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**

<table>
<thead>
<tr>
<th>Agenda Item</th>
<th>Lead Member</th>
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<tbody>
<tr>
<td><strong>Welcome to Members of the Public and the Press</strong></td>
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<tr>
<td><strong>Apologies for Absence</strong></td>
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<tr>
<td><strong>1. Items for Approval</strong></td>
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<tr>
<td>1.1. Minutes of the Previous Board Meeting held on 1 October 2014</td>
<td>BH *</td>
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<tr>
<td>1.2. Performance Management</td>
<td>AMcM *</td>
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<tr>
<td>1.3. Corporate Risk Register</td>
<td>DF *</td>
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<tr>
<td>1.4. Committee Membership and Terms of Reference</td>
<td>BH *</td>
</tr>
<tr>
<td>1.5. Partnership Centre Bundle: Full Business Case</td>
<td>SG *</td>
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<tr>
<td>1.6. The Third Joint Health Protection Plan 2014-16</td>
<td>AKM *</td>
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<tr>
<td>1.7. Healthcare Associated Infection Update</td>
<td>MJ *</td>
</tr>
<tr>
<td>1.8. Audit &amp; Risk Committee - Minutes of 29 September 2014</td>
<td>JB *</td>
</tr>
<tr>
<td>1.9. Finance &amp; Resources Committee - Minutes of 27 August &amp; 27 October 2014</td>
<td>GW *</td>
</tr>
<tr>
<td>1.10. Healthcare Governance Committee - Minutes of 23 September 2014</td>
<td>MB *</td>
</tr>
<tr>
<td>1.11. Strategic Planning Committee - Minutes of 9 October 2014</td>
<td>BH *</td>
</tr>
<tr>
<td>1.12. East Lothian Community Health Partnership Sub-Committee - Minutes of 13 August 2014</td>
<td>MA *</td>
</tr>
<tr>
<td>1.13. East Lothian Health &amp; Social Care Partnership Shadow Board - Minutes of 4 September 2014</td>
<td>MA *</td>
</tr>
<tr>
<td>1.14. Edinburgh Community Health Partnership Sub-Committee - Minutes of 13 August 2014</td>
<td>SA *</td>
</tr>
<tr>
<td>1.15. West Lothian Health &amp; Care Partnership Sub-Committee - Minutes of 9 October 2014</td>
<td>FT *</td>
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<tr>
<td>1.16. West Lothian Health &amp; Care Partnership Board - Minutes of 7 October 2014</td>
<td>FT *</td>
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</tbody>
</table>

* = 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. **Items for Discussion** (subject to review of the items for approval) *(9:45am - 12:00pm)*

2.1. Unscheduled Care & Winter Planning  
2.2. Workforce Risk Assessment  
2.3. Waiting Times Performance, Progress and Elective Capacity Investment  
2.4. Quality Report  
2.5. Financial Position 2014/15 and Forward Look 2015/16  
2.6. Local Access Policy Audits  
2.8. NHS Lothian Health Inequalities Strategy  

3. **Next Development Session:** Wednesday 14 January 2015 at 9:00 a.m. in the Boardroom, Waverley Gate.

4. **Next Board Meeting:** Wednesday 4 February 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 1 October 2014  

7. Matters Arising

8. Strategic Plan Update  

9. Any Other Competent Business

### Board Meetings in 2015

<table>
<thead>
<tr>
<th>Date</th>
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<tbody>
<tr>
<td>1 April 2015</td>
</tr>
<tr>
<td>24 June 2015</td>
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<tr>
<td>5 August 2015</td>
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<tr>
<td>7 October 2015</td>
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<td>2 December 2015</td>
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### Development Sessions in 2015

<table>
<thead>
<tr>
<th>Date</th>
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<tr>
<td>4 March 2015</td>
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<tr>
<td>6 May 2015</td>
</tr>
<tr>
<td>15 July 2015</td>
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<tr>
<td>2 September 2015</td>
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<tr>
<td>3 November 2015 <em>(Tuesday)</em></td>
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<tr>
<td>Action Required</td>
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<tr>
<td><strong>Renewing NHS Values (24/07/13)</strong></td>
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<tr>
<td>• Arrange engagement sessions for service teams.</td>
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<tr>
<td>• Development of the Implementation Plan to be included as a separate Board seminar.</td>
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<tr>
<td><strong>NHS Lothian Homeopathy Service</strong></td>
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<tr>
<td>• Cease provision of an NHS Homeopathy Service in Lothian and cease NHS referral to the Glasgow Homeopathic Hospital from 1 April 2014.</td>
</tr>
<tr>
<td><strong>Scottish Public Services Ombudsman Case 201200092 (23/10/13)</strong></td>
</tr>
<tr>
<td>• Report to a future Board meeting on how NHS Lothian now deals with complaints and demonstrate the benefits in terms of improved performance.</td>
</tr>
<tr>
<td>Action Required</td>
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<td>--------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Workforce Risk Assessment</td>
</tr>
<tr>
<td>• Further consideration is needed in a future paper around overall developments, staffing, culture &amp; values and their impact on individual areas including service redesign.</td>
</tr>
<tr>
<td>• The Medical Director and Director of Human Resources &amp; 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</td>
</tr>
<tr>
<td>• The Director of Human Resources &amp; Organisational Development to bring a paper to a future Board meeting detailing how long posts had been vacant and by vacancy group. The report would show comparable data comparisons with other large organisations and examples of work being done to make jobs more attractive to include consideration of the benefits or otherwise of making regional appointments.</td>
</tr>
<tr>
<td>Financial Position to 31 December 2013 (05/02/2014)</td>
</tr>
<tr>
<td>• Finances / LRP to be discussed at a future development session.</td>
</tr>
<tr>
<td>Integration Process &amp; Milestones (05/02/2014)</td>
</tr>
<tr>
<td>• The four draft integration plans would be submitted to the Board in December.</td>
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<tr>
<td>Action Required</td>
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<tr>
<td>--------------------------------------------------------------------------------</td>
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<tr>
<td><strong>Strategic Plan (02/04/14)</strong></td>
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<tr>
<td>• An updated strategic plan to be brought to the Board in February 2015 to allow work to be concluded and to align with the timescale for the financial planning for the Board and establishment of new integration bodies for 2015 /16. The Board to also receive an implementation plan to deliver the health and inequalities strategy as part of the overall strategic plan in 2014 as well as a similar implementation plan to delivery the cancer strategy to the same timeframe..</td>
</tr>
<tr>
<td><strong>Integrating Children Services in Lothian (02/04/14)</strong></td>
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<tr>
<td>• Formal consultation on the proposals to be undertaken between May &amp; July 2014.</td>
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<tr>
<td><strong>Local Access Policy (02/04/04)</strong></td>
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<td>• A 6 month post implementation audit would be undertaken.</td>
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<tr>
<td><strong>Staff Survey Results (02/04/14)</strong></td>
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<tr>
<td>• The Board would receive a further presentation once the Staff Governance Committee had considered the survey outcomes in detail.</td>
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<tr>
<td><strong>CAHMS and Psychological Therapies (06/08/14)</strong></td>
</tr>
<tr>
<td>• An update paper to be brought to the Board early in 2015.</td>
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<tr>
<td><strong>Integration Update (25/06/14)</strong></td>
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<tr>
<td>• Update report to future Board meetings.</td>
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<tr>
<td>Action Required</td>
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<tr>
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</tr>
<tr>
<td><strong>Unscheduled Care Update</strong> (25/06/14)</td>
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<tr>
<td>• Paper to December Board meeting.</td>
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<tr>
<td><strong>Financial Position</strong> (25/06/14)</td>
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<tr>
<td>• A benchmarking approach to be adopted to understand the reasons for the 10% increase in acute drug costs.</td>
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<tr>
<td><strong>Revised Corporate Communications Strategy</strong> (25/06/14)</td>
</tr>
<tr>
<td>• Arrange further discussion either at a development session or at a future Board meeting.</td>
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<tr>
<td><strong>Waiting Times, Performance, Progress &amp; Elective capacity Investment</strong> (01/10/14)</td>
</tr>
<tr>
<td>• Discuss investments and outcomes at the November Board Seminar.</td>
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</table>
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday 1 October 2014, in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

Non-Executive Board Members: Mr B Houston (Chair); Mrs S Allan (Vice Chair); Mr M Ash; Mr J Brettell; Councillor D Grant; Councillor R Henderson; Professor J Iredale; Mr P Johnston; Mr A Joyce (Employee Director); Mrs A Meiklejohn; Mrs A Mitchell; Councillor F Toner; Mr G Walker; Dr R Williams and Mr R Wilson.

Executive and Corporate Directors: Mr T Davison (Chief Executive); Mr A Boyter (Director of Human Resources & Organisational Development); Mr J Crombie (Director of Scheduled Care); Dr D Farquharson (Medical Director); Mrs S Goldsmith (Director of Finance); Ms M Johnson (Executive Director Nursing, AHPs & Unscheduled Care); Professor A K McCallum (Director of Public Health & Health Policy) and Professor A McMahon (Director of Strategic Planning, Performance Reporting & Information).

In Attendance: Mr A Milne (Project Director); Mr D Weir (Corporate Services Manager) and Mr S R Wilson (Director of Communications & Public Affairs).

Apologies for absence were received from Mrs K Blair, Dr M Bryce, Councillor C Johnstone, Mrs J McDowell and Mr G Warner.

Declaration of Financial and Non-Financial Interest

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

43. Welcome and Introduction

43.1 The Chairman welcomed members of the public to the meeting.

43.2 The Chairman commented that whilst the role of Board was to lead a large and complex organisation to improve patient care, it was important to take stock and inspiration from the way the organisation delivered this care. He provided a touching example of where staff had gone well beyond the scope of their normal duties by bringing forward the wedding arrangements of a 42 year old terminally ill patient to enable her to be married just hours before she died. The Board agreed this was an example of the type of patient centred care delivered by the organisation on a routine but largely unreported basis.

44. Items for Approval

44.1 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 received.

44.2 It was noted however that Dr Williams wished to raise a matter arising from the previous meeting. It was agreed that whilst the minute of the meeting would be agreed under the consent agenda that the specific matter arising would be raised under the ‘For Discussion’ part of the meeting. 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.

44.3 Minutes of the Previous Board Meeting held on 6 August 2014 – Approved.

44.4 Running Action Note – Approved.

44.5 Performance Management – The Board received the update on the current performance against all of the current 2014/15 HEAT targets, and relevant standards as set out in appendix 1 of the paper. The Board also noted that the report included the latest data available, which for some items related to the 2013/14 targets / milestones. These lines would be updated in future editions of the report to include the 2014/15 targets / milestones when the data became available.

44.6 Healthcare Associated Infection – The Board acknowledged receipt of the Healthcare Associated Infection reporting template for August 2014. It noted NHS Lothian’s staphylococcus aureus bacteremia March 2015 target was a rate of 0.24 per 1000 bed days (≤184 incidences). The current rate was 0.30. Multidisciplinary effort was required if progress towards the target was to be sustained. The Board further noted NHS Lothian’s clostridium difficile infection target by March 2015 was to achieve a rate of 0.32 per 1000 bed days (≤ 262 incidences). The current rate was 0.53. NHS Lothian was currently off trajectory therefore pan Lothian multidisciplinary effort was essential if the target was to be achieved. The Board supported the antimicrobial team activities in relation to the antimicrobial prescribing review and the reduction of antimicrobials associated with clostridium difficile and supported the business case for norovirus near patient testing in Liberton.

44.7 Local Unscheduled Care Action Plan (LUCAP) – The Board noted the actions being taken forward to support NHS Lothian’s performance outcomes for unscheduled care with the LUCAP document attached as an appendix. The Board further noted that this years LUCAP had been submitted and approved by the Scottish Government with the approval letter attached as a further appendix. The targets for measurement and NHS Lothian’s performance were noted as were the funding arrangements in support of unscheduled care performance for 2014/15.

44.8 Corporate Risk Register – It was agreed to use the updated NHS Lothian corporate risk register, highlights of which were contained in section 3.3 of the paper and summarised in appendix 1 of the paper, to inform assurance requirements. It was noted that the Board in August had agreed to adopt the proposed mechanism for reporting NHS Lothian’s risk Appetite at each Board meeting.

44.9 Corporate Objectives – The Board received an update on the latest progress by NHS Lothian’s Corporate Management Team towards the delivery of the Health Boards corporate objectives against the triple aims for achieving the Scottish Governments 2020 Vision as set out in tables 1, 2, 3 and 4 of the Board report.
The Board agreed to focus initially on objectives with a red status and to receive assurance from the lead director about aligned resources and actions in order to advance the delivery of them; table 1. Whilst noting that the domains of these objectives with a status of red are larger within ‘quality of care’ and ‘secure value and financial sustainability’. By definition closely linked to HEAT and performance targets for measures of success.

The Board noted that as appropriate performance against delivery of objectives was being sought from NHS Lothian’s formal Board committee meetings as well as through the Corporate Management Team and the Risk Management Group to ascertain that action plans had been put in place within the remit of those committees to capture, control and strengthen the delivery of objectives within their terms of reference. A targeted approach for objectives was noted within tables 1, 2 and 3 of the circulated report.

The Board noted the corporate objectives without measure(s) of success or had not indicated a status, provided within table 3 of the paper. This required to be remedied in order that a clearer position could be stated at the next reporting period to the Board in February 2015. This would provide a managed position of performance over the crucial period of integration of 2014/15 and 2015/16.

Child and Adolescent Mental Health Services (CAMHS) and Psychological Therapies – 18 Weeks Referral to Treatment HEAT Paper – The Board acknowledged that a successful migration to TRAK had been completed on 13 June 2014. The ongoing delay in performance reporting to ISD was noted which was being addressed by e-health colleagues and the A12 Team. The Board noted the planned timescale for the commencement of performance reporting to ISD and the Board and supported the quality assurance measures that had been established and the continued support to TRAK users as they became familiar with the systems. The Board further acknowledged that recruitment to CAMHS and psychological therapy services to achieve the additional capacity had been completed as planned. The risks to achieving potential service capacity for CAMHS services in north and south Edinburgh were acknowledged due to ongoing accommodation issues.

Acute Hospitals Committee – Minutes of 15 July 2014 – Adopted.

Healthcare Governance Committee – Minutes of 22 July 2014 – Adopted.

Staff Governance Committee – Minutes of 30 July 2014 – Adopted.

Staff Governance Committee – Minutes of 30 July 2014 – Adopted.

Strategic Planning Committee – Minutes of 10 July and 14 August 2014 – Adopted.

Edinburgh Shadow Health and Social Care Partnership – Minutes of 18 July 2014 – Adopted.

Midlothian Community Health Partnership – Minutes of 20 March, 15 May and 17 July 2014 – Adopted.
44.21 Midlothian Health and Social Care Partnership Shadow Board – Minutes of 17 April and 26 June 2014 – Adopted.

44.22 West Lothian Health and Care Partnerships Sub-committee – Minutes of 10 July and 14 August 2014 – Adopted.

44.23 West Lothian Health and Care Partnership Board – Minutes of 27 May and 12 August 2014 – Adopted.

44.24 Committee Memberships and Terms of Reference – The Board agreed to appoint Mrs A Meiklejohn and Mrs A Mitchell to the Acute Hospitals Committee and to appoint Mr B Houston to Chair the St John’s Hospital Stakeholder Group. The Board also appointed Ms P Donald, Interim AHP Manager to the West Lothian Community Health and Care Sub-committee. The Board further agreed on an amendment to the terms of reference of the Acute Hospitals Committee increasing the membership from 4 to 6 Non Executive Board Members.

45. **Items for Discussion**

45.1 Matters Arising from the previous meeting.

45.2 Royal Hospital for Sick Children / Department of Clinical Neurosciences at Little France – Full Business Case – Dr Williams commented that he had been surprised and disappointed about the statement in the previous Board minutes that there was limited capacity to increase bed numbers. He commented that he had raised this question in the past and was concerned that the bed numbers were unrealistically small and he had been assured previously there would be a contingency, with ability to increase provision if necessary in future. He commented that having learned from the experiences of the Royal Infirmary of Edinburgh he would have hoped that the need for capacity to extend if required was essential. He stressed without requiring any delay in the process and without any requirement to withhold approval that he was hoping to obtain reassurance that some imaginative thought would be given to where additional capacity could be found as and when required.

45.3 It was confirmed that the minute of the previous meeting reported that the site was constrained although there would be the possibility of creating extra capacity through the conversion of the patient hotel. The point was made that the generic strategic options to cope with the increased capacity on the Royal Infirmary of Edinburgh site was to displace activity currently at the Royal Infirmary of Edinburgh to elsewhere; extend the main ward ARC or in partnership with the University of Edinburgh expand the NHS Lothian presence on the Bioquarter site which linked to option 1 to displace activity from the Royal Infirmary of Edinburgh site.

45.4 Dr Williams welcomed the update and assurance provided.

46. **Strategic Plan Consultation and Next Steps**

46.1 The Board noted that a total of 918 people had taken part in the consultation process through 45 formal events, responses to an online survey and through letter / emails. The consultation feedback confirmed general support for the aims and direction of the policy.
It was noted the patient pathway had been seen as a valuable way to focus redesign on person centred care to meet peoples health and care support needs.

46.2 A major issue had been around the lack of capacity in primary care and community services to meet current service needs. It was noted that the greater use of IT and innovation to improve communication and information sharing was widely supported. The proposed decision making criteria was supported by 82% of the respondents.

46.3 The Board noted that there had been general support for a number of the priority actions proposed in the Health and Equality Strategy. It was further noted that 62% of online respondents fully supported the cancer strategy. Public and external respondents had been supportive of continued engagement and dialogue.

46.4 The Board noted that immediate action was proposed on work to identify options for reducing costs through efficiency and productivity. Discussion with service teams on the scope to re-profile the workforce were planned.

46.5 The Board noted that it was proposed that an updated strategic plan would be brought to the February 2015 meeting as agreed at the previous Board development session and this would be aligned to the financial plan and Integrated Joint Board establishments.

46.6 The Board agreed that the report before it was comprehensive. It was noted that 71% of online survey responders had agreed that the plan addressed the most important issues, a position supported by consultation and other communication events. The remaining 29% of views were not significantly divergent and in the main related to primary care and inequalities issues. It was noted there would be a need to clarify financial issues and affordability of the plan before the February 2015 Board meeting as there was a need to build up the primary care infrastructure to reduce dependence on the acute sector.

46.7 The Board were reminded that the Human Resources and Organisational Development Strategy had expired in March 2014 and with Board approval had been extended to the end of the current calendar year to take account of the strategic plan and the need to ensure that the people management direction was consistent with aspirations contained within it. It was noted that the revised strategy had been drafted and that in conjunction with the Employee Director a partnership based meeting had been held to look at the current draft. It was noted that this meeting had expressed a significant amount of satisfaction and contentment with the draft as well as having suggested areas where additional aspects could be included. It was noted that a further meeting with Trades Union colleagues would be held to finalise the plan which would then be discussed at the Area Partnership Forum in November prior to coming forward for final approval to the Board in December 2014.

46.8 It was noted that it would be useful if the next iteration of the strategy paper identified the changes to the strategy as a consequence of the consultation process. The engagement with Trades Union side was welcome. It was noted in terms of capacity around primary and community care it would be important to demonstrate what was going to change and that this was clearly articulated in the final version of the financial plan.

46.9 A concern was raised that the primary care workforce element was not captured in the NHS Lothian Organisational Human Resources and Organisational Development (HR & OD) plan. Whilst it was recognised that these staff were largely not NHS Lothian employees they still constituted a significant resource in terms of delivering the strategic
plan. It was reported that although the HR & OD strategy did not apply to GPs and their staff that this did not stop its principles being applied in dealings with independent contractors. It was noted that some of the issues would be addressed through the integration agenda.

46.10 The Board were advised that a number of meetings had been held with general practitioner representatives where issues around their workplans had been discussed within the context of national constraints. It was noted that issues around demand capacity and premises were covered within the primary care strategy which would support the overall strategic plan. There was however a need to agree the overall decision making process.

46.11 It was noted that there had been issues raised through the consultation about perceptions around the commitment to invest in primary and community services with further details being sought on the timing for this work to progress. It was reported that this would be considered in advance of the February 2015 Board meeting. The Board were reminded that 4 separate commissioning plans would require to be produced for the Integrated Joint Boards and these would be instrumental in determining the future direction of primary care and community services which would need to be reflected in the strategic integrated approach.

46.12 The Board were advised that as much as possible alignment would be made to the integration schemes and commissioning plans. Significant work was already in place around the development of the strategic commissioning plans with nuances from individual partnerships being an integral part of the overall process.

46.13 At a meeting held the previous week it had been agreed that rather than simply consolidating primary care and community issues into the overall NHS Lothian position that Joint Directors would bring forward their own individual partnership area priorities.

46.14 The Board agreed that communication messages with patients would be important around shifting the balance of care. The focus should be on the benefit to patients of receiving treatment as close to home as possible and not about financial issues. The Board were reminded that independent practitioners were not all general practitioners and included pharmacists and opticians etc.

46.15 The point was made that a February 2015 timeline for the development of financial aspects to include primary care development felt quite constrained. It was questioned whether the process would also look at options for reducing costs. It was advised that not all responses would be available for February 2015 and that a better framework was being developed for managing change within the available resources. The LRP process was not fit for purpose in the run up to partnership working with there being a proposal to engage external support to develop an appropriate framework through a deep dive methodology approach.

46.16 The Board noted within the context of moving into a position of interdependency that a key issue would be what local authorities could bring to the table in respect of social care capacity. The alternative was that the NHS was forced to spend significant amounts of money in the hospital environment for patient safety reasons if people could not be discharged.
45.17 It was pointed out that the consultation process had tried to describe a strategic vision and direction of travel to allow the 4 Integrated Joint Boards to start with a clear strategic direction to apply local priorities down to locality areas. The strategic commissioning plans would require to bring forward investment proposals to build primary care and community capacity in order to adhere to the Scottish Government 2020 vision. A key issue was how the system would manage to afford the development of the necessary capacity to reduce the dependence on the acute sector. It was felt there was a need to engage with other Boards and the Scottish Government Health and Social Care Directorate (SGHSCD) about the ongoing capacity and affordability conundrum. It was suggested that the Board had a good view of what it wanted to achieve as well as the blocks to delivery. There were a few months available to debate the matter further internally, with local authorities and the SGHSCD in order to reconcile the position.

45.18 The point was made that whilst staff engagement in the consultation process had been good this had been less so from a public perspective. It was noted this was a complex issue and there was a possibility the public attention and focus had been diverted to a wider national issue during the consultation period. The Board noted once established the Integrated Joint Boards would have a responsibility to engage with the public. It was noted community councils were representative of the population and it would be important to engage fully with them through their routine meetings as the integration process developed. It was reported as part of the ongoing engagement process that local communities would be specifically targeted.

45.19 The point was made when communicating with local authorities and the SGHSCD that when changes were made to services this was often sensitive and difficult for patients and this needed to be fully recognised with the benefits being clearly explained. It was noted discussions had been held with the third sector in recognition of the difficulties people often had in dealing with large organisations.

45.20 The Board noted further discussion would be held at the private session later in the day.

45.21 The Board recognised the key themes arising from the consultation on the strategic plan and supported the embedding of the decision making criteria in NHS Lothian’s strategic position making and financial planning mechanism.

45.22 The Board supported an urgent deep dive diagnostic review to investigate opportunities for reducing costs and increasing efficiency and productivity with the intention of identifying specific priority areas which would have the greatest impact for the organisation and deliver the strategic ambitions set out in the 2020 vision. The remit in terms of the external support would be approved by the Chairman and Chief Executive.

45.23 It was agreed that an updated strategic plan be brought to the Board in February 2015 to allow work to be concluded and to align with the timescale for the financial planning for the Board and establishment of new integration bodies for 2015 /16. The Board would also receive an implementation plan to deliver the health and inequalities strategy as part of the overall strategic plan in 2014 as well as a similar implementation plan to delivery the cancer strategy to the same timeframe.
46. **Workforce Risk Assessment**

46.1 The Board received an update report on the actions currently underway to ameliorate risks to service sustainability within specialties where high levels of risk had been identified.

46.2 It was noted on a national basis work continued to plan to increase the attractiveness of medical trainee posts and that a national unscheduled care recruitment and retention short life working group had been established. It was noted that NHS Lothian had taken up the opportunity of a trade stand at the trainee forum in Glasgow which had been very well received and it was hoped this would help to support recruitment in future.

46.3 The Board noted that the Lothian Medical Workforce Group had been re-established to address workforce problems. The group would ensure that it considered the implications of the Greenaway Report and that lessons from ophthalmology and radiology recruitment would be learned in order to ensure future benefits.

46.4 The Board noted that the Maternity Programme Board was now being led by the Director of Scheduled Care. It was recognised that staffing for the paediatric unit at St Johns Hospital continued to be heavily reliant on a small number of staff doing additional night and weekend shifts to cover rota gaps. A further recruitment process to a consultant vacancy at St Johns Hospital had been unsuccessful. It was noted that the availability of anaesthetists was key to delivery of the waiting time agenda and this was a key area of recruitment. It was noted that there was a need to recruit additional posts in medicine of the elderly and ophthalmology.

46.5 The Board were reminded that it had discussed the report of NHS Lothian’s internal assessment following the HIS (Health Improvement Scotland) Review of NHS Lanarkshire Acute Services. The report had highlighted concerns in relation to the reduction of staffing within medicine and its specialties after 5pm and at the weekend with a consequent knock-on impact on quality and patient flow. Variation on how public holidays were staffed were also highlighted and a recommendation made within the report to realign staffing, particularly at weekends and public holidays.

46.6 The Board noted this report was being reviewed by the Associate Medical Director’s for the Royal Infirmary of Edinburgh, Western General Hospital and St John’s Hospital. 14 new clinical development fellow posts had been recruited to and a number of additional core medical trainee posts in 2004 all of whom contributed to the out of hours cover on site.

46.7 A view was expressed by one Board member that the focus on international recruitment and trade stands, whilst welcomed, had a danger of focus being lost at local level. Assurance was sought that vacancies were being made as attractive as possible. The Board were advised part of the reason for re-establishing the Lothian Medical Workforce Group had been to share best practice and make job descriptions and job plans as attractive as possible. It was recognised that the experience of candidates reflected back into the job market. The Board noted lessons learned from anaesthetic and emergency medicine recruitment would be incorporated into future exercises.

46.8 The Board agreed that the Medical Director would take away the points raised and come back with proposals about how to scope the job offer to candidates to make the posts as attractive as possible.
46.9 It was noted in respect of paediatrics cover at St Johns Hospital that as reported to the
Stakeholder Group there had been no ward closures. The vulnerability and arduous
nature of the month on month rota was acknowledged. It was reported that the attempt
to build capacity through the deployment of Burmese doctors had been less successful
than expected because the development requirement had been underestimated. The
Board were advised innovative recruitment exercises continued across the range of
specialties at St John's Hospital including offering sessions at other Lothian hospitals.
Despite all of this work the rota remained vulnerable.

46.10 The focus on engaging the non medical workforce to include AHPs and pharmacists
amongst others was welcomed as this would be necessary for patient sustainability
reasons in future. It was noted when trying to recruit to posts on the edges of Lothian
that consideration was being given to joint appointments between Edinburgh and more
rural areas as links to the centre often made jobs more attractive. The demographics of
the ageing nursing workforce particularly in health visiting, district nursing and care of the
elderly services was noted as was the national work around this position.

46.11 The Board noted a paper would be brought to a future Board meeting by the Director of
Human Resources & Organisational Development detailing how long posts had been
vacant and by vacancy group. The report would show comparable data comparisons
with other large organisations and examples of work being done to make jobs more
attractive to include consideration of the benefits or otherwise of making regional
appointments. The point was made that 17 consultants had been successfully recruited
to accident and emergency partly because the local clinical department had created its
own job description and produced an interactive website.

46.12 It was noted that the paper presented the picture from a largely acute perspective and
had no specific costs attached. The point was made if there was to be more focus on
delivering primary care solutions then currently there was insufficient primary care
workforce data available and thought was needed on how this could be taken forward.
The Board were advised this was a national issue with discussions ongoing with the
SGHSCD in respect of how information could be provided. It was noted that the age
profile of the organisation increased by 3½ years every 8 years. The Occupational
Health Service had been asked to look at physically demanding posts and steps that
could be taken to support people in these posts.

46.13 The Board noted there had been discussion at the GP Sub-committee about the
strategic plan which had included debate about whether GPs would voluntarily provide
information about workforce plans. It was noted even if a 100% response was not
received this would at least provide indicative data.

46.14 It was noted that Lothian job fill rates including medical training posts despite having
some specific difficulties were generally the highest in Scotland. The point was made in
respect of the GP practice workforce that the issue was not just about capacity on a day
by day basis but also how issues like the out of hours service was staffed as merely
increasing levels of payment to practitioners did not increase the level of staffing to run
the service.

46.15 In terms of national issues debate was being held around the cost of recruiting to hard to
fill vacancies as currently there was no financially sustainable solution to these problems
either in safety or cost terms. It was acknowledged that to date the discussions around
medical staffing had been largely acute focussed. Since the Chief Executive had taken up post 17 extra emergency medicine consultants had been recruited to sustain patient safety. It was not felt possible to have future discussions in isolation from the 2020 vision. There was a fundamental dilemma about resourcing the acute sector and shifting the balance of care with there being a need for NHS Lothian to influence the wider national context.

46.16 It was noted in the meantime there was a need to continue to engage in national work and acknowledge the strategic planning context in respect of primary care and community care. It would also be important to continue doing all that was possible in the organisations own powers to assist in recruitment and retention.

46.17 The Medical Director and the Director of Human Resources & Organisational Development would liaise to bring forward an update paper to a future Board meeting.

46.18 The Board agree the recommendations contained in the circulated paper.

47. Unscheduled Care

47.1 The Board noted a performance level of 93% had been achieved in August with attendances up because of the festival. Increased attendances in October were however not yet translating into admissions. The un-validated September performance was 94% and it had been disappointing because of operational pressures that 95% had not been achieved. It was noted significant further work was needed to achieve the Scottish Government Health and Social Care Department (SGHSCD) target of 98%.

47.2 The Board were provided with a site by site comparison of performance with it being noted that the Western General Hospital site had been an area of focus for a number of months. It was noted that service changes were being implemented at the Western General Hospital around the Minor Injuries Unit, new Surgical Assessment Unit, Lothian Unscheduled Care Service, Ambulatory Care and the Acute Receiving and Assessment Unit bed areas. In addition a direct GP to consultant telephone facility was being piloted. Discussions were also underway to divert some 999 ambulance activity to the Royal Infirmary of Edinburgh and to balance this by looking to rezone some GP referrals to the Western General Hospital. Appropriate 999 admissions would continue. Ward 15 would be opened as an acute ward and work would continue to improve patient flow through discharge.

47.3 It was noted the delayed discharge position remained a significant problem and had been subject to discussion at a number of Board committees although as yet no improvement was being evidenced. The Board were advised delayed discharges represented a risk to patients in terms of independence, infection and mortality. Similar risk to patients could be evidenced through increased length of stay, boarding and elective surgery cancellations. The Board were advised a significant amount of management and clinical time was being spent trying to mitigate the position.

47.4 The Board noted currently there were a number of unfunded beds open within the system with significant joint work being undertaken with local authority partners. Positive discussions were also being held with the Care Inspectorate about closer working to support care homes where issues were evident. It was noted despite additional step-
down beds opening in East Lothian and an increase in Edinburgh in the recruitment of care workers that the benefits were not evidencing themselves in reducing numbers.

47.5 The Board noted that the winter plan was focussing on extending the bed base to support the delayed discharge position. It was reported that there was not yet full confidence that enough capacity was in place to see the system through December and January.

47.6 The Board were advised in response to a question from a Non Executive Board member that the reasons for patient breaches were captured daily and reviewed and analysed at least on a weekly basis. The most significant reason was patients waiting for a bed because of poor patient flow. The detail of this work would be included in the next Board paper although the most significant specialties were around care of older people and medicine. It was noted however that there were two types of boarding with boarding from the front door of the hospital being the least acceptable. The other aspect was boarding from wards. More information would be provided in the next Board paper and would include details of the specific boarding position at St Johns Hospital.

47.7 The Board sought assurance that when definitions changed that this would not be in a way that skewed the real position and continued to capture all boarders. It was advised that boarding was an important issue as it represented poor practice and that from an operational perspective patient safety was paramount. The Board were assured if the model of care at the Western General Hospital or elsewhere was being changed then this would be in an open and transparent manner and in a way that continued to meet government standards.

47.8 The Board agreed the recommendations contained in the circulated paper and the actions being taken forward to support NHS Lothian’s performance outcomes for unscheduled care.

48. Waiting Times Performance, Progress and Elective Capacity Investment

48.1 The Board noted that both 31 and 62 day performance against cancer remained at 95% in July and this continued the pattern set in the previous quarter. Challenges still persisted in some areas particularly head and neck and lung cancer.

48.2 The Board were advised that figures for patients waiting for outpatient appointments in the Edinburgh Dental Institute (EDI) were not available. It was noted that reporting and other issues at the EDI had surfaced as part of the Internal Access, Performance and Governance Group established to bring leverage to the management process. It had been agreed to bring the EDI under the governance umbrella to ensure systems were put in place to meet normal waiting time standards. It was noted in future that data would be reported through the warehouse and that processes had been reinvigorated at the EDI. The Board were advised once issues had been identified around EDI data that this had immediately been reported to the Boards Acute Hospital Committee as well as to the internal Acute Recovery Group.

48.3 The Board were assured that forensic work was being undertaken by the Service General Manager at EDI given the lack of reportable data for July and August. It was noted that data was now being received from the warehouse suggesting an overwhelmingly better position than the previously reported scenario by Information
Services Division (ISD). For July and August 53 and 82 patients were being reported as having waited more than 12 weeks. It was noted that through normal data cleansing processes that there was an anticipation that the 82 figure would reduce down to 5. The Board agreed this was a good example of demonstrating that the governance process was working properly.

48.4 The Board were advised that the difficulties in cystoscopy as a result of junior doctor availability had caused the diagnostic position at the end of August to worsen with 517 scope patients waiting more than 6 weeks. It was anticipated that the position would be recovered in October.

48.5 The Board noted that a total of 568 patients against a trajectory of 470 were waiting beyond the treatment time guarantee at the end of August with 402 having been seen in month. It was reported that the number of delayed discharges and boarding patients was compromising the throughput of elective care. The safety impacts of patients being cancelled, often more than once for elective procedures was acknowledged. The Board was advised that the system had tested the concept of ring fencing elective beds in September at the Western General Hospital and this position had held for only 9 days and had to be compromised on patient safety grounds. It was noted between April and August around 300 elective patients had been cancelled. Contingency plans continued to be developed and there was confidence that there would be improvements in the future.

48.6 The point was made by a Non Executive Board member that at best performance had flat lined despite significant investment in extra beds and staff. There was a need therefore to be able to measure the outputs from investments made. The investments and outcomes would be characterised at the November Board Development Session.

48.7 The Board noted that the current delayed discharge position had worsened since the same time in the previous year. It was reported if the 300 elective cases had not been cancelled then the position would be ahead of trajectory. Length of stay was also at the heart of boarding which led to the cancellation of elective admissions. At the moment it was not possible to reconcile the position. The Board were assured that patient safety remained the main priority and it was for this reason that the proposal to ring fence elective capacity at the Western General Hospital had been so carefully considered.

48.8 The Board were advised one of the key strategic decisions was about the future role of the Western General Hospital in conjunction with the location of elective orthopaedic surgery. An option would be to create elective orthopaedic services on a separate site which would have the effect of geographically ring fencing elective activity away from emergency electives. The view was expressed by members of the Board that this proposal should be expedited as it was the only sensible way forward to stop the cancellation of elective admissions. A concern was expressed about building more capacity if this could not be demonstrated to be effective with there being a danger that the system would move to a position where resources were lying idle.

48.9 The Board were reminded of a previous debate about increasing resources for Mental Health and Child and Adolescent Mental Health Services. A paper would come forward to the Board later in the year reporting on progress towards meeting the national targets.

48.10 The Board were advised there was clarity about what needed to be done and that some of the issues were not mutually exclusive. There was still a sum of £5m being spent in
the private sector in respect of orthopaedics. There had been an agreement to develop
the in-house orthopaedics service with there being a need for more beds and theatres
and to ensure these were not inappropriately filled by the wrong category of patient.

48.11 The point was made in respect of the future provision of elective orthopaedics that this
could be provided at either the Western General Hospital or St John’s Hospital. The
proposal would require significant capital investment and would take a minimum of 2½
years to deliver. Given the strategic desire to redirect investment to primary care this
proposal represented an immediate conundrum. The Board was advised it was not yet
possible to reconcile affordability and this might mean difficult choices would require to
be made given there were more development aspirations than funding available. The
Board suggest there was a need to come back with a framework to address these
issues.

48.12 The Board received the update on performance and progress in inpatient, outpatient and
other waiting times as detailed in the circulated paper.

49. Integration of Health and Social Care: Delegation of Health Functions

49.1 The Board noted that integration schemes required to be submitted to the SGHSCD with
drafts needing to go through the governance process at both NHS Lothian and the
respect local authorities by the end of December. Consultation would thereafter occur
prior to integration schemes being finalised by March 2015.

49.2 It was agreed there was a need to be clear what would be delegated to Integrated Joint
Boards to strategically plan. It was noted in the current week the Scottish Government
had issued a response to one set of the regulations. Issues around the acute sector and
what must be delegated had been clarified which included general dental and
pharmaceutical services. The Board paper had been based on the extant position at the
point of drafting and was therefore only seeking approval in principle.

49.3 The Board noted that the second part of the Board paper referred to Children’s Services.
A previous Board paper had set out the Edinburgh position and its complexities. It had
been affirmed that a governance structure had been established to manage Health and
Social Care Services for Children. The point was made that aspirations for delivering the
service needed to be set out in the integration scheme for consultation.

49.4 It was agreed that appendix 2 of the paper needed to be updated to reflect clarification
received from the SGHSCD. In terms of corporate functions it was agreed at the
appropriate time once revised arrangements had settled to look at reducing cost to
support front line services.

49.5 The point was made that although there was a need for significant commonality around
the Integrated Joint Boards that each would be able to address its own unique
geographical nuances and to reflect issues like financial pressures and ambitions. The
Board noted that local authorities would have their budget finalised by the end of March
and that NHS Lothian’s position would go through the Finance and Resources
Committee to a similar timescale.

49.6 There was detailed discussion about the position in West Lothian in respect of the future
delivery of Children’s Services. The wording in the paper would be amended to reflect
the actual position in West Lothian and whether there were additional opportunities for further integration.

49.7 The point was made given the creation of 4 new corporate bodies that care would need to be taken to ensure issues were not discussed at the Board in isolation. There would be a need to look at the impact of services commissioned by the Integrated Joint Boards. The point was made that the outcome of the Greenaway Review on medial staffing would require to be implemented over the course of the next 5 years and there was a likelihood that Integrated Joint Boards would not be as sighted on this as the current NHS Board was. Issues around research and educational requirements would still need oversight to assist Integrated Joint Boards to deliver their remit whilst safeguarding what was already being delivered well.

49.8 The Board noted under the new arrangements that that provision of emergency medicine would be delegated to the 4 Integrated Joint Boards to address through their strategic commissioning plans. This would require the 4 Integrated Joint Boards to come together in order to ensure services were not skewed as a consequence of multiple ownership. It was noted therefore that strategic decisions needed to be coherent and would be an area of concentration over the next few months.

49.9 The Board agreed the recommendations in the circulated paper with the exception of recommendation 2.6 to identify those Non Executive Directors who would participate in the proposed governance arrangements for Children's Services in Edinburgh which would be addressed outwith the meeting.

50. **Quality Report and Person Centred Culture**

50.1 It was agreed to discuss paper ‘2.6 Quality Report’ and ‘2.9 Person Centred Culture’ together.

50.2 **Quality Report** – The Board noted that the inpatient national survey was released in 2014. The overall rating of care and treatment during hospital stay in Lothian from 2378 respondents was 91% positive against the Scottish response of 93%. The results of the survey would be looked at on a site basis to deliver and inform improvement plans. It was noted that the Lothian position had demonstrated issues around noise at night and feeling safe in accident and emergency. Lothian was an outlier in terms of surgical readmission and the data was being looked at with the results to be fed back to the Board in due course.

50.3 It was reported that the latest release of HSMR data demonstrated that for all 3 acute sites in Lothian they were below the Scottish average although only the position at the Royal Infirmary of Edinburgh was statistically significant. It was noted that it was too early to see the impact of actions on deteriorating patients and sepsis.

50.4 The HEAT target for the reduction of c-difficile and staphylococcus aureus bacteraemia had not yet been achieved and the actions to address this were covered in the HAI paper on the Board agenda.

50.5 It was noted an update report on progress against circular CEL19 (Next Steps for Acute Adult Safety – Patient Safety Essentials & Safety Priorities) would be submitted to the Healthcare Governance Committee in November.
50.6 The point was made that the pressure ulcer target was a good target. It was concerning that numbers had increased despite previous assurances that measures were in place to move to a zero tolerance position. The Board noted there had been a blip earlier in year which had led to an increase in pressure ulcer numbers. A number of changes had been made since then with there being a belief that the organisation was better at reporting incidents as a consequence of increased awareness of work being done in this important area. An improvement process was being developed using a collaborative approach on a ward level basis in a number of areas. The collaborative work was looking at falls, hydration and nutrition. The Board were assured that the change in numbers of pressure sores although significant for the patients involved were not statistically significant. It was stressed that this had been a target for time and was one of the medical reasons for delayed discharge and that in the most serious incidents could prove fatal to patients.

50.7 The point was made that the outcome of the patient survey had been excellent and that few organisations would be able to achieve such positive satisfaction ratings. The accident and emergency satisfaction rate had also been welcome and in that context it was questioned whether the move from a 95% target to a 98% target was the correct thing to do. It was agreed whilst it was not within the Board gift to change the target it should try to influence the change if possible.

50.8 The Board were advised the survey results had been shared with the Healthcare Governance Committee and that the outcomes of such surveys was important particularly in respect of learning lessons when patients were not satisfied with the service received.

50.9 It was noted there were clear links to the Person Centred Culture work and the Primary Care and maternity satisfaction surveys. It was reported in addition that enhancements were being made to the ‘tell us 10 things’ initiative to reflect national work. Further analysis of all of these issues including complaints and other feedback were being progressed and would link to the Person Centred Culture work.

50.10 The Board agreed the recommendations in the circulated Quality Report.

50.11 Person Centred Culture – The Board were reminded that following a recent development session there had been a desire for further information on how this workstream was being taken forward. Patient stories were a good way of giving real examples of the impact of the Person Centred Culture.

50.12 The Board noted that the national collaborative aim was to achieve a position where 90% of people using services would have a positive experience by December 2015. Progress reports would continue to be made through the Healthcare Governance Committee. It was reported that the improvement methodology was being moved in organisational terms to the newly established Quality Improvement Department.

50.13 Reference was made back to the debate around elective orthopaedics and the fact that the patient safety culture was all about the organisations aspirations and needed to be embedded to take wider considerations into account. It was noted advance work was underway around shared decision making with patients as referenced by the virtual patient Hannah.
50.14 The Board noted that the national staff survey was underway and early results suggested a significant increase in the response rate. The results once available would be presented to a Board development session the timing of which would be dependant upon the time it took for the results to be analysed at national level. The Board agreed in any event that the results of the staff survey should be distributed to Board members as soon as it became available in order to address concerns raised in previous years.

50.15 The Board agreed the recommendations contained in the Person Centred Culture paper.

51. Royal Edinburgh Hospital Campus Redevelopment – Phase 1 Full Business Case

51.1 The Board were reminded that a revised covering paper with a new recommendation 2.3 had been issued the previous day. In the covering note it had been advised that the draft minute of approval for delegated authority had only just been received from the legal team (a copy of which is attached as an appendix to the Board minute). It was anticipated that it would be possible to move to financial close for phase 1 of the Royal Edinburgh Hospital in late October. The amendment to the recommendation was to delegate approval of the final terms of the project agreement to a sub-committee of the Finance and Resources Committee which would allow the conclusion of financial close prior to the next meeting of the Finance and Resources Committee on 12 November.

51.2 The Board noted that the Finance and Resources Committee had scrutinised the business case during which 2 main concerns had been raised. The first of these had been the reduction of beds from 183 to 165. It was reported this figure had been arrived at following a detailed benchmarking exercise. The position in respect of 20 delayed discharge beds for complex care placements was being discussed with the city of Edinburgh Council to ensure joint planning through the Royal Victoria Hospital Integrated Care Facility which was at design stage.

51.3 The second issue discussed by the Finance and Resources Committee had been the additional revenue cost requirement since the outline business case had been presented. It was noted although the unitary charge had reduced this had been offset by an increase in the extended facilities cost and the move from 4 to 5 acute wards. Further benchmarking work was needed around facilities costs with a view to driving these down. In respect of clinical costs it had been known that existing staffing levels would require to be enhanced and this had been recognised in the 2015/16 financial plan. The Board were advised that as the project was progressing on the basis of a non profit distributing (NPD) model that this attracted welcome revenue funding from the Scottish Government.

51.4 The Board noted that the clinical process to deliver the bed model and the provision of rehabilitation were both predicated on the provision of community facilities.

51.5 The Chair of the Finance and Resources Committee commented there had been significant concerns about the finances and bed numbers associated with the full business case and this had necessitated for the first time ever the committee having to vote on a proposal prior to its approval. The committee had been concerned about the continued requirement to add revenue onto revenue and how this should be prioritised in future. There was a need to consider how best to reflect Board committee debate like this within the formal Board papers.
51.6 The Board noted a key issue of concern for a Non Executive Board member who had voted against the proposal had been that whilst the proposed facility was excellent the service being proposed felt illogical within the context of current demographics given it provided less beds than currently available at greater cost.

51.7 The point was made given the predicted revenue position for 2015 onwards and given the proposal was predicated on a model of care not in front of the Board there might be merit in the Finance and Resources Committee looking at the business case and obtaining advice on the overall package. It was felt although this would incur additional cost that it would place the Board in a better position to make an informed decision. It was noted with the loss of the change fund that aspirations would need to change with there being a need to look at all pressures. It was noted that financial planning in future would be done differently in order to reflect these issues.

51.8 The Board were reminded that previous investment in Mental Health Services had been low and in terms of the need to think about reinvestment that the proposal represented an exciting project. It was important when people absolutely needed to spend time in hospital that the facility should be fit for purpose. The parallel development of good services in the community would also be important.

51.9 The Chief Executive accepted the importance of the debate and felt the recommendations in the paper provided solid reasons why the project should be progressed particularly given the lack of investment in Mental Health Services in the past. He commented that the totality of plans drove a deficit that would need to be met from efficiency plans. The new facility would transform the model of care and provide services in a facility that was fit for purpose. The existing facility had been adversely commented upon by the Mental Welfare Commission. A key issue for the Board was therefore to maintain the dignity and safety of patients as a top priority.

51.10 The Board were advised that improved staffing levels would need to be provided irrespective of whether the project progressed or not. Any delay in the project commencing would lead to increased capital and revenue costs. The Board were informed that the proposal before them represented phase 1 and that further phases would be able to address bed numbers if necessary. The Chief Executive urged the Board to support the business case.

51.11 The Board agreed the recommendations contained in the circulated paper including the revised recommendations at 2.3.

52. Financial Position to 31 August 2015

52.1 The Board noted that the month 5 financial position was reporting a year to date overspend of £3,303m including unachieved LRP. It was reported that it would be misleading to say that the financial position was anything other than difficult and would not get any easier. It was noted that the overspend represented the position following £5.5m of non recurrent support having been played in as well as a further £869k as part of the mid year review. The paper before the Board provided significant detail which had been discussed at the Finance and Resources Committee.

52.2 The Board were advised that the key drivers behind the financial position were the shortfall in delivery of LRP with steps being taken to identify the reasons for this slippage.
Nursing costs were also an issue partly in relation to the need to staff additional beds and the decision not to leave vacancies uncovered thereby incurring extra costs. Other cost pressures remained around prescribing and procurement.

52.3 It was reported as part of the ongoing financial review that all types of expenditure were being scrutinised and management actions agreed. In addition a lot of work was underway around efficiency in areas like procurement, prescribing, rates and agency costs. The Board noted the importance of recognising the balance between supporting clinical capacity and pressures and addressing financial issues.

52.4 The Board noted that in recognition of the forthcoming winter period that £5.4m of non recurrent support had been identified.

52.5 The Board noted that the Director of Finance was still confident that financial breakeven would be delivered in the current financial year. The reported position also reflected a prudent approach around assumptions and strong corporate control around flexibility. Discussions continued with the SGHSCD about the possible availability of financial support for the winter period.

52.6 It was reported that in 2015/16 the Board would be out of recurrent balance and once this position moved beyond 1% it was more of a challenge from a financial governance perspective.

52.7 The Board noted that the recommendations in the paper related solely to the current financial year and a more radical approach was being worked on for the future with there being a need to align the financial plan with the strategic plan.

52.8 The question was raised about whether it was responsible for the Board to set certain LRP levels when history demonstrated these were not achieved and would be difficult to achieve given the parameters within which the Board needed to operate.

52.9 The Chairman advised issues around finding different and more radical and better ways of closing the financial gap would be discussed later when the Board moved into private session.

52.10 The Board agreed the recommendations in the circulated paper recognising the need to take away and report back on the bigger issues reflected upon during the debate at the meeting.

53. Hannah

53.1 The Board were advised of the importance of being kept up to date on the work around developing patient pathways to understand better how patients use services. It was noted the virtual patient Hannah was based on a real person who used NHS Services on a daily basis. Other virtual patients were being worked up in respect of Scott (older person), Callum (Royal Edinburgh Hospital Services – substance misuse etc) and Sophie (child with complex care issues).

53.2 It was noted there had been good clinical engagement through general practitioners and public health with a real energy and enthusiasm having been evident from the outset as the project developed. It was noted in terms of person centred care the project would be
piloted with governance wrapped around the process. It had been agreed with the 4 Joint Directors that the needs of the 4 virtual patients would drive the draft Strategic Commissioning Plans with a focus on prevention. Callum would be launched at an event on 31 October.

53.3 The Board noted that the process had involved a review of literature and wider consultation. Results had been sense checked and built on work in progress around long term conditions with general practice and academic colleagues. Further work was needed to setup and progress development and outcomes in order that these could be monitored and evaluated to ensure implementation of improved care in the way intended. Detailed financial plans would be developed and discussed further with the Public Reference Group. The Project Management Board would formally report progress through the Strategic Planning Committee although it was intended to use a host of collaborative methodologies to maintain enthusiasm.

53.4 The Board welcomed the innovative work and agreed the recommendations contained in the circulated paper.

54. Date and Time of Next Meeting

54.1 The next meeting of Lothian NHS Board would be held at 9.30am on Wednesday 3 December 2014 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

55. Invoking Standing Order 4.8

55.1 The Chairman sought permission to invoke standing order 4.8 to allow a meeting of Lothian NHS Board to be held in private. The Board agree to invoke standing order 4.8.
TO WHOM IT MAY CONCERN

Date 30 October 2014
Your Ref  
Our Ref  TD/REH (Phase 1)
Enquiries to  
Extension 35807
Direct Line 0131 465 5807
Email chief.executive@nhslothian.scot.nhs.uk
EA elaine.watters@nhslothian.scot.nhs.uk

Dear Sirs

ROYAL EDINBURGH HOSPITAL (PHASE 1) (the “Project”)

I refer to the hub design and build, finance maintenance agreement (“DBFM”) and the ancillary documents relating to the above Project shortly to be entered into by the Board.

I confirm that the following persons have been authorised by the Board to execute the DBFM and the Project Documents (as set out in paragraph 4(v) of the Minutes of the Meeting of Lothian Health Board dated 1 October 2014) and to consider and agree any amendments proposed to the Project Documents after the date of the meeting and to consider and agree the terms of any further ancillary documents required in connection with the Project:

<table>
<thead>
<tr>
<th>Full Name</th>
<th>Position</th>
<th>Specimen Signature</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tim Davison</td>
<td>Chief Executive</td>
<td>[Signature]</td>
</tr>
<tr>
<td>Susan Goldsmith</td>
<td>Director of Finance</td>
<td>[Signature]</td>
</tr>
</tbody>
</table>

I confirm that the specimen signatures set opposite the names of the persons are the true signatures of the persons referred to.

Yours faithfully,

For and on Behalf of Lothian Health Board

[Signature]

TIM DAVISON
Chief Executive
LOTHIAN HEALTH BOARD

Extract of Minutes of a Meeting of Lothian Health Board
held in Edinburgh
on 1 October 2014 at 9:30 a.m.

PRESENT

Mr Brian Houston (in the Chair)

Mrs Shulah Allan
Mrs Alison Meiklejohn
Professor John Iredale
Dr Richard Williams
Mr George Walker
Mr Peter Johnston
Cllr Donald Grant
Cllr Ricky Henderson
Cllr. Frank Toner
Mr Michael Ash
Mr Jeremy Brettell
Mrs Alison Mitchell
Mr Robert Wilson
Mr Alex Joyce
Mr Tim Davison
Mrs Susan Goldsmith
Dr David Farquharson
Professor Alison McCallum
Ms Melanie Johnson

IN ATTENDANCE

Mr Douglas Weir
Mr Stuart Wilson

1. APOLOGIES

Ms Kay Blair
Dr Morag Bryce
Cllr Catherine Johnstone
Mrs Julie McDowell
Mr Graeme Warner

2. DECLARATION OF INTERESTS

No declarations of interests were raised in relation to any of the matters to be discussed.
3. ROYAL EDINBURGH HOSPITAL (PHASE 1) (the “PROJECT”)

There was submitted by the Chief Executive of the Board the “Royal Edinburgh Hospital – Phase 1, Stage 2 Approval Submission dated August 2014” outlining the hub project to be entered into on or around 29 October 2014 together with a brief report (i) advising members of the proposed hub project, the hub design and build, finance maintenance agreement (“DBFM”) and ancillary documents as listed in paragraph 4(v) of these minutes, particularly those to which the Board is to be a party; (ii) seeking formal approval for the appropriate officer to negotiate, agree, finalise (in liaison with Andrew Milne, Project Director), execute and deliver the DBFM and ancillary documents as listed in paragraph 4(v) of these minutes (the “Project Documents”) on behalf of the Board; and (iii) seeking formal approval for the Board to inject 30% of the subordinated debt (being a sum of £1,360,000.00) into the Project via REH Phase 1 Subhub Limited at the end of the construction period (the “Injection of Subordinated Debt”).

AFTER DISCUSSION AND DUE CONSIDERATION THE BOARD AGREED THAT:

i. The Board has statutory powers to enter into the Project Documents and effect the Injection of Subordinated Debt. The Project Documents and the Injection of Subordinated Debt are calculated to facilitate and to procure facilities as incidental to the discharge of the Board’s function as Health Board for the promotion of the improvement of the physical and mental health of the people of Scotland, and the statutory provision conferring this function is Section 2A of the National Health Service (Scotland) Act 1978 as modified by the National Health Service Reform (Scotland) Act 2004, as amended;

ii. The Board is satisfied that the Project meets with its internal approvals, policies, procedures, constraints and requirements, including its Standing Orders, current Scheme of Delegation and Standing Financial Instructions;

iii. The Board confirms that it has obtained all consents, authorisations and approvals necessary for their authorisation of the Project to be effective and for the Project Documents to be enforceable against the Board all in accordance with its Standing Orders, current Scheme of Delegation and Standing Financial Instructions;

iv. The Board approve the terms and contents of the “Royal Edinburgh Hospital – Phase 1, Stage 2 Approval Submission dated August 2014” and the brief report referred to in Paragraph 3 above;

v. The Board authorises Tim Davidson, Chief Executive, or in his absence Susan Goldsmith, Director of Finance, whose specimen signatures shall be set out in a certificate in the form annexed hereto, to negotiate, agree, finalise (in liaison with Andrew Milne, Project Director), execute and deliver the DBFM together with
the following Project Documents (each as defined in the DBFM) for the Project and documents on behalf of the Board:

a. the Funders’ Direct Agreement;

b. the Contractor’s Collateral Agreement;

c. the Service Providers Collateral Agreement;

d. the Key Subcontractor Collateral Agreements;

e. the Independent Tester Contract;

f. the Insurance Proceeds Account Agreement;

and any other ancillary documents to be signed by the Board in connection with the Project;

vi. The Board authorises those persons identified in paragraph 4(v) to consider and agree (having considered the advice of the Board’s external advisors) any amendments proposed to the Project Documents after the date of this meeting and to consider and agree the terms of any further ancillary documents required in connection with the Project;

vii. The Board authorises the performance of the DBFM and Project Documents by it following the finalisation, execution and delivery of the same;

viii. The Board authorises the Chief Executive or his nominated representative to provide a certificate to whomsoever it may concern setting out the names and specimen signatures of the Chief Executive and Director of Finance who are authorised by paragraph 4(v) to execute and deliver the DBFM and the Project Documents on behalf of the Board by virtue of paragraph 4(v);

ix. The Board authorises the Chief Executive or his nominated representative, to provide to whosoever it may concern certified copies of the Board’s current:

a. current Scheme of Delegation;

b. Standing Orders; and

c. Standing Financial Instructions.

x. The Board approves the Injection of Subordinated Debt.
SUMMARY PAPER - PERFORMANCE MANAGEMENT

This paper aims to summarise the key points.

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Summary</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.3</td>
<td>Receive performance where information is available by partnership from 2015</td>
</tr>
<tr>
<td>2.4</td>
<td>Replace the previous performance reporting template with focused information as positioned within this paper.</td>
</tr>
<tr>
<td>4.2</td>
<td>Heat id H11.1; Early Access to Antenatal Care. The latest data published by ISD covers up to 31/03/2013 and shows that the Board’s performance was 83.2% against a target of 73%. This was 14% above target</td>
</tr>
<tr>
<td>4.3</td>
<td>Heat id 8.2; Energy Efficiency. Reduction of energy is -5.41% against a target required of -3.94% and is therefore better than target</td>
</tr>
<tr>
<td>4.9</td>
<td>The latest Cancer Waiting Times publication was released by ISD Scotland on the 30th of September 2014. This report covers performance in the period April – June 2014 (quarter-2). NHS Lothian achieved both of the waiting times standards. Our 62-day performance was 95.2%. NHS Lothian was one of only 5 NHS Boards to meet the 62-day target in the period. For Scotland 92.9% of patients met the target. Our 31-day performance was 96.6%. This compared to 96.3% across Scotland.</td>
</tr>
</tbody>
</table>

Julie Drysdale
Strategic Programme Manager
7 November 2014
Julie.Drysdale@nhslothian.scot.nhs.uk

Alex McMahon
Director of Strategic Planning,
Performance Reporting & Information

Julie.Drysdale@nhslothian.scot.nhs.uk Alex.McMahon@nhslothian.scot.nhs.uk
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 current 2014/15 HEAT
targets and other relevant standards.

2.2 Approve that performance will be presented against the all Scotland position where
available using published ISD data

2.3 Receive performance where information is available by partnership from 2015

2.4 Replace the previous performance reporting template with focused information as
positioned within this paper.

3  Discussion of Key Issues

3.1 The HEAT system sets out targets and measures which the NHS Boards are
monitored and evaluated against, along with the 2014 –15 Heat National Standards.
For those referenced in this paper the table below sets out NHS Lothian’s current
achievements against targets, with a more detailed description of these being provided
under item 4 of the paper, key risks and area’s to highlight.

<table>
<thead>
<tr>
<th>Heat ID</th>
<th>Description</th>
<th>Current Status</th>
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<td>H6.1</td>
<td>Smoking Cessation.</td>
<td>Green</td>
<td>AKM</td>
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<tr>
<td>H11.1</td>
<td>Early Access to Antenatal Care</td>
<td>Green</td>
<td>AMcM</td>
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<tr>
<td>E8.1</td>
<td>Carbon Emissions</td>
<td>Red</td>
<td>AB</td>
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<tr>
<td>E 8.2</td>
<td>Energy Efficiency</td>
<td>Green</td>
<td>AB</td>
</tr>
<tr>
<td>A12.2</td>
<td>Psychological Therapies</td>
<td>Red</td>
<td>JF</td>
</tr>
<tr>
<td>A12.1</td>
<td>Child and Adolescent Mental Health</td>
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<td>JF</td>
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<td>T15.1</td>
<td>Delayed Discharge</td>
<td>Red</td>
<td>MJ</td>
</tr>
<tr>
<td>T12.1</td>
<td>Reduction in Emergency Bed Days</td>
<td>Red</td>
<td>MJ</td>
</tr>
<tr>
<td>T11.2</td>
<td>Clostridium difficile Infection (CDI) and</td>
<td>Red</td>
<td>MJ</td>
</tr>
<tr>
<td></td>
<td>Staphylococcus aureus Bacteraemia (SAB)</td>
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</table>

2014 –15 HEAT NATIONAL STANDARD

<table>
<thead>
<tr>
<th>Cancer 31 day performance</th>
<th>Green</th>
<th>MJ/JC</th>
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<tbody>
<tr>
<td>Cancer 62 day performance</td>
<td>Green</td>
<td>MJ/JC</td>
</tr>
<tr>
<td>Stroke Bundles</td>
<td>Red</td>
<td>MJ</td>
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</table>
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.

4 Key risks and areas to highlight:

HEALTH IMPROVEMENT

4.1 Heat id H6.1; Smoking Cessation. Last updated June 2014 Ranking of performance by Health Board Lothian positioned 6 out 14 (Responsible Director: Director of Public Health and Health Policy)

The latest data published by ISD on Smoking Cessation covers up to 31/03/2014 and shows that the Board’s performance was 9,279 successful quits against a target of 7,001. This was 32.3% above target, placing NHS Lothian 6th out of the 14 Boards monitored. The all Scotland performance on this indicator was 42.3% above target.

4.2 Heat id H11.1; Early Access to Antenatal Care Last updated September 2014 Ranking of performance by Health Board Lothian positioned 5 out 14 (Responsible Director: Director of Strategic Planning, Performance Reporting & Information)

The latest data published by ISD covers up to 31/03/2013 and shows that the Board’s performance was 83.2% against a target of 73%. This was 14% above target (the all Scotland figure being 7.2% above target), placing NHS Lothian 5th out of the 14 Boards.

The performance in September 2014 was 90.46% overall. Our focus remains on the 10% not being booked within 12 weeks. Actions being taken to mitigate risks are:
- Meetings with ISD to ensure consistency of reporting and comparing of data.
- Regularly reviewing real time data on Maternity TRAK re: Quintiles linked to booking and births.
- Using data collected to inform work with Community Planning Partners and using the Early Years Collaborative methodology to engage women.

EFFICIENCY AND GOVERNANCE IMPROVEMENT

4.3 Heat id E8.1&8.2; Carbon Emissions and Energy Efficiency (Responsible Director: Director of Human Resources and Organisational Development)

NHS Lothian completed a two year energy investment programme at end of March 2014, with total investment of £1.5 million. The completion of boiler decentralisation at Astley Ainslie, removal of theatre humidification at RIE, variable speed drives in WGH ventilation plant and various other projects has helped NHSL towards achieving HEAT target but further and more major investment such as CEF for St John’s boiler replacement is essential. In addition, for the future, we need to design low energy new buildings and our efforts with new RHSC and REH are meeting with difficulty where derogation on BREEAM Excellent has been granted following agreement with HFS and Scottish Government, "affordability" is the key issue and contrasts with requirements of the Climate Change Act.

Reduction of CO2 is -6.93% against a target required of 11.47% and is therefore worse than target.
Reduction of energy is -5.41% against a target required of -3.94% and is therefore better than target.

ACCESS TO SERVICE

4.4 Heat id A12.2; Psychological Therapies Last updated September 2014 Ranking of performance by Health Board Lothian positioned 10 out 13 (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

The latest data published by ISD on Psychological Therapies covers up to 30/06/2014 and shows that the Board’s performance was 58.1% against a target of 85%. This was 31.6% below target (the all Scotland figure being 0.6% below target), placing NHS Lothian 10th out of the 13 Boards for which figures are available.

There has been a gap in reporting wait times for Psychological Therapies RTT since the migration to TRAK in June. The A12 Team have been working with e heath and services to resolve a number of issues relating to data cleansing, staff training and support and developing functionality to allow reporting of monthly submission to ISD. The provisional data for July and August has been submitted to ISD on 24th October and further work is being completed to allow re-submission of a final revised data set to ISD by 5 November 2014.

On-going support and guidance for clinical staff will be required to ensure the efficient and effective use of the TRAK system to allow accurate reporting of wait times. This work will continue to be supported by the A12 Team.

4.5 Heat id A12.1; Child and Adolescent Mental Health Last updated September 2014 Ranking of performance by Health Board Lothian positioned 9 out 12 (Responsible Director: Director of Community Health and Care Partnership, West Lothian)

The latest data published by ISD on CAMHS covers up to 30/06/2014 and shows that the Board’s performance was 71.2% against a target of 85%. This was 16.2% under target (the all Scotland figure being 5.8% under target), placing NHS Lothian 9th out of the 12 Boards for which figures are available.

There has been a gap in reporting wait times for CAMHS RTT since the migration to TRAK in June. The A12 Team have been working with e heath and services to resolve a number of issues relating to data cleansing, staff training and support and developing functionality to allow reporting of monthly submission to ISD. The provisional data for July and August has been submitted to ISD on 24th October and further work is being completed to allow re-submission of a final revised data set by 5th November.

On-going support and guidance for clinical staff will be required to ensure the efficient and effective use of the TRAK system to allow accurate reporting of wait times. This work will continue to be supported by the A12 Team.

TREATMENT APPROPRIATE TO INDIVIDUALS

4.6 Heat id T15.1; Delayed Discharge Last updated September 2014 Ranking of performance by Health Board Lothian positioned 12 out 14 (Responsible Director: Director of Nursing, AHPs and Unscheduled Care)
The latest data published by ISD on Delayed Discharge covers up to 15/07/2014 and shows that the Board’s performance was 119 patients waiting more than 2 weeks against a target of 21. This was 466.7% above target, placing NHS Lothian 12th out of the 14 Boards monitored. Performance across Scotland was 199.4% above target.

Delayed discharge remains a key pressure on the system. We continue to experience more delayed discharges than at any time since accurate records were kept.

On the 13th October a 2nd Business Continuity Workshop focusing on Delayed Discharge took place. This built on the action plan drawn up following the 1st session on 18th August.

An action and implementation plan covering the points below will be monitored through NHS Lothian’s CMT meetings:

- Review of health and social care respite
- Reviewing the capacity that can be released through out-patient repeat follow ups
- The alignment with care workers to Out of Hours to support people better at home to prevent admissions
- A general communications campaign with staff and with patients, relatives and the public about Moving On and how to keep people safe at home.

4.7 Heat id T12.1; Reduction in Emergency Bed Days Last updated November 2014

Ranking of performance by Health Board Lothian positioned 8 out 14  
(Responsible Director: Director of Nursing)

The latest data published by ISD on rate of occupied bed days per 1000 population (75+) covers up to 31/05/2014 and shows that the Board’s performance was 5,143 against a target of 4,852. This was 6% above target (the all Scotland figure being 1.9% below target), placing NHS Lothian 8th out of the 14 Boards monitored.

The HEAT target reduces month-on-month by 0.3% with the aim of reducing by 8.7% to 4,709 between April’11 and March’15. Currently the monthly target is at 4,852 (May’14). The revised target for Lothian from April 2014 (an increase from 4,799 to 4,867) has meant an overall reduction in divergence with Lothian reporting 6% above target (March’14: 13.5%). The latest published figures (ISD, October 2014) show that for the previous rolling year (May’13-May’14) NHS Lothian has seen an overall decrease of 7.7% (interim) in bed days. The reduction in bed days may show the impact of various Change Fund and other initiatives across Health & Social Care designed to increase prevention and prevent admission. Also the introduction of Hospital at Home/Compass+ initiatives.
Whilst all areas now report a reduction against the same month previous year, the key to reducing the emergency bed day rate will be managing East Lothian and City of Edinburgh activity which continue to be the highest area above target month-on-month. Midlothian now shows the largest drop in bed day rates with West Lothian stable.

4.8 **Heat id T11.2; Clostridium difficile Infection (CDI) and *Staphylococcus aureus* Bacteraemia (SAB) Last updated October 2014 Ranking of performance by Health Board Lothian positioned 14 out 15 (Responsible Director: Nurse Director of Healthcare Associated Infection)**

The latest data published by ISD on rate of C.diff Infections in Ages 15+ per 1,000 total occupied bed days covers up to 30/06/2014 and shows that the Board’s performance was 0.52 against a target of 0.37. This was 40.5% above target, placing NHS Lothian 14th out of the 15 Boards monitored. Performance across Scotland was exactly on target for this indicator.

NHS Lothian’s SAB 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 2015 with a current rate of 0.31.

NHS Lothian continues to exceed the HEAT target for CDI. NHS Lothian’s 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 2015 in patients aged 15 and over, with a current rate of 0.52. Key actions to assist NHS Lothian to reduce CDI include:

- NHS Lothian’s Director of Medical Education will be supporting the Infection Prevention and Control Team with their Clostridium difficile Infection Action Plan.
- The Antimicrobial Management Audit Nurses (1 Whole Time Equivalent) have commenced their role and will be support the surveillance of Clostridium difficile.
Infection specifically focussing on antimicrobial prescribing within 6 months prior to acquisition of Clostridium difficile Infection.

- A 90 Day Workout has commenced within 2 areas at the Royal Infirmary of Edinburgh with the objectives to reduce Clostridium difficile Infection by carrying out a review of all Clostridium difficile Infections in the last 3 months, a range of initiatives to take this work forward. Diarrhoea Integrated Care Pathway is being trialled within Colorectal Ward at Western General Hospital.

2014 –15 HEAT NATIONAL STANDARDS

4.9 Cancer 31 and 62 day performance (Responsible Director: Director of Scheduled Care/ Director of Unscheduled Care)

95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat, and 95% of those referred urgently with a suspicion of cancer to begin treatment with 62 days of receipt of arrival.

Our monthly management information report for August 2014 shows that we are exceeding the 95% standard expected for 31-day cancer performance, with August performance at 98.5% (July 96.3%).

Our 62-day cancer performance level decreased in August to slightly under the target level of 95%, with performance in August standing at 94.8% (July, 96.5%). The lung, colorectal, and urology teams meet with the Director – WGH to review performance, assess progress, and troubleshoot issues weekly.

The latest Cancer Waiting Times publication was released by ISD Scotland on the 30th of September 2014. This report covers performance in the period April – June 2014 (quarter-2). NHS Lothian achieved both of the waiting times standards. Our 62-day performance was 95.2%. NHS Lothian was one of only 5 NHS Boards to meet the 62-day target in the period. For Scotland 92.9% of patients met the target. Our 31-day performance was 96.6%. This compared to 96.3% across Scotland.

4.10 Stroke (Responsible Director: Director of Nursing, AHPs and Unscheduled Care)

Lothian’s performance against the bundle: June 65.8%, July 62.6% and August 50.5%. Local Delivery Plan stroke bundle target to be met by April 2015: 65%.

During financial year 2014/15, stroke performance will be monitored against a composite stroke bundle, which will measure the proportion of patients with an initial diagnosis of stroke receiving four key elements of care. By 31st March 2015 NHS Boards will be expected to demonstrate an increase in the number of patients receiving the bundle. This will give a more rounded picture of stroke care, but it will, in the first instance, mean that performance will appear to be lower than under the HEAT standard.

Trajectories have been submitted to SGHD and agreed for each of the four elements and the overall bundle performance. Our local targets are noted below. From June to August 2014, performance in each of the four elements changed as follows;

a) Access to a stroke unit by the day after admission – decreased from 77.8% to 56.4% [June – 77.8%, July 72.3%, Aug - 56.4%] (local target = 85%)

b) Imaging undertaken within 24 hours – increased from 95.7% to 96.8% [June – 95.7%, July 95.3%, Aug – 96.8%](national target = 90%)
c) Swallow screen – decreased from 81.2% to 80% [June – 81.2%, July 85%, Aug - 80%] (local target = 90%)
d) Aspirin – decreased from 88.9% to 82.9% [June – 88.9%, July 85.9%, Aug – 82.9%] (local target = 90%)

Our agreed local target for bundle performance is 65%, and overall performance against the bundle has decreased from 65.8% to 50.5% from June 2014 to August 2014. A significant portion of the reduction in bundle performance is explained by the reducing performance for access to a stroke unit by the day after admission, whereas scanning and swallow screening have both remained fairly static. However, performance for aspirin treatment improved month on month for the first half on the year, but had deteriorated since then which has also impacted on the reduction in bundle performance.

5 Risk Register

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

6 Impact on Inequality, Including Health Inequalities

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

7 Involving People

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

8 Resource Implications

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

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Strategic Planning, Business Continuity Resilience and Public Records
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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.

<table>
<thead>
<tr>
<th>Para</th>
<th>3.2.1 &amp; Table 1</th>
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</thead>
<tbody>
<tr>
<td><strong>•</strong> This report sets out the Quarter 2 position and provides a summary of the corporate risks and movement in risk grading over the last 4 quarters and illustrates minimal movement in risk grading.</td>
<td></td>
</tr>
<tr>
<td><strong>•</strong> Table 2 compliance with Risk Appetite 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 1), patient experience (Corporate Objective 2) and improving the way we deliver unscheduled care (Corporate Objective 4). The Board is also outwith appetite with respect to ensuring a sustainable Financial Framework.</td>
<td>3.3 &amp; Table 2</td>
</tr>
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</table>

There are a number of papers on the Board agenda which seeks to improve the current position with respect to healthcare acquired infections, unscheduled care and finance.

---

Jo Bennett  
Clinical Governance & Risk Manager  
6 November 2014  
Jo.bennett@nhslothian.scot.nhs.uk
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

The Board is recommended to:

2.1 Use the updated NHS Lothian Corporate Risk Register, highlights of which are contained in section 3.2.1 and summarised in Appendix 1, to inform healthcare governance assurance requirements

3 Discussion of Key Issues

3.1 As part of our systematic review process, the risk registers are updated on Datix on a quarterly basis at a corporate and an operational level. Risk are given an individual score out of 25; based on the 5 by 5 Australian/New Zealand risk scoring matrix used; 1 being the lowest level and 25 being the highest. The low, medium, high and very high scoring system currently used, is based on the same risk scoring matrix, remains unchanged.

3.2 This report sets out the Quarter 2 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 September 2014 updates. When a risk’s adequacy of control is inadequate or uncertain, the rationale is stated on the individual risk.

3.2.1 If you have an electronic version of this report, links to each risk in the appendix have been embedded in the below table (please click on individual Datix risk number in the table). This table illustrates that there has been minimal movement in risk grading over the last year. The Healthcare Associated Infection risk (1076) has been upgraded from Medium 9 to High 16 to reflect the current position.
<table>
<thead>
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<td>3567</td>
<td>Health &amp; Social Care Integration</td>
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<td>3211</td>
<td>Achievement of National Waiting Times Targets (Standing Board Agenda item under Performance Report)</td>
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<td>3480</td>
<td>Patient Safety (Safety Measures in monthly Quality Report SPSP reported January &amp; June 2013 to Board)</td>
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<td>1085</td>
<td>Public Protection (Child, Adult, MAPPA) (Standing item on HCG Committee. Reported to Board via Minutes)</td>
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<td>3600</td>
<td>The scale or quality of the Board's services is reduced in the future due to failure to respond to the financial challenge.</td>
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<td>3527</td>
<td>Medical Workforce Sustainability - which replaces/incorporates: ID 1103 Paediatric Services at St John’s Hospital, now closed</td>
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**Table 1**
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</tr>
</thead>
<tbody>
<tr>
<td>3328</td>
<td>Roadway / Traffic Management (Risk escalated from UHD 06/03/2013) (Reported at H&amp;S Committee, via Staff Governance Committee Minutes)</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
<td>High 12</td>
</tr>
<tr>
<td>3531</td>
<td>Lack of Management Capacity</td>
<td>High 15</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
<td>Medium 9</td>
</tr>
</tbody>
</table>

#### 3.3 Articulating Risk Appetite

The Board agreed in August 2014 to report Lothian’s Risk Appetite at each meeting using the table below.

