component of the Japanese approach to quality improvement. Ishikawa's work focuses on the idea of *kaizen* (a Japanese word translated roughly as 'continuous management'). This concept, developed by Japanese industry in the 1950s and 1960s, is a core principle of quality management today, and holds that it is the responsibility of every staff member to seek to improve what they do.[9]

7 Feigenbaum, A V. *Total quality control.* New York: McGraw-Hil, 1961.

8 The Institute for Healthcare Improvement has a number of useful tools, including Ishikawa's cause and effect tool www.ihi.org/IHI/Topics/Improvement/ImprovementMethods/Tools

9 Ishikawa, K. *What is total quality control? The Japanese way.* Englewood Cliffs: Prentice-Hall, 1985 [translated by DJ Lu]. Ishikawa, K. *Introduction to quality control.* London: Chapman & Hall, 1990 [translated by JH Loftus].

W Edwards Deming developed a 14-point approach to quality improvement and organisational change (1986).[10] Deming was also the creator of the Plan, Do, Study, Act (PDSA) cycle of continuous improvement, which is used in many quality improvement approaches within the NHS today.[11] His work has been underpinned by his system of profound knowledge, which offers insight into how to make changes that will result in improvements in a variety of settings. Crucially, he highlighted how different elements interacted with each other – for example, arguing that knowledge about psychology is incomplete without knowledge about variation. Organisations can harness this knowledge to drive forward improvements.

Joseph Juran published the *Quality control handbook* in 1951.[12] His philosophy focused on the role of management responsibility for quality. An important aspect of Juran's work was his focus on staff empowerment. Juran recognised that every individual in the workplace needed to take responsibility for quality improvement, and that if staff were not empowered to do so, results would be limited. In this respect, quality improvement is regarded as an ongoing process and part of everyday business and work.

[10] Deming W E. *Out of the crisis.* Cambridge, MA: Massachusetts Institute of Technology Center for Advanced Engineering Study, 1986.

[11] Deming W E. *The new economics for industry, government, and education.* Cambridge, MA: The MIT Press, 2000.

[12] Juran J. *Quality control handbook.* New York: McGraw-Hill, 1951.

Donald M Berwick President and Chief Executive Officer of the US Institute for Healthcare Improvement (IHI) has had considerable influence on the application of quality improvement in the healthcare sector.[13] The IHI, based in Boston, is a catalyst for change, cultivating innovative concepts for improving patient care and implementing programmes for putting those ideas into action.

The IHI has adapted the US Institute of Medicine's six dimensions of quality (see p8) into a 'no needless' framework, which aspires to promote:

– no needless deaths

– no needless pain or suffering

– no helplessness in those served or serving

– no unwanted waiting

– no waste

– no one left out.[14]

These leaders in quality improvement approaches and philosophy have built a body of knowledge about implementing and sustaining change across a range of industries including healthcare. There are a number of approaches that draw upon the work of these pioneers. The next section details some of the more common ones.

For a useful overview of the history of quality improvement, please go to: www.businessballs.com/qualitymanagement.

[13] Berwick D, Godfrey A B, Roessner J. *Curing health care: new strategies for quality improvement.* Hoboken: Jossey-Bass, 1990. Berwick D. *Escape fire: designs for the future of health care.* Hoboken: Jossey-Bass, 1990.

[14] www.ihi.org/ihi/about

COMMON APPROACHES TO QUALITY IMPROVEMENT

4

We have looked at what we mean by quality, and quality improvement, and have seen where quality improvement approaches have come from.

We now go on to look at the theory in practice, by identifying some of the best known approaches to quality improvement.

These are approaches, rather than tools. This means that they can – and often are – used simultaneously, and are underpinned by a common set of principles.

The most common approaches to quality improvement

Business process re-engineering
Fundamental rethinking of how processes are designed, with change driven from the top by a visionary leader, and organisations set up around key processes rather than specialist functions.