**Table 2**

<table>
<thead>
<tr>
<th>Corporate Objective 1 – Improving Patient &amp; Staff Safety</th>
<th>Current Status</th>
<th>Current Position</th>
<th>Data Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Scotland target to reduce acute hospital mortality by 20% (Scotland-14.4%) with a tolerance of 15-20% by Dec 2015</td>
<td>Green</td>
<td>10.5%</td>
<td>Quality Report (Graphs 7-9)</td>
</tr>
<tr>
<td>• Achieve 95% harm free care with a tolerance of 93-95% by Dec 2015</td>
<td>Green</td>
<td>99.7%</td>
<td>Patient Safety Programme Annual Report (July)</td>
</tr>
<tr>
<td>• Achieve 184 or fewer SAB by March 2015 with a tolerance of 95% against target. n=193 to 184</td>
<td>Red</td>
<td>73 (as at July 2014)</td>
<td>Quality Report (Graph 12)</td>
</tr>
<tr>
<td>• Achieve 262 or fewer C.Diff by March 2015 with a tolerance of 95% against target. n=275-262</td>
<td>Red</td>
<td>146 (as at July 2014)</td>
<td>Quality Report (Graph 11)</td>
</tr>
<tr>
<td>• Reduce falls with harm by 20% with a tolerance of 15-20% by Dec 2015</td>
<td>Green</td>
<td>20%</td>
<td>Quality Report (Graph 15)</td>
</tr>
<tr>
<td>• Reduce staff harm – to be agreed with executive lead</td>
<td>Tbc</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Corporate Objective 2 – Improving Patient & Staff Experience**

<table>
<thead>
<tr>
<th>Corporate Objective 2 – Improving Patient &amp; Staff Experience</th>
<th>Current Status</th>
<th>Current Position</th>
<th>Data Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 95% of patients would rate their care experience as good/very good with a tolerance of 93-95%</td>
<td>Red</td>
<td>91%</td>
<td>Inpatient Survey August 2014 reported in October Quality Report</td>
</tr>
<tr>
<td>• 90% of staff would recommend NHS Lothian as a good/very good place to work by Dec 2015 with a tolerance of 93-95%</td>
<td>Tbc</td>
<td>Tbc</td>
<td>To be collected</td>
</tr>
<tr>
<td>• Staff absence below 4% with a 5% tolerance (4-4.2%)</td>
<td>Red</td>
<td>4.3%</td>
<td>Quality Report (Graph 6)</td>
</tr>
</tbody>
</table>

**Corporate Objective 3 – Improving the way we deliver Scheduled Care**

<table>
<thead>
<tr>
<th>Corporate Objective 3 – Improving the way we deliver Scheduled Care</th>
<th>Current Status</th>
<th>Current Position</th>
<th>Data Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 90% of patients of planned/elective patients commence treatment within 18 weeks with a tolerance of 85-90%</td>
<td>Green</td>
<td>86.2%</td>
<td>Scheduled Care Report</td>
</tr>
</tbody>
</table>

---

1 This is a Scotland-wide target which NHS Lothian will contribute to.
<table>
<thead>
<tr>
<th>Current Status</th>
<th>Current Position</th>
<th>Data Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 95% of patients have a 62 day cancer referral to treatment with a tolerance of 90-95%</td>
<td>Green 93%</td>
<td>Quality Report (Graph 18)</td>
</tr>
</tbody>
</table>

**Corporate Objective 4 – Improving the way we deliver Unscheduled Care. Low Risk Appetite**

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Current Position</th>
<th>Data Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 98% of patients are waiting less than 4 hours from arrival to admission by Sept 2014 with tolerance of 93-98%</td>
<td>Green 93%</td>
<td>Quality Report (Graph 17)</td>
</tr>
<tr>
<td>• No of patients will wait no more than 14 days to be discharged by April 2015 with a tolerance of 13 to 14 days</td>
<td>Red 122</td>
<td>Quality Report (Graph 5)</td>
</tr>
<tr>
<td>• 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</td>
<td>Red 75</td>
<td>Quality Report (Graph 5)</td>
</tr>
<tr>
<td>• 90% of all stroke patients to be admitted to stroke unit on day of admission following a stroke with a tolerance of 85-90%</td>
<td>Red 65%</td>
<td>Quality Report (Graphs 19-21)</td>
</tr>
</tbody>
</table>

**Corporate Objective 6 – Protect and Improve Health in Lothian for all. Medium Risk Appetite**

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Current Position</th>
<th>Data Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• To deliver 7,001 quits successful quits at 12 weeks post-quit in the 40% most deprived within board SIMD areas, i.e. the bottom two local SIMD quintiles over the 1 year ending March 2015.</td>
<td>Green 32.3% above target</td>
<td>Performance Report</td>
</tr>
<tr>
<td>• 80% of pregnant women have access to antenatal care by 12th week by March 2015, with a tolerance of 70-80%</td>
<td>Green 90.46%</td>
<td>Performance Report</td>
</tr>
</tbody>
</table>

**Corporate Objective 7 – Ensure the delivery of a sustainable financial framework. Medium Risk Appetite**

<table>
<thead>
<tr>
<th>Current Status</th>
<th>Current Position</th>
<th>Data Report</th>
</tr>
</thead>
<tbody>
<tr>
<td>• In the preceding month, the monthly overspend against the total core budget for the month is not more than 0.5%</td>
<td>Red £436k overspend at period 6 (inc. unachieved LRP), equating to 0.4%</td>
<td>Period 6 Finance Report</td>
</tr>
<tr>
<td>• For the year to date, the overspend against the total core budget for the year to date is not more than 0.1%</td>
<td>Red £3,739k overspend for the year-to-date (inc. unachieved LRP) equating to 0.6%</td>
<td>Period 6 Finance Report</td>
</tr>
</tbody>
</table>

3.3.1 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 1), patient experience (Corporate Objective 2) and improving the way we deliver unscheduled care (Corporate Objective 4). The Board is also outwith appetite with respect to ensuring a sustainable Financial Framework.

3.4 Review of Risk Registers - Update

In June 2014, the Audit & Risk Committee agreed a proposal to carry out a self-assessment of the Risk Management System using the Audit Scotland Best Value
Toolkit for Risk Management and highlight areas for improvement at a corporate and service level.

Sample risk registers have now been reviewed and meetings taken place with:

- The senior management team for Scheduled Care
- REAS
- Edinburgh CHP
- Facilities

These sessions have proved useful and improvements have been agreed and beginning to be implemented. These are principally around updating and refining risk register documentation and re-establishing routine review mechanisms following organisational change. Technical support is being provided as required by the Clinical Governance and Risk Management Support Team.

Sessions have been arranged for November/December 2014 with the Unscheduled care management team, RIE site management team and the diagnostics clinical management team.

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
Clinical Governance & Risk Manager
6 November 2014
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Summary of Corporate Risk Register
<table>
<thead>
<tr>
<th>ID</th>
<th>NHS Lothian Corporate Objectives</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Risk level (current)</th>
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<th>Owner</th>
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</tr>
</thead>
</table>
| 3480 | Improving Patient Safety | Patient Safety | 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.  
• 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  
• 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. | October 2014: Risk Reviewed, control in place and notepad updated.  
Established a single system medicines reconciliation group. Mapping current process on three acute sites and RHSC. To inform improvement Plan.  
Review of Executive walkrounds complete.  
HIS review of all four work streams taken place included engagement with frontline staff and Executive team.  
Reviewing HSMR plan in light of recent data and priorities.  
Risk grade/rating remains unchanged High/16 | Adequate but partially effective; control is properly designed but not being implemented properly | High/16 | Medium 6 | Dr David Farquharson | Healthcare Governance Committee |
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<tbody>
<tr>
<td>3527</td>
<td>8: Ensure the Delivery of a Sustainable Workforce Framework</td>
<td>Medical Workforce Sustainability</td>
<td>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 &amp; Gynaecology. Achievement of TTGs is at risk due to medical workforce supply risks within Anaesthetics, Geriatrics and Ophthalmology.</td>
<td>• 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 coordinate 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 been 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.</td>
<td>November 2014: Risk Reviewed, controls and notepad updated. Following successful recruitment of Clinical Fellows, additional Consultant staff and the introduction of Advanced Nurse Practitioners to support the middle grade doctor rota, the level of risk within Emergency Medicine has reduced and is no longer considered a high risk. The other areas identified however remain areas of high risk. A refresh of the medical workforce risk assessments will be undertaken over November 2014 to January 2015. Evidence will be provided to the UK Migration Advisory Group to support the additional of an expanded range of specialties onto the shortage occupation list, which makes overseas recruitment easier. Risk Grade/Rating remains as High/16</td>
<td>Adequate but partially effective; control is properly designed but not being implemented properly</td>
<td>High 16</td>
<td>Low 2</td>
<td>Dr David Farquharson</td>
<td>Staff Governance Committee</td>
</tr>
<tr>
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</table>
| 3567 | 11: Improve Integration - Integrated Joint Boards | 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.  
  • Board will approve draft Integration Schemes for East, Mid and Edinburgh in December. It is unclear if the West Lothian Integration Scheme will be submitted. If not it is very likely that the ministerial deadline will not be achieved  
  • 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 | Oct 2014: Risk Reviewed and Controls Updated. Adequacy of controls remain as inadequate. Potential that risk is now higher in West Lothian than other areas  
  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 | Low | Alex McMahon | NHS Lothian Board |
<table>
<thead>
<tr>
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</tr>
</thead>
</table>
| 3189 | 7: Ensure the Delivery of a Sustainable Financial Framework | Maintenance Backlog | 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 revised backlog maintenance sum has been reported at circa. £65.8 million. The Property Asset Management Strategy (PAMS) describes how this figure will be reduced by disposals and Reprovision Programme.  
•The financial plan has allowed for a further £5m BLM allocation for 2014/15 and 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 2014/15 has a number of capital projects which will improve the physical condition of the estate and reduce backlog maintenance. For example, investment in ARAU of the WGH, Royal Victoria Hospital.  
•The programme of works will continue to address high and significant risks. The programme continues into the financial year 2013/14.  
•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.  
•A Project Board has been set up to review the programme and amended subject to the monitoring processes put in place to measure performance.  
•A series of planned reprovision covering significant sites in Lothian will reduce the burden considerably over the next 4-5 years. | October 2014: Risk Reviewed, controls updated.  
The backlog maintenance programme of works for 2014/15 is currently being undertaken – this will see a further improvement to the estates. A number of disposals have been concluded since April 2014 which will impact on BLM.  
Risk Grade Rating remains High/16 | Adequate but partially effective, control is properly designed but not being implemented properly | High 16 | Medium 4 | Alan Boyter | Finance & Resources Committee |
<table>
<thead>
<tr>
<th>ID</th>
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</tr>
</thead>
</table>
| 1085 | 6: Protect and Improve Health in Lothian for All | Public Protection (Child Adult MAPPA) | There is a risk of harm to individuals and to the Organisation’s reputation because of increasing complexity of cases, reduced capacity of medical and nursing specialist services including the vacancy for the Designated Doctor for Child Protection and the limitations of the existing IM &T infrastructure. This has the potential to be a contributing factor in the occurrence of harm to a patient, public or member of staff. This may lead to adverse outcome for the organisation. | • A revised structure for Public Protection following a review in 2011 is now firmly embedded across NHS Lothian.  
• Designated leads for child and adult protection as well as the Multiagency Arrangements for Public Protection (MAPPA) are in place reporting directly by the Assistant Director for Public Protection to the Executive Director for Public Protection (Public Protection Framework attached).  
• The Public Protection arrangements are supported by range of robust policies, procedures and guidelines both interagency and health.  
• A comprehensive Public Protection training strategy is in place.  
• The governance arrangements for public protection are monitored by the Executive Lead through the relevant public protection action group.  
• There are interagency structures in place across Lothian to ensure effective partnership working at operational and strategic level.  
• Processes are in place with health and interagency to investigate significant incidents and disseminate learning. | October 2014: Risk Reviewed and updated  
The Clinical Director for Learning Disabilities Dr Tracey Sanderson has taken on the role of Lead Consultant for Adult Protection and commenced in September 2014. Dr Sanderson will work with Anne Neilson Assistant Director Public Protection and the Public Protection Team to strengthen arrangements for Adult Support & Protection.  
The Clinical Nurse Manager for Child Protection has recently retired and a new Clinical Nurse Manager for Public Protection has been appointed. The post holder will take up post on 13th October.  
The Designated Doctor for Child Protection is now established in post, however there are some challenges with giving her adequate time to undertake the role as attempts to recruit a paediatrician to backfill her post has to date been unsuccessful. A consultant lead for child protection in now in place across each CHP/CHCP area.  
Cover for health input to IRD in West Lothian is very stretched and fragile following two resignations and inability to recruit. Consultant cover is being reviewed with a view to moving to a Lothian wide IRD service.  
Risk grading/rating remains unchanged - High15 | Satisfactory; controls adequately designed to manage risk and working as intended | High 15 | Medium 9 | Melanie Johnson | Healthcare Governance Committee |
<table>
<thead>
<tr>
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<th>Risk level (Target)</th>
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</tr>
</thead>
</table>
| 1 | Improving Patient Safety        | Health & Safety | 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. 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.  
• H&S policies and procedures in place (attached document).  
• Competent specialist H&S advice in place. Robust Occupational Health Services. Learning lessons through incident investigation.  
• Director of Occupational Health & Safety/Occupational Physician delivers an annual report to the NHSL H&S Committee with specific actions within these reports. | October 2014 - Risk reviewed, Controls in place and Notepad updated formally by the NHS Lothian Health and Safety Committee on 21 October 2014. Despite significant activity in relation to the ROSPA audit and manual revision, it was agreed that the risk should remain at the level of the previous review.  
Risk grading/rating remains unchanged High/15 | Adequate but partially effective; control is properly designed but not being implemented properly | High 15 | Medium 6 | Alan Boyter | Staff Governance Committee |
<table>
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</tr>
</thead>
</table>
| 321 | Improve the way we deliver Scheduled Care | Achievement of National Waiting Times Targets | There is a risk of:  
Not achieving 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 Scheduled Care 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 provided in September 2014.  
The approach to recovering the waiting time position is outlined in Delivering for Patients, due to be considered at the Board in February 2014.  
Papers on CAMHS and psychological therapies presented to the Board in June outlining difficulties in delivering standards of 18 weeks coming into force in December. Further investments were approved. | October 2014: Risk Reviewed – Controls and Action Progress updated | Satisfactory; controls adequately designed to manage risk and working as intended | High 12 | Low 1 | Jim Crombie | NHS Lothian Board |
<table>
<thead>
<tr>
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<th>Risk level (Target)</th>
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<th>Assurance</th>
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</thead>
</table>
| 3328 | 1 Improving Patient Safety | Roadways / Traffic Management | There is a risk of injury to staff, patients and the public from ineffective traffic management across NHS Lothian sites | • Traffic surveys have been conducted across all hospital sites, and action plans have been prepared. Higher risks have been prioritised and actions taken where funding has permitted.  
• Actions include:  
  o segregation of vehicle and pedestrian traffic where possible;  
  o risk assessing and controlling reversing manoeuvres for drivers and vehicles under NHSL control  
  o creation of protected walk ways where possible;  
  o development and use of one way systems where possible  
  o use of barriers and entry systems to control traffic where possible  
  o drop-off areas and disabled spaces;  
  o additional parking attendants.  
• Interim measures have been put in place to prevent illegal and inappropriate parking including temporary barriers and bollards.  
• RIE Site Campus Group has been put in place to co-ordinate the re-provision of DCN & RHSC, including impact on activity on traffic management. Action plans have been revisited on a number of hospital sites and has resulted in additional high risk works being undertaken  
• Banks man arrangements in place on high volume high risk delivery areas.  
• Risk assessments and procedures are being developed and reviewed all areas where risk has been identified – a more robust risk assessment process has been developed  
• NHSL fleet vehicles fitted with reversing cameras and audible alarms.  
• Traffic Management training in place along with regular refreshers.  
• Work Place Transport policy available and reviewed within agreed time scales.  
• Escalation process in place should congestion become an issue  
• Site traffic management groups to review all sites established.  
• Action plans developed from the above groups and implemented monitored and reviewed by Traffic Management Review Groups  
• Capital proposals to introduce engineered solutions for in-patient sites.  
• High Risk Capital proposals funded.  
• Reviews regularly carried out as to effectiveness of plans and operational procedures  
• Site walk rounds in place conducted by site stakeholders  
• Improved monitoring systems in place – formally recorded  
• Known areas of people v vehicle conflict segregation measures put in place to avoid risk of injury due to contact where reasonable and practicable to do so | October 2014 – Risk Reviewed. Controls and notepad updated.  
The Pan Lothian TM Plan is being updated monthly and tabled quarterly at each Heads of Service Meeting. This details the risks, controls and further actions required at each site.  
A draft monitoring tool has been developed to ensure the TM Groups are carrying out formal and effective monitoring, findings will be discussed at each TMG and issues escalated to the Pan Lothian Plan as required.  
A review of all TM Risk Assessments in currently underway using an improved process and linked in to the monitoring activities (above) and will be reviewed at each TMG as they are updated  
A programme of Traffic Management Risk Assessment training will commence at the end of October to upskill those carrying out the TM Risk Assessments.  
Risk grade/rating remains unchanged - High/12 | Inadequate; controls is not designed to manage the risk and further controls & measures required to manage the risk | High | Medium | Alan Boyter | Staff Governance Committee |
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<th>ID</th>
<th>NHS Lothian Corporate Objectives</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Owner</th>
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<td></td>
<td>2 Improve Patient and Staff Experience</td>
<td>Patient Experience</td>
<td>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.</td>
<td>The Quality Report, reported to the Board monthly, contains a range of measures that impact on patient experience and clinical care. • 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. • Quality Improvement Strategy (2011-14) set out a range of improvement programmes to improve patient experience and outcome of care. • 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, these lists have been reviewed and discussions are ongoing as to how we further strengthen the linkages between all aspects and tie back to the person-centred agenda October 14. • Quality of care is subject to Internal Audits and compliance with audit recommendations reported via Audit &amp; Risk Committee and Healthcare Governance Committee • The Delivering Better Care Hub has been established as a resource for staff (primarily nursing) but where appropriate, other disciplines. • As part of the improving care to vulnerable patient’s the rollout of a support manual with detailed information inclusive of a rapid patient essential care check sheet has been implemented within acute and community in patient facilities. Review of the usefulness of this tool has indicated that staff have found it helpful and wish to retain. • The National Person Centred &amp; Care Collaborative is a key priority for NHS Lothian with the aim of capturing and responding to patient, carer and staff experience and the Quality Improvement Plan was approved by NHS Lothian Board in October 2014. The aim is to ensure all patients receive a positive experience and get the outcome they expect (by Dec 2015). This will be demonstrated in a number of ways which will include a specific measure of 95% achieved. A local collaborative will take place in December 2014 and will link patient and staff experience to develop a ‘person centred culture’ across our organisation. Following a visit to Northumbria we will be testing their questionnaire in a number of different in-patient areas across NHS Lothian. We will also be testing ‘Shadowing’ the patient journey and will involve clinical and non-clinical staff following patients through our system. • A review of Tell us Ten Things will take place during November 2014 to ensure the questions are mapped to the ‘Must do with me’ elements of the PCHC Collaborative. • Enhanced reporting arrangements will be put in place via the Healthcare Governance Committee and NHS Lothian Board. • Funding to support this for 2014/15 has been confirmed by Scot Gov, NB does not cover all costs.</td>
<td>October 2014: Risk Reviewed The DBC hub now established on the WGH site has secured further funding for 15/16. Discussions are ongoing to agree how this future funding will be allocated. The vulnerable Patients Quality Improvement Framework has been revisited in light of the OPAC September 14 self-assessment. The framework is a live document however at UHS May CMG it was agreed that the e document required refining to make more user friendly and a driver diagram is currently being consulted on this will be reported back to CMG in October 14. Feedback from previous patient experience surveys have been fed back to the local teams. NHS Lothian Board have approved the Person Centred Culture QI Plan and a local collaborative will take place in December 2014. The patient Quality Indicator tool (PQI) has been reviewed and now also incorporates Person centred questions. Adequacy of controls changed to Inadequate following discussion at Risk Management Steering Group. Risk Grade/Rating remains unchanged - High/12</td>
<td>Adequate; control is not designed to manage the risk and further controls &amp; measures required to manage the risk</td>
<td>High 12</td>
<td>Medium 6</td>
<td>Melanie Johnson</td>
<td>Healthcare Governance Committee</td>
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<td>3544</td>
<td>NHS Lothian Corporate Objectives</td>
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<td>Patient Experience</td>
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<td>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.</td>
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<td>October 2014: Risk Reviewed The DBC hub now established on the WGH site has secured further funding for 15/16. Discussions are ongoing to agree how this future funding will be allocated. The vulnerable Patients Quality Improvement Framework has been revisited in light of the OPAC September 14 self-assessment. The framework is a live document however at UHS May CMG it was agreed that the e document required refining to make more user friendly and a driver diagram is currently being consulted on this will be reported back to CMG in October 14. Feedback from previous patient experience surveys have been fed back to the local teams. NHS Lothian Board have approved the Person Centred Culture QI Plan and a local collaborative will take place in December 2014. The patient Quality Indicator tool (PQI) has been reviewed and now also incorporates Person centred questions. Adequacy of controls changed to Inadequate following discussion at Risk Management Steering Group. Risk Grade/Rating remains unchanged - High/12</td>
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<td>High 12</td>
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<td>Melanie Johnson</td>
<td>Healthcare Governance Committee</td>
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<td>3486</td>
<td>1: Improving Patient Safety</td>
<td>Data Quality</td>
<td>There is a risk that poor data quality impacts upon patient safety. Poorly entered data could lead to the incorrect information being extracted for patient management or performance reporting.</td>
<td>A Data Quality Steering Group has been established to identify and address risks associated with poor quality. It has been accepted by the CMT that issues that cannot be resolve through the group, which includes operational elements of the service, will be escalated to the Corporate Management Team. Minutes of the meeting with a covering report if necessary, are provided to the JMT for meeting. Given the number of issues to address the group has opted focus on the area of beds at this current time, investigating discrepancies in local and national reporting as well as information shared through site and capacity discussions operationally. Some issues around the reporting of elective care were outlined to the Acute Hospitals Committee in September 2014.</td>
<td>September 2014: Risk Reviewed - Controls updated. Risk Grade/Rating remains unchanged - High/12</td>
<td>Adequate but partially effective; control is properly designed but not being implemented properly</td>
<td>High</td>
<td>Medium</td>
<td>Alex McMahon</td>
<td>Healthcare Governance Committee</td>
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<td>3600</td>
<td>7: Ensure the delivery of a sustainable financial framework</td>
<td>The scale of quality of the Board’s services is reduced in the future due to failure to respond to the financial challenge.</td>
<td>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. 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.</td>
<td>The Board has already established a financial governance framework and systems of financial control. Further work is required to address the strategic financial challenge, and this can include:  • The best way to identify the actual effect of reducing resources on the provision of services.  • The best way to avoid an unacceptable impact on services as a result of reducing resources. Identifying how best to support the organisation in implementing its strategies and policies whilst remaining within the financial envelope  • How to step up the necessity for re-design in all activities.  • Whether there are opportunities to revisit the implementation of current strategies and policies, so as to deliver the same objectives in the context of reducing resources.  • Whether there are any activities/ policy objectives which need to be scaled back in the context of reducing resources.</td>
<td>November 2014 – Risk Reviewed - actions added and actions updated. Risk Grade/Rating remains unchanged - High/12</td>
<td>inadequate; control is not designed to manage the risk and further controls &amp; measures required to manage the risk</td>
<td>High</td>
<td>Medium 6</td>
<td>Susan Goldsmith</td>
<td>Finance &amp; Resources Committee</td>
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<td>3203</td>
<td>4: Improve the way we deliver Unscheduled Care</td>
<td>Unscheduled Care</td>
<td>Unscheduled Care</td>
<td>A range of governance arrangements are in place for Unscheduled Care notably:</td>
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<td>Melanie Johnson</td>
<td>Finance &amp; Resources Committee</td>
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<td>- Bi monthly Unscheduled Care Board meeting jointly chaired by the Director of Health &amp; Social Care (City of Edinburgh Council) and NHS Lothian’s Director for Unscheduled Care – Oversee performance and the strategic direction for Unscheduled Care across the NHS Lothian Board area.</td>
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<td>- This is supplemented by further governance arrangements including quarterly formal SMT meetings and fortnightly Informal SMT meetings. Both are chaired by the Director for Unscheduled Care.</td>
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<td>- The Unscheduled Care Programme Group (Executive Leads for CEC and NHS Lothian) meets on a weekly basis.</td>
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<td>- Further weekly briefings to the Scottish Government on performance across the 4 main acute sites (RHSC, RIE, WGH, SU).</td>
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<td>- Upward reporting to Acute Services Committee</td>
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<td>A number of performance metrics are considered and reviewed, including:</td>
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<td>- 4 hour Emergency Care Standard and performance against trajectory</td>
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<td>- 8 and 12 hour breaches</td>
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<td>- Attendance and admissions</td>
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<td>- Adherence to national guidance/recommendations</td>
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<td>- Delayed Discharge</td>
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<td>- Boarding of Patients</td>
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<td>- Winter Planning</td>
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<td>- Cancellation of Elective Procedures</td>
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<td>NHS Lothian’s strategic approach to improving unscheduled care performance is outlined within the Local Unscheduled Care Action Plan (LUCAP). NHS Lothian’s LUCAP will reflect a ‘whole systems’ approach to planning and delivery of unscheduled care operating across acute, primary care and health and social care settings.</td>
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<td>Increasing pressures on patient flow due to number of delayed discharges continues to hamper performance. Additional winter beds to be opened to deal with anticipated heightened demand.</td>
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<td>Strategic workshops for unscheduled Care held during May and June ’14 have gathered significant data and have supported a range of service redesign initiatives. A further strategic development day is planned for 6th November ‘14.</td>
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<td>Specific work to review patient flow across all 3 adult acute sites taking place during October in the form of Flowpoly.</td>
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<td>Risk grade/rating remains at High/10</td>
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<td>2812</td>
<td>1: Improving Patient Safety</td>
<td>Data Protection Act 1998 Compliance</td>
<td>There is a risk that NHS Lothian breaches the Data Protection Act 1998 by accidental or unauthorised disclosure to third parties, of identifiable sensitive data relating to patients or staff. Disclosure of manual or electronic identifiable data could occur by accidental loss such as theft, or by failure to implement policy or appropriate control and security of, use and disclosure of personal data. Consequence of inappropriate disclosure are; distress to individuals, reputational damage to organisation, legal action or financial penalty up to £500,000.</td>
<td>1. Annual reporting to the Healthcare Governance Committee. 2. Information Governance Assurance Board committee 1/4ly review 3. Information Governance Working Group 1/4ly meeting 4. Audit &amp; Risk Committee commission internal audits and monitor recommendations and management actions 5. Incident reporting procedures and controls on further escalation established 6. Information Governance, Data protection and IT Security Policy and procedures are in place, and are review and update in line with any incidents. 7. Staff Mandatory training and education in place, and ongoing awareness raising exercises</td>
<td>October 2014: Risk Reviewed and updated Information Governance Assurance Board committee reviewed status of Data Protection Act Compliance as a Corporate Risk 22nd July 2014. The decision was not to reclassify to a lower level. Action relating to staff communications ongoing. Letter issues to all staff, payslip message and leaflet enclosed with payslips and at induction Next committee date 28th October 2014. Risk grade/rating remains unchanged - Medium/9</td>
<td>Adequate but partially effective; control is properly designed but not being implemented properly</td>
<td>Medium 9</td>
<td>Low 1</td>
<td>Alison McCallum</td>
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Healthcare Governance Committee
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| 1076 | 1: Improving Patient Safety | 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 and further treatment requirements. Outbreaks and increased incidence of infection as well as harm to patient has the potential to adversely affect NHS Lothian through impact on capacity, patient flow and adverse publicity damaging the reputation of NHS Lothian. Factors that can contribute to a development of HAI are inadequate or no training, failure to comply with Infection Prevention and Control Policies and poor decontamination of reusable equipment. | • NHS Lothian has an Infection Prevention & Control Service to provide access to specialist knowledge. There are 4 geographical area teams (Edinburgh North, Edinburgh South, Mid & East and West Lothian) established to cover both acute and community settings.  
• The UHS and CHP Infection Prevention and Control Committees are in place and report to the board through LICAC.  
• IT based system in place to facilitate the IPCN to monitor incidences of HAI within their clinical remits and to monitor for trends and patterns. SPSP have provided a collection of tools to support good practice to minimise potential for HAI risk to patients. IPCNs work collaboratively with clinical teams and bed management to provide advice and guidance on isolation and restriction of patient movements to balance the risk of transmission and impact on patient flow.  
• IPCNs communicate directly with clinical services, escalating as appropriate. SAB and CDI rates are reported weekly and monthly through IPCT reports which are sent by email and available on intranet. At senior management level there is CMG, Healthcare Governance and board papers. All incidences of SAB & CDI are investigated, clusters of 2 or more have further investigations for links and SBARs are provided to report findings and advise if any recommendations. Systems are in place to escalate investigations. HAI Matrix utilised to identify reporting level HAIORT. Communications provide support to manage public release of information as required.  
• Packages of audits are in place to monitor standards and are linked to the National Standard Infection Control Precautions Chapter.  
• HAI education is within Corporate Induction and mandatory update programme. Other packages are available through LearnPro and the Education Strategy is available on line.  
• There is a Decontamination Operational Group to progress/monitor actions associated with reusable surgical, dental and podiatry equipment. | September 2014: Risk reviewed and updated  
Grading has been increased as the HPS will be publishing a quarterly report where trend analysis in patients aged 15-64 years comparing the year-ending June 2013 with the year-ending June 2014 indicates there has been a statistically significant increase in NHS Lothian.  
Actions reviewed and updated to reflect current situation  
Risk Grade/Rating increased at High/16 | Adequate but partially effective; control is properly designed but not being implemented properly | High/16 | Medium 6 | Sarah Ballard-Smith | Healthcare Governance Committee |
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| 3531 | 8.Ensure the Delivery of a Sustainable Workforce Framework | Lack of Management Capacity | There is a risk that management capacity, particularly in the acute sector and at executive level, will impact on developing and implementing robust plans to deliver key strategic objectives, or that operational management will be stretched to the extent that objectives are not met. | • Board reports on delivery of organisational objectives, risks and response.  
• Annual appraisals and mid-year reviews.  
• Review of organisational development needs including visible leadership at points of care.  
• Articulate organisational priorities to focus management efforts and identify areas of risk the organisation can tolerate in areas, particularly around internal audit recommendations.  
• Audit & Risk Committee commission internal audits and monitor recommendations and management actions.  
• Staff Governance Committee to lead on management capacity and capability from a governance perspective. | October 2014: Risk Reviewed  
Site management arrangements are in place for RIE, WGH and SJH for Unscheduled Care.  
Appointments have also been made in Scheduled Care.  
Joint Directors are also in place for each of the 4 Partnerships.  
Further changes in structure are planned which should further strengthen the management capacity.  
Proposed that the Risk grade/rating is reduced to Low  
Risk grade/rating remains at Medium/9 | Adequate but partially effective; control is properly designed but not being implemented properly | Medium 9 | Low 3 | Tim Davison | Staff Governance Committee |
<table>
<thead>
<tr>
<th>ID</th>
<th>NHS Lothian Corporate Objectives</th>
<th>Title</th>
<th>Description</th>
<th>Controls in place</th>
<th>Updates</th>
<th>Adequacy of controls</th>
<th>Risk level (current)</th>
<th>Risk level (Target)</th>
<th>Owner</th>
<th>Assurance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>6. Protect and Improve Health in Lothian for All</td>
<td>Preparedness in Emergency Planning</td>
<td>NHS Lothian is a Category 1 responder under the Civil Contingencies Act 2004 (CCA) and associated Scottish regulations. There is a risk that insufficient preparedness for some emergencies would mean that people might suffer avoidable harm and that our statutory duties under CCA would not be met. These duties often require joint working with other agencies, e.g. Police and local authorities. The main multi-agency forums for this are the East Scotland Regional and Local Resilience Partnership (RRP &amp; LRP). Guidance on emergency preparedness is given in Scottish Government Preparing Scotland and in Preparing for Emergencies – Guidance for Health Boards in Scotland.</td>
<td>• There is a Resilience website on the NHS Lothian intranet to provide easily accessible information about resilience to all staff. • The NHS Lothian has established an executive led Resilience Committee to provide leadership, governance for emergency preparedness and resilience work, as recommended in Scottish Government guidance. This is chaired jointly by the Director of Public Health and Health Policy and the Director of Strategic Planning. It • NHS Emergency Planning matters are also reported at several other key meetings, including JMT, HG&amp;RM and EPSAG. • NHS Lothian is represented by the Director of Public Health and Health Policy on the strategic, multi-agency, Regional Resilience Partnership and by the Emergency Planning Officer on the Local Resilience Partnership, NHSScotland Resilience Forum and other tactical and operational groups. The Emergency Planning Officer is also a member of several RRF work stream groups. • Structured debriefs are held after major and other significant incidents so that lessons can be identified and resilience strengthened, by improving plans, procedures and skills. • NHS Lothian staff regularly take part in emergency planning training and exercises at local, regional and national levels.</td>
<td>October 2014: Risk Reviewed, notepad updated Recently published plans: • NHS Lothian Tactical Incident Management Plan part 1 &amp; 2 • Persons of Interest to Media and Security (PIMS) protocol – replacing the VIP policy Training and exercises in last 6 months: • Leonard’s workshop (jointly with Scottish Resilience Development Service chairing incident management teams &amp; rapid briefing) • Ex. Sheldon, (28 May) main NHS Lothian annual resilience exercise, whole day, over 100 tactical and strategic staff up to and including the Chief Executive. • Ex Falcon (Sept), full day, real-time, multi-agency exercise; live play element including media management (200+ participants) • Forthcoming (Oct): Port Health Exercise of response to ebola case on aeroplane. Debriefing: Lessons identified from several significant incidents (bomb threats, attack on patient leading to multiple site lock downs) are being followed up. Multi-agency: The PH Resilience Lead leads regional groups on mass casualties and mass fatalities and has drafted the national mass casualties mutual aid agreement. Staffing: One full time member of resilience staff has retired and the BC Lead has taken on several non-resilience duties. Learning and Improving: Some external risks have increased (ebola, terrorism threat) and exercise and incidents have identified areas for improvement (e.g. communications with staff during emergencies) and but our improved awareness of these is allowing them to be addressed. Risk Grade/Rating increase Medium 8</td>
<td>Medium 8</td>
<td>Low 2</td>
<td>Alison McCallum</td>
<td>Healthcare Governance Committee</td>
<td></td>
</tr>
</tbody>
</table>

21
SUMMARY PAPER - COMMITTEE MEMBERSHIPS AND TERMS OF REFERENCE

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

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

<table>
<thead>
<tr>
<th>• Elaine Duncan, Clinical Director at St John’s Hospital, has replaced James McCallum as Clinical Director and should be appointed to replace him on the West Lothian Community Health &amp; Care Partnership Board</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Following a reduction in the number of non-Executive members of the Staff Governance Committee its Terms of Reference need to be amended to reduce the quorum from six, of which three must be members of Lothian NHS Board to four, of which two must be members of Lothian NHS Board to ensure that meetings are quorate.</td>
</tr>
</tbody>
</table>

Peter Reith  
Secretariat Manager  
17 November 2014  
peter.reith@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
3 December 2014

Chairman

COMMITTEE MEMBERSHIPS AND TERMS OF REFERENCE

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the appointment of Elaine Duncan, Clinical Director at St John’s Hospital, who replaces James McCallum the previous Clinical Director, to the West Lothian Community Health & Care Partnership Board and an amendment to the Terms of Reference of the Staff Governance Committee to reduce the quorum from six, of which three must be members of Lothian NHS Board to four, of which two must be members of Lothian NHS Board.

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

2 Recommendations

2.1 To appoint Elaine Duncan, Clinical Director at St John’s Hospital to the West Lothian Community Health & Care Partnership Board to replace James McCallum.

2.2 To agree an amendment to the Terms of Reference of the Staff Governance Committee.

3 Discussion of Key Issues

3.1 Elaine Duncan has replaced James McCallum as Clinical Director at St John’s Hospital and it is appropriate for her to be appointed as a members of the West Lothian Community Health & Care Partnership Board. This proposed appointment has gone through the appropriate process and has been signed off by the CHCP Chair, Frank Toner.

3.2 The Board reduced the number of non-Executive Board members on the Staff Governance Committee from six to four at its meeting on 8 August 2014 and it is proposed to reduce the quorum for the Committee from six, of which three must be members of Lothian NHS Board to four, of which two must be members of Lothian NHS Board in order to reduce the risk of meetings being inquorate.

4 Key Risk

4.1 If Elaine Duncan is not appointed to West Lothian Community Health & Care Partnership Board the Clinical Director at St John’s Hospital would not be represented on the Partnership Board.

4.2 The Staff Governance Committee has already experienced one inquorate meeting and the present quorum of six at least three of which must be non-Executive Board members increases the risk that subsequent meetings could be inquorate.

5 Risk Register

5.1 There are no implications for NHS Lothian’s Risk Register.
6 Impact on Inequality, Including Health Inequalities

6.1 Not required as this is an administrative matter.

7 Involving People

7.1 The member and Committee Chairs involved have been consulted.

8 Resource Implications

8.1 There are no resource implications.

Peter Reith
Secretariat Manager
17 November 2014
peter.reith@nhslothian.scot.nhs.uk
SUMMARY PAPER - FULL BUSINESS CASE FOR PARTNERSHIP CENTRE BUNDLE

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

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

<table>
<thead>
<tr>
<th>Point Description</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>• The FBC describes the case for developing Partnership Centres in Blackburn (with West Lothian Council), Firrhill and North West Edinburgh (both with City of Edinburgh Council) as a bundle through a revenue funded Design, Build, Finance &amp; Maintain contract.</td>
<td>3.1 on</td>
</tr>
<tr>
<td>• Key risks around planning consents and land for the projects are detailed.</td>
<td>4.1</td>
</tr>
<tr>
<td>• The total capital expenditure required for the bundle is anticipated to be £32,302,000. The NHS Lothian share of the capital expenditure is £25,200,000.</td>
<td>7.1 to 7.3</td>
</tr>
<tr>
<td>• Revenue implications for NHS Lothian are an additional £527,000.</td>
<td>7.7</td>
</tr>
<tr>
<td>• The required investment will be prioritised against the new primary care fund.</td>
<td>7.7</td>
</tr>
</tbody>
</table>

Campbell Kerr
Project Director
14 November 2014
Campbell.kerr@nhslothian.scot.nhs.uk
PARTNERSHIP CENTRE BUNDLE - FULL BUSINESS CASE

1. Purpose of the Report

The purpose of this report is to ask the Board to approve the Full Business Case (FBC) for the proposed Partnership Centre Bundle for consideration. The Bundle includes the Blackburn Partnership Centre, Firrhill Partnership Centre and North West Edinburgh Partnership Centre. Copies of the FBC are available to Board members from the Director of Finance.

2. Recommendation

2.1 Note that the Finance and Resources Committee of 12 November 2014 scrutinised and approved the FBC for submission to the Board.

2.2 Approve the submission of the FBC to the Scottish Government Health and Social Care Directorates (SGHSCD) Capital Investment Group (CIG).

2.3 Agree that, subject to the approval of the Full Business Case by Scottish Government, the approval of the final terms of the Project Agreement and associated contract documentation be delegated to the Chief Executive, the Director of Finance for NHS Lothian or another nominated person from the Finance and Resources Committee.

2.4 Agree that, subject to the approval of the final terms of the Project Agreement, the signing of the Project Agreement at Financial Close be delegated to the Chief Executive or the Director of Finance for NHS Lothian.

3. Summary of Key Issues

3.1 Scope of the Full Business Case (FBC)

The FBC describes the case for developing Partnership Centres in Blackburn, Firrhill and North West Edinburgh.

The project will be procured through the hub initiative with the bundle being delivered through a sub-hubCo. The contractual arrangement will be a Design, Build, Finance & Maintain contract. The bundle will be procured under one contract with the lead participant being NHS Lothian. The services and funding period of the contract will be 25 years.

The purpose of this Full Business Case (FBC) is to:

- Confirm the finalised scheme and verify that this delivers optimum value for money
Outline the negotiated commercial and contractual arrangements for the deal
Demonstrate that it is unequivocally affordable
Confirm the management arrangements for the successful delivery of the scheme

Given that the Outline Business Case (OBC) was prepared in accordance with guidance, and the procurement has followed accepted best practice, much of the work in developing the FBC has focused on updating the OBC and documenting the outcome of the procurement process.

3.1.1 Blackburn Partnership Centre

The Blackburn Partnership Centre is being developed in partnership with West Lothian Council and will provide accommodation for the following services:

- Ashgrove Medical Practice
- CHCP Community Services
- New General Dental Practice
- Library
- Sports Facilities
- Community Facilities
- Community Information Service
- Credit Union

The Planning Approval was granted for the development on 21 July 2014.

3.1.2 Firrhill Partnership Centre

The Firrhill Partnership Centre will provide accommodation for the following services:

- Craiglockhart Medical Practice
- Firrhill Medical Practice
- CHP Community Services
- Health and Social Care Administration Accommodation

The Planning Approval was granted for the development on 18 July 2014.

3.1.3 North West Edinburgh Partnership Centre

The North West Edinburgh Partnership Centre, in the Muirhouse area, is being developed in partnership with the City of Edinburgh Council and will provide accommodation for the following services:

- New GP Practice
- CHP Community Services
- Primary Care Dental Service
- CAMHS
- Community Paediatric Services
• NW Children and Families Social Work Practice
• NW Edinburgh Carers Project
• Community Creche

The Planning Approval for the development was granted on 28 August 2014.

3.1.4 Following approval, by NHS Lothian, the FBC will be formally submitted to the SGHSCD Capital Investment Group.

The following table shows the key milestones of the project:

<table>
<thead>
<tr>
<th>Milestone</th>
<th>Milestone dates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage 2 submission</td>
<td>October 2014</td>
</tr>
<tr>
<td>Stage 2 approval</td>
<td>November 2014</td>
</tr>
<tr>
<td>SGHSCD FBC Approval</td>
<td>December 2014</td>
</tr>
<tr>
<td>Commercial Close</td>
<td>December 2014</td>
</tr>
<tr>
<td>Financial Close</td>
<td>January 2015</td>
</tr>
<tr>
<td>Construction commencement</td>
<td>March 2015</td>
</tr>
<tr>
<td>Construction completion</td>
<td>May – July 2016</td>
</tr>
<tr>
<td>Services Commencement</td>
<td>May – July 2016</td>
</tr>
<tr>
<td>Services Completion (Expiry Date)</td>
<td>May – July 2041</td>
</tr>
</tbody>
</table>

3.2 Changes from Outline Business Case to Full Business Case

The FBC represents a refinement of the OBC report previously approved at the Board meeting of 6 August 2014 detailing any changes since approval and additional detail in some sections.

The scope of the project and the preferred option remain unchanged from the OBC.

4. Risk Register

4.1 A risk management plan for the delivery of the bundle is in place and risk workshops have been held regularly to identify and evaluate risk. The risk register is populated from these sessions and the top risks are identified within the FBC.

Current and immediate risks being considered for all three individual projects are:

• Completion of the Advanced/enabling works at Blackburn and NWEPC
• Finalisation of the Occupancy Agreements with the GP practices
• Completion of the Firrhill site purchase from CEC

As the projects are being procured as a bundle they can only proceed at the pace of the slowest. Therefore if there is an issue with one project, such as a delay in the site acquisition, there will be consequences to the programme for all three projects.

5. Health and Other Inequalities

5.1 The Rapid Impact Assessments carried out at OBC have been revisited and updated. There are no significant issues as a consequence.
6. Involving People

6.1 There have been frequent meetings with staff, for all three centres during the development of the clinical brief and design stages.

A number of community engagement events have been held with the local populations of Blackburn, Firrhill and Muirhouse. Community events will continue as the project progresses.

Communication Plans have been created for each project.

7. Resource Implications

7.1 The total capital value of the project for all participants is £32.3m, an overall reduction of £0.7m compared to the OBC. The position is summarised in the table below.

<table>
<thead>
<tr>
<th></th>
<th>Blackburn £'000</th>
<th>Firrhill £'000</th>
<th>NWEPC £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Affordability Cap</td>
<td>7,639</td>
<td>6,980</td>
<td>11,097</td>
<td>25,716</td>
</tr>
<tr>
<td>Out with Affordability Cap</td>
<td>1,646</td>
<td>1,675</td>
<td>3,264</td>
<td>6,586</td>
</tr>
<tr>
<td><strong>Total capital cost</strong></td>
<td><strong>9,285</strong></td>
<td><strong>8,655</strong></td>
<td><strong>14,361</strong></td>
<td><strong>32,302</strong></td>
</tr>
<tr>
<td>Outline Business Case</td>
<td>9,495</td>
<td>8,688</td>
<td>14,793</td>
<td>32,976</td>
</tr>
<tr>
<td><strong>Increase/decrease</strong></td>
<td><strong>210</strong></td>
<td><strong>33</strong></td>
<td><strong>432</strong></td>
<td><strong>674</strong></td>
</tr>
</tbody>
</table>

7.2 The affordability cap was forecast as £25.7m, at OBC stage, for all three facilities, including the proposed refurbishment of the existing Firrhill Medical Practice. The overall cap has not changed. However following the market tendering and testing process, movements in the cost of some elements have led to a slight increase in the NHS Lothian share from £19.8m to £20.1m. This is summarised in the table below:

<table>
<thead>
<tr>
<th></th>
<th>NHS £'000</th>
<th>WLC £'000</th>
<th>CEC £'000</th>
<th>FBC Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blackburn</td>
<td>3,671</td>
<td>3,968</td>
<td>0</td>
<td>7,639</td>
</tr>
<tr>
<td>NWEPC</td>
<td>9,439</td>
<td>0</td>
<td>1,658</td>
<td>11,097</td>
</tr>
<tr>
<td>Firrhill</td>
<td>6,980</td>
<td>0</td>
<td>0</td>
<td>6,980</td>
</tr>
<tr>
<td><strong>Total affordability Cap</strong></td>
<td><strong>20,090</strong></td>
<td><strong>3,968</strong></td>
<td><strong>1,658</strong></td>
<td><strong>25,716</strong></td>
</tr>
<tr>
<td>Outline Business Case</td>
<td>19,815</td>
<td>4,052</td>
<td>1,849</td>
<td>25,716</td>
</tr>
<tr>
<td><strong>Variance under/(over)</strong></td>
<td><strong>(275)</strong></td>
<td><strong>84</strong></td>
<td><strong>191</strong></td>
<td><strong>0</strong></td>
</tr>
</tbody>
</table>
7.3 There are also costs that are excluded from the Affordability Cap. These costs include items such as equipment, land purchases, and advance works. These are summarised in the table below:

<table>
<thead>
<tr>
<th></th>
<th>NHSL £'000</th>
<th>WLC £'000</th>
<th>CEC £'000</th>
<th>FBC Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advance works</td>
<td>127</td>
<td>0</td>
<td>333</td>
<td>460</td>
</tr>
<tr>
<td>Drainage impact assessment</td>
<td>356</td>
<td>89</td>
<td>0</td>
<td>444</td>
</tr>
<tr>
<td>Road realignment</td>
<td>0</td>
<td>0</td>
<td>398</td>
<td>398</td>
</tr>
<tr>
<td>Land Purchase</td>
<td>870</td>
<td>0</td>
<td>0</td>
<td>870</td>
</tr>
<tr>
<td>Other capital cost</td>
<td>3,757</td>
<td>420</td>
<td>238</td>
<td>4,415</td>
</tr>
<tr>
<td><strong>Total costs out with affordability cap</strong></td>
<td><strong>5,110</strong></td>
<td><strong>509</strong></td>
<td><strong>968</strong></td>
<td><strong>6,587</strong></td>
</tr>
<tr>
<td>Outline Business Case</td>
<td>5,210</td>
<td>547</td>
<td>503</td>
<td>6,260</td>
</tr>
<tr>
<td><strong>Variance under/(over)</strong></td>
<td><strong>100</strong></td>
<td><strong>39</strong></td>
<td><strong>(465)</strong></td>
<td><strong>(327)</strong></td>
</tr>
</tbody>
</table>

7.4 The total capital impact for NHS Lothian, compared to the OBC position, is detailed in the following table:

<table>
<thead>
<tr>
<th></th>
<th>FBC £'000</th>
<th>OBC £'000</th>
<th>Variance £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Senior Debt</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Share of affordability cap</td>
<td>20,090</td>
<td>19,815</td>
<td>(275)</td>
</tr>
<tr>
<td>Borrowing cost</td>
<td>2,290</td>
<td>3,643</td>
<td>1,353</td>
</tr>
<tr>
<td>Subordinated debt and upfront payments</td>
<td>(2,767)</td>
<td>(2,643)</td>
<td>124</td>
</tr>
<tr>
<td><strong>Total Senior Debt</strong></td>
<td>19,613</td>
<td>20,815</td>
<td>1,202</td>
</tr>
<tr>
<td><strong>Total cost out with affordability cap</strong></td>
<td><strong>5,110</strong></td>
<td><strong>5,210</strong></td>
<td><strong>100</strong></td>
</tr>
<tr>
<td><strong>Funding offset</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Capital Enabling Funds</td>
<td>(915)</td>
<td>(1,011)</td>
<td>(96)</td>
</tr>
<tr>
<td><strong>Total NHSL Requirement</strong></td>
<td>23,808</td>
<td>25,014</td>
<td>1,206</td>
</tr>
</tbody>
</table>

7.5 The Unitary Charge calculation is based on a debt requirement of £19.6m and current terms set within the financial model, the total unitary charge payable over 25 years is £59.9m (excluding any interest receivable on subordinated debt) across three projects. The elemental breakdown, based on the draft financial model received from hubCo, is shown in the table below:
Debt & Interest Repayment 44,231
Special Purpose Vehicle (SPV) 3,678
Lifecycle 6,138
Hard FM 5,833

**Total Unitary Charge**: 59,880

7.6 Elements of ongoing running costs (hard FM) will be covered by the unitary charge, whilst other services, such as cleaning, will be provided by NHS Lothian and partners. The table below shows the breakdown of the associated cost for each of the participants, based on occupancy shares.

<table>
<thead>
<tr>
<th>Recurring Running Costs</th>
<th>NHSL £'000</th>
<th>WLC £'000</th>
<th>CEC £'000</th>
<th>Others £'000</th>
<th>Total £'000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reception/caretaker/security</td>
<td>125</td>
<td>21</td>
<td>5</td>
<td>4</td>
<td>155</td>
</tr>
<tr>
<td>Land Lease</td>
<td>13</td>
<td>(13)</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Facilities</td>
<td>413</td>
<td>151</td>
<td>63</td>
<td>227</td>
<td>854</td>
</tr>
<tr>
<td>Soft FM</td>
<td>120</td>
<td>43</td>
<td>18</td>
<td>94</td>
<td>275</td>
</tr>
<tr>
<td>Depreciation</td>
<td>169</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>169</td>
</tr>
<tr>
<td>VAT</td>
<td>24</td>
<td>11</td>
<td>4</td>
<td>11</td>
<td>50</td>
</tr>
</tbody>
</table>

**Total running costs**: 863 214 90 336 1,503

7.7 The net revenue impact for NHS Lothian is £0.52m, as shown below. This compares to an affordability gap of £0.470m at the time of the OBC.
The £0.52m increase in costs is a result of the proposed developments that will deliver a range of benefits for NHS Lothian and its partners.

These include a new GP practice in Muirhouse; a new General Dental Practice in Blackburn; an increase in GP list capacity across the three centres; providing modern, fit for purpose accommodation; enhancing the ability to work collaboratively with councils and other partners.

The required investment will therefore be prioritised against the new primary care fund.

Campbell Kerr
Project Director
14 November 2014
campbell.kerr@nhslothian.scot.nhs.uk
THE THIRD JOINT HEALTH PROTECTION PLAN, 2014 - 2016

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.

<table>
<thead>
<tr>
<th>Seek approval for the third Joint Health Protection Plan and support the implementation of the Plan.</th>
<th>2.1</th>
</tr>
</thead>
<tbody>
<tr>
<td>To meet the legal requirement of working collaboratively with the local authorities to develop a Joint Health Protection Plan every two years.</td>
<td>3.1- 3.2</td>
</tr>
<tr>
<td>To review the performance of the previous plans and to build on achievements made. The previous first two plans helped NHS Lothian and partner agencies to identify and map out resources. The partners have realised benefits of improved relationships, better working arrangements, joint training and continuing professional development.</td>
<td>3.3</td>
</tr>
<tr>
<td>The objective of the current plan is to emphasise the means for preventing ill health and death arising from communicable diseases and environmental health.</td>
<td>3.4</td>
</tr>
<tr>
<td>Seeking to ensure that the Board meets its statutory obligations by producing a Joint Health Protection Plan.</td>
<td>4.1 – 4.2</td>
</tr>
<tr>
<td>The plan minimises impact of inequality, including inequalities in health by addressing social determinants of health.</td>
<td>6.1</td>
</tr>
<tr>
<td>Implementing the Public Health Act requires financial resources to be put aside, particularly for compensation claims made by people affected by public health orders and for the recurrent cost of case management software.</td>
<td>8.1 – 8.2</td>
</tr>
</tbody>
</table>

Dr Richard Othieno
Consultant in Public Health Medicine
18 November 2014
Richard.Othieno@nhslothian.scot.nhs.uk
THE THIRD JOINT HEALTH PROTECTION PLAN, 2014 - 2016

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board approve the third Joint Health Protection Plan and support the implementation of the plan. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations

2.1 Support the implementation of the third Joint Health Protection Plan 2014-16, in collaboration with Local Authorities as required by the 2008 Public Health (Scotland) Act.

3 Discussion of Key Issues

3.1 The 2008 Public Health (Scotland) Act requires Health Boards to develop and publish a two-year plan relating to public health protection, in consultation with relevant Local Authorities and in accordance with guidance issued by Scottish Ministers. The 2010 Scottish Government guidance on managing public health incidents emphasises the need for Health Boards and Local Authorities to form joint Incident Management Teams, provide the necessary resources for incident management on a twenty-four hour basis and ensure continuous improvement in the quality of incident management.

3.2 The Joint Health Protection Plan Steering Group finalised the third Joint Health Protection Plan 2014-2016 on 1/4/2014; the Plan is operational and has been ratified by the relevant Local Authorities.

3.3 The first plan provided guidance for the introduction of systems, identified resources that are required for delivery of health protection in Lothian and mapped out key components for implementing the Public Health Act. Both the second and the third plan, in addition, identify joint areas of working between NHS Lothian and the four Local Authorities and key priorities to be implemented over the two year period. The partners have realised some benefits from the first and second plan, including better relationships and working arrangements which have resulted in improved joint incident and outbreak management, joint training and continuing professional development sessions.

3.4 The objectives of this plan include prevention of illness and death from communicable disease and environmental hazards; early identification of potential outbreaks of communicable disease so that effective control measures can be put in place as soon as possible; improving the ability to prevent further outbreaks and working with partner agencies to put in place measures for effective management of non-communicable disease public health incidents; health improvement measures to mitigate health impact of environmental hazards.
4 Key Risks

4.1 As the 2008 Public Health (Scotland) Act requires Health Boards to develop and publish a two-year plan relating to public health protection in consultation with relevant Local Authorities, failure to implement the Plan could result in NHS Lothian failing to meet its statutory obligations.

4.2 Capacity plans should ensure that NHS Lothian and partner organisations can meet their statutory responsibilities under the Public Health (Scotland) Act and Civil Contingencies Acts.

5 Risk Register

5.1 There are no new risks associated with this Plan at present. The implications of Lothian becoming an international shipping hub under the International Health regulations are currently being scoped.

6 Impact on Inequality, Including Health Inequalities

6.1 The Plan is designed to contribute to delivery of the following specific objectives that support reducing inequalities, addressing the social determinants of health and considering health in all policies:

- Reduce the health, social and economic burden of communicable disease
- Reduce the impact of HIV/AIDS and Tuberculosis
- Reduce the health consequences of emergencies
- Promote a healthy environment

7 Involving People

7.1 Involving people is achieved by working across the NHS, Local Authorities, wider public sector, the voluntary sector and other community groups when planning health services and policies. Patient and public involvement in health protection activities takes place through service provision planning and research interventions; individual interaction; group interaction; information and educational proactive media releases; helplines; patient/public representatives on groups such as Hepatitis C Action Plan groups and the Lothian Infection Control Advisory Committee.

8 Resource Implications

8.1 Funds need to be set aside to compensate individuals who suffer loss of earning as a result of Public Health orders. This is monitored jointly by Public Health and Finance and addressed from strategic reserves. To date, the cost has been less than £10,000 per annum.

8.2 Funds need to be set aside for eHealth. The procurement of incident management software that facilitates surveillance and early detection of incidents, accurate logging of information, monitoring actions, report writing and audit has been completed by Health Protection Scotland and the Scottish Government. The Scottish Government funded most of the development and infrastructure and the boards paid and will continue to pay the recurrent costs. This year NHS Lothian’s share was £64,000.
8.3 Clinical, professional, technical, scientific and support staff costs related to implementing and monitoring the Plan, exercises and training activities and equipment provision are being met within existing resources.

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18 November 2014  
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Appendix 1: The third Joint Health Protection Plan 2014-2016
LOTHIAN

JOINT HEALTH PROTECTION PLAN

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Foreword

This is the third Lothian Joint Health Protection Plan, produced as a requirement under the Public Health etc (Scotland) Act 2008\(^1\). This plan has been prepared in close collaboration between NHS Lothian and the four Local Authorities of the City of Edinburgh, East Lothian, Midlothian and West Lothian.

The partners have realised some benefits from the first and second plan which include better relationships and working arrangements which have resulted in improved joint incident and outbreak management, joint training and continuing professional development (CPD) sessions.

The first plan provided guidance for the introduction of systems, identified resources that are required for delivery of health protection in Lothian and mapped out key components for implementing the Public Health Act. Both the second and the third plan, in addition, identify joint areas of working between NHS Lothian and the four local authorities and key priorities to be implemented over the two year period.

NHS Lothian Public Health and Health Policy Directorate, of which the Health Protection Team (HPT) is a part, already work closely with colleagues in Environmental Health at Lothian Councils in the investigation and management of cases involving communicable diseases and environmental hazards. The Public Health etc. (Scotland) Act 2008 (The Act) which came about as a response to the International Health Regulation (IHL), the human rights act and emerging issues such as new infectious diseases and terrorism has been helpful in clarifying roles and responsibilities in this existing arrangement.

Scotland’s goals in reducing mortality and morbidity from communicable disease, reducing exposure to environmental hazards, improving health, wellbeing, the quality and sustainability of the environment are set out in the national and international policy documents\(^{1,2,11,26,36,38}\). These are echoed in the key objectives of the communicable disease and environmental health functions of NHS Lothian and Local Authorities which are:

- To reduce preventable illness and death from communicable disease and environmental hazards
- To identify potential outbreaks of communicable disease at an early stage so that effective control measures can be put in place as soon as possible
- To improve the ability to prevent further outbreaks, and
- To work with partner agencies to put in place measures for effective management of non-communicable disease public health incidents and health improvement measures to mitigate health impact of environmental hazards.

The Act has also provided an opportunity to develop our planning process, linking not only local departmental plans but also ensuring that our objectives match closely those of the wider NHS and Lothian Councils’ planning systems.
Over the next two years we will continue to work towards meeting these objectives, reporting progress on an annual basis through the existing planning processes.

The collaborative approach between NHS and local authorities has been re-emphasised in the 2011 Scottish Government guidance on managing public health incidents. The guidance clarifies the role of NHS Boards in sharing statutory responsibility for improving and protecting public health with Local Authorities and other partner agencies. Critical in this role is the joint formation of incident management teams, the provision of the necessary resources for management of incidents on a 24 hour basis and the continuous improvement of the quality of incident management.

Over the last two years, some key national health protection priorities have been restated in policy documents. These include the publication of the fourth edition of the Approved Code of Practice (ACOP) for the control of Legionella Bacteria in Water System, the VTEC/E coli O157 Action Plan for Scotland 2013-2017 which aims to reduce the incidence of this infection by setting strategic direction for key partners and emphasising collaborative roles. Additionally, NHSScotland Resilience Guidance requires chief executives to ensure adequate preparedness for major incidents and emergencies.

This plan also supports key priorities identified in the Single Outcome Agreements (SOA) for each of the local authority areas between the Councils, NHS Lothian and their other community planning partners, particularly in relation to the Scottish Government national outcomes for health improvement, reducing health inequalities and delivering quality public services.

We wish to continue to improve our knowledge and the quality of the service we provide for the population of Lothian and welcome comments on this plan – please send these to health.protection@nhslothian.scot.nhs.uk
Professor Alison McCallum  
Director of Public Health and Health Policy  
NHS Lothian

Mr Tim Davison  
Chief Executive  
NHS Lothian

Ms Angela Leitch  
Chief Executive  
East Lothian Council

Ms Sue Bruce  
Chief Executive  
City of Edinburgh Council

Mr Kenneth Lawrie  
Chief Executive  
Midlothian Council

Mr Graham Hope  
Chief Executive  
West Lothian Council
1. Preface

This joint plan for NHS Lothian and Local Authorities has been produced in accordance with the Part 1 guidance for the new Public Health etc. (Scotland) Act 2008\(^1\). This aims to:

- Provide clarity about which agency and persons have overall responsibility in protecting the public health, for example ensuring lessons learned from the fatal accident inquiry into the Central Scotland E. coli O157 outbreak\(^3\).

- Ensure preparedness and enhance co-operation among agencies in combating major emergencies, for example bioterrorism and lessons from SARS.

- Resolve gaps and uncertainties in the adequacy of statutory powers that might be required for communicable disease control, particularly for emerging hazards, for example early interventions in avian or pandemic flu.

- Update the principles and concepts underpinning public health legislation for the twenty-first century to reflect changes in public health ethics and values, new scientific developments and the response to globalisation.

**Purpose of the plan**

The purpose of the plan is to provide an overview of health protection (communicable disease and environmental health) priorities, provision and preparedness and to support the collaborative arrangements that exist between NHS Lothian and Local Authorities. A joint overall steering group will continue to oversee the plan's implementation.

**Geographical extent of the plan**

This plan covers the NHS Lothian Health Board area, which includes the City of Edinburgh, East Lothian, Midlothian and West Lothian Councils.

**Statutory responsibility**

NHS Lothian has the statutory responsibility to produce this plan in consultation with the City of Edinburgh, East Lothian, Midlothian and West Lothian Councils.

**Authors**

The plan has been written through a consultative process by a working group comprising NHS Lothian’s Director of Public Health and Health Policy, a Consultant in Public Health Medicine and other staff members and the Chief Officers of Environmental Health of the City of Edinburgh, East Lothian, Midlothian and West Lothian Councils. The agency representatives at the steering group which developed the plan were:
Name | Designation
--- | ---
Mr Andrew Blake | Environmental Health and Trading Standards Manager, West Lothian Council
Mr David Evans | Senior Environmental and Consumer Services Manager, East Lothian Council
Professor Alison McCallum | Director of Public Health and Health Policy, NHS Lothian
Dr Richard Othieno | Consultant in Public Health Medicine, NHS Lothian – Chair
Mrs Edel Ryan | Partnership Manager, Environmental Health, East and Midlothian Councils
Mr Colin Sibbald | Food, Health and Safety Manager, City of Edinburgh Council

Governance arrangements
This plan has been approved by the Board and Corporate Management Team of NHS Lothian, each of the Councils and the relevant elected member forum of each Local Authority. It has been adopted by NHS Lothian’s Lothian Infection Control Advisory Committee (LICAC) and Healthcare Governance Committee (HCG).

Status
This plan is a public document and can be accessed by the public from NHS Lothian and Local Authorities’ websites. Variations of this plan will be subject to consultation with the partner local authorities. This plan covers the period 2014-2016. This plan will be formally reviewed every two years.
2. Overview of the Lothians

2.1 Population

Lothian is a geographically diverse area covering approximately 700 square miles, with a population of 843,700. The largest population centre is the City of Edinburgh (population 482,600). The remaining area is split into East Lothian (100,900), Midlothian (84,200) and West Lothian (176,000). The gender ratio is 48% male to 52% female.

The age profile shows that 16% of the Lothian population is 20-29 years old, as compared to the Scottish average of 13.5%. This difference is attributed to the large numbers of students attending higher education institutions across Lothian. Figure 1 illustrates the current population profile by age and sex of Lothian.

![Figure 1: Lothian estimated population by age and sex: June 2012](source)

The population growth rate in Lothian is higher than any other Scottish Health Board. By 2035, the population of Lothian is expected to have increased by 24% from 2010 base population, compared to a national rate of 10%. The population of East Lothian is expected to increase the most, with a 33% increase projected by 2035, from 97,500 in 2010 to 129,729. The population of older adults in Lothian is also expected to grow significantly in the next ten to fifteen years as people are living longer due to improvements in health.
The population of residents aged 65 years or older in Lothian is expected to rise by 36% by 2035, from 124,000 in 2010 to 220,000. This rise will be most noticeable in West Lothian, which has traditionally had a younger demographic than other areas in Lothian but whose population of residents aged 65 years or older, is expected to increase by 52% from 23,500 in 2010 to 47,600\cite{4,5}.

**Migration and ethnicity**

The most recent data available for the ethnic make-up of Lothian is from the 2011 National Census. In 2011, the population of the Lothians was made up of predominantly ‘White Scottish’ (77.8%), ‘Other White British’ (9.6%), White Polish (2%) and ‘Other White’ (4.9%). The remaining groups made up 5.6\%\cite{6}. There has been a significant rise in the migrant population over the last ten years, with the highest increase reported in the City of Edinburgh Council area (Figure 2).

**Figure 2: Net Migration to Lothian by Local Authority Area: 2011/12**

![Net Migration to Lothian by Local Authority Area: 2011/12](chart.png)

*Source: National Records Scotland (NRS)*\cite{41}

Net migration figures have fluctuated over the past five years. East and West Lothian saw an increase up to 2008/09 but figures have generally since been decreasing. The migration rate increased steadily up to 2008/09 but has since decreased. On average between 2010-12 there was a net inflow of 6,631 people into City of Edinburgh per year, meaning that more people entered City of Edinburgh (30,137 per year) than left (23,506 per year) (Figure 2).
The Department of Work and Pensions collects information on the number of National Insurance Number allocations to overseas nationals. Table 1 shows the five most common countries of origin associated with National Insurance numbers issued to overseas nationals in 2007 by council area. This highlights G8 countries, Australia, India and the Republic of Ireland. It should be noted that these figures do not include dependants or adults who are not economically active.

Table 1: Countries of origin of persons seeking a National Insurance Number allocation in 2007.

<table>
<thead>
<tr>
<th>Council Area</th>
<th>Number of countries of origin</th>
<th>Top five most common countries of origin</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Edinburgh</td>
<td>79</td>
<td>Poland, Australia, India, Spain, Republic of Ireland, France</td>
</tr>
<tr>
<td>West Lothian</td>
<td>20</td>
<td>Poland, Slovakia, India, Hungary, Latvia</td>
</tr>
<tr>
<td>East Lothian</td>
<td>19</td>
<td>Poland, Lithuania, India, Republic of Ireland, Bulgaria</td>
</tr>
<tr>
<td>Midlothian</td>
<td>7</td>
<td>Poland, Latvia, Spain, Romania, Australia</td>
</tr>
</tbody>
</table>

Source: National Records Scotland (NRS)

Culture
Lothian is a host to major cultural, educational and political establishments and events, which can present challenging health protection and emergency planning issues. These include:

- Edinburgh is the capital city, with the Scottish Parliament and Executive, Holyrood Palace and Edinburgh Castle.
- Higher education institutions – Edinburgh has four universities and several colleges, with a total student population of 35,000.
- There are five teaching hospitals, with a staffing population of 28,000.
- There are twelve annual international festivals, including the Edinburgh Festival, which bring many thousands of visitors to the city.
- There are major sporting events, such as rugby internationals, football matches and open golf championships.
- On occasion, Edinburgh and East Lothian hosts major world events such as the G8 Summit, the Commonwealth Games, open golf championships and Royal events.

Transport
Lothian has a complex transport network linking it to major cities in the rest of Scotland and United Kingdom. These include:

- Major trunk roads include A1, A720 (city bypass), M8, M9, A68 and A7.
- Edinburgh airport, Waverley and Haymarket railway stations and St Andrews bus station. These are destinations and connection points for many local and international travellers.
• Water transport – Lothian hosts the Leith Docks and Hound Point where many international vessels berth. It also has proximity to the Rosyth European Ferry Terminal.
• Lothian also has a canal that links Edinburgh and Glasgow. The canal is now largely used for recreational purposes.
• The development of the new tram system for the City of Edinburgh is nearing completion. It is anticipated that once commissioned the trams will contribute to better air quality in Edinburgh.
• Traffic pollution contributes to poor air quality. Air quality is monitored in all Lothian Local Authorities. There are three air quality management areas (AQMA) in Edinburgh (the city centre, Leith and Corstorphine); one in Midlothian (Pathhead – primarily due to particulate matter, influenced by fossil fuel burning) and one in West Lothian (Broxburn). It is likely further areas will be added to or extended in the foreseeable future...
• There were almost 370,000 licensed vehicles in Lothian in 2008. Car ownership patterns reflect the provision of public transport. In 2008, there were 0.32 cars per head of population in the City of Edinburgh, whereas in East Lothian, Midlothian and West Lothian there were more than 0.42 cars per head of population25.
• Cycling – the city has a significant length of safe, off-road, cycle routes but there are gaps in the network between paths. The Council is delivering a city-wide, Active Travel Action Plan, to plug these gaps and to increase walking and cycling levels substantially by 2020 through other, complementary, measures. They are established in some locations and are in development in others. Considerable effort is being devoted to promote walking and cycling to school for children to address traffic congestion, in conjunction with work on preventing obesity and reducing the proportion of people who are inactive.

2.2 Disease Burden

The most common causes of death among the people of Lothian in the period 2011/2012 are listed in
Figure 3. The physical environment plays a significant role in the causation of the top ten diseases which contribute to death in Lothian. Infectious disease processes feature as one of the top twenty causes of death in Lothian.
Communicable Diseases

The number of cases of notifiable diseases reported to the NHS Lothian HPT between 2010 and 2012 is shown in Table 2. Gastrointestinal diseases are the most common notifiable infectious disease conditions. Each case requires follow up by the HPT operation team and colleagues in Environmental Health, to ensure appropriate control measures are in place and to investigate the source of the infection.

The number of tuberculosis (TB) cases in Lothian has risen since 2003. In 2012 there were 79 notifications* compared with 74 (a three-year average from 2004 to 2006) and 57 between 2000-2003. The average incidence rate is now 10.6 per 100,000 (average from 2008 to 2010) in Lothian up from 9.4 per 100,000 (average from 2005 to 2007).
The average TB incidence rate across NHS Lothian between 2010-2012 was 9.9 per 100,000*, (95% confidence intervals 9.0 to 10.8) compared with 10.8 per 100,000* between 2009-2011, 10.6 per 100,000 between 2008-2010 and 9.4 per 100,000 between 2005-2007.

Between 2010-2012 the City of Edinburgh has higher rates of TB (13.3 per 100,000*) than Lothian overall with the highest average annual rate again seen in the north east of the city (21.2 per 100,000*) and the south east of the city (18.7 per 100,000*).

Between 1999 to 2000 31% of TB cases in Lothian were born outside the UK, this proportion had risen by 2004 to nearly 50% and by 2010 57% (63/110) of cases were born outside the UK. This proportion continues to rise; by 2011 68% of cases were born outside the UK.

Within Lothian, in addition to being born outside the UK, homelessness, social deprivation and alcohol misuse are important risk factors for tuberculosis. The steps required in the prevention and treatment of TB are set out in the national action plan and the international agreement to eliminate TB from Europe.

Although only a small proportion of the total public health notifications are for TB, each TB case requires a large input of nursing and public health time including specialist nursing, to ensure that people are able to continue taking their medicines reliably throughout the six months treatment period. Many patients require daily direct observation of treatment and a small number are detained in hospital each year. The nurses also identify contacts and screen those at increased risk of infection.

The complex nature of TB requires a multidisciplinary approach and regular case review with TB nurses, clinical teams in primary and secondary care, microbiology and public health. Over recent years the TB nursing service has expanded from one to two members of staff to cope with the larger number of TB cases being seen in NHS Lothian.

*(NB uses SIDSSv2 notifications and the population data is taken from CHI September 2012 populations)
Table 2: Number of cases of notifiable diseases in NHS Lothian, 2010 – 2012

<table>
<thead>
<tr>
<th>Notifiable Diseases/Organisms</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
</tr>
</thead>
<tbody>
<tr>
<td>Campylobacter</td>
<td>1234</td>
<td>934</td>
<td>969</td>
</tr>
<tr>
<td>Mumps</td>
<td>132</td>
<td>94</td>
<td>103</td>
</tr>
<tr>
<td>Salmonella</td>
<td>132</td>
<td>94</td>
<td>97</td>
</tr>
<tr>
<td>Cryptosporidium</td>
<td>177</td>
<td>106</td>
<td>117</td>
</tr>
<tr>
<td>Giardia</td>
<td>63</td>
<td>55</td>
<td>63</td>
</tr>
<tr>
<td>TB (respiratory)</td>
<td>66</td>
<td>47</td>
<td>44</td>
</tr>
<tr>
<td>TB (non respiratory)</td>
<td>44</td>
<td>30</td>
<td>35</td>
</tr>
<tr>
<td>Bacillary Dysentery</td>
<td>34</td>
<td>34</td>
<td>15</td>
</tr>
<tr>
<td>E. coli O157</td>
<td>15</td>
<td>21</td>
<td>21</td>
</tr>
<tr>
<td>Pertussis</td>
<td>8</td>
<td>27</td>
<td>312</td>
</tr>
<tr>
<td>Meningococcal</td>
<td>13</td>
<td>18</td>
<td>14</td>
</tr>
<tr>
<td>Rubella</td>
<td>6</td>
<td>&lt;5</td>
<td>8</td>
</tr>
<tr>
<td>Measles</td>
<td>6</td>
<td>20</td>
<td>11</td>
</tr>
<tr>
<td>Meningitis - other</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>0</td>
</tr>
<tr>
<td>Legionellosis</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>108*</td>
</tr>
<tr>
<td>Vibrio Cholera</td>
<td>&lt;5</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Listeria Monocytogenes</td>
<td>&lt;5</td>
<td>0</td>
<td>&lt;5</td>
</tr>
<tr>
<td>E. coli non O157 VTEC</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td>Haemophilus influenzae type B</td>
<td>0</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>2001</strong></td>
<td><strong>1455</strong></td>
<td><strong>1809</strong></td>
</tr>
</tbody>
</table>

Source: SIDSS V2

NB notifiable diseases are based on clinical notifications.

*Includes cases from Southwest Edinburgh outbreak

Vaccine preventable diseases (for example, whooping cough (pertussis), measles, mumps and rubella) account for a small but significant proportion of notifications in Lothian. Each notification and laboratory confirmed case is followed up by the HPT to reduce the likelihood of further cases and offer vaccination if required.