Collaboratives
Groups of hospitals or health economies addressing the same problems as each other, and learning from each other's experience.

Lean
A quality management system developed by the Japanese car manufacturer Toyota, focusing on value, flow and waste reduction.

Plan, Do, Study, Act (PDSA)
An approach to continuous improvement where changes are tested in small cycles.

Six Sigma
A process or product improvement approach that focuses on reducing what customers would define as 'defects'.

Statistical process control
Examines the difference between natural variation (common cause) and special cause variation, and enables data to be collected over time to show whether a process is within control limits.

Total quality management (TQM)
Also known as continuous quality improvement. Emphasises the need for leadership and management involvement to understand work processes.[15]

[15] For further information on these approaches, see Boaden R, Harvey G, Moxham C and Proudlove N. *Quality improvement: theory and practice in healthcare.* Coventry: NHS Institute for Innovation and Improvement/University of Manchester Business School, 2008.

SOME COMMON PRINCIPLES

Despite their different names and apparent differences in methods, many quality improvement approaches share some simple underlying principles. These include the following:

1

Data and measurement for improvement

In some notable examples of failures in healthcare, boards have not known that their organisations were doing badly on vital aspects of care.[16] Data can help flag up a problem such as a high infection rate. Data can also help boards identify which areas of focus should be a priority for quality improvement. Providing a baseline is an important step towards quality improvement, as it helps assess the impact of an intervention.

Some quality improvement techniques take a 'whole organisation' approach, but this can be daunting, so some boards prefer to concentrate on the areas in greatest need of improvement, or on the specific areas in which their performance compares poorly with their competitors.

[16] See, for example, the case of Mid Staffordshire NHS Foundation Trust. Healthcare Commission. *Investigation into Mid Staffordshire NHS Foundation Trust.* London: Healthcare Commission, 2009.

[17] The Institute for Healthcare Improvement has promoted an approach to reliability in healthcare. See also *How safe are clinical systems?* a report examining reliability in terms of the nature, type and extent and variation of defects in healthcare system reliability that have the potential to cause harm. (The Health Foundation. *How safe are clinical systems?* London: Health Foundation, 2010.)

2 Understanding the process

As we have seen, having access to data is vital when assessing whether there is a problem. However, it will not explain why the problem exists. This is where understanding the process becomes important.

Process mapping is a tool used to chart each step of a process. It is commonly used to map the pathway or journey through part or all of the patient's healthcare journey. Processes mapping is extremely useful as a tool to engage staff in understanding how the different steps in a patient journey fit together – or do not. Through the mapping process, people are able to identify which steps add value to the process, and which do not. This approach has been adapted to incorporate patient experience along the pathway, as this can highlight changes that are needed but that would not have surfaced on a traditional process map.

3 Improving reliability

Once a process is understood, then a key focus of quality improvement is improving the reliability of the system and clinical processes. Ensuring reliability mitigates against waste and defects in the system, and reduces error and harm.

Systematic quality improvement approaches such as Lean (see p21), seek to redesign system and clinical pathways, based on tools such as 'care bundles', to create error-free processes that deliver high-quality, consistent care and use resources efficiently. [17]

4 Demand, capacity and flow

When there are backlogs, waiting lists and delays in a service, a common response to these problems is to say that there is a capacity problem – in other words, that there are insufficient staff, machines or equipment to deal with the volume of patients. However, unless there has been measurement of the demand (the number of patients requiring access to the service) and the flow (when the service is needed), it is impossible to say whether there is a capacity shortfall. It may simply be that the capacity is in the wrong place, or is provided at the wrong time.

For a process improvement to be made, there needs to be a detailed understanding of demand, capacity and flow. Often demand is relatively stable, flow can be predicted in terms of peaks and troughs, and it is the variation in the capacity available that causes the problem (for example, staff sickness or unplanned leave).

5 Enthusing, involving and engaging staff

Evidence about successful quality improvement indicates that it is not necessarily the method or approach used that predicts success, but the way in which the change is introduced. Factors that contribute to this include leadership, staff engagement (particularly of clinicians) and patient participation.

It is important not to underestimate the importance of involving staff other than doctors – including non-clinical staff, who are often the first point of contact for patients. However, most evidence about staff engagement in quality improvement activities is concerned with involving doctors.

Engaging any frontline clinical staff (especially doctors) is crucial for any quality improvement programme, but it can be challenging. Many clinicians will be keen to improve the quality of the service they offer, and will already have done so through methods such as clinical audit, peer review and adoption of best practice. However, they may be unfamiliar with quality improvement approaches.

For this reason, capability building and facilitated support are key elements of building clinical commitment to improvement. Other important aspects include:

- involving the clinical team early on, when setting aspirations and goals
- ensuring senior clinical involvement and peer influence
- obtaining credible endorsement – for example, via the royal colleges
- involving clinical networks across organisational boundaries
- providing evidence that the change has been successful elsewhere.

Clinicians are more likely to engage with the process if the main emphasis appears to be on quality improvement rather than cost-cutting measures.

6 Involving patients and co-design

Patients, carers and the wider public have a significant role to play: not only in designing improvements, but in monitoring whether they have the desired impact – not least because they are the only people who really experience the patient pathway from start to finish. Board members must constantly ask the question 'how do we know what constitutes good care?' If patients and carers are engaged in quality improvement, then they can help provide the answer.

Patients may define quality differently from clinicians and managers. What they view as the 'problem' or value within a system may be surprising. So, boards need to question how patient involvement is being embedded in their organisation's quality improvement programmes.

Questions to ask your organisation: constructively challenging quality

Q

At what points in the quality improvement process are patients and the wider public involved?

Q

What methods are being used to engage patients in quality improvement, and why have they been chosen?

Q

How is participation being encouraged and made easy?

Q

What methods are you using to really listen to patients?

Q

How are staff responding to patient involvement?

Q

Are those who are invited to contribute kept informed of what is expected from them and how their views will influence any outcome?

Q

What support is available to patients who make a long-term commitment to a project?

Q

How is the final outcome affected by the patient (and broader public) participation process?

KEY LEARNING

There are a variety of approaches to quality improvement, but also some key principles common to all. Organisations need to build quality improvement skills and capability across all levels of staff.

THE ROLE OF THE BOARD

5

Boards and senior leaders in healthcare organisations have two key roles in improving quality:

- governance – ensuring minimum standards and reporting on mandatory targets and incidents
- leadership – driving the organisational strategy for transformation and continuous improvement.

GOVERNANCE

The governance role involves seeking assurance that the necessary actions are being taken throughout the organisation, and that reporting and monitoring are carried out and performance targets reached.

This role has been particularly prominent with safety issues such as minimising healthcare acquired infections like MRSA, and with externally imposed quality targets, such as time limits for access to care (for example, the accident and emergency four-hour wait). As we saw on p10, these are sometimes referred to as extrinsic motivators, as they are requirements placed on organisations by an external body, to achieve a minimum level of performance.

LEADERSHIP

All quality improvement requires good leadership. Organisational transformation requires exceptional leadership in order to demonstrate the will to make change happen, the ambition to set high-level goals, and an unerring focus on implementation. Without support from high-level leadership, initiatives to improve quality will fail at the outset, or will not be sustained.

The role of leading the organisational strategy for continuous improvement involves:

- being clear about the organisation's goals in terms of improving the quality of services
- agreeing and resourcing the approach that the organisation will take to achieve its goals
- measuring for improvement (for information about how this differs from measuring for judgement, see the table on p32)
- focusing on implementing and monitoring progress
- regularly and consistently giving quality improvement a high priority within the board of at least equal status to financial matters
- recognising, rewarding and celebrating improvement when ambitious goals are met.