The countries in the European Region of the WHO, including Scotland, are committed to the elimination of measles and rubella by 2015 through increased rates of vaccine uptake. Childhood immunisation rates in NHS Lothian are amongst the highest in the UK for an urban population and close to the Scottish national average (Figure 4, Figure 5). By 2013, MMR uptake rates by five years of age in Lothian reached >95% uptake first dose and >90% second dose.

Although current uptake of MMR in infants is high, young people aged 10-17 who were infants when MMR dipped may be underimmunised and susceptible to measles. Accordingly a short catch up campaign was run in early summer 2013.
In Lothian 8029 children aged 10-17 were identified as still due one or two doses of MMR. They were invited during June 2013 for vaccination at GP or community clinics. As a result 1974 (24%) received at least one dose of MMR.

Ongoing work is still investigating differences in the uptake of immunisation between localities in NHS Lothian, aiming to increase immunisation uptake among children and young people in groups and settings where immunisation coverage is low.

Even so, the measles and rubella elimination target remains a particular challenge given the widespread recent outbreaks of measles in many countries of the world including Pakistan, many countries in the EU and in England. A very large outbreak in Wales during 2013 resulted in 1,200 cases, 88 hospital admissions and one death. The first two cases spread infection to a further 2944. Significant outbreaks of rubella also occurred in Poland, Turkey and Japan during 2013.

Figure 4: Rates of Childhood Immunisation Coverage at 24 Months for Lothian, 2003 to 2012

Source: SIRS Immunisation System, Information and Statistics Division (ISD) Scotland
Environment and Health

The European Public Health Association, in its 2011 report, noted that the environment is increasingly more complex and the link between health and environment has become so evident that it recommends immediate action by all governments and public health communities. According to a recent WHO study, about 24% of the global burden of disease and 23% of deaths are attributable to environmental risk factors. In a country like Scotland, WHO estimates that the proportion of the total burden of disease attributable to environmental risk factors is about 14%. Of the total global burden of disease, WHO estimates that 5.7% was attributable to environmental exposure to chemicals, the largest contributors being indoor smoke from second-hand tobacco smoke, solid fuel use and outdoor air pollution. The greatest impacts on health are on rates of cancers, cardiovascular disease, injuries and neuropsychiatric disorders.

There is substantial evidence that climate change is affecting many aspects of the world around us. Weather patterns are shifting, extreme weather is becoming more commonplace and temperatures in most parts of the world are rising. Some of the health effect of climate change includes earlier seasonal appearance of respiratory symptoms and longer duration of exposure to aeroallergens. Climate change may exacerbate health risks and inequalities associated with building overheating, indoor air pollution, flooding damage, and water and biological contamination in the indoor environment, if adequate adaptation measures are not taken.
In defining the role of health professionals, WHO identifies health institutions as highly visible, high-energy-use centres which can serve as models by reducing their own carbon emissions, improving health and saving money\textsuperscript{48}. It recommends energy management, transport, procurement (including food and water), waste disposal, buildings and landscape, employment and skills, and community engagement as good practice areas which have been shown to improve staff health and morale, create healthier local populations, stimulate faster patient recovery rates and save money.

Evidence that poor air quality due to air pollution has both short- and long-term adverse effects on health continues to accumulate\textsuperscript{49}. WHO defines air pollution as contamination of the indoor or outdoor environment by any chemical, physical or biological agent that modifies the natural characteristics of the atmosphere. Household combustion devices, motor vehicles, industrial facilities and forest fires are common sources of air pollution. Exposure to air pollutants is largely beyond the control of individuals and requires action by agencies at the national, regional and international levels\textsuperscript{49}. A multi-agency approach, engaging such relevant sectors as transport, housing, energy production and industry, is needed to develop and effectively implement long-term policies that reduce the risks of air pollution to health.

Creating safe and positive environments for health requires us to think, plan and deliver in new and more effective ways. The quality of the environment can vary between different areas and communities. There is evidence that people who are socially and economically disadvantaged often live in the worst environments\textsuperscript{28, 29}. Poor environment can affect people's health and wellbeing and can add to the burden of social and economic deprivation\textsuperscript{29}. The causes of these inequalities are often complex and long-standing. Some of the environmental problems are due to the historical location of industry and communities; others are the result of the impacts of new developments such as traffic, urban planning that has not prioritised healthy built environments. Tackling environmental inequalities and ensuring that all people have access to a good quality environment in the future is a continuing challenge. The responsibilities of health and local authorities are outlined in \textit{Good Places, Better Health}\textsuperscript{10}.

The contribution of physical surroundings to the health of those living in our most deprived areas of society is significant, a view increasingly supported by the flow of evidence. There are indications that there is no significant socioeconomic gradient in the level of known, direct environmental hazards to human health. Frequently though, less affluent communities are untidy, damaged and lacking in amenities. These factors create neighbourhoods which are often alienating and even threatening. This creates indirect environmental hazards to human health that act through a more complex causal pathway. This produces an unhealthy built environment that contributes to a cocktail of disadvantage inconsistent with health and wellbeing for adults and children\textsuperscript{10}.
Health outcomes are consistently poorer in communities with poor neighbourhood environments\textsuperscript{21-24}. In \textit{Equally Well}\textsuperscript{11}, the Health Inequalities Task Force highlighted the need to work to reduce further exposure to factors in the physical and social environments that cause stress, damage health and wellbeing and contribute to health inequalities. Action to improve housing, increasing physical activity or reducing traffic pollution can only happen by working with local authority partners to identify opportunities for health improvement in areas such as land use planning, transport, housing and environment.

The responsibilities of environmental and public health professionals for protecting and improving the environment include responding to current incidents, events and situations and preventing avoidable hazards and the consequent risks to public health by intervening before exposure has occurred.

The environmental protection functions undertaken by environmental health professionals complement those undertaken by the NHS. Health Boards and Local Authorities have a duty to co-operate in pursuit of protecting and improving the health and wellbeing of the local population. Environmental Health professionals advise on the development of laws, regulations and policies at local, national and international level and carry the major responsibility for local implementation and enforcement in the following areas:

- Air quality
- Contaminated land sites
- Noise and other statutory nuisances
- Recreational water quality
- Drinking water quality – particularly private supplies
- Food safety
- Living and working conditions
- Intentional and unintentional injuries at home and at work
- Public safety - exposure to hazardous substances
- Skin piercing and sunbed regulation

The NHS role is complementary and focuses on prevention, assessment, protection and mitigation of human exposure to environmental hazards and their health effects. In addition to food and water, these include:

- Chemicals, toxins, and poisons
- Ionising and non-ionising radiation – Electromagnetic Frequencies (EMF)
- Physical hazards – particulates, fibres and other factors related to the physical environment including climate change, extremes of heat, cold, flooding
- Accidental or deliberate or malicious release scenarios including Chemical Biological, Radiological and Nuclear (CBRN) warfare agents
Systematic approaches are used to assess the potential positive and negative impact of developments on those who will be affected. The tools employed include: Health Impact Assessment, Strategic Environmental Assessment, Environmental Impact Assessment, screening of Pollution, Prevention and Control applications, assessment of planning applications and investigating the health issues associated with contaminated land. These are essential elements of this work programme.

In a major incident, joint working is essential to ensure that the Scientific and Technical Advice to the Regional Resilience Partnership reflects the complementary expertise of public health and environmental health professionals.

3. Health protection planning infrastructure

NHS Lothian and the Local Authority Environmental Health Department(s) have shared health protection plans and standard operating procedures (SOPs), some of which are developed jointly between the agencies, while others are produced nationally (Appendix III). The plans are normally developed and reviewed every three years.

4. National and local priorities

4.1 National Priorities
Scottish Government long term goals and priorities are aligned with those of the UK and Europe for protecting and improving health. The World Health Organisation (WHO) European Region is pursuing health in all policies as a key objective of policy making. This also includes a commitment to reducing disease inequalities in health outcomes across societies. In its Health 2020 vision, WHO European Region, sets out four priority area of action which include, investing in health through a life-course approach and empowering citizens; tackling Europe’s major disease burdens of non-communicable and communicable diseases; strengthen people-centred health systems and public health capacity, including preparedness and response capacity for dealing with emergencies; and creating supportive environments and resilient communities. In 2007, the WHO’s Commission on the Social Determinants of Health set out the evidence for change and objectives for action, as did the recent Fair Society, Healthier Lives Strategic Review of Health Inequalities in England post 2010. Equally Well and Good Places, Better Health have already established Scottish priorities in terms of tackling health inequalities and the importance of the links between environment and health.

The Scottish Government now operates under a National Outcomes Framework with a commitment to ‘focus government and public services on creating a more successful country, with opportunities for all of Scotland to flourish, through increasing sustainable economic growth.’
In addition, the Government Economic Strategy\textsuperscript{27} includes population growth as a key component of future sustainable economic development. Among the Scottish Government’s five strategic objectives are commitments to a Scotland that is healthier, wealthier, fairer, safer, stronger and greener\textsuperscript{27}. These objectives are linked to a series of outcomes and associated indicators. A concordat, agreed by Convention of Scottish Local Authorities (COSLA), set the terms of a new relationship between the Scottish Government and local government. The development of a Single Outcome Agreement (SOA) formed an important part of this relationship. The SOAs produced for each Local Authority area\textsuperscript{30-33} contain an overview of how the local community planning partners (including the Local Authority and NHS Lothian) will promote the Scottish Government’s fifteen National Outcomes\textsuperscript{12} and how these link to local outcomes. Health Boards and Local Authorities commit to delivering these outcomes jointly:

- Our children have the best start in life and are ready to succeed.
- We live longer, healthier lives.
- We have tackled the significant inequalities in Scottish society.
- We have improved the life chances for children, young people and families at risk.
- We live our lives safe from crime, disorder and danger.
- We live in well-designed, sustainable places where we are able to access the amenities and services we need.
- We have strong, resilient and supportive communities where people take responsibility for their own actions and how they affect others.
- We value and enjoy our built and natural environment and protect it and enhance it for future generations.
- We reduce the local and global environmental impact of our consumption and production.
- Our public services are high quality, continually improving, efficient and responsive to local people’s needs.

The delivery of these activities aligns with a wide range of national and local strategies, including:

- \textit{Good Places, Better Health. A New Approach to Environment and Health in Scotland} (Scottish Government 2008)\textsuperscript{10}: this is an implementation plan looking at how the physical environment influences health. The Environmental Health contribution will be in protecting these environments.

- A \textit{Children’s Environment and Health Strategy for the UK} (Health Protection Agency)\textsuperscript{15}: this is a strategy for protecting children’s health, including ensuring that they are free from food and water based infection, noise, heavy metals and breathe clean air, all of which are core Environmental Health activities.

- \textit{The Food Standards Agency (FSA) Strategic Plan} (2010)\textsuperscript{16}: this has three key targets: food safety; eating for health; choice. These are addressed through routine enforcement work, and developing work with the Community Health [Care] Partnerships (CHP/CHCP) in promoting healthy eating choices in local catering establishments.
• All councils have their own Anti-Social Behaviour Strategy documents. These recognise and value the importance of partnership working at various levels to tackle behavioural factors that impact on the health and resilience of local communities. Through their public health teams, Local Authorities contribute to tackling many of the environmental health issues impacting on people’s wellbeing. This helps Local Authorities to fulfil their duty to improve quality of life including ensuring community safety, reducing injury, violence and self-harm as set out in the Local Government in Scotland Act 2003.

Health and Safety Executive (HSE) Five-Year Strategy (2009): Local authorities operate in partnership with HSE to ensure that duty holders manage their workplaces with due regard to the health and safety of their workforce and those affected by their work activities. To achieve this, local authorities provide advice and guidance on what the law requires, conduct inspections and investigations and take enforcement action where appropriate. In November 2013 a revised fourth edition of The Approved Code of Practice (ACOP) “The Control of Legionella Bacteria in Water Systems” also known as L8 was published by the Health and Safety Executive. This revised edition seeks to both simplify and clarify the text; this is in part achieved by separating management responsibilities from the technical guidance which is now published separately. In particular the ACOP now requires duty holders to:

1. Carry out and document suitable and sufficient risk assessments
2. Implement a written Control Scheme
3. Appoint a competent person to manage the control of the risk system (Known as the responsible person)
4. Carry out periodic reviews of control measures
5. Specify the duties and responsibilities of those involved in the design, manufacture, import, supply or installation of water systems.

In 2001, the joint Scottish Executive/Food Standards Agency (Scotland) Task Force reported on E. coli O157 and made 104 recommendations to reduce the incidence and severity of verotoxin producing Escherichia coli (VTEC) infections in Scotland. Despite these recommendations incidence rates of E. coli O157 infection have remained largely unchanged since 2001 and are consistently higher in Scotland than in other UK countries.

The VTEC/E coli O157 Action Plan for Scotland 2013-2017 aims to reduce the incidence of such infections by setting strategic direction for key partners each of whose collaborative roles in implementing a total of 86 recommendations are clearly identified. For Scottish local authorities this means addressing key transmission pathways with a particular focus on (1) Issues connected to private water supplies and their potential to pose a health risk if they are not correctly installed maintained and protected from sources of contamination such as animal faeces. (2) Food sources which may pose a risk by focusing on the protection of ready to eat foods from raw, untreated or treated products which may contain E coli O157. By implementing guidance aimed at controlling the risk of cross contamination.
Whilst ensuring that consumers can make informed choices e.g. by the provision of point of sale information for unpasteurised cheeses sold loose and (3) by controlling contamination of the environment from animal faecal material at e.g. zoos, farm attractions and agricultural shows including ensuring that pasture is cleared of animal faeces both before and after recreational events involving animals. The role for NHS Lothian, though not explicit in the plan, involves collaborating with local authorities in identifying possible sources of VTEC and instituting measures for control during management of cases and incidents.
Table 3 shows health protection priority activities undertaken by local authorities in the Lothians. This list is not exhaustive but illustrates the range of services within the four authorities.
<table>
<thead>
<tr>
<th>Local authority priority activities</th>
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<tbody>
<tr>
<td><strong>Corporate and Business Advice</strong> – advising on local environmental health and public safety matters</td>
</tr>
<tr>
<td>Supporting Business through advice and training to meet Environmental Health Standards</td>
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<tr>
<td>Civic government licensing</td>
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<tr>
<td>Advisor to Licensing Board</td>
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<tr>
<td><strong>Emergency Planning</strong> – training for and responding to emergencies</td>
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<tr>
<td>Flood management</td>
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<tr>
<td>Emergency planning preparedness</td>
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<tr>
<td>Scientific services advice</td>
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<tr>
<td><strong>Food safety</strong> - securing the hygienic standards of premises, and the compositional standards of food and water</td>
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<tr>
<td>Food Hygiene Inspections (cleanliness)</td>
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<tr>
<td>Food Standards Inspections (composition)</td>
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<tr>
<td>Food Sampling – Bacteriological</td>
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<tr>
<td>Food Sampling – Chemical</td>
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<tr>
<td>Food Alerts</td>
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<tr>
<td><strong>Hazards</strong> – securing consumer and public safety issues</td>
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<tr>
<td>Petroleum Licensing</td>
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<tr>
<td>Explosive Safety/Licensing</td>
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<tr>
<td>Consumer/product Safety</td>
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<tr>
<td>Anti-counterfeiting</td>
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<td>Chemical incidents</td>
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<tr>
<td><strong>Housing</strong> – securing residential accommodation meets minimum standards</td>
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<tr>
<td>Housing Support Services</td>
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<tr>
<td>Rough Sleeping Initiatives</td>
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<td>Housing Standards Issues</td>
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<tr>
<td>Houses in multiple occupation</td>
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<tr>
<td>Caravan Site Licensing</td>
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<tr>
<td><strong>Public Health &amp; Nuisance</strong> – investigation and enforcement of public health nuisances and concerns</td>
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<tr>
<td>General Public Health/nuisance</td>
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<tr>
<td>Communicable Disease Investigation</td>
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<tr>
<td>Pest control</td>
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<tr>
<td>Port Health control</td>
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<tr>
<td>Mortuaries and Crematoria</td>
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<tr>
<td>National assistance Act burials etc</td>
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<td>Smoking in public places</td>
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<tr>
<td><strong>Occupational Health &amp; Safety</strong> – securing health, safety and welfare standards in local workplaces</td>
</tr>
<tr>
<td>Accident Investigation</td>
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<tr>
<td>Health and Safety Inspections &amp; other interventions</td>
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<tr>
<td>Register of cooling towers (Legionella)</td>
</tr>
<tr>
<td>Sun bed regulation</td>
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<tr>
<td>Regulation of tattooing and skin piercing</td>
</tr>
<tr>
<td><strong>Pollution and contamination</strong> – environmental monitoring and investigation of incidents and concerns</td>
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<tr>
<td>Noise Control</td>
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<tr>
<td>Contaminated Land</td>
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<tr>
<td>Chemicals and oil spills</td>
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<tr>
<td>Radiation Monitoring</td>
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<tr>
<td>Air Quality Monitoring</td>
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<tr>
<td>Vehicle emission testing</td>
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<tr>
<td>Consultee on Planning Applications (Fumes, dust, noise impact of developments on health, contaminated land remediation)</td>
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<tr>
<td>Environmental impact assessment</td>
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<tr>
<td><strong>Water Quality</strong> – monitoring of drinking water and recreational water quality</td>
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<tr>
<td>Water Sampling – Private and Public supplies</td>
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<tr>
<td>Swimming Pool Sampling</td>
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<tr>
<td>Recreational water quality – coastal and inland waters</td>
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<tr>
<td><strong>Animal Health</strong> investigation &amp; enforcement of animal health and welfare standards</td>
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<tr>
<td>Animal Health and Welfare</td>
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<tr>
<td>Animal Feed Stuffs</td>
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<td>Animal breeding and boarding</td>
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<td>Dog controls</td>
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4.2 Local health protection priorities

4.2.1 NHS Lothian
Health protection priorities in Lothian are determined by international, national and locally identified potential hazards. The national priorities are set by the Scottish Government. Local priorities are determined as part of the annual planning process during which hazards and potential hazards are identified. Prevention and mitigation are then allocated appropriate resources. The Chief Medical Officer for Scotland identified the 2008-2010 national health protection priorities listed below. These remain as key national health protection priorities.

- Healthcare Associated Infections (HAI) and antimicrobial resistance
- Vaccine preventable diseases and their impact on current and planned immunisation programmes.
- A potential pandemic of influenza.
- Environmental exposures which have an adverse impact on health.
- Gastro-intestinal and zoonotic infections.
- Hepatitis C and other blood borne viruses.
- Tuberculosis
- Integrated Pollution Prevention and Control (IPPC)
- Strengthening surveillance
- Prevention of injuries

4.2.2 Health Improvement, Efficiency, Access to services and Treatment (HEAT) targets
HEAT targets are a core set of national objectives, targets and measures for the NHS. The targets are set for a three year period and progress towards them is measured through the Local Delivery Plan (LDP) process. Two of the targets relate to reduction in Healthcare Associated Infection and improvement in childhood immunisations. Under these targets NHS Lothian will focus its efforts towards:

- Further reducing healthcare associated infections so that by March 2014/15 NHS Boards’ staphylococcus aureus bacteraemia (including MRSA) cases are 0.24 or less per 1000 acute occupied bed days; and the rate of Clostridium difficile infections in patients aged 15 and over is 0.25 cases or less per 1000 total occupied bed days.
- Improving childhood immunisations and vaccine uptake to 95% for all childhood primary and booster vaccinations by analysing uptake by practice regions and identify localised actions for improving uptake.
Specific programme priorities include:

- Eradicating measles and rubella by 2015
- Viral hepatitis: To reduce the avoidable burden of ill-health and premature death, including liver failure. NHS Lothian will implement actions on hepatitis B and C outlined in the Scottish Government Sexual Health and Blood Borne Virus Framework through the NHS Lothian Hepatitis Managed Care Network (MCN).
- Pandemic Flu Plan: NHS Lothian continues to maintain robust plans in conjunction with partner agencies involved with health and social care, including business continuity arrangements. NHS Lothian also actively targets at risk and occupational group with seasonal flu vaccination.
- Influenza: To contribute to the reduction in the burden of disease from respiratory infections and their complications, ongoing surveillance of influenza continues and NHS Lothian will ensure arrangements are in place to offer vaccination to the Lothian population against this virus as appropriate.
- HPV vaccine programme: To reduce the burden of HPV related disease, specifically avoidable death from cervical cancer, NHS Lothian continues to implement the HPV programme for girls (born on or after September 1993) in school.
- Tuberculosis (TB) control and prevention: To prevent the spread of TB, and to reduce the burden of disease, particularly among people who have other illnesses, NHS Lothian is implementing the national TB action plan priorities including, high risk groups; exploring local ways of identifying new entrants, implementing local systems of case-finding for latent TB infection in these entrants; working with statutory and voluntary organisations and groups who regularly come into contact with new entrants to support GP registration; and engaging with primary care teams to highlight the increased risk of TB amongst problem alcohol users, homeless and drug users.
- HIV action plan: To reduce the burden of avoidable infection and illness, NHS Lothian will develop an integrated care pathway that includes prevention, early diagnosis, effective care and treatment provision to implement HIV standards produced by Healthcare Improvement Scotland in 2011.

4.2.3 Emergency Planning and Business Continuity

NHS Lothian is required to ensure emergency planning preparedness and business continuity in accordance with the Civil Contingencies Act of 2004. NHS Lothian has experience of effectively managing serious incident and working with partner agencies. It continues to implement a rolling programme of plan development, training and capability improvement. NHS Lothian has recently established and executive level Resilience Committee to implement the Scottish Government’s Preparing for Emergencies Guidance (2013), which brings together Emergency Preparedness and Business Continuity.
4.3 Health protection risks/challenges unique to the Lothians and how they are managed

While there are shared health protection risks nation wide, Lothian also has its own unique ones. The Public Health etc. (Scotland) Act 2008 and other legislation provide a statutory basis for interventions and there is a shared risk assessment process with stakeholders. These stakeholders include Environmental Health and other appropriate local authority services, the police and fire services, the Scottish Ambulance Services (SAS), Scottish Water (SW) and the Scottish Environment Protection Agency (SEPA). The risks and challenges unique to Lothian and how they are managed are detailed in Table 4. In addition, Appendix II lists key health protection plans to manage incidents.

Table 4: Health protection risks/challenges unique to the Lothians

<table>
<thead>
<tr>
<th>Unique Situation/Position</th>
<th>Risk/Challenges</th>
<th>Mitigation Measures</th>
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<tbody>
<tr>
<td>Host to several universities with large numbers of students in Halls of residence, flats and houses, for example, the University of Edinburgh has 16,000 students.</td>
<td>Increased opportunity for introduction and spread of infection. Increased use of houses in multiple occupation (HMO).</td>
<td>NHS Lothian works closely with universities regards monitoring and control of infection such as mumps and meningitis. Local authorities regulate HMOs.</td>
</tr>
<tr>
<td>University centres for research including veterinary schools, nuclear medicine, biohazards and life sciences research and bio-research facilities, for example Pentland Science Park.</td>
<td>Bio-hazards, use of radioactive materials.</td>
<td>National arrangements are in place for the regulation and control of nuclear medicine and biohazards in the universities and hospitals.</td>
</tr>
<tr>
<td>Host to Scotland’s Capital City, Holyrood Palace, and the Scottish Parliament and associated VIPs.</td>
<td>Increased potential for terrorist incidents.</td>
<td>Lothian and Borders has emergency plans for CBRN\textsuperscript{20} incidents and major incidents. City of Edinburgh Council is developing an evacuation plan.</td>
</tr>
<tr>
<td>Centre of culture which hosts annual festivals, Hogmanay /New Year celebrations, international events such as the G8 and major international sporting events (for example World Cup Sevens rugby), as well as associated VIPs.</td>
<td>Brings together populations from different parts of the world with a risk of new infection coming into the areas. There is potential risk of terrorism in large crowds.</td>
<td>Annual multi-agency plans are in place for such events. The Hogmanay plan is tested prior to the season starting. Appropriate plans are put in place for international events.</td>
</tr>
<tr>
<td>Port Health - Major local and international transport hubs in the local area including: Edinburgh Airport, Leith Harbour, South Queensferry terminal,</td>
<td>There is a risk of imported infectious diseases from other countries.</td>
<td>NHS Lothian and City of Edinburgh Council have a port health response plan developed in collaboration with the airport authorities. Plans are underway for the development of other port</td>
</tr>
<tr>
<td>Unique Situation/Position</td>
<td>Risk/Challenges</td>
<td>Mitigation Measures</td>
</tr>
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<tr>
<td>Waverly/Haymarket Train Stations. St Andrews Bus Station.</td>
<td>Climate change is presenting a potential risk of increased opportunity for displacement of individuals due to flooding, plus disease risk after any flooding incident.</td>
<td>Emergency flood response plans are in place. Flood Prevention Act duties are undertaken by local authorities.</td>
</tr>
<tr>
<td>Sites of potential flooding, for example River Esk, Almond, Water of Leith, Braid Burn, Burdiehouse Burn, Figgate Burn, River Tyne, Briel water, Brocks Burn and Linlithgow Mains.</td>
<td>Risk of nuclear incident. Public concern.</td>
<td>Emergency plans are in place with partnership agencies.</td>
</tr>
<tr>
<td>Host to Torness Nuclear Power Station.</td>
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<tr>
<td>Host to Addiewell (West Lothian) and Edinburgh prisons – includes vulnerable populations.</td>
<td>Prison population known to be at higher risk of hepatitis B. As a closed communal setting it is also at risk of communicable disease outbreaks. This population also has an increased burden of non-communicable disease.</td>
<td>NHS Lothian has close working relationship with prison staff for the provision of appropriate preventive measures and early intervention in incidents and outbreaks.</td>
</tr>
<tr>
<td>Old reservoirs and water treatment plants in need of development.</td>
<td>Potential risk of contamination of drinking water supply.</td>
<td>Scottish Water has long term plan for replacement of the installations. Regular sampling and monitoring of supply and distribution system.</td>
</tr>
<tr>
<td>Private water supplies in more remote rural communities across the area.</td>
<td>Risk of contamination with infection and chemicals.</td>
<td>Routine sampling and monitoring by Environmental Health with grant aid available to improve the quality of the water supply.</td>
</tr>
<tr>
<td>Coastal water quality along the Firth of Forth is critical to the high quality environment for residents and visitors.</td>
<td>These waters have a potential of flooding or being contaminated by agents such as oil spillage which could be a risk to public health. Breakdown of sewage infrastructure resulting in coastal water contamination. Major oil spill from tanker traffic in Firth of Forth</td>
<td>Multi agency emergency plans, including the Waste Water Incident Plan. Local monitoring by LAs and SEPA.</td>
</tr>
<tr>
<td>Tourism is a major contributor to local economy</td>
<td>Loss of reputation if major public health incident</td>
<td>Incident management plans Food and water safety controls.</td>
</tr>
<tr>
<td>Potential emissions and incidents relating to industrial processes in the area including; distilling and brewing; electricity generation; open cast</td>
<td>Risk of major incidents and release of toxic chemicals. Increase air pollution from routine emissions. Legionella in cooling towers.</td>
<td>All the agencies have major incident plans which are regularly exercised. Local authorities maintain cooling towers registers.</td>
</tr>
<tr>
<td>Unique Situation/Position</td>
<td>Risk/Challenges</td>
<td>Mitigation Measures</td>
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<tr>
<td>mining and quarrying; cement manufacture.</td>
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<tr>
<td>Legacy of an industrial history and the associated issues of contaminated land including ex-mining areas and former landfill sites.</td>
<td>Potential chemical environmental pollution. Complaints from communities with assertions of health risk.</td>
<td>Contaminated land issues are addressed either by enforcing conditions attached to planning consents or invoking the powers contained in part IIA of the Environmental Protection Act (EPA) 1990. Monitoring by the local authorities and investigation and control of incidents where there is potential human exposure.</td>
</tr>
<tr>
<td>West Lothian hosts the second largest poultry flock in Scotland, arable beef and dairy farming and an operational slaughterhouse.</td>
<td>Potential animal health risks (for example bird flu and other zoonoses).</td>
<td>Disease contingency plans are in place with relevant partner agencies (East Lothian, SG, Police, Animal Health)</td>
</tr>
<tr>
<td>Substance misuse.</td>
<td>Substance misuse is a common cause of ill health, death and drug related crimes.</td>
<td>Most people with substance misuse problems are cared for by General Practitioners. Comprehensive range of multi-agency, evidence based prevention, treatment and care services in place coordinated through Alcohol and Drug Partnerships, Hepatitis action plans.</td>
</tr>
<tr>
<td>Air quality issues.</td>
<td>Increased risk of respiratory and cardiovascular diseases.</td>
<td>Local authorities monitor air quality declaring Air Quality Management Areas (AQMAs) and developing action plans as appropriate.</td>
</tr>
</tbody>
</table>

4.4 Dealing with Public health incidents or outbreaks

Across the Lothians a number of health protection incidents and outbreaks of communicable diseases are dealt with each year. As reported in the Director of Public Health Annual Reports, there were 56 incidents in 2012 and 48 in 2013. About a quarter of these incidents are related to healthcare associated infections. Where necessary, these incidents and outbreaks have been managed within joint multi-agency and multi-disciplinary frameworks involving NHS Lothian and one or more of the four Local authorities. Larger or more complex incidents may involve the Regional Resilience Partnership (RRP), Local Resilience Partnership (LRP) or the Scottish Government (SG), for example, the Southwest Edinburgh legionella outbreak in 2012, the Dalmeny Tank Farm incident of 2011 and the Pandemic Influenza outbreak in 2009. Some of the other incidents managed in the same period have been smaller in scale but have required specialist expertise and a considerable amount of resources to manage.
As part of the continuous improvement of incident and outbreak management, NHS Lothian, the Local Authorities and other partner agencies are revising and amending policies and practice. Lessons learned are disseminated actively to spread learning, including by debriefing meetings, final reports and review of the implementation of recommendations.

5. Resources and operational arrangements

NHS Lothian and the four local authorities in Lothian are committed to complying with the requirements stipulated in the 2011 Scottish Government guidance, on Management of public health incidents\(^{35}\), the VTEC/E. coli Action Plan\(^{43}\), NHS Scotland Resilience Guidance and the revised Code of Practice (ACOP) for the control of Legionella Bacteria in Water System\(^{44}\) as priority areas. This will include providing staff trained to the agreed standard that are able to participate in Incident Management Teams (IMTs). These documents require that partner agencies maintain a level of resources regarded as adequate for and the support required to prevent and manage public health incidents.

5.1 Staffing

NHS Lothian and the four Local Authorities have each appointed competent persons and share competent persons lists, in accordance with the Public Health etc (Scotland) Act 2008. Table 5 shows the numbers of competent persons appointed by each agency. Each of the agencies will maintain sufficient numbers of competent persons and update the lists as appropriate. The next formal review of competent persons will be carried out in 2016.

<table>
<thead>
<tr>
<th>Agency</th>
<th>NHS Lothian</th>
<th>City of Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Designated competent persons</td>
<td>13</td>
<td>41</td>
<td>7</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>

In addition to the designated competent persons, local authorities and NHS Lothian can call upon a number of other staff who work within the overall remit of their services to assist in the investigation of incidents if necessary and appropriate.

5.2 IT and communications technology

Information and Communications technologies are available to NHS Lothian and local authorities to facilitate health protection and environmental health work, including the management of incidents and outbreaks are set out below.
5.2.1 NHS Lothian Electronic Guidance and guidelines:

- NHS Lothian staff have access on the web e-library – the NHS electronic health library.
- NHS Lothian Public Health Staff who work out of hours are provided with a set of local guidance and guidelines for reference.
- NHS Lothian Health Protection Team (HPT) keeps a database of on-call guidance.
- SHPIR, the Scottish Health Protection Information Resource (Health Protection Scotland [HPS]) provides a suit of key nationally updated guidance.
- On-call staff have access to international travel advice and guidance via TRAVAX website.

Information Technology:

- Mobile phones and bleeps are issued to out of hours staff.
- Encrypted laptops and encrypted memory sticks are available for staff to take home when on-call.
- A standard operating procedure for establishing a telephone helpline within NHS Lothian is currently being developed by the HPT and Telecommunication Department is nearing completion. This will ensure that a helpline can be set up rapidly, where it is considered appropriate to have an additional point of contact for the public during an incident, to supplement NHS24.
- TRAK, the patient management system, is used for accessing laboratory results and information relating to hospital patients.
- NHS Lothian SCI-store e-results, the Scottish Care Information System are used by GPs for notification to the board and storage of laboratory results used for managing patients.
- Scottish Environmental Incident Surveillance System (SEISS) is a database of environmental health incidents in Scotland.
- Toxbase, a database that provides information on toxin and poisons for managing cases and incidents.
- The Scottish Infectious Disease Surveillance System (version 2) (SIDSS 2,) for infectious diseases is used for notification by Boards to HPS.
- The Scottish Immune Recall System (SIRS) is a database used as a call and re-call system immunisation programmes.
- Community Health Index (CHI) provides authorised members of staff patient identifier information which is used for tracing patients. Access is controlled by the Director of Public Health and Health Policy as Guardian of the CHI.
- The Electronic Communication of Surveillance in Scotland (ECOSS) is used for laboratory services notification to NHS Lothian Public Health Directorate and from the Directorate to HPS.
The Airwave encrypted digital radio system was installed within NHS Lothian, in March 2011 with base sets, provided by Scottish Ambulance Service, located in our Emergency Departments. Two hand-held radios were issued by Scottish Government to Emergency Planning for use during a major incident.

NHS Lothian is part of MTPAS, the Mobile Telecommunications Privileged Access Scheme. Under this scheme a Network Service Provider (NSP) a single special privileged access SIM cards (MTPAS SIMs) to Category 1 (including NHS Lothian) and 2 responders, as defined in the Civil Contingencies Act (CCA) 2004, to allow continued communication when there is a network congestion or shutdown.

NHS Lothian is joining other Scotland health boards in introducing HPZone-Scotland – a secure web-based decision support system for the control, surveillance and management of cases and incidents of infectious diseases and environmental hazards.

5.2.2 Local Authorities

Local authorities have databases with addresses and contact details for all food businesses. These systems are capable of interrogation and can be used to produce specific premises lists subject to the coding structures used. Edinburgh and West Lothian use Authority Public Protection (APP) by Civica; East and Midlothian use the Uniform system by IDOX technology.

- The Airwave encrypted digital radio system has been adopted by the Local Authorities Emergency Planning and Business Continuity Services. Two hand-held radios were issued by Scottish Government to each LA for Emergency Planning for use during a major incident. Additional handsets may be accessed in the event of an emergency.
- A number of the Lothian Local Authorities have key personnel who are also part of MTPAS, the Mobile Telecommunications Privileged Access Scheme to allow continued communication when there is a network congestion or shutdown.

5.3 Scientific and Laboratory Services

The scientific and laboratory services which NHS Lothian and local authorities require for surveillance and management of public health incidents, which are currently available include:

- NHS microbiological and biological laboratories based at the Royal Infirmary of Edinburgh and the national reference laboratories.
- Edinburgh Scientific Services
- Scottish water laboratories
- Scottish Environment Protection Agency (SEPA) Laboratories
5.4 Collaborative arrangements

NHS Lothian has collaborative arrangements and links with national organisations and groups and at international level through Health Protection Scotland (HPS) and the Scottish Government (SG) for dealing with communicable diseases and environmental Hazards. Locally, organisational arrangements are in place to facilitate good collaborative working between NHS Lothian, Local Authorities and other health protection partners, including Animal Health Services, Scottish Water and other utility companies, the FSA and SEPA. As part of emergency planning arrangements, these agencies are represented at the Strategic Co-ordinating Group (SCG) bi-monthly tactical group meeting and may attend quarterly meetings. Lothian Infection Control Advisory Committee also meets on a bi-monthly basis to review policies and infection control issues. Health protection incident review activities also take place in a number of committees and groups. These include:

- The NHS Health Protection Joint Liaison Group Meeting which includes Animal Health and Local Authorities is held quarterly. This group implements most of the planned joint activities of this Joint Health Protection Plan.
- Hepatitis Managed Care Network holds regular event.
- Immunisation incidents are reviewed at the Local Immunisation Co-ordinating Group (LICOG) meetings.
- The Avian and Pandemic Influenza Planning Group (AIPG) meets two to three times a year.
- Research and teaching programmes between NHS Lothian and Edinburgh universities.

Over the last two years arrangements have been made for joint working and learning from cases and incidents between the Health Protection Team, Medical Microbiology, Virology and Occupational health. Joint CPD sessions have been held with local authority colleagues. Sharing experience and learning has also been established with the poisons unit at the Royal Infirmary of Edinburgh.

As part of the Scottish annual influenza vaccination policy, NHS Lothian has offered immunisation to social care staff at the same time as their own staff. During 2014-16, efforts will continue to increase uptake among staff.

The UK Joint Committee on Vaccination and Immunisation (JCVI) recommended extension of the seasonal flu vaccination programme to all children aged 2-17. During 2013-14, the first phase has been undertaken with immunisation offered to all 2-3 year olds via general practice and a pilot of vaccination using nasal spray in around 20% primary schools in Lothian.
This pilot project was a collaboration between NHS Lothian, Local Authority Departments of Education and head teachers in the pilot schools. Immunisation was offered to all children in more than 60 primary schools across Lothian from 1 October 2013. Around 11,000 children were immunised – an uptake of about 72%. The pilot allowed significant lessons to be learned as to the best model to use from 2014 onwards but in general evaluated very well. The high uptake rate and good evaluation was very much as a result of the excellent cooperation between the NHS and local authorities.

Figure 6 is an illustrative summary of the joint working and areas of collaboration between NHS Lothian and the four Lothian Local Authorities. The details on specific areas of joint working are in Appendix I.

Figure 6: Joint health protection activities between NHS Lothian and Lothian Local Authorities. (Illustrative rather than comprehensive)
5.4 Out of hours response arrangements

5.4.1 NHS Lothian

NHS Lothian out of hours arrangement involves the provision of on call staff. Public Health and Health Policy provides a 24/7 response and there is a contacts directory and a call-out process from the Royal Infirmary Edinburgh (RIE) switchboard in the event of an emergency. In the case of major incidents and outbreaks such as a flu pandemic situation, support from other parts of the organisation, for example, scientific and analytical staff in Lothian Analytical Services, for weekend reporting as and when required. NHS Lothian has a service level agreement with Public Health Intelligence at National Services Scotland for the provision of public health intelligence and analytical services. From 2014 this responsibility will be set out explicitly in the service level agreement. The on call team can be contacted out of hours on 0131 242 1000.

5.4.2 Local Authorities

The four Local Authorities have emergency out-of-hours procedures in place. These are accessed through call centres within each authority. The FSA has lists of nominated contact officers for each authority in case of emergency food borne incidents. Contact centre details are:

- City of Edinburgh 0131 200 2000
- East Lothian Council 01875 612 818
- Midlothian Council 0131 663 7211
- West Lothian Council 01506 282 000

5.5 Reviewing Health Protection Standard Operating Procedures (SOP) or guidance

The Directorate of Public Health and Health Policy has standard operating procedures for significant infectious diseases other hazards, outbreaks and major incidents. The Health Protection Team workplan includes reviewing standard operating procedures with partners. Those requiring review are identified based on their review date or the emergence of new national guidance.

Debriefs for significant incidents or major outbreaks are held to learn lessons from how they have been managed. These debriefs can be multi-agency and multi-disciplinary within the Directorate as appropriate.

The Local Authorities have standard operating procedures for a wide range of environmental health functions, including food safety and health and safety incidents. The two standard operating procedures, which are developed jointly between the Directorate of Public Health and the Local Authorities, are the sporadic food borne disease and gastrointestinal illness and the major outbreak plans.
NHS Lothian and the Local Authorities will continue to review operating procedures, including those that relate to the Public Health etc. (Scotland) Act 2008 duties (Appendix III).

5.6 Staff knowledge, skills and training
The following arrangements are in place for ensuring the maintenance of knowledge, skills and competencies for staff with health protection duties.

5.6.1 NHS Lothian
The Director of Public Health and Health Policy issues a weekly professional update that includes training opportunities, courses and conferences as well as updates on policy, evidence and key meetings.

Audit and peer review sessions on on-going public health projects and activities are part of the weekly information exchange meetings and CPD sessions held in the Directorate.

The HPT organises, as a minimum, twice yearly on-call updates as part of regular continuing professional development (CPD) sessions within NHS Lothian’s Directorate of Public Health and Health Policy. Additional related sessions, providing training and exercising for Emergency Planning, are also provided.

HPT will informs on-call staff of other training day courses and conferences organised regionally or nationally and all staff on-call are required to participate in an Emergency Planning exercise on an annual basis. All on-call staff are required to spend a full week with HPT at least every two years. This is arranged with the operational team at mutually convenient times. Ideally staff will be offered the opportunity to attend the HPS on call course once every two years. There are limited places available each year for Health Protection Scotland (HPS) on call and Scientific and Technical Advice Cell (STAC) training. NHS Lothian supports CPD requirements for registered medical and other public health and the knowledge and skills framework requirements for professional, scientific and support staff for whom formal registration requirements are not yet in place.

5.6.2 Lothian Local Authorities
All Local Authorities have procedures in place for annual review of staff development needs, including support for meeting professional CPD requirements where appropriate. All environmental health staff are encouraged to attend training or update events organised by NHS Lothian, HPS, the Royal Environmental Health Institute of Scotland (REHIS) and Food Standards Agency, for example. All local authority staff working in food safety and food standards are required to meet minimum competency and the ongoing professional development requirements of the Food Law Code of Practice. Similar formal requirements have been developed in relation to staff working in relation to occupational health and safety.
NHS Lothian and the Local Authorities will keep training requirements under review, including developing joint training opportunities, particularly in relation to the Public Health etc (Scotland) Act 2008 duties (Appendix II).

6. Capacity and resilience

6.1 NHS Lothian

NHS Lothian, in conjunction with Local Authorities and HPS, last assessed the capacity and resilience of local health protection services in the spring of 2009. The assessment put a set of criteria into place and these were used to assess the status of health protection services. These criteria covered a number of areas, including: team composition; resources and education; communication mechanisms and technology; information management and facilities standards; policies; procedures; joint working and governance; on call and surveillance arrangements.

In the early part of 2011, NHS Scotland Resilience, following a review of emergency preparedness as part of a national audit of Health Boards, noted that there continues to be a proactive attitude towards emergency planning in NHS Lothian, which reaches through to the wider organisation.

NHS Lothian is developing more extensive mutual aid arrangement with neighbouring Health Boards and reciprocal appointment of Competent Persons as required by the new Public Health etc. (Scotland) Act 2008.

NHS Lothian led the review of the capacity and competence of the public health function in Scotland by the Association of Schools of Public Health in the European Region in January 2013. This was a positive visit. During the first quarter of 2014 there will be a rapid review of the capacity and resilience of the public health function in Lothian. This will attempt to marry the requirements of reduced budgets with Scottish Government’s commitment to strengthen public health capacity.

6.2 Local Authorities

Each of the Local Authorities provides a core level of trained and competent staff to deliver a wide range of statutory environmental health duties. Local authorities undertake their own service reviews on a regular basis. In addition they are subject to external scrutiny by the FSA audit branch in relation to meeting the requirements of food safety legislation. Historically, all of the Local Authorities have been able to provide health protection related services.

The 2013 Audit Scotland Report - Protecting Consumers, raised concerns about the longer term sustainability of Trading Standards (TS) Services particularly at smaller Councils (classed as those with less than 8 TS staff) and also looked at food safety services.
The report acknowledged that Food Services were, on the whole, currently better resourced than Trading Standards but raised concerns for both services about loss of experience and expertise and ensuring core competencies and training for the future.

The report recommended more formal joint working arrangements and shared service options as possible solutions. While the report did not address wider environmental health functions, (e.g., public health work, environmental monitoring & investigations, nuisance and housing standards work, health & safety enforcement etc), there are similar concerns about these service areas too.

East and Midlothian Councils have agreed to the two Councils developing a partnering approach to delivering Environmental Health and Trading Standards Services. This entails Midlothian leading on Environmental Health and East Lothian on Trading Standards and as such a twelve month pilot commenced on 4 November 2013.

The potential benefits for developing a partnership approach include:

- Continuity of service delivery
- Long term / future service resilience
- Service efficiencies
- Improved service flexibility and quality through sharing specialist expertise.

### 6.3 Approach to regulation

We will develop a work programme to introduce new ways of working designed to minimise the adverse impact of deregulation on the ability of the Health Board and Local Authorities to comply with their duties to protect and improve the health and wellbeing of the population. In developing our priorities for action we will examine the population impact of potential adverse events against the level of risk they pose and the likelihood of occurrence. Used appropriately, regulation is an efficient, effective and equitable tool for improvement. We will introduce new interventions designed to improve performance and new tools to measure our achievements.
7. Public involvement and feedback

7.1 NHS Lothian

7.1.1 Patient and Public Involvement

In NHS Lothian, involving patients and the public means involving them in how health services are designed and delivered. This is achieved by working in partnership with local authorities, the voluntary sector and other community groups when planning health services and health policies.

Patient and public involvement in NHS Lothian health protection activities takes place largely during individual interaction with cases and contact of cases, general educational messages sent out as a preventive measure during incidents and outbreaks. Public involvement during these incidents and outbreaks takes place via proactive media releases and response to media queries and a public helpline, if established. In addition, feedback is obtained during a variety of conferences and working groups. For example, the Hepatitis C Action Plan sub-groups and Lothian Infection Control Advisory Committee have public representatives.

In October/November 2013, an audit of the patient experience with the HPT during exclusion/restriction was carried out. In general most participants were satisfied with the communication, levels of contact and advice given to them by the HPT over exclusion and felt that little needed to be improved. Areas that some interviewees felt were important and had room for improvement include letters being sent to employers earlier, clearer information on re-imbursement for loss of earnings, more proactive follow up of samples and results with the labs, clarity on the number of samples required, information on the process of lifting exclusions and providing them with the source of infection.

7.1.2 Staff and Partnership

The NHS Lothian Partnership Forum has been established as part of an area-wide employee relations framework that allows staff to influence how NHS Lothian works. In health protection terms this forum provides the opportunity of early involvement and the ability to influence decision making on health protection issues which affect staff. Partnership involvement is considered essential when any incident moves from being a Problem Assessment Group (PAG) which is a professional assessment of a potential incident to an incident being declared and a formal Incident Management Team being established. One of the most obvious roles for Partnership is providing advice and helping to ensure high levels of understanding and uptake when staff screening is necessary as part of incident management.
7.2 Lothian Local Authorities
Local authorities carry out a variety of client and community consultation and feedback activities, using the results to improve the efficiency and effectiveness of service delivery. However, for the purposes of the Joint Health Protection Plan, the main area of cross-client contact by environmental health staff is the investigation of incidences of gastrointestinal infections out-with a hospital setting.

8. Monitoring and review

An action plan has been developed (Appendix II) to ensure that this Joint Health Protection Plan is implemented effectively. The plan will be kept under strategic review by the steering group comprising the Director of Public Health and Health Policy, NHS Lothian and the Chief Officer(s) of Environmental Health of City of Edinburgh, East Lothian, Midlothian and West Lothian Councils.

The detailed implementation of the plan (see action plan Appendix II) including review of incidents, procedures, staff training will continue to be the responsibility of the NHS Health Protection Joint Liaison Group, which meets quarterly in Lothian.
9. References
8. NHS Lothian Health Protection Team. Scottish Infectious Disease Surveillance System v2 (SIDSS 2) and GRO(S) Mid-year population estimates, accessed 25/02/2014


http://intranet.lothian.scot.nhs.uk/NHSLothian/Corporate/A-Z/PartnershipForum/Documents/Partnership%20Agreement.pdf

38 World Health Organisation (WHO) Resolution. Renewed commitment to elimination 
of measles and rubella and prevention of congenital rubella syndrome by 2015 and 
Sustained support for polio-free status in the WHO European Region, Regional 
Committee for Europe, Sixtieth session, Moscow, 13–16 September 2010. 


40 NHS Lothian. Involving people – improving people’s experiences of care. NHS 
Lothian strategy 2009-2013. 

http://www.gro-scotland.gov.uk/statistics/theme/population/estimates/mid-
year/2012/list-of-tables.html.


43 Health and Safety Executive (HSE) Legionnaires’ disease. The control of legionella 
bacteria in water systems. Approved Code of Practice and guidance on regulations. 

Report of the agencies which responded to the outbreak. October 2013 

45 Chief Medical Officer (Scotland) CMO (2013) 07 Short catch up campaign for 
measles immunisation in Scotland. 2013 


47 Joseph Rowntree Foundation. Climate change and social justice: an evidence 

48 World Health Organisation. Protecting health from climate change – top 10 actions 
for health professionals – WHO – 2009 
http://www.who.int/phe/10_actions_FINAL.pdf

49 World Health Organisation Office for Europe. Review of evidence on health aspects 
## Appendix I: Joint Health Protection Activities

Priorities: We have specified what are the current deliverables for completion in 2012-14, what are for delivery in two to three years time or, for further in the future. These can be listed as:

- **Deliverables** - for the coming year with expected outcomes and milestones;
- **Developmental** - for a specific timescale beyond the coming year with expected outcomes and/or milestones listed and;
- **Directional** – Horizon scanning for future public health issues;
- **Sustainability** - We ensure that once targets are reached we can maintain that level.

### Subject | Health Protection Issues | Local Authority Role | NHS Health Protection Role | Joint NHS/Local Authority role | Priority level
--- | --- | --- | --- | --- | ---
**Public health incidents** | Ensuring the most effective protection of public through NHS and Local Authorities co-operation in investigation and control of outbreaks | Perform duties and functions defined under the Public Health (S) Act. Assign appropriate staff and contribute resources required for the investigation and control of incidents and outbreaks. Exclude workers in high-risk occupations confirmed as having relevant infectious disease. | Perform duties and functions defined under the new Public Health (S) Act. Provide leadership for investigation of public health incidents and outbreaks. Pay for exclusion of high risk workers. | Draw up joint plans for the investigation and control of incidents and outbreaks. Participate in incident and outbreak investigation, review and audits. Participate in multiagency exercises and planning events. | Deliverable
**Port Health** | Potential risk of importation of exotic infection from other countries. Increased potential for drug use. Lothian has major local and international transport hubs in the local area including: |
- Inspection of ships for hygiene and vermin/pests
- Monitoring of water supplies.
- Enforcement of international health regulations, a designated port authority for the purpose of issuing ship sanitation etc. certificates. |
- Imposing appropriate Controls on ships and passengers when disease reported or suspected.
- Liaison with other agencies and health authorities. |
<table>
<thead>
<tr>
<th>Subject</th>
<th>Health Protection Issues</th>
<th>Local Authority Role</th>
<th>NHS Health Protection Role</th>
<th>Joint NHS/Local Authority role</th>
<th>Priority level</th>
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</thead>
<tbody>
<tr>
<td>Mass Gatherings</td>
<td>Lothian is a centre of culture which hosts annual festivals, Hogmanay/New Year celebrations, international events such as the G8 and major international sporting events (e.g. World Cup Sevens rugby), as well as associated VIPs. This brings together populations from different parts of the world with a risk of new infection coming into the areas. There is potential risk of terrorism in large crowds.</td>
<td>Work with the police to ensure safety at venues. Various licensing activities for entertainment, civic government, alcohol.</td>
<td>Ensure that Accident and Emergency department in hospitals have emergency plans to receive casualties. Work with other agencies to ensure adequate presence of first aiders.</td>
<td>Develop and test Hogmanay plans prior to the season starting. Monitor upcoming events and put in place appropriate plans for international and other large size events. Identify and plan mitigation measures for public health issues that the Commonwealth Games in Glasgow (2014) may impact on Lothian.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Climate change</td>
<td>Climate change presents a potential risk of Increased displacement of individuals due to flooding, plus disease risk after any flooding. Incident sites of potential flooding include River Esk, Almond, Water of Leith, Braid Burn, Burdiehouse Burn, Figgate Burn, River Tyne, Biel water, Brocks Burn and</td>
<td>Put in place emergency flood response plans dealing with displacement and remediation. Implement Flood Prevention Act duties.</td>
<td>Provide advice on potential health risk in the event of flooding. Ensure healthcare provision for vulnerable populations during flood incidents. Provide healthcare to the affected individuals Contribute to the local authority flood plans.</td>
<td>Participate in multiagency exercises and flood planning events. Participate in multiagency flood incident management. Develop plans in line with Scottish Govt Climate Change Adaptation framework 2012</td>
<td>Sustainable</td>
</tr>
<tr>
<td>Subject</td>
<td>Health Protection Issues</td>
<td>Local Authority Role</td>
<td>NHS Health Protection Role</td>
<td>Joint NHS/Local Authority role</td>
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<tr>
<td>Radiation - Ionising and non-ionising</td>
<td>Potential risk to public from radiation sources. Risk of nuclear incident. Risk of malicious release (terrorism). Sunbed use increasing cancer risk. Radon accumulations increasing cancer risks.</td>
<td>Draw up a multi-agency off-site nuclear incident plan. Inspection and appropriate licensing of sun-bed operators. Monitor of radon gas in public building owned by the local authority and support families to monitor homes in potentially affected areas.</td>
<td>Identify NHS Lothian sites that are vulnerable to flood risk and establish plans to mitigate the risk and ensure business continuity. Implement NHS Lothian Strategic Development strategy with actions to reduce carbon emissions.</td>
<td>Contribute to a multiagency off-site plan. Monitor of radon gas in public building owned by the NHS and support families to monitor homes in potentially affected areas. Participate in multiagency radiation exercises and planning events. Participate in multiagency radiation incident management.</td>
<td>Deliverable</td>
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### Good Places Better Health™ (National Health Policy) issues

| Prison accommodation | Lothian hosts two prisons – includes vulnerable populations. Increased risk of disease outbreaks such as hepatitis B, HIV and tuberculosis among prisoners. | Inspection of Prison kitchens under food safety and food standards legislation. | Develop close working relationship with prison staff for the provision of appropriate preventive measures and early intervention in incidents and outbreaks. | Participate in incident and disease outbreak investigation and control. | Deliverable |

<p>| University accommodation | Lothian hosts several universities with large Regulation of HMOs. Investigation of housing | Put in place plans to work with university authorities in | Investigate and manage incident of infections and | | |</p>
<table>
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<tr>
<th>Subject</th>
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<tr>
<td>numbers of students for example the university of Edinburgh has 16,000 students. Increased opportunity for introduction and spread of infection. Increase use of Houses in Multiple Occupation (HMO).</td>
<td>standards issues. Protection of Private tenants through registration of private landlords. Promote Landlord Accreditation to increase standards above the statutory minimum</td>
<td>monitoring and control of infection such as mumps and meningitis.</td>
<td>outbreaks when they occur.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Air quality.</td>
<td>Potential emissions and incidents relating to industrial processes in the area including: distilling and brewing, electricity generation, open cast mining and quarrying, cement manufacture etc. Risk of major incidents and release of toxic chemicals. Increase air pollution from routine emissions. Increased risk of respiratory and cardiovascular diseases.</td>
<td>Monitor air quality compliance with legislative standards. Declaration of Air Quality Management areas as appropriate and formulation of action plans. Respond to planning applications where air quality may be impacted Participate in the vehicle emissions and vehicle idling partnership</td>
<td>Contribute to the development of the national Air Quality Monitoring during major incidents. Ad hoc and advice on analyses of health impacts of air quality. Participate in multiagency air quality exercises and planning events. Participate in multiagency air quality incident management. Consultation on air quality action plans.</td>
<td></td>
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<tr>
<td>Home Safety</td>
<td>Carbon monoxide poisoning. Fire risk. Safety of appliances. Risk from goods bought</td>
<td>Advice and complaint investigation about the safety of goods sold. Potential for surveys and test purchasing to check the</td>
<td>Possibility of being asked for advice on potential risk to humans from products (e.g. those containing specific substances)</td>
<td>Health Impact Assessments of housing development and regeneration schemes.</td>
<td>Developmental</td>
</tr>
<tr>
<td>Subject</td>
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<td>Housing</td>
<td>Poor quality, energy inefficient housing is associated with respiratory ill health and winter mortality and fuel poverty. Overcrowding is associated with poor health. Housing design features may affect mental health, accessibility and risk of domestic injury.</td>
<td>Work in partnership with housing services to assess quality of housing with regard to the Tolerable Standard and to use statutory powers to secure improvement where funding permits or is of significant public health risk. Conduct the registration of Private Landlords scheme Develop and deliver the Local Housing strategy Deliver the Statement of Support for health impact assessments of housing developments.</td>
<td>Health Impact Assessments of housing development and regeneration schemes. Ad hoc advice and support relating to health impacts of housing.</td>
<td>Deliverable</td>
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| Contaminated Land| Lothian has a legacy of an industrial history and the associated issues of contaminated land including ex mining areas, former landfill sites etc. Potential chemical environmental pollution. Complaints from communities with assertions of health risk. | Assistance in terms of housing improvements                                                              | Identification of contaminated land and addressing problems found in accordance with national guidance contained in part IIA of EPA 1990. (guidance is not contained in statute also most issues of contamination are dealt with as part of the Planning process as part of redevelopment Monitoring of sites and investigation and control of incidents where there is potential human exposure. Use a phased, risk based approach to the identification, investigation and remediation of contaminated land sites. | Statutory consultee advising on risk to human from a wide variety of contaminants.  
Investigation of assertions of risk and assessment of impact of remediation measures.  
Investigate contaminated land and take action to ensure health risks are eliminated or adequately reduced. | Developmental |
<p>| Greenspace       | High quality accessible green space is associated with better mental health and increased physical activity.                                                                                                            | Open space strategy                                                                                      | Ad hoc advice on benefits of green space. Build into work on physical activity. Support for community gardening projects and greening of NHS estate. | Health impact assessments of green pace proposals                                                                                     | Developmental |
| Transport        | Transport can affect air quality, physical activity, injuries, access to health-promoting facilities, noise.                                                                                                         | Local Transport Strategy                                                                                 | Advice on health issues arising from transport policies and proposals                                                      | Health impact assessments of transport policy and strategy                                                                             | Developmental |</p>
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</thead>
<tbody>
<tr>
<td>Quality of public realm</td>
<td>Design of public spaces may affect levels of physical activity, mental wellbeing, social cohesion etc.</td>
<td>Planning policies – formulation, implantation and monitoring</td>
<td>Advice on health issues arising from planning proposals</td>
<td>Health impact assessment of planning policies</td>
<td>Developmental</td>
</tr>
<tr>
<td>Strategic Environmental Assessment</td>
<td>SEA includes consideration of Human Health</td>
<td>Offer ad hoc advice and support on health issues in SEAs</td>
<td>Joint work on scope of SEAs</td>
<td>Developmental</td>
<td></td>
</tr>
<tr>
<td>Equally Well†† (joint work to tackle the social determinants of health inequalities) – National health policy</td>
<td>Food poisoning, Legionella.</td>
<td>Investigation of potential sources, contacts and causes in partnership with NHS. Taking appropriate formal and informal action to ensure potential source is adequately dealt with. Hold register of cooling towers etc. Exclude high-risk persons. Sampling of swimming pools to ensure no risk to users.</td>
<td>Addressing medical needs of affected persons. Investigation of potential sources, contacts and causes with assistance of Local Authorities. Advising on potential control options. Exclude high-risk persons.</td>
<td>Developing SOPs, planning for incident management, managing and controlling outbreaks and incidents and surveillance. Review of incident management and learning lessons. Exclude high-risk persons.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Animal Health and zoonotic</td>
<td>Procedures supporting the control of BSE, bird flu,</td>
<td>Monitoring of controls on animal health.</td>
<td>Working with Animal health to monitor the occurrence of</td>
<td>Investigation and control of incidents and outbreaks of</td>
<td>Deliverable</td>
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</tbody>
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<tr>
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<tbody>
<tr>
<td>diseases</td>
<td>rabies, bovine tuberculosis etc.</td>
<td>Appropriate formal and informal action to deal with problems found. Monitoring of controls imposed as part of animal diseases, such as animal movement orders.</td>
<td>zoonotic disease in livestock and domestic animals. Advice on potential risk to human arising from animal health activities including outbreaks of animal diseases. Advice on vaccination to population at risk including travel abroad.</td>
<td>zoonotic diseases.</td>
<td></td>
</tr>
<tr>
<td>Smoking, alcohol and substance misuse</td>
<td>Smoking is the single largest preventable cause of premature mortality. Substance misuse is a preventable cause of ill health, death and drug related crimes.</td>
<td>Responsibility for ensuring goods are not sold to those under 18. Age Related Sales Tobacco, Cigarette, Lighter Refills Fireworks. No-smoking legislation implementation regarding smoking in public places. Licensing standards officer’s interventions regarding age verification policy and responsible drinking.</td>
<td>Follow up of individual cases of infection connected with substance misuse. Assess alerts about contaminated alcohol and new drugs causing potential ill health. Advise on appropriate measures to prevent and treat HIV, Hepatitis B and C. Develop and implement action plans through the HCV MCN.</td>
<td>Participate in disease incident and outbreaks related to substance misuse Underlying and long term issues addressed through planning and delivery of services in partnership through the Smoking &amp; Health, Alcohol and Drug Partnerships (ADPs) and Community Safety Partnerships.</td>
<td>Developmental</td>
</tr>
<tr>
<td>Noise Control</td>
<td>Anti social behaviour. Exposure to occupational noise. Exposure to nuisance noise which may affect health.</td>
<td>Powers to issue fixed penalty notices for anti-social activities. Powers to investigate and control noise nuisance generally through statutory nuisance legislation of</td>
<td>Advice on health effects on humans arising from noise producing activity.</td>
<td>Provide public health advice on incidents</td>
<td>Sustainable</td>
</tr>
<tr>
<td>Subject</td>
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<tr>
<td>Licensing</td>
<td>Activities Including: Alcohol, Street Trading Tattooing &amp; Skin Piercing Petroleum. Alcohol related health harm and community safety linked to availability. Spread of infection such as hepatitis B and C and sexually transmitted diseases. Monitoring of alcohol licensing via licensing standards officers Licensing monitoring and inspection of street traders, tattooists, skin piercers and petroleum storage. Dealing with complaints and taking appropriate informal or formal action.</td>
<td>Advice on health risks of activities, the impact of alcohol on population health and the link with outlet density. Advice on implementing the public health principle in alcohol licensing including on licensing conditions and/or options to control problems and arising from incidents</td>
<td>Underlying and long term issues around alcohol misuse addressed through planning and delivery of services in partnership through the Alcohol and Drug Partnerships (ADPs) and Community Safety Partnerships.</td>
<td>Developmental</td>
<td></td>
</tr>
<tr>
<td>Pest Control</td>
<td>Vermin — potential to spread disease. Insects — disease spread potential, can arise from unhygienic conditions with human health risk. Inspection of area for vermin and pests taking appropriate informal or formal action to address problems found. Treating of vermin and insects (discretionary).</td>
<td>Advice on potential risk to humans from a variety of pests.</td>
<td>Investigation and control of pest related diseases.</td>
<td>Developmental</td>
<td></td>
</tr>
<tr>
<td>Dog Control</td>
<td>Stray dogs — safety and potential for disease spread Dog fouling — potential to spread disease. Dangerous dog threat or attack. Noise nuisance from</td>
<td>Uplift of stray dogs Enforcement of fouling and dangerous dog Legislation Promote responsible dog ownership to minimise Barking, fouling and poor control.</td>
<td>Advice on potential risk to humans from dog fouling Linkages to promotional work on best practice and other dog related issues</td>
<td>Investigation and control of zoonotic disease related to dogs.</td>
<td>Developmental</td>
</tr>
<tr>
<td>Subject</td>
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<tr>
<td>Public Health Nuisances</td>
<td>Variety of statutory nuisance conditions affecting local residents / community.</td>
<td>Monitor area and respond to complaints with regard to statutory nuisance issues such as dirty houses, unhygienic living conditions, drainage problems, odour problems, etc.</td>
<td>Advice on risks and effects on the health of occupants and other relevant persons.</td>
<td>Follow up complaints and investigate nuisance that affect public health.</td>
<td>Developmental</td>
</tr>
<tr>
<td>Houses in Multiple Occupation and Private sector rental accommodation</td>
<td>Nuisance and health effects on occupants from poor living conditions and disrepair. Overcrowding, fire, safety.</td>
<td>Licensing of HMOs and registration of Private Landlords. Monitor local housing for defects and respond to complaints. Inspect for compliance Enforce against unlicensed/unregistered Premises.</td>
<td>Advice on risks and effects on the health of occupants and other relevant persons Advice on risks to health of Occupants. Joint investigation as appropriate for HMO related public health incident</td>
<td></td>
<td>Developmental</td>
</tr>
<tr>
<td>Health &amp; Safety at Work.</td>
<td>Illness or injury to persons.</td>
<td>Enforcement of Health and Safety legislation: to reduce the incidence of accidents and ill health at work in partnership with the HSE. This involves adherence to inspection/sampling programme, participation in national campaigns and other interventions as directed by HSE and investigation of accidents and complaints.</td>
<td>Advice on health risks (Healthy Working Lives) Explore the link between LA health and safety investigations/intervention planning to NHS accident/emergency data.</td>
<td></td>
<td>Developmental</td>
</tr>
<tr>
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<tr>
<td>Water Supplies</td>
<td>Old reservoirs and water treatment plants in need of development. Risk from consumption of contaminated water supplies. Lead in Water Guidance relating to WHO standards 2012.</td>
<td>Regulation and monitoring of private water supplies and ensuring national standards are met. Administer grant assistance scheme for improvement of private water supply quality.</td>
<td>Work with Scottish Water to ensure regular sampling and monitoring of supply and distribution system Advice on medical aspects of risk to individuals and groups.</td>
<td>Investigation of water related infections and contaminants of drinking water supply. A Health Protection Joint Liaison Subgroup on private water supply.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Food Safety</td>
<td>Reduction in food poisoning. Ensure food ingredients are safe and food appropriately labelled to ensure vulnerable people are protected (e.g. — allergens)</td>
<td>Inspection of food premises. Inspection of production facilities for hygiene and composition. Sampling of food to check for compliance with standards. Promotion of good hygienic practice. Promotion and information on labelling/composition</td>
<td>Advice on medical aspects on request. Linkages to promotional work on hygienic practices and other food related issues. Expert advice on potential health effects arising from conditions found.</td>
<td>Investigation and control of foodborne infectious disease incidents and outbreaks</td>
<td></td>
</tr>
<tr>
<td>Food hygiene and food standards</td>
<td>Food is a potential vehicle for transmission of infectious diseases.</td>
<td>Implement an effective inspection programme based on a risk based approach including adherence to inspection/sampling/ audit programmes, provision of food hygiene and food safety training to business community. There is adoptive not required participation in national campaigns as promoted by FSA, investigation of food</td>
<td>Promote hand washing practice and food hygiene to members of the general public during incidents.</td>
<td>Participate in investigation of incidents and outbreaks of food borne and gastrointestinal infections.</td>
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</tr>
</tbody>
</table>

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<tr>
<td>TB services</td>
<td>Increasing numbers of TB cases, drug resistance, poor compliance amongst vulnerable groups such as people who are homeless, or with problematic alcohol and/or drug use.</td>
<td>Provision of housing to vulnerable groups Investigation of accommodation standards</td>
<td>Identify, investigate and treat cases and contacts, offer BCG vaccination. NHS Lothian is currently implementing Scotland TB plan and the piloting and evaluating of a web based TB surveillance system for Scotland.</td>
<td>Investigation and management of TB incidents.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Sexual Health and HIV services</td>
<td>Preventing spread of sexually transmitted infections</td>
<td>Licensing of sex shops / establishments Teaching about sexual health and relationships.</td>
<td>Diagnosis, counselling and treatment of cases.</td>
<td>Joint planning for sexual health and HIV – strategy development HIV treatment and care – joint agreement for Milestone House.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Care Settings and Health Improvement, Efficiency, Access Treatment (HEAT) Targets</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Healthcare associated</td>
<td>There is a risk of patients who are free from infection</td>
<td>Food hygiene inspections of hospital catering. Expert</td>
<td>NHS Lothian has plans to achieve a reduction of the investigation of incidents/outbreaks.</td>
<td></td>
<td>Deliverable</td>
</tr>
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<tr>
<td>infections</td>
<td>acquiring it from care institutions when they get admitted for other reasons.</td>
<td>support and advice for healthcare associated infections</td>
<td>rate of <em>Clostridium difficile</em> infections in patients aged 15 and over to 0.25 cases or less per 1,000 total occupied bed days by 2014/15. To further reduce healthcare associated infections so that by 2014/15 NHS Lothian’s <em>staphylococcus aureus</em> bacteraemia (including MRSA) cases are 0.24 or less per 1,000 acute occupied bed days.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Childhood Vaccinations</td>
<td>There is a risk of vaccine preventable diseases to re-emerge or cause outbreaks when the population vaccination coverage is low. Recent examples have been outbreak of measles and mumps.</td>
<td>Education – school and further employment, work with local businesses</td>
<td>NHS Lothian has a childhood immunisation programme that aims to vaccinate at least 95% of children according to national schedules (2011 uptake of MMR at 24 months was 93.5%).</td>
<td>Reservoirs of infection</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Human papilloma virus (HPV) vaccine programme:</td>
<td>HPV infection is responsible for the development of almost all cases (90+%) of cervical cancer, effective against the two strains. HPV vaccines are s of the virus. The HPV vaccine for girls aged 12 to 13 years is aimed at protection against 70% of cervical cancers.</td>
<td></td>
<td></td>
<td></td>
<td>Deliverable</td>
</tr>
<tr>
<td>Viral hepatitis</td>
<td>Prevention of BBV in drug</td>
<td>Regulation of tattooing and</td>
<td>NHS Lothian actions outlined</td>
<td>Social worker involvement in</td>
<td></td>
</tr>
</tbody>
</table>

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<tr>
<td>Pandemic Influenza</td>
<td>A pandemic is one of the most severe national challenges likely to affect Scotland and Lothian. Proportionate planning and drawing on lessons learnt from H1N1 is essential for mitigation of the potential impact of a pandemic.</td>
<td>Develop local plans for response and recovery from a pandemic.</td>
<td>NHS Lothian continues to identify, treat and monitor cases of influenza A(H1N1) and will ensure arrangements are in place to offer vaccination to the Lothian population against this virus as appropriate.</td>
<td>Participate in Local and Regional Resilience Partnership pandemic planning process.</td>
<td>Sustainable</td>
</tr>
<tr>
<td>Public Health (S) Act 2008</td>
<td>Sharing information is essential for effective implementation of health protection interventions.</td>
<td></td>
<td>NHS Lothian has arrangement for ensuring that Health professionals employed or contracted have the training and support necessary to allow them to balance their responsibilities for patient confidentiality, with public safety and health protection when sharing information.</td>
<td>Regularly review effectiveness of arrangement for information sharing between NHS Lothian and local authorities.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Provision of Improper or delayed disposal</td>
<td></td>
<td>Arrangement for disposal of</td>
<td>Advice on health risks in</td>
<td>Joint investigations as</td>
<td>Developmental</td>
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<tbody>
<tr>
<td>Mortuaries</td>
<td>of dead bodies can result in spread of infection</td>
<td>dead under National Assistance Act provisions.</td>
<td>relation to contaminated/infected bodies.</td>
<td>necessary</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Provision of mortuary facilities</td>
<td></td>
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Mortuaries of dead bodies can result in spread of infection. Provision of mortuary facilities necessary.
### Appendix II: Joint Health Protection Action Plan

<table>
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<tr>
<th>Reference Section</th>
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<th>Timescale</th>
<th>Outcome</th>
<th>Priority Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The steering group will continue to oversee the implementation of the plan.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Regular review of planned activities</td>
<td>Deliverable</td>
</tr>
<tr>
<td>1</td>
<td>Ensure implementation and compliance with all the requirements within the act</td>
<td>DPH/Chief EHO and Lead CPHM and respective teams</td>
<td>Annual</td>
<td>Implement all aspects of the new act according to the law.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>2.2</td>
<td>Investigate of assertions of risk and assessment of impact of remediation measures.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Adequate risk assessment and risk management carried out</td>
<td>Deliverable</td>
</tr>
<tr>
<td>2.2</td>
<td>Investigate contaminated land and take action to ensure health risks are eliminated or adequately reduced.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Adequate risk assessment and risk management carried out</td>
<td>Deliverable</td>
</tr>
<tr>
<td>2.2</td>
<td>Carry out health impact assessments of greenspace, transport policy and strategy proposals, planning policies and joint work on scope of SEAs</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>HIA reports available to inform policy and planning</td>
<td>Developmental</td>
</tr>
<tr>
<td>4.1</td>
<td>Health Impact Assessments of housing development and regeneration schemes.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>HIA reports available to inform housing policy</td>
<td>Developmental</td>
</tr>
<tr>
<td>4.1</td>
<td>Address underlying and long term issues through planning and delivery of services in partnership through the Smoking &amp; Health, Alcohol and Drug Partnerships (ADPs) and Community Safety Partnerships.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Declining substance misuse rates and associated long term issues</td>
<td>Sustainable</td>
</tr>
<tr>
<td>4.1</td>
<td>Investigation and control of pest related diseases zoonotic disease related to dogs.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Reduced pest incidents and zoonotic diseases</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Reference Section</td>
<td>Action</td>
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<td>Outcome</td>
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</tr>
<tr>
<td>4.1</td>
<td>Follow up complaints and investigate nuisance that affect public health.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Reduced complaints associated with nuisances.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.3</td>
<td>Reduce risk of disease entering country via ports by responding to airport call outs, ship sanitation inspection and vermin control.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Prompt response to port health call out</td>
<td>Sustainable</td>
</tr>
<tr>
<td>4.3</td>
<td>Develop and test emergency plans for mass gathering including national and international events such as games and sports and the Hogmanay plans prior to the season starting.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Event health emergencies adequately handled</td>
<td>Sustainable</td>
</tr>
<tr>
<td>4.3</td>
<td>Participate in multiagency climate change mitigation emergency plans such as flood plans. Develop plans in line with Scottish Govt Climate Change Adaptation framework 2012</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>On-going</td>
<td>Continuous mitigation of environment impact arising from climate change</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.3</td>
<td>Participate in multiagency radiation exercises and planning events.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Two-yearly</td>
<td>Staff capacity and resilience for response to radiation incidents improved</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.3</td>
<td>Participate in multiagency air quality exercises and planning events and consultations on air quality action plans.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Effective response to air quality incidents</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.4</td>
<td>Ensure that lessons learnt from incidents and outbreak informs the development and review of plans.</td>
<td>DPH/Chief EHO and Lead CPHM and respective teams</td>
<td>Annual</td>
<td>Plans and SOPs are suited to local needs.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.2.2</td>
<td>Joint planning for sexual health and HIV – strategy development HIV treatment and care – joint agreement for</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Joint sexual health and HIV strategy in place and used.</td>
<td>Deliverable</td>
</tr>
<tr>
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<tr>
<td>Milestone House.</td>
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<tr>
<td>4.2.2</td>
<td>Involve social workers in hepatitis Managed Clinical Networks. Joint working via alcohol and drug action teams</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Social workers participate in Hepatitis MCN</td>
<td>Deliverable</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Participate in multiagency exercises and planning events.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Continuous improvement of staff capacity and resilience</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5</td>
<td>Draw up joint plans for the investigation and control of incidents and outbreaks and audits</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Dec 2014</td>
<td>Plans in place and applied</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.1</td>
<td>Share lists of competent persons as required by the act</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Agencies have up-to-date lists of competent persons for Lothian</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.1</td>
<td>Appoint and review competent persons list.</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Sufficient numbers of competent persons within agencies</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.5</td>
<td>Hold major incident plan exercise (joint LA/ NHS Lothian) Regularly exercise key health protection plans including GI and food incidents and the major incident plan.</td>
<td>PH/EHO/Med/Vet/ SW liaison group</td>
<td>Annual</td>
<td>Update of plans based on exercises. Staff trained during exercises.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.5</td>
<td>NHS Lothian and the Local Authorities will keep Standard Operating Procedures (SOPs) under review, including developing and reviewing procedures up-to-date in relation to the Public Health etc (Scotland) Act 2008 duties.</td>
<td>Health Protection Joint Liaison group</td>
<td>Annual</td>
<td>Staff working with updated SOPs</td>
<td>Deliverable</td>
</tr>
<tr>
<td>5.5</td>
<td>Review Lothian Joint Health Protection Plan (2014-16)</td>
<td>DPH/Chief EHO and Lead CPHMNHS</td>
<td>April 2016</td>
<td>Revised plan in place and up-to-date.</td>
<td>Sustainable</td>
</tr>
<tr>
<td>5.6</td>
<td>Developing joint training opportunities, particularly in relation to the Public Health etc (Scotland) Act</td>
<td>DPH/Chief EHO and Lead CPHM</td>
<td>Annual</td>
<td>Joint training taking place.</td>
<td>Deliverable</td>
</tr>
<tr>
<td>Reference Section</td>
<td>Action</td>
<td>Responsibility</td>
<td>Timescale</td>
<td>Outcome</td>
<td>Priority Level</td>
</tr>
<tr>
<td>-------------------</td>
<td>--------</td>
<td>----------------</td>
<td>-----------</td>
<td>---------</td>
<td>----------------</td>
</tr>
<tr>
<td>2008 duties.</td>
<td>Joint Liaison group</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.6.2</td>
<td>NHS Lothian and the Local Authorities will keep training requirements under review, including for competent persons and investigator knowledge and skills, developing joint training opportunities, particularly in relation to the Public Health etc (Scotland) Act 2008 duties.</td>
<td>Health Protection Joint Liaison group</td>
<td>Annual</td>
<td>List of training requirement in place and shared with staff</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Assess capacity and resilience to provide health protection services in Lothian</td>
<td>DPH/Chief EHO and Lead CPHM NHS Lothian and LA s</td>
<td>Annual</td>
<td>NHS Lothian and Lothian Local Authorities have sufficient numbers of competent persons and investigators for both in and out of hours interventions</td>
<td></td>
</tr>
<tr>
<td>6.3</td>
<td>Explore and identify new ways of working in response to revised approach to regulation.</td>
<td>DPH/Chief EHO and Lead CPHM NHS Lothian and LA s</td>
<td>Annual</td>
<td>New ways of working identified and applied.</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Develop and implement public involvement activities and how their contribution can be used for improving health protection in all agencies.</td>
<td>Health Protection Joint Liaison group</td>
<td>Annual</td>
<td>Review of plans with consideration of public input.</td>
<td></td>
</tr>
<tr>
<td>5.2, 5.3</td>
<td>Ensure the acquisition and use of appropriate information technology for the investigation and management of outbreaks and incidents</td>
<td>DPH/Chief EHO and Lead CPHM and respective teams</td>
<td>Annual</td>
<td>Accurate recording and reporting of incidents and outbreaks. Timely availability of epidemiologic al information.</td>
<td></td>
</tr>
</tbody>
</table>
### Appendix III: Key health protection plans for the Lothian area