Without sound leadership from the board, quality improvement approaches are unlikely to bring about sustainable change, and there needs to be an appropriate balance between a focus on governance and on quality improvement.

The board needs to see quality improvement approaches as a means to continuous improvement. It needs to understand that this is a marathon, rather than a sprint. The work will take time, resources and skills, and will often involve changing the culture of the organisation.

Part of this culture change is the understanding that indicators for improvement differ from indicators for judgement. The box below provides some comparisons.

Characteristics of indicators used for judgement and improvement

Indicators for judgement	Indicators for improvement
Unambiguous interpretation	Variable interpretation possible
Unambiguous attribution	Ambiguity tolerable
Definitive marker of quality	Screening tool
Good data quality	Poor data quality tolerable
Good risk adjustment	Partial risk adjustment tolerable
Statistical reliability necessary	Statistical reliability preferred
Cross-sectional	Time trends
Used for punishment/reward	Used for learning/changing practice
For external use	Mainly for internal use
Data for public use	Data for internal use
Stand alone	Allowance for context possible
Risk of unintended consequences	Lower risk of unintended consequences

Source: Raleigh VS and Foot C (2010)[18]

[18] Raleigh VS and Foot C. *Getting the measure of quality opportunities and challenges.* London: King's Fund, 2010, p6.

RESPONSIBILITIES OF BOARD MEMBERS

Boards often have a 'helicopter view' of their organisations, seeing only aggregated data. Dashboards that give equal status to quality and safety enable boards to drill down to specific areas of concern. Research into the characteristics of successful quality improvement approaches demonstrates that senior leadership, both clinical and managerial, is vital in terms of building the organisational will to improve and to ensure the required focus for successful implementation. The involvement of the chief executive is particularly important.

All board members share responsibility for the leadership of quality improvement across the organisation and its execution. Each board member can play a part in this – for example, by carrying out regular safety walkabouts. For further examples of how board members can contribute to patient safety initiatives, see the Patient Safety First Campaign[19] and the report *What every healthcare board needs to understand about patient safety.*[20]

Meanwhile, executive directors hold specific roles and responsibilities that relate to their leadership on quality improvement approaches. For example, a financial director may take an explicit role in reducing waste, an operational director in improving efficiency, and a nurse director in ensuring a positive patient experience. Medical directors and clinical directors are particularly important as role models, and play a vital part in engaging clinicians in quality improvement approaches.

[19] See: www.patientsafetyfirst.nhs.uk

[20] Good Governance Institute. *What every healthcare board needs to understand about patient safety.* GGI, 2010.

Boards also need to ensure that quality improvement work is aligned with other strategic objectives, where possible, and that it is pursued consistently and coherently throughout the organisation. Policies and procedures must be aligned with a quality improvement approach and should therefore influence everyday practice.

This approach can be supported by writing such a requirement into job descriptions, appraisal processes and contracts. Board members (particularly non-executives) need to be equipped with the appropriate skills and knowledge to carry this out.

Questions to ask your organisation: constructively challenging quality

Source: Adapted from Powell et al (2008)[21]

Q

Is our organisation applying methods consistently over a sufficiently long timescale, with demonstrated sustained organisational commitment and support?

Q

Are we involving doctors and other health professionals in a wide team effort while providing adequate training and development?

Q

In what ways are we seeking active involvement of middle and senior managers, the board and, most obviously and visibly, the chief executive?

Q

How are we integrating quality improvement into the organisation's other activities and strategic goals?

Q

To what extent are we tailoring the selected methods to local circumstances?

Q

Is our organisation creating robust IT systems that enable measurement of processes and impacts, iteratively refining the approaches used?

Q

Is there evidence that we are acknowledging – and reducing, as far as possible – the impact of competing activities and changes?

You will find more useful tips for board members on p38.

KEY LEARNING

Without sound leadership from the board, quality improvement approaches are unlikely to bring about sustainable change. There needs to be an appropriate balance between a focus on governance and on quality improvement.