<table>
<thead>
<tr>
<th>Shared Plans</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Scotland Major Incident Plan</td>
<td>N/A</td>
<td>Under development</td>
</tr>
<tr>
<td><strong>East of Scotland Regional Resilience Partnership</strong> Generic Emergency Plan (maintained by SCG Co-ordinator)</td>
<td>05/2011</td>
<td>05/2012</td>
</tr>
<tr>
<td><strong>East of Scotland Regional Resilience Partnership</strong> Pandemic Influenza (maintained by SCG Co-ordinator)</td>
<td>05/2010</td>
<td>Under review</td>
</tr>
<tr>
<td><strong>East of Scotland Regional Resilience Partnership</strong> Community Risk Register</td>
<td>04/2011</td>
<td>Under review</td>
</tr>
<tr>
<td><strong>East of Scotland Regional Resilience Partnership</strong> Public Communications Plan</td>
<td>05/2011</td>
<td>05/2012</td>
</tr>
<tr>
<td><strong>East of Scotland Regional Resilience Partnership</strong> Animal Health Plan</td>
<td>05/2010</td>
<td>Under review</td>
</tr>
<tr>
<td>The City of Edinburgh Council Emergency Plan (General Plan for the Council's response to Serious Emergencies or Major Incidents).</td>
<td>02/2010</td>
<td>Under review</td>
</tr>
<tr>
<td>The City of Edinburgh Council Pipelines Emergency Plan (Statutory Requirement under the Pipelines Safety Regulations)</td>
<td>01/2009</td>
<td>Under review</td>
</tr>
<tr>
<td><strong>Edinburgh Site Specific Response Plan</strong> (maintained by Police Scotland on behalf of East of Scotland Regional Resilience Partnership)</td>
<td>03/2012</td>
<td>05/2013</td>
</tr>
<tr>
<td>NHS Borders Pandemic Influenza Plan</td>
<td>02/2009</td>
<td>Under review</td>
</tr>
<tr>
<td>The City of Edinburgh Council BP Dalmeny Installation Off Site Plan (Statutory Requirement under the Control of Major Accident Hazards Regulations)</td>
<td>12/2011</td>
<td>12/2014</td>
</tr>
<tr>
<td>Joint Port Health Plan</td>
<td>2009</td>
<td>2012</td>
</tr>
<tr>
<td><strong>Police Scotland</strong> Severe Weather plan</td>
<td>07/2011</td>
<td>06/2012</td>
</tr>
<tr>
<td>Scottish Waterborne Hazard Plan</td>
<td>07/2010</td>
<td>02/2012</td>
</tr>
<tr>
<td>The City of Edinburgh Council Emergency Flooding Plan (To be replaced by a joint Police Scotland/City of Edinburgh Council Flooding Emergency Plan in next few months.)</td>
<td>11/2011</td>
<td>11/2012</td>
</tr>
<tr>
<td>Sporadic food and gastrointestinal infection incidents plans</td>
<td>2009</td>
<td>2012</td>
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<tr>
<td>Blue Green Algae in Inland Waters Assessment and Control etc. Plan</td>
<td>2009</td>
<td>2010</td>
</tr>
<tr>
<td>Shared Waste Water Incident Plan</td>
<td>2009</td>
<td>07/2012</td>
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<table>
<thead>
<tr>
<th>Lothian</th>
<th>Joint Health Protection Plans</th>
<th>Approved: 1 April 2014</th>
</tr>
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<tr>
<td></td>
<td></td>
<td>Revision due: March 2016</td>
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</table>
### NHS Lothian

<table>
<thead>
<tr>
<th>Plan</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Lothian Major Outbreak Plan for Lothian</td>
<td>2009</td>
<td>Under review</td>
</tr>
<tr>
<td>NHS Lothian Major Incident Strategic Response Plan</td>
<td>2012</td>
<td>Under review</td>
</tr>
<tr>
<td>Contingency Plan for Pandemic Influenza: Strategic Policy</td>
<td></td>
<td>March 2012</td>
</tr>
<tr>
<td>NHS Lothian and Port Health Authority Procedure for cases of illness in vessels arriving at Leith and other anchorages in Lothian</td>
<td></td>
<td>Under review</td>
</tr>
<tr>
<td>NHS Lothian and Port Health Authority Procedure for cases of illness in aircraft arriving in Edinburgh</td>
<td>09/2010</td>
<td>Under review</td>
</tr>
<tr>
<td>Drug and Alcohol Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The Sexual Health and Blood Borne Virus Framework</td>
<td>2011</td>
<td>2015</td>
</tr>
<tr>
<td>NHS Lothian Standard Operating procedures for specific diseases including meningitis, E.coli O157.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### City of Edinburgh Council

<table>
<thead>
<tr>
<th>Plan</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>The City of Edinburgh Council Emergency Plan (General Plan for the Council's response to Serious Emergencies or Major Incidents)</td>
<td>03/2012</td>
<td>Under review</td>
</tr>
<tr>
<td>The City of Edinburgh Council Pipelines Emergency Plan (Statutory Requirement under the Pipelines Safety Regulations)</td>
<td>04/2012</td>
<td>Under review</td>
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<tr>
<td>The City of Edinburgh Council BP Dalmeny Installation Off Site Plan (Statutory Requirement under the Control of Major Accident Hazards Regulations)</td>
<td>12/2011</td>
<td>12/2014</td>
</tr>
<tr>
<td>Corporate Business Continuity Plan</td>
<td>10/2010</td>
<td>Under review</td>
</tr>
<tr>
<td>Business Continuity Pandemic Flu Plan</td>
<td>07/2009</td>
<td>Under review</td>
</tr>
<tr>
<td>Severe Winter Weather Business Continuity Plan</td>
<td>12/2012</td>
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### West Lothian Council

<table>
<thead>
<tr>
<th>Plan</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
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</thead>
<tbody>
<tr>
<td>West Lothian Major Incident Plan</td>
<td>2013</td>
<td>2016</td>
</tr>
<tr>
<td>Severe Weather Plan</td>
<td>2011</td>
<td>2014</td>
</tr>
<tr>
<td>Major Accident Hazard Pipelines Emergency Plan</td>
<td>2013</td>
<td>2016</td>
</tr>
<tr>
<td>Control of Major Accident Hazard Off Site Emergency Plan</td>
<td>2013</td>
<td>2016</td>
</tr>
<tr>
<td>Livingston Shopping Centre Emergency Plan</td>
<td>2009</td>
<td>2014</td>
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</tbody>
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**Lothian Joint Health Protection Plans**

Approved: 1 April 2014
Revision due: March 2016
<table>
<thead>
<tr>
<th>Plan Description</th>
<th>Last Review Date</th>
<th>Next Review Date</th>
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<tbody>
<tr>
<td>East Lothian Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business Continuity Plan</td>
<td>2012</td>
<td>2014</td>
</tr>
<tr>
<td>Torness Off Site Emergency Plan</td>
<td>2012</td>
<td>2014</td>
</tr>
<tr>
<td>Corporate Emergency Plan</td>
<td>2012</td>
<td>2014</td>
</tr>
<tr>
<td>Chemical Incident Response</td>
<td>2009</td>
<td></td>
</tr>
<tr>
<td>Oil Pollution Plan</td>
<td>2009</td>
<td>2014</td>
</tr>
<tr>
<td>Severe weather response plan</td>
<td>2013</td>
<td>2014</td>
</tr>
<tr>
<td>Pipeline Plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rabies Emergency Plan</td>
<td>2009</td>
<td>2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian Council</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian Registered Care Homes Stage 2 Plan</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Midlothian Council Business Continuity Plans</td>
<td>2012</td>
<td>2014</td>
</tr>
<tr>
<td>Recovery Plan*</td>
<td>2012</td>
<td>2014</td>
</tr>
<tr>
<td>Midlothian Council's Registrars Emergency Plan</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Fuel Plan</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>LBSCG Pandemic Influenza guidelines</td>
<td>??</td>
<td>??</td>
</tr>
<tr>
<td>Midlothian Council Avian Flu Plan</td>
<td>20??</td>
<td>20??</td>
</tr>
<tr>
<td>Midlothian Council Severe Weather Plan</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>Pipeline plan</td>
<td>2013 current review</td>
<td>2015(tbc)</td>
</tr>
<tr>
<td>Midlothian Council Food Service Plan</td>
<td>2012</td>
<td>2013</td>
</tr>
<tr>
<td>LBSCG Disease of Animals Plan</td>
<td>2010</td>
<td>2013</td>
</tr>
<tr>
<td>Rabies Outbreak Contingency Plan</td>
<td>2010</td>
<td>2013</td>
</tr>
</tbody>
</table>
### Appendix IV: Significant public health incidents or outbreaks 2012-2013

**NHS Lothian**

**Business Continuity:**

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pandemic Flu</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Chemical / radiological and biological</strong></td>
<td></td>
</tr>
<tr>
<td>Chemical Incident at Pallet Factory near hospital – Denatonium Benzoate</td>
<td></td>
</tr>
<tr>
<td>Tyre Fire in quarry – SEPA investigation in to black deposits landing on cars, children, cats and dogs etc.</td>
<td></td>
</tr>
<tr>
<td>Cryptosporidium – cases had all attended city farm to pet baby lambs.</td>
<td></td>
</tr>
<tr>
<td>Legionnaires’ Disease outbreak – cooling towers investigated</td>
<td></td>
</tr>
<tr>
<td>Cyanide contaminated body</td>
<td></td>
</tr>
<tr>
<td>Chemical suicide in city hotel</td>
<td></td>
</tr>
<tr>
<td>Chemical spill at hospital</td>
<td></td>
</tr>
<tr>
<td><strong>Food</strong></td>
<td></td>
</tr>
<tr>
<td>Outbreak of Scombroid Fish Poisoning in Lothian</td>
<td></td>
</tr>
<tr>
<td>Cases of Salmonella branderup linked to Malysian Restaurant</td>
<td></td>
</tr>
<tr>
<td>Salmonella Singapore investigated</td>
<td></td>
</tr>
<tr>
<td><strong>Specific Diseases</strong></td>
<td></td>
</tr>
<tr>
<td>Outbreak of influenza A in nursing home</td>
<td></td>
</tr>
<tr>
<td>Confirmed case of anthrax in Intravenous drug user (IDU)</td>
<td></td>
</tr>
<tr>
<td>Legionella Longbeachae cases relating to compost/topsoil.</td>
<td></td>
</tr>
<tr>
<td><strong>Health Care Acquired Infections (HAI)</strong></td>
<td></td>
</tr>
<tr>
<td><em>Clostridium difficile</em> (CDI) positive, Orthopaedics, RIE</td>
<td></td>
</tr>
<tr>
<td>Incident/Outbreak</td>
<td>Improvement to plans</td>
</tr>
<tr>
<td>------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Pertussis HDU RHSC</td>
<td></td>
</tr>
<tr>
<td>MRSA within ITU at St Johns Hospital</td>
<td></td>
</tr>
<tr>
<td>Norovirus at Liberton Hospital</td>
<td></td>
</tr>
<tr>
<td>Information and advice for contacts of confirmed Carbapenem Resistant Enterobacteriaceae (CRE) and Meropenem Resistant Acinetobacter (MRA) case.</td>
<td></td>
</tr>
<tr>
<td>Information and advice for contacts of confirmed Carbapenem Resistant Enterobacteriaceae (CRE) and Meropenem Resistant Acinetobacter (MRA) case.</td>
<td></td>
</tr>
<tr>
<td>Acinetobacter baumanii, ward 108, RIE</td>
<td></td>
</tr>
<tr>
<td><strong>Blood Borne Viruses</strong></td>
<td></td>
</tr>
<tr>
<td>Lookback exercise due to lapse in Infection Control procedures in dental practice.</td>
<td></td>
</tr>
<tr>
<td><strong>Tuberculosis</strong></td>
<td></td>
</tr>
<tr>
<td>Increase in TB cases and incidents – 26 incident/outbreaks investigated in two years</td>
<td></td>
</tr>
<tr>
<td><strong>Vaccine Related</strong></td>
<td></td>
</tr>
</tbody>
</table>

**City of Edinburgh Council:**

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Environmental (EIA)</strong></td>
<td></td>
</tr>
<tr>
<td>Outbreak of Legionellosis in South West Edinburgh</td>
<td>enhanced joint working, revision of national guidance, partner agencies have reviewed their response and resilience capability</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lothian Joint Health Protection Plans</th>
<th>Approved: 1 April 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revision due: March 2016</td>
</tr>
</tbody>
</table>
### West Lothian Council:

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Environmental (EIA)</strong></td>
<td></td>
</tr>
<tr>
<td>Redevelopment of former Polkemmet Colliery, Whitburn</td>
<td></td>
</tr>
<tr>
<td>Redevelopment of former Riddochhill Colliery, Blackburn</td>
<td></td>
</tr>
<tr>
<td>Upgrading of Newbridge Junction to Bathgate railway</td>
<td>Heavy overnight engineering works in densely populated areas</td>
</tr>
<tr>
<td>Conversion of abandoned railway course / cycle path to operational railway</td>
<td></td>
</tr>
<tr>
<td>Demolition of asbestos clad former ‘Edgar Allen’ Foundry, Bathgate</td>
<td></td>
</tr>
<tr>
<td>Major Fire at Campbell’s Prime Meat, Brock’s Way, Broxburn (May 2009)</td>
<td></td>
</tr>
<tr>
<td><strong>Water</strong></td>
<td></td>
</tr>
<tr>
<td>Major Flooding in Broxburn incident</td>
<td></td>
</tr>
<tr>
<td><strong>Food</strong></td>
<td></td>
</tr>
<tr>
<td>Sudan dye incidents</td>
<td></td>
</tr>
<tr>
<td><strong>Specific Diseases</strong></td>
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</table>

### East Lothian Council:

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chemical / radiological and biological</strong></td>
<td></td>
</tr>
<tr>
<td>Unexploded WW2 grenades Incident at Macmeery school (2013)</td>
<td>Review of procedures undertaken</td>
</tr>
<tr>
<td>Investigation of Legionella in garden compost (2013)</td>
<td></td>
</tr>
<tr>
<td><strong>Environmental (EIA)</strong></td>
<td></td>
</tr>
<tr>
<td>Various localised oil pollution incidents 2012-13</td>
<td>Review of local harbour oil spill response arrangements</td>
</tr>
</tbody>
</table>

### Midlothian Council:

<table>
<thead>
<tr>
<th>Incident/Outbreak</th>
<th>Improvement to plans</th>
</tr>
</thead>
<tbody>
<tr>
<td>Leak of grouting material into the water – Linked to work being carried out on railway</td>
<td></td>
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</tbody>
</table>

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Lothian Joint Health Protection Plans

Approved: 1 April 2014

Revision due: March 2016
<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<td>ACOP</td>
<td>Approved Code of Practice</td>
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<tr>
<td>AIPG</td>
<td>Avian &amp; Influenza Pandemic Group</td>
</tr>
<tr>
<td>APP</td>
<td>Authority Public Protection</td>
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<tr>
<td>AQMA</td>
<td>Air Quality Management Area</td>
</tr>
<tr>
<td>BBV</td>
<td>Blood Bourne Viruses</td>
</tr>
<tr>
<td>CBRN</td>
<td>Chemical Biological, Radiological &amp; Nuclear</td>
</tr>
<tr>
<td>CEC</td>
<td>City of Edinburgh Council</td>
</tr>
<tr>
<td>CHI</td>
<td>Community Health Index</td>
</tr>
<tr>
<td>CNS</td>
<td>Central Nervous System</td>
</tr>
<tr>
<td>COSLA</td>
<td>Convention of Scottish Local Authorities</td>
</tr>
<tr>
<td>CPD</td>
<td>Continuing Professional Development</td>
</tr>
<tr>
<td>CPHM</td>
<td>Consultant in Public Health Medicine</td>
</tr>
<tr>
<td>DPH</td>
<td>Director of Public Health</td>
</tr>
<tr>
<td>EC</td>
<td>European Commission</td>
</tr>
<tr>
<td>ECOSS</td>
<td>Electronic Communication of Surveillance in Scotland</td>
</tr>
<tr>
<td>EHO</td>
<td>Environmental Health Officer</td>
</tr>
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<td>ELC</td>
<td>East Lothian Council</td>
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<td>EMF</td>
<td>Electromagnetic Field</td>
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<td>EPA</td>
<td>Environmental Protection Act</td>
</tr>
<tr>
<td>EU</td>
<td>European Union</td>
</tr>
<tr>
<td>FSA</td>
<td>Food Standards Agency</td>
</tr>
<tr>
<td>GROS</td>
<td>General Register Office for Scotland</td>
</tr>
<tr>
<td>HAI</td>
<td>Healthcare Associated Infection</td>
</tr>
<tr>
<td>HCG</td>
<td>Healthcare Governance Committee</td>
</tr>
<tr>
<td>HEAT</td>
<td>Health Improvement, Efficiency, Access Treatment</td>
</tr>
<tr>
<td>HIV</td>
<td>Human immunodeficiency virus</td>
</tr>
<tr>
<td>HMO</td>
<td>House in Multiple Occupation</td>
</tr>
<tr>
<td>HPS</td>
<td>Health Protection Scotland</td>
</tr>
<tr>
<td>HPT</td>
<td>Health Protection Team</td>
</tr>
<tr>
<td>HPV</td>
<td>Human Papiloma Virus</td>
</tr>
<tr>
<td>HSE</td>
<td>Health and Safety Executive</td>
</tr>
<tr>
<td>IHP</td>
<td>International Health Regulation</td>
</tr>
<tr>
<td>IMT</td>
<td>Incident Management Team</td>
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<tr>
<td>JCVI</td>
<td>Joint Committee on Vaccination and Immunisation</td>
</tr>
<tr>
<td>LBSCG</td>
<td>Lothian and Borders Scottish Co-ordinating Group</td>
</tr>
<tr>
<td>LDP</td>
<td>Local Delivery Plan</td>
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<tr>
<td>LICAC</td>
<td>Lothian Infection Control Advisory Committee</td>
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<tr>
<td>LRP</td>
<td>Local Resilience Partnership</td>
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<td>RIE</td>
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<td>World Health Organisation</td>
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### 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.

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<td>Progress against Health Efficiency Access Treatment Targets</td>
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<td><em>Staphylococcus aureus</em> Bacteraemia (SAB): NHS Lothian’s target by</td>
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<td>March 2015 is to achieve a rate of 0.24 per 1000 acute occupied bed</td>
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<tr>
<td>days (&lt;184 incidences). The current rate is 0.33 (152 incidences).</td>
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<td><em>Clostridium difficile</em> Infection (CDI): NHS Lothian’s target by</td>
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<td>March 2015 is to achieve a rate of 0.32 per 1000 total occupied bed</td>
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</tr>
<tr>
<td>days (&lt;262 incidences). The current rate is 0.51 (245 incidences).</td>
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<td>Norovirus outbreaks: Health Protection Scotland advised that the</td>
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<td>Norovirus Season started on Monday 29th September 2014. Since July</td>
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</tr>
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<td>2014 within NHS Lothian there has been 31 Norovirus Outbreaks.</td>
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</tr>
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<td>Ebola Preparedness: In response to outbreak in Western Africa NHS</td>
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<td>Lothian has set up a Multi-disciplinary Ebola Preparedness Group.</td>
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<td>As of 23 November there have been no positive cases in Scotland</td>
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<td>The Meticillin Resistant <em>Staphylococcus aureus</em> (MRSA) Screening</td>
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<td>Programme: the latest quarterly report issued by Health Protection</td>
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<td>Scotland revealed NHS Lothian’s compliance with the Clinical Risk</td>
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<td>Assessment and swabbing increased to 62% and 78% respectively.</td>
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<td>of July 2014 to 30th of September 2014, 1127 procedures were</td>
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<td>performed and 7 Surgical Site Infections were detected at a rate of</td>
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<td>0.6%.</td>
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<td>Antimicrobial Management Team: a review of the Antibiotic Guidelines</td>
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<td>is being undertaken with an aim to reduce the use of antimicrobials</td>
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<td>associated with <em>Clostridium difficile</em>.</td>
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<td>Healthcare Environmental Inspectorate: The report for the unannounced</td>
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<td>inspections at St Johns Hospital carried out in August 2014 was</td>
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<td>published on 15 October 2014. An Unannounced Inspection was carried</td>
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<td>out at the Western General Hospital on 18-19 November 2014.</td>
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Fiona Cameron  
Head of Infection Prevention and Control Services  
24 November 2014  
fiona.cameron@nhslothian.scot.nhs.uk
HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report
1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection (HAI) across NHS Lothian. Any member wishing additional information should contact the Executive Nurse Director in advance of the meeting.

2 Recommendations
2.1 The Board is recommended to:
   • acknowledge receipt of the Healthcare Associated Infection Reporting Template for October 2014. (Appendix 1)
   • note NHS Lothian’s *Staphylococcus aureus* Bacteraemia March 2015 target is a rate of 0.24 per 1000 bed days (<184 incidences). The current rate is 0.33 (152 incidences). Multidisciplinary effort is required if progress towards target is to be sustained.
   • note NHS Lothian’s *Clostridium difficile* Infection target by March 2015 is to achieve a rate of 0.32 per 1000 bed days (<262 incidences). The current rate is 0.51 (245 incidences). NHS Lothian is currently off trajectory therefore a pan Lothian multidisciplinary effort is essential if target is to be achieved.
   • note the publication of the report from the Vale of Leven enquiry on 24th November 2014.
   • support the Antimicrobial Team activities in relation to Antimicrobial Prescribing Review and reduction of antimicrobials associated with *Clostridium difficile*.
   • Support the delivery of the actions outlined in the report and action plan provided to Corporate Management Team in relation to *Clostridium difficile*.

3 Discussion of Key Issues
3.1 Progress against Health Efficiency Access Treatment (HEAT) Targets March 2015
3.2 *Staphylococcus aureus* Bacteraemia: NHS Lothian’s 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 2015 with a current rate of 0.33. There were 29 episodes of *Staphylococcus aureus* Bacteraemia in October 2014 (3 Meticillin Resistant *Staphylococcus aureus*, 26 Meticillin Sensitive *Staphylococcus aureus*), compared to 24 in September 2014 (4 Meticillin Resistant *Staphylococcus aureus*, 20 Meticillin Sensitive *Staphylococcus aureus*).

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<td>Year Ending 31/3/2015</td>
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* Cumulative to date

3.2.1 Key Messages:
- Health Protection Scotland have stepped down from the monthly *Staphylococcus aureus* Bacteraemia Review Teleconference as processes have now been established. The case reviews will continue at local levels.
- The National Enhanced Surveillance became mandatory on 1st October 2014; the impact to NHS Lothian is minimal as the majority of the enhanced components were previously established within Infection Prevention & Control surveillance.

3.3 *Clostridium difficile* Infection: NHS Lothian’s 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 2015 in patients aged 15 and over, with a current rate of 0.51. There were 32 episodes of *Clostridium difficile* Infection in patients aged 15 or over in October 2014, compared to 30 in September 2014.

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<td>Year Ending 31/3/2015</td>
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<td>245</td>
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* Cumulative to date

3.3.1 Key Messages
- The Corporate Management Team have been provided with a detailed report on the data in relation to CDI and to antimicrobial prescribing. The report also includes an action plan to prevent, control and manage *Clostridium difficile* Infections (Appendix 2). One of the actions is a proposal to change the antimicrobial policy in the acute services.
- NHS Lothian’s rate is 0.51 per 1000 total occupied bed days compared to last published NHS Scotland rate of 0.34.
- Health Protection Scotland Consultant Nurse, at our request, undertook a review of NHS Lothian surveillance processes for identifying new cases and potential cross infections of *Clostridium Difficile*. NHS Lothian was assured appropriate surveillance systems and process for the above are in place.

3.4 Norovirus: on Friday 2 October, Health Protection Scotland advised that the Norovirus Season started on Monday 29 September 2014 and advised that Stay at Home campaign material is available on their website.
Since July 2014 within NHS Lothian there has been 31 Norovirus Outbreaks.

Norovirus outbreaks can be classed as “possible outbreak” where 2 or more possible norovirus infection cases or “confirmed outbreak” where 1 or more confirmed norovirus infection cases in a single care unit e.g. ward. The IPCT may assess patients as possible cases based on the overall presentation of an outbreak.

3.5 Ebola Preparedness: In response to the ongoing outbreak of Ebola Virus Disease in Sierra Leone, Guinea and Liberia, NHS Lothian has set up an Ebola Preparedness Group comprising key departments and disciplines in NHS Lothian and the Scottish Ambulance Service. This complements the national teleconferences which are being led by Scottish Government and Health Protection Scotland. Priority areas in all NHS Lothian sites (eg. Accident and Emergency Departments, Critical Care Units, Laboratories) have been preparing their own area’s response and working to NHS Lothian guidance led by the Regional Infectious Disease Unit. Subgroups have been formed to deal with issues of Personal Protective Equipment for staff and Laboratory Procedures. Regular updates have been sent to front line staff and the Communications Department is leading on developing and maintaining information for staff on the NHS Lothian intranet and public information on the NHS Lothian internet. As of 23 November 2014 there have been no positive cases of Ebola Virus Disease diagnosed in Scotland and the risk of such a case remains low.

3.6 Meticillin Resistant Staphylococcus aureus (MRSA) Screening Programme
The compliance with Clinical Risk Assessment (CRA)-based screening is a level 3 HA1 Key Performance Indicator (KPI). The compliance in NHS Lothian was significantly lower than the Scottish average during 2013/14; 54% compared with the national average of 77%. This resulted in notification to NHS Lothian of this exception and we requested that Health Protection carry out a review of the impact of the method of data submission to determine whether this may have had an impact on the results. NHS Lothian collects the information through electronic surveillance compared to other boards who collect the information manually. Representatives from Health Protection Scotland Informatics Unit undertook a review in October 2014. The overall conclusion is that the secondary use of existing data is the direction of travel within NHS Scotland. Therefore HPS would not advocate changes to the system recommending Infection Prevention & Control continue the work locally to improve completion of the electronic Clinical Risk Assessment form as this would likely improve compliance

The latest quarterly report for NHS Lothian provided by Health Protection Scotland on 2 October 2014 indicated some improvement in compliance. Clinical Risk Assessment has improved from 59% to 62% and swabbing increasing from 66% to 78%.

3.7 Mandatory Surgical Site Infection Surveillance: for the period 1 July 2014 to 30 September 2014 the Surgical Site Infection Reporting System Database identified 1127 procedures (for Caesarean Sections, Hip Arthroplasty and Repair of Neck of Femur) were performed and 7 Surgical Site Infections were detected at a rate of 0.6%. Surgical Site Infection rates for caesarean section (inpatient and post discharge to day 10) for NHS Lothian are marginally up this quarter from 0.5% to
0.8, all were post-discharge infections and were classified as superficial infections. In previous years in NHS Lothian there was typically an increase in infections during this quarter for caesarean sections which was not seen this year since the introduction of Chloraprep skin preparation. Hip Arthroplasty rates are low and remain below the national rate. There were no Surgical Site Infections reported for Repair of Neck of Femur fracture this quarter.

3.8 Antimicrobial Management Team: Clostridium difficile Infections is associated with patients having received antibiotics and particular antibiotics are more likely to be associated with Clostridium difficile Infections. In the acute setting, NHS Lothian’s use of all antibiotics is very similar to the other teaching boards in Scotland. However, use of so-called ‘c.diffogenic’ antibiotics which are Cephalosporins, Clindamycin, Quinolones, Co-amoxiclav and Pipercillin-tazobactam is higher than other boards.

Source: Hospital Medicines Utilisation Database, information extracted 30.9.14 and Scottish Antimicrobial Prescribing Group Primary care Prescribing Indicators, Annual Report 2013-14

As part of the action plan noted in section 3.3.1 the Antimicrobial Management Team are reviewing antibiotic guidelines with an aim to reduce the use of antimicrobials associated with Clostridium Difficile. A proposal has been agreed by the Clinical Management Group to support the introduction of revised guidelines. Infection Control are providing financial support to develop an interactive App to assist medical staff in decision making for prescribing and ensures access to current guidelines.

3.9 Healthcare Environmental Inspectorate: The Healthcare Environment Inspectorate carried out an Unannounced Inspection at St Johns Hospital on 20-21 August 2014 and a return visit on 27 August 2014. The report and associated action plan were published on 15 October 2014. The report identified 4 requirements and 3 recommendations which were addressed in the action plan. The report noted progress and the steps NHS Lothian had taken to address issues promptly from the initial inspection. The Deputy Nurse Director visited St Johns Hospital on 5th November to monitor progress against the action plan. She specifically visited the Emergency Department and reviewed, with the senior staff, their current internal action plan which has been implanted as per schedule with some facilities issues that require finalising. Overall she was satisfied with the improvements and progress being made within the department. She also undertook general observation / visits around uniform policy, hypochlorite solution concentrations and cleanliness / tidiness and can report progress on these issues also being made within the hospital.

The Healthcare Environment Inspectorate carried out an Unannounced Inspection at Western General Hospital on 18-19 November 2014. The draft report will be issued to the Board on 17 December 2014, with the factual accuracy and action plan to be returned to the Inspectorate on 8 January 2015 with the report anticipated to be published on 25 January 2015.

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.

4
• Usage of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
• Based on current trend for *Clostridium difficile* Infection NHS Lothian is not on target to achieve the set Health Efficiency Access Treatment Target.

5 **Risk Register**

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

6 **Impact on Inequality, Including Health Inequalities**

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

7 **Involving People**

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

8 **Resource Implications**

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

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Head of Infection Prevention and Control Services  
24 November 2014  
fiona.cameron@nhslothian.scot.nhs.uk

**List of Appendices**

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian  
Appendix 2: Corporate Management Team - CDI Update
## NHS LOTHIAN

### Staphylococcus aureus Bacteraemia Monthly Case Numbers

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# ROYAL INFIRMARY OF EDINBURGH

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**WESTERN GENERAL HOSPITAL**

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### ST JOHNS HOSPITAL

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**LIBERTON HOSPITAL**

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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
- Royal Edinburgh Hospital
- Royal Victoria Hospital
- St Columba's Hospice
- St Michaels Hospital
- Tippethill Hospital

Staphylococcus aureus Bacteraemia Monthly Case Numbers

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Clostridium difficile Infection Monthly Case Numbers

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OUT OF HOSPITAL INFECTIONS

Staphylococcus aureus Bacteraemia Monthly Case Numbers

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Clostridium difficile Infection Monthly Case Numbers

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NHS LOTHIAN

Corporate Management Team
November 2014

Melanie Johnston
HAI Executive Lead

UPDATE ON CLOSTRIDIUM DIFFICILE INFECTIONS

1 Purpose of the Report

1.1 The purpose of this report is to update the Corporate Management Team on NHS Lothian’s current position with respect to *Clostridium difficile* Infections (CDI) and to outline the improvement actions planned.

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

2 Recommendations

2.1 The Corporate Management Team is recommended to:

- Note that NHS Lothian will fail to meet the Health Efficiency Access Treatment (HEAT) target and that *Clostridium difficile* Infections rates are higher than those elsewhere in Scotland.
- Note the publication date for the Vale of Leven Public Inquiry of 24th November 2014.
- Support the actions outlined in the *Clostridium difficile* Infections action plan.

3 Discussion of Key Issues

Current position:

3.1 At the time of the Vale of Leven outbreak, Lothian had a very similar rate of *Clostridium difficile* Infections to Greater Glasgow and Clyde (approximately 150 *Clostridium difficile* Infections per 100,000 Occupied Bed Days in patients >65 years).

3.2 In common with other boards across Scotland, Lothian then underwent a significant reduction in *Clostridium difficile* Infections. However, over the last few years this reduction has levelled off and has levelled off at a rate that is higher than other boards across Scotland (Figures 1 and 2).

3.3 The Health Efficiency Access Treatment (HEAT) target for Lothian to achieve fewer than 262 *Clostridium difficile* Infections episodes in 2014/15 will not be met as 214 episodes have been recorded between 1st April and 30th September 2014.

3.4 For the latest quarter’s data, Lothian is ‘outside the lines’ of the funnel plot for those >65 years, indicating that the rate is statistically different to the rest of Scotland (Figure 3). In the latest data release, Health Protection Scotland also states that there has been a statistically significant increase in the rate in 15-64 year olds when comparing the most recent year with the previous year.
3.5 *Clostridium difficile* Infections are currently attributed the clinical area where the sample was sent from. The greatest numbers of *Clostridium difficile* Infections cases are reported from Royal Infirmary of Edinburgh, General Practice and Western General Hospital (Figure 4). However, a review of data from Oct. 2013 – Sept. 2014 within Trak suggests that most infections (approximately 70%) are acquired in the acute setting (that is, patients have had a hospital admission in the 12 weeks prior to their positive sample).

3.6 *Clostridium difficile* Infections is associated with patients having received antibiotics and particular antibiotics are more likely to be associated with *Clostridium difficile* Infections. In the acute setting, NHS Lothian’s use of all antibiotics is very similar to the other teaching boards in Scotland. However, use of so-called ‘c.diffogenic’ antibiotics which are Cephalosporins, Clindamycin, Quinolones, Co-amoxiclav and Pipercillin-tazobactam is much higher (Figure 5). Likewise, in primary care, use of all antibiotics is low compared to Scotland overall, whereas use of antibiotics associated with *Clostridium difficile* Infections is higher than Scotland overall (Figure 6).

3.7 The different usage of antibiotics compared to elsewhere probably reflects NHS Lothian’s antimicrobial policy, which recommends use of the drugs more likely to be associated with *Clostridium difficile* Infections. This is different to many of the other boards across Scotland, including Greater Glasgow and Clyde. There are limited data available on compliance with antimicrobial policy and with markers of good ‘antimicrobial stewardship’. Those available suggest that there is room for improvement here particularly on recording the reason for treatment and duration.

3.8 Reliable use of Standard Infection Control Precautions (SICPS) and Transmission Based Precautions (TBPs) are also essential in preventing acquisition of *Clostridium difficile* Infections and transmission to other patients. Data routinely collected by ward staff on hand hygiene show good compliance. However, local work on wards with *Clostridium difficile* Infections (Infection Prevention and Control visits, Microbiology-led *Clostridium difficile* Infections ward rounds) suggests that there is room for improvement in this area. This is supported by the finding of limited spread between patients in a cluster of cases in Royal Infirmary of Edinburgh earlier this year.

**Actions to date:**

3.9 NHS Lothian are working pro-actively with Health Protection Scotland. This has included a review of internal surveillance systems to identify new patients and potential cross infections. HPS were confident in the ability of NHS Lothian for early identification of potential outbreaks.

3.10 Additional work done to date to prevent, control and improve the management of *Clostridium difficile* Infections has included:

| Surveillance          | • Case note review with Clinical teams and Health Protection Scotland of all patients involved in the cluster of *Clostridium difficile* Infections seen in the Royal Infirmary of Edinburgh earlier this year: clinical teams participated in de-brief meetings where lessons learned were shared. Key lessons noted were: |

2
Antimicrobials noted as a contributing factor to acquisition.
To risk assess symptomatic patients prior to results being available.
Inconsistency in the application of both Standard Infection Control Precautions and Transmission Based Precautions.
- Ongoing Microbiology-led *Clostridium difficile* Infections ward rounds with feedback to clinical teams;
- Problem Assessment Groups used in wards where any concern about an increase in cases;
- Preliminary review by Health Protection Scotland of Epidemiological Typing Data identifies sufficient strain diversity to indicate cross transmission is unlikely to be the underlying cause of increased incidence within the health board;

**Education**
- Information gathering to inform 90 day workout on wards 105 and 107 in Royal Infirmary of Edinburgh; The 90 day programme will focus on prevention, control and management of *Clostridium difficile* Infection contributing to an overall reduction in patient harm.
- Awareness sessions to be arranged in November in the three main acute sites, this will include posters and presentations.

**Environment**
- Re-launch of ‘Actichlor Plus’ took place throughout September. 251 members of staff attended education sessions across different sites. New Actichlor Plus posters have also been distributed to clinical areas;

**Antimicrobial Stewardship**
- Review of data in relation to *Clostridium difficile* Infections and antimicrobial prescribing;
- Lunchtime talk and Question & Answers at Royal Infirmary of Edinburgh with video link to both Western General Hospital and St Johns Hospital with the Infectious Diseases consultant from NHS Greater Glasgow & Clyde who led the changes in antimicrobial prescribing following the Vale of Leven outbreak.

**Actions planned:**

3.11 The priority actions are described in Appendix 1. These form part of a broader programme of work which will be captured in a *Clostridium difficile* Infections work plan. This work has started but some of it is likely to require one year to complete as whole system changes are required.

3.12 The measurement framework to accompany this work is envisaged as a more generic 'infection' measurement framework and is being developed. Considering a more generic approach will assist with a move away from organism-specific management and plans and towards the approach advocated in the National Infection Prevention and Control Manual. The framework will include reliability of care and consider the prevention of other infections, which in turn will prevent antibiotics (one of the biggest risk factors for the acquisition of *Clostridium difficile* Infections) from being prescribed initially. The framework will therefore include measures from programmes/teams such as Scottish Patient Safety Programme and the Antimicrobial Management Team.
4 Key Risks

4.1 The key risks associated with the recommendations are:
• Failure to comply with the recommendations resulting in harm and distress to patients.
• Increased cost - average additional resources for inpatients with *Clostridium difficile* Infection is £4,000.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register is currently graded high due to reported incidences of *Clostridium difficile* Infection impacting on negative trend to achieving Health Efficiency Access Treatment Target. The risk register covers *Staphylococcus aureus* Bacteraemia, 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 An impact assessment was carried out with the main findings:
• Advancing age owing to diminishing immune system response resulting in *Clostridium difficile* becoming the predominant enteric pathogen in the over-65s;
• Patients or public with long term chronic conditions are more susceptible if receiving repeated antimicrobial therapy.

7 Involving People

7.1 The development of an Infection Prevention and Control *Clostridium difficile* Infections Work plan outlines a multi-disciplinary approach for the prevention, control and management of *Clostridium difficile* Infection.

8 Resource Implications

8.1 The resource implications for *Clostridium difficile* Infection are:
• Increased length of stay and additional treatment with the estimated cost of an average of £4,000 per patients acquiring *Clostridium difficile* Infection.

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Fiona Cameron
Head of Infection Prevention and Control Services
Fiona.Cameron@nhslothian.scot.nhs.uk

03 November 2014

List of Appendices

Appendix 1: Figures 1- 6
Appendix 2: NHS Lothian Action Plan to Reduce Harm from *Clostridium difficile* Infections
Appendix 1:

Figures 1 and 2: Clostridium difficile Infections episodes in Lothian and Scotland

CDI rates per 100,000 OBDs with confidence intervals for 15-64 years for Lothian and Scotland

CDI rates per 100,000 OBDs with confidence intervals for >65 years for Lothian and Scotland
Figure 3: Funnel plot for Lothian, >65 years (latest quarter’s data) showing *Clostridium difficile* Infections rate per 100,000 OBDs
Figure 4: Pareto Chart of NHS Lothian *Clostridium difficile* Infection, locations with >2 (CDI Oct 2013 – Sept 2014) N = 264

Source: Data provided by NHS Lothian IPCT
C-diffogenic antibiotic use by board (acute teaching hospitals only) - DDDs per 1,000 OBDs

Source: HMUD; Date extracted: 30/09/2014
C-diffogenic antibiotics included: Cephalosporins, clindamycin, quinolones, co-amoxiclav and piperacillin-tazobactam.
Hospitals included: Glasgow west (Gartnavel and Western Infirmary), GRI, RIE, WGH, SGH, Ninewells, ARI).

N.B. There is a known issue with the mis-ordering and costing of certain issues of piperacillin-tazobactam at the WGH in 2010/11. These known errors are corrected in local data, but NSS cannot apply fixes to data which has been submitted to national systems, so 2010/11 4C usage figures are unreliable so have been excluded.
Figure 6: NHS Scotland use of anti-bacterials associated with a higher risk of *Clostridium difficile* infection in primary care by NHS board, proportion of total items, 2008/09 – 2013/14

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Source: Scottish Antimicrobial Prescribing Group Primary care Prescribing Indicators, Annual Report 2013-14
Appendix 2: NHS Lothian’s Action Plan
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<td>IPCN GLx</td>
<td>Oct-14</td>
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<td>Development of CDI management SOP/Pathway</td>
<td>Lead IPCN</td>
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<td>Complete</td>
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<td>Introduction of Clinical Risk Assessment for each CDI patient</td>
<td>IPCT</td>
<td>Nov-14</td>
<td>Testing</td>
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<td>2. Surveillance</td>
<td>Retrospective RCA of a sample of cases since April 2014</td>
<td>IPCT &amp; Additional Support</td>
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<td>Analysis of retrospective RCA findings</td>
<td>IPCT &amp; EE</td>
<td>Nov-14</td>
<td>Measurement framework designed. Analysis to commence in Nov. In progress</td>
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<td></td>
<td>Epidemiological report from samples sent to reference lab for typing in previous 9 months</td>
<td>Health Protection Scotland</td>
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<td>Introduction of Root Cause Analysis for every CDI in-patient to improve learning/prevention and to correctly attribute cases.</td>
<td>IPCT &amp; Clinical Teams</td>
<td>Nov-14</td>
<td>Testing</td>
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<td>Continue CDI Ward Rounds for every CDI in-patient.</td>
<td>IPCT &amp; Clinical Teams</td>
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<td>CDI Ward Rounds ongoing. Data reports to be set up in ICNet by Jan 2015.</td>
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<td>Findings to be collated in ICNet to allow feedback and data reports. This will measure compliance with CDI key prevention and control factors.</td>
<td>IPCT &amp; Clinical Teams</td>
<td>Nov-14</td>
<td>Testing</td>
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<td>Commence monthly review of CDI themes with dissemination of key learning to clinical teams involved in the patients care.</td>
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<td>Jul-14</td>
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<td>Engagement with GPs.</td>
<td>IPCT &amp; Clinical Teams</td>
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<td>Development of RCA letter to be sent for community CDIs, requesting drug history, letters to be sent back to IPCT to add to data analysis systems</td>
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<td>Review available data in relation to CDI, antimicrobials and other risk factors.</td>
<td>EB, JD, LT, FC, NO</td>
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<td>Text improvements to the way data are reported at all levels.</td>
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<td>NHS GDG&amp;C presentation on restricted A by Guidelines</td>
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<td>Oct-14</td>
<td>Complete</td>
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<tr>
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<td>Development of local CDI module to be completed by clinical staff. Completion of module will count as HAI element in eKSF complete.</td>
<td>Lead IPCN</td>
<td>Nov-14</td>
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<td>Re-launch of SICPs &amp; TBP as per National Infection Prevention &amp; Control Manual</td>
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<td>Adhoc education sessions in specific areas</td>
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<td>On-going</td>
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<td>4. SICPs/TBP</td>
<td>Gap analysis of O/Ds infection control audits in comparison to the National Infection Prevention &amp; Control Manual</td>
<td>Lead IPCN &amp; SSIP</td>
<td>Sep-14</td>
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<td>Implement changes to address gaps &amp; move towards National audits for SICPs compliance</td>
<td>Coordinated by Lead IPCN</td>
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<td>Baseline audit required initially. Education &amp; roll out required subsequently for all in-patient areas.</td>
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<tr>
<td></td>
<td>Trial of Integrated Care Pathways for the Patient with Diarrhoea received in Ward 27 at WGH.</td>
<td>IPCT, IC, OEF, Clinical Staff</td>
<td>Dec-14</td>
<td>In progress, education sessions completed in Oct 14, trial in Nov 14, feedback in Dec 14</td>
</tr>
<tr>
<td>5. Environment</td>
<td>Antichlor Plus Refresher Training. Audit to take place in December to assess knowledge gained and products available.</td>
<td>Lead IPCN &amp; Ecolab</td>
<td>Dec-14</td>
<td>Initial training done, review in Dec for follow up.</td>
</tr>
<tr>
<td></td>
<td>Publish revised Cleaning Matrix</td>
<td>Robert Arsen</td>
<td>Dec-14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Review of existing cleaning schedule template as part of 90 Day Workout</td>
<td>IPCT, IC, OEF, Clinical Staff, Patient Safety</td>
<td>Nov-14</td>
<td></td>
</tr>
<tr>
<td>6. Antimicrobials</td>
<td>Review antibiotic policy &amp; associated tools to improve antimicrobial stewardship</td>
<td>AMT</td>
<td>TBC</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Stewardship</td>
<td>To be discussed at CMG in Nov. Planning/education/implementation of any change required further work &amp; discussion.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Discussion with GPs on CDI risk factors and prescribing habits</td>
<td>IPCT</td>
<td>May-14</td>
<td>Complete</td>
</tr>
<tr>
<td></td>
<td>Better links between IPCT &amp; Anti-microbial team, e.g. Commence PCN representation in</td>
<td>IPCT</td>
<td>Oct-14</td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMT meeting &amp; presentation of RCA data</td>
<td></td>
<td>Ongoing</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scoping work to improve PRP prescribing</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>AMT audit nurse support in the completion of RCAs for CDI</td>
<td>SE</td>
<td>Dec-14</td>
<td>Ongoing</td>
</tr>
</tbody>
</table>
The draft minutes of the meeting held on 29 September 2014 are attached.

The Board is referred to the minutes of the meeting, but key items for noting by the Board in this report are:

**Risk Reporting / Risks OUTSIDE of Board Approved Risk Appetite**
The reporting framework has developed well, and a short “dashboard” will be reported to the Board. The Board is asked to take particular note of those risks that are outside of the Board approved risk appetite, as these are key items for Board review, challenge and discussion.

**Current Risks Escalated to the Board** – as they are outside of the Board approved risk appetite are:

<table>
<thead>
<tr>
<th>Risk</th>
<th>Target / Tolerance</th>
<th>Current Status</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>SAB Trends Low Risk Appetite</td>
<td>Achieve 184 or lower by 3/15</td>
<td>RED – already 84</td>
<td></td>
</tr>
<tr>
<td>C.Diff Infections Low Risk Appetite</td>
<td>Achieve 262 or lower by 3/15</td>
<td>RED – already 146 (at July)</td>
<td></td>
</tr>
<tr>
<td>Patient Care Low Risk Appetite</td>
<td>95% rate their care experience as good or very good (Tol 93-95)</td>
<td>RED – 91%</td>
<td>? consider target ?</td>
</tr>
<tr>
<td>Delayed Discharges Low Risk Appetite</td>
<td>No patient waits more than 14 days by April 2015. Tolerance 13-14.</td>
<td>RED – 119 Days</td>
<td></td>
</tr>
<tr>
<td>Delayed Hospital Discharges Low Risk Appetite</td>
<td>No patient waits more than 28 days by April 2015. Tolerance 26-28</td>
<td>RED – 83 Days</td>
<td></td>
</tr>
<tr>
<td>Stroke Unit Admission Low Risk Appetite</td>
<td>90% admitted to stroke unit on day of admission Tolerance 85-90%</td>
<td>RED – 60%</td>
<td></td>
</tr>
<tr>
<td>Financials Medium Risk Appetite</td>
<td>YTD overspend no more than 0.1% of core budget</td>
<td>RED – 0.9%</td>
<td></td>
</tr>
</tbody>
</table>

**Internal Audit – Resourcing**
The Committee approved the proposal to outsource Management of the Internal Audit Function as an interim arrangement pending a decision on full outsourcing to either National Shared services or an external Professional firm. In the meantime an interim Chief Internal Auditor and Audit Manager will be contracted to manage the internal team.

**Internal Audits**
The new system of rating internal audits applied from this meeting, together with a new system for releasing “accepted” internal audits to be published.

The Board should note that three audits had a red rating:
- Complaints
- Physical Security
- Recruitment
Of most concern are the ongoing deficiencies in the complaints process, where it is acknowledged that the key drivers relate to insufficient resource and a potential changeover of systems. In the meantime concerns have been escalated to both the staff governance committee (in respect of resources and staffing) and also Information governance committee (in respect of identifying whether there is a possible data protection breach in relation to data held).

The Chairman of the Committee has escalated his concerns regarding Complaints generally to the Board Chair.

Jeremy Brettell
Committee Chairman: September 2014.
Minutes of the Audit & Risk Committee Meeting held at 9.00 am on Monday, 29 September 2014 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr J Brettell (in the Chair); Mr M Ash; Councillor D Grant; Councillor R Henderson and Councillor C Johnstone.

In Attendance: Ms J Bennett (Clinical Governance & Risk Manager); Mr A Boyter (Director of Human Resources & Organisational Development); Mr D Gillan (Head of Soft Facilities Management); Mrs S Goldsmith (Director of Finance); Mr B Houston (Chairman); Ms D Howard (Head of Financial Control); Mr D McConnell (Audit Scotland); Mr A Payne (Corporate Governance Manager); Mr D Proudfoot (Deputy Chief Internal Auditor); Professor A Timoney (Director of Pharmacy); Mr S Wilson (Director of Communications); and Miss L Baird (Committee Administrator).

Apologies for absence were received from Mr Lodge, Mr Marriott, Dr McCallum and Ms McDowell.

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

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

23 Minutes of the Previous Meeting

23.1 Minutes of the previous meeting held on 23 June 2014 – The Committee approved the circulated minutes as a correct record.

24 Matters Arising

24.1 Matters Arising from the Meeting of 23 June 2014 – the Committee received the paper detailing the matters arising from the Audit & Risk Committee meeting held on 23 June 2014, together with the action taken and the outcomes.

24.2 Mr Payne advised that an update on the Staff Governance Committee being provided with the Board’s corporate risk register would come to the next meeting. He advised that progress had been delayed due to the timing of meetings of that Committee.

24.3 The Committee accepted the Running Action Note.
25 Risk Management

25.1 NHS Lothian Corporate Risk Register Update

25.1.1 Ms Bennett gave a detailed overview of the report. She drew the Committee’s attention to the changes made to date, and advised that both the Healthcare Associated Infection risk (risk ID: 1076) and Unscheduled care risk (risk ID: 3203) are being considered for increasing the risk level given the current performance situation.

25.1.2 In response to Mr Ash’s concerns surrounding the integrated care fund, previously the change fund, Ms Bennett agreed to highlight the issue to the Risk Management Steering Group, and request that they consider it as an emerging risk.\[JB\]

25.1.3 The Committee discussed the four “Very High” risks associated with the Astley Ainslie Hospital within the Edinburgh Community Health Partnership Risk Register. Ms Bennett advised the Committee that the Risk Management Steering Group had concluded that there were mitigating measures and controls were in place, and therefore the risk exposure was acceptable. The Committee agreed that a residual risk of “Very High” should never be regarded as acceptable. The Committee also questioned why the “current risk level” for those risks on the risk register, which is presumed to be the residual risk, was scored as “Very High” if management have judged that there are mitigating measures and controls in place. There appears to be an inconsistency.

25.1.4 Ms Bennett agreed to:

- Determine how the Risk Management Steering Group assesses risks against the Board’s newly developed Risk Appetite and Tolerances in order to reach a conclusion on the acceptability of any given risk. It was agreed that the management must operate within the Board’s Risk Appetite.\[JB\]
- Revisit the reported “current risk level” of each risk with the relevant managers, to ensure that risk registers properly reflected the residual risk.\[JB\]

25.1.5 The Committee noted that the risk “Achievement of National Waiting Times Targets” (Risk ID: 3211) has had a constant risk level of High (with a score of 12). However the Board’s performance on waiting times has been on a deteriorating trend. The Committee requested that the risk score be reviewed by management in light of the trend in performance.\[JB/JC\]

25.1.6 The Committee agreed that future reports going to the Board should present the current position against the Board’s risk appetite at the start of the paper. For any measures where the performance leads to a status of RED, there should be a short and clear summary of the action being taken to bring performance back within the Board’s risk appetite.\[JB\]

25.1.7 The Committee agreed that future reports to the Board should highlight the Top 3 risks, explain whether mitigation of the risk is actually achievable, and if mitigation is not possible, then the risks should be immediately taken to the Risk Management Steering Group for its review.\[JB\]
25.1.8 The Committee agreed to accept the report, and welcomed the continued improvement in risk management reporting.

25.2 Litigation Annual Report 2013/14

25.2.1 Ms Bennett introduced the previously circulated litigation annual report. The Committee asked if there was an apparent reason why the number of new clinical cases had increased from 54 in 2012/13 to 80 in 2013/14. Ms Bennett advised that the numbers can vary from one year to the next in the normal run of events, however it is possible that a rise in mesh claims could in part explain the increase in 2013/14. 

25.2.2 The Committee asked Mr Payne agreed to refer this matter to the Chair of the Healthcare Governance Committee, to gain assurance that the Healthcare Governance Committee is satisfied that it has adequate systems in place to monitor and understand any trends in the causes of claims. AP/MB

25.2.3 The Committee agreed to accept the report.

26 Internal Audit Reports

26.1 Internal Audit - Progress Report September 2014

26.1.1 Mr Proudfoot gave a brief overview of the report and highlighted that the audit plan for 2013/14 was complete, while good progress is being made with the audits in the plan for 2014/15. He went on to advise that Internal Audit had amended the control objectives within the proposed Clinical Governance Audit to better reflect current clinical governance practices.

26.1.2 Following concerns raised at the previous Committee meeting, that 69% of management actions were over their target date, Mr Proudfoot advised that the situation had improved and of 56 management actions outstanding at 15 September 2014, 27% of those actions had passed their target date. The Committee noted the positive action taken to reduce the number of overdue management actions.

26.1.3 Noting the forthcoming audit on Compliance with Policies and Procedures, and in response to a query about the large number of NHS Lothian policies, Mr Payne advised the Committee about significant work completed following the previous audit, mainly through the development and introduction of mandatory policy packages. Also, the Chief Executive, Director of Finance and Mr Payne had met with Mr Proudfoot and agreed that the audit scope, would focus on operation of the mandatory policy packages while taking account of the Board’s risk appetite.

26.1.4 The Chair requested that, if appropriate, Mr Proudfoot consider including unavailability data and checks carried out by NHS Lothian within the scope of the NHS Waiting Times Arrangements – Sampling & Checking audit. DP

26.1.5 The Committee accepted the Internal Audit Progress Report – September 2014.
26.2 Internal Audit - Reports with Amber or Green Ratings

26.2.1 Mr Proudfoot introduced this report, being the first since the grading system for audit reports had been changed to RED/ AMBER/ GREEN (starting with the 2014/15 audit plan).

26.2.2 The report included Property Transactions (June 2014) – GREEN and DATIX System (June 2014) – AMBER. Mr Proudfoot noted there were no specific issues within the reports to be highlighted to the Committee.

26.2.3 Mr Proudfoot highlighted that two reports with a “Requires Improvement” opinion (from 2013/14 audit plan) were being presented in full at today’s meeting. However, under the new scoring system, the audit reports would have been given an AMBER rating and would have been presented in summary only. In recognising the Committee’s previous agreement that audit reports would be routinely published on the Board’s website (from 2014/15 plan and once reports had been accepted by the Committee), Mr Proudfoot highlighted a risk that the Committee may not be fully aware of significant issues included within reports published.

26.2.4 Following discussion, the Committee agreed that for its next two meetings, any AMBER reports should be presented in full. The Committee would then review its requirements in light of the experience of the volume of papers, and the issues being raised in the reports. DP

26.2.5 The Committee agreed that for RED reports, the minute of the Committee’s consideration of the report should be included in the published version of the report. DP

26.2.6 The Committee agreed to accept the report.

26.3 Internal Audit – Complaints June 2014

26.3.1 Mr Proudfoot gave a brief overview of the complaints report, which had been rated RED. He highlighted that though there was general compliance with Scottish Government guidance and instructions, significant weaknesses had been identified within the overall control framework, in particular relating to the investigation process and the quality of responses to complainants.

26.3.2 Mr Boyter and Mr Wilson provided the Committee with details of actions being taken to address the issues in the report. Following discussion it was agreed that:

- The Committee would not accept this report as a final report.
- The “Management Action” in Issue 1 is to be revised and enhanced to fully reflect the actions that have been taken already along with those planned, with the revised report to be brought to the next Committee meeting. DP/AB
- Mr Boyter will test the new complaints system against a sample of previous complaints that could have been handled better. This is to determine whether or not the new system will address the issues that arose in those previous complaints. AB
Mr Wilson left the meeting.


26.4.1 Mr Proudfoot presented the report which had an overall opinion of “Requires Improvement”. He highlighted two key areas for improvement related to full implementation of security service standards across all services as well as better compliance with the Management of Violence & Aggression Policy (in particular, local assessment of risks to staff, patients & visitors).

26.4.2 In responding to the audit report, Mr Boyter explained that violence & aggression is the most significant health & safety risk facing the organisation. He advised that a short life Working Group had taken forward a programme of work in response to an improvement notice from the Health & Safety Executive. The Health & Safety Executive acknowledged that appropriate action had been taken to mitigate the risk surrounding violence and aggression, and closed the improvement notice without the need for a further visit to the Board’s premises.

26.4.3 Members noted that following a review of the physical security standards against the current framework, an action plan had been developed and was to be considered by the Health & Safety Committee in October 2014. The Committee requested that the Health and Safety Committee be asked to provide assurance that it was satisfied with the action plan and timescale for completion.

26.4.4 The Committee agreed to accept the report.

Mr Gillan left the meeting.

26.5 Internal Audit – Recruitment July 2014

26.5.1 Mr Proudfoot presented the report which had an overall opinion of “Requires Improvement”. He highlighted that overall there was a reasonable framework of controls were in place. However, issues were identified relating to the consistent application of procedures, the evidencing of pre-employment checks, and the retention of personal details for longer than required.

26.5.2 The Committee agreed to accept the report. The Committee further agreed that:

- The report be referred to the Staff Governance Committee, to provide assurance that it is content with the issues in the report and the agreed management actions.
- The report be referred to the Information Governance Assurance Group, to consider the potential Data Protection Act issue highlighted by the audit, and to provide assurance from the Group on any necessary actions.

Mr Houston left the meeting.

Mr Houston left the meeting.
26.6  Counter Fraud Services – Referrals and Operations September 2014

26.6.1  Mr Proudfoot introduced the summary of CFS referrals and operations as at September 2014. He advised that 3 referrals and 5 operations were currently open.

26.6.2  The Committee noted that an intelligence alert had been issued following recent referrals related to the right to work within the UK.

26.6.3  The Committee accepted the CFS – Referrals & Operations report subject to Mr Proudfoot providing a redacted report for the Committee’s records.

267  Counter Fraud Checklist 2014/15

26.7.1  Mr Proudfoot requested that the Committee comment upon and approve the draft checklist for 2014/15.

26.7.2  The Committee approved the Counter Fraud Checklist 2014/15.

27  External Audit

27.1  NHS Lothian Annual Report of the 2013/14 Audit

27.1.1  Mr McConnell gave a brief overview of the report, highlighting the key messages detailed therein. He advised that overall it was a positive report that highlighted the key challenges that NHS Lothian faced in terms of financial position and organisational development including integration.

27.1.2  In response to Mr Ash’s request Mr McConnell agreed to widen the scope of future audit reports to include the health and social care aspect of integration.

27.1.3  The Committee agreed to accept the report.

28.  General Corporate Governance

28.1  Store Loss – Cancer Medication Fridge Failure Incident

28.1.1  Professor Timoney gave a brief overview of the incident and action taken to address the issues. She highlighted that as well as the incident at the Western General Hospital, a similar incident with the same model of fridge had occurred previously at the Royal Hospital for Sick Children, however it had not been significant enough to trigger an investigation.

28.1.2  Members noted that procurement had received a letter advising of the fault with this particular model of fridge. It was also noted that the Pharmacy Operations Group had also taken action to implement a rolling programme of preventative maintenance where fridges would be replaced every 2 years.

28.1.3  The Committee endorsed the action taken in response to the failure. Members acknowledged that though processes and systems were followed, a small risk remained. The Committee agreed to accept the report.
28.2 **Overseas Patients’ Debt**

28.2.1 Ms Howard presented this report, which had been prepared in response to a request from the Committee.

28.2.2 The Committee accepted the report as assurance that the Board has satisfactory systems in place to minimise the losses which can be incurred as a result of non-UK resident patients not paying their charges for healthcare.

28.3 **Performance Audit Reports**

28.3.1 Mr Payne presented this paper to advise the Audit and Risk Committee how Audit Scotland national performance reports have been communicated and are being used within NHS Lothian.

28.3.2 Mr Ash queried whether reports that flagged recommendations specifically aimed at NHS Board members would be sufficiently flagged by this process. Mr Payne agreed to look at this aspect further.

28.3.3 Apart from the above query, the Committee accepted the report as assurance that there is an adequate process to make Board members and management aware of Audit Scotland national performance reports.

*Mr Proudfoot left the meeting.*

28.4 **Future Provision of the Internal Audit function.**

28.4.1 Mrs Goldsmith introduced the report. She highlighted the proposed options in the paper for the future provision of the internal audit function. There are two broad options, either provide the function in house, or elect for some form of outsourcing.

28.4.2 The Committee agreed that the preferred option would be to outsource the internal audit function. The Committee acknowledged that further work is required before the long term solution could be determined, i.e. the provider of the outsourced function could be NSS Scotland, or it could be an external firm.

28.4.3 The Committee agreed that an interim solution needed to be put in place to fill vacancies in the current structure. The Committee supported the action already being taken to procure the provision of a Chief Internal Auditor and an Audit Manager as a short term solution.

29. **Any Other Competent Business**

29.1 There were no other items of competent business.
30. Date of Next Meeting

30.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 8 December 2014 at 9:00 in Waverley Gate, Edinburgh. Committee members only were asked to attend by 8.45 for the scheduled 15-minute pre-meeting.

30.2 The members highlighted that there was some confusion as to the date of the meeting scheduled in February 2015. Mr Payne agreed to liaise with Mr Reith to confirm the date and advise the members.
FINANCE & RESOURCES COMMITTEE

The minutes of the meeting held on 27 August 2014 are attached. Key issues discussed included:

- The Committee noted the overview of the 2014/15 year end forecast based on Quarter 1 and that the corporate reserve would be used to achieve breakeven at the end of the financial year. (33.1)

- The Committee endorsed the change to Datix corporate risk 3600: Ensure the Delivery of a Sustainable Financial Framework. (29.2)

- The Committee noted the importance of discussions that had taken place at the recent business continuity event on 15 August 2014 on Delayed Discharge. (31.3)

- Members agreed to approve the business case for the Royal Edinburgh Hospital re-provision following a majority vote. (32.4)

Key issues on the horizon are:

- Members noted that following the slippage of Financial Close and Payment Mechanism for the Royal Hospital for Sick Children and the Department of Clinical Neuroscience Project, progress would be closely monitored through monthly meetings to ensure that financial close remained on target for November 2014. (29.1.1 -29.1.2)

George Walker/Susan Goldsmith
Chair/Executive Lead
NHS LOTHIAN

FINANCE & RESOURCES COMMITTEE

Minutes of the Meeting of the Finance & Resources Committee held at 9:00am on Wednesday 27 August 2014 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr G Walker (Chair); Mrs K Blair; Mr J Brettell; Mr T Davison; Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Mr B Houston; Councillor P Johnson and Dr A McCallum.

In Attendance: Miss L Baird; Mr B Currie (for item 29.1); Mr I Graham; Mr P Gabittas; Professor A McMahon; Mr P Reekie; Mr A Milne (for Item); Mr D A Small and Mr S Wilson.

There were no apologies for absence.

Declaration of Financial and Non-Financial Interest

The Chair reminded members that they should declare any financial and non-financial interests they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

27. Minutes of Previous Meeting

27.1 The previously circulated minutes of the Finance & Resources Committee meeting held 9 July on 2014 were approved as a correct record.

28. Running Action Note

28.1 The Committee received a previously circulated running action note detailing the matters arising from the Finance and Resources Committee meeting held on 9 July 2014, together with the action taken and the outcomes.

28.2 The Committee noted that Professor Timoney would attend the November meeting to make a further presentation on horizon scanning and affordability.

28.3 Members were advised that an overview of the level of resources required for integration would be brought forward to the 12 November 2014 meeting of the Finance and Resource Committee.

28.4 The Committee accepted the previously circulated action note and the information detailed therein.

29. Matters Arising

29.1 Process to Financial Close and Payment Mechanism for RHSC/DCN Project

29.1.1 Mrs Goldsmith gave a brief verbal overview of the process to financial close and
payment mechanism for the Royal Hospital for Sick Children and the Department of Clinical Neuroscience Project. She highlighted that following IHSL failing to achieve the deadline for the RIE interface documentation Financial Close for this Project would be delayed until November 2014.

29.1.2 Members noted that following the slippage a meeting had been convened with partners and progress would be closely monitored through monthly meetings to ensure that financial close remained on target for November 2014.

Councillor Henderson entered the meeting.

29.1.3 Mr Reekie of Scottish Futures Trust and external member of the RHSC/DCN Project Steering Board gave a brief overview of key contractual provisions and their difference from the RIE project. He firstly reiterated that the services to be delivered by the NPD contractor are significantly less than by the PFI contractor at the RIE. Catering and cleaning for example will remain NHSL responsibilities so that the day-to-day visibility and impact of the contractor on visitors, patients and most staff will be lower. Secondly he discussed the robust payment and contractual terms which are again very different from the RIE contract and allow for meaningful financial deductions to be made for sub-standard performance. Poor performing sub-contractors and ultimately the main NPD contract can also be terminated for persistent poor performance. Finally he explained that whilst making changes to buildings in use is generally an expensive and disruptive activity, the SFT contract has improved rights for the Board and pricing transparency to give better value when changes, whether minor or major, are required as they inevitably will be over the life of the building.

29.1.4 The Committee acknowledged the benefits of the appointment of a Contract Manager to the RHSC / DCN Hospital project, in that one of their key role would be to maintain good lines of communication between NHS Lothian, Consort and key stakeholders.

29.1.5 Members recognized the importance of how lessons learnt could be improved upon for the Royal Edinburgh Hospital Project.

29.1.6 Mrs Goldsmith advised the Committee that a further report would be brought to the committee at the point of close.

Mr Reekie left the meeting.

29.2 Action Plan for the Corporate Risk: Ensure the Delivery of a Sustainable Financial Framework

29.2.1 Mrs Goldsmith introduced the paper that advised the Committee of the changes to the risk register that mitigate the risk associated with the delivery of a sustainable financial framework.

29.2.2 The Committee endorsed the change to Datix corporate risk 3600.

29.3 Royal Hospital for Sick Children & Department of Clinical Neurosciences at Little France – Update

29.3.1 The Committee received the previously circulated report. Members noted the specific requirements and wording for the legalised minute outlined in appendix 1.
that supported the contract for delivery.

29.3.2 The Committee agreed to note the wording in appendix 1 and that approval of minor changes required could be delegated the Mr Walker, Chair of the Finance and Resources Committee in the run up to financial close.  

30. **Business Case: St John’s Hospital Dental Decontamination Unit**

30.1 The Committee noted that the upgrading of the dental decontamination unit at St John’s Hospital would ensure that the unit was fit for purpose and compliance would be achieved. It was noted that work had been delayed to accommodate the pharmacy facilities originally not detailed within the plans.

30.2 Members expressed concerns that there appeared to be no linkage between business case and that following the inclusion of additional services at the site the cost of the build had increased significantly. It was noted that additional expanded services available at St John’s hospital benefited the local population and producing savings for the future.

30.3 The Committee were reassured that the infrastructure within St John’s was robust. Mr Walker proposed that Mr Graham bring forward a report on lessons learnt from the St. John’s Business case to a future meeting for consideration.

30.4 The Committee agreed to approve the addendum to the standard business case.

31. **Delayed Discharge in Lothian**

31.1 Professor McMahon introduced a previously circulated report giving an overview of the considerable pressures on NHS Lothian from the high volume of patients currently within delayed discharge. He noted that as at June 2014 there were 439 people in hospital with a delayed discharge and the April-June quarter had seen a 20% increase within delayed discharge from the previous year.

31.2 Members discussed the 4 week HEAT target and the proposed reduction to 2 weeks from April 2015. At present the only health and social care system whom had achieved the 4 week target was West Lothian. Members noted the significant work and commitment required by all health and social care systems as NHS Lothian moves forward with the reduced target.

31.3 The Committee noted the importance of discussions that had taken place at the recent business continuity event on 15 August 2014. Robust action plans had arisen from the event to address the review of health and social care respite, release of capacity through the utilisation of outpatient services, alignment of services and a robust communications program.

31.4 With the development of joint working and the transfer of responsibilities for planning and delivery of health and social care from two distinct organisations to one Integrated Joint Board, members acknowledged the importance of consultation with key partners during the allocation of resources and consideration of the draft regulations. It had been proposed that the resources be considered as a single resource; therefore if either parent bodies overspent it
would be picked up on a 50/50 risk share basis ensuring that neither body is disadvantaged.

31.5 The Committee agreed that the key actions required were the alignment of resources and acute hospital targets as the NHS Lothian moved forward with addressing delayed discharge.

31.6 The Committee agreed to note the previously circulated report on delayed discharge in NHS Lothian and the recommendations therein.

Dr McCallum left the meeting

32. Royal Edinburgh Hospital Re-provision

32.1 The Committee received a detailed presentation on the business case for the Royal Edinburgh Hospital Re-provision. The presentation highlighted the:
- Detailed phase 1 site plan.
- Principle changes to the business case.
- Proposed bed numbers.
- Procurement cost and arrangements.
- Revenue implications.
- Clinical benefits.
- How phase 1 links in to the master plan.

32.2 Members received assurance that clinical staff had been involved in the consultation process and were content with the proposed design.

32.3 Following a lengthy debate surrounding the approval of high cost projects in a time of significant financial pressure it was agreed that Mr Walker and Mrs Goldsmith would devise appropriate language that reflected the Committees concerns to the Board.

32.4 Members agreed to approve the business case following a majority vote. Mr Brettell felt that he was unable to support the approval of the recommendation to the Board in respect of the on-going revenue implications, however, he conceded that the report would go forward as all other members present had agreed to approve the recommendation. The committee agreed to:
- Approve the submission of the FBC to Lothian NHS Board to seek recommendation to proceed to the Scottish Government Health and Social Care Directorates (SGHSCD) Capital Investment Group (CIG).
- Recommend to the Board that, subject to the approval of the Full Business Case by Scottish Government, the approval of the final terms of the Project Agreement and associated contract documentation be delegated to Finance and Resources Committee.
- recommend to the Board that, subject to the approval of the final terms of the Project Agreement and by the Finance and Resources Committee, the signing of the Project Agreement at Financial Close be delegated to the Chief Executive or the Director of Finance for NHS Lothian.
33. Financial Performance

33.1 Quarter 1 Financial Review 2014/15

33.1.1 Mrs Goldsmith introduced the previously circulated report and provided the committee with an overview of the 2014/15 year end forecast based on Quarter 1. She advised the Committee that the corporate reserve would be used to achieve breakeven at the end of the financial year. Flexibility had been achieved from pulling both recurring and non recurring funds.

33.1.3 Members were assured that Mrs Goldsmith and her team would continue to work with Caroline Gardiner, Chief Auditor, Audit Scotland to identify emerging financial concerns as intelligence to inform the financial plan.

33.1.4 The Committee agreed to note the position detailed within the report.

33.2 Quarter 1 Efficiency and Productivity Plan

33.2.1 The Committee noted the previously report on the Quarter 1 Efficiency and Productivity Plan and agreed to accept the recommendations detailed therein.

33.3 Financial Position to 31 July 2014

33.3.1 The Committee noted the previously circulated report overview of the financial position for period 4 of the financial year 2014/15 and accept the recommendations detailed therein.

34. Results from Committee Member Survey

34.1 The Committee accepted the report on the results from the Committee Member survey and the results detailed therein.

35 Property Asset Programme

35.1 St. John’s Hospital Campus Master Planning

35.1.1 Mrs Goldsmith introduced the initial outcome of the ongoing master planning regarding St John’s Hospital. Members noted that the aim of the plan was support the Strategic Plan by providing additional theatre capacity in-house for NHS Lothian. At SJH this specifically meant additional capacity for Head and Neck services with the potential for additional capacity to transfer from other sites to assist with relieving pressure elsewhere and support repatriation from the private sector. In addition the current proposal under development also supports the consolidation of critical care and high dependency beds into one location from the current three on the site maximising services and capacity. The plan proposed that the preferred option would be to build the facility at the rear of the current hospital. Chris Stirling reported that in addition to the main proposed development on the site, the masterplanning process was providing a process for controlling the development of other planning issues on site which need to be taken forward including car park provision which is a significant concern at the site.
35.1.2 Members acknowledged the benefits that would arise from the development, including raising the profile of the hospital and attractive job opportunities that would bring a higher calibre of medical staff to Lothian.

35.1.3 The Committee agreed to note the information detailed within the report and accept the approach taken to progress the action plan.

35.2 Property & Asset Management Investment Programme 2014/15

35.2.1 It was noted noted that the previously circulated report provided the Committee with an update on the property and asset investment programme for the current year.

36. For Information

36.1 Property and Asset Investment Programme 2014/15 Business Case Monitor

36.1.1 The Committee noted the report on the Property and Asset Investment Programme 2014/15 Business Case Monitor for information.

37. Any Other Competent Business

37.1 There were no other items of competent business raised.

38. Date of Next Meeting

38.1 It was noted that the next meeting of the Committee would be held on Wednesday 12 November 2014 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
FINANCE & RESOURCES COMMITTEE

The minutes of the meeting held on 27 October 2014 are attached.

Key issues discussed included:

- The Committee agreed to approve the funds required to complete the Western General Hospital Front Door Services Development Project recognising that the current financial plan for 2015/16 did not balance. (39.56)

Key issues on the horizon are:

- The Committee stressed that a wider Board discussion on priorities for future years would be required. (39.56)

George Walker/Susan Goldsmith
Chair/Executive Lead
Minutes of a special meeting of the Finance & Resources Committee held at 11am on Monday 27 October 2014 in the Telepresence Suite, Waverley Gate, 2-4 Waterloo Place Edinburgh.

Present: Mr G Walker (Chair); Ms K Blair (by teleconference); Dr D Farquharson; Mrs S Goldsmith; Councillor R Henderson; Mr B Houston; Professor J Iredale; Ms M Johnson and Mr P Johnston.

In Attendance: Mr J Crombie (Director of Scheduled Care); Mr I Graham (Director of Capital Planning and Projects); Professor Alison McCallum (Director of Public Health and Health Policy) and Mr P Reith.

Apologies for absence were received from Mr J Brettell and Mr T Davison.

Declaration of Financial and Non-Financial Interest

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

39. Western General Hospital Front Door Services Development Project

39.1 Ms Johnson introduced a previously circulated report together with the standard business case for the Western General Hospital Front Door Services Development Project. The committee noted that the proposals in the business case for the redesign of front door services at the Western General Hospital were intended to ensure safe and effective patient care, prevent unnecessary elective cancellations, improve NHS Lothian’s compliance against the 4 hour emergency access standard and urgently address expected increases in activity and winter pressures in 2014/15 and 2015/16.

39.2 Ms Johnson explained that there was a growing view that the Western General Hospital should be developed as a ‘cool’ site. This concept was not included in the business case which concentrated on the issues around the bed base.

39.3 It was noted that the Royal Infirmary of Edinburgh was still sensitive to changes in patient flow within the system and if the Western General Hospital had problems with increased patient flow and delayed discharges then this impacted on the Royal Infirmary of Edinburgh.

39.4 Ms Johnson emphasised that the proposals were driven by concerns about patient safety. There had been wide ranging discussions with clinicians and staff on ways to improve the throughput and efficiency of the Western General Hospital and these were incorporated in the business case before the committee.

39.5 Ms Johnson advised that the performance of the ‘front door’ and Western General Hospital was associated with poor markers of patient experience across the hospital and figures relating to the period 1 January - 31 July indicated that there was an average of 44 boarders per day, or 6.8% of the funded bed base. In addition there were 391 deferred surgical procedures, 344 patients who were delayed in a critical
39.6 Urgent redesign was therefore now required to ensure the service was fit for purpose and able to meet demand during the winter of 2014/15. It was unlikely that any emergency actions taken for this winter would fully resolve the issues and therefore a broader review of the configuration of Western General Hospital services would be required.

39.7 Ms Johnson apologised that on this occasion it had not been possible to follow normal governance procedures because of the need to urgently develop proposals to address the potential patient safety issues.

39.8 Ms Johnson explained that the preferred solution set out in the business case proposed the creation of a new surgical assessment unit which would see 25 – 30 patients per day and the establishment of an urgent ambulatory care service in the existing ARAU trolley area (day medicine unit).

39.9 In addition, a new GP pre-hospital triage line would be created to route patients to the most appropriate care facility and would allow the scheduling of urgent care for patients on an outpatient or day case basis.

39.10 It was also proposed to expand the existing 21 ARAU bed base to 31 with the creation of 10 additional fast–turnaround assessment beds (acute medicine unit).

39.11 The key outcomes of this work would be improved patient safety, patients being treated sooner by a more appropriate professional and an improvement in performance against the 4 hour standard. In addition, the availability or additional inpatient bed capacity and additional assessment / treatment capacity would help cope with increased activity.

39.12 The proposals would ensure a fit for purpose medical staffing model with a reduction in the numbers of patients being admitted into a hospital bed and a reduction in the levels of boarding as well as patient / relative / carer complaints.

39.13 The proposals would lead to improved efficiency and productivity across the department, a reduction in cancelled elective procedures and corresponding reduction in independent sector spend as well as a reduction in delayed discharges.

39.14 Ms Johnson explained that the consequences of not proceeding with the investment be the exacerbation of these points as well are the risk of unplanned costs requited to open beds at short notice to cope with increasing patient demand.

39.15 The committee noted that efficiency gains were expected in admission avoidance (an estimate of a minimum of 329 days per annum), a reduction in elective surgical cancelations, the avoidance of private sector costs and a reduced reliance on emergency theatres time.

39.16 It was noted that the project had Corporate Management Team approval and it was hoped that new service models and associated accommodation would be operational by 1 December 2014.

39.17 Mr Johnston commented on the absence of a fully costed option for investment in the community. The current direction of travel was to prevent admissions into the care setting and unable to move to a ward bed and 66 patients waiting longer than 12 hours on a trolley.
acute sector which investment in development such as hospital at home, step-up facilities, etc should have been examined.

39.18 Ms Johnson explained that whilst these were medium to long term objectives, the immediate problem required to be addressed and the vast majority of attendees at the Western General Hospital were not in a ‘preventable’ category. They had mostly already been seen by a general practitioner and required treatment in a hospital facility.

39.19 Ms Johnson explained that NHS Lothian was working closely with local authorities and community partners to reduce delayed discharges but the number of delays remained exceptionally high at a level which could not be sustained. With winter approaching, urgent action was required to create this additional capacity.

39.20 Mr Johnston commented that ideally a number of options should have been presented.

39.21 Ms Johnson explained that these issues had been captured in the discussion and consultation with staff and apologised that the circulated report did not contain more details of this.

39.22 Mr Crombie commented that there had been a number of alternative investments to reduce the impact to delays on the Western General including additional beds additional investment with local authorities in a number of packages to facilitate the discharge of patients to home as quickly as possible. Whilst these had had some impact it was insufficient to address the major problem in time for winter.

39.23 The Chair suggested that the discussion focussed firstly on the business case, then the financing and finally the governance process.

39.24 Ms Blair asked for greater expansion on benefit realisation, particularly in light of the Boards financial position. In addition, she questioned where the staff for this unit would come from given the previous recruitment difficulties.

39.25 Ms Johnson explained that the staffing model was not particularly different from the current system. The medical cover was currently being reviewed. She was confident that the staff to run this could be recruited and she was optimistic that one of the key groups forming part of proposals was the recruitment of advanced nurse practitioner and she was optimistic that these could be recruited. The newly appointed Associate Medical Director for the Western General Hospital was looking at how the existing staff could be flexed.

39.26 Ms Johnson accepted that difficulties had already been encountered in recruiting appropriate consultant and specialist grades and this was why other options were being explored.

39.27 Ms Johnson advised that in terms of benefit realisation, it had been calculated that at least a 1.7% improvement in the 4 hour performance could be achieved across Lothian in addition to which there would be significant savings in the reduction in the use of private sector facilities.

39.28 The process proposed would enable at least 229 bed days could be saved and it was too early to say what the return in investment in primary care would deliver but appropriate metrics had been out in place to monitor everything.
39.29 Professor Iredale commented that the proposals would create opportunities for patients presenting to be properly assessed and given an appointment for scheduled care rather than being admitted as unscheduled care patients.

39.30 The Chair questioned whether facilities build for approving admissions could still be used if the model of care changed for the Western General to avoid direct admissions.

39.31 Ms Johnson advised that it should be possible for much of the proposed work could be adapted if that were the case.

39.32 Mr Graham advised that a proportion of the work would have been required anyway under routine maintenance and would always have been necessary.

39.33 Mrs Goldsmith commented that it was unlikely that any significant changes could be made to patient admissions through the front door of the Western General Hospital until additional beds were in place at the Royal Infirmary of Edinburgh and St John’s Hospital and this could take several years.

39.34 Mrs Blair related her concerns about investing in this business case without further information concerning potential improvement to outcomes, efficiencies, benefits, savings and the intended funding sources.

39.35 The committee noted that £1,162,000 of capital funds had already been released in order to allow the appointment of the design team, early contractor appointment and the procurement of the modular accommodation. £490,000 had been agreed by the Lothian Capital Investment Group and approved at the Acute Recovery Group in order to meet the required timeframe for project completion.

39.36 It was noted that the total estimated capital costs for the project would be £3,246,000 and there would be in-year revenue costs of £1,900,000 for the current financial year with recurring costs of £3,460,000 for the full year.

39.37 Ms Johnson explained that rising attendances and increased numbers of delayed discharges meant that the proposed investment was the only way in which the Boards required targets could be met.

39.38 Mrs Goldsmith advised the committee it had been recognised in the summer that further investment would be required at the Western General Hospital and once the scope and cost of the scheme had been identified, discussions had been held with the Board Chairman and the Chief Executive who supported the proposal.

39.39 The committee noted that the Director of Finance and Chief Executive did have delegated powers over revenue expenditure.

39.40 Mrs Goldsmith apologised that the full governance procedures had not been followed in this case because of the urgency surrounding the medical views on patient safety.

39.41 Mr Houston commented that he had agreed with the proposals on the basis of the need for patient safety and accepted that it would be preferable for such matters to be taken to committee as early a stage as possible. In this particular case he had
taken the view that if funding was not released at that stage then the option to put a solution in place before winter would not have been available.

39.42 Mr Johnston commented that local authorities had emergency powers to agree such expenditure subject to homologation.

39.43 Professor Iredale commented that there was a need for a framework for such decisions and for appropriate changes to the structure in this scheme of delegation.

39.44 Mrs Goldsmith undertook to consult with the committee Chair on bringing appropriate proposals to the Board.

39.45 Ms Johnson undertook to meet with Mrs Goldsmith and Mr Crombie to identify additional information.

39.46 Councillor Henderson questioned whether the approval of this level of capital expenditure was within the remit of the Finance and Resources Committee and Mrs Goldsmith confirmed that this was within the scheme of delegation. She advised that there had been some governance around the revenue and the financial plan included a facility to step-up acute hospital spending of around £11m as the necessary detail had not been available at the stage when the financial plan was being approved.

39.47 Mrs Goldsmith reminded the committee that NHS Lothian was approaching 2015/16 with an unbalanced budget and there would need to be a much broader discussion about the overall financial plan to determine what choices could be made in expenditure to achieve financial balance.

39.48 Mr Houston commented that NHS Lothian was not alone in its concerns and he would be leading discussions with the Board Chairs at their meeting with the Cabinet Secretary that evening.

39.49 The Boards were taking the view that they were not prepared to compromise on patient safety and care. The issue was how to best address the funding gap and discussions on this would be escalated.

39.50 Mrs Goldsmith confirmed that since the enquiry into Mid Staffordshire Health Authority the Health Boards ability to compromise patient safety for financial reasons no longer existed.

39.51 Professor Iredale commented that sufficient Non Executive involvement at an earlier stage would make it easier to redeploy much of the investment if changes to the role of the Western General Hospital were agreed.

39.52 Mr Johnston commented that he did not believe that the medium to long term solution would be to spend more money on acute services and it was necessary to ensure the community options were considered in future.

39.53 Mrs Blair commented that a number of good action points had arisen from the discussions and whilst there were some concerns about the process she was happy to support the business case.

39.54 Professor McMahon commented that the November Board Development Session would look at both acute and primary care services.
39.55 The chair advised that he would be looking at a process for future business cases and for dealing with emergency issues.

39.56 The committee agreed: -

- To note the early approval of capital funds released to date of £1,162,000 in order to allow the appointment of the design team, early contractor appointment and the procurement of the modular accommodation in order to meet the required timeframe for project completion.

- To approve the total estimated capital costs of £3,246,000 for the project.

- To approve the in-year revenue costs of £1,900,000 for 2014/15 and recurring costs of £3,460,000 for the full year recognising that the current financial plan for 2015/16 did not balance and that a wider Board discussion on priorities for future years would be required.

- That Ms Johnson would meet with Mrs Goldsmith and Mr Crombie with a view to identifying additional information concerning potential improvement to outcomes, efficiencies, benefits, savings and funding sources. MJ/SG/JC

- The Director of Finance would consult with the committee chair and bring forward proposals to the Board to incorporate a framework including Non Executive involvement in the inclusion in the scheme of delegation of emergency decisions on capital and revenue expenditure in exigent circumstances. SG/GW

- Future business cases for any clinical services provision must include consideration of alternative models of care in primary, community, social and acute care including any inter-relationships or impact. SG

40. Date of Next Meeting

40.1 It was noted that the next meeting of the committee would be held on Wednesday 12 November 2014 at 9am in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
The draft minutes of the meeting held on 23 September 2014 are attached.

1.0 Key Issues Discussed

1.1 Unscheduled Care and Delayed Discharge

A verbal report and discussion indicated that the impact of delayed discharge on the quality and safety of patient care was within the remit of the Healthcare Governance Committee and we would seek assurance that appropriate plans were in place to mitigate this impact and reduce the numbers of delayed discharges. It was noted that the operational details of delayed discharge were the remit of the acute committee in partnership with the Shadow IJBs but the quality of care and patient safety issues required Healthcare Governance Committee to request information to provide assurances on these matters at future meetings.

1.2 Maternity Services

Healthcare Governance Committee received an update paper on Maternity services requested after the March meeting of HCG where a number of significant concerns had been noted in relation to the quality and safety of patient care by the service and an action plan to mitigate these concerns was outlined. The update paper offered reassurance and assurance to Healthcare Governance Committee members that the issues identified had appropriate improvement plans in place and review if the effectiveness of these action plans was robust and ongoing. The service was commended for the work that had been done to address issues of quality of care and patient safety in Maternity services.

1.3 Clostridium difficile Infection HEAT Target

It was noted that the Heat Target for CDiff remains off trajectory in the Hospital Associated Infection update and that a range of actions were being taken to improve this situation including linking the Person centred Culture work with managing HAI and quality improvement work. Ms Johnson offered assurance to HCG that there was a plan to integrate Healthcare Associated Infection work better with other work including person centred culture work, significant adverse events work and Scottish Patient Safety Programme. Further assurance of progress in this area came from information that Ms Bennett’s team was working on a plan for Healthcare Associated Infection improvement using improvement methodology. Dr Simon Edgar had agreed to liaise with the Infection Control Team and help encourage engagement from clinical staff on implementation of strategies to reduce the incidence of Healthcare Associated Infection.

Dr Morag Bryce
Chair of the Healthcare Governance Committee
7 October 2014
Chair’s Welcome and Introductions

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

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

24. Patient Story

24.1 Ms Johnson read out a letter from a patient which described her very positive experience of giving birth at the Royal Infirmary of Edinburgh.

25. Committee Cumulative Action Note and Minutes from Previous Meeting (22 July 2014)

25.1 The previously circulated updated cumulative action note was noted.

25.2 The minutes from the meeting held on 22 July 2014 were approved as a correct record.
26. Emerging Issues

26.1 Unscheduled Care and Delayed Discharge

26.1.1 This item was a verbal update to the Committee. Ms Johnson noted that numbers of patients who had to wait for unscheduled treatment on admission for over 8 or over 12 hours were monitored, as evidence suggested that a longer wait resulted in a poorer outcome for the patient. Evidence also showed that a high number of bed moves resulted in a poorer outcome for the patient.

26.1.2 A high number of delayed discharges affected the capacity and therefore the length of patients’ wait on admission. Ms Johnson noted that there had been 285 delayed discharges the previous day. As well as affecting hospital capacity, delayed discharges were also of higher risk to the delayed patient in terms of reducing independence, and increasing the risk of infection.

26.1.3 Work was in progress with the City of Edinburgh Council to try and reduce the number of delayed discharges but this was taking time and there had been setbacks including the closure of the Pentland Hill Nursing Home. The numbers of delayed discharges have continued to be high over the summer and were expected to increase further over the winter season.

26.1.4 Ms Johnson noted that operational detail could be discussed by the Acute Hospitals Committee, but that the real work needed to be done by the Community Health Partnership Committees. A meeting had been arranged for Council and NHS Lothian representatives with the Integration Joint Boards to discuss this, and more information would be available at the next meeting.

26.1.5 Ms Garrod noted delayed discharge had an impact on patients and also cost implications for NHS Lothian, and asked whether integration with health and social care was expected to improve the situation. Ms Johnson agreed that this was expected and work was being done to expand integrated groups and joint working prior to integration, but noted that the problem that needed to be solved was that there were currently not enough downstream beds for the number of patients requiring them.

26.2 Quality Improvement Infrastructure

26.2.1 A paper had been previously circulated. Ms Bennett advised that the paper set out the diagnostic processes carried out by the Corporate Management Team, and noted that the process focused on enabling improvement by clinicians, and measuring improvement. The Framework had been tested against the values of the 2020 Vision for Health and included measures to ensure changes made were positive across different patient areas and did not cause a deterioration of patient experience, and looked at capacity and capability for change.

26.3.2 Ms Bennett noted that a visit from Healthcare Improvement Scotland had been arranged to look at the areas identified for improvement. This assessment would be for NHS Lothian’s benefit and would not be published, but HIS would be able to suggest similar projects being carried out in other healthcare environments in Scotland and internationally. One of the representatives attending from HIS had
worked on leadership and health improvement internationally and was an expert in building capability for quality improvement.

26.3.3 Dr Bryce welcomed this paper and felt that the policy it outlined would have a positive effect on NHS Lothian’s culture.

27. Corporate Risk Register

27.1 A paper had been previously circulated. Dr Farquharson advised that the paper had been discussed at the Risk Management Steering Group and that there were no particular areas to highlight. Dr Bryce noted that the papers received by the Committee for assurance could be compared with the risk appetite work outlined in this paper.

28. Person Centred Care

28.1 Person Centred Culture Programme

28.1.1 A paper had been previously circulated. Ms Johnson noted that the terminology should be changed from ‘person centred care’ to ‘person centred culture’. This was to emphasise the cultural aspect of this work and to ensure that it involved all staff, all policies and all work, not just nursing. A definition of ‘person centred’ which it was suggested that NHS Lothian adopt, was included in the paper.

28.1.2 Ms Johnson advised that there had been a number of local and international comparisons of methods of recording and improving patient experience, and that Healthcare Improvement Scotland had identified that NHS Lothian was in a similar position to other areas and was moving in the right direction.

28.1.3 The national programme for person centred culture expected Boards to be able to show that patients were reporting at least 90% positive experience in all areas. NHS Lothian had chosen some test areas which show that this could be done. Progress on the implementation of the proposed plan would be reported to the Board and to Healthcare Governance quarterly in more detail; reporting would be partly qualitative patient stories and partly measurement of patient experience outcomes. The paper received was a high level outline.

28.1.4 A patient questionnaire ‘tell me 10 things’ was currently being used across the Royal Infirmary of Edinburgh and had been successful; the plan was to introduce it to all areas. The GP survey was also already in place, and other methods of recording patient experience were being considered.

28.1.5 Ms Johnson noted that a key issue in person centred culture was the involvement of staff, and the measurement and improvement of staff satisfaction. The staff survey and other methods were being considered.

28.1.6 Ms Meiklejohn welcomed this initiative, and noted that it should help NHS Lothian to celebrate its successes and the valuable experiences that patients and staff had.

28.1.7 Ms Gormley suggested that in the ‘impact on health inequalities’ section of the paper should be phrased to focus on equality considerations, rather than inequality.
28.1.8 Ms Johnson advised that the culture change aspect of this work would take a number of years to embed; a visit to a hospital in Northumberland which was celebrated for its progress with person centred culture had shown that over a number of years they had improved intelligence and warning systems based on patient experience, and this had led to improvement in patient and staff experience.

28.1.9 Ms Scott Macfarlane noted that Accident and Emergency was such a busy area that it would be challenging to introduce these changes there. Ms Johnson agreed that this would be challenging but advised that there had been some work done in medical admissions through the Compassionate Care Programme, and work was also being done on patient flow to improve patient experience.

28.1.10 Ms Bennett noted that the work on the complaints service was integral to the person centred culture work.

29. Safe Care

29.1 Public Protection Update

29.1.1 A paper had been previously circulated. Ms Johnson highlighted item 3.1.1 in the paper which advised that the Serious Offender Liaison Service which had been quickly established as a very successful service was now at risk of discontinuation as the Scottish Government was withdrawing funding. Extension of funding was in negotiation with the hope that the service could be continued with funding from NHS Lothian and the City of Edinburgh Council.

29.1.2 The Serious Offender Liaison Service was currently located in the Vega Building which was leased by the Police; as the lease was ending all services in this building were relocating. It was felt appropriate that this service should be hosted by NHS Lothian as it was not a Police service. A branch of the service was also located at St John’s Hospital, but an Edinburgh branch was also required. It was unclear why funding was being withdrawn for this service. Ms Johnson, Dr Bryce and Professor McCallum agreed to write to the Scottish Government to establish the reason for this.

29.1.3 In response to a question from Ms Garrod, Ms Johnson explained that the Pentland Hill Nursing home was run by BUPA and had been contracted by the City of Edinburgh Council and that the decision by BUPA to close the home was a commercial decision, not due to an improvement notice or standards of care. BUPA was not prepared to sell or lease the home to the City of Edinburgh Council. It was noted however that there was an ongoing issue with care standards in some nursing homes.

29.2 Improving Management and System Learning from Adverse Events

29.2.1 A paper had been previously circulated. Ms Bennett advised that opportunities were constantly being sought for learning from adverse events and making improvements, for example in local Mortality and Morbidity Meetings. One initiative was the development of a scorecard for each ward which would keep data together and ensure a verified process outcome in various areas including cost, patient safety, Health and Safety, falls, bank staff, etc. This would help to put adverse events in the context of the work of each service. Work was also beginning on a
similar integration of information for the Integrated Joint Boards to cover primary care as well as acute areas. Numerous forums were used to learn from patient experience including adverse events and complaints, and integrating these would be important for service improvement.

29.2.2 It was noted that quality improvement required the involvement of staff in all areas and should be integrated into policy.

29.3 Healthcare Associated Infection Update

29.3.1 A paper had been previously circulated. Ms Johnson noted that NHS Lothian was still not meeting the HEAT target for incidence of *Clostridium difficile* Infection and that the position was unlikely to be recovered, but work was being done to minimise risks to patient safety.

29.3.2 Ms Johnson noted that there was a plan to integrate Healthcare Associated Infection work better with other work including person centred culture work, significant adverse events work and Scottish Patient Safety Programme as these areas were not separated. Ms Bennett’s team was working on a plan for Healthcare Associated Infection improvement using improvement methodology. Dr Simon Edgar had agreed to liaise with the Infection Control Team and help encourage engagement from clinical staff on implementation of strategies to reduce the incidence of Healthcare Associated Infection.

29.3.3 Ms Johnson noted that the Antimicrobial Team was also important in reducing the prescription of broad spectrum antibiotics and therefore reducing the risk of *Clostridium difficile* Infection. A further pharmacist and consultant for the team were being recruited.

29.3.4 Ms Johnson advised that she would be taking over the Chair of the University Hospitals Service Infection Control Committee, and that there would be discussion over whether to integrate this Committee with the CHP Infection Control Committee as the two areas could not be considered separately as the same patients passed through both areas.

29.3.5 Work was also being done on available Healthcare Associated Infection policies and protocol, to check that they encouraged best practice, and that they were being followed.

29.3.6 The format of the standing paper to the Healthcare Governance Committee was being considered, with a view to showing more clearly what actions were being taken and what improvements had been made.

29.3.7 Dr Bryce suggested that a social media campaign on standard infection control precautions could be beneficial. Ms Johnson noted that an extensive national campaign had previously been very successful, but that there had not been anything recently. It was suggested that a local campaign could be effective.

29.3.8 In response to a question from Ms Scott Macfarlane regarding decontamination of ophthalmology equipment, Professor McCallum advised that all equipment from Ophthalmology at the Princess Alexandra Eye Pavilion was sent to the central
decontamination unit at the Royal Infirmary of Edinburgh, and was integrated with the scheduled care process.

29.4 Maternity Services Update Report

29.4.1 Dr Bryce welcomed Dr Doyle, Dr Hughes, and Ms Wilson to the meeting. Dr Doyle spoke to the previously circulated paper, explaining that two years on from some serious adverse events in the service, the incident review process had been reconsidered and learning, evidence of learning and system change had taken place. The evidence in the paper showed that the service was safe and compared well with other similar services.

29.4.2 Dr Farquharson noted that the paper started to address the concerns raised at the Committee in March 2014 and showed that good progress had been made. In future updates he would like to see more information about the Maternity Services Programme Board and more about changes made as a result of learning from adverse events.

29.4.3 In response to a question from Dr Bryce, Mr Crombie advised that the workstreams highlighted in paragraphs 3.2.6 and 3.2.9 of the report would be overseen by the Maternity Services Programme Board which met monthly. This Programme Board would be a short term intervention the duties of which would later be handed back to the Directorate.

29.4.4 In response to a question from Dr Bryce, Ms Wilson advised that in response to the negative impact on staff of adverse events two years ago, counselling services and psychology had been used to help staff. Culture surveys and workshops on communication when things go wrong have helped prepare staff further.

29.4.5 In response to a question from Ms Gormley, Ms Wilson advised that the Maternity Services Liaison Group was chaired by a lay representative and allowed patients to have a say in maternity services processes. Maternity patient representatives also sat on all Government policy groups for relevant policies.

29.4.6 Ms Meiklejohn asked how the areas of high risk indicated in the report were being addressed. Ms Wilson advised that the introduction of a central bookings system helped with capacity as both the St John’s Hospital Unit and the Royal Infirmary Unit could both be fully used. Dr Hughes noted that the numbers of caesarean sections carried out under general anaesthetic were low and an effort was made to reduce this occurrence, but it was recognised that it was sometimes unavoidable due to the patient’s condition. The 5% threshold had been chosen by the service as a target for reduction.

29.4.7 Dr Farquharson noted that incidents with harm in the categories of sepsis, post-partum haemorrhage and breech births had appeared in the Quality Report for the first time this month. Ms Wilson advised that work was being done as part of the Scottish Patient Safety Programme to reduce the incidence of post-partum haemorrhage due to the related high mortality. The incidence of post-partum haemorrhage in NHS Lothian was similar to in other comparable units.

29.4.8 Ms Wilson advised that breech babies were usually identified and delivered by caesarean section, and those which were not were when women chose to deliver
the breech baby or when women arrived in spontaneous labour and complications
including breech occurred. It was noted that breech births were related to a poor
outcome for the baby, but were rare. All women diagnosed with breech at 36 weeks
were offered the ECV service to turn the baby.

29.4.9 Dr Hughes advised that the higher number of reported cases of sepsis was due to
improved recording of incidences, as previously antibiotics may have been given
but sepsis not diagnosed. Better recording would improve awareness of the
number of incidences and means of reducing incidence.

29.4.10 In response to a question from Ms Scott Macfarlane, Ms Wilson advised that when
patients were transferred between St John’s Hospital and the Royal Infirmary of
Edinburgh, relatives were informed and transport offered to the patient. This could
sometimes be inconvenient but was of less risk to the patient than being admitted
to a unit over capacity.

29.5 Healthcare Improvement Scotland Scottish Patient Safety Programme Visit

29.5.1 This item was a verbal report. Dr Farquharson advised that Healthcare
Improvement Scotland had visited NHS Lothian on 12 and 13 August 2014 and had
looked at all Scottish Patient Safety Programme initiatives in acute, primary care,
Mental Health and Maternity and Paediatric Services. This was an informal visit to
trial the combined visit; previously each SPSP area would be visited separately.

29.5.2 A report had been received following the visit, which Dr Farquharson summarised.
The team were impressed by the engagement of staff, and that improvement
structures were not person dependent; they commended the daily safety huddle at
the Royal Infirmary of Edinburgh identifying boarding patients, and were keen to
see this sort of group established at the Western General Hospital and St John’s
Hospital also; they were happy with the use of data for improvement and the
adherence to CEL 19. Areas for improvement noted included: better
acknowledgement of the time and effort put into SPSP work by members of staff; a
requirement for better assurance of sustainability of SPSP work, for instance some
SPSP posts were temporary; medicines reconciliation; extension into more
programmes, although no consensus was given as to which areas would be most
beneficial. A more detailed written report on NHS Lothian’s response to the visit
would be submitted to the next meeting.

29.6 Memorandum of Understanding between the General Pharmaceutical Council and
NHS Lothian

29.6.1 A paper had been previously circulated. Professor Timoney noted that the
memorandum needed to be signed to clarify the responsibilities of both the General
Pharmaceutical Council and NHS Lothian in terms of pharmacy, premises and
inspections. No changes had been made to the current duties expected.

29.6.2 The Committee supported the memorandum.

29.6.3 Dr Bryce noted that more assurance on work in progress to improve medicines
reconciliation would be useful, including a paper at a future meeting. Professor
Timoney advised that Dr Nikki Maran was leading on a Committee at each site to
improve and oversee medicines reconciliation.
30. Effective Care

30.1 Quality Report

30.1.1 A paper had been previously circulated. Dr Farquharson noted that medical readmissions work had shown some improvement but that there may be cause for concern on surgical readmissions.

30.1.2 Ms Allan noted that the 2014 Inpatient Survey showed a lot of good work, but felt that the gap between the five questions with the best results and the five questions with the least good results was significant, and that she would like to know the improvement plans for these areas.

30.1.3 Ms Bennett noted that the five questions with the least good results were new and felt that some of them needed to be refined, others were more practical and improvement plans were being discussed. Ms Bennett also noted that work was being done on dividing responses by site as this would show any variation and help improvement.

30.1.4 Ms Scott Macfarlane felt that it would be useful if questions on the following areas were also included in the questionnaire: whether hospital transfer was well managed; whether medical staffing was adequate and patient was seen by medical staff timeously; and medicines reconciliation. Ms Johnson explained that the questions were set nationally but that some of these areas were important and could be fed back for consideration by the team setting the questions. She also noted that these were areas where NHS Lothian was working on improvement plans.

30.1.5 In response to a question from Ms Gormley about how survey results tied in with management work and whether changes in responses over time correlated with improvement programmes, Ms Bennett advised that some correlation had been observed in Accident and Emergency where a lot of work had been done, but that other areas were less clear and changes in response were probably based on a number of factors over time. Ms Bennett also noted that it was important to link positive responses with outcomes as well as negative; for instance patients reported that the environment was clean, which showed that many precautions against Healthcare Associated Infection were having an effect.

30.2 Staff Governance Committee Update on Mandatory Training

30.2.1 This item was a verbal report. Dr Bryce noted that although Mandatory Training was the responsibility of the Staff Governance Committee, the Healthcare Governance Committee required assurance on this area to allow it to cover its own remit.

30.2.2 Mr Joyce reported that Amanda Langsley was working on putting a system in place to allow measurement of completion of mandatory training. Although some progress had been made, completion of advanced level and face to face training were still not recorded centrally; therefore any data produced from the system currently in place would be unrepresentative. The lack of a system to record staff
training had been recognised as a problem in all Health Boards nationally and work was in progress with NHS Education Scotland on developing a better system.

30.2.3 In response to a question from Dr Bryce, Ms Johnson advised that there were opportunities for staff to make it known if they had not received the correct training, for example at appraisals with line managers. Ms Johnson and Mr Joyce agreed that on a clinical ward level it was known which members of staff had completed which training, but that this was not captured or monitored centrally.

30.2.4 Some problems affecting compliance with mandatory training were noted, including problems with staff finding time away from their duties to complete training, staff who were not competent with use of IT equipment for eLearning; problems with access to a PC in some areas; and problems with a slow internet connection in some areas. Ms Eccles noted that the location of training also affected the amount of time staff had to take away from their duties, and the importance of providing training locally.

30.3 Bowel Screening Prescribing Practice and Costs; Action from Internal Audit

30.3.1 A paper had been previously circulated. Dr Farquharson noted that this paper was in response to the action from internal audit about considering alternatives to sending laxatives for bowel preparation to patients in the post, a practice which was carried out in all Boards in Scotland. The paper laid out the processes for mitigating risk.

31. Exception Reporting Only

31.1 Hepatitis C Incident Reports

31.1.1 Professor McCallum summarised the reports which had been previously circulated. There were two incidents of suspected transmission of Hepatitis C between patients in hospital; the probable source for one incident was identified as a combination of contaminated equipment and healthcare worker via the source patient. These were incidents of serious harm which resulted in a comprehensive improvement programme being put in place in Accident and Emergency.

31.1.2 A diligent investigation and look back exercise had taken place and all patients who may have been affected were contacted and offered counselling and testing; all patients were tested and there was found to have been no further transmission. This was the first incident of this sort, and processes were found to not in place for adequate decontamination of some items of equipment. A decontamination protocol had now been implemented.

31.2 Mother and Baby Unit: Governance and Assurance Management Review

31.2.1 A paper had been previously circulated. Dr Farquharson noted that an external review of the Mother and Baby Unit at St John’s Hospital had been previously discussed at the Committee and had shown areas of very good practice and raised no concerns regarding quality of care. This analysis had more recently been confirmed by the Royal College of Psychiatrists ‘Excellent’ rating of the Unit.
31.2.2 The purpose of the paper circulated was to provide assurance that mechanisms and systems were in place in the Mother and Baby Unit for governance arrangements, given the current high profile of the Unit in the media.

31.3 Members noted the following items for information:

31.3.1 Lothian Viral Hepatitis Managed Care Network Annual Report 2013-14;
31.3.2 Lothian Infection Control Advisory Committee Annual Report 2013-14;
31.3.3 East of Scotland Renal Transplant Service Annual Report 2013-14;
31.3.4 Healthcare Improvement Scotland Feedback on Controlled Drugs;
31.3.5 Quality Improvement Teams Annual Report 2013-14;
31.3.6 Complaints Report – Maternity Services.

32. Other Minutes: Exception Reporting

Members noted the minutes from the following meetings for information:

32.1 Area Drug and Therapeutics Committee, 1 August 2014;
32.2 Clinical Management Group, 10 June 2014, 8 July 2014, 12 August 2014;
32.3 Acute Hospitals Committee, 15 July 2014;
32.4 Lothian Infection Control Advisory Committee, 27 May 2014

33. Date of Next Meeting

33.1 The next meeting of the Healthcare Governance Committee would be held from 9.00-12.00 on Tuesday 25 November 2014 in Room 7, Second Floor, Waverley Gate.

33.2 Meetings in 2015 would take place on the following dates:
- 27 January 2015;
- 24 March 2015;
- 26 May 2015;
- 28 July 2015;
- 22 September 2015;
- 24 November 2015.
Minutes of the Strategic Planning Committee Meeting held at 10am on Thursday 9 October 2014 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr B Houston (Chair); Mr A Boyter; Mr J Brettell; Mr T Davison; Mrs S Goldsmith; Ms M Johnson; Professor A McCallum; Professor A McMahon; Mrs A Meiklejohn; Ms D Milne; Mrs A Mitchell and Dr R Williams.

In Attendance: Ms L Irvine (for item 58); Dr G Scott (for item 55); Mr D A Small; Ms L Tait and Mr D Weir.

Apologies for absence were received from Mrs J Anderson, Mrs K Blair, Mr J Crombie, Mrs P Eccles, Dr D Farquharson, Professor J Iredale, Mr A Joyce, Mr G Walker and Mrs E McHugh.

51. Declaration of Financial and Non Financial Interest

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

52. Agenda Reordering

52.1 The committee agreed to reorder the agenda to consider the Sexual Health and HIV Services in Lothian presentation immediately following the minutes and matters arising. This would then be followed up with an update from the October Board meeting as well as a debrief from the Board Chief Executives meeting held the previous day.

53. Minutes of the Previous Meeting held on 14 August 2014

53.1 The minutes of the previous meeting held on 14 August 2014 were approved as a correct record subject to the deletion of 45.10.

53.2 It was noted that following the Board Development Session held on 10 September it had been agreed to cancel the Strategic Planning Committee meeting on 11 September.
54. **Matters Arising**

54.1 **E-health Strategic Delivery – E-communications Project** – The committee were provided with an update on how e-health could become better linked with the strategic plan. It was noted the refresh of the local e-health strategy would be aligned to the national one with a focus on tele-health and tele-care which linked well with how services for the elderly might be delivered in future. It was noted although £10m had been allocated by the Scottish Government for this work across Scotland it was not all new money. A business case had been produced to start emailing patients with their waiting time offer. A further update would be brought forward to the committee in order that they could understand the process more fully.

54.2 In addition, the launch of a Health and Social Care Information Portal in Edinburgh was reported with it being noted it was hoped to roll this out wider across Lothian. This should assist in making information more visible across all spectrums of the service. A concern was raised that a lot of this information would be news to GPs with their being a danger of duplication of data. The Director of Strategic Planning, Performance Reporting and Information commented he would be happy to provide an update to the GP Sub Committee as well as circulating further details to the Strategic Planning Committee. It was noted that through another forum the GP Sub Committee had an excellent e-health champion.

54.3 The committee noted the update report.

54.4 **Information Plan Update** – It was reported a session would be held at the end of the month to bring senior managers and clinicians together to identify how to use information and to agree actions. The output of this event would be reported to the Strategic Planning Committee.

54.5 The committee noted the update report.

55. **Sexual Health and HIV Services in Lothian**

55.1 The Chairman welcomed Dr Gordon Scott to the meeting advising that he and Ms Milne would be providing the committee with an update on Sexual Health and HIV Services in Lothian.

55.2 The committee noted the Board had not yet received any updates on sexual health and HIV services in Lothian recently. The position in respect of population level data and service developments were explained. The strategy had a clear executive level lead (Dona Milne) and a clear clinical lead (Gordon Scott).

55.3 It was reported that colleagues had looked at clinical priorities to shift services from less deprived areas into more deprived areas and this would represent an ongoing focus of service redesign. The committee noted that the new Chalmers Centre had brought together two previously busy services into one in a new building to provide an integrated service.

55.4 The committee were advised moving forward that the priorities would be around increasing the provision of long acting reversible contraception through both
primary care and specialist services. It was reported that agreement had been reached that the financial cap on this service would be removed. It was noted a further priority area was around the prevention of HIV particularly in respect of increased testing particularly amongst men who had sex with men and Africans to reduce the numbers of people being diagnosed so late in order to get them into treatment and reduce the likelihood for onward transmission. The establishment of a fuller abortion service with good contraceptive provision at the Chalmers Centre to reduce the number of repeat abortions in Lothian and to reduce rapid repeat unintended pregnancies was also a current priority.

55.5 The committee noted that Health and Social Care Integration had created an avenue where people could speak to one another on an individual basis. The key point was about building relationships and focussing on the anticipatory care element of the service.

55.6 It was reported a group had been established working with the Scottish Prison Service to help people find employment as they came towards the end of their sentence. In East Lothian some community payback orders were served in the NHS. An update was provided in respect of how changing legislation around saunas would impact on women in Lothian working in the sex industry and whether enough was being done to help these people into other employment which in most instances they would prefer. It was noted a multi agency group had been established to look at issues affecting men and women working in the sex industry and there was a lot of multi-agency work taking place in saunas and other settings. A process had been put in place to text women advertising on escort sites advising them of the services available to them through the NHS. It was noted currently there were significant tensions around saunas and rights of access by different agencies. Police Scotland were supportive of the interventions made by the Health Service in addressing some of these issues.

55.7 It was agreed that discussions would be held outwith the meeting about ring fencing an increased number of places on the Health Care Academy Programme in the short term to assist people in this group to move towards alternative employment status.

55.8 The point was made in terms of long acting reversible contraception that there was a capacity issue at Chalmers due to increasing numbers of patients overall. Additional support could be provided by primary care nurses but because of the previous cap on funding GPs had previously had limited ability to provide assistance. It was frustrating that it had taken so long to remove the funding cap in an area where the benefits of increasing capacity were so obvious. There was a feeling in general that the organisation was slow to respond to such opportunities.

55.9 It was noted that the removal of the funding cap had been a bi-product of refreshed engagement with the GP subcommittee. In the past engagement with GPs had been bureaucratic and in future more dynamic interactions would happen through the GP Forward Group, the strategic plan and the Integrated Joint Boards who would have a responsibility to engage with GPs. It was agreed there was a need to empower decision making at lower levels in the organisation in order to eradicate unnecessary blockages.
55.10 The Strategic Planning Committee agreed to receive a case study presentation at some point in the future.

55.11 The recommendations contained in the circulated paper were supported by the committee. Dr Scott left the meeting.

56. Follow up from Boards Chief Executive Meeting on 8 October 2014

56.1 An update on the debate at the Board Chief Executives meeting the previous day was provided.

57. Follow-up from October Board meeting

57.1 Modelling Delivery Alternatives and Efficiency Deep Dive – The committee recalled a number of actions had flowed from both the Board Development Session held on 10 September and the Private Board meeting held the previous week. As part of this debate it had been agreed to undertake a financial deep dive exercise initially around older people services and some aspects of cancer services. The structure to pull together and undertake this work would be through a newly established corporate programme office the details of which would be discussed later on the agenda. Following previous debate it had been agreed to undertake a gap analysis specifically around primary care and the funding conundrum with acute services. An update on this work would be provided at the November Board Development Session. The final strategic plan would be considered at the February 2015 Public Board meeting. In the interim there was a need for national dialogue as there were national and regional opportunities.

57.2 The need for a communications plan to include spending options was agreed. There would as a matter of courtesy be a need to communicate with staff and others who had responded to the consultation exercise. It was noted the communications plan would be discussed with the Director of Communications and Public Affairs the following week.

57.3 The committee noted the recommendations contained in the circulated paper.

58. Developing a Corporate Programme Office in NHS Lothian

58.1 The committee were advised of the proposal to establish a Corporate Programme Office (CPO) to coordinate the strategic plan priority workstreams and enhance the capacity and capability for project management in the organisation. It was noted this proposal had been supported by the Strategic Planning Programme Board. If the proposals were supported by the Strategic Planning Committee formal signoff would be sought from the Organisational Change Group on 20 October 2014. The CPO would report to the Director of Strategic Planning, Performance Reporting and Information with a strong dotted line to the Director of Finance. The CPO was being established to create a common approach to delivering an improved model of care and efficiencies in a sustainable manner.
58.2 Members of the committee whilst supporting the general direction of travel sought assurance that the establishment of the CPO would not come at significant extra cost and spawn an additional bureaucracy. The committee were advised that the proposal was fundamentally about bringing together existing resources and that any vacancies were existing ones that were re-designated to come in to the team. The proposal was that the CPO Team would in due course integrate with the Quality and Patient Safety Team. The working methodology between the two teams would be the same.

58.3 The committee noted the challenge would be when integrated schemes were being produced for the Integrated Joint Boards to recognise and provide for their planning and financial responsibilities. One option would be to retain a central planning structure and people to support the Integrated Joint Boards. An alternative option would be to redeploy planning to give generic support to Integrated Joint Boards. In any event NHS Lothian would not be the lead planning organisation. It was noted a paper was being produced for further discussion to ensure balance in planning terms between the NHS and local authorities.

58.4 The committee supported the recommendations in the circulated paper.


59.1 The Chairman welcomed Ms Irvine to the meeting advising she would update the committee on the implementation of ‘A Sense of Belonging’.

59.2 The committee received a substantial presentation from Ms Irvine the details of which were contained in copies of the presentation distributed to members immediately following the meeting. It was reported that a report would be submitted to the February 2015 Public Board meeting. The workstreams between now and then were explained with the work plan between October and December being detailed.

59.3 The committee welcomed and applauded the amazing array of localised work and the participation of multiagency partnership and the positive results this had achieved. It was noted that the approach being adopted was both innovative and creative. The point was made that the Royal Edinburgh Hospital business case had been to the Board and it was important not to see this in isolation but to accept that research and evaluation were important.

59.4 It was noted members of the committee had been overwhelmed by the amount and calibre of work and felt this was a classic example of achieving progress through communication with partners. It was agreed consideration should be given to submitting the project to the Celebrating Success Award process for 2015 (entries were closed for the current year).

59.5 The point was made that the presentation reflected back to the debate about how to support Integrated Joint Boards as the process would shift commissioning responsibility for mental health services to them with an implementation approach being required. The benefits of a holistic approach were recognised with the challenge being around how to apply this to the acute and older peoples
agenda whilst also considering the relationship to the community and third sectors.

59.6 It was noted discussions were underway in East Lothian around Integrated Older Peoples Services to include mental health all of which were being taken forward on a holistic basis.

59.7 The committee noted there were a number of patients who moved out of Lothian because appropriate services were not available. It was felt until such time as suitable services were available there was a need to reduce the risk to these patients through the application of appropriate clinical governance arrangements. It was noted a paper was being produced in respect of the management of such patients and this would come to the Corporate Management Team in November.

59.8 The committee agreed and welcomed the recommendations contained in the circulated paper.

60. **Alcohol Related Brain Damage Unit**

60.1 The committee received a detailed presentation around the Alcohol and Brain Damaged Step Down Unit run jointly by NHS Lothian, City of Edinburgh Council and the Penumbra Charity. The details of the presentation were circulated to committee members immediately following the meeting.

60.2 It was noted that an evaluation process was in place and a breakdown of the outcomes would be reported back to the committee.

60.3 The development was welcomed and moving forward it would be important to learn from the real world client group and change the model of care to suit their needs. There should no barriers to sharing good models of care with the key issue being to clear away any bureaucratic processes that inhibited this happening. The point was made that some people in the community would benefit from a spell in a step-up facility like the one detailed in the presentation. The future development of similar models of care should hopefully reduce reliance on the acute sector.

60.4 It was noted that the unit had opened in July and since then some patients had been in and out of the unit. The outcomes from the first patients to go through the whole programme were awaited with interest.

60.5 The committee noted the update report.

61. **Date and Time of Next Meeting**

61.1 The next meeting of the Strategic Planning Committee would be held at 10am on 13 November 2014 in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
The draft minutes of the meeting held on 28 August 2014 are attached.

Key issues discussed included:

- Keep Well Annual Report - Five practices within East Lothian are delivering Keep Well Programme. Only one practice in Musselburgh (the highest risk area) has taken up the programme. Prison Healthcare are also delivering it.

- East Lothian Community Hospital Scottish Government approved the initial Agreement. Reported that two key issues not included are third sector base and GP Practices however these will be re-visited in the Outline Business Case.

- Prestonpans Health Centre Initial Agreement - Three options were presented and £46,000 was identified for revenue costs of the preferred option. Sub Committee supported the preferred option and paper will be presented to the Finance and Resources Committee for approval.

- Delayed discharges – noted that other initiatives will need to be developed in order to meet the four week target and the two week target and further reduce the total number.

Key issues on the horizon are:

- Delayed Discharges – Committee to receive reports on further steps being taken at next meeting.

Mike Ash
Chair/Executive Lead
 Minute of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Thursday, 28 August 2014, in Esk Room 1, Brunton Hall, Musselburgh

Present: Michael Ash in the chair (MA)  
David Small, Director of Health & Social Care (DAS)  
Councillor Donald Grant, East Lothian Council (DG)  
David Heaney, Acting Head of Adult Wellbeing, East Lothian Council (DH)  
Ann McCarthy, PPF Representative (AMc)  
Gill Colston, PPF Representative (GC)  
Andrew Tweedy, Carers of East Lothian (AT)  
David King, Head of Finance (DK)  
Alison MacDonald, Head of Health for East Lothian (AXM)  
Thomas Miller, Partnership Representative (TM)

Apologies: Moyra Burns, Health Promotion (MB)  
Judith Gaskell, Head of Human Resources (JG)  
Angela Leitch, Chief Executive, East Lothian Council (AL)  
Carol Lumsden, Integration and Transformation Manager (CL)  
Fiona Mitchell, Director of Operations, NHS Lothian (FM)  
Sue Muir, Senior Health Promotion Specialist (SM)  
Dr Amy Small, EL GP Representative (AS)  
Jon Turvill, Clinical Director (JT)  
Sian Tucker, Acting Clinical Director, LUCS (ST)

In Attendance: Barbara Gilbert, PA (minutes)  
Peter Gilfoyle, Programme Manager (PG)  
Alison Milne, Project Manager (AM)

1.0 Welcome and Apologies  
MA welcomed new member David Heaney, Acting Head of Adult Wellbeing.

1.1 Update on Health and Social Care Partnership  
MA reported that due to timing of regulations being finalised it is unlikely that the date for the new partnership going live will be before May 2015. The outcome for the CHP is that work will continue until the end of March 2015 and possibly one meeting beyond this time. DAS agreed to circulate to groups the envisaged Timetable to enable all members of groups to be aware of plans.

ACTION: DAS

1.2 Presentation – Pilot of the Young Carers ID - Julie Deegan Wood has been unable to attend and the presentation may be given at a future meeting.

1.3 Keep Well Annual Report – Alison Milne talked to this paper which was gratefully received. Five practices within East Lothian are delivering Keep
Well Programme. Only one practice in Musselburgh (the highest risk area) has taken up the programme. Prison Healthcare is also delivering it. One concern for GP Practices was that data requirements would slow their IT systems which will be passed on at the next GP meeting in September. MA will report to Shadow Board the discussion that has taken place at this meeting. MA thanked AM for her attendance and for the informative report.

2.0 Minutes of Previous Meeting held on 08.05.14
DG chaired last meeting and agreed minutes of 08.05.14 were an accurate record.

3.0 Action Note Previous Meeting
Locums for GP Practices – DAS has dealt with proposal to fund internal locums. This has been checked with the Scottish Government and GP Practices should have been informed of this decision in June.

4.0 Matters Arising
4.1 East Lothian Community Hospital
Agreed at NHS Lothian board. Scottish Government approved the Initial Agreement. Reported that two key issues not included are third sector base and GP Practices however these will be re-visited in the Outline Business Case. Andrew Milne will be the Project Director and a project team will be established.

5.0 Items for Decision
5.1 Prestonpans Health Centre Initial Agreement
Peter Gilfoyle, Programme Manager, spoke to the circulated paper. Prestonpans Health Centre is located within the second highest populated ward area in East Lothian. The ward is also the most deprived in East Lothian. There are currently 9,000 patients registered with the Practice and this has increased by 16% since 2009 due to new housing development on the south side of Prestonpans over recent years and more is planned. At present there are insufficient meeting rooms to meet clinical and administrative demands. Three options were presented in the paper: -

1. Health Centre to remain within existing premises and continue as it presently stands.
2. Construct ground floor extension with minor internal refurbishment to accommodate new extension – cost of £489,009. Preferred option.

£46,005 was identified for revenue costs of the preferred option.

The Sub Committee to support the preferred option and that the paper should be presented to the Finance and Resources Committee for approval.

6.0 Items for Discussion
None noted.
7.0 Performance Reports

7.1 Joint Director’s Report
Consultation on guidance and regulations is now complete. It is anticipated that the integration scheme will be presented in December 2014. The main issues are:

Legislation/Regulations – Scottish Government has consulted on two sets of draft guidance and regulations. Both NHS Lothian and East Lothian Council responded to the consultation. It is anticipated that revised regulations will be placed before the Scottish Parliament by the end of September.

Timescales – Planning is underway for the Scheme of Integration to be Submitted to the Council and NHS Board in December 2014 for agreement to consult. This must then be submitted to the Scottish Government no later than 1st April 2015.

Shadow Board has established a Shadow Strategic Planning Group which met for the first time on 20.08.14 and due to meet again on 27.10.14. Donald Grant is chairing this meeting.

7.2 Head of Health Update
Delayed discharges will be discussed under 7.8. Work has been undertaken to disaggregate the previous NHS management arrangements in East and Midlothian in order to better reflect the proposed new structures within the HSCP and these have been presented to the NHS Lothian Workforce and Organisational Change Group. Mental Health Services are looking at the integration opportunities and as a first step a staff engagement event is scheduled for late August to start the process of aligning services to either East or Midlothian. Children’s Services are likely to be brought into both partnerships within second phase of integration.

7.3 Staff Governance Report
Sickness record is a concern with 5.1% being high for East Lothian however it should be noted that 3.33% is longer term sickness. All managers are actively working on these figures. There are a significant number of Health Visitors over the age of 55 who are planning to retire which will have a significant impact on the team in the future.

7.4 Clinical Director’s Report
Tranent Practice has agreed to provide medical cover for 20 step down beds within Crookston Care Facility. Eskbridge Practice in Musselburgh has agreed to continue as lead practice in support of six of the seven care homes in Musselburgh area with additional support from the CHP. Discussions are underway with the Scottish Government to see if they will adopt this as a pilot. There are continued concerns about the shortage of consultants in Care of the Elderly Medicine and on call rotas have been amalgamated with other hospitals so that our consultants have moved from a 1:4 to a 1:15 rota. Paper regarding “Legal Highs” was distributed which related to a shop recently being opened in Musselburgh selling these. A meeting is to be convened with Social Workers in the near future to discuss this.

7.5 Finance Report / Financial Plan 2014/15
DK reported an overspend of £715,000 at the end of Month 4. There are three main drivers:

Prescribing – overspend of c. £139,000
LRP – unachieved c. £307,000
Operational pressures (net) - £269,000 overspend.
The CHP management team have developed a recovery plan and it should be noted that the CHP is committed to meeting its LRP target in year and to support the NHS Lothian Prescribing position.

7.6 **LUCS Report**
LUCS has experienced a challenging time over the summer with rotas becoming increasingly difficult to fill over the summer holidays. On 2\(^{nd}\)/3\(^{rd}\) August staff were redeployed from Roodlands as a temporary measure to protect and ensure that a robust service could operate from the WGH and RIE, however a car and doctor remained within East Lothian to attend any home visits. Any patient from East Lothian requiring an appointment was offered one at either the RIE or Midlothian Community Hospital. The LUCS Computer system has now been successfully changed to hosted ADASTRA and. The final report of the LUCS review is likely to come out in September 2014 and it will be discussed at all CHPs.

7.7 **Prison Healthcare Report**
AMacD reported that the Mental Welfare Commission had visited recently and the result was positive. A new Self referral process of Drop-In sessions held within the halls is now in place. An Initial Assessment Clinic has been introduced to which all the members of the multi-disciplinary team and SPS can refer prisoners. The service is currently recruiting a band 8b psychologist to enhance services available across both prisons. Nursing staff issues have been resolved which has strengthened the structure.

7.8 **Delayed Discharges**
DAS reported on the current situation. The Committee noted with concern the current level of delays and supported the steps being taken. It was noted that other initiatives will need to be developed in order to meet the Four week target and further reduce the total number. The Committee also noted that in the longer term these initiatives alone may not be adequate and the Committee will receive reports on further steps being taken its next meeting.

8.0 **Public Partnership Forum**
AT reported Joint Older People’s Planning Group had discussed concerns at their recent meeting about their purpose in relation to health and social care planning. It was agreed that DAS will agree a process to discuss this with the planning groups.

Action: DAS

9.0 **Carer’s Forum Report**
Nil to report.

10.0 **Date of Next Meeting**
30.10.14
1400 – 1630
Council Chamber, Town House, Haddington

BG to circulate two more dates in mid January and Early March
The draft minutes of the meeting held on 4 September 2014 are attached.

Key issues discussed included:

- **Scottish Government Guidance on Integration** – Presentation was delivered to members on legislation, regulations, governance and the developing clarity on the role of the IJB. Confirmed that the governance arrangements of NHS Board and Council would remain since the two bodies retained their statutory accountabilities, ownership of assets and employment of staff. The operational director would account to the governance structure of each body for service delivery.

- **Shadow Strategic Planning Group** – Group met on 20.08.14 and will continue to meet over the next six months. Reported that the Strategic Plan will be ready for discussion at the October meeting of the group. Communication plan is being developed by a joint team. Shadow Board agreed communications and engagement plans should be joined up.

- **Strategic Plan First Draft** – Progress reported and progress will be presented at the next meeting of the Shadow Board and Shadow Strategic Planning Group. Engagement will commence in November 2014. Formal consultation will take place in the New Year. The plan would propose three delivery programmes:-
  - Fit for the future – prevention
  - Care closer to home
  - Efficiency and Effectiveness

- **Scheme of Integration First Draft** – Reported that the key sections within the scheme will be: -
  - Aims and Outcomes of Integration Scheme
  - Type of Integration Model
  - Local Governance Arrangements
  - Board Governance
  - Delegation of Functions
  - Local Operational Delivery Arrangements
  - Clinical and Care Governance
  - Workforce
  - Finance

- **Organisational Development Plan Update** – Paper will be brought to November meeting. Proposed to partly use the fund to develop the Public Sector Improvement Framework (PSIF) for health and social care.

Key issues on the horizon are:

- **Scottish Government Guidance on Integration**
- **Strategic Plan First Draft**
- **Visits to other Health and Social Care Partnerships** – Cumbria on 18.11.14

Mike Ash
Chair/Executive Lead
1. **Welcome and Apologies**  
MA welcomed those present to the meeting.

2. **Minutes of Previous Meeting**
These were agreed as a correct record.

3. **Matters Arising**
3.1 **Older People’s Change Fund: Consequences for Integrated Care Fund**
CL reported that the Shadow Board had discussed this at its April and June meetings. It was noted that the criteria for Integrated Care Fund are different from the Change Fund, with more focus on prevention, multi-morbidity and under 65s.

The Change fund delivery group has been managing this fund and the evaluation of the funded projects. Current projects have been asked for feedback. The Delivery Group will meet again in October to finalise a proposal for continuation form the Integrated Care Fund. This will be discussed by the Shadow Strategic Planning Group and the Shadow Board for inclusion in the strategic plan.

Proposals for the Integrated Care Fund should be submitted to Scottish Government by 14th December 2014 and must be agreed with partners. This will require some key decisions to be made before the strategic plan is finalised.

MA confirmed that this will be a key discussion at the next Shadow Board meeting in November.

AL asked if we knew the funds involved. CL reported that the Integrated Care Fund is 1.7m and the Change Fund 1.2m.

4. **Standing Items**
4.1 **Chair’s Report**
MA reported that he had attended a Carers event in Musselburgh and will meet with MSP Ian Gray. MA has also met with the Health Network to discuss how they can continue to be involved and provide support in the future.

Some visits are being organised in order to observe other partnerships in Scotland. The first is 16th September 2014 to Inverclyde. Members discussed the possibility of visiting Torbay and Nairn due to their similar populations and different approaches. KM suggested that the shadow board could meet other boards across Lothian.

MA confirmed that the start date for the Body Corporate is scheduled for May 2015. Future dates for the Shadow Board will be set to take account of this.

**Action: circulate membership of the other Lothian Boards.**
4.2 Director’s Report

DAS highlighted Section 3 in his report and asked members to note the weblinks that were noted within. There will be further discussion under 5.4 & 5.5. DAS summarised the timelines in the preparation of the Scheme of Integration and establishment of the Integration Joint Board. This now looked like May 2015.

DAS reported that the East Lothian Community Hospital Initial Agreement had been approved by the Cabinet Secretary. Work is now underway to establish a full time project team. This team will develop the Outline Business Case and ensure engagement and involvement in models of care, bed numbers etc.

JG asked if the Herdmanflat Hospital site would then be surplus and available for housing. DAS responded that this had been NHS Lothian’s intention in the past. DAS added that since the IJB will not own assets it will not have the authority to make such decisions. The IJB will “direct” the NHS Board and the Council to provide services based on the strategic plan. The disposal of assets will remain the responsibility of the NHS Board and Council.

MM said that the agreement non the hospital is very good news for East Lothian as it has been long awaited, and she was surprised at the low key communication of the approval.

DAS emphasised that communications and engagement with stakeholders and staff would be key to progress.

DS reported that a paper on Delayed Discharges had been discussed at the CHP sub committee. This paper had been circulated. DAS emphasised that whilst the Shadow Board did not have decision making powers in these areas yet it was important to be aware of such key issues since resolving them would feature in the strategic plan.

MM asked for clarity on a number of issues.

In Tranent Care Home why has the number of beds changed from the Older People’s Strategy. DAS responded that the step down beds in Tranent have been introduced in the last 9 months in order to support Delayed Discharges, this has not changed the total bed numbers in the home, however the use of these beds has been re categorised.

Why is there a difference in what beds are called i.e. residential or nursing. DH responded that the profile of people’s needs has changed and people being discharged from hospital to care homes could be less frail than those being admitted from home having been sustained at home for longer with...
support. The classifications are those used by the Care Inspectorate.

What are all the functions of the teams such as Elsie, Hospital at home, hospital to home, intermediate beds? It would be helpful to be clear on what these are and who leads them. This can be confusing for the public. The key issue is how to access these services. AMac responded these teams are all in place to support delayed discharge, reduce admissions and to support older people at home. AMac agreed more work was needed to create a smooth pathway for service users.

AL stressed that the shadow board should continue to get support on producing and analysing performance information. The Single Outcome Agreement and other outcomes are what we should be focusing on.

5.  **Items for Discussion**

5.1  **Scottish Government Guidance on Integration**

DAS and JM gave a presentation to members on legislation, regulations, governance and the developing clarity on the role of the IJB.

This highlighted to members the importance of being clear that the IJB key responsibilities would be to oversee the development of the strategic plan, agree the plan, “direct” the NHS Board and Council to deliver services to meet the plans outcomes and to monitor performance on the delivery of the plan.

The strategic plan would be based on the functions that the NHS Board and Council agreed to delegate to the IJB. If it was agreed to delegate children’s services after the first year there would need to be a change to the Scheme of Integration and that would need to be re-submitted. This would mean that children’s services might not feature in the first version of the strategic plan.

DAS reported that the IJB will only employ two staff in the first instance. The Chief Officer and the section 95 officer. The Chief Officer’s role in delivering the functions of the IJB and being accountable to the IJB for that, would be distinct from the operational director’s role in managing services with accountability to the two Chief Executives in that capacity.

JM and DS confirmed that the governance arrangements of the NHS Board and Council would remain since the two bodies retained their statutory accountabilities and ownership of assets and employment of staff. Therefore no changes to committee structures were anticipated. The operational director would account to the governance structure of each body for service delivery.

5.2  **IJB Governance Issues**

Covered in the above
5.3 Shadow Strategic Planning Group Membership

DG reported that group had met on 23rd August with good representation and attendance. This group will continue to meet over the next 6 months. CL reported that the strategic plan will be ready in first draft for the October meeting of the group.

The meeting noted the updated membership of the group.

MM suggested that there needs to be a communication plan or a briefing bulletin regularly to advise and inform people of the development of the plan.

CL reported that there is a communication plan in respect of the Strategic Plan and Integration Scheme. This is being developed by a joint team.

KM suggested that engagement and communications should be brought together.

The shadow board discussed this issue and agreed communications and engagement plans should be joined up.

**Action.** Communications and engagement to be discussed under strategic plan at next meeting

5.4 Strategic Plan First Draft

CL reported on progress with the development of the strategic plan. The next meetings of the shadow strategic planning group and the shadow board will discuss this in more detail. The draft plan will be presented at both meetings. Engagement will commence in November 2014. Formal consultation will take place in the new year. CL referred the shadow board to the timetable covered in item 4.2.

CL reported that the establishment of baseline data has been a key effort. This will allow information on which to focus service development proposals. Some planning “gaps” such as dementia were already evident. The data would show differences at Area Partnership level as well as the East/West higher level split.

The plan would propose three delivery programmes.

Fit for the future - prevention
Care closer to home
Efficiency and Effectiveness

MA suggested if members wished further information in the meantime they should contact CL.

AM supported the emphasis on place-based information and planning and suggested the shadow board is in a strong position to support the people of East Lothian.

MA thanked CL and her colleagues for their work.

5.5 Scheme of Integration First Draft

JM introduced herself as the Council legal advisor drafting the Scheme of Integration. JM is working between the working with Council, NHS Board and Scottish government.

JM reported that the key sections within the scheme will be:

- Aims and Outcomes of Integration Scheme
- Type of Integration Model
- Local Governance Arrangements
- Board Governance
- Delegation of Functions
- Local Operational Delivery Arrangements
- Clinical and Care Governance
- Workforce
- Finance

The document will allow for the legal requirements but will have sufficient flexibility to support future changes without the need to seek approval from Scottish Government for minor adaptations or changes. This would exclude major changes such as the inclusion of new delegated functions.

TM asked about terms and conditions of staff. Assurances were given that the NHS Board and Council would remain the employers and there was no proposal to change staff terms and conditions. DAS added that there would be proposals for staff to work in different ways in joint teams, but these would be fully discussed with staff and unions. AL added that she felt this would be important to realise the benefits of integration.

MA said she was disappointed that the independent sector is not included in the current draft regulations on board membership. DAS said the regulations were draft and were only minimum membership. East Lothian could vary this.
5.6 Organisational Development Plan Update

CL reported there is a budget of 144k. A paper will be brought to the November meeting. Meetings had been held to discuss the benefits of working together on this across Lothian including buying in capacity regarding to promote culture change and to include the independent and third sector in this piece of work.

Another priority is to fund backfill for teams moving to early integration to allow time for development and to develop team leaders.

Communication and engagement strategy - some resource for this to be done well and innovatively

It is also proposed to use the fund to develop the Public Sector Improvement Framework (PSIF) for health and social care. AL suggested that West Lothian be asked to present on this since they have used this framework and the outcomes have been very positive. AL gave a brief explanation of the framework

Action CL to circulate information

6. Items for Noting
6.1 NHSL and ELC Responses to consultation

DAS reported that these had been submitted.

6.2 Visits

See chairs report.

7. Any Other Business

None

8. Date of Next Meeting
6th November 2014 1400 – 1600
Adam Room, John Muir House, Haddington

11th December 2014 meeting will be held at the Brunton Hall in Musselburgh
Key issues discussed included:

- **IPCC bed reconfiguration move now completed to RVH and planning underway for relocation of the delayed discharge ward;**
- **Bundle projects:** Muirhouse, Firrhill and Ratho GP premises approved for submission to Finance and Resources. Two options are under consideration for the Ratho surgery;
- Agreement in principle to align boundaries across Public Sector. Noted major engagement underway with GP Practices but initial responses very positive;
- **Update on integration:** Children’s service will not be included in the integration scheme because a separate partnership between NHS and CEC is being proposed;
- **Learning Disabilities:** Joint directors have approved new infrastructure for Learning Disabilities across 4 localities. Relationships with teams throughout will be redesigned. The 4 areas will require separate models to suit their own populations;
- **Finance:** LRP progress meetings scheduled at management level to work towards a break even position. It was noted that £4.6m secured against £5.2m target. Star Chamber events organised to review both LRP progress and current in year financial position;
- **Strategy** currently being developed for young carer ID cards and a pilot taken forward aimed at children and young people aged between 5 and 21 years

Key issues on the horizon are;

- Health inequalities future reporting arrangements

Shulah Allan, Chair

Peter Gabbitas, Executive Lead
Welcome & Introductions

Apologies were noted as above.

Shulah Allan (Chair) welcomed those present. Brief introductions were made.

Minutes of previous meeting of 15th May

The minutes from 15th May 2014 were agreed as an accurate record.

Matters arising

IPCC Bed Reconfiguration
Beds will be moved from Corstorphine to RVH on 26th August and planning is underway for relocation of the delayed discharge ward. In terms of staff engagement, due process will be followed. Following the move on 26th August Corstorphine Hospital will be securely locked as the building will be vacant. The relocation to Liberton is scheduled for 29th September.

Update on GP Premises
The bundle project, which contains Muirhouse, Firrhill and Ratho surgeries, has now been approved by the board and is showing good progress.
There are 2 options for the new build at Ratho. It was agreed that finding an existing surgery would be ideal. Brief discussion took place around the current practice and the possibility of the GP and nurse sharing a consulting room. The difficulties this would present were recognised. With the ever increasing population in Ratho the issues are ongoing.

**Development of localities**
David is leading this project. There was brief discussion about the current boundaries and it was noted that there may be a lack of understanding around Neighbourhood Partnerships at the moment. Initially, a consensus will be required on policies etc with updates added as we move forward. GP Practices affected by shifting boundaries must be aware of the changes and it was agreed that the organisational change process should take place this year, while the CHP is still live. The new partnership will be taking over at the start of the new financial year. It was felt that it could be helpful for David to do a master class as part of the upcoming workshop. If anyone else would like to attend the workshop with David they should request an invite.

4. **Integration Update**

Proposed arrangements for integration of Health and Social Care Services in Edinburgh are currently under review. Consideration is being given to the strengths of two options, an Integrated or Lead Agency model. Children’s services will not be included in what emerges as the favoured arrangement. A separate partnership between NHS Lothian and the City of Edinburgh Council for children’s services is being proposed. Responses to the draft regulations have been submitted and issues have been raised by both the NHS and council as clearer details of the services to be included in the partnership are required. Confirmation is also required on whether acute services will be commissioned by the partnership. Commissioning services would require staff with significant expertise, but could result in less staff at a corporate level. 55% of the budget currently goes on external commissioning with procurement holding a small portion. Light touch commissioning could be used for the acute sector, particularly in the run up to winter when additional beds are required. This is a good opportunity for a thorough review of service provision in all areas in order to ensure challenging areas can be covered e.g. gaps in the service, waiting times, shortfalls.

5. **Learning Disability Update**

*See attached LD Integration CMT Report*

The report has gone to the Corporate Management Team. The joint directors have approved a new infrastructure across 4 localities, delivered mainly from the Royal Edinburgh Hospital. Functions of the department in entirety will go to the joint board with smaller services being commissioned back. This will include the CAMMS service, special complex needs clinic, Learning Difficulties and the epilepsy service. All other departments will be integrated into the joint board and then commissioned a proportion of funding once successful delivery has been proven. The relationships still need worked out as the teams throughout will be redesigned. The 4 areas will require separate models to suit their own population therefore there will be no universal model. Details of the current spend are required as the last logged figures were back in 2009 and this must be stated in the draft strategic plans. There are a lot of unknown figures as people with Learning Difficulties are often cared for by family members therefore don’t come to the authorities attention until the family are no longer around. The Independent Living Fund has not been available to
patients for the last 18 months. It was highlighted that following integration there will be only one budget.

6. Health Inequalities: Future Reporting Arrangements

See attached Investment in Prevention of Health Inequalities paper

This paper was first brought to the Committee a year ago for approval and PG had requested more information. The team are keen to move forward with the project and migrate the teams seamlessly. If the joint partnership group can continue as they are, then the Board are happy to approve the plans.

7. Finance Updates inc. LRP progress

See attached paper Financial position to 30th June 2014

Discussions are taking place across the board about the current financial challenges. The CHP’s have started work on proposals to address the issues. There are meetings coming up at management level to work towards a break even position. In terms of savings within LRP it was noted that there is already in Edinburgh a projected £4m overspend within prescribing for rehab, which is currently sitting at a £1m overspend. Sickness absence covers high numbers and there is also a need to reduce the community equipment spend. Drugs are being brought with patients to the ortho beds, keeping costs down for the hospitals. It is not possible to claw back the money from acute as we cannot pin point where it came from originally. Finance will find the projected figures challenging. 1:1 meetings are taking place in the coming weeks to discuss major overspends and the efficiency programme. The Committee are aware that the financial position will take time to resolve and it is hoped that improvements will be seen shortly.

8. Young Carers ID Card

This project is being led by Julie Deegan - Wood alongside Donny Scott. A strategy is being developed and a pilot taken forward, aimed at children and young people aged between 5 and 21 years. The project has been approved with funding for 2014/15. The ID card can provide information on the person the child is caring for. Cards are being designed at present and should help promote health and wellbeing of the young people involved.

9. A.O.C.B.

There was brief discussion around the integration of health and social care enabling the service to take peoples skills and expertise to new levels.

10. D.O.N.M.

This is scheduled for 13th November 2014 at 9.30 a.m. in PMR Room, SMART Centre, AAH
<table>
<thead>
<tr>
<th>MEETING</th>
<th>KEY ISSUES</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>West Lothian CHCP Sub-Committee - 9th October 2014</td>
<td>Review of the Single Outcome Agreement – Progress throughout the last year.</td>
<td>A report was provided highlighting key success areas under this outcome, areas for improvement and action plan</td>
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<tr>
<td></td>
<td>Our Children have the best start in life and are ready to succeed</td>
<td>A report was provided highlighting key success areas under this outcome, areas for improvement and action plan</td>
</tr>
<tr>
<td></td>
<td>Older People are Abel to Live Independently in the community with an improved quality of Life</td>
<td>A report was provided highlighting key success areas under this outcome, areas for improvement and action plan</td>
</tr>
<tr>
<td></td>
<td>We live longer, healthier lives and have reduced health inequalities</td>
<td>A report was provided highlighting key success areas under this outcome, areas for improvement and action plan</td>
</tr>
<tr>
<td></td>
<td>Public Protection and Community Safety</td>
<td>A report was provided highlighting key success areas under this outcome, areas for improvement and action plan</td>
</tr>
<tr>
<td></td>
<td>Community Safety Board</td>
<td>A report was provided highlighting the Quality of Life Results</td>
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Minutes of the West Lothian Sub Committee held on 9th October 2014, 1400 – 1600, Strathbrock Partnership Centre.

Present

Frank Toner (FT) Chair, West Lothian CHCP
Jim Forrest (JF) Director, West Lothian CHCP
Marion Christie (MC) Head of Health / General Manager, WLCHCP
Jennifer Scott (JS) Head of Social Policy, WLC
Julie Cassidy (JC) Public Involvement Co-ordinator
Jane Kellock (JK) Senior Manager, Children & Early Intervention
John Richardson (JR) Public Partnership Forum Rep
Pamela Main (PM) Senior Manager – Community Care, Assessment and Prevention

Jane Kellock (JK) Senior Manager – Children and Early Intervention
Nick Clater (NC) Group Manager
Mary Vest (MV) Health and WB co-ordinator (Education)
Lorraine Gillies (LG) Community Planning Development Manager
Jane Houston (JH) Partnership Lead

Apologies

Mary-Denise McKernan (MMc) Manager, Carers of West Lothian
Alan Bell (AB) Senior Manager, Community Care Support & Services
Lindsay Seywright (LS) West Lothian College
Gill Cottrell (GC) Chief Nurse
Chris Stirling (CS) SJH Site Director
Alistair Shaw (AS) Head of Service WLC
Pat Donald (PD) Acting AHP Manager
Andreas Kelch (AK) GP PCCF Rep
Moira Niven (MN) Deputy Chief Executive

In Attendance

Marjory Brisbane Admin Manager (Minutes)

1. APOLOGIES

As above.

2. ORDER OF BUSINESS INCLUDING NOTICE OF URGENT BUSINESS

As agenda

3. ANY OTHER BUSINESS FOR TODAY

No other business notified.

4. DECLARATION OF INTEREST

FT declared he is chair of the CHCP and non executive member of NHS Lothian.