[21] Powell AE, Rushmer RK, Davies HTO. *A systematic narrative review of quality improvement in healthcare.* Edinburgh: NHS Quality Improvement Scotland, 2008.

CHECKLIST FOR BOARDS

6

Use this checklist to ensure that your board maintains a strong focus on quality improvement that results in high-impact improvement initiatives.

DO…

- ✔ Develop a corporately agreed quality strategy with output goals that are reported on a regular basis, underpinned by a collective understanding of how you think change can be stimulated and embedded.

- ✔ Ensure that quality improvement approaches are seen through the patient's eyes and include the whole of the patient's journey, including those parts outside their own responsibility.

- ✔ Have clarity of thought as to what measures you use to assess quality and what those measures are useful for. This must include the full suite:
  – measures for accountability
  – measures for comparability and benchmarking
  – measures for improvement.

- ✔ Agree what balance you want to achieve between investment in quality assurance and quality improvement capability and capacity.

- ✔ Bring safety and quality alive through patient stories – in person or on video and by making safety the first item on the agenda.

DON'T…

- ✖ Run a series of one-off, disconnected quality projects.

- ✖ Allow the project to concentrate narrowly on those parts of the process for which the organisation is paid.

- ✖ Enable a narrow focus on measures for accountability, leaving the doctors to deal with clinical benchmarking and doing no measurement for improvement.

- ✖ Have a confusing myriad of disconnected measures and rely on the judgement of others (such as the Care Quality Commission, Monitor and the Royal Colleges) to assess their performance.

- ✖ Employ an army of quality assurance staff, which could lead to complacency.

- ✖ Bury data and information in lots of other matters.

DO…

- ✔ Make sure that non-executive directors and executives take part in structured walk rounds.
- ✔ Plan for sustainability and spread.
- ✔ Embed quality in cost improvement initiatives, ensuring that cost improvement programmes do not damage quality but also not claiming that quality improvement will solve all the financial problems of the trust.

DON'T…

- ✖ Think it is sufficient for non-executive directors to say that they 'stay close to the shop floor' if this is unorganised and learning is limited.
- ✖ Over rely on enthusiasts – if they move on, the momentum dies.
- ✖ Enable quality and cost-improvement programmes to run in silos.

FREQUENTLY ASKED QUESTIONS

7

Q Are there examples of industrial models of quality improvement being applied successfully in healthcare?

A

There are relatively few examples (in the UK or elsewhere) of the whole-scale application of industrial models of quality improvement in healthcare. In the UK, the Royal Bolton Hospital NHS Foundation Trust has taken an ambitious approach to introducing Lean thinking across the hospital, in an approach called the Bolton Improving Care System.

In the US, some hospitals, and groups of hospitals, have taken a whole-organisation approach to quality improvement. For example, Cincinnati Children's Hospital prides itself on measuring improvement across the organisation in terms of safety, efficiency and patient centredness.

Quality improvement is a long-term strategy, and therefore requires the measurement of impact over a considerable length of time. Most health organisations that have used quality improvement approaches report some benefits – particularly at the start of the initiative, when staff engagement and motivation is high.

Healthcare organisations are highly complex, and improvement interventions will vary in their application from place to place, context to context. This makes overall evaluation of their efficacy challenging – whether this is defined as improved efficiency, cost reduction, patient experience or safety.

Q Can quality improvement save money?

A

The Health Foundation believes that quality improvement should be a key part of an organisation's mission because it is the right thing to do for patients. However, in some cases improving the quality of care can bring financial and productivity benefits for organisations. A recent review[22] found that quality improvement can make an important, if limited, contribution to the cost-efficiency of healthcare.

For example, continuing with poor or sub-optimal care results in unnecessary costs. Longer stays for patients with a healthcare-acquired infection or with central-line associated bloodstream infections add to hospital costs. Improving care and hygiene standards will reduce costs per case, and can boost productivity such as throughput of patients per bed.

Issues that can be addressed to produce cost-savings in healthcare include:

- delays, such as patients waiting for tests
- reworking – in other words, performing the same task more than once
- overproduction, such as unnecessary tests
- unnecessary movement of materials or people
- 'defects', such as medication errors
- waste of spirit and skill, through the daily hassles of staff not being addressed.

Q How can quality improvement approaches help productivity?

A

A key challenge for NHS organisations over the coming years will be to ensure that they achieve the best possible value for money from their spending, and that quality of care is embedded in that concept.

For providers, reducing variation, streamlining processes, cutting out waste and reducing errors can contribute to a more productive workforce. From a commissioner's perspective, there is evidence of variation in the value for money that PCTs achieve. This suggests there is scope either for improving quality outcomes without increasing spending, or for retaining current outcomes while spending less.

Incentives within contracting also contribute to the drive to improve quality. For example, the Commissioning Quality and Innovation (CQUIN) framework is the mechanism through which commissioners are able to contract for quality improvement. It is the only way in which providers are able to secure resources additional to those specified in the contract for services.

[22] Øvretveit J. *Does improving quality save money? A review of the evidence of which improvements to quality reduce costs to health service providers.* London: Health Foundation, 2009, p8.

Q

A

Why is there such a focus on variation in quality improvement?

There are two broad types of variation in healthcare: variation in the organisation of services or processes, and variation in clinical practice. Quality improvement approaches are focused on improving processes and systems, and sometimes clinical practice.

Variation in the systems and processes adopted in healthcare leads to inefficiency, waste and increased waiting times. In clinical processes, variation in situations for which there is an established evidence-based best practice can result in error and harm, as well as poor outcomes for the patient. Addressing this can be described as increasing the reliability of care – a key competent of which is standardisation.

However, a certain amount of variation is considered normal, so it is important to understand how variation works. Many quality improvement approaches assess whether a system, process or clinical practice is in control. They use this as a key measurement tool, to help understand the level of variation in the system and to measure it over time.

Q

A

Can quality improvement have unintended consequences?

At times, change in one area can cause pressure in another. For example, improved early discharge may lead to increased re-admission. In these circumstances, leaders need to be able to identify the change and react to it, and may need to make decisions about scheduling or sequencing of initiatives. These are the unintended consequences of quality improvement. However, any negative effects are usually short term. Quality improvement is likely to be more effective if it is seen as a long-term, sustained change.

Q

A

Do we need a team of experts to lead quality improvement in our organisation?

Quality improvement approaches are underpinned by a philosophy and a set of competencies. For this reason, research indicates that quality improvement initiatives are more successful if frontline staff are supported by facilitators who have capability in improvement science (methods, approaches, tools and techniques). However, building the organisation's capability for quality improvement is also important, and this should be part of the organisation's overall quality improvement strategy.

Q What is the link between quality improvement and patient safety?

A

In recent years it has been widely recognised that unnecessary harm is caused in the process of providing healthcare.[23] Quality improvement approaches are increasingly being used to address these system failings. The reliability of the application of evidence has been used as a key approach in the Patient Safety First Campaign, to encourage healthcare organisations to measure and aim to reduce harm.

Safer Clinical Systems: a Lean approach to patient safety

The Health Foundation is working with five NHS organisations, and other partners, to promote safer clinical systems. Clinical staff define what parts of a clinical care process might be compromising safe care. These could be some distance from the bedside, such as access to sterile supplies. The teams then work with expert advisers to co-design and test a range of interventions aimed at eliminating these problems. The impact of these interventions will be evaluated, with the ultimate aim of wider adoption in the NHS.[24]

[23] See: www.patientsafetyfirst.nhs.uk

[24] See: www.health.org.uk /safersystems

Q What are the barriers to successful quality improvement?