5. DRAFT MINUTE OF WEST LOTHIAN CHCP SUB COMMITTEE

The minutes of the meeting held on 14th August 2014 were approved as being an accurate record.
6. CONFIRMATION OF ACTION POINTS
   Action points confirmed

7. MINUTES OF WEST LOTHIAN PUBLIC PARTNERSHIP FORUM FOR HEALTH CARE (WLPPFHC) MEETING
   Noted minutes of 31/07/14

8. MINUTES OF PRIMARY CARE JOINT MANAGEMENT GROUP
   Noted minutes of 14/08/14

9. MINUTES OF CHILDREN AND FAMILIES MANAGEMENT GROUP AND SUB GROUPS REPORT
   Noted minutes of 25/08/14

10. MINUTES OF COMMUNITY PLANNING STEERING GROUP
    Noted minutes of 12/08/14

11. OUR CHILDREN HAVE THE BEST START IN LIFE AND ARE READY TO SUCCEED
    JK talked to the paper summarising key success areas over the last year which included a consistent decline of teenage pregnancy, implementation of intensive support for vulnerable young mothers and psychology of parenting project (POPP). POPP still has areas to improve with regards to reaching out to families. The aim of the project is to engage with families going through a clinical range of difficult behaviour to help move to normal behaviour. Dental health is another area of success with 65.7% of West Lothian primary 1 children with no obvious dental caries which is above the Scottish target of 60% although this is less than the Scottish average of 67%. The development of the Mental and Emotional Well-being screening service has brought together standalone resources across NHS and social policy and funded additional children’s counsellor, resilience worker and mental health link workers. This has resulted in streamlining exciting services and the matching of over 530 referrals to appropriate services.

    JK highlighted key areas for improvement and development which include the 27 – 30 month development milestones which has been re-introduced. West Lothian succeeded the Scottish average of 72.1% reaching 74% although this is lower than the other areas across Lothian. Children in Poverty target has been set by the council at 19.2% with West Lothian in 2012 – 13 reaching 18%. The council target is set below the Scottish average as welfare expenditure is forecast to reduce in 2014/15 and 2015/16. The prevalence in breastfeeding has remained static over the last decade and there is a strong correlation between breastfeeding and deprivation. This is an area that has been highlighted for improvement. Pre school attendance is an issue with vulnerable families and is an area which requires additional support. The requirement to offer 600 hours per annum early learning and childcare to 2 year old children who are looked after has been a challenge for the service provision especially since this was rolled out to children living in “workless” households and certain families receiving benefits. In additional as of Aug 2014 the level of early learning and childcare increases from 475 hours a year to a minimum of 600 hours for 3 and 4 year olds. The above policy requirements have been a challenge but West Lothian council (education) and social policy has enhanced and increased its provision to enable demand to be met.

    An action plan for these areas have been previously developed and will continue with the actions already in place.

    The Sub Committee approved the report.
OLDER PEOPLE ARE ABLE TO LIVE INDEPENDENTLY IN THE COMMUNITY WITH AN IMPROVED QUALITY OF LIFE
PM talked to the report stating maintaining the status quo was not suffice and significant shifts towards anticipatory and preventative approaches are required. The change fund has enabled a key range of new services focusing on preventing admissions to high tariff and institutional care, support for carers and improving service. These include Reablement and Crisis Care, Rapid Elderly Assessment Care and Treatment (REACT) Older People Assessment and Care Team (OPACT) Redesign of Older People Mental Health Service and Older people Day Care Service, Home Support for Dementia and Supporting Older People into Caring. In addition a strategic approach to commissioning has been developed which makes no presumption to service requirement and begins with the process of analysis of need ensuring resources are deployed to meet priority outcomes.

The change fund is due to come to an end and the Scottish Government have introduced an Integration Fund which covers all age groups but will help to continue to support projects already in place. A draft plan for the Integration Fund is well underway identifying further areas for improvement applying the current strategic commissioning process.

JH raised a concern re NHS posts funded through the change fund. MC to discuss with JH.

The Sub Committee accepted the recommendations in the report.

WE LIVE LONGER, HEALTHIER LIVES AND HAVE REDUCED HEALTH INEQUALITIES
JK talked to the paper highlighting health inequalities are worse in areas of deprivation. The key success areas include the Early Years Programme which has developed a range of activities targeted to communities where the impact of health inequalities is greatest. The Older People Programme is another key success area which has development a much greater range of activities to similar areas as the Early Years Programme. The Choose Life Programme has helped reduce the annual suicide rates in West Lothian in 2013 from 31 to 25 and the annual 2013 suicide Memorial Service had its highest attendance of 26 receiving positive feedback. Education has provided over 400,000 free breakfasts since April 2013 continually extending this provision. Pupils from Fallahil Primary School in Fauldhouse have just received an award from ASH Scotland for the creation of a DVD which involved an tobacco education project to ‘Create a world where young people choose not to smoke’

Areas for improvement include a structural change across employment, achievement, housing and homelessness and the impact on welfare reforms. A focus on life stages and target vulnerable communities is required. Healthy Weight is a concern with an increase of overweight children recorded at Primary 1. A holistic approach is required to tackle this and CPP action plans are required to support the outcome of healthy weight. The West Lothian Sexual Health and HIV have developed an action plan to improve areas under their remit and the CPP is developing a strategic approach to tobacco issues based on the 2013 report Smoking and Mental Health this is being led by Gill Cottrell, Chief Nurse

LG asked if she could be provided with the information regarding the uptake on free school meals. MV to provide figures

The Sub Committee noted the paper.
14. PUBLIC PROTECTION AND COMMUNITY SAFETY
NC talked to the report highlighting the two outcomes closely related to public protection under the Single Outcome Agreement. Reducing re-offending is one of the key priorities currently being taken forward with strong evidence that alcohol and drug misuse is a factor for re-offending.

Key Success areas include robust strategies in place in West Lothian to deal with high tariff offenders with a priority in working with children and families at a early stage in their life to divert away from crime. Youth offending has shown an overall reduction in referrals to Early and Effective Intervention for 8 – 15 year olds and a dramatic drop of the number of young people being sent to residential schools and secure provision from its peak at 9 to current figure of 1. The numbers for re–registering children on the child protection register has fallen from 15% to 10% from the previous year. Under domestic abuse the number of women feeling safer due to DASAT involvement was 90% which is well in excess of the target. Adult protection performance indicators are also performing in excess of their target with 90% feeling safer.

Area for improvement include Multi Agency Public Protection Arrangements (MAPPA) which is developing a fuller suite of indicators to help monitor progress in this area. Child protection indicator is making positive progress but sitting at 50% with a target of 80%. There are issues on how this is being measured and work is being undertaken to improve the accuracy of this measurement. The measurement of young people under 22 who have previously been looked after and go on to receive a custodial sentence target of 25% has not been achieved. This is a longer term aspiration with a view to reduce homelessness and substance misuse. Sample sizes within domestic abuse remain small and it is intended to increase the sample sizes in coming years.

Action plan for improvement for the above areas are reported to three public protection committees and their various sub committees.

JH highlighted the potential for re-investing the monies saved through the drop in numbers from 9 – 1 for young people being sent to residential schools and secure provision.

15. COMMUNITY SAFETY BOARD – QUALITY OF LIFE RESULTS
LG talked to the paper highlighting the Quality of Life results. This was set up in 1999 and is carried out every 3rd year. This report gives details of the 6th survey that the CPP has carried out. There has been an increase in membership when it was refreshed in 2013 from approximately 2800 to approximately 3000. Questionnaires are developed in partnership with a response of 1764 (57%) this is a slightly lower response from previous surveys which has been put down to the length of the survey, this has been taken noted for future surveys. The survey has been approved by the CPP Board.

The sub committee note the report.

16. ANY OTHER COMPETENT BUSINESS
The meeting closed at 3.15pm

DATE, TIME OF NEXT MEETINGS
CHCP Sub Committee meetings at 2pm – 4pm in Strathbrock Partnership Centre.
18th December 2014
12th February 2015
16th April 2015
11th June 2015
<table>
<thead>
<tr>
<th>MEETING</th>
<th>KEY ISSUES</th>
<th>ACTION</th>
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<tbody>
<tr>
<td>West Lothian CHCP Board 7 October 2014</td>
<td>West Lothian Keep Well Annual Report 2013-14</td>
<td>Content of the report noted and work is ongoing to explore the evolution of Keep Well.</td>
</tr>
<tr>
<td>Falls Response Pathway – Crisis Care and Scottish Ambulance Service</td>
<td></td>
<td>Noted the partnership developments with the Scottish Ambulance Service and agreed to support the key aim of ensuring that falls response services are well targeted and integrated; and that a report should be brought to Board providing up-to-date information on the overall crisis care service, including the performance of the falls prevention service.</td>
</tr>
<tr>
<td>Clinical Governance – Distress Tolerance Project</td>
<td></td>
<td>Noted report contents. Agreed to support the progress being made and that Board members should be provided with an electronic copy of the project’s interim report.</td>
</tr>
<tr>
<td>Care Governance – Update on Adult and Child Protection</td>
<td></td>
<td>Noted ongoing work within adult and child protection.</td>
</tr>
<tr>
<td>Staff Governance</td>
<td></td>
<td>Noted updates on Person Centred Health and Care Programme, National learning session, Delivering Better Care Leadership Programme, GP Nursing, NHS Scotland Staff Survey and West Lothian Council Absence Management.</td>
</tr>
<tr>
<td>Director’s Report</td>
<td></td>
<td>Noted updates on Integrated Care Fund, Draft Regulations Relating to the Public Bodies (Joint Working) (Scotland) Act 2014, Re-offending Rates in West Lothian, Children’s Services Information Day, Transforming Care After Treatment and the New Hearing Aid Battery Distribution Service.</td>
</tr>
</tbody>
</table>
MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, 189(A) WEST MAIN STREET, BROXBOURN, EH52 5LH, on 7 OCTOBER 2014

Present – Frank Toner (Chair), Brian Houston, Jane Houston, John McGinty, Anne McMillan, Ed Russell-Smith

Apologies – Janet Campbell and Alison Mitchell

In Attendance – Jim Forrest (CHCP Director), Jennifer Scott (Head of Council Services), Marion Christie (Head of Health Services), Gill Cottrell (Chief Nurse, NHS Lothian), Dr Elaine Duncan, (Clinical Director), Carol Bebbington (Primary Care Manager, NHS Lothian); Alison Milne (Keep Well Team Lead); John Richardson (PPF)

1. DECLARATIONS OF INTEREST

Councillor Frank Toner declared a non-financial interest as he was the council’s appointment to the Board of NHS Lothian as Non-Executive Director.

2. MINUTE

The Board approved the minute of its meeting held on 12th August 2014 as a correct record.

3. CHCP RUNNING ACTION NOTE

The Board considered the Running Action Note (which had been circulated).

Decision

To note and agree the Running Action Note.

4. NOTE MINUTE OF MEETING OF THE CHCP SUB-COMMITTEE

The Board noted the minute of the CHCP Sub-Committee held on 10th July 2014.

5. WEST LOTHIAN KEEP WELL

The Board considered a report (copies of which had been circulated) by the Head of Health Services presenting the Keep Well in NHS Lothian Annual Report 2013-14 which had been provided as an appendix to the report.
The report recalled the history and purposes of the programme and provided details on the model of delivery in Lothian. Key points arising from the report were as follows:-

- NHS Lothian had exceeded the target of delivering 4800 Keep Well checks in a year and continued to develop its relationships with General Practices with 58 practices throughout Lothian engaged by March 2014 and partners who supported vulnerable groups.

- Scottish Government funding contributions would continue largely unchanged in 2014 (£1,119,000 for NHS Lothian) and would reduce nationally from £11 million in 2014-15 to £7 million and £3 million for 2015-16 and 2016-17 respectively.

- Work had commenced to develop an options appraisal to explore how Keep Well would evolve, given the changing environment and changes to funding arrangements.

The report concluded that during the review process, the project would remain focused on the main objective of reducing inequalities and continue to improve focus on person centred care, with further communications with CHCPs to follow as work developed.

Decision

1. To note the content of the Keep Well in NHS Lothian Annual Report 2013-14.

2. To note that the annual report had been approved by NHS Lothian Board and submitted to the Scottish Government.

3. To note that work was ongoing to explore the evolution of Keep Well in Lothian.

6. FALLS RESPONSE PATHWAY – CRISING CARE AND SCOTTISH AMBULANCE SERVICE

The Board considered a report (copies of which had been circulated) by the Head of Social Policy advising of the recent partnership work with the Scottish Ambulance Service to develop a falls response pathway focussed on better outcomes for those at risk of falls.

The report recalled that in 2012 a report had been commissioned by NHS Scotland to examine the resources, costs and benefits associated with implementing care bundles to prevent falls in the community which had concluded that care bundles improved people’s quality of life, decreased morbidity and mortality and enabled people to be independent for longer. The financial implications of not implementing care bundles was expected to result in a 40% rise in costs by 2020 which would place a major strain on the ability to co-ordinate care effectively and with compassion for increasingly frail people.
The report explained that nationally, 80% of individuals the Scottish Ambulance Service (SAS) responded to post fall were conveyed to A&E which was not always clinically warranted or in the best interests of the individual. In addition, patients responded to by the SAS did not have access falls bundles which resulted in falls and bone health risk factors not being fully assessed and appropriate interventions to decrease risks being put in place. The report provided details of new national guidance which had been developed by the SAS to reduce the number of people who attended A&E when it was not clinically warranted. Under the guidance, if an individual was clinically stable but had new support needs, there was now a pathway between the SAS and health and social care services to ensure a same day or next day response to conduct an assessment of needs.

Within West Lothian, a Crisis Care Service had been developed that had a significant and positive impact in improving and streamlining response to falls. Appropriate screening and development tools had been developed to enable those at risk of future falls to be identified and an appropriate preventative programme to be implemented. Over the last year, pathways had been developed to ensure falls bundles were available.

The report concluded that whilst some challenges remained, the introduction of an integrated pathway with the SAS would ensure falls response services were better targeted and integrated.

Decision

1. To note the partnership developments with the Scottish Ambulance Service (SAS).
2. To agree to support the key aim of ensuring that falls response services were well targeted and integrated.
3. To agree that a report should be brought to a future meeting of the Board to provide up-to-date information on the overall crisis care service, including the performance of the falls prevention service.

7. CLINICAL GOVERNANCE – DISTRESS TOLERANCE PROJECT

The Board considered a report (copies of which had been circulated) by the Clinical Director advising of the progress of the distress tolerance project and the findings of an interim report.

The report recalled the background to the introduction of the project which aimed to assist patients who had difficulty coping with distress caused by life events through the provision of a 12 week course to teach new methods of coping with internal feelings of distress. The three key aims of the project were provided within the report.

The feedback from course attendees had been overwhelmingly positive and indicated that it had made a substantial improvement to their lives.
Furthermore, feedback from health professionals indicated that the programme was the most advanced of its kind in Scotland and an excellent example of evidence based treatment for Borderline Personality Disorder that was fully implemented and supported by all local statutory agencies.

The report concluded that a sustainability working group was analysing how the project could be taken forward in the longer term on a more sustained basis by examining the cost benefits to a range of frontline statutory services (Primary Care and Secondary Care, A&E, SAS, Social Work and Police).

Decision

1. To note the contents of the report.

2. To agree to support the progress being made to provide appropriate, accessible care for the patient group.

3. To agree that Board members should be provided with an electronic copy of the Distress Tolerance Project Interim Report June 2014.

8. CARE GOVERNANCE – UPDATE ON ADULT PROTECTION AND CHILD PROTECTION

The Board considered a report (copies of which had been circulated) by the Head of Council Services providing an update on adult protection and child protection activity in the CHCP over the last 6 months as follows:-

- Employment of an additional administrative assistant to support the Adult Protection Committee in view of the 25% increase in the number of meetings and to assist with meeting performance targets.

- Active engagement with the voluntary sector to supplement and enhance the future development of the Safe and Sound Adult Protection Service User and Forum.

- A suite of Adult Protection Performance Indicators approved by the APC which provided greater emphasis on outcomes than previous indicators and focussed on ensuring timescales were measured. Further work to be carried out to include an audit of assessment and plans used in the adult protection process.

- A new Adult Protection Committee action plan had been developed that would focus on the adult protection case conference process. Two audits had been carried out which had resulted in a number of recommendations and improvement actions being implemented.

- The Learning and Development Sub-Committee of the APC had developed an action plan focussed on assessment training and
scoping further skills-based training. The current training programme required a degree of revision to take account of the increasing complexity of adult protection work.

- The APC would submit it biennial report for 2012-14 on Adult Protection Activity when it submitted to the Scottish Government in October 2014.

- The priorities of the Child Protection Committee (CPC) continued to be self-evaluation, promotion of good practice, training and staff development to improve outcomes for children involved in the child protection system.

- The quality of joint investigative interviews conducted by Social Workers and police continued to be assessed with a more consistent approach having been noted.

- The Quality Assurance and Self Evaluation subcommittee scrutinised cases where the names of unborn children had been placed on the register and remained after 12 months of agencies’ intervention.

- Following an audit of the quality of all aspects of Child Protection Case Conferences (CPCC), changes had been made to ensure CPCCs focussed on the risks to children and the planning to reduce those risks. CPCC chair’s had been provided with a script to ensure consistency. A further audit carried out in 2014 had identified that whilst there had been an improvement in focussing CPCCs on the impact of risk factors of the child and planning to reduce the impact, auditors had noted that some improvements were still required and that work would continue to address those issues.

- The Practice and Training subcommittee had focussed on sexual abuse and had provided seminars on child protection and the internet and the impact of sexual abuse. A seminar raising awareness of child exploitation and West Lothian’s procedure would be held in October 2014.

**Decision**

To note the ongoing work within adult and child protection.


The Board considered a report (copies of which had been circulated) by the Head of Social Policy and Head of Health Services providing a joint report on financial performance in respect of West Lothian Community Health and Care Partnership (WLCHCP) based on figures for the period 31 July 2014.
The report advised that the anticipated out-turn for both the CHCP council services and the CHCP health services was forecast to breakeven.

**Decisions**

1. To note the information in the report regarding financial performance in the CHCP to 31 July 2014.

2. To note that the CHCP Council services outturn for the year was forecast to break even.

3. To note that the CHPC health services outturn for the year was expected to break even.

4. To note that service managers were taking management action to address areas of financial pressure within their own service area to ensure spend was contained within the budget available.

10. **STAFF GOVERNANCE**

The Board considered a report (copies of which had been circulated) by the Head of Social Policy and the Head of Health Services providing a comprehensive update on staff issues within the CHCP.

**Decision**

To note the updates provided in relation to:-

- Person Centred Health and Care Programme
- National learning session
- Delivering Better Care Leadership Programme
- General Practice Nursing
- NHS Scotland Staff Survey
- West Lothian Council Absence Management

11. **DIRECTOR’S REPORT**

The Board heard a report by the CHCP Director providing an update on key areas of work in which the partnership had been involved in since the last meeting of the Board.

**Decision**

To note the information and work undertaken in relation to:-

a) Integrated Care Fund
b) Draft Regulations relating to Public Bodies (Joint Working) (Scotland) Act 2014.

c) Re-offending Rates in West Lothian.

d) Children’s Services Information Day.

e) Transforming Care After Treatment.

f) New Hearing Aid Battery Distribution Service.
SUMMARY PAPER - UNSCHEDULED CARE & WINTER PLANNING

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

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

- NHS Lothian’s unscheduled care performance against the 4 hour standard for the month of October 2014 was **92.62%** (93.83% during September).  
  3.1.1

- During October 2014 there were 14 twelve hour breaches along with 164 eight hour breaches.  
  3.2.1

- The cumulative number of boarders for the week ending 2nd November was 658  
  3.3.2

- The overall number of Delayed Discharges across NHS Lothian has increased from 177 during July 2014 to 195 during October 2014  
  3.4.1

- Significant work is being undertaken to help address the issues of delayed discharge. These include Community Clinical Support Workers, the commissioning of ‘Hospital to Home’, hospital admission prevention models such as REACT and COMPASS, Discharge Hubs and the joint venture with City of Edinburgh Council to establish additional winter bed capacity at Gylemuir House (Pentland Hills).  
  3.5

- The total investment received from the Scottish Government in support of unscheduled care in 2014-15 is £2.17M. A quarterly update of NHS Lothian’s Local Unscheduled Care Action Plan (LUCAP), was submitted to the Scottish Government in September. A further update is due at the end of December.  
  4

- A total of **£3.6 million has been allocated this year** to support winter planning  
  5.3.3

- Additional bed capacity is available in excess of last year's requirements.  
  5.3.4

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Unscheduled Care Manager  
neil.wilson@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
3 December 2014

Executive Director: Nursing, AHPs & Unscheduled Care

UNSCHEDULED CARE & WINTER PLANNING

1. Purpose of the Report

1.1 The purpose of this report is to provide the Board with an update on Unscheduled Care performance and our measurement against agreed national targets as well as an update on this year’s winter planning approach.

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

2. Recommendations

2.1. To note the actions being taken forward to support NHS Lothian’s performance outcomes for unscheduled care.

2.2. To note the key challenges being faced by the service in relation to patient flow and performance.

2.3. To note the anticipated additional resource required to support effective service delivery during winter 2014/15.

- In total, £3.6 Million has been allocated this year to support winter planning
- Additional bed capacity has been identified although final numbers have yet to be confirmed.

2.4. To note local winter plans collated for acute sites and all 4 health and social care partnerships.

2.5. To note that ‘winter’ is defined as the months of January, February and March, although it is likely that the ‘effects of winter’ may be felt within the system out with this period.

3. Performance

3.1. The 4 Hour Standard

3.1.1 NHS Lothian’s unscheduled care performance against the 4 hour standard for the month of October 2014 was 92.62% (93.83% during September).

3.1.2 The performance across individual sites for October 2014 was as follows (September figures are shown in brackets):
- RIE – 92.83% (93.18%)
- WGH – 85.48% (89.02%)
- StJ – 93.47% (95.12%)
- RHSC – 97.60% (98.63%)
3.1.3 The latest compliance data for NHS Lothian shows that our overall performance at the end of October falls short of the revised agreed LUCAP October 2014 trajectory of 95%. [The national target is to achieve a minimal compliance rate of 95% as at September 2014 and 98% thereafter - See graph below.]

![NHS Lothian: 4 Hour Performance](image)

3.2 8 and 12 Hour Breaches

3.2.1 A key measure of patient safety and improved patient experience can be considered against NHS Lothian’s unscheduled care performance in terms of the number of 8 and 12 Hour Breaches. The graph below plots NHS Lothian’s performance against both (Dec 12 – Oct 14).

![NHS Lothian: 8 and 12 Hour Breaches](image)
3.2.2 The following table highlights the number and reasons for 12 hour beaches (by site) for the period October ’13 to October 14.

<table>
<thead>
<tr>
<th>12 Hour Breaches</th>
<th>ARAUT</th>
<th>RIE ED</th>
<th>SJHAE</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical exception</td>
<td>1</td>
<td>3</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Other (please specify)</td>
<td>1</td>
<td>1</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Wait for 1st assessment</td>
<td>3</td>
<td>5</td>
<td>1</td>
<td>9</td>
</tr>
<tr>
<td>Wait for bed - Monitored</td>
<td>11</td>
<td>3</td>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>Wait for bed - Non Monitored</td>
<td>116</td>
<td>26</td>
<td>2</td>
<td>144</td>
</tr>
<tr>
<td>Wait for diag test result - Bloods</td>
<td>1</td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Wait for NHS transport</td>
<td>10</td>
<td></td>
<td></td>
<td>10</td>
</tr>
<tr>
<td>Wait for specialist - Orthopaedics</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Wait for specialist - Other</td>
<td>2</td>
<td></td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>Wait for specialist - Surgery</td>
<td>4</td>
<td></td>
<td></td>
<td>4</td>
</tr>
<tr>
<td>Wait for treatment to end</td>
<td>3</td>
<td>1</td>
<td></td>
<td>4</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>132</strong></td>
<td><strong>60</strong></td>
<td><strong>5</strong></td>
<td><strong>197</strong></td>
</tr>
</tbody>
</table>

3.3. Boarding of Patients

3.3.1 The following graph shows the number of patients ‘boarded out’ across the system for the period since October 2013. However the trend does indicate a slight decline over this period.

3.3.2 Information on boarding is currently undertaken on a ‘snapshot’ daily basis by the Site and Capacity Team. The primary function of this data is for daily operational use to support the safe management of flow and ensuring patients are safely under a consultant at all times.
3.4. Delayed Discharge Performance

3.4.1 The overall number of Delayed Discharges across NHS Lothian has increased from 136 during April 2014 to 195 during October 2014 – and is well above the figure recorded at the same time last year. Using the latest Monthly Census data, the following tables outline the delayed discharge numbers in more detail.

<table>
<thead>
<tr>
<th></th>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>136</td>
<td>173</td>
<td>185</td>
<td>177</td>
<td>210</td>
<td>178</td>
<td>195</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Edinburgh</td>
<td>97</td>
<td>133</td>
<td>139</td>
<td>133</td>
<td>147</td>
<td>114</td>
<td>151</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>East Lothian</td>
<td>25</td>
<td>19</td>
<td>30</td>
<td>25</td>
<td>30</td>
<td>43</td>
<td>30</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Midlothian</td>
<td>7</td>
<td>13</td>
<td>17</td>
<td>18</td>
<td>19</td>
<td>7</td>
<td>5</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>West Lothian</td>
<td>4</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>9</td>
<td>9</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Lothian</td>
<td>2</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

3.4.2. Using the latest Monthly Census data - as at October 2014- the following table details the number and description of the delays by Council Area.

<table>
<thead>
<tr>
<th>Council/Area</th>
<th>Description</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>City of Edinburgh</td>
<td>11A - Awaiting commencement of post-hospital social care assessment</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>11B - Awaiting completion of post hospital social care assessment</td>
<td>25</td>
</tr>
<tr>
<td></td>
<td>24A - Awaiting place in Local Authority Residential Home</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>24B - Awaiting place in Independent Residential Home</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>24C - Awaiting place in Nursing Home (not NHS funded)</td>
<td>40</td>
</tr>
<tr>
<td></td>
<td>24D - Awaiting place in Specialist Residential Facility for under 65 yrs</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>24E - Awaiting place in Specialty Residential Facility for over 65 yrs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>24F - Awaiting place availability in care home (EMI/Dementia bed required)</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>25D - Awaiting completion of social care arrangements -in order to move</td>
<td>13</td>
</tr>
<tr>
<td></td>
<td>25DOT - Health OT assessed POC under 14hours</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>25E - Living in own home - awaiting procurement/delivery of equipment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>25F - Specialist Housing Provision (including homeless patients)</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>67 - Disagreement between patient/carer/family and health/social services</td>
<td>3</td>
</tr>
<tr>
<td>City of Edinburgh Total</td>
<td></td>
<td>151</td>
</tr>
<tr>
<td>East Lothian</td>
<td>11A - Awaiting commencement of post-hospital social care assessment</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>11B - Awaiting completion of post hospital social care assessment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>24A - Awaiting place in Local Authority Residential Home</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>24C - Awaiting place in Nursing Home (not NHS funded)</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>25D - Awaiting completion of social care arrangements -in order to move</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>25DOT - Health OT assessed POC under 14hours</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>25F - Specialist Housing Provision (including homeless patients)</td>
<td>2</td>
</tr>
<tr>
<td>East Lothian Total</td>
<td></td>
<td>30</td>
</tr>
<tr>
<td>Midlothian</td>
<td>11B - Awaiting completion of post hospital social care assessment</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>24C - Awaiting place in Nursing Home (not NHS funded)</td>
<td>1</td>
</tr>
<tr>
<td>Midlothian Total</td>
<td></td>
<td>3</td>
</tr>
<tr>
<td>Non-Lothian</td>
<td>24C - Awaiting place in Nursing Home (not NHS funded)</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>25F - Specialist Housing Provision (including homeless patients)</td>
<td>1</td>
</tr>
<tr>
<td>Non-Lothian Total</td>
<td></td>
<td>2</td>
</tr>
<tr>
<td>West Lothian</td>
<td>11A - Awaiting commencement of post-hospital social care assessment</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>24C - Awaiting place in Nursing Home (not NHS funded)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>24E - Awaiting place in Specialty Residential Facility for over 65 yrs</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>25D - Awaiting completion of social care arrangements -in order to move</td>
<td>5</td>
</tr>
<tr>
<td>West Lothian Total</td>
<td></td>
<td>9</td>
</tr>
<tr>
<td>Grand Total</td>
<td></td>
<td>195</td>
</tr>
</tbody>
</table>
3.4.3. The total number of delays along with the average length of delay, by month, is illustrated in the following chart.

### Average Length of Delay

<table>
<thead>
<tr>
<th>Month</th>
<th>Total Delays</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 13</td>
<td>136</td>
</tr>
<tr>
<td>May 14</td>
<td>173</td>
</tr>
<tr>
<td>Jun 13</td>
<td>185</td>
</tr>
<tr>
<td>Jul 13</td>
<td>177</td>
</tr>
<tr>
<td>Aug 13</td>
<td>210</td>
</tr>
<tr>
<td>Sep 13</td>
<td>178</td>
</tr>
<tr>
<td>Oct 13</td>
<td>195</td>
</tr>
<tr>
<td>Nov 13</td>
<td></td>
</tr>
<tr>
<td>Dec 13</td>
<td></td>
</tr>
<tr>
<td>Jan 14</td>
<td></td>
</tr>
<tr>
<td>Feb 14</td>
<td></td>
</tr>
<tr>
<td>Mar 14</td>
<td></td>
</tr>
</tbody>
</table>

### Average LOS/days

<table>
<thead>
<tr>
<th>Month</th>
<th>Average LOS/days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Apr 13</td>
<td>27</td>
</tr>
<tr>
<td>May 13</td>
<td>33</td>
</tr>
<tr>
<td>Jun 13</td>
<td>36</td>
</tr>
<tr>
<td>Jul 13</td>
<td>38</td>
</tr>
<tr>
<td>Aug 13</td>
<td>33</td>
</tr>
<tr>
<td>Sep 13</td>
<td>38</td>
</tr>
<tr>
<td>Oct 13</td>
<td>31</td>
</tr>
<tr>
<td>Nov 13</td>
<td></td>
</tr>
<tr>
<td>Dec 13</td>
<td></td>
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<tr>
<td>Jan 14</td>
<td></td>
</tr>
<tr>
<td>Feb 14</td>
<td></td>
</tr>
<tr>
<td>Mar 14</td>
<td></td>
</tr>
</tbody>
</table>

3.5. **Tackling Delayed Discharge**

3.5.1. The number of Delayed Discharges (DD) continues to cause concern. NHS Lothian is proposing to provide temporary support to patients to allow patients to be discharged home while they wait for their social services package of care to be actioned.

3.5.2. The two main reasons for Delayed Discharge are:

1. Awaiting Nursing Home (a bed)
2. Awaiting Domiciliary Care (Package of Care – POC)

3.5.3. While Packages of Care are organised and allocated from Social Services, NHS Lothian is recruiting NHS experienced unregistered nursing staff (Community Clinical Support Workers) to support the City of Edinburgh Council (CEC) to reduce the number of DD patients. CEC are also recruiting to expand “Reablement” and Intermediate Care.

3.5.4. NHS Lothian has also recruited a team of CCSW’s for the East Lothian Council area working in the same way as the team in CEC. This team are also being trained to carry out rehabilitative physiotherapy during quieter times of the day (afternoon). This allows the Domiciliary Physiotherapists to take additional patients. This physiotherapy rehabilitation increases the patient’s independence and reduces the number of hours of support (POC) that they require.

3.5.5. In addition, NHS Lothian has developed a training package to train the CCSW’s to assist patients to take medication. This builds on the training already available in CEC. A paper is being presented to the NHS Lothian Healthcare Governance Committee on 25 November 2014 to seek support for this initiative. Support workers can then undertake an extended range of duties to better support patients in their own homes.

3.5.6. NHS Lothian have also supported the Mid Lothian Partnership to recruit support workers to support patients at home until packages of care become available.
3.5.7 NHS Lothian has also commissioned a ‘Hospital to Home’ pilot in partnership with a voluntary organisation who supply staff to support patients to be discharged until their POC is available. This work is funded by a grant from the Health Foundation.

3.5.8 West Lothian are running a very successful Rapid Elderly Assessment Team (REACT) service which offers care and support for elderly patients to prevent hospital admission. This project is currently being expanded to implement a ‘Discharge to Assess’ model where patients are discharged after a stay in hospital first and assessed for a POC in their own homes. Patients are always better able to cope in their own environment and assessment in this process results in the requirement for a POC of fewer hours.

3.5.9 By supporting the early discharge of any patients to their own home, we are better able to improve patient flow through our system. To improve this each hospital site is focused on improving early discharge with increasing use of the discharge lounges and a range of process improvement projects. Currently performance against discharge pre 11am and 2pm is improving but still has significant potential to release capacity and improve patient flow.

3.5.10 NHS Lothian is also running a very successful project termed Comprehensive Assessment for Elderly People COMPASS. This is a multi-disciplinary group who assess and care for elderly patients, enabling them to be discharged from hospital and prevent re-admission. COMPASS runs for the South East and North West of the City of Edinburgh area and plans are in place for COMPASS Plus to increase the area covered and work towards ‘Discharge to Assess’.

3.5.11 The Director of Allied Health Professionals is currently leading an improvement project focused on the pathway for South of Edinburgh Orthopaedic patients. In comparison to Orthopaedic patients in the North of the City, these patients wait an additional 14 days to be discharged. The plan is to recruit 5 or 6 of the CCW team to be AHP Assistants based at Liberton Hospital. This team would identify the South of Edinburgh Orthopaedic patients in the Liberton wards and commence rehabilitative physiotherapy until the patient requires other clinical input. The patient would then be discharged, the physiotherapy would continue in the patients own home until they were ready to be assessed for a POC or other support.

3.5.12 NHS Lothian is also working in collaboration with the City of Edinburgh Council to lease vacant nursing home capacity.

3.5.13 To ensure that patients are prioritised and co-ordinated for discharge, NSH Lothian set up three Discharge Hubs in the Royal Infirmary of Edinburgh (RIE), the Western General Hospital (WGH) and St John’s Hospital (SJH). These are multi-disciplinary and centralise both the NHS professionals and Council Social Workers, Occupational Therapists, Physiotherapists and others. The Discharge Hubs have successfully created excellent functional relationships between the organisations, co-ordinated information and regular teleconference and meetings ensuring that patients are discharged quickly. Current work involves the creation of shared electronic information systems.

3.5.14 NHS and Council are also working together to improve the implementation of the ‘Moving On’ guidance to ensure that all Health and Social care professionals understand the changes to the process and that patients and relatives are fully informed of the patient and organisations rights. The Moving On guidance in Lothian will be agreed by all Council areas and the same information and process used so that there are no ‘postcode’ differences.
4. **LUCAP**

4.1. Following NHS Lothian’s Local Unscheduled Care Action Plan (LUCAP), submission to the Scottish Government, a total of £1,120k has been provided to NHS Lothian in support of unscheduled care.

4.2. A further sum of £1050k (non-recurring) has also been received from the Scottish Government to specifically support initiatives in partnership with local councils to tackle our discharge from hospital performance.

4.3. An update on NHS Lothian’s LUCAP was submitted to the Scottish Government in September as part of the quarterly reporting process. Further quarterly updates are required in December ’14 and March ’15.

4.4. NHS Lothian’s LUCAP was formally presented to the Board on 1 October 2014 and will be published on our web site.

5. **Winter Planning**

5.1 **Purpose of Winter Planning**

5.1.1. The purpose of the winter planning process this year is to support effective service delivery over winter that maintains patient safety, satisfactory performance levels and to mitigate against a detrimental experience for patients and their families during peaks in activity during the winter period.

5.1.2. NHS Lothian’s Winter Planning process (2014/15) builds on the overall work noted within NHS Lothian’s Local Unscheduled Care Action Plan (LUCAP). To supplement this ongoing improvement work each winter additional bed capacity is provided across acute hospitals to deal with anticipated surges in activity as well as any pressures caused by delayed discharge.

5.1.3. Such additional temporary capacity allows NHS Lothian to continue to provide safe and effective person centred care while supporting improved performance measured against HEAT targets and related national standards.

5.1.4. Significant surges in emergency activity have the potential to be detrimental to patient experience most likely in the form of delays in access to assessment, treatment, and admission to hospital, boarding out, cancellation of elective procedures and delayed discharge out of hospital. Such factors expose patients to greater risk in terms of morbidity and mortality and poor experience.

5.1.5. This year’s winter planning will build on the experiences gathered in previous years while at the same time fulfilling local and national requirements in terms of monitoring and reporting requirements.

5.1.6. The winter planning process needs to be flexible to deal with a range of challenges:- the potential early on-set of winter, a prolonged winter period, icy weather causing an increase in orthopaedic trauma, particular respiratory illnesses and norovirus.
5.2. **Winter Performance**

5.2.1 Historical trend data shows the impact that the effects of winter can have on levels of performance across NHS Lothian. The following graph compares the performance against the 4 hour emergency standard (95%) and the number of 8 and 12 hour breaches recorded from October 2013 to October 2014.

![Graph showing NHS Lothian Performance (Oct 13 to Oct 14)](image)

5.2.2 National performance targets for the 4 hour emergency access standard increased from 95% to 98% from October 2014 onward with an expectation that as a minimum, we will maintain performance levels at 95% throughout the winter period.

5.3 **Winter Planning Approach 2014/15**

5.3.1 An array of stakeholders, including Site Directors and Health and Social Care Leads, were issued with a number of templates to record the anticipated additional capacity required to support service delivery during the winter period. The templates also allowed for the completion of local winter plans.

5.3.2 This information was used to quantify the additional capacity required and the level of winter funding to be committed this year. See Appendix 1 Additional Bed Capacity.

5.3.3 A total of £3.6 million has been allocated this year to support winter planning although we continue to use a number of unfunded beds across the acute hospitals to support patient flow on a daily basis. These cost pressures are reflected in the acute unscheduled care budget overspends.

5.3.4 Additional bed capacity has been identified in support of winter planning and overall more beds will be available than during last winter. Significantly a number of these beds are out with the acute hospitals and avoid use of substandard facilities.

5.3.5 Should further bed capacity be required then substandard facilities may require to be used. There is no further funding available to open these beds so this will increase the overspend in Unscheduled Care. The need to open this bed capacity would be escalated by the Director of Unscheduled Care and the decision taken by the Acute Recovery Group.

5.3.6 Patient flow in Unscheduled Care will also be pressured by the need to “ring fence” beds in surgical wards. Currently boarding into these beds supports flow but the need to achieve the Treatment Time Guarantee by ending elective cancellations will severely limit access to this bed capacity.
As winter ends in March 2015 all additional beds funded by Winter or other temporary funding as well as those opened on an unfunded basis will need to close and remain closed as funding is not available via the 2015/16 financial plan. To achieve this significant improvement in patient flow processes is required and we may have to tolerate some deterioration in the 4 hours emergency access target.

6 Key Risks

6.1 The failure to deliver against the 4 hour emergency care access standard, particularly throughout the winter period will compromise patient safety and experience.

6.2 High numbers of patients with delayed discharges will impact on hospital flow, performance and patient safety and experience.

6.3 The need to deal with current demand and capacity issues while also securing the necessary additional capacity (beds/ workforce) for winter 2014-15

6.4 The impact on bed footprint as a result of Norovirus/ Infection Control issues during winter.

6.5 The financial impact of winter, especially if the additional bed capacity, is beyond that recognised in the current financial plan.

7 Risk Register

7.1 Risks are noted within the NHS Lothian corporate risk register for Unscheduled Care.

7.2 Risk Registers are now in place for Unscheduled Care on each acute hospital site and at a corporate level.

8 Resource Implications

8.1 The Scottish Government has released additional investment (£2.17M) to NHS Lothian in support of our on-going commitments within LUCAP and for tackling issues of delayed discharge

8.2 The resource implications for unscheduled care, including winter, are regularly reviewed with Finance colleagues and through Unscheduled Care.

8.3 The anticipated costs of supporting services during winter are currently estimated as £3.6 M.

Neil Wilson
Unscheduled Care Manager
neil.wilson@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Additional Bed Capacity November 2014
## Additional Bed Capacity November 2014

### BEDS

<table>
<thead>
<tr>
<th>HOSPITAL</th>
<th>WARD</th>
<th>Reduction</th>
<th>New Capacity</th>
<th>WINTER - funded</th>
<th>Temporary funding</th>
<th>Unfunded - average</th>
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<td>Liberton</td>
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<td>Nursing Home Capacity with CEC</td>
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<td>CEC Step-down</td>
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<td>ELC Step-down</td>
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<td>Milestone House</td>
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<td>Astle Ainslie - Millbank/ Fraser</td>
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<td>IPCC transferred to RVH. Ortho Rehab to Liberton</td>
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SUMMARY PAPER - WORKFORCE RISK ASSESSMENT

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Obstetrics &amp; Gynaecology – Recognise that staffing pressures within O&amp;G remain, however from February 2015 all consultant vacancies will be filled. The service has submitted a plan for consideration as part of the financial planning process to recruit 10 additional consultant posts between 2015 and 2018. This would both sustain the trained obstetric medical workforce in the medium to long term and enhance patient safety with 24/7 resident consultant cover.</td>
<td>3.21</td>
</tr>
<tr>
<td>• To ensure a robust review of these concerns the Board, Deanery and GMC have agreed that there should be an external review of the service by the Royal College of Obstetricians and Gynaecologists and arrangements for that review to take place are being made.</td>
<td>3.21</td>
</tr>
<tr>
<td>• Paediatrics – Recognise staffing for the paediatric unit at SJH continues to be heavily reliant on a small number of staff doing additional night and weekend shifts to cover rota gaps. A locum post is currently under recruitment; however previous attempts have been unsuccessful.</td>
<td>3.22</td>
</tr>
<tr>
<td>• MOE – Recruitment to 2 additional consultant posts on RIE site has resulted in 1 appointment being made to an existing member of staff, which in turn creates another locum vacancy. There are ongoing difficulties in appointing to a Consultant post covering RIE ortho-geriatrics and Roodlands</td>
<td>3.23</td>
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<tr>
<td>• 2 out of 3 locum specialty doctor/clinical fellow posts covering RIE/Liberton sites were filled in August. The remaining post was re-advertised, however no appointment has been made.</td>
<td>3.23</td>
</tr>
<tr>
<td>• There has been successful recruitment to 3 consultant posts at SJH, which will help enhance operating capacity on this site, appointees commence in December/early January. Recruitment for 6 Locum for Training (LAT) posts based at the RIE for the period February to August 2015 is underway. These are to cover gaps that have emerged and successful recruitment will be important in sustaining trainee rotas.</td>
<td>3.23.2</td>
</tr>
<tr>
<td>• Ophthalmology continue to have difficulties in recruiting to a number of consultant posts. Ophthalmology and the Lothian Medical Workforce Group have had a follow up meeting in early November to discuss the risks and challenges and formulate joint actions to support sustainability.</td>
<td>3.23.3 &amp; 3.27</td>
</tr>
<tr>
<td>• The Scottish Government wrote to all Boards on the 31st October detailing a proposal for training fellowships, which could be used to help sustain the medical workforce. The Medical Director has written out to Clinical Directors asking them for expressions of interest.</td>
<td>3.26</td>
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WORKFORCE RISK ASSESSMENT

1 Purpose of the Report

The purpose of this report is to update the Board on the actions currently underway to ameliorate risks to service sustainability within specialties where high levels of risk have been identified. The scope of the paper has been widened to consider workforce risk within the wider workforce.

2 Recommendations

2.1 Recognise the steps that are being taken to both sustain the trained obstetric medical workforce in the medium term and enhance patient safety with 24/7 resident consultant cover.

2.2 Note that arrangements for an external review of the Obstetric service by the Royal College of Obstetricians and Gynaecologists are being made.

2.3 Recognise staffing for the paediatric unit at SJH continues to be heavily reliant on a small number of staff doing additional night and weekend shifts to cover rota gaps.

2.4 Note that recent recruitment efforts within Medicine for the Elderly Services have been only partially successful with consultant vacancies remaining at the Royal Infirmary and Roodlands sites.

2.5 Support the actions being taken forward nationally to support boards in the development of international recruitment opportunities.

3 Discussion of Key Issues

3.1 Background

The overall in-post consultant workforce has increased from 711wte to 792wte between 2011 and 2014, an increase of 81wte (9.7%). This investment has been made to help respond to increasing demand from a growing population and provide additional capacity to reduce treatment times. This has to a significant extent been funded through an increased national resource funding allocation (NRAC), designed to provide additional support for boards where there is a disproportionate increase in population or deprivation. It has also been in response to a reduction in trainee numbers in some areas and a move to become less reliant on trainees for service delivery. The main areas of increase have been in Paediatrics, Surgery, Anaesthetics, Emergency Medicine and Obstetrics & Gynaecology. During this period the level of retireals within the consultant workforce has declined from 26 in 2011/12 to 17 in 2013/14, however indications based on the first 6 months of 2014/15 suggest that there is likely to increase once more.

There have also been a number of areas, as detailed in this paper, where it has not been possible to grow the workforce to the extent that has been identified by capacity planning and where posts have not been able to be filled where staff have
retired. This represents one of the key workforce risks faced by NHS Lothian along with other Health Boards in Scotland.

Since June 2013 a Medical Workforce Risk Assessment paper has been taken to the NHS Lothian Board to highlight the areas of high risk and the actions underway to reduce the level of risk. Over this time there have been on-going updates around Emergency Medicine, Paediatrics and O&G as these were identified as key areas of risk as part of the medical workforce risk assessment process.

Emergency Medicine (EM) is now no longer covered as an area of high risk following successful recruitment of additional trained doctors, the creation and recruitment of clinical development fellow posts to support out of hours (OOH) cover and the implementation of an updated model of care at St John’s Hospital (SJH). EM is no longer included as an area of high risk.

This paper also provides detail around other areas of significant risk where NHS Lothian has been unable to provide additional capacity and improve patient flow within Anaesthetics, Medicine of the Elderly (MoE) and Ophthalmology due to recruitment difficulties.

Many of the workforce challenges that are faced within the medical workforce are faced across Scotland and this paper details the range of work streams and actions that are underway nationally to address them.

This paper also details recruitment and retention challenges within the wider workforce that are currently being faced and the actions underway to address them.

3.2 Progress in addressing key medical workforce risks

3.2.1 Obstetrics & Gynaecology

The South East Scotland O&G training programme experiences a high level of gaps due to trainees going Out of Programme (OOP) for research/experience, maternity leave and less than full time working. In addition to ongoing recruitment of Locums Appointed for Training (LATs) this has resulted in increased internal locum usage and consultants covering resident middle grade OOH shifts several times a month with a consequent impact on day time availability. The numbers of gaps varies on a month by month basis and at the RIE it can be difficult to find competent external locums to provide cover.

In 2012/13 the Board made funding available for eight new consultant posts to contribute to the resident middle grade rota at RIE and from February 2015 all of these posts will be filled. However, recruitment has been difficult and ongoing turnover is anticipated. A request to fund ten additional posts over three years has been submitted to be considered for inclusion in the Financial Plan. This further recruitment is intended to increase the attractiveness of these posts, ensure sustainability of medical staffing and enhance patient safety with 24/7 resident consultant cover. Recruitment to these posts will take several years and in the interim, the funding could be used for fixed term appointments of clinical fellows to contribute to the rotas. Again recruitment to such posts will not be easy. It may be appropriate for Lothian to join the proposed Scottish Government programme to recruit clinical fellows nationally and for the HR processes for non-EU nationals to be managed centrally.
At SJH there have been gaps in General Practice Specialty Trainees (GPSTs) due to maternity leave and variation in the number of trainees on rotation. The gaps in this rota from August 2014 to December 2014 were partially filled by the employment of two unfunded Clinical Development Fellows. The situation from February 2015 currently appears to be more secure.

It is recognised that the challenges that are faced by the service at not purely associated with medical workforce recruitment issues. The Director of Scheduled Care has established 4 work streams to examine in detail all the key elements of this service. The four workstreams are;

- Capacity & Demand analysis
- Consultant, medical & midwifery staffing
- Evolving effective skill mix models
- Effective Capacity Management

These work streams commenced in April 2014.

Possibly related to these challenges, in September 2014 concerns were raised about some aspects of training and patient safety by trainees during a routine Deanery inspection. To ensure a robust review of these concerns the Board, Deanery and GMC have agreed that there should be an external review of the service by the Royal College of Obstetricians and Gynaecologists and arrangements for that review to take place are being made.

Within elective gynaecology services sickness absence and a resignation will present challenges for planned outpatient and inpatient work over the next six months. A locum consultant has been appointed from December 2014 for six months and two consultant posts in gynaecological oncology will be advertised shortly.

### 3.2.2 Paediatrics

As detailed in previous papers there have been considerable efforts made to sustain paediatric and neonatal rotas across Lothian in the face of considerable gaps.

The situation at SJH detailed in previous Board papers however remains broadly unchanged, with only four of the nine out of hours slots filled on a substantive basis. The staffing situation for the combined paediatric and neonatal service remains very difficult, heavily reliant on a small number of people doing additional night and weekend shifts and prone to short notice collapse because of sickness or other unplanned absence.

One of the three new consultant paediatricians appointed in 2012 at SJH resigned in November 2013 and the most recent recruitment effort was unsuccessful. In addition one of the staff in the resident middle grade rota will start a period of maternity leave in February. A locum post has been advertised.

Recent successful recruitment to medical and nursing posts in neonatology has significantly mitigated the risk to the neonatal service at SJH.
3.2.3 Other areas of the medical workforce that have been identified with high levels of risk.

The October and November Board papers highlighted that Anaesthetics, Medicine of the Elderly (MOE) and Ophthalmology are also facing significant challenges in attracting and sustaining the required numbers of trained medical staff to meet treatment time guarantees and achieve improved patients flow. The following points detail the outcomes of recent recruitment.

3.2.3.1 MOE

Within MOE efforts to recruit to training grade and career grade staff continue across all sites.

Western General Hospital (WGH)

At the WGH 2 full-time consultants and 2 part-time consultants started at the end of August and beginning of September. These posts are a combination of new and replacement posts and will provide the consultant workforce element required to support COMPASS initiative in North Edinburgh aimed at improving assessment and subsequent clinical case management, monitoring and review of frail elderly patients. The 1.5wte Specialty Doctors element of COMPASS was however unsuccessful in appointing any suitable candidates.

Recruitment to a 9 month LAT post at the WGH to cover gaps in the training grade rota was successful, with the successful candidate due to take up post in November. There is also a replacement 12 month 0.8wte locum consultant post under recruitment with a closing date in December.

RIE & Liberton

2 wte additional consultant posts have been under recruitment for the RIE, 1 wte new consultant post in MOE & Stroke and 1wte consultant to support increased capacity on RIE infirmary site. However only one of the posts has been filled by an existing Locum consultant and as such does not provide significant additional capacity. Further recruitment efforts to the unfilled post and locum post are being considered, however it will be difficult to fill these posts with no individuals set to complete higher specialty training in the remainder of 2014 and only 2 per year in each of the next two years within the South East Region.

Recruitment to 3 locum specialty doctor/clinical fellow posts covering the RIE and Liberton sites was partially successful, with 2 replacement posts filled from the beginning of August. However the third post has remained unfilled following a further attempt to recruit.

There has been successful recruitment to 2wte junior trainee locum posts based at the RIE who started in August which will help cover current gaps in the trainee rota.

There are ongoing difficulties in appointing to a Consultant post covering RIE ortho-geriatrics and Roodlands and thus far two attempts to recruit have been unsuccessful and as a consequence the team covering are on 1 in 3
weekends. Recruitment to a new 0.5wte Specialty Doctor post based at Roodlands in September was successful with the applicant taking up post at the end of October.

A consultant post in East Lothian to support their frailty model also remains unfilled and further recruitment efforts are under consideration.

### 3.2.3.2 Anaesthetics

Within Anaesthetics there have been ongoing difficulties in filling consultant posts across all sites during 2014. These roles are key in ensuring optimum theatre utilisation and ensuring a consistent flow in activity.

There was a concerted recruitment campaign at the end of 2013 across the 3 main adult acute sites which were successful filling 8 out of 13 posts. A new 12 month Locum Consultant post also commenced at SJH in August helping support operating capacity.

A recent recruitment exercise for consultant anaesthetist posts at SJH has resulted in the appointment of 3 full time posts. These successful appointments will help enhance operating capacity on this site, with the appointees commencing in December/early January.

Recruitment has also begun for 6 Locum for Training (LAT) posts based at the RIE for the period February to August 2015. These post are to cover gaps that have emerged and successful recruitment will be important in sustaining trainee rotas.

There will be a number of retirements in the coming months and it is therefore another major recruitment exercise in being planned towards the end of 2014 /early 2015 to coincide with the output from the Anaesthetic training programme. Filling these vacancies will be very challenging and it will therefore remain difficult to increase capacity.

### 3.2.3.3 Ophthalmology

Within Ophthalmology there have been on-going difficulties in filling vacant Consultant posts. A recent recruitment exercise for a new specialist Corneal Ophthalmologist was successful and the successful candidate took up post early in June. A second attempt to recruit to a Paediatric Ophthalmologist post has again been unsuccessful with the only candidate withdrawing prior to interview. The service is currently considering further recruitment options which may include international recruitment.

As detailed in section 3.2.7 there has been a further meeting between the service and the Lothian Medical Workforce Group to discuss the risks and challenges and formulate joint actions to support sustainability.

### 3.2.4 National planning to increase attractiveness of medical trainee posts

The risk assessment process has however flagged up a difficulty in filling posts that arise out with the annual recruitment process either as a result of trainee withdrawal, maternity leave and trainees going out of programme to undertake research PhDs. As detailed previously these gaps can be very difficult to fill other
than by using agency or bank locums, as posts may be less than full time and for a relatively short period.

As detailed in the previous Board paper the national StART Alliance led by NES is developing a range of measures aimed at improving recruitment and retention within training programmes.

3.2.5 National Unscheduled Care Recruitment and Retention Short Life Working Group

There are a range of pressures within the unscheduled care medical workforces across Scotland and the UK. NHS Lothian as with others Health Boards has been working locally to expand the trained medical workforce in areas such as emergency medicine to sustain services. There remain however ongoing challenges in many boards within urgent, emergency and out of hours services that require a national focus. A Recruitment and Retention Short Life Working Group has been established by the Scottish Government to address these areas. The group comprises representation from the Scottish Government, Chief Executives, Medical Directors, NHS Education for Scotland and Royal Colleges. The group has five key objectives:

- Reach a common understanding of the recruitment and retention challenges in these key services.
- Identify and share existing ways Health Boards are covering gaps and possible other short and medium term options.
- Identify possible complementary models, including the involvement of other clinicians that we could investigate.
- Explore possible alternative, including international models that may be pertinent to Scotland.
- Consider ways of attracting former NHS Scotland medical staff back from working in other UK and international locations.

The Scottish Government, in partnership with NES and Scottish Health Boards is taking the following measures in relation to international recruitment:

- Exercise undertaken by NES for Accident and Emergency and Acute Medicine trainee doctors to recruit UK doctors, failing which EEA and then overseas doctors who are eligible to apply. This was however only successful in recruiting three doctors to fill gaps in the West of Scotland as a result of this exercise.
- A strategy for Medical Recruitment Advertising has been developed by the NHS Scotland Medical Recruitment Advertising Group including advertising and promoting medical opportunities through a wide range of websites amd social media.
- Co-ordination of any central initiative for consultant recruitment with actions already underway within some boards.
- More generic international recruitment campaign which gives out the message that Scotland is interested in recruiting a range of medical staff,
whether middle grade, consultant, GP or specialty doctor. This will be aimed at attracting both doctors who have not previously worked here and Scottish doctors who have moved abroad and may be persuaded to return.

3.2.6 Sustaining Medical Workforce in Scotland – Proposal for training fellowships

The Scottish Government wrote to all Boards on the 31st October detailing a proposal for training fellowships, which could be used to help sustain the medical workforce. The objective of the proposal is to provide extra high quality posts to address gaps in the provision of service, using training grade contracts. Boards have been asked to:

- Submit proposals for fellowships in any specialty, including a well defined clinical training/academic development opportunity with clear educational and service objectives.
- Fund the salary for the posts and act as employer to successful fellows.

The training content will be assessed by NES Specialty Training Boards and representatives from Royal Colleges. NES will support delivery, supervision and assessment. The posts will be advertised internationally as ‘Advanced Training Fellowships in Scotland’, with a bursary available for candidates to support relocation expenses. The Scottish Government anticipate that the immigration route is likely to be through the existing Medical Training Initiative scheme or by a distinct Scottish scheme however this is not yet confirmed.

This initiative was discussed at the November Lothian Medical Workforce Group meeting where some concerns were highlighted around the short timescale of 28th November for Boards to respond. The Medical Director has written out to Clinical Directors asking them for expressions of interest. A similar process is underway within other Boards in SEAT and Forth Valley as a regional approach may be beneficial in some areas. The initiative will also be discussed at the Regional Medical Workforce Group on the 21st of November.

3.2.7 Lothian Medical Workforce Group

The Lothian Medical Workforce Group met on the 6th of November where the key items that were discussed as part of the main business agenda were:

- Ensuring and demonstrating safe and appropriate staffing levels – a detailed medical workforce trend paper covering all key medical workforce indicators was discussed. There was agreement that further work to integrate with quality measures would be beneficial in a balanced scorecard in help inform decision making.
- The proposal for training fellowships was discussed as outlined in the previous section.
- The group discussed a letter from Paul Gray (Director General of NHS Scotland) asking Boards to ensure that junior doctors hours of working were both European Working Time Compliant and represented safe working patterns. A risk assessment is currently underway to review all rotas to highlight any areas of concern the outcome of which will be considered at the next meeting.

In the clinical review clinical review section the meeting is intended to provide an opportunity for services to discuss the risks and challenges and formulate
joint actions to support sustainability. At the 6th November meeting the Clinical Director of Ophthalmology delivered a presentation highlighting the demands and pressures for the service and the workforce development underway to help sustain service. Concerns were highlighted around what the potential changes there may be as part of the UK Change in the Shape of Training Initiative in relation to Ophthalmology, whilst there were also potentially some opportunities further clarity was needed. It was agreed that there was a need for active participation from boards and specialties in the process to influence the direction of change.

The group discussed recruitment challenges particularly in relation to medical ophthalmology and some of the opportunities there may be for further role extension within the non-medical workforce and the development of medical fellowship posts.

One of the main challenges in relation to capacity is the physical capacity within the Princess Alexandra Eye Pavilion site which is insufficient and limiting in terms workflow. Planning for a new site has commenced and is being designed within clinicians around both the needs of patients and the efficient patient flow. The group undertook to support the service in reviewing recruitment options and role extension. The service will pull this together into a phased plan which can be shared with other organisations such as NES who may be able to provide support around role development.

Arrangements are being made for the group to review another specialty where workforce pressures have been highlighted at the next meeting in January.

3.2.8 Workforce risk assessment update process

A programme for the review of medical workforce risk assessments has commenced, and will cover all areas covered previously as well as some community areas not specifically covered previously. These will be fed into the Lothian Medical Workforce Group as well as clinical/site management teams and key areas of risk will also be reflected within future board papers.

4 Risk Register

4.1 The NHS Lothian risk register contains a ‘Medical Workforce Sustainability’ risk, which relates the risk that workforce supply pressures in conjunction with activity pressures will impact on service sustainability and/or NHS Lothian’s ability to achieve its corporate objectives. The multi-factorial risk assessments that have been carried out will be reviewed and updated where necessary on a 6 monthly basis or where there are significant changes.

5 Impact on Inequality, Including Health Inequalities

The introduction of the medical workforce risk assessment process has been subject to a rapid impact assessment for which a report has been prepared.
6  **Involving People**

Before any changes in service provision across any site in NHS Lothian are made, there would need to be engagement and consultation with appropriate audiences with the guidance of the Scottish Health Council.

7  **Resource Implications**

7.1 There are potential resource implications, which are identified as part of the planning process within specialties to reduce the level of workforce risk. These will be progressed through the appropriate local management structures to secure necessary support. Paediatrics and Obstetrics & Gynaecology have all been supported financially at both a local and national level to reduce workforce risks as detailed within the report.

Nick McAlister  
Head of Workforce Planning  
nick.mcalister@nhslothian.scot.nhs.uk  
18 November 2014
The key points of the paper are summarised here.

<table>
<thead>
<tr>
<th>Point</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td>NHS Lothian will not achieve TTG compliance by the end of December, the timescale outlined in <em>Delivering for Patients</em>. The Board is asked to recognise the requirement for additional funding and the potential deterioration in TTG position in last quarter 2014/15.</td>
</tr>
<tr>
<td>3</td>
<td>A total of 486 patients (trajectory: 318) were beyond the treatment time guarantee at end of October.</td>
</tr>
<tr>
<td>3</td>
<td>150 inpatient and daycase patients not covered by the treatment time guarantee were waiting over 12 weeks at the end of October.</td>
</tr>
<tr>
<td>4</td>
<td>Outpatients over 12 weeks numbered 2716 at the end of October.</td>
</tr>
<tr>
<td>6</td>
<td>18 week performance from referral to treatment for September remains stable at 86.1%. October’s figure is unavailable at the time of writing.</td>
</tr>
<tr>
<td>7</td>
<td>Both 31 and 62 day performance against Cancer continued to be above 95% in October, continuing the pattern set over the quarter previously.</td>
</tr>
<tr>
<td>8</td>
<td>Difficulties in cystoscopy capacity, relating to consultant capacity, are responsible for the majority of those waiting for key diagnostic tests at the end of October with 710 scope patients waiting more than 6 weeks. 8 radiology patients also exceeded the standard.</td>
</tr>
<tr>
<td>9</td>
<td>End of October’s surveillance endoscopy position saw 577 waiting beyond their due date with cystoscopy responsible for the majority of those waiting.</td>
</tr>
<tr>
<td>10</td>
<td>No patient was waiting beyond the standards in place in audiology at the end of October.</td>
</tr>
<tr>
<td>11</td>
<td>The forthcoming standard for IVF continues to be met.</td>
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</table>
WAITING TIMES PERFORMANCE, PROGRESS AND ELECTIVE CAPACITY INVESTMENT

1 Purpose of the Report

1.1 The purpose of this report is to update the meeting on recent performance on waiting times.

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

2 Recommendations

2.1 Receive this update is received on performance and progress on inpatient, outpatient and other waiting times;

2.2 Recognise the projected TTG position for December and the issues relating to additional funding requirement

2.3 Discuss additional funding request for 2014/15 as part of Financial Position Paper (Agenda item 2.5)

3 Inpatients and Daycases

3.1 NHS Lothian detailed in Delivering for Patients how the number of patients waiting beyond the treatment time guarantee and outpatient standard would be addressed by December 2014 and March 2015 respectively.

3.2 It is now projected that NHS Lothian will not be able to deliver this TTG position at end December

3.3 Although initial progress against the trajectory was good, delivery more recently has been compromised. This has been caused by unscheduled care pressures linked to available beds and the impact of ‘delayed discharge’ patients. (see Unscheduled Care Paper agenda item 2.1) and recruitment challenges. These are outlined in more detail below.
3.4 Table 2 outlines the number of patients waiting beyond the waiting time standard at month end. The position at the end of October, NHS Lothian was behind trajectory of 318 outlined in Delivering for Patients by 168 patients.

### Table 2 – Treatment Time Guarantee Patients waiting beyond standard at month end

<table>
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<tr>
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<td>502</td>
<td>510</td>
<td>568</td>
<td>532</td>
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</tbody>
</table>

3.5 As will be known, there are some patients admitted as inpatients and daycases who are not included within the Treatment Time Guarantee. The numbers of these patients waiting over 12 weeks is outlined in Table 3.

### Table 3 – Inpatients and Daycases not covered by Treatment Time Guarantee and waiting over 12 weeks

<table>
<thead>
<tr>
<th></th>
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</table>

3.6 Figures on list size and unavailability. These will be reported as usual at the next meeting. The position on choice codes is shown below.

---

1 Source changed from Trak to Warehouse in July 2014, with impact of new calculation apparent from May.
Table 4 – Choice codes in Inpatients (October)

<table>
<thead>
<tr>
<th>Specialty Classific. Description</th>
<th>Patient Request - wishes named consultant</th>
<th>Patient Request - wishes to be treated within Health Board</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedic Surgery</td>
<td>7</td>
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<tr>
<td><strong>Grand Total</strong></td>
<td><strong>23</strong></td>
<td><strong>6</strong></td>
<td><strong>29</strong></td>
</tr>
</tbody>
</table>

3.7 Update on end November position will be available verbally as part of this agenda item.

4 Outpatients

4.1 Across NHS Lothian 2716 were over 12 weeks at the end of October, figures by specialty are shown in the table below. This was as a direct result of consultant resource being directed at IP & DC activity. The position in November is projected to returned to previously reported levels. There remains to be an element of administrative ‘clean up’ on these numbers and final position will be update over next two weeks.

Table 5 – Trend in Outpatients over 12 weeks – Key Specialties

<table>
<thead>
<tr>
<th>Specialty Classific. Description</th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>Dec-13</th>
<th>Jan-14</th>
<th>Feb-14</th>
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<td>196</td>
<td>218</td>
<td>224</td>
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<td>294</td>
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</tr>
<tr>
<td>Colorectal/Surgery</td>
<td>531</td>
<td>433</td>
<td>276</td>
<td>380</td>
<td>164</td>
<td>127</td>
<td>131</td>
<td>176</td>
<td>152</td>
<td>256</td>
<td>226</td>
<td>305</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>445</td>
<td>465</td>
<td>488</td>
<td>904</td>
<td>827</td>
<td>409</td>
<td>402</td>
<td>351</td>
<td>350</td>
<td>339</td>
<td>328</td>
<td>269</td>
</tr>
<tr>
<td>Dermatology</td>
<td>354</td>
<td>250</td>
<td>233</td>
<td>241</td>
<td>176</td>
<td>87</td>
<td>12</td>
<td>24</td>
<td>26</td>
<td>18</td>
<td>18</td>
<td>36</td>
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<td>Orthopaedic Surgery</td>
<td>72</td>
<td>71</td>
<td>104</td>
<td>71</td>
<td>56</td>
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<td>34</td>
<td>24</td>
<td>26</td>
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<tr>
<td>Rheumatology</td>
<td>71</td>
<td>81</td>
<td>71</td>
<td>62</td>
<td>73</td>
<td>44</td>
<td>48</td>
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<td>33</td>
</tr>
<tr>
<td>Plastic Surgery</td>
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<td>631</td>
<td>650</td>
<td>691</td>
<td>693</td>
<td>565</td>
<td>627</td>
<td>635</td>
<td>554</td>
<td>439</td>
<td>328</td>
<td>133</td>
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<tr>
<td>Plastic Surgery</td>
<td>21</td>
<td>23</td>
<td>42</td>
<td>38</td>
<td>25</td>
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<td>12</td>
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<td>403</td>
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<td>88</td>
<td>250</td>
<td>414</td>
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<td>Vascular Surgery</td>
<td>198</td>
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<td>168</td>
<td>132</td>
<td>111</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>8</td>
<td>3</td>
<td>3</td>
<td>7</td>
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<td>Neurosurgery</td>
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<td>114</td>
<td>124</td>
<td>159</td>
<td>91</td>
<td>85</td>
<td>114</td>
<td>71</td>
<td>99</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Pain</td>
<td>290</td>
<td>115</td>
<td>116</td>
<td>100</td>
<td>69</td>
<td>46</td>
<td>95</td>
<td>120</td>
<td>103</td>
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<td>35</td>
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<td>Sleep</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Others</td>
<td>150</td>
<td>104</td>
<td>204</td>
<td>288</td>
<td>315</td>
<td>140</td>
<td>109</td>
<td>209</td>
<td>323</td>
<td>434</td>
<td>406</td>
<td>323</td>
</tr>
<tr>
<td><strong>Total exc EDI</strong></td>
<td>3925</td>
<td>3602</td>
<td>3469</td>
<td>3714</td>
<td>3529</td>
<td>1987</td>
<td>2074</td>
<td>3614</td>
<td>2659</td>
<td>2580</td>
<td>2745</td>
<td>2421</td>
</tr>
<tr>
<td><strong>TOTAL (inc EDI)</strong></td>
<td>4335</td>
<td>4094</td>
<td>4039</td>
<td>3982</td>
<td>3848</td>
<td>2003</td>
<td>2057</td>
<td>2510</td>
<td>2882</td>
<td>2580</td>
<td>2745</td>
<td>2535</td>
</tr>
</tbody>
</table>

4.2 As with inpatients, figures on list size and unavailability are yet to be compiled this month. These will be reported as usual at the next meeting. The position on choice codes is shown in the table below.

Table 6 – Choice codes in Outpatients (October)

<table>
<thead>
<tr>
<th>Specialty Classific. Description</th>
<th>Patient Request - wishes named consultant</th>
<th>Patient Request - wishes to be treated within Health Board</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TRAUMA AND ORTHOPAEDIC SURGERY</strong></td>
<td><strong>1</strong></td>
<td><strong>22</strong></td>
<td><strong>23</strong></td>
</tr>
<tr>
<td><strong>GASTROENTEROLOGY</strong></td>
<td><strong>2</strong></td>
<td><strong>7</strong></td>
<td><strong>9</strong></td>
</tr>
<tr>
<td><strong>DERMATOLOGY</strong></td>
<td><strong>4</strong></td>
<td><strong>2</strong></td>
<td><strong>6</strong></td>
</tr>
<tr>
<td><strong>GYNAECOLOGY</strong></td>
<td><strong>2</strong></td>
<td><strong>1</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td><strong>GENERAL SURGERY (EXCL VASCULAR)</strong></td>
<td><strong>3</strong></td>
<td><strong>0</strong></td>
<td><strong>3</strong></td>
</tr>
<tr>
<td><strong>OPHTHALMOLOGY</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
<td><strong>2</strong></td>
</tr>
<tr>
<td><strong>CLINICAL ONCOLOGY</strong></td>
<td><strong>0</strong></td>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>RHEUMATOLOGY</strong></td>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>EAR, NOSE &amp; THROAT (ENT)</strong></td>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>PLASTIC SURGERY</strong></td>
<td><strong>1</strong></td>
<td><strong>0</strong></td>
<td><strong>1</strong></td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>14</strong></td>
<td><strong>36</strong></td>
<td><strong>50</strong></td>
</tr>
</tbody>
</table>

2 - new calculation apparent from May. Edinburgh Dental Institute figures not included for July and August.
5 Contributing factors impacting on Delivery

Unscheduled Care

5.1 As board members will be aware, there are significant difficulties in meeting the challenge of emergency admissions and this is demonstrated by the additional beds that have been opened to accommodate these pressures and the level of delayed discharge patients waiting in NHS Lothian’s beds.

5.2 As is well understood, with these beds downstream full, beds planned for elective surgery – which are also close to the front door - are used to “board” these patients. Such a practice is seen as inappropriate and the National Unscheduled Care Action Plan identified this as something to be eliminated. The Board’s Strategic Plan shares this aim.

5.3 With elective beds unavailable, cancellation of waiting list cases result, not only leading to the unused theatre time but also the rescheduling of the surgery displaces another patient. This leads to unused expensive resource in theatres – potentially doubling the cost of treating one patient.

5.4 It is unquestionable that this can be of significant upset to the Scheduled Care patients affected, who could be preparing to come in – or already in – hospital for their operation. We have recorded a small, but none the less significant, number of patients who have had to endure ‘on the day’ cancellation of elective procedure twice or even three times.

5.5 This of course must be balanced against the needs of vulnerable unscheduled care patients requiring treatment & care however the balance of risk assessment between these two groups of patient cohorts must be more comprehensive as we move forward.

5.6 A new framework for more comprehensively balancing the needs of these two clinical cohorts of patients and providing a clearer approach to managing clinical & financial risk is being developed by the Medical, Nurse and Scheduled Care Directors. This proposal will include operational plans to support ‘ring fencing’ of scheduled care beds. Whilst complex to implement effectively the real and significant emotional and potentially physical impact that ‘on the day’ cancellations of scheduled care procedures can have on individuals must be recognised. This proposed Framework will be reviewed at the next Healthcare Governance Committee.

5.7 The figure below shows the level of cancellations recorded in the theatre session, ORSOS, over the first half of this year.

![Figure 7 – Cancellations from ORSOS](image-url)
Recruitment

5.8 The philosophy underpinning Delivering for Patients was to build sustainable NHS capacity to enable compliance with standards, with use of the independent sector to provide bridging support while internal capacity was put in place.

5.9 Subsequently, with the necessary capacity in place within NHS Lothian, and waiting lists reduced, withdrawal from the private sector would be possible. This approach was demonstrated in the improvement trajectories put forward. The pace of improvement was anticipated to quicken in the latter part of 2014 as the commencement of additional posts increased the rate of patients being seen.

5.10 The table below shows the difference in medical staffing establishment, including DFP investment, in key specialties against staffing currently in place. The actual figures reported take account of temporary staffing arrangements.

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Budget Establishment</th>
<th>Actual (October)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Orthopaedics</td>
<td>29.48</td>
<td>26.14</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>27.39</td>
<td>25.78</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>17.20</td>
<td>16.04</td>
</tr>
<tr>
<td>Urology</td>
<td>17.30</td>
<td>14.63</td>
</tr>
</tbody>
</table>

5.11 The success in our series of recruitment initiatives over the last 8 months has been compromised by either:
- Not attracting applicants, as was the case in gastroenterology
- Identifying no suitable candidates to shortlist (Orthopaedics, Ophthalmology and Plastics)
- Where appointments have been made but there is a long lag time till individuals will be in post (Anaesthetics and ENT).

5.12 In addition to recruitment problems, within the last 12 weeks there has been the unexpected loss of consultant capacity in specialties Orthopaedics, Urology, Gynaecology, Plastic Surgery and Oral surgery.

5.13 It was further to this analysis of the impact of these most recent capacity losses that resulted in NHS Lothian advising Scottish Government that the board would not meet the TTG target in December.

Financial Performance

5.14 DFP outlined a projected requirement for £8.4M in year investment in NHS capacity and a further £9M of non-recurring resources to support use of the independent sector.

5.15 Contingency plans and recovery actions have seen a significant shift in the profile of expenditure against plan, with a greater proportion of total expenditure being incurred via independent sector and in the use of waiting list initiatives and agency locum staff. The revenue impact of these being partially offset by slippage on internal investment plans.

5.16 Additional spend with external providers has been as a direct result of a number of factors, including the need to deliver service capacity to meet ongoing demand, to support progress towards trajectories and to provide additional capacity to correct

---

Footnotes:
3 The establishment figures noted above do not include repatriation of Orthopaedic surgery from Independent Sector – an initial assessment of Consultant Medical staff required to support repatriation has been estimated at a further 2WTE, however proposals for repatriation of this workload have not yet been finalised.

Actual WTE includes NHS and Agency locums, staff bank and waiting list initiatives.
deviation from original plans, involving – as outlined above - the additional activity undertaken to offset some of the lost capacity due to cancellations directly related to beds being unavailable to admit.

5.17 A forecast prepared at Mid Year Review has highlighted a projected overspend of circa £4M against available resources, based on current expenditure profile. This includes adjustments to independent sector contracts agreed in October which have resulted in improved pricing based on volume commitments with specific providers.

<table>
<thead>
<tr>
<th>Table 9 - Actual/Forecast Expenditure 2014/15 against Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td>Internal</td>
</tr>
<tr>
<td>Independent Sector</td>
</tr>
<tr>
<td>Other Contractors</td>
</tr>
<tr>
<td>Other NHS</td>
</tr>
<tr>
<td></td>
</tr>
<tr>
<td>Average Monthly</td>
</tr>
</tbody>
</table>

5.18 The table above shows actual and projected expenditure at Mid Year Review.

5.19 The additional activity undertaken externally has however not been sufficient to enable performance against the planned trajectory to be held. Essentially, the use of external capacity has allowed NHS Lothian to sustain a waiting time position in the face of vacancies in key staff groups and unscheduled care challenges and to demonstrate ongoing reductions in numbers.

5.20 Variation from planned expenditure is driven by two main factors discussed earlier. Firstly the additional transactional cost of amendments to timescales for implementation of internal investment, typified by delays in recruitment, resulting in continued use of independent sector and other contractors. Secondly, to address the impact of variation from trajectory, in particular the impact of cancellations.