A

In a recent study of clinical engagement in quality improvement,[25] healthcare professionals identified the following barriers to quality improvement:

- lack of time
- lack of resources
- high workload, inadequate managerial support and inadequate skills to access and implement evidence (cited by therapists)
- staff shortages, their own lack of authority and the need for active consultant support, and difficulties reconciling research evidence with what happens in practice (cited by nurses)
- a wide range of barriers including incompatible computer systems, not enough secretarial time, and their own fear of being undermined by assessment and criticism (cited by doctors).

[25] Davies H, Powell A and Rushmer R. *Healthcare professionals' views on clinician engagement in quality improvement.* London: The Health Foundation, 2007.

WHERE CAN I FIND OUT MORE?

8

The following organisations provide information and case studies on improvement approaches:

Advisory Board Company

A leading US healthcare consultancy that provides comprehensive performance improvement services to the healthcare and education sectors, including operational best practices and insights.

www.advisoryboardcompany.com

Health Foundation

Independent UK charity that wants to see a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable. Working at every level of the healthcare system, they aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

www.health.org.uk

Institute for Healthcare Improvement

US-based independent not-for-profit organisation that seeks to improve healthcare worldwide through building the will for change, cultivating promising concepts for improving care, and helping healthcare systems to put them into action.

www.ihi.org

King's Fund

UK charity that seeks to understand how the health system in England can be improved, and works with individuals and organisations to shape policy, transform services, and bring about behavioural change.

www.kingsfund.org.uk

National Leadership and Innovation Agency for Healthcare

Part of NHS Wales set up to share expertise, knowledge and resources to support health professionals in improving patient care and to help the Welsh Assembly Government and NHS Wales to identify areas for improvement.

www.nhs.wales.uk

National Patient Safety Agency

Arms-length body of the Department of Health that leads and contributes to improved, safe patient care in England by informing, supporting and influencing the health sector.

www.npsa.nhs.uk

NHS Evidence

NHS website that offers access to a comprehensive evidence base that covers clinical and non-clinical information, and examples of best practice and commissioning guidance. (Formerly the National Library for Health.)

www.evidence.nhs.uk

NHS Improvement

National improvement plan that works with NHS organisations and clinical networks to help transform, deliver and build sustainable improvements across the entire pathway of care in cancer, diagnostics, heart and stroke services.

www.improvement.nhs.uk

NHS Institute for Innovation and Improvement

Special health authority of the NHS in England that aims to support the NHS to transform healthcare for patients and the public by rapidly developing and spreading new ways of working, new technology and leadership.

www.institute.nhs.uk

Patient Safety First

Campaign supported by the National Patient Safety Agency, the NHS Institute for Innovation and Improvement and the Health Foundation that seeks to prioritise patient safety and promotes a vision of no avoidable death or harm in the NHS.

www.patientsafetyfirst.nhs.uk

Quality Improvement Scotland

NHS special health board that seeks to improve the quality of care and treatment delivered by NHS Scotland. It provides advice and guidance, drives and supports quality improvements, and assesses performance.

www.nhshealthquality.org

Social Care Institute for Excellence

Independent charity that aims to identify and spread knowledge about good practice to the large and diverse social care workforce and support the delivery of transformed, personalised social care services.

www.scie.org.uk

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Designed by www.togetherdesign.co.uk

The Health Foundation is an independent charity working to continuously improve the quality of healthcare in the UK. We want the UK to have a healthcare system of the highest possible quality – safe, effective, person-centred, timely, efficient and equitable

We are here to inspire and create the space for people, teams, organisations and systems to make lasting improvements to health services.

Working at every level of the healthcare system, we aim to develop the technical skills, leadership, capacity, knowledge, and the will for change, that are essential for real and lasting improvement.

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The Health Foundation
90 Long Acre
London WC2E 9RA
Tel 020 7257 8000
Fax 020 7257 8001
info@health.org.uk

Registered charity number: 286967
Registered company number: 1714937

www.health.org.uk