5.21 Internal spend has been substantially lower than plan, with significant delays to projected implementation timescales in ENT, Plastic Surgery, Ophthalmology & Oral and Maxillofacial Surgery.

5.22 Offsetting internal slippage has been an increase against projection in the use of agency locums and ongoing use of waiting list initiatives to maximise use of internal capacity. An element of this cost is charged directly against internal vacancies.

5.23 The impact of cancellations on independent sector usage cannot be directly quantified because of the dynamic of overall flow, however, based on the first seven months, it is estimated that there will be approximately 400 cases displaced in with a cost impact of £2.5M.

This cost reflects a skewed casemix which has seen displaced cases focussed on a number of specialties – i.e. Urology, Colorectal Surgery and Orthopaedic Surgery.

5.24 A review of anticipated movement over the coming months does not envisage this position materially altering. Continued use of the independent sector in line with current projections would support a broadly stable waiting time position but not the achievement of compliance with the Treatment Time Guarantee.
Additional investment of £4M in 2014/15 is required to maintain the position outlined above. Without this funding, actions to manage resources within budget are expected to have a material impact on both TTG performance and delivery of outpatients and diagnostics standards.

5.25 If no funds were provided this additional expenditure can be avoided through reducing activity outside core – both internally and in the independent sector. Actions for management of the financial performance within budget have been identified and could result in a stepped reduction in spend from £1M to £4M based on options to be considered.

5.26 The associated loss of capacity is expected to result in significant deterioration of the waiting list position. Based on management of performance within current available budget, approximately 1800 patients will be over 12 weeks against TTG.

5.27 The level of deterioration cannot be explicitly demonstrated in component parts but initial analysis would suggest;

- With £1M investment end March position circa 1450
- With £2M investment end March position circa 1100
- With £3M investment end March position circa 750
- With £4M investment end March position circa 400

5.28 There will also be an impact on outpatient and diagnostic performance against standards and this is currently being assessed. The divisional team will review & implement actions to minimise this impact but substantive improvement of projection would be unlikely.

5.29 Recognising the current position, the Director of Scheduled Care is working with teams to provide rapid improvements proposals from April 2015. These will be finalised when the financial plan is completed for this next year. It is however self evident that reductions in spend in 2015/16 for Access Recovery will have a significantly detrimental impact on performance in this area.

5.30 If no funds were available to support this financial requirement, Board members are asked to recognise this projected position for March 2015.

5.31 The issue of financial support will be discussed under the Financial Position item on of the agenda (Item 2.5).

6 18 Weeks Referral to Treatment Standard

6.1 The figure below shows the recent trend for combined performance for admitted and non-admitted pathways against the 18 week referral to treatment standard up to September 2014. 90% compliance is expected. The figure for October is not available at the time of writing.

Table 10 - Trend in 18 Week Performance and Measurement

<table>
<thead>
<tr>
<th></th>
<th>Sep-13</th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>Dec-13</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients journeys within 18 weeks (%)</td>
<td>85.1%</td>
<td>88.6%</td>
<td>88.7%</td>
<td>86.4%</td>
<td>85.4%</td>
<td>84.7%</td>
<td>85.2%</td>
<td>86.0%</td>
<td>86.4%</td>
<td>85.9%</td>
<td>86.1%</td>
<td>86.0%</td>
<td></td>
</tr>
<tr>
<td>Number of patient journeys within 18 weeks</td>
<td>13,335</td>
<td>13,284</td>
<td>13,048</td>
<td>10,857</td>
<td>12,670</td>
<td>11,861</td>
<td>12,797</td>
<td>12,552</td>
<td>12,742</td>
<td>13,178</td>
<td>12,947</td>
<td>12,573</td>
<td>13,415</td>
</tr>
<tr>
<td>Number of patient journeys over 18 weeks</td>
<td>1,660</td>
<td>2,080</td>
<td>2,382</td>
<td>1,594</td>
<td>2,174</td>
<td>2,135</td>
<td>2,217</td>
<td>2,044</td>
<td>2,003</td>
<td>2,164</td>
<td>2,098</td>
<td>2,044</td>
<td>2,163</td>
</tr>
<tr>
<td>Patients journeys that could be fully measured (%)</td>
<td>86.5%</td>
<td>85.9%</td>
<td>86.7%</td>
<td>85.6%</td>
<td>86.6%</td>
<td>86.2%</td>
<td>86.1%</td>
<td>86.3%</td>
<td>85.7%</td>
<td>86.6%</td>
<td>86.6%</td>
<td>86.5%</td>
<td>86.3%</td>
</tr>
</tbody>
</table>

7 Cancer

7.1 Performance against cancer standards is shown in the following tables.
7.2 Provisional information places both 31 and 62 day performance above the 95% expected in October.

Table 11 – Trend in Cancer Performance (31 days from diagnosis to treatment)

<table>
<thead>
<tr>
<th>All cancer types</th>
<th>Lothian Quarter Apr - Jun 14</th>
<th>Scotland Quarter Apr - Jun 14</th>
<th>Lothian July 2014</th>
<th>Lothian August 2014</th>
<th>Lothian September 2014</th>
<th>Lothian October 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancer types</td>
<td>96.6%</td>
<td>96.7%</td>
<td>96.3%</td>
<td>98.5%</td>
<td>97.9%</td>
<td>98.2%</td>
</tr>
</tbody>
</table>

Table 12 – Trend in Cancer Performance (62 days from urgent referral to treatment)

<table>
<thead>
<tr>
<th>All cancer types</th>
<th>Lothian Quarter Apr - Jun 14</th>
<th>Scotland Quarter Apr - Jun 14</th>
<th>Lothian July 2014</th>
<th>Lothian August 2014</th>
<th>Lothian September 2014</th>
<th>Lothian October 2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>All cancer types</td>
<td>95.2%</td>
<td>92.9%</td>
<td>96.5%</td>
<td>94.9%</td>
<td>96.2%</td>
<td>96.8%</td>
</tr>
</tbody>
</table>

8 Diagnostics

8.1 The tables below show the breakdown on waits in both areas by diagnostic test. For scopes, cystoscopy remains responsible for most instances exceeding the national standard of 6 weeks due to consultant capacity. In radiology, there were 8 patients waiting over 6 weeks at the end of October.

Table 13 – Waiting Times for Key Diagnostic Tests (Endoscopy)

<table>
<thead>
<tr>
<th>Diagnostic Test</th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>Dec-13</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
<th>Oct-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>40</td>
<td>11</td>
<td>26</td>
<td>15</td>
<td>28</td>
<td>10</td>
<td>24</td>
<td>14</td>
<td>26</td>
<td>13</td>
<td>26</td>
<td>37</td>
<td>42</td>
</tr>
<tr>
<td>Upper Endo</td>
<td>43</td>
<td>14</td>
<td>21</td>
<td>22</td>
<td>24</td>
<td>21</td>
<td>14</td>
<td>12</td>
<td>22</td>
<td>20</td>
<td>20</td>
<td>21</td>
<td>24</td>
</tr>
<tr>
<td>Flexi Sig</td>
<td>24</td>
<td>4</td>
<td>13</td>
<td>15</td>
<td>23</td>
<td>14</td>
<td>23</td>
<td>12</td>
<td>21</td>
<td>19</td>
<td>20</td>
<td>25</td>
<td>29</td>
</tr>
<tr>
<td>Flexi Cysto</td>
<td>261</td>
<td>247</td>
<td>265</td>
<td>255</td>
<td>226</td>
<td>257</td>
<td>199</td>
<td>219</td>
<td>234</td>
<td>180</td>
<td>190</td>
<td>269</td>
<td>334</td>
</tr>
<tr>
<td>Total</td>
<td>908</td>
<td>644</td>
<td>591</td>
<td>552</td>
<td>462</td>
<td>462</td>
<td>390</td>
<td>439</td>
<td>422</td>
<td>371</td>
<td>410</td>
<td>491</td>
<td>577</td>
</tr>
</tbody>
</table>

9 Surveillance Endoscopy

9.1 The number of patients waiting beyond their planned review date is outlined in the Table 15, with 577 waiting longer than their planned review date, with over half of whom waiting for a cystoscopy.

Table 15 – Surveillance and Review Patients overdue appointment

<table>
<thead>
<tr>
<th>Diagnostic Test</th>
<th>Oct-13</th>
<th>Nov-13</th>
<th>Dec-13</th>
<th>Jan-14</th>
<th>Feb-14</th>
<th>Mar-14</th>
<th>Apr-14</th>
<th>May-14</th>
<th>Jun-14</th>
<th>Jul-14</th>
<th>Aug-14</th>
<th>Sep-14</th>
<th>Oct-14</th>
</tr>
</thead>
<tbody>
<tr>
<td>Colonoscopy</td>
<td>46</td>
<td>11</td>
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<td>28</td>
<td>10</td>
<td>24</td>
<td>14</td>
<td>26</td>
<td>13</td>
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<td>37</td>
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<tr>
<td>Upper Endo</td>
<td>43</td>
<td>14</td>
<td>21</td>
<td>22</td>
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<td>21</td>
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<td>12</td>
<td>22</td>
<td>20</td>
<td>20</td>
<td>21</td>
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<tr>
<td>Flexi Sig</td>
<td>24</td>
<td>4</td>
<td>13</td>
<td>15</td>
<td>23</td>
<td>14</td>
<td>23</td>
<td>12</td>
<td>21</td>
<td>19</td>
<td>20</td>
<td>25</td>
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<tr>
<td>Flexi Cysto</td>
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<td>247</td>
<td>265</td>
<td>255</td>
<td>226</td>
<td>257</td>
<td>199</td>
<td>219</td>
<td>234</td>
<td>180</td>
<td>190</td>
<td>269</td>
<td>334</td>
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<tr>
<td>Other</td>
<td>51</td>
<td>59</td>
<td>59</td>
<td>41</td>
<td>43</td>
<td>52</td>
<td>59</td>
<td>62</td>
<td>59</td>
<td>57</td>
<td>52</td>
<td>59</td>
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<tr>
<td>Total</td>
<td>908</td>
<td>644</td>
<td>591</td>
<td>552</td>
<td>462</td>
<td>462</td>
<td>390</td>
<td>439</td>
<td>422</td>
<td>371</td>
<td>410</td>
<td>491</td>
<td>577</td>
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</tbody>
</table>
10 Audiology

10.1 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.

10.2 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.

10.3 Performance against these two standards for these services is shown in the tables below to the end of October, when no patient was waiting longer than was aimed for.

Table 16 – Adult Audiology – Performance against Standard

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Number waiting 9 weeks and over</td>
<td>0</td>
<td>1</td>
<td>82</td>
<td>80</td>
<td>2</td>
<td>11</td>
<td>17</td>
<td>14</td>
<td>38</td>
<td>11</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total number waiting</td>
<td>1719</td>
<td>1818</td>
<td>1962</td>
<td>1565</td>
<td>1648</td>
<td>1730</td>
<td>1677</td>
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</thead>
<tbody>
<tr>
<td>Number waiting 9 weeks and over</td>
<td>0</td>
<td>8</td>
<td>57</td>
<td>48</td>
<td>4</td>
<td>21</td>
<td>33</td>
<td>33</td>
<td>108</td>
<td>45</td>
<td>3</td>
<td>1</td>
<td>0</td>
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<tr>
<td>Total number waiting</td>
<td>897</td>
<td>892</td>
<td>922</td>
<td>942</td>
<td>842</td>
<td>901</td>
<td>944</td>
<td>1001</td>
<td>1001</td>
<td>931</td>
<td>983</td>
<td>995</td>
<td>1007</td>
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</thead>
<tbody>
<tr>
<td>Number waiting 9 weeks and over</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>8</td>
<td>1</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>0</td>
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<tr>
<td>Total number waiting</td>
<td>122</td>
<td>98</td>
<td>146</td>
<td>108</td>
<td>113</td>
<td>105</td>
<td>105</td>
<td>42</td>
<td>92</td>
<td>126</td>
<td>96</td>
<td>67</td>
<td>84</td>
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</table>

Table 17 – Paediatric Audiology – Performance against Standard

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</tr>
</thead>
<tbody>
<tr>
<td>Number waiting 12 weeks and over</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
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<td>0</td>
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<tr>
<td>Total number waiting</td>
<td>130</td>
<td>195</td>
<td>198</td>
<td>187</td>
<td>240</td>
<td>228</td>
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<td>264</td>
<td>216</td>
<td>142</td>
<td>144</td>
<td>101</td>
<td>168</td>
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</tr>
</thead>
<tbody>
<tr>
<td>Number waiting 6 weeks and over</td>
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<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total number waiting</td>
<td>19</td>
<td>14</td>
<td>32</td>
<td>26</td>
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<td>40</td>
<td>50</td>
<td>3</td>
<td>7</td>
<td>12</td>
<td>6</td>
<td>8</td>
<td>7</td>
</tr>
</tbody>
</table>

11 IVF

11.1 IVF treatment is expected to be within 12 months by March 2015.

11.2 NHS Lothian is currently meeting this standard and using capacity in its centre at the Royal Infirmary to assist reducing IVF waiting times elsewhere in Scotland.

11.3 Publication of this information commenced nationally in November for the quarter ending September 2014. The numbers waiting at month end since July are outlined below and excludes those patients seen on behalf of other centres.

Table 18 – IVF Waiting Time

<table>
<thead>
<tr>
<th>Numbers waiting</th>
<th>July-14</th>
<th>August-14</th>
<th>September-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>234</td>
<td>261</td>
<td>234</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Numbers over 12 months</th>
<th>July-14</th>
<th>August-14</th>
<th>September-14</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
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</table>
NHS LOTHIAN

Board Meeting
3 December 2014

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.

<table>
<thead>
<tr>
<th>Para</th>
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<tbody>
<tr>
<td>3.1.1</td>
</tr>
</tbody>
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- NHS Lothian appears to be an outlier for surgical readmissions for both 7 and 28 days. The two hospitals contributing to this are the Western General Hospital (WGH) and Royal Infirmary of Edinburgh (RIE) with respect to both 7 and 28 day surgical readmissions. When looking at this data over time, there are no underlying trend changes in the data for 7 or 28 day readmissions for either the WGH or the RIE. The RIE is, however, for this quarter (January-March 2014) a statistical outlier for both 7 and 28 days. It is interesting to note from the last two quarters data that NHS Lothian is no longer an outlier for medical readmissions.

- The HEAT target for reduction in C.Difficile and Staph. aureus bacteraemias has not been achieved. Actions to address this are set out in the Healthcare Associated Infection paper on the Board agenda 3.1.3 and Graphs 11&12

- Patients who are ready for discharge continue to wait longer than 2 weeks (target to be achieved by April 2015) with a number of patients waiting over 4 weeks. NHS Lothian is also not meeting the A&E 4 Hour Waiting Times target. Actions to address this current situation are set out in the Unscheduled Care Report to the Board. 3.1.4 & Graphs 5&17

- Compliance with stroke targets for timely admission to stroke unit remain challenging as does swallow screening on day of admission. Actions to address this current situation are set out in the Unscheduled Care report. Graphs 19&20

Jo Bennett
Clinical Governance & Risk Manager
18 November 2014
Jo.bennett@nhslothian.scot.nhs.uk
QUALITY REPORT

1 Purpose of the Report

1.1 This report presents the Quality Report for October 2014, 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 NHS Lothian appears to be an outlier for surgical readmissions for both 7 and 28 days. The two hospitals contributing to this are the Western General Hospital (WGH) and Royal Infirmary of Edinburgh (RIE) with respect to both 7 and 28 day surgical readmissions. When looking at this data over time, there are no underlying trend changes in the data for 7 or 28 day readmissions for either the WGH or the RIE. The RIE is, however, for this quarter (January-March 2014) a statistical outlier for both 7 and 28 days. It is interesting to note from the last two quarters data that NHS Lothian is no longer an outlier for medical readmissions.

3.1.2 The number of formal complaints remains fairly stable (Graph 3). Graph 4 shows a subset of these complaints which are prison complaints which account for a large number of the overall complaints. It is interesting to note, however, that the prisons services are compliant with the 20 day response.

3.1.3 The HEAT targets for reduction in C.Difficile and Staph. aureus bacteraemias are not being achieved (see graphs 11&12). Healthcare Associated Infection is a separate agenda item and paper.

3.1.4 A number of reports on the Board agenda examine in more detail delayed discharges, A&E 4 hour waits, Cancer 62 day waits and compliance with stroke standards.

3.2 Older People in Acute Care Update

3.2.1 Healthcare Improvement Scotland (HIS) requested updates in terms of progress against those issues identified during previous visits. These updates were
submitted in April 2014 and again in September 2014 using a revised format and are reported through the Healthcare Governance Committee.

3.2.2 HIS have indicated that they are now reviewing their inspection process and have said that they would wish to get away from the inspection teams being seen as “Arriving, Belittling, Criticising and Departing” (ABCD) and would wish to be seen much more as enablers to ensure that “inspections are for a sustained improvement”, to this end three Health Boards have participated in a pilot of a revised inspection process and it is likely that NHS Lothian will be visited early in the New Year.

The new approach will see a team of Inspectors and clinical experts meeting initially with key Board staff. Following which a focus group will be held with a cross selection of staff, this will be led by HIS clinical experts. The announced one day visit will give the opportunity for staff to present their current position and learn more about HIS ambition. Boards will be given 6-8 weeks advanced notice of the initial one day visit, with an unannounced one day visit 6-8 weeks later.

The most recent self-assessment for NHS Lothian has indicated where we are doing well and where there is room for improvement, this is summarised as:

3.2.3 Doing well/plans in place:
- Use of Getting to know me
- Care Rounding
- Specialist teams e.g. IMPACT, ECAT, Palliative Care
- MDT working
- Patient Alerts on TRAK
- Deteriorating patient collaborative
- Nutrition and hydration framework
- Tissue Viability Intranet Site / Team
- Clinical Nurse Manager meetings with Edinburgh North Partnership
- Education framework

3.2.4 Areas for improvement:
- Initial patient assessment – this will include hydration, nutrition, falls risk, cognition and medicines reconciliation
- Clear person centred care and treatment plans and documentation of the same
- Anticipatory care plans, in particular as they relate to end of life care, this will include DNACPR orders
- Communication with appropriate others, namely carers and relatives where the patient has cognition issues
- Increase awareness of carer assessment / requirements
- Management of challenging behaviours

3.2.5 To support this work the Vulnerable Patients Quality Improvement Framework continues to progress and a virtual improvement/progress group is in the process of being identified via the acute management teams. This virtual group will actively progress the requirements within their own areas of practise utilising both the Quality Improvement Teams and existing key staff, in particular clinicians with a specific interest in elderly care, dementia champions, education staff and vulnerable patient link staff.
Quality Dashboard – October 2014 (dates for each data item stated in background charts)

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

If you have an electronic version of this report, links to each measure chart have been embedded in the headings below.

**QUALITY AMBITION**

**PERSON-CENTRED - Process Measures**
- 20-day Complaints Response Rate *
- 3-day Complaints Response Rate *
- Delayed Discharges and Average Length of Stay *

**PERSON-CENTRED - Outcome Measures**
- Number of Complaints (excluding HMP Healthcare) *
- Number of Complaints for HMP Healthcare *
- Staff Absence Levels *
- Patient Experience
- Staff Experience

**SAFE – Outcome Measures**
- Hospital Standardised Mortality Ratios for RIE, WGH & St. John’s
- Incidents with harm *
- C. Difficile Numbers *
- Staph. Aureus Bacteraemia Numbers *
- Number of Cardiac Arrests *
- Rate of Cardiac Arrests *
- Inpatient Falls with Harm *
- Inpatient Pressure Ulcers Grade 2 or above *

**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**

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Lothian Rate (Per 1000 admissions)</th>
<th>Scottish Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standardised Surgical Readmission rate within 7 days</td>
<td>23.83</td>
<td>21.73</td>
</tr>
<tr>
<td>Standardised Surgical Readmission rate within 28 days</td>
<td>43.30</td>
<td>40.22</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 7 days</td>
<td>48.36</td>
<td>51.88</td>
</tr>
<tr>
<td>Standardised Medical Readmission rate within 28 days</td>
<td>115.19</td>
<td>112.69</td>
</tr>
<tr>
<td>Average Surgical Length of Stay – Adjusted</td>
<td>0.95</td>
<td>1.00</td>
</tr>
<tr>
<td>Average Medical Length of Stay – Adjusted</td>
<td>1.10</td>
<td>1.00</td>
</tr>
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</table>
**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."

<table>
<thead>
<tr>
<th>Title: 20-day Complaints Response Rate (Graph 1)</th>
<th>Title: 3-day Complaints Response Rate (Graph 2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Number of complaints responded to within 20 days</td>
<td>Numerator: Number of complaints responded to within 20 days</td>
</tr>
<tr>
<td>Denominator: Number of complaints</td>
<td>Denominator: Number of complaints</td>
</tr>
<tr>
<td>Goal: 85% of complaints responded to within 20 days</td>
<td>Goal: 100% formal acknowledgement within 3 working days</td>
</tr>
</tbody>
</table>

### Process Measure

**20-Day Response Target across NHS Lothian**

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

### Process Measure

**3-Day Response Target across NHS Lothian**

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

<table>
<thead>
<tr>
<th>Title: Number of Complaints (excluding Prison Complaints) (Graph 3)</th>
<th>Title: Number of Prison Complaints (Graph 4)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator: Total number of complaints</td>
<td>Numerator: Total number of prison complaints</td>
</tr>
<tr>
<td>Goal: Reduction in number of formal complaints</td>
<td>Goal: Reduction in number of formal complaints</td>
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</table>

### Outcome Measure

**NHS Lothian Formal Complaints (excluding HMP)**

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

### Outcome Measure

**HMP Healthcare Formal Complaints**

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

<table>
<thead>
<tr>
<th>Title: Delayed Discharges &amp; Average Length of Stay (Graph 5)</th>
<th>Title: Staff Absence Levels (Graph 6)</th>
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</thead>
<tbody>
<tr>
<td>Goal: No patient waiting longer than 2 weeks for discharge, by April 2015</td>
<td>Numerator: Total staff hours lost</td>
</tr>
<tr>
<td>Denominator: Total staff hours available</td>
<td>Goal: 4% or less</td>
</tr>
</tbody>
</table>

### Outcome Measure

**Delayed Discharge and Average LOS/days**

- **Data Source:** Local data captured on EDISON shared data with Health & Social Care
- **Exec Lead:** Melanie Johnson

### Outcome Measure

**SWISS Sickness Absence**

- **Data Source:** Scottish Workforce Information Strategic Systems (SWISS)
- **Exec Lead:** Alan Boyter
Safe
“There will be no avoidable injury or harm to people from healthcare they receive, and an appropriate, clean and safe environment will be provided for the delivery of healthcare services at all times.” Progress on this ambition is measured through standardised hospital mortality ratios, incidents with harm, HAI indicators, arrest calls, falls with harm and pressure ulcers.

<table>
<thead>
<tr>
<th>Title</th>
<th>Hospital Standardised Mortality Ratio (NHS Lothian Acute Hospitals) (Graphs 7 – 9)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Total number of in-hospital deaths and deaths within 30 days of discharge from hospital</td>
</tr>
<tr>
<td>Denominator</td>
<td>Predicted total number of deaths</td>
</tr>
<tr>
<td>Goal</td>
<td>20% reduction against 2006/07 baseline by December 2015</td>
</tr>
</tbody>
</table>

**Outcome Measure**
Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – March 2014

**Outcome Measure**
Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – March 2014

**Outcome Measure**
Quarterly Hospital Standardised Mortality Ratios in St John's Hospital, October 2006 – March 2014

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

<table>
<thead>
<tr>
<th>Title</th>
<th>Incidents with harm (Graph 10)</th>
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<tbody>
<tr>
<td>Numerator</td>
<td>Number of incidents associated with serious harm reported per month in NHS Lothian (Dec 2011- Nov 2013)</td>
</tr>
<tr>
<td>Goal</td>
<td>There are specific goals for reductions in Falls &amp; Pressure Ulcers. See separate graphs for progress against these.</td>
</tr>
</tbody>
</table>

**Outcome Measure**
Progress against HEAT Target for C. difficile Infection (CDI)

<table>
<thead>
<tr>
<th>Title</th>
<th>C. difficile associated disease against HEAT Target 2012-13 (Graph 11)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator</td>
<td>Total number of patients aged 15 and over with C. difficile toxin positive stool sample (CDI)</td>
</tr>
<tr>
<td>Goal</td>
<td>NHS Lothian is to achieve 262 or fewer CDI by March 2015 as shown by trend line.</td>
</tr>
</tbody>
</table>

**Outcome Measure**
Progress against HEAT Target for C. difficile Infection (CDI)
### Safe (cont’d)

**Title:** Staph. aureus bacteraemias (SABs) against HEAT Target 2012-13 (Graph 12)

**Numerator:** The number of SAB patient episodes (i.e. both MRSA and MSSA bloodstream infections)

**Goal:** NHS Lothian is to achieve 184 or fewer SABs by March 2015 as shown by trend line.

![Progress against HEAT Target for S.aureus Bacteraemia](image)

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

### Outcome Measure

**Title:** Number of Cardiac Arrests (Acute Wards) (Graph 13)

**Numerator:** Arrest – Number of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ITU/day care procedures are excluded.

**Goal:** 50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

![Outcome Measure](image)

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

**Title:** Rate of Cardiac Arrests (Acute Wards) (Graph 14)

**Numerator:** Arrest – Rate of 2222 calls which were for a cardiac arrest with chest compressions. Calls relating to Staff, Visitors, False Alarms, Cancelled Calls, Out of Hospital Arrests and outpatient CCU/ITU/day care procedures are excluded.

**Goal:** 50% reduction in Cardiac Arrests with chest compressions by December 2015 from February 2013 baseline

![Outcome Measure](image)

**Title:** Patient Falls with Harm (Graph 15)

**Numerator:** Number of falls reported resulting in moderate or major harm or death (define moderate/major). Data for NHS Lothian inpatient sites

**Goal:** 20% reduction in inpatients falls and associated harm by December 2015

![Outcome Measure](image)
**Title:** Number of Pressure Ulcers per month across NHS Lothian (Graph 16)

**Numerator:** Number of Grade 2 or above pressure ulcers

**Goal:** To achieve a reduction in the number of grade 2 or above pressure ulcers by March 2015 (from one a day to none a day)

**Outcome Measure**

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

“The most appropriate treatments, interventions, support and services will be provided at the right time to everyone who will benefit, and wasteful or harmful variation will be eradicated.” Progress on this ambition is measured through clinical quality indicators and stroke care.

<table>
<thead>
<tr>
<th>Title:</th>
<th>A&amp;E 4 Hour Wait (Graph 17)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of patients waiting less than 4 hours from arrival to admission or discharge</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of patients attending</td>
</tr>
<tr>
<td>Goal:</td>
<td>98% of patients waiting less than 4 hours from arrival to admission by March 2015</td>
</tr>
</tbody>
</table>

**Process Measure**

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

<table>
<thead>
<tr>
<th>Title:</th>
<th>Cancer Waits 62 Days from Diagnosis to Treatment (Graph 18)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of patients waiting 62 days to treatment</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of cancer patients</td>
</tr>
<tr>
<td>Goal:</td>
<td>95% of patients from diagnosis to treatment wait no longer than 62 days</td>
</tr>
</tbody>
</table>

**Process Measure**

Data Source: SGHD Management Information
Exec Lead: Jim Crombie

<table>
<thead>
<tr>
<th>Title:</th>
<th>Admission to Stroke Unit within 1 day of admission (Graph 19)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of patients with initial diagnosis of stroke admitted to an acute or integrated stroke unit within 1 day of admission</td>
</tr>
<tr>
<td>Denominator:</td>
<td>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</td>
</tr>
<tr>
<td>Goal:</td>
<td>90% of patients admitted with acute stroke should be in a Stroke Unit by the day after hospital admission</td>
</tr>
</tbody>
</table>

**Process Measure**

Note: 2014 data is not validated and should be treated as provisional

Data Source: ISD  Exec Lead: Melanie Johnson

<table>
<thead>
<tr>
<th>Title:</th>
<th>Stroke Treatment Measures (Graph 20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of admitted patients with initial diagnosis of stroke that have a swallow screen on the day of admission</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of patients admitted with initial diagnosis of stroke</td>
</tr>
<tr>
<td>Goal:</td>
<td>100% of patients with initial diagnosis of stroke should receive a swallow screen on day of admission</td>
</tr>
</tbody>
</table>

**Process Measure**

Note: 2014 data is not validated and should be treated as provisional

Data Source: ISD  Exec Lead: Melanie Johnson
Effective (cont’d)

<table>
<thead>
<tr>
<th>Title:</th>
<th>Stroke Treatment Measures (Graph 21)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Numerator:</td>
<td>Number of admitted patients with initial diagnosis stroke that have a brain scan within 24 hours of arrival</td>
</tr>
<tr>
<td>Denominator:</td>
<td>Number of patients admitted with initial diagnosis of stroke</td>
</tr>
<tr>
<td>Goal:</td>
<td>90% of patients with initial diagnosis of stroke should receive a brain scan within 24 hours of admission</td>
</tr>
</tbody>
</table>

**Process Measure**

Note: 2014 data is not validated and should be treated as provisional

![Graph showing scanning within 24 hours over time]

Data Source: ISD  Exec Lead: Melanie Johnson

4 **Key Risks**

4.1 Achieving the HAI HEAT target, 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. Patient Experience 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 Not applicable.

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
Clinical Governance & Risk Manager
18 November 2014
jo.bennett@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Supporting Context and Technical Appendix
Context and Technical Appendix

Quality Report Development

The NHS Scotland Quality Strategy set out three levels in its quality measurement framework. Level 1 – national quality outcome indicators, level 2 – HEAT targets, and level 3 – all other local and national measurement for quality improvement. The NHS Lothian Quality Report has been a standing item on the Board agenda since March 2010 and sets a range of measures against NHS Scotland’s quality ambitions and across levels 1 to 3.

Within this report is an updated set of process and outcome measures which are presented in a dashboard format. These measures will be reported at each Board on a monthly or quarterly basis. Data which has been updated since the last Quality Report is highlighted with an asterisk on page 10. The existing rolling programme of effectiveness measures for priority areas (diabetes, stroke, coronary heart disease, cancer, mental health and child & maternal health) will accompany the dashboard at every other Board meeting. This report contains core measures and Patient Safety clinical effectiveness measures.

The Quality Report is intended to link with NHS Lothian’s Quality Improvement Strategy (2011-14) and therefore will also include a range of measures set out in this strategy which will be reported in the dashboard on a regular basis, e.g. stroke and Delivering Better Care targets. The Dashboard will be changed over time to reflect local and national priorities and is currently going through a review.

The process measures in the dashboard relate to staff undertaking standard evidence-based care. Quality is improved by applying this standard, evidence-based care every time. A compliance level is set for most of these indicators at 95%, (i.e. when audited the care is provided in line with good practice at 95% of the time). Hence the Committee should look for the trend arrows to go up or if the compliance level has been met, that this is maintained.

Outcomes are measured using rates where possible (normally set per 1000 occupied bed days). The Committee should look for the arrows to be decreasing or to remain low.

The Scottish Government commenced production of a Hospital Scorecard in 2012 in response to the first Francis Report of February 2010, set within a Scottish context. The Quality Report reflects the National Hospital Scorecard and seeks to report these measures in a timely manner to inform assurance needs of the Board, with the exception of measures reported elsewhere, (e.g. A&E waiting times).

Hospital Standardised Mortality Ratio (HSMR)

HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level ‘warnings’ for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

S.aureus Bacteraemia (SAB) rate

New SAB HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year. This explains the increased target line in the chart below for April 2013. Thus the current HEAT target for NHS Lothian is to achieve 184 or fewer SAB by March 2015.
**C. difficile Infection (CDI) rate**
New CDI HEAT targets were set in April 2013 which will be measured against the actual number achieved in the previous year and now includes patients aged 15 and over. Thus the current HEAT target for NHS Lothian is to achieve 254 or fewer CDI by March 2015.

**Incidents associated with harm**
Incidents are reported by staff using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.

**Surgical readmissions within 7 days**
This is the emergency readmissions to a surgical specialty within 7 days of discharge as a rate per 1000 total admissions to a surgical specialty. The data are presented for calendar year 2011. This measure has been standardised by age, sex and deprivation (SIMD 2009).

**Surgical re-admissions within 28 days**
As for 7 day readmissions.

**Medical Re-admissions Within 7 Days**
This is the emergency readmissions to a medical specialty within 7 days as a rate per 1000 total admissions to a medical specialty.
The data are presented for calendar year 2011.
This measure has been standardised by age, sex and deprivation (SIMD 2009).

**Medical Re-admissions Within 28 Days**
As for 7 day readmissions.

**Average Length of Surgical Stay (Adjusted)**
Ratio of ‘observed’ length of stay over ‘expected’ length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay.
A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

**Average Length of Medical Stay (Adjusted)**
Ratio of observed length of stay over expected length of stay.
This indicator is case mix adjusted by HRG* and specialty. The expected length of stay is calculated by working out the average length of stay nationally (Scotland only) for each specialty and HRG combination. This is then multiplied by the total number of spells to get the expected length of stay. A hospital with a value above the national average (e.g. 1.01 will be 1% above the national average) and a hospital below the national average (e.g. 0.99 is 1% below the national average).

* HRG: Healthcare Resource Groups. These are standard grouping of clinically similar treatments that use common levels of healthcare resource. They are usually used to analyse and compare activity between organizations.
**SUMMARY PAPER - FINANCIAL POSITION 2014/15 AND FORWARD LOOK 2015/16**

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

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>The Board is reporting an overspend of £6.374m at the end of October. This is a significant deterioration of £2.635m in the month.</td>
<td>3.1</td>
</tr>
<tr>
<td>The Mid Year Review indicates the potential for an overspend of £6.56m, which when the impact of the month 7 position is factored in this rises to £9.4m.</td>
<td>4.2</td>
</tr>
<tr>
<td>The current assessment of the year end is that breakeven is still deliverable provided there is no further deterioration in our financial performance from month 8 onwards, and the action outlined is taken.</td>
<td>4.8</td>
</tr>
<tr>
<td>In putting together a financial plan for 15/16 and beyond, it is clear that delivery of the 14/15 financial target is being achieved in an unsustainable way.</td>
<td>5.4</td>
</tr>
<tr>
<td>It is unlikely that work underway will be sufficient to deliver a balanced financial plan and in developing its LDP for 15/16 the Board will require to carefully consider how it balances patient safety and quality, delivery of its performance targets and financial balance</td>
<td>5.10, 5.11</td>
</tr>
</tbody>
</table>

Susan Goldsmith
Director of Finance
28 November 2014
Susan.Goldsmith@nhslothian.scot.nhs.uk
NHS LOTHIAN

Board Meeting
3 December 2014

Director of Finance

FINANCIAL POSITION 2014/15 AND FORWARD LOOK 2015/16

1 Purpose of the Report

1.1 The purpose of this report is to provide a high level overview of the month 7 financial performance, along with the Mid Year Review forecast outturn position for the current year and the implications for the Financial Plan for 15/16.

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 Note that the financial position for 2014/15 remains very fragile with breakeven dependent on there being no worsening of the financial performance from month 8 onwards, and the action outlined in the report;

2.2 Note that the further investment required to support the Delivering for Patients trajectory will only be agreed once there is more confidence about the financial performance, after month 8 is finalised;

2.3 Note that the draft Financial Plan for 15/16 is currently not balanced and further consideration, working with our external partners, needs to be given to how we balance our requirement to give assurance about Patient Safety and Quality, meet performance targets and deliver a financial breakeven position.

2.4 Note the early work being undertaken to develop sustainable and affordable services to meet future needs, both internally and with other NHS Board colleagues and Scottish Government colleagues.

3 Discussion of Key Issues

3.1 At period 7 of this financial year, NHS Lothian has seen further deterioration in its financial performance with an adverse movement in the month of £2.635m bringing the overspend to £6,374m at the end of October. The table below sets out the RRL position with a detailed analysis by expenditure type attached in Appendix 1 and by operational unit in Appendix 2. The table also shows that the monthly position has been partly offset by further non-recurring flexibility identified as part of the Mid Year Review.
A full detailed analysis of the month 7 position will be considered by CMT and is available to Board members on request. However this report will concentrate on the Mid Year Review and in particular the financial position as we plan for 15/16 and beyond.

4 Mid Year Review

4.1 A detailed review of the year end forecast was undertaken on the basis of the month 6 results and is set out in table 2 below indicating the potential for an overspend of £6.56m unless corrective action is taken.

<table>
<thead>
<tr>
<th>Mid Year Review Forecast</th>
<th>Baseline £000</th>
<th>LRP £000</th>
<th>Total £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>East Lothian CHP</td>
<td>241</td>
<td>(241)</td>
<td>0</td>
</tr>
<tr>
<td>Midlothian CHP</td>
<td>70</td>
<td>(70)</td>
<td>0</td>
</tr>
<tr>
<td>Edinburgh CHP</td>
<td>(4,736)</td>
<td>(1,270)</td>
<td>(6,006)</td>
</tr>
<tr>
<td>West Lothian CHCP</td>
<td>187</td>
<td>(117)</td>
<td>70</td>
</tr>
<tr>
<td>Scheduled Care</td>
<td>(6,409)</td>
<td>(4,471)</td>
<td>(10,880)</td>
</tr>
<tr>
<td>Unscheduled Care</td>
<td>(3,135)</td>
<td>(2,527)</td>
<td>(5,662)</td>
</tr>
<tr>
<td>Facilities &amp; Consort</td>
<td>34</td>
<td>(46)</td>
<td>(12)</td>
</tr>
<tr>
<td>Corporate Services</td>
<td>828</td>
<td>(426)</td>
<td>402</td>
</tr>
<tr>
<td>Strategic Other</td>
<td>562</td>
<td>(147)</td>
<td>415</td>
</tr>
<tr>
<td><strong>Operational Position</strong></td>
<td><strong>(12,306)</strong></td>
<td><strong>(-9,315)</strong></td>
<td><strong>(21,621)</strong></td>
</tr>
</tbody>
</table>

**Additional Pressures:**

- **Unscheduled Care**
  - £5,500
- **Capacity / Waiting Times**
  - £4,000
- **SMC Drugs**
  - £3,000

**Total Other Pressures**

- (£12,500) 0 (£12,500)

**Reserves & NR Flexibility**

- 27,556

**NHS Lothian Forecast**

- 2,750

4.2 Clearly the further deterioration of the financial position seen in month 7, not reflected in this forecast, requires that this action is taken rapidly. An initial assessment of the impact of the month 7 position on the year end position is that this increases the overspend to £9.4m. This movement is principally driven by the overspend on prescribing (£1m) and an additional £1.8m based on supplies expenditure within Scheduled Care.
4.3 The figures contained within the above table show that the forecast comprises an overspend on operational performance of £12m, driven by additional nursing costs, supplies and equipment costs and prescribing, as well as unachieved LRP (in year) in excess of £9m. On top of this the Mid Year Review has captured the financial impact of 3 key pressures: estimated expenditure on the new Hep C drug, Sofosbuvir is estimated at £3m more than was anticipated in year and provided for in the SMC budget; an additional requirement of £5.5m to support both the WGH front door and winter beds over and above the financial plan; and finally a further £4m to maintain the waiting times trajectory. At this stage the additional investment in waiting times has not yet been agreed, however it is clear from the Waiting Times Report that without this spend there will be a deterioration in performance which will have to be recovered next year. Given the concern about the financial performance to date it is proposed to defer a commitment on this expenditure until the month 8 results are available.

4.4 The Mid Year Review also identified additional sources of non recurring support to supplement the £13.2m target including slippage on financial plan investments and allocations, VAT recovery and rates rebates, and reserves bringing the total offset to £27.5m.

4.5 In order to deliver our statutory requirement to deliver breakeven by the year end a number of actions have been agreed with business units and CMT and delivery of these must be a priority across the organisation, recognising our continuing obligation to assure quality. These actions include:

- A programmed reduction of supplementary staffing, including stopping the use of agency staffing. Agency staff costs NHS Lothian circa £1m per month.
- All staffing vacancies will now be prioritised for recruitment.
- Review of planned opening of beds in relation to the Winter Plan where there is no commitment of costs to date.
- Review of allocations as they are received to ensure that flexibility within the allocation can be utilised to support overall financial performance.
- Control of discretionary spend.
- Review usage of Hep C drugs and specifically Sofosbuvir to prioritise implementation and positive discussions have taken place with the SGHSCD to recognise the pressure caused by Hepatitis C drugs.
- Review of the costs associated with rates on GP premises. There is potential for a financial benefit in-year and on a recurrent basis, although further work is required to establish whether this benefit will be achieved.

4.6 Inevitably within the forecast position there are a number of risks and assumptions. These include issues for which no costs are assumed that may well impact before the year end and are detailed in the table below.

4.7 Not withstanding these risks the current assessment of the year end is that breakeven is still deliverable provided there is no further deterioration in our financial performance from month 8 onwards.
### Table 12 Risks and Assumptions

<table>
<thead>
<tr>
<th>Key Assumptions / Risks</th>
<th>Risk rating</th>
<th>Impact / £</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Reinvestment Programme</td>
<td>High</td>
<td>Delivery of recurring savings to the value required to meet the known gap between anticipated income and planned activities.</td>
</tr>
<tr>
<td>Parental and Adoption Leave</td>
<td>High</td>
<td>The implementation of paid parental leave until the child is 14 years has been modelled with various scenarios. No cost has been included in the forecast position but may need to be accrued for by the year end.</td>
</tr>
<tr>
<td>Rates Rebates and Property Sales</td>
<td>Low/Medium</td>
<td>The ongoing rateable value appeal of the GMS properties could generate substantial backdated rebates.</td>
</tr>
<tr>
<td>Prescribing</td>
<td>Medium</td>
<td>A sustained level of short supply has been included in the year end forecast; however there is the potential for this to get worse. An assumption has been made that volumes will come back into line with expected levels by year-end.</td>
</tr>
<tr>
<td>Changes to the IPTR process</td>
<td>Medium</td>
<td>Changes to the process have not yet fully bedded down, however based on the year to date the financial impact has been assessed at £2.6m to NHS Lothian. It has been assumed that these costs will be offset by national savings in the drug tariff along with any further costs incurred in year.</td>
</tr>
<tr>
<td>Hep C Drugs</td>
<td>High</td>
<td>The usage of the new Hep C drug (Sofosbuvir) is greater than originally anticipated. A £3m overspend in year is forecast</td>
</tr>
<tr>
<td>Changes to pay terms &amp; conditions including discussions with Consort on the full implication of the Two Tier Agreement</td>
<td>Medium</td>
<td>These issues can’t at the moment be fully quantified. The financial consequence will be monitored as the year progresses</td>
</tr>
<tr>
<td>CNORIS</td>
<td>Low</td>
<td>The final valuation for CNORIS will not be known until the end of the year</td>
</tr>
<tr>
<td>Equal Pay</td>
<td>Medium</td>
<td>Discussions are continuing with CLO and Audit Scotland with regards to the treatment of this potential financial exposure.</td>
</tr>
</tbody>
</table>

### 5 Financial Plan 15/16 and Beyond

#### 5.1 A number of reports have been published recently, including the Audit Scotland Annual Overview Report, NHS England five year forward view, and from the Health Foundation all of which highlight the challenges the NHS is facing in dealing with the demographic challenge, performance targets and the changes in technology in the context of the overall NHS budget starting to decrease in real terms. In particular the Audit Scotland Overview Report had 2 (out of 3) key messages which highlighted that there are signs that NHS Boards are facing increasing difficulty meeting financial targets and that some are doing this in unsustainable ways, and that there are also signs of pressure on NHS Boards ability to meet demanding performance targets.  

#### 5.2 The Directors of Finance, as a group, also reported on the financial challenges facing the health service in Scotland over the next 5 years. They advised that over the next five years, the anticipated reduction in baseline funding increases, together with known financial cost pressures would present significant challenges to Boards when faced with achieving financial cost pressures, meeting targets and taking forward changes as envisaged within health and social care integration.
The report is not designed to provide a comprehensive action plan or purport to have all the answers to the issues but rather to inform a debate regarding the strategic challenges and the need for a joint local, regional and national approach to the planning for a sustainable, high quality health service in line with our aspirations for 2020.

5.3 Despite the development of a strategic plan which outlines the Board’s response to the challenges it faces it has not been able to develop a financial framework which is capable of supporting the investment in acute infrastructure to deliver its waiting times targets internally, capacity in Primary care and community services, and freeing up capacity to deliver changes in patient pathways.

5.4 What is clear is, that in putting together a financial plan for 15/16 and beyond, NHS Lothian has now reached the point where delivery of the financial target for 14/15 is being achieved in an unsustainable way and this is creating a significant issue when faced with the range of requirements to be delivered next year.

5.5 In considering the draft financial plan at the Finance and Resources Committee, members of the Committee concluded that it was critical that this initial assessment of next year be considered at the formal Board meeting in order to give the Board an opportunity to discuss the position.
Table 3 below sets out the first draft of the financial plan.

### Table 3 – Draft Financial Plan

<table>
<thead>
<tr>
<th>NHS Lothian Draft Financial Plan 2015/16</th>
<th>Recurring</th>
<th>Non-Recurring</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Income</td>
<td>33,894</td>
<td>4,200</td>
<td>38,094</td>
</tr>
<tr>
<td>Recurring Deficit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baseline Overspend per Q1</td>
<td>(10,954)</td>
<td>0</td>
<td>(10,954)</td>
</tr>
<tr>
<td>Recurring LRP gap per MYR</td>
<td>(15,188)</td>
<td>0</td>
<td>(15,188)</td>
</tr>
<tr>
<td>Total recurring deficit</td>
<td>(26,142)</td>
<td>0</td>
<td>(26,142)</td>
</tr>
<tr>
<td>Additional Expenditure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay uplift</td>
<td>(9,211)</td>
<td>(9,211)</td>
<td></td>
</tr>
<tr>
<td>Consultant Seniority/Discretionary Points</td>
<td>(1,763)</td>
<td>(1,763)</td>
<td></td>
</tr>
<tr>
<td>Workforce Plans</td>
<td>(948)</td>
<td>(948)</td>
<td></td>
</tr>
<tr>
<td>Other Pay Issues</td>
<td>(223)</td>
<td>(223)</td>
<td></td>
</tr>
<tr>
<td>Employers Pension Contribution</td>
<td>(12,425)</td>
<td>(12,425)</td>
<td></td>
</tr>
<tr>
<td>Medicines</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>GP Prescribing</td>
<td>(5,500)</td>
<td>(5,500)</td>
<td></td>
</tr>
<tr>
<td>Secondary Care Prescribing</td>
<td>(7,500)</td>
<td>(7,500)</td>
<td></td>
</tr>
<tr>
<td>Other Medicines Investment</td>
<td>(376)</td>
<td>(376)</td>
<td></td>
</tr>
<tr>
<td>Supplies Uplift</td>
<td>(7,653)</td>
<td>(7,653)</td>
<td></td>
</tr>
<tr>
<td>Delivering for Patients</td>
<td>0</td>
<td>(9,000)</td>
<td>(9,000)</td>
</tr>
<tr>
<td>Unscheduled Care Investments 14-15 step-up</td>
<td>(5,311)</td>
<td>(5,311)</td>
<td></td>
</tr>
<tr>
<td>Sustainable Delivery of TTG/WT Standards</td>
<td>(5,297)</td>
<td>(5,297)</td>
<td></td>
</tr>
<tr>
<td>Psychology/CAMHs Capacity</td>
<td>(657)</td>
<td>(247)</td>
<td>(904)</td>
</tr>
<tr>
<td>Parental Leave</td>
<td>(3,291)</td>
<td>(3,291)</td>
<td></td>
</tr>
<tr>
<td>Service Developments</td>
<td>(1,600)</td>
<td>(84)</td>
<td>(1,684)</td>
</tr>
<tr>
<td>Infrastructure</td>
<td>(1,127)</td>
<td>(1,127)</td>
<td></td>
</tr>
<tr>
<td>Strategic Investments</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Edinburgh Hospital</td>
<td>(270)</td>
<td>(414)</td>
<td>(684)</td>
</tr>
<tr>
<td>RHSC &amp; Neurosciences</td>
<td>(3,406)</td>
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<td>(3,876)</td>
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<td>(3,460)</td>
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<td>(163)</td>
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<td>(4,177)</td>
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<tr>
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<td>(1,191)</td>
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<td>Total Expenditure</td>
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<td>(6,178)</td>
<td>(73,812)</td>
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</table>
5.6 The above table shows that we are starting the year with a brought forward “shortfall” of £26m. This is made up of brought forward LRP and a range of cost pressures which operational managers have not been able to manage. These include incremental drift, medical supplies and equipment, and transport amongst others. This is the “best case” position following month 7 and further work is required to better assess the recurrency of the baseline overspend in 14/15.

5.7 Although there is still further work required to scrutinise all of the additional expenditure, and the position on Pensions will be determined by the budget statement on the 3 December, it is clear that there is a major gap, of circa £70m, between our additional uplift for 15/16 and our assessment of the additional expenditure requirements.

5.8 In previous years this gap has been become the Board’s LRP “requirement” and in developing the financial plan each year a judgement has been taken about what level of LRP can be delivered to support the aspirations of the organisation. However for this year it is clear that setting an LRP target of this level would not be credible and certainly not deliverable without major urgent service change.

5.9 NHS Lothian has reliably produced recurring LRP savings of circa £25m, and generally will be able to generate a non-recurring flexibility of a further £15m from both recurrent and non recurrent reserves but this will still leave a gap in excess of £30m which, even if it could be bridged in some way, would further destabilise the organisation as it moves out of recurring financial balance, particularly when 16/17 is taken into account.

5.10 Recognising the extent of the challenge a number of significant pieces of work are being developed. In line with the recommendation of Audit Scotland for Boards and their Partners to develop sustainable and affordable services to meet future needs it is proposed to undertake detailed Intensive reviews in 2 or 3 areas using future population projections and looking at different models of care. This will be linked to patient pathways but will take time and resource, but should start to shape how we fundamentally redesign services for the medium/longer term.

5.11 Working with Scottish Government colleagues we have started to explore the option of undertaking a detailed diagnostic review taking a systematic approach to reviewing our data and benchmarking our performance and costs against other systems. This may identify shorter term opportunities to reduce our cost base by improving performance, but also give us a basis for assessing the impact of the service redesign required.

5.12 Active engagement with clinical colleagues has also taken place about how we implement some of the more difficult changes for which there is broad consensus, and Chairs and Chief Executives are also working together to consider the opportunities there may be for more regional and national working across a range of work streams. The latter will also be a key component of a medium to longer term redesign of services.

5.13 However it is unlikely that this will be sufficient to deliver a balanced financial plan for 15/16 which, in the context of an equally difficult financial position for 16/17, is not a sustainable position for the Board going forward.
5.14 Thus in developing its LDP for 15/16 the Board will require to carefully consider how it balances patient safety and quality, delivering of its performance targets, and financial balance, both in the short term and in the longer term by a significant reshaping of services.

6 Risk Register

6.1 There is nothing further to add to the Risk Register at this stage.

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.

Susan Goldsmith  
Director of Finance  
28 November 2014  
susan.goldsmith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: NHS Lothian Income & Expenditure Summary 31 October 2014  
Appendix 2: NHS Lothian Summary by Operational Unit to 31 October 2014
### NHS Lothian Income & Expenditure Summary 31 October 2014

<table>
<thead>
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<th>YTD Actuals</th>
<th>YTD Variance</th>
<th>Period Variance</th>
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<td>£k</td>
<td>£k</td>
<td>£k</td>
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<td>13</td>
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<td>(52)</td>
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<td>(11)</td>
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<td>(991)</td>
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<td>(240)</td>
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<td>(907)</td>
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<td>(181)</td>
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<td>(1,511)</td>
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<td>(41)</td>
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| Income    | (1,640,746) | (155,492) | (157,777) | 2,285 | 682 |

| Sub Total Core Baseline Position | (30,635) | 732,908 | 742,680 | (9,772) | (4,107) |

| Savings Target Non-Pay | (17,341) | (5,860) | 0 | (5,860) | (1,185) |
| N/R Corp Savings LRP | 7,700 | 7,700 | 0 | 7,700 | 1,100 |
| Additional Reserve Flexibility | 1,558 | 1,558 | 0 | 1,558 | 1,558 |
| TOTAL | (38,718) | 736,306 | 742,680 | (6,374) | (2,635) |
## APPENDIX 2

### NHS Lothian Summary by Operational Unit to October 2014

<table>
<thead>
<tr>
<th>Description</th>
<th>SUNSHD Unscheduled Care</th>
<th>SCHED Scheduled Care</th>
<th>SCHPEL East Lothian Chp</th>
<th>SCHPCE Edinburgh Chp</th>
<th>SCHPML Midlothian Chp</th>
<th>SCHPWL West Lothian Chp</th>
<th>SFMCON Facilities And Consort</th>
<th>SCORP Corporate Services</th>
<th>STRAT Strategic Services</th>
<th>Total</th>
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<td>76,651</td>
<td>301,926</td>
<td>51,900</td>
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<td>(16)</td>
<td>(81)</td>
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<td>(3,803)</td>
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<td>(5)</td>
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<td>(9)</td>
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<td>6</td>
<td>(5)</td>
<td>0</td>
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<td>(2)</td>
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<td>7</td>
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<td>(5)</td>
<td>(54)</td>
<td>3</td>
<td>(11)</td>
<td>0</td>
<td>(2)</td>
<td>(2)</td>
<td>12</td>
<td>4</td>
<td>(55)</td>
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<tr>
<td>Sub Total Non-Pay</td>
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<td>(3,641)</td>
<td>(762)</td>
<td>(2,700)</td>
<td>(462)</td>
<td>(904)</td>
<td>(147)</td>
<td>(1,160)</td>
<td>(510)</td>
<td>(10,064)</td>
</tr>
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<td>Income</td>
<td>264</td>
<td>894</td>
<td>83</td>
<td>(105)</td>
<td>8</td>
<td>(33)</td>
<td>511</td>
<td>397</td>
<td>267</td>
<td>2,285</td>
</tr>
<tr>
<td>Core Position</td>
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<td>(4,411)</td>
<td>(653)</td>
<td>(3,354)</td>
<td>(372)</td>
<td>(378)</td>
<td>(155)</td>
<td>2,024</td>
<td>555</td>
<td>(9,771)</td>
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<td>(2,362)</td>
<td>(147)</td>
<td>(1,377)</td>
<td>(5)</td>
<td>6</td>
<td>13</td>
<td>(330)</td>
<td>93</td>
<td>(5,880)</td>
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<td>N/R Corp Savings LRP</td>
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<td>0</td>
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<td>0</td>
<td>0</td>
<td>7,700</td>
<td>7,700</td>
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<td>0</td>
<td>0</td>
<td>1,558</td>
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<tr>
<td>Total</td>
<td>(4,779)</td>
<td>(6,773)</td>
<td>(800)</td>
<td>(4,731)</td>
<td>(377)</td>
<td>(371)</td>
<td>(142)</td>
<td>1,693</td>
<td>9,906</td>
<td>(6,373)</td>
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SUMMARY PAPER - LOCAL ACCESS POLICY AUDITS

This paper aims to summarise the key points.

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

<table>
<thead>
<tr>
<th></th>
<th>Para</th>
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</thead>
<tbody>
<tr>
<td>• It is recommended that the Board receive this update regarding audits relating to the Local Access Policy approved in April 2014 (specifically around the change of reasonable offer period from 14 to 7 days).</td>
<td>2.1, 3.2</td>
</tr>
<tr>
<td>• The following audits were conducted:</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Mail delivery times</td>
</tr>
<tr>
<td></td>
<td>o Telephone call activity</td>
</tr>
<tr>
<td></td>
<td>o Period of notice provided on written offers</td>
</tr>
<tr>
<td></td>
<td>o Patient satisfaction on notice period provided</td>
</tr>
<tr>
<td></td>
<td>4.1 – 4.8</td>
</tr>
<tr>
<td></td>
<td>5.1 – 5.4</td>
</tr>
<tr>
<td></td>
<td>6.1 – 6.6</td>
</tr>
<tr>
<td></td>
<td>7.1 – 7.6</td>
</tr>
<tr>
<td>• Improving communication to patients was also reviewed in terms of:</td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>o Information provided on outpatient letters and leaflets</td>
</tr>
<tr>
<td></td>
<td>o Information provided to patients with additional needs</td>
</tr>
<tr>
<td></td>
<td>8.1 – 8.2</td>
</tr>
<tr>
<td></td>
<td>9.1 – 9.6</td>
</tr>
<tr>
<td>• Review of progress by Access, Performance and Governance concluded that ongoing oversight was required in the above areas to be assured that patients receive the necessary information clearly and in good time. It will therefore remain a topic at the monthly meeting of the group and it is recommended that the progress in these areas is subsequently discussed at the Acute Hospitals Committee.</td>
<td>10.1 - 10.2</td>
</tr>
</tbody>
</table>

Jim Crombie  
Director of Scheduled Care  
13 November 2014  
j.crombie@nhs.net
LOCAL ACCESS POLICY AUDITS

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on the audits implemented following changes to the Local Access Policy in April 2014.

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 and asks that progress on the actions identified are considered by the Board’s Acute Hospitals Committee.

3 Background

3.1 The Scottish Government expects that Boards articulate their approach regarding the management of waiting list in a local access policy. The NHS Lothian Local Access Policy was approved by the Board in April 2014.

3.2 At the time of approval monitoring was requested of the change of reasonable offer period from 14 days to 7 days. This was necessary to ensure that information used locally was consistent with that being reported nationally from the ISD National Data Warehouse.

3.3 The 7 day rule determines the amount of notice that routine patients must receive in advance of an appointment. It also determines the amount of time a patient has to indicate that an offer made is not suitable before there is any impact on their waiting time clock.

3.4 It should be highlighted that 7 days is the minimum amount of notice that could be given to routine patients but the majority receive significantly longer than this.

3.5 A number of audits were set up following the meeting in April 2014 and have been reported to the monthly Access, Performance and Governance Meeting. The results of these audits are detailed in the following sections.

3.6 Where appropriate the actions to be progressed in each area are noted.

4 Mail Delivery

4.1 Patient appointment letters in NHS Lothian are sent from numerous sites across the area. These letters are collected and sorted by local mail rooms before being
picked up for processing by either TNT or Royal Mail. The Facilities Department has service level agreements in place with both companies for the delivery of mail.

4.2 An audit of mail delivery time for letters was carried out over 3 months from the main NHS Lothian hospital sites to a mixture of addresses both in and outside of the NHS Lothian area. This audit looked at the time from the letter being placed in the department mail tray to receipt at destination.

4.3 The results of this audit showed that time from the letter being placed in the department mail tray until it reached its destination varied from 1 day to 5 days with 80% of letters being delivered within 1-3 days. This is within the service level agreement that is in place with both TNT and Royal Mail.

4.4 Five letters (9%) did not arrive at their destination. There was no apparent common link between posting department and recipient address. The details of these letters have been passed to Facilities to investigate further and a further mail audit will check whether this is an ongoing feature.

4.5 Board members will be aware any decision to remove a patient from the waiting list in light of not attending an appointment is considered clinically. If the patient is to be removed then this decision is communicated to both the patient and the GP. The letter includes an offer to reinstate the patient back onto the waiting list if appropriate.

4.6 eHealth is currently developing a business case, in conjunction with ATOS, to reduce reliance upon the mail. A system is being explored that would allow patients to receive their appointment letters and information via a web based portal rather than by post and therefore reducing the delivery time to minutes and reduce the risk of loss.

4.7 The detail of the implementation plan is already being worked on, anticipating a roll out across NHS Lothian from Jan 2015 and the full programme is expected to last 2 years.

4.8 The review has also led to a review of the information placed on the intranet on operating hours of the mail service and pick up times. Facilities expect to complete this by the end of next month.

5 Telephone Call Activity

5.1 The Telecommunications Department provided call reports on extension numbers within NHS Lothian. These reports include the number of calls received by outcome (answered, busy, and unanswered) and also longest and average ring times.

5.2 These call reports were produced for key telephone numbers in both outpatient and inpatient booking offices.
5.3 A summary of the latest call reports is shown below:

5.4 As can be seen, this suggests a particular issue in the Health Records Department at the Royal Hospital for Sick Children. This was explored by Health Records, who concluded that the figures available were likely to be incorrect as it did not reflect experience in the department nor was this the subject of many complaints. In spite of this, a change was made to ensure that only external calls were received by this extension and the implementation of call centre technology in the area is to be brought forward.

6 Notice period of offers

6.1 A report was developed by Analytical Services to show the number of days between the appointment/admission letters being printed until the date of the appointment/admission.

6.2 The latest iteration of this report for routine outpatient offers made in October 2014 that were subsequently declined is shown below:

<table>
<thead>
<tr>
<th></th>
<th>Under 7 days</th>
<th>8 - 10 days</th>
<th>11 - 14 days</th>
<th>15 - 21 days</th>
<th>Over 21 days</th>
<th>Grand Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>160</td>
<td>152</td>
<td>130</td>
<td>183</td>
<td>430</td>
<td>1055</td>
</tr>
</tbody>
</table>

6.3 Given that written offers rely upon the mail, the Access, Performance & Governance Group has agreed that written offers should not be sent to patients less than 10 days. As can be seen there are 312 outpatients whose letter was printed less than 10 days prior to their appointment date.
6.4 Health Records staff reviewed those written offers being made with less than 10 days notice across a number of areas and concluded that the majority of these are recording errors and were actually verbal offers. Independent sampling has confirmed this.

6.5 The correct recording of offer type (“verbal” as opposed to “written”) has hence been identified as a training need within this staff group and this will be taken forward by Health Records.

6.6 The reports will continue to be produced for the next 6 months to monitor the change in practice.

7 Patient Surveys

7.1 A short patient survey was developed in conjunction with the NHS Lothian Public Involvement Coordinator. A copy of this survey is attached as Appendix 1.

7.2 This survey was undertaken with 60 outpatients across 5 different sites in NHS Lothian.

7.3 The results showed that 90% of patients were happy with the amount of notice that they were given for their appointment. Those who could remember how much notice they received estimated an average of 34 days notice.

7.4 There were mixed views about the amount and quality of information that was sent to patients with their appointment letter with 82% stating they felt the letters contained enough information about their appointment. There is more information on the work being done in this area in section 8.

7.5 89% of those patients who said they had to call to change their appointment felt that they were able to get through to the right person quickly and easily.

7.6 A number of those surveyed felt that a reminder system particularly via text message would be helpful and this information has been passed to Telecommunications as they are currently investigating the options in this area.

8 Review of outpatient letters and accompanying information

8.1 Communication on waiting times is a theme being considered by a Short Life Working Group established by the Scottish Government. A draft of the proposed letter content was received in May 2014 and feedback was given on these but the final version has not yet been received. NHS Lothian has also contributed to discussions about a national waiting times information leaflet and a draft of this is expected for review soon.

8.2 Whilst this national work has progressed, a local working group has agreed a generic outpatient appointment letter, ensuring that the focus of the letter is on the key information for patients such as appointment date, time and location. This letter is being introduced in Endoscopy in November 2014 and a roll out plan is under development.
9 Additional Needs

9.1 Board members will be aware that in December 2013 Audit Scotland highlighted the work currently underway locally to improve communication with those with additional needs.

9.2 When this change to reasonable offer period was agreed some points highlighted included that the shorter timescale can be a challenge for those with additional needs. It was suggested that those patients who are also carers may require longer to make arrangements to attend and it may take longer for those who have difficulty with English or of low literacy to seek help to understand a letter.

9.3 The Additional Needs & Diversity Information Task Force has introduced a pilot to record patient’s additional needs in the Trak system. This pilot started in October 2014.

9.4 Two of the additional needs being collected are what the patients preferred language for written communication is and if they have visual impairment and would benefit from a letter in large font.

9.5 There is new letter functionality in the Trak system that will allow letters to be produced in another language or in a large font. This functionality has been tested and the Trak Project Board will now need to agree the priority given to this work and where it will feature in the Trak eHealth work plan.

9.6 The assessment of this pilot will be carried out by the Additional Needs & Diversity Information Task Force and will be reported to Access, Performance and Governance in April 2015.

10 Next Steps

10.1 Review of progress by Access, Performance and Governance concluded that ongoing oversight was required in the above areas to be assured that patients receive the necessary information clearly and in good time. It will therefore remain a topic at the monthly meeting of the group.

10.2 It is recommended that the progress in these areas is subsequently discussed at the Acute Hospitals Committee, to which Access, Performance and Governance reports.

11 Risk Register

11.1 The risks to achievement of waiting times standards is already included in the corporate risk register.

12 Impact on Inequality, Including Health Inequalities

12.1 An impact assessment was carried out in March 2014.
13 Involving People

13.1 Opinions, particularly focusing on amount of notice that patients received for their appointment, were gathered through the patient surveys outlined in section 7 above.

14 Resource Implications

14.1 There are no additional resource implications.

Hazel Neilson
Strategic Planning
12 November 2014
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List of Appendices

Appendix 1: Patient survey
We would really like to hear your views about the amount of notice you were given for your outpatient appointment and the information you received so we can make any necessary improvements. Please tick the most appropriate box for each question and give us further comments if you wish.

**If your appointment was booked by letter, answer questions 1 and 2 then go to question 4.**

1. How many days before your appointment did the letter arrive?
   - Number of days
   - Not sure

2. Were you given enough notice for your appointment?
   - Yes
   - No
   - Not sure

If you answered ‘no’ or ‘not sure’ what would have made it better for you.

<table>
<thead>
<tr>
<th>If your appointment was booked by phone</th>
</tr>
</thead>
<tbody>
<tr>
<td>3. Did you receive a letter confirming your appointment?</td>
</tr>
<tr>
<td>Yes (go to Q4)</td>
</tr>
</tbody>
</table>

If you answered 'no' or 'not sure' would a letter have been useful?

<table>
<thead>
<tr>
<th>4. Did your letter give you enough information about your appointment?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

If you answered 'no' or 'not sure' what other information would have been helpful?
5. If you received leaflets with your letter what did you think of them?

- Helpful with the right amount of information
- Helpful but too much information
- Not helpful, too much information
- Not helpful, not right information
- Did not receive any information

What, if anything, would have been more helpful?

6. Did you need to call to change your appointment?

- Yes (go to Q7)
- No (go to Q8)
- Not sure

7. Were you able to get through to the right person?

- Yes, quickly and easily
- Yes, but with difficulty
- No

What else can you tell us about your experience?

8. If we were able to send your appointment information by email would you be interested?

- Yes
- No
- Not sure

9. If you have any other comments about making your appointment or the information you received please tell us in the box below:

Thank you very much for taking the time to complete this survey. Please hand it back to reception or give it to the person who gave you it.
This paper aims to summarise the key points in the full paper.

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

<table>
<thead>
<tr>
<th>Point</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>This paper submits the finalised cancer strategy to the Board following public consultation</td>
<td>1</td>
</tr>
<tr>
<td>The Board is asked to approve the strategy</td>
<td>2</td>
</tr>
<tr>
<td>The majority of respondents to consultation were supportive of the strategy with earlier detection, prevention, support for a new regional cancer centre, and affordability being key issues raised</td>
<td>3</td>
</tr>
<tr>
<td>Primary care related issues, in particular, have been considered and factored into the strategy based on feedback, with ongoing engagement with the LMC and cross-reference to our primary care strategic programme</td>
<td>4.1</td>
</tr>
<tr>
<td>A focus on earlier detection and prevention is central to the current strategy and will be further strengthened as we take forward the cancer and public health work programmes</td>
<td>4.2</td>
</tr>
<tr>
<td>Public support for a new regional cancer centre is accompanied with a request to keep services as local as possible, where possible. This will inform implementation work.</td>
<td>4.3</td>
</tr>
<tr>
<td>Affordability and resourcing issues require to be considered as part of taking forward our overall strategy ‘Our Health, Our Care, Our Future’</td>
<td>4.4</td>
</tr>
<tr>
<td>Strategy implementation will be phased – with the first phase of work involving a ‘Deep Dive’ intensive review of cancer pathways; developing clinical leadership and engagement; delivering key parts of the current cancer programme; and initiating the capital planning programme for the cancer centre as part of developing the Initial Agreement for the Western general Hospital development programme</td>
<td>5.1 – 5.4</td>
</tr>
<tr>
<td>To ensure the strategy progresses, the ‘Deep Dive’ review must be productive, the business case for the Edinburgh cancer Centre must be developed, and contingency plans to maintain radiotherapy capacity must be finalised and operationalised</td>
<td>6</td>
</tr>
<tr>
<td>Radiotherapy service risks are already highlighted in the Board Risk Register</td>
<td>7</td>
</tr>
</tbody>
</table>
- Impact Assessment has been conducted for those aspects of the strategy where it is possible to do so currently, and further impact assessment will be undertaken after the 'Deep Dive' intensive review has been completed and resultant recommendations to are known.

- Public involvement has been supported via consultation over the summer and via ongoing involvement mechanisms described in the strategy.

- To secure resources for implementation national capital funding needs to be secured via the Business Case for the Cancer Centre; forthcoming cancer allocations need to be prioritised for implementation support; medicines management and governance must continue to assist in the managed introduction of new medicines; and the ‘Deep Dive’ intensive review must help to shape and develop a fully costed plan for implementation.

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**Peter McLoughlin**  
Strategic Programme Manager – Cancer & Palliative Care  
19 November 2014  
peter.mcloughlin@nhslothian.scot.nhs.uk
1 Purpose of the Report

The purpose of this report is to submit the updated and finalised Cancer Strategy to the Board following a period of public consultation on the strategy undertaken over the summer of 2014.

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

2 Recommendations


3 Discussion of Key Issues - feedback from public consultation

3.1 The draft cancer strategy was presented to the Lothian NHS Board meeting of 2 April 2014, where it was approved for public consultation. Consultation was undertaken between May and September 2014.

3.2 The finalised draft strategy was subsequently taken to Strategic Planning Committee on 13 November 2014 to share the outcome of consultation, and to present the updated strategy.

3.3 Those responding to consultation on the strategy were generally supportive of it. Seventy-three percent of respondents (who gave feedback via the online survey monkey questionnaire) expressed a direct view indicating their agreement and support. The remainder of respondents gave no direct indication that their view was either supportive or not, but instead provided comments relating to either their personal experience of cancer care in NHS Lothian, or a comment on a specific aspect of the strategy.

3.4 Analysis of the views expressed on the cancer strategy revealed 4 main themes (in order of support):

- **Earlier detection of cancer is supported** as central to the strategy, with some particular reference to supporting the role of general practice, and providing rapid access to key diagnostic tests.

- **A strong focus on prevention of cancer is supported.**

- **There is support for a new regional cancer centre at the Western General Hospital.** Within this there was also support for making sure that as much care delivery as possible is decentralised.

- **The strategy is seen as ambitious, requiring significant investment to deliver.** This relates to the cost associated with a new cancer centre development, the net costs inherent in reviewing, modernising and developing cancer services across Lothian, and meeting the cost of cancer medicines.
4 How has the Lothian Cancer Strategy changed and developed as a result of feedback from consultation?

4.1 Primary Care related issues have been a key feature of both local discussion and the consultation responses to the draft cancer strategy. The Lothian Medical Committee feedback has also helpfully provided a greater focus on pathways and ways of working, and to reinforce the breadth of the plan as more far reaching than the development of new cancer centre premises alone. The specific issues that have been raised in relation to primary care activity have been given greater acknowledgement in the finalised strategy. These issues will be picked-up within the cancer strategic programme, in particular in our review of the model of cancer care delivery in Lothian, our modernisation programme for oncology (particularly around chemotherapy delivery), and our redesign programme for palliative and end of life care services. Work on the core issue of primary care capacity will be progressed in the primary care strategic programme and linkage has already been made between the emerging primary care strategy and the cancer and palliative care strategies.

4.2 Strong support has been given to a focus on the earlier detection and prevention of cancer. These are key features of the Lothian strategy, and will be strengthened further as we go forward with implementation work. Additionally these core aims will be taken forward directly via the NHS Lothian Detect Cancer Early programme, and in our disease prevention programmes. These programmes inherently include a focus on tackling cancer inequalities in health.

4.3 Consultation feedback provided support for the development of a new regional South East of Scotland cancer centre, with a strong focus on decentralisation of services where this can be achieved. This will be picked-up in strategy implementation, and our initial work on cancer centre reprovisioning is already being supported by a South East of Scotland regional steering group. The key principle of keeping services as local as possible will guide our further pathway review work.

4.4 Significant resource related issues have been highlighted in consultation feedback including the challenge of financing a new cancer centre, prioritising developments in cancer care, and developing the primary and community services workforce and capacity. These key issues will be factored into taking forward our principal strategy – ‘Our Health, Our Care, Our Future’.

5 Development and implementation of the Cancer Strategy – major workstreams

5.1 The approach to strategy implementation will be phased to firstly allow efficiency review work to inform next steps. The first phase of work, which will be taken forward over the first half of 2015, will therefore include undertaking a ‘Deep Dive’ intensive review of cancer pathways to assist with reviewing our model of care. There is much work that has already been undertaken that will assist with this including the non-surgical oncology review; the national review of breast screening services; colorectal cancer service improvement work undertaken in an international leading-systems network with McKinsey & Company; the Lothian palliative care redesign programme; the radiotherapy capacity planning programme in the South East of Scotland; as well as waiting times capacity planning and pathway development work.

5.2 Clinical leadership and engagement, as well as patient and public engagement, will be paramount and it is anticipated that the new Associate Medical Director for cancer services will play a strong leadership role. Additional support through the proposed organisational change management team will also be identified.
5.3 In this phase of work key elements of the Cancer and Palliative Care strategic programme will also be delivered. In particular the Lothian Detect Cancer Early programme will be developed to support further investment and redesign in 2015/16 (via specific government funding allocation), and the strategic business case for palliative care service redesign will be completed, to support delivery of prioritised schemes.

5.4 We will also develop the programme initiation for the Cancer Centre, as a core element of developing the wider programme Initial Agreement for the Western General Hospital.

5.5 In the second phase of work, later in 2015, we will continue to develop the regional infrastructure and clinical engagement in place to support cancer centre rep provision planning. Additionally, and informed by work in phase-1, we will determine priorities, key outcomes, and success measures for the programme going forward including the development of a costed implementation plan.

6 Key Risks

6.1 We know that the incidence of cancer is rising at a faster rate than in previous decades, driven by demographic change. We are also now experiencing in the service the effect of increasing complexity of patient need associated with age and multi-morbidity. This combination presents a greater burden on diagnostics, treatment planning and delivery and requires consideration of further redesign to cancer pathways. Given this, and the financial challenges we face, our efficiency and productivity driven ‘Deep Dive’ review of cancer pathways in the region must produce recommendations and opportunities for service change as a first step. Achieving this will require strong regional collaboration and participation, and work to support this approach has already started.

6.2 Business case development for the South East of Scotland Cancer Centre needs to be progressed, in the context of developing in parallel to this the Initial Agreement for the Western General Hospital development programme. Work to develop the Western General Hospital Initial Agreement and the business case for the Cancer Centre has commenced, with a view to submission to the Scottish Government in 2015.

6.3 The maintenance of sufficient radiotherapy capacity in the South East of Scotland is paramount. Our forecast, based on detailed analytical work, shows demand for radiotherapy exceeding available capacity as soon as early 2016. Additionally a necessary ‘in-room’ planned machine replacement of one of the linear accelerators is scheduled for 2017 and may reduce available capacity further (a potential reduction of one linear accelerator from the established machine compliment for six months). The timescales described above are significantly earlier than our ability to redevelop Edinburgh Cancer Centre facilities on the Western General Hospital site, including the provision of new additional radiation shielding bunkers to house the linear accelerators required. Options and contingency plans to manage these issues and maintain capacity are being pursued now in the South East of Scotland region.

7 Risk Register

7.1 The need to maintain and develop radiotherapy capacity, and to allow an efficient programme of machine replacement and technology and skills development is already referenced in the risk register.

8 Impact on Inequality, Including Health Inequalities

8.1 An impact assessment has already been completed on some aspects of the strategy for example in relation to Palliative and End of Life Care, and the Detect Cancer Early Programme.
8.2 The Cancer Strategy will initially be implemented in two phases starting in 2015, as outlined in section 5 above. Once the ‘Deep Dive’ review of cancer pathways has been undertaken, and the impact of these further recommendations and potential changes to our strategic approach to the development of cancer care are known, then further impact assessment will be undertaken to ensure that these aspects are covered.

9 Involving People

9.1 As outlined in section 3 above, public and professional stakeholder consultation was undertaken between May and September 2014. In addition, section 6 of the Lothian Cancer Strategy describes involvement in the planning and development of Cancer Services within NHS Lothian.

10 Resource Implications

10.1 A new South East of Scotland Cancer Centre is an ambitious project and the associated business case needs to be developed and submitted into the national capital programme for approval and prioritisation. Work to develop the Initial Agreement for the Western General Hospital development Programme has commenced, with a view to submission to the Scottish Government in 2015.

10.2 To support implementing the cancer strategy, forthcoming national allocations for specific workstreams in the cancer programme need to be prioritised and applied for use as implementation support funding. There may also be a need to consider opportunistically the use of any additional development / partnership funding that may become available as the implementation programme progresses.

10.3 As new cancer medicines are introduced, subsequent to guidance from the Scottish Medicines Consortium and our internal processes utilising the Lothian Joint Formulary, an increase in the basic medicine spend and requirement for increased services to administer and dispense them is expected. This will be managed via the existing governance structure which ensures medicines are utilised safely, effectively and efficiently.

10.4 Outputs from the ‘Deep Dive’ intensive review and the impact of the expected recommendations and potential changes to the strategy as a result will need to be assessed. This information will also be required to support the achievement of a fully costed and sustainable financial strategy for the development of cancer care in Lothian.

Peter McLoughlin
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19 November 2014
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List of Appendices

Appendix 1: Better Cancer Outcomes in Lothian – A Strategy for Cancer 2015 - 2020
BETTER CANCER OUTCOMES IN
LOTHIAN – A STRATEGY FOR
CANCER 2015 - 2020

November 2014
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INTRODUCTION

Overview
This document outlines NHS Lothian’s Cancer Strategy for 2015 – 2020. Its direction is in line with our public health and major health service plans in Lothian, the South East of Scotland Regional Cancer Plan, and the national Better Cancer Care plan workstreams.

The document is structured around the six aims previously developed in our Strategic Clinical Framework and now included in our Strategic Plan 2014-2024 - “Our Health, Our Care, Our Future”. The six aims are:

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

These six aims seek to ensure we can deliver safe, effective and person-centred health and social care. And in turn, these aims are aligned with the triple aim objectives of the 20-20 Vision around improving quality of care; improving population health and securing value and financial sustainability. Sections 2 to 7 of this document use one of the six aims as the section heading, to support linking the domains of the cancer strategy clearly to the wider strategic aim.

This document should also be read in conjunction with ‘Living and Dying Well in Lothian – Lothian’s Palliative and End of Life Care Strategy 2010 – 2015’. This strategy, and supporting materials, is available on NHS Lothian’s website at:

http://www.nhslothian.scot.nhs.uk/OurOrganisation/Strategies/ladwinlothian/Pages/default.aspx

A summary of the aims of the Palliative Care strategy, and our strategic redesign programme, is given in section 5 of this document also.

What does the Cancer Strategy cover?
‘Better Cancer Outcomes in Lothian – A Strategy for Cancer 2015 – 2020’ provides an overview of:

- The changing demand and challenge of cancer in Lothian and South East Scotland
• Our required focus on prevention and tackling cancer inequalities
• Our need for integrated care, to be delivered across primary, secondary and social care and regionally across the South East of Scotland
• The rapid pace of technological change and our need to modernise cancer care based on evidence, best practice and innovation
• Our work to deliver care in the right place and in a way that is appropriate to particular needs
• Our mechanisms for patient involvement in cancer planning
• Our vision for cancer care delivery and in particular our need to redevelop the Edinburgh Cancer Centre
• How the Lothian cancer programme is measured
• Some key strategic resource considerations associated with pursuing the cancer strategy

Planning and partnership working at local, regional and national levels
NHS Lothian, in partnership with other statutory and voluntary sector agencies provides a wide range of services and support related to cancer in Lothian. These include prevention, screening, genetics, and primary, secondary and tertiary healthcare services. Specialist assessment, diagnostic and treatment services are provided across Lothian. In partnership with other agencies, support services such as welfare rights, disability assessment, information and advice, and counselling and support services are provided.

NHS Lothian is also engaged in the registration, collection and reporting of cancer statistics vital to national, regional and local planning. An extensive programme of cancer research is also undertaken, some in partnership with the University of Edinburgh, in Lothian and across the South East of Scotland, including laboratory research, clinical trials, service research, evaluations, and work to assess patient experience.

In addition to territorial NHS Board level planning and delivery, NHS Lothian is part of the SCAN regional cancer network. Through participation in this network NHS Lothian works collaboratively with NHS Borders, NHS Fife, and NHS Dumfries & Galloway to plan and deliver cancer services across the South East of Scotland.

NHS Lothian, and SCAN clinical and management leads, participate in national level policy and planning through for example groups such as the Scottish Cancer Taskforce, the Detect Cancer Early Programme Board, the Radiotherapy Programme Board, the Chemotherapy Advisory Group, and the Scottish Government National Advisory Group for Palliative and End of Life Care. Additionally, service redesign and our population health screening programmes such as breast, bowel and cervical screening are co-ordinated with the national planning agencies (such as National Services Division) via the public health screening co-ordinator and strategic planning.

Challenges, changing experience, and service responses
In common with most of the world, the incidence of cancer is rising in Lothian and in all areas of the South East of Scotland region, and the rate of increase is higher than in previous years due to population change. Many more people however are living with and beyond cancer. Focussing on prevention and early detection, improving
treatment, and tackling known cancer inequalities will help to meet the challenge of cancer, and improve cancer care and survival further.

1. THE CHALLENGE OF CANCER IN LOTHIAN

Age-standardised cancer incidence in Lothian, South East Scotland, and in Scotland overall is significantly higher than the UK average. The incidence of cancer is increasing, and the rate of increase is faster than experienced in the last few decades. Over the current decade in Lothian (2010 – 2020) it is estimated that there will be a 20.5% increase in the incidence of cancer. The most common cancers in South East Scotland region are prostate, lung, colorectal, and breast cancers. The projected change in the South East of Scotland, by tumour type, is shown in chart 1 below.

Most of these cancers, for Lothian residents or residents of other South East Scotland NHS Boards, will be referred to NHS Lothian (either for assessment, diagnosis, staging, treatment, or all of these elements of the cancer pathway).

The prevalence of many cancers is also increasing (due for example to increasing incidence, better treatment and survival). As cancer is often a disease of old age, and more people are surviving cancer, increasingly multi-morbidity will be experienced by some cancer survivors. This means that as well as there being more able-bodied cancer survivors, there will also be more people living with the consequences of cancer, or cancer treatment, who also have other health conditions or disease, all of which increases the complexity of care planning and delivery.
Chart 2 below shows cancer incidence rates per 100,000 of the population in the South East of Scotland cancer planning region, by age-band. There is a clear increase in incidence with older age. Incidence data shown is for 2011, which is the most recent period of published data.

Significant improvement in survival has been seen over the last few decades. Appendix 2 to this document shows trends in cancer survival in Scotland over this period. We know that better survival prospects are associated with:

- Earlier presentation by patients
- Participation in screening programmes (where screen detected cancers are often found at an earlier stage)
- Improvements in specific treatments

Conversely, survival is worst in patients presenting with advanced stage disease, often as emergencies, and for cancers for which current treatments are less effective (such as lung, brain, and pancreatic etc).

Over the entire South East of Scotland cancer planning area the picture of changing incidence, prevalence and survival is common. All highly specialist cancer care is provided to these patients in NHS Lothian. Where possible, assessment and diagnosis is undertaken locally in the NHS Board of patient's residence. Some patients from other South East of Scotland NHS Boards will however be referred to NHS Lothian for clinical assessment and diagnosis of suspected cancer. Some treatment services in the South East of Scotland such as radiotherapy and complex
chemotherapy provision are exclusively provided by NHS Lothian as provider Board for the Edinburgh Cancer Centre. Healthcare planning and subsequent capacity delivered needs to take due account of the patient volumes and patient pathways followed across the whole of the South East of Scotland region.

2. PRIORITISE PREVENTION, REDUCE INEQUALITIES AND PROMOTE LONGER HEALTHIER LIVES FOR ALL

Preventing Cancer in Lothian

Public Health, Primary Care, and Health Improvement – Smoking is the single biggest risk factor for cancer, alongside poor diet, lack of physical exercise, and alcohol misuse. A public health based strategy, and focus on health improvement is fundamentally required as a central component to any effective cancer strategy. Primary care has a key role to play in preventing cancer through for example action on smoking, lifestyle, diet, physical activity, and alcohol.

The Lothian health improvement strategies, many flowing from areas with HEAT targets associated with them, are vital. The HEAT framework, which outlines performance standards and targets agreed each year between NHS Lothian and the Scottish Government Health Directorates, has diet, physical activity, smoking cessation, obesity, and health inequalities as a central focus, alongside cancer access and quality standards. All of these domains of work are central to the cancer programme in Lothian and need to increasingly align with specific cancer programme workstreams and operational delivery.

Public health also has a crucial role to play in supplying data and information to planners and service providers across Lothian and nationally, to guide priorities and help to assess delivery and performance.

Reducing the damage caused by the use of tobacco – NHS Lothian is implementing its Smoke Free Lothian Vision. This strategy is aligned to the Scottish Governments 2013 tobacco control strategy ‘Creating a tobacco-free generation - a tobacco control strategy for Scotland’. The national strategy has a headline aim of creating a tobacco free generation of Scots by 2034. The headline outcome measure is achieving an adult smoking prevalence below 5% by 2034. In Lothian, in 2011, smoking prevalence is recorded at 18.7% (with significant variation across our most disadvantaged to our most affluent communities and populations).

Lothian’s Smoke Free vision is being pursued currently via focussing work in three major domains:

Tackling health inequalities and focussing on specific groups – via joint work with Lothian Local Authorities and the voluntary sector. Focussing for example on young people’s health behaviour and their health education, and working with vulnerable young people such as looked-after children and young offenders, as well as building effective alliances to tackle the availability of illicit tobacco.

Improving Health protection – offering advice on creating smoke free homes, working with specific organisations such as the Scottish Prison service to plan smoke free
prison facilities, and implementing our ‘Smoke Free NHS Lothian’ plan from May 2014, ensuring enforcement and compliance by March 2015.

Supporting smoking cessation – by continuing to develop and deliver our Smoke Free services, and target programmes for example to increase the number of women referred, and successfully quitting, by ensuring effective care pathways for smoking in pregnancy.

**Tackling obesity, improving diets, and increasing physical activity** - we will do this by:

- Supporting staff to promote healthy lifestyles, by encouraging health eating and regular physical activity, and improving training opportunities for staff i.e. in the delivery of brief intervention / brief advice.

- Increasing the awareness of recommended levels of physical activity and understanding of food and diet to maintain healthy weight.

- Developing and implementing specific initiatives to increase physical activity and promote healthy eating, and become an exemplar organisation in promoting health improvement.

- Supporting effective local and national programmes that aim to increase physical activity and promote healthy eating.

- Use our Sustainability Strategy, and the Green Travel Plan, to promote active travel and dissuade people from using cars, and promote walking or cycling including the development of secure cycle parking for NHS staff and patients on our sites.

- With partners in Local Authorities and the third sector we will provide appropriate evidence based interventions for people who are overweight and obese through our Lothian Weight Management Services.

- By continuing to develop “Get Going!” our innovative weight management programme aimed at children and young people. The programme aims to develop young people’s interest in exercise, recreation and health-related issues to increase opportunities for them to participate in physical activity within their local communities.

- Developing our catering strategy, and become an exemplar organisation in the provision of food on our premises, and through participating in the ‘Food for Life’ programme with partner organisations.

- Supporting the free school meals programme, led by Lothian Local Authorities, and developments in the curriculum on healthy living. National guidance exists for both nutritional content of meals and the health promotion activities within schools.
Tackling alcohol misuse - We will do this by:

- Supporting the specialist Alcohol Problems Service, and dedicated Drug and Alcohol Action Teams within each local authority area in Lothian.

- Work with Local Licensing Boards to map the provision of alcohol sales outlets in Lothian, and oppose any over provision.

- Expanding our programme of alcohol brief interventions, many of which are provided in primary care settings by general practitioners. We will continue to train clinical staff to deliver these interventions throughout the NHS.

- Supporting the Lothian and Edinburgh Abstinence Programme (LEAP). LEAP offers an alternative choice and opportunity for those with alcohol problems to change drinking habits.

Human Papillomavirus (HPV), and Hepatitis – protecting against the cancer risk factors associated with HPV and Hepatitis is part of the work of the NHS Lothian Health Protection team. These areas are subject to specific programmes of work and action plans for health improvement. Programmes include the HPV immunisation programme, the Lothian Hepatitis C Managed Care Network, and the Lothian Enhanced Service in General Practice for GP’s to provide Hepatitis B vaccination. The enhanced service scheme has been extended in 2014 however, in line with UK policy, does not extend to universal vaccination at present.

Tackling Cancer Inequalities

We know that the incidence of cancer is higher, and cancer outcomes poorer, in our most deprived communities – including differences in the pattern of cancer in some ethnic groups. Socio-economic status is an important independent prognostic factor for most common cancers in adults.

Socio-economic differences in the stage of disease at diagnosis, and in access to and participation with optimal diagnostic and treatment services may explain at least some of the association between deprivation and poorer cancer survival. Full explanations for differences in survival are not completely documented in research. However reasons that some groups may be disadvantaged can fall into 3 groups of underlying causes:

1. Tumour factors – late stage of detection; delays in seeking healthcare or delayed referral; 'stage shift' whereby cancers are classified and recorded as earlier stage than they actually are. This is possibly because some patient groups are not completing full staging investigations (and the extent of spread is thus not detected).

2. Patient factors – psychosocial factors such as lack of social support; unclear access or delay in seeking healthcare; perceived social stigma attached to cancer; individual perception of personal risk; poorer mental health; poorer communication with healthcare professionals. Co-morbidity may also reduce
survival by adversely interacting with or limiting the range of treatment given for
cancer.

3. Healthcare system factors – lower uptake of screening services; treatment
differences (either options not offered, for example in more elderly or co-morbid
patients, or options not taken-up for example follow-up appointments);
emergency admissions; and the availability of medical expertise.

Our focus on health inequalities and health improvement is vital therefore to both
cancer prevention and improving cancer outcomes. Through Lothian’s Detect Cancer
Early programme we are seeking to tackle many of the potential underlying causes of
poorer survival, as listed above. A focus on these areas will continue to be developed
throughout all of our work on prevention, health improvement, treatment and service
delivery.

The Health Promoting Health Service concept - ‘every healthcare contact is a health
improvement opportunity’ – is based on person centred and effective practice, and
will underpin our approach. We will do this by working in partnership, and adopting a
focus on health improvement and tackling health inequalities via development,
assessment, and implementation all of our policies and plans.

Managing the late effects of cancer
In tandem with building our focus on Transforming Care After Treatment, to support
longer healthier lives we need to ensure that as we develop our cancer pathways the
late effects of cancer are recognised and effective management is supported. Late
effects may include the development of second cancers, and additional needs
associated with cardiology, endocrinology, bone health, lymphoedema, and sexual
health / gynaecology.

3. PUT IN PLACE ROBUST SYSTEMS TO DELIVER THE BEST MODEL OF
INTEGRATED CARE FOR OUR POPULATION – ACROSS PRIMARY,
SECONDARY AND SOCIAL CARE

Earlier detection of Cancer

The Detect Cancer Early Programme is an ambitious programme of work to improve
survival for people with cancer in Scotland to amongst the best in other European
countries by diagnosing and treating the disease at an earlier stage. The Detect
Cancer Early programme was formally launched by the Cabinet Secretary on
February 20, 2012. The NHS Lothian Detect Cancer Early (DCE) Programme is now
established, focussed on breast, lung and bowel cancer. A Lothian Programme
Board has been formed to develop and steer the programme over a three-year
period (2012/13 – 2014/15), in line with the initial government investment period. Our
approach is based on a review of the cancer inequalities evidence base, and on the
national DCE programme framework. It focuses on tacking inequalities and identified
‘wicked-issues’ in cancer care, building-up our diagnostic and treatment capacity,
integrating early detection into our existing service redesign work across Lothian, and
increasingly focusing on targeted action in primary and secondary care to identify
opportunities and service approaches to detect a higher proportion of cancers at stage 1 of disease.

In years one and two of the programme, investment has gone into primary care, diagnostic and treatment services providing care for patients with lung, breast, and bowel cancer, as well as cancer audit, e-health, and investment in cancer informatics.

Delivery of the Detect Cancer Early programme is measured via the HEAT performance framework. The programme target, at national level, is to increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015. NHS Lothian’s baseline position (an average of the combined years 2010 and 2011) was 22.6% of all breast, lung and bowel cancers diagnosed at stage 1 of the disease. By the end of 2015 we need to be achieving 29%.

Over the next two years of the programme we will focus on a number of key areas including: progressing targeted initiatives in the bowel and breast cancer screening programmes and with primary care teams to increase screening participation and service capacity; develop our lung cancer pathway including building capability focused on earlier detection and support, and redesign referral and initial diagnostic pathways, develop our referral and diagnostic assessment pathways for the 3 DCE tumour group areas across primary and secondary care to support referral at the earliest opportunity of people with signs and / or symptoms of suspected cancer; continue to improve our cancer intelligence strategy and deliver DCE programme reporting; invest further in diagnostic and treatment capacity; and support national and local awareness campaigns.

Providing population Screening Programmes:

Bowel Screening Programme

NHS Lothian’s participation in the National Bowel Screening programme commenced in May 2008, with our first two-year screening cycle running between May 2008 and April 2010. The administration of invitations to participate in screening, and the testing of returned screening kits, is undertaken by the national screening centre located in Kings Cross Hospital in Dundee. The rate of positive screening tests was 2.2% in Lothian (i.e. the proportion of tests that are positive from all samples returned for testing), compared to a Scottish average of 2.5%. NHS Lothian provides the clinical assessment, diagnostic and treatment pathway for all Lothian residents who return positive screening tests to the central laboratory.

The national standard for bowel screening uptake is 60%, and this is monitored by Healthcare Improvement Scotland. Uptake in Lothian in 2010 – 2012 was 53.5%, compared with a Scottish average of 54.9%. Uptake remains lower in areas of higher deprivation.

In Lothian, through the screening programme, 1,190 people have been diagnosed with an adenoma or an invasive cancer or polyp cancer. 172 of these were an invasive cancer or polyp cancer (based on screening programme data to 2012). Our
yearly screening accounts for the detection of around 15-20% of all colorectal cancers in Lothian. Cancers detected through the screening programme show an earlier stage profile compared to those not detected through screening.

Our action plan for the Lothian Bowel Screening Programme includes exploring a greater use of nurse colonoscopists as part of the screening programme accredited endoscopy workforce, and exploring how radiology can be further used to support capacity in the programme, and more widely to support endoscopy capacity in Lothian.

In spring 2013, as part of the local DCE campaign, a breast and bowel screening pilot commenced with 10 GP practices in Lothian. The aim of the pilot is to identify and test ways to increase screening uptake. Additionally, the majority of GP practices in Lothian (110 of 126 practices) have signed up to take part in the new bowel screening Scottish Quality Outcomes Framework (SQoF) initiative (2013 – 2015) which will reward practices for increasing their bowel screening uptake.

**Breast Screening Programme**

The South East of Scotland Breast Screening Service is commissioned and funded by National Services Division (NSD) with the service hosted by NHS Lothian for the South East of Scotland region. Overall uptake of the breast screening programme in NHS Lothian is 72% (over the period 2008/09-2010/11). This figure is above the QIS standard of 70% and below the Scottish average of 75%.

The overall uptake level is similar for NHS Lothian, NHS Lanarkshire and NHS Greater Glasgow & Clyde – where the majority of appointments are offered at a static centre. Uptake rates tend to be higher in Board areas where the majority of screening is undertaken in mobile units.

Our lowest uptake groups are:

- Women new to screening (first invitation) and
- Women who are invited outwith five years of last attendance – (i.e. previous non attendees)

In order to address these target groups we continue to work closely with colleagues in primary care, health promotion, community development and cancer charities to promote the benefits of screening. We so provide staff with training and information to ensure a higher, positive profile of the programme at primary care level. Specific actions include:

- Introducing changes to the appointments schedule to allow extended periods of screening for localities.
- Providing targeted visits to low uptake practices by colleagues in health promotion prior to the screening round in order to support staff in promoting screening to patients.
- Providing practices with additional information to identify defaulting or DNA patients.
• Liaising with the Learning Disabilities Service to provide additional specialist care to clients.
• Providing workshops for Lothian primary care staff to update knowledge and further promote the benefits of screening.

In Lothian, uptake levels vary across deprivation categories from 79% (least deprived) to 58% (most deprived). This pattern is reflected across Scotland. An 'Immediate Action' pilot has been established with the agreement of some practices to evaluate whether additional targeted primary care efforts can improve uptake at practice level.

The South East Scotland Breast Screening Programme (SESBS) has implemented 2-view mammography for all women attending for screening from April 2010. Implementation of 2 views has led to higher numbers of cancers diagnosed (up by approx 25% based on 2011/12 figures).

During 2011 the National Planning Forum commissioned NSD to undertake a review of Breast Screening Service in Scotland. The Review was prompted by concern regarding the sustainability of the programme in light of work force pressures and the need to realise efficiency savings to fund the introduction of new technology. The Review's findings were subject to a formal option appraisal. The Review has since recommended that the status quo in terms of the organisation and commissioning of breast screening be maintained but that efforts should to be directed at achieving greater integration of the screening and symptomatic services. NSD will establish work streams to deliver the necessary service reconfiguration.

Over 2013 the South East Scotland Breast Screening Programme modernised mammography imaging by moving to digital mammography. This development is a key part of delivering the change required as part of the national service review, and will assist in improving the efficiency of the service and in supporting the earlier detection of breast cancer.

Cervical Screening
Overall the cervical screening programme in Lothian has been very successful. Age standardised incidence rates for Lothian have declined from 18.0 per 100,000 persons at risk in 1988 to 12.6 per 100,000 persons at risk in 2011. Lothian has seen a decrease in mortality from cervical cancer from 5.7 per 100,000 persons in 1986 to 3.1 per 100,000 in 2011 (25 to 15 deaths). Survival rates continue to improve for women diagnosed with cervical cancer. Five year survival is now 58.6% and one year survival is 78.6% (a 6.7% and 3.3% improvement over the last 20 years).

NHS Lothian laboratory process nearly 80,000 smears per annum. Laboratory turnaround times and overall reporting times are lower than the national average. Unsatisfactory rates are in line with practice across Scotland. The percentage of smears reported as negative is 89.1% which is slightly lower than the national average of 90.3%. Our data is quality assured by the national SCCRS laboratory group.
The cervical screening programme is at a time of transition and there is significant activity at national level to agree a new policy for future service delivery. Nationally uptake rates have been falling across Scotland over the last 5 years. Whilst there are many reasons for this the key driver is falling uptake in the 20-25 age group due to confusion about risk perception. Furthermore emerging evidence now indicates that women in this age group should not be offered screening. With this in mind there are two major changes to policy on the horizon:

1) The age range and frequency thresholds will be changed from 2015 (women between 20-25 will not be called, and women 60+ will be offered screening 5 yearly)
2) HPV screening will be implemented from 2016 with cohort clinical pathways embedded.

As a consequence the screening programme will look very different and new performance measures (uptake) will have to be agreed.

NHS Lothian has been targeting certain groups of women to shift the pattern of attendance to be more in line with the evidence base, and future national policy. Therefore our uptake rates are lower in the 20-25 age group and higher in the 40+ age group. We will continue to work collaboratively to develop and improve the screening programme in line with national policy and implementation planning.

**Primary Care, and the Primary Care cancer workplan**

Many aspects of cancer care are managed in primary and community health service settings routinely across Lothian. General Practitioners are crucial to preventative work but also to early detection and their unique diagnostician role is central to this. Primary care has a key role to play in preventing cancer through for example assessing smoking status and providing advice and support regarding stopping smoking, supporting a healthy lifestyle and diet, physical activity (including the ability to prescribe exercise programmes), and advising on alcohol related issues and the provision of brief interventions, where necessary, on alcohol intake.

Primary care teams co-manage cancer care (alongside secondary care delivered treatment) at all stages of disease, and often this includes the management of patients with multi-morbidity over and above their cancer which may involve additional review and change to monitoring and clinical management plans. This impact is especially felt in areas of high social deprivation in Lothian where both the incidence of cancer and multi-morbidity is higher.

An increased demand (for example pre and post treatment bloods, PSA bloods) and changes to the pattern of work in primary care (for example variations to tasks undertaken by district nurses and general practitioners) may also be experienced as a result of clinical pathway developments, often arising in secondary care.

To support a focus on specific development work NHS Lothian and Macmillan Cancer Care support a GP Lead post and a Nurse Consultant post for Cancer & Palliative Care. This team, working with colleagues across the system, manage a programme of work which aims to support:

- Participation in the Detect Cancer Early Programme at local and national level including developing and implementing specific Lothian initiatives
• Improving access to diagnostic services to support earlier detection, including scoping the potential for pathway redesign and working alongside national improvement programmes
• Assist practices in improving their screening programme uptake, in particular supporting the bowel screening Scottish Quality and Outcomes programme initiative in 2013/14 and 14/15
• Supporting the improvement of cancer referral guidelines by working locally and nationally, and supporting their local implementation in liaison with referrals advisors and others
• Supporting the palliative care programme including supporting learning and development associated with the Palliative Care Directed Enhanced Service (DES), and supporting the Lothian Palliative Care Redesign Programme
• Assessment of redesign potential to improve follow-up, and participation in the Lothian Transforming Care After Treatment programme.

Supporting the GP diagnostic process is central and we will continue to develop work on referrals guidance for urgent suspected cancer, and on initial advice and access to diagnostic services that best support efficient and effective working and early detection. Continued support for the cancer and palliative care leadership posts in primary care is vital to this.

Supporting community based palliative and end of life care is a central objective to Lothian’s Palliative Care Strategy ‘Living and Dying Well in Lothian’ - section 5 of this document refers to this and to the Lothian Palliative Care Redesign Programme that is underway. The redesign programme will make recommendations to support capacity requirements for community management, and as such will support the emerging strategies of the planned Integration Joint Boards (see below).

A stronger collaborative approach to cancer pathway development, joint planning, and service redesign is required. Opportunity exists around the establishment of the new Integration Joint Boards arising from the implementation of the Public Bodies (Joint Working) (Scotland) Bill. The new Integration Boards will take over the role of Community Health Partnerships and are required to strategically plan to meet the needs of their local populations. NHS Lothian is expecting that the four new Integration Joint Boards (one in each Lothian Local Authority area) will be established from April 2015.

Additionally, we will seek to work with both secondary and primary care stakeholders as part of planning work to review cancer pathways and models of care in Lothian to be taken forward as part of the Cancer Centre reprovision programme. This will support joint consideration of the value, evidence, and priority for cancer pathway redesign and the consequential impact on workload, workforce and service requirements in secondary, primary, and social care settings.

Lymphoedema
The NHS Lothian Primary Care Lymphoedema Service provides a service for people living in Lothian with a diagnosis of primary or secondary lymphoedema e.g. non cancer and cancer related lymphoedema. The service also receives referrals and provides care for people who have a diagnosis of lipoedema.
The NHS Lothian Primary Care Lymphoedema Service is provided on five sites (South & north Edinburgh, Mid, East and West Lothian) to facilitate care nearer to the patient’s home. All patients seen by the service (those with lymphoedema and those with lipoedema) have a comprehensive assessment, care options discussed, self care management, garment provision and treatment provided all of which tailored to meet the needs of the individual.

A secondary care based Lymphoedema service is also in place at the Western General Hospital for oncology patients with breast cancer related lymphoedema.

4. ENSURE THAT CARE IS EVIDENCE-BASED, INCORPORATES BEST PRACTICE, FOSTERS INNOVATION AND ACHIEVES SEAMLESS AND SUSTAINABLE CARE PATHWAYS FOR PATIENTS

Better Treatment:
Modernisation of cancer services requires a collaborative regional approach across the South East of Scotland, to ensure efficient, effective and quality care is provided as close to the patient as possible. This must incorporate all the aspects of service provision, technological development and improvement to the patient pathway. Effective local and regional arrangements to support the planning and management of cancer services in an integrated way across NHS Lothian services, and with all South East Scotland NHS Boards, is vital to achieving this.

Scheduled care:

Radiotherapy
Edinburgh Cancer Centre provides radiotherapy for patients from across the South East of Scotland. Radiotherapy provision is changing rapidly, and demand for radiotherapy is set to grow significantly over the next decade, and beyond.

Our strategic priorities include
- Providing evidence on the number and location for the future provision of linear accelerators.
- Keeping pace with current technology, and ensuring that patients have timely access to the appropriate, evidence-based advancements in radiotherapy.
- To ensure optimal efficiency of the use of the machines, and to allow patients to be treated at times more suited to their needs, we will work towards the provision of extended working days, and the potential for a 7-day service, keeping in line with planned capacity requirements.

Chemotherapy
Our strategic priorities include:
- To provide chemotherapy delivery as close to the patient’s home as possible, where it is safe and effective to do so.
- To ensure optimal efficiency of the use of capacity, and to allow patients to be treated at times more suited to their needs, we will work towards extended working and consider the potential for a 7-day service.
Cancer surgery
- Ensure the outcomes for surgical intervention are compliant with best practice.
- Services are provided at locations where expert intervention is provided, and, where the evidence supports such an approach, ensure optimum outcomes through focusing pathways to high volume services

Clinical Radiology and Oncology Imaging
- The provision of imaging services should be strengthened on the site of the cancer centre to ensure complex imaging can be provided, and integration with other systems and image transfer is harmonised. This should also include the ability to link remote imaging from other Health Board areas to support efficient local and remote working.

PET scanning provision in the South East of Scotland
- In line with national planning for the provision of PET, we will continue to review the usage of PET scanning in SCAN, and ensure adequate provision for the future in conjunction with good cancer care and evidenced based medicine. PET provision in NHS Lothian should be considered alongside reviewing imaging provision to support cancer services on the Western General Hospital campus.

Unscheduled care:

Oncology Emergency Care – Effective Acute Cancer Services
Through the advancement of acute oncology services, the unscheduled element of care will continue to grow and will need to be effectively formalised across the region, maximising the contribution of services such as the cancer treatment helpline. Our strategic priorities include:

- Through safe treatment protocols and timely access to advice and interventions, to reduce as much as possible, emergency admissions for the complications of cancer therapies

- Progressing and developing management arrangements for emergency presentations by the appropriate use of telehealth

- Ensuring that all patients with cancer, who are managed outside of the Edinburgh Cancer Centre, are managed according to the best practice for their condition, including timely access to the same expertise as those managed in the Edinburgh Cancer Centre.

To support the development of a more formally agreed and co-ordinated system, the potential of telehealth should be assessed. This should consider, for example, improving arrangements for remote access to health records and clinical management advice such that clinicians seeing Oncology patients presenting anywhere in the region will have access to the same clinical data and could be discussed within a defined period of time of presentation with the on-call team at the Western General Hospital.
Cancer Modernisation and Innovation:
Over 2012/2013 and 2013/2014 we have invested in the modernisation of acute oncology, surgical oncology and radiotherapy services. We will seek to consolidate and build on the progress made in these areas. We will also seek to continue to build on the regional approach taken to date in some of our areas of specific modernisation initiatives, such as in radiotherapy and acute oncology.

South East of Scotland Non-Surgical Oncology Review
In 2010, the regional cancer network commissioned a review of non-surgical oncology services in the context of increasing demand as a result of increasing incidence, prevalence and detection of cancer and the increasing complexity of treatments.

The review concluded that the non-surgical oncology service is a highly efficient and successful service. It noted that a substantial amount of redesign work had already been undertaken but identified some scope to improve efficiency further. The review report emphasised that the recommended redesign programme, while capable of releasing some capacity, would not be sufficient to meet the expected increase in demand in the longer term and that boards would need to consider potential increases in expenditure in future if they wished to provide the same levels of service. It was estimated that implementing the redesign programme might delay the need for additional investment in non-surgical oncology services until 2014.

The review report envisaged a rolling programme of review and redesign and set out a series of recommendations grouped under seven key themes: team-based practice; acute oncology; clinical pathways, policies & guidelines; patient information; eHealth, telehealth and intelligence systems; managing interfacing and support systems; sustainability.

As a result of implementing the redesign programme, the regional boards have improved the efficiency of the non-surgical oncology service in its current configuration. Radical new approaches to service delivery will be required to meet increasing service demand and complexity over the next 5 years. Regional boards will need to exploit the opportunities offered by national and regional initiatives, such as the Edinburgh Cancer Centre Reprovision project, the development of a national strategy for radiotherapy workforce capacity, the Transforming Care After Treatment Programme (TCAT), implementation of Quality Performance Indicators (QPI), and implementation of Systemic Anti Cancer Therapy (SACT) CEL (30) 2012.

Colorectal Cancer Services Improvement
Over 2012 and 2013 NHS Lothian was one of 5 healthcare systems internationally to participate in the Colorectal Cancer Service Improvement Network. This data driven exercise adopted a pathway focussed approach to service improvement in colorectal cancer. As a result of participating in the network, ten priority value areas began to emerge across all 5 healthcare systems internationally. These were:

- Improving screening uptake in targeted populations
NHS Lothian’s top 3 improvement priorities have been identified as below, and are being pursued particularly through the Lothian Detect Cancer early Programme and in diagnostics capacity planning.

- Increasing the share of early-stage cancers to meet Detect Cancer Early goals
- Reducing the rate of emergency presentation through improvements in diagnostic pathway
- Finding more cancers with fewer colonoscopies with improved referral protocols

Cancer Multi-Disciplinary Meetings (MDM’s)

NHS Lothian will utilise and seek to adhere to the National Cancer Audit Team Standards for the management of cancer Multi-Disciplinary-Meetings (MDM’s). Recognising that this is a critical element of the patient pathway work is being undertaken to support clinical teams in delivering safe, efficient and effective MDMs. This will enable performance against the standard to be regularly monitored, and support governance issues in being identified and addressed to ensure the delivery of appropriate clinical treatment decisions.

NHS Lothian is currently implementing a programme of work to provide a TRAK MDM module to each MDM to support meeting administration, clinical decision making, and governance. This rolling programme of work will complete in 2015. The TRAK module dataset will support efficient working and improve quality, and will include capture of the cancer Quality Performance Indicators (QPI’s) for each tumour type, which NHS Lothian is obligated to collect and report on as part of the National Cancer Quality Programme. The TRAK MDM programme is supported as part of the Lothian Detect Cancer Early Programme implementation, as a key part of improving our use of cancer information and associated improvements in care co-ordination.

Access to Cancer Medicines

Access to existing and new cancer medicines within NHS Lothian sits within a transparent governance structure which ensures medicines are utilised safely, effectively and efficiently.

The Edinburgh Cancer Centre acts as a hub for the majority of this activity within SCAN, and multidisciplinary staff across the network work together to ensure relevant polices and procedures are implemented and maintained by all staff. NHS
Lothian cancer services ensure that the process encompassing patient access to medicines is efficient for both existing and new medicines. Staff are in full control of the medicine supply chain to ensure that marketed and clinical trial medicines are available, and that they meet quality standards.

New medicines are introduced subsequent to guidance from the Scottish Medicines Consortium and internal processes utilising the Lothian Joint Formulary. In addition, NHS Lothian acts as a hub for an agreed regional approach to the consideration and approval of applications for funding of non-formulary cancer medicines for patients across SCAN who are treated by ECC clinicians. This is formalised between SCAN Boards, and is managed by the cancer medicines management committee on behalf of NHS Lothian.

The amount of chemotherapy prescribed and administered within NHS Lothian is increasing which has led to a requirement for new services, more efficient medicine pathways, and also increased medicine budgets. In 2014 there may be changes to NHS Scotland’s system for accessing new medicines. Two changes involve:

1. A transformation of the Scottish Medicines Consortium approval process which will provide clinicians and patients a stronger voice on SMC decisions for life-limiting and rare conditions. This encompasses cancer.
2. The introduction of the Peer Approved Clinical System (PACS) which will replace the Individual Patient Treatment Request (IPTR) for assessing medicines not approved for regular use within NHS Scotland.

Assuming the policy change described above is approved and implemented nationally, these two changes will increase the number of medicines approved for use, and by association the basic medicine spend and requirement for increased services to administer and dispense them. The exact effects of these changes will become evident during 2014/15.

Cancer Informatics

NHS Lothian is a data rich system, and has comparatively an advantage over many other healthcare systems in terms of our existing data and information infrastructure and its reach across the whole system of care. We hold a vast amount information about cancer patients. A strategy for cancer informatics is required to support the integration of all related systems containing information about cancer patients and their treatment and to pull this data together in a way that best informs practice. An integrated cancer information system capability would allow reporting on patient pathways, care of specific groups of patients, anticipating care needs, and supporting the planning of services.

Under the Detect Cancer Early Programme NHS Lothian has invested in dedicated cancer analytical resource and further supported cancer audit and e-health systems development to support more efficient data capture. Furthermore, NHS Lothian Cancer Services will be appointing a Programme Manager in 2014 to undertake a review of the production, development and promotion of a range of information services, including statistical analysis, for cancer associated services within NHS Lothian and the Southeast of Scotland. The Programme will work alongside the Director of the Edinburgh Cancer Centre, strategic planning functions of S.E Scotland NHS Boards, and the Oncology Clinical Management Team to develop
long term plans and provide strategic direction for Oncology, Haematology and Breast Services. Early priorities will include the amalgamation of 2 existing teams into a single Cancer Information Service, and also the transfer of the existing Oncology database on to a new and more stable platform.

The programme will also seek to identify the linkages between NHS Lothian’s cancer management information requirements and those of university researchers – both current and future; ensuring that approved statistical analysis is available for a variety of stakeholders across all aspects of healthcare. It will seek to ensure close working and undertaking of collaborative clinical research projects with academic bodies including local universities, Chief Scientists Office, MRC, Cancer Research UK etc. enabling the Edinburgh Cancer Centre to derive full potential for data contribution within joint academic - NHS research projects, including medical informatics, analyses of clinically annotated tissues etc.

Essential to the informatics strategy is single entry, multiple use of clinical data. Accurate recording at the appropriate point of care will ensure reliable data which can be made available on a “need-to-know” basis across the care pathway, and allow collation of data to facilitate detailed planning of services, anticipation of complications, whether acute or chronic, and analysis of outcomes. A portal approach creating summary data on diagnosis and treatments to facilitate a patient centred view of each cancer journey will enhance communication between the many different health care professionals involved at all stages of cancer care delivery.

Robot-assisted surgery for urological cancers

Across the South East of Scotland prostate cancer will see the greatest percentage increase in incidence over the next decade. Developing our approach to treatment and our capacity, including improving care after treatment for this group, is essential. In 2013 The Cabinet Secretary for Health & Wellbeing recommended that Scotland move to provision of radical prostatectomy being undertaken in high volume centres utilizing minimal access or laparoscopic techniques. High-volume is defined as at least 150 cases per year. At present NHS Lothian is the only Health Board in Scotland where at least 150 laparoscopic radical prostatectomies are performed. Partial nephrectomy and cystectomy are still performed as open procedures in NHS Lothian.

Across North America, Europe and England & Wales there has been widespread adoption of robot-assisted surgery for prostate cancer (in the USA 70%, and in England almost 50% of radical prostatectomies are currently performed using a robotic system). The robotic systems are also widely used to undertake partial nephrectomy for renal cancer and radical cystectomy for bladder cancer. In England NICE has recommended that commissioners consider commissioning robot-assisted radical prostatectomy only where at least 150 cases per annum are performed, in order to ensure economic efficiency.

As the use of such technology becomes more common across the rest of the UK and Europe the training opportunities in laparoscopic radical prostatectomy in super-specialist units performing >400 cases per year will almost certainly disappear as these super high-volume centres move exclusively to robotics.
At present there are no robotic systems in Scotland. Two charities are actively raising funds to purchase systems for use in NHS Scotland (UCAN specifically for Aberdeen with the explicit support of NHS Grampian; Prostate Scotland for the central belt with support from NHS Scotland). NHS Lothian will assess the value and advantage of robot-assisted surgery, to help develop our capacity in line with national planning and developments. This will include consideration of the whole pathway of care for prostate cancer, the potential skills development for surgical staff, and imaging requirements.

Over 2014 / 15 there is therefore a requirements to work regionally to ensure that for laparoscopic prostatectomy care is being delivered in line with National Planning Forum recommendations. NHS Lothian must also assess the value and advantage of robot-assisted surgery, and assess the potential advantages, costs and risks associated with adoption or non-adoption in Lothian.

5. DESIGN OUR HEALTHCARE SYSTEMS TO RELIABLY AND EFFICIENTLY DELIVER THE RIGHT CARE AT THE RIGHT TIME IN THE MOST APPROPRIATE SETTING

Teenage Cancer
For young people with cancer, the provision of a dedicated teenage cancer unit makes the cancer pathway more bearable, makes it easier to engage with treatment, easier to keep going and easier to maintain existing social and support networks. NHS Lothian is working with the Teenage Cancer Trust (TCT) to achieve this. The TCT aims to ensure that every young person with cancer and their family receive the best possible care and professional support throughout their cancer journey. The Trust also empowers young people through education and advocacy.

In the East of Scotland our joint goal is to have age appropriate units at:
- The new Royal Hospital for Sick Children, Edinburgh, for 13-16 year olds (a refurbished unit opened at the RHSC in 2010, and this unit is included in re-provision plans for the new children’s hospital)
- The Western General Hospital, Edinburgh, for older teenagers and young adults aged 16 – 24 years (with a new unit opened in 2013, which will be further considered in the reprovision of the Edinburgh Cancer Centre).

The overall benefits associated with the provision of a dedicated unit for teenagers and young adults with cancer are:

- treatment can be delivered in a suitable environment, at appropriate times and an appropriate location
- enables the delivery of specialist care that has been demonstrated to significantly benefit this patient group
- peer support for teenage and young adults with cancer
- provide areas for patients, siblings and friends of teenagers and young adults with cancer to meet and support each other
• supports the aims of the Cancer Plan for Children and Young people in Scotland 2012-2015

Children and Young Adults – Managing Transitions in Care Provision

From the Patient Experience Programme staff in both paediatric and adult neuro-oncology services identified the need to design a better transition between services for the increasing number of teenage patients who are being seen in age inappropriate environments. The enthusiasm of key clinical staff to be involved in the design of a transition process created an ideal situation for a small scale project to begin the project work, and also demonstrated a commitment to working with hard to reach patient population groups.

Parents and teenagers feel safe and supported by their consultant and teams at Sick Children’s and express anxiety about transition to adult services. The move from children’s services should occur when the individual patient is ready and the decision should be agreed by staff in partnership with patient and parents. An outcome from the teenagers and young people’s experiences in neuro-oncology project was to create a transition clinic for current young patients and for newly diagnosed patients in this age group, which can be replicated in other specialities. Alongside the change in physical surroundings changes in practice must occur such as the young people being encouraged to see the clinicians alone as well as with their parents so that they take ownership of managing their health as they mature.

As part of the national programme of revision to referral guidelines for urgent suspected cancer a guideline for the referral of children and young people will be produced. This will support the service and locally, once available, the guidance will be built into the Lothian e-referral system.

Transforming Care After Treatment

The Transforming Care After Treatment (TCAT) programme is a collaboration between Macmillan Cancer Support and NHS Scotland and aims to ensure that people diagnosed with cancer are prepared for and supported to live with the consequences of the diagnosis and its treatment. With more people living longer after cancer treatment and incidence also increasing, by 2030 there are likely to be around 360,000 people living with or after cancer treatment in Scotland. Health services need to consider how care and support should be delivered after the initial management phase of treatment is complete to support and enable people affected by cancer to live as healthy and as good a quality of life for as long as possible.

TCAT is a major component of the Scottish Cancer Taskforce Workplan, which will be delivered in partnership with the Scottish Government, Regional Cancer Networks, Health Boards, Local Authorities and the Voluntary Sector. Macmillan Cancer Support is providing £5 million over 5 years to facilitate the development and implementation of models of care that:

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Enable people affected by cancer to play a more active role in managing their own care.

Provide services which are more tailored to the needs and preferences of people affected by cancer.

Give people affected by cancer more support in dealing with the physical, emotional and financial consequences of cancer treatment.

Improve integration between different service providers and provide more care locally.

The principles for future practice which should be integral elements of all new models of cancer care after treatment are risk stratification, personalised care planning, information to meet individual needs, care coordination across care settings and rapid access to appropriate health or care professional when problems arise. We want to promote a culture shift towards shared decision making and supporting self management. The wellbeing of people affected by cancer will be greater and their demand for services lower if they get the support that is relevant to their particular needs.

In December 2013 NHS Lothian’s TCAT proposal “Developing a recovery-based approach to cancer care in Lothian” was approved, securing Macmillan funding for a 2-year development project. The overall aim of this scheme is to evaluate the immediate and intermediate benefits of a recovery-based approach to care in patients treated for prostate, breast, gynaecological, anal/rectal and lung cancer. Needs assessment, and End of Treatment Assessment Clinics will be delivered.

The specific objectives of the scheme, to be delivered over 2014 – 2015, are:

1. To prepare and inform people about what to expect after completion of treatment including follow-up, offering tailored advice on what they can do for themselves and how to access further sources of support;

2. To evaluate the implementation of Holistic Needs Assessment and care planning and/or specific interventions to support the identified needs of patients at 6-12 weeks post treatment;

3. To evaluate the implementation of an end-of-treatment review about care and treatment received, possible treatment toxicities and/or late effects, ongoing management plan and any actions/goals to support recovery which would inform both the patient and the primary care teams;

4. To evaluate the benefits of conducting a supportive end-of-treatment approach to recovery from the perspectives of both patients and health care professionals;

5. To evaluate the feasibility of embedding this service in everyday care;

A secondary objective will be to review the key concerns raised by patients and assess whether there are common themes for all patients or within specific tumour groups. This data may help inform future intervention work.

Phase-2 of the programme, during 2014, will see the development of the TCAT initiatives further with the involvement of Lothian Health and Social Care
Partnerships. This brings the opportunity to extend the improvement in care to Local Authority and NHS provided community based services.

**Breast Service Redesign**

NHS Lothian is the host Board for The South East Scotland Breast Screening Programme (SESBSP) which is commissioned by National Services Division (NSD). The service provides screening and diagnostic services for the NHS Lothian, NHS Fife (except North-East Fife), NHS Forth Valley and NHS Borders region. Breast Screening services are located at Ardmillan House, in South West Edinburgh. Symptomatic Breast services are provided at the Western General Hospital (WGH). Patients diagnosed with breast cancer in the screening pathway are referred to the breast service at the WGH for further assessment and treatment.

The screening static centre at Ardmillan carries out routine screening for over 50% of the City of Edinburgh eligible population; along with follow-up assessment. The screening service currently operates 5 mobile units to cover the eligible population of South-East Scotland.

Over the course of October and November 2013 digital screening was introduced into the screening programme (the first region in Scotland to be fully digitised). This removes the requirement to store films in the future, and is a major step forward in terms of image quality and diagnostic capability. It is anticipated that the introduction of digital screening will lead to the detection of more early stage breast cancers, including more DCIS (Ductal Carcinoma In Situ).

The screening population served is predicted to increase by 14% over the next 3 screening rounds. It is likely that with the anticipated increase in eligible population, increasing uptake from the 71+ age bands and marketing campaigns designed to increase attendance that within 5 years demand will exceed capacity available in the breast screening service.

The Mammography Department at the WGH also provides breast diagnostic imaging services for symptomatic women in Edinburgh, with localisation services for patients with impalpable lesions from across Lothian, Fife, Borders, and half of Forth Valley regions. Long-term follow-up screening service for patients who have been treated for breast cancer is also provided.

Increasingly the screening and symptomatic services work in an integrated way and planning for redesign and modernisation of the breast service pathway includes consideration of the total breast pathway. As we further consider service capacity requirements, and link this work to planning for a new cancer centre, the co-location of breast symptomatic and screening services needs to be reviewed to determine if the advantages of full co-location can be achieved in the context of potentially taking forward a major cancer services capital programme on the Western General Hospital site.

In early 2011 the National Planning Forum commissioned NSD to undertake a major review of the Breast Screening Programme across Scotland. The review group concluded that the screening service should retain a six-centre model, but pursue further integration with symptomatic breast services.
Work is underway in Lothian to assess and plan redesigned services, particularly at this stage associated with the Detect Cancer Early Programme. NHS Lothian, alongside other NHS Boards in Scotland which host breast screening services, will work with NSD and other partners as the implementation plan following the national review is rolled-out.

**Palliative and End of Life Care**

The Lothian Palliative and End of Life Care strategy was approved by the NHS Board, and our partner agencies involved in co-developing the strategy, in 2010.

Our vision is for high quality Palliative and End of Life care available in all settings, utilised by all who require it, and prioritised according to the patient’s need, rather than medical condition. By 2015 clinical teams in all settings across Lothian will be reliably identifying and assessing patients as they reach a palliative phase of their illness, and developing and updating integrated care plans for them and their carers, based on patients and family preferences.

Our aim is to ensure access to high quality Palliative Care to all who need it, irrespective of diagnosis, age, gender, ethnicity, religious belief, disability, sexual orientation, and socio-economic status.

Public and professional feedback alike highlighted the importance of supporting choice for people with palliative and end of life care needs. Based on this, the goals of strategic implementation in relation to supporting choice focus on action to:

- Identify people who would benefit from palliative care, and to develop care plans with people which include establishing preferred place of care and preferred place of death
- Maximise the time spent in people’s preferred place of care (home, care home, and community hospital)
- Minimise emergency admissions where these could be avoided by good anticipatory care planning
- Support realistic choice of place of death (taking into account a holistic assessment of patient, family and carer needs)

We are taking forward a model of palliative care which seeks to support the integration of disease modifying treatment and palliative care. Our approach breaks down palliative care planning and delivery into 3 tiers:

- Working with people with Long Term Conditions to make sure that the need for palliative care is identified as part of routine care at the earliest stage appropriate, helping people to plan, direct and be actively involved their own care.
- Adopting the Palliative Care Approach from as early a stage as is agreed appropriate. The palliative care approach seeks to maximise quality of life, by maintaining good symptom control, offering holistic assessment including
family and carers needs, and seeks to agree choices around treatment options, place of care and preferred place of death.

- Planning for and managing end of life care in the last days of life in a tightly co-ordinated and structured manner.

As a result of development work in recent years, there is now a stronger platform from which to make further service improvement, however our strategic indicators show that progress towards overall goals and strategy outcomes is not being made quickly enough. There is therefore a need to re-focus on the main pathways of care in palliative and end of life care to achieve better and more reliable co-ordination of care within and across service settings. All partners recognise the need for more of an emphasis on integrated community based care.

To support the necessary redesign, NHS Lothian and Marie Curie UK are jointly sponsoring the Lothian Palliative Care redesign programme, with the participation of all stakeholders. The development phase of the programme runs over 2013 and 2014, with change initiatives being delivered thereafter. In summary the programme aims to:

- Assist in taking further the community based model of palliative care in place across Lothian, and to accelerate progress in shifting the balance of end of life care towards greater community based care
- To improve co-ordination of care, within and across settings, to support patients and families with complex and unstable palliative and end of life care needs
- To increase capabilities to identify patients and to plan care in anticipation and in advance of needs
- To enhance education, and support greater recognition of non-cancer palliative care identification and planning requirements
- To increase community based care service provision


**Bereavement Care in NHS Lothian**

death and dying from the point of view of the bereaved, developing staff training and support, considering ways of improving the advice and guidance given to bereaved people following a death, and developing links with other stakeholders.

To support achievement of these recommendations NHS Lothian employs a designated Bereavement Co-ordinator within Lothian Acute Hospitals. This post was the first of its kind in the NHS in Scotland, and has been used as the model for the type of coordinated service recommended within CEL (2011) 9. This post, and our Shaping Bereavement Care action plan, is managed in Spiritual Care & Bereavement Services.

The management of elderly patients with complex needs
Fifty percent of the increasing incidence in cancer is in the retired population. Building on pilot work being undertaken in haematology to consider the additional needs associated with elderly cancer patients with complex needs, we need to further consider pathways and clinical management arrangements for older patients. A systematic analysis of need is required to support the development of pathways and protocols across the region.

Tumour specific Group issues:
Tumour Specific Groups (TSGs) are in place as part of the South East Scotland Cancer Network. Groups are in place for the following: Breast, Colorectal, Gynaecology, Haematology, Lung, Skin, Upper GI, Head & Neck and Urology.

The work programme of all of the TSG’s includes common features supporting the achievement of reliable and high quality care delivered in the right setting. Features such as:

- Identifying best practice and supporting evidence based care into practice
- Allowing regional clinical management collaboration to support and achieve new standards of care across regional units
- Participation in the development and implementation of the new Cancer Quality Performance Indicators
- Participation in cancer clinical audit
- Development of guidelines and protocols to support clinical management
- Pathway development specific to the tumour type
6. INVOLVE PATIENTS AND CARERS AS EQUAL PARTNERS, ENABLING INDIVIDUALS TO MANAGE THEIR OWN HEALTH AND WELLBEING AND THAT OF THEIR FAMILIES

Cancer patients input to service programmes and the Better Together Patient Experience Programme
Patient involvement has been, and will continue to be, a fundamental element of the planning and development of Cancer Services within NHS Lothian.

NHS-24 Cancer Treatment Helpline
Within the Acute Oncology Programme, NHS Lothian has participated as an early implementer of the NHS-24 Cancer Treatment Helpline (CTH). Lothian patients were closely involved in the planning of this national development via the SCAN (South East of Scotland Cancer Network) Patient Forum. The views and experiences of patients accessing this service continue to be sought from patients accessing this service via telephone interviews undertaken by the CTH team in Lothian. This feedback is being used to further inform service change as implementation within the other Health Boards is undertaken.

Transforming Care After Treatment (TCAT)
Other major programmes which have had local patient involvement from the start include the Transforming Care After Treatment (TCAT) Programme. NHS Lothian patients have been involved in the discussion and selection of potential projects from all SCAN Boards. The successful projects in each phase of this 5 year programme will be managed by a local steering group where active involvement from patients will be sought. Indeed the first project to be undertaken has been developed with direct input from the Lothian Prostate Cancer Support Group.

Patient Experience Cancer Quality Performance Indicators (QPI’s)
The first collection of Patient Experience Quality Performance Indicators (QPIs) will be undertaken in 2014. These were developed during 2013 with contribution from the SCAN Patient Involvement Manager, and duly ratified by the national group in December 2013. The local delivery plan for monitoring against these indicators is currently being devised and will include patient involvement via the Tumour Specific Groups (TSGs).

Tailored Information for People of Scotland (TIPS)
September 2013 saw the launch of Tailored Information for People of Scotland (TIPS). This is a web based service which aims to guide patients towards the information that may be useful to them at a specific point in time. It seeks to avoid ‘information overload’. The design and development of this website has involved patients from it’s inception. The information chosen to support the Chemotherapy section is taken directly from patient information leaflets developed within the Edinburgh Cancer Centre.

Better Together Patient Experience Programme
NHS Lothian will continue to strive to improve services based on patient feedback such as those seen in recent years. Many of these were a direct result of the Better Together
Programme launched in 2008 by the Scottish Government Health Department. Projects include:-

- Development of Head and Neck specific section on SCAN website, including a DVD for patients
- A neck lump clinic set up in 2012 to ensure timely access to appropriate diagnosis
- Development of a transition clinic for young adults, as they move between paediatric and adult services.
- Redesign of chemotherapy booklet for patients, based on individual experiences
- Creation of the Teenage Cancer Trust Unit on WGH site, which opened in July 2013.
- Ongoing development of One Stop Breast Clinics at St John’s Hospital, following the Breakthrough Breast Cancer Service Pledge to patients
- Expansion of the Mammography Unit at WGH
- Recorded conversations in Urology consultations now commonplace (following on from the innovative Decision Navigator Study)
- Improvement in provision of snacks for those undergoing chemotherapy treatments
- Development of visual information to use with patients with learning difficulties in respect of Cancer treatments

SCAN Patient Forum

NHS Lothian is represented in each SCAN Tumour Specific Group. These groups now all have patient representation, thus ensuring patient involvement in all discussion around clinical developments.

The establishment of a Bladder Cancer Support Group has resulted from some of these discussions within the SCAN Urology TSG. This has a Patient and Carer reference Group as a sub group – the first of its kind in SCAN and developed to support patients and carers together. There is an aspiration to roll this out to the other TSGs, particularly Gynae and Breast.

Undertaking patient satisfaction / experience surveys will be a core part of service delivery. Following a pilot in December 2013, the ECC will be undertaking a regular programme of patient experience work within their own local quality strategy.

A national patient satisfaction survey relating to radiotherapy treatment will be completed between March and June 2014.

In undertaking the Edinburgh Cancer Centre Re-provision Programme patient involvement will be initially supported via use of the SCAN Patient Forum. Thereafter individual contribution will be built into the relevant workstreams, as required by the programme.
Our Vision for Cancer Care Delivery: Cancer Centre Reprovisioning and the Western General Hospital

The Western General Hospital is Lothian’s Cancer Services campus, providing oncology services for Lothian and the South East of Scotland region. The cancer service provided is greater than Edinburgh Cancer Centre (ECC) direct provision, for example it includes acute care provided both directly by ECC and by acute services, surgical oncology, and physician led cancer care in various specialties. As such, elements of oncology care pathways are provided all across most services at the Western General Hospital (and indeed the other Lothian main acute sites). This multi-disciplinary approach is how cancer pathways operate, supported by co-ordinated care managed by the cancer multi-disciplinary meetings. These clinical linkages and dependencies need to be recognised and developed to support the delivery of high quality cancer care across Lothian, and to achieve a focus for cancer care at the Western General Hospital as Lothian’s principal cancer site.

Our previous planning work on visioning and the potential for reprovisioning of the Edinburgh Cancer Centre confirmed the Western General Hospital as the preferred site for a new cancer centre. A long list of eight options were considered (including looking at the Lothian main acute sites, other Lothian sites, doing nothing / minimum, and phased development on the existing Cancer Centre). Of these options the preferred option, based on a limited (non financial) options appraisal was for a ‘New build on the Western General Hospital development zone (DCN) – New co-located cancer centre capable of meeting 2025 activity’. This was based on consideration of the best strategic fit, service integration and clinical effectiveness, physical environment, sustainability, and deliverability.

Critically the Western General Hospital is supported in its potential to become Lothian’s designated cancer campus because of the presence of key services, capabilities and facilities, for example:

- Clinical Genetics services
- Colorectal Surgery provision in Lothian centralised on the site
- Urology
- The potential to develop leading expertise and integrated provision of complex pelvic surgical services by bringing together gynaecology, colorectal surgery, urology, and oncology for joint procedures and integrated planning and management
- The Lothian Bowel Screening Service is co-ordinated from the Western General Hospital
- Breast cancer symptomatic assessment, diagnostic and treatment services are based on the site with further potential to integrate with breast screening services
- Specialist Palliative Care services are provided
- Significant cancer imaging is undertaken, with the potential to further develop and redesign imaging services to support cancer pathways
• The Maggie’s Centre is on the Western general Hospital Site
• The University of Edinburgh, Edinburgh Cancer Research Centre is on the campus

To further progress service improvement and the delivery of co-ordinated pathways of care we will take forward throughout 2015 a review of pathways and ‘Model of Care’ workstream as part of the planning programme for the new cancer centre. This will consider, for each tumour group area, key clinical linkages and dependencies, pathways, and the model of care required to support effective service arrangements in each area.

The planning programme for the new cancer centre will focus around the principal workstreams of radiotherapy, workforce, accommodation, and models of care. Key cross-cutting principles such as delivery of care closest to a patients' home without loss of quality, access or efficiency, and maximising the role and involvement of primary care will be central. In designing plans for the new centre, integration of ambulatory care facilities, acute assessment and inpatient beds will be specifically considered, as well as other key issues such as the co-location of our breast screening and symptomatic services. Maximising the potential benefits telemedicine can bring will also be key. Working with regional partners our concept will be to build a South East of Scotland Cancer Centre as the hub of a regional cancer service, with decentralised service delivery where possible, and with strong links to imaging, pathology and surgical services.

eHealth and Cancer in Lothian
Section 4 of this document rehearses our plan to develop cancer informatics.

Our e-health developments include, for example:

• Developing the TRAK system to support cancer patient pathway management by using this system both for cancer tracking and, increasingly, to support multi-disciplinary groups (MDM’s).

• Increasingly utilising the Clinical Portal system to integrate clinical systems and support collaborative working between clinical teams, whether that be within Lothian, across the South East of Scotland Cancer Network, or nationally.

• Providing e-referral systems including cancer specific referrals guidance in line with nationally agreed cancer referral guidelines.

• Testing and further considering telehealth and telepresence technology to potentially allow remote consultation and collaboration between professionals.
• Using the C-PORT system in chemotherapy to assist with capacity and demand modelling and scenario planning. We are also utilising and further developing the CEPAS system to support prescribing.

• Using the R-PORT system to support radiotherapy department level capacity planning.

• Developing a South East of Scotland cancer e-health strategy to support all regional Boards.

• In palliative and End of Life care we are utilising the Key Information Summary (KIS) system to record and communicate palliative care anticipatory care plans across in and out-of-hours services. We are also planning to establish secure data connections between the NHS Lothian Network and the two Lothian Independent Hospices to allow electronic referral via Gateway and to support greater clinical communication.

Access to Cancer Care in Lothian
There are two headline national cancer waiting times’ targets in Scotland:

• 62 days from urgent referral with suspicion of cancer (and referrals from the national screening programmes) to first treatment

• 31 days from decision to treat to first treatment (irrespective of route of referral)

NHS Lothian’s performance against both of the headline targets in recent years has been either over the required standard or, where dips in performance in 62-days have been experienced, close to the 95% standard required. Lung cancer 62-day performance is being further scrutinised in 2014 and an action plan for improvement in lung cancer will be developed, including review and redesign of the lung cancer pathway. Lung cancer, Head & Neck Cancers, and Lymphoma are the pathways where compliance with the 62-day pathway requires ongoing support.

NHS Lothian has consistently met the standards for acute leukaemia and for children’s cancers, both of which are subject to a separate reporting mechanism to the 62 and 31 day standards.

The leukaemia target is a maximum wait from urgent referral to treatment for acute leukaemia of one month

The children’s cancer target is a maximum wait from urgent referral to treatment for children's cancers of one month

Cancer Research
If we aspire to optimise outcomes, incorporating clinical research as a core service is essential. Research should be embedded into the clinical service across the region, as there is a growing body of evidence that those hospitals that conduct clinical research deliver better outcomes for all their patients, not just those enrolled into
clinical trials. Support departments (imaging, nursing, diagnostics, portering etc.) all have a key role to play in facilitating and maximising research activity.
8. STRATEGY MEASUREMENT

Routine measures
Cancer services in Lothian are subject to continuous measurement and reporting, all of which contribute to service scrutiny and improvement. The main areas of routine measurement are noted below.

<table>
<thead>
<tr>
<th>Area</th>
<th>Measure</th>
<th>Published</th>
<th>Description</th>
<th>Source</th>
<th>Lothian Performance</th>
<th>Scotland Performance</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bowel Screening</td>
<td>Uptake</td>
<td>Annually</td>
<td>Bowel Screening Key Performance Indicator report which includes 28 indicators.</td>
<td>ISD</td>
<td>53.5%</td>
<td>54.9%</td>
<td>60%</td>
</tr>
<tr>
<td>Breast Screening</td>
<td>Uptake</td>
<td>Annually</td>
<td>Report on the KC62 Health Board Standards. This includes a number of indicators around breast screening including uptake.</td>
<td>ISD</td>
<td>71.7%</td>
<td>74.5%</td>
<td>80%</td>
</tr>
<tr>
<td>Cervical Screening</td>
<td>5.5 year Uptake</td>
<td>Annually</td>
<td>Data covering uptake, workload, processing, turnaround and reporting.</td>
<td>ISD</td>
<td>75.5%</td>
<td>78.1%</td>
<td>80%</td>
</tr>
<tr>
<td>Access</td>
<td>62-day referral to treatment</td>
<td>Quarterly</td>
<td>95% of those referred urgently with a suspicion of cancer to begin treatment within 62 days of receipt of referral</td>
<td>ISD</td>
<td>96.9%</td>
<td>94.5%</td>
<td>95%</td>
</tr>
<tr>
<td></td>
<td>31-day decision to treat</td>
<td>Quarterly</td>
<td>95% of all patients diagnosed with cancer to begin treatment within 31 days of decision to treat</td>
<td>ISD</td>
<td>99.6%</td>
<td>98.1%</td>
<td>95%</td>
</tr>
<tr>
<td>Area</td>
<td>Measure</td>
<td>Published</td>
<td>Description</td>
<td>Source</td>
<td>Lothian Performance</td>
<td>Scotland Performance</td>
<td>Target</td>
</tr>
<tr>
<td>---------------------------</td>
<td>----------------------------------------------</td>
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<td>----------------------------------------------------------------------------------------------------------------------------------------------</td>
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<td>------------------------------</td>
</tr>
<tr>
<td><strong>HEAT targets</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DCE HEAT Target</td>
<td>Proportion of cancers detected at stage 1 (HEAT target H10.1)</td>
<td>Annually</td>
<td>To increase the proportion of people diagnosed and treated in the first stage of breast, colorectal and lung cancer by 25% by 2014/2015</td>
<td>ISD</td>
<td>10.20%</td>
<td>4.30%</td>
<td>Local: 28.3% National: 25%</td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Successful Quits (HEAT target H6.1)</td>
<td>Quarterly</td>
<td>NHS Scotland to deliver universal smoking cessation services to achieve at least 80,000 successful quits (at one month post quit) including 48,000 in the 40% most deprived within-Board SIMD areas over the three years ending March 2014</td>
<td>ISD</td>
<td>7,779</td>
<td>48,396</td>
<td>Local: 7,011 National: 48,000</td>
</tr>
<tr>
<td><strong>Quality &amp; Outcome indicators</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cancer Quality Performance indicators</td>
<td>Various - Yet to be published</td>
<td>Annually</td>
<td>The QPIs have been developed collaboratively with the three Regional Cancer Networks, Information Services Division (ISD), and Healthcare Improvement Scotland. QPIs will be kept under regular review and be responsive to changes in clinical practice and emerging evidence. They include small sets (approximately 10-15 indicators) of tumour specific and generic national quality performance indicators (QPIs).</td>
<td>HIS/ISD</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Incidence</td>
<td>Incidence</td>
<td>Annually</td>
<td>Incidence statistics by cancer type, sex, network and health board. The data is also split by age group at network level and above.</td>
<td>ISD</td>
<td>Total: 4,614</td>
<td>EASR: 445.1</td>
<td>Total: 30,125 EASR: 425.2</td>
</tr>
</tbody>
</table>
Mortality

Mortality Annually

Mortality statistics by cancer type, sex, network and health board. The data is also split by age group at network level and above.

ISD Total: 1,113 EASR: 179.4
EASR: 198.6

Survival

Survival Annually

The National Cancer Intelligence Network (NCIN) produces a cancer e-Atlas tool that includes incidence, mortality and survival indicators for the whole of the UK.

NCIN Currently being revised Currently being revised

Quality Report – Clinical Governance

Quality Report – Clinical Governance Annually

A yearly cancer quality report is produced in NHS Lothian. Clinical effectiveness measures presented include: mortality rates, smoking cessation outcomes, uptake of the three screening programmes and primary care review of patients newly diagnosed with cancer. The QOF indicator used for the final measure requires that patients are reviewed in primary care within six months of the practice receiving confirmation of the cancer diagnosis.

QoF Calculator 96.3%

Area

Measure Published Description Source Lothian Performance Scotland Performance Target

Palliative Care Indicators

Occupied bed days Annually Reduction in the number of occupied bed days in last year of life (for deaths in domiciliary and care home settings) LAS 26,923 - 22,603

Deaths/year Annually 10% reduction in deaths/year in acute hospital settings between 2008 and 2015 LAS -0.3% - -10%

Palliative Care Quality Outcome Measure 10 Annually Percentage of last six months of life spent at home or in a community setting ISD 92.0% 91.2% -
9. STRATEGIC RESOURCING

NHS Lothian’s operating budget for oncology in 2013 / 14 was £43.85m (covering breast screening, oncology services including breast services and palliative care, and haematology). We manage a strategic budget of £4.3m to commission hospice care in Lothian and support the palliative care strategic programme, including the managed clinical network (MCN). Specific aspects of the strategic programme such as the Detect Cancer Early Programme and the cancer modernisation programme bring additional allocations which are used to support specific services and initiatives across the system. The NHS Lothian Detect Cancer Early Programme was allocated £1.5m in revenue and £0.3m in capital in 13/14, and will be subject to further (variable) income allocations in 14/15 and 15/16 to support the programme. Cancer modernisation in NHS Lothian was allocated £0.5m in 13/14 (with 0.3m of this for regional radiotherapy modernisation), with further investment to come in 14/15. Other specific allocation routes also support the provision of cancer care in Lothian, such as for key diagnostic capacity and development (for example PET provision), and via primary care funding routes such as the GP contract / Scottish Quality and Outcomes Framework, which are for example currently being utilised nationally to further support local Detect Cancer Early Programmes and screening programmes.

Cancer pathways operate across the whole system of care. As an example, lung cancer care will include a GP or Emergency Department presentation and onward referral, initial diagnostic imaging, respiratory medicine assessment and related endoscopic diagnostics, may include thoracic surgery, and most cases will necessitate assessment, planning and treatment in oncology (radiotherapy, chemotherapy or a combination treatment), and may require palliative and end of life care. Such co-ordinated care happens across specialties and settings of care, and often across NHS Board boundaries. We do not have an accurate mechanism to determine the full costs of cancer care across the whole system. The development of the Integrated Resource Framework (IRF) in Lothian may assist in achieving a better estimate of cancer pathway costs.

At the South East of Scotland regional level the shared costs of cancer care (cross charging other South East of Scotland NHS Boards for specialist care provided by NHS Lothian) are managed via service level agreements across the region. Under this model, recovery of costs is based on annual average case volumes and costs per case.

Section 7 of this strategy outlines our ambition to develop the Western General Hospital as Lothian’s cancer campus and the base for a new South East of Scotland Cancer Centre. In order to support this ambition the associated business case needs to be completed locally and submitted into the national capital programme for consideration and prioritisation. Production of an Initial Agreement and, subject to approval, an Outline Business Case will be taken forward during 2015/16.
APPENDIX 1 - GOVERNANCE – CANCER PLANNING AND MANAGEMENT PROCESSES

This appendices provides two schematics. The first shows the organisation of the national cancer programme and the South East of Scotland regional arrangements. The second shows the Lothian cancer and palliative care programme in the context of the NHS Lothian strategic planning arrangements.
## APPENDIX 2 – TRENDS IN CANCER SURVIVAL 1983-2007

All malignant neoplasms excluding non-melanoma skin cancer (ICD-9 140-208 excl. 173; ICD-10 C00-C97 excl. C44)

### Trends in survival by age group and period of diagnosis

**Observed and relative survival (%) at 1, 3, 5 and 10 years; patients diagnosed 1983-2007.**

### All Persons

<table>
<thead>
<tr>
<th>Age group</th>
<th>Period</th>
<th>Number of cases analysed</th>
<th>Observed survival (% at 1 yr)</th>
<th>Relative survival (% at 1 yr)</th>
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</thead>
<tbody>
<tr>
<td>15-44</td>
<td>1983-1987</td>
<td>7,237</td>
<td>82.6</td>
<td>82.8</td>
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<tr>
<td></td>
<td>1988-1992</td>
<td>7,818</td>
<td>84.4</td>
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<td></td>
<td>1993-1997</td>
<td>8,115</td>
<td>87.6</td>
<td>87.8</td>
</tr>
<tr>
<td></td>
<td>1998-2002</td>
<td>8,290</td>
<td>89.4</td>
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<td>2003-2007</td>
<td>8,487</td>
<td>90.4</td>
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<td>45-54</td>
<td>1983-1987</td>
<td>9,744</td>
<td>65.9</td>
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<td></td>
<td>1988-1992</td>
<td>10,554</td>
<td>70.9</td>
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<td>1993-1997</td>
<td>11,889</td>
<td>74.7</td>
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<td></td>
<td>1998-2002</td>
<td>12,223</td>
<td>78.1</td>
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<tr>
<td></td>
<td>2003-2007</td>
<td>12,560</td>
<td>81.0</td>
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<tr>
<td>55-64</td>
<td>1983-1987</td>
<td>22,274</td>
<td>52.7</td>
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<td></td>
<td>1988-1992</td>
<td>22,086</td>
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<td></td>
<td>1993-1997</td>
<td>22,593</td>
<td>63.8</td>
<td>64.7</td>
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<td></td>
<td>1998-2002</td>
<td>23,092</td>
<td>68.0</td>
<td>69.0</td>
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<tr>
<td></td>
<td>2003-2007</td>
<td>25,133</td>
<td>71.6</td>
<td>72.4</td>
</tr>
<tr>
<td>65-74</td>
<td>1983-1987</td>
<td>30,446</td>
<td>45.4</td>
<td>47.5</td>
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<td></td>
<td>1988-1992</td>
<td>32,063</td>
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<td>35,819</td>
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<td>34,357</td>
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<td>2003-2007</td>
<td>34,970</td>
<td>71.6</td>
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<td>1983-1987</td>
<td>23,669</td>
<td>36.3</td>
<td>38.8</td>
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<td>1988-1992</td>
<td>25,794</td>
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<td>27,953</td>
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<td>1998-2002</td>
<td>29,067</td>
<td>57.7</td>
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<td>2003-2007</td>
<td>30,581</td>
<td>61.2</td>
<td>64.0</td>
</tr>
<tr>
<td>85-99</td>
<td>1983-1987</td>
<td>5,537</td>
<td>26.8</td>
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<tr>
<td></td>
<td>1988-1992</td>
<td>7,183</td>
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<td>1993-1997</td>
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<td>52.8</td>
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<td>1998-2002</td>
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<td>2003-2007</td>
<td>10,072</td>
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<tr>
<td>15-74</td>
<td>1983-1987</td>
<td>69,701</td>
<td>54.5</td>
<td>56.6</td>
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<tr>
<td></td>
<td>1988-1992</td>
<td>72,521</td>
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<td>60.2</td>
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<tr>
<td></td>
<td>1993-1997</td>
<td>78,416</td>
<td>62.9</td>
<td>64.6</td>
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<tr>
<td></td>
<td>1998-2002</td>
<td>77,962</td>
<td>67.3</td>
<td>68.9</td>
</tr>
<tr>
<td></td>
<td>2003-2007</td>
<td>81,150</td>
<td>70.9</td>
<td>72.4</td>
</tr>
<tr>
<td></td>
<td>1988-1992</td>
<td>105,498</td>
<td>52.2</td>
<td>55.0</td>
</tr>
<tr>
<td></td>
<td>1993-1997</td>
<td>115,552</td>
<td>56.4</td>
<td>59.3</td>
</tr>
<tr>
<td></td>
<td>1998-2002</td>
<td>116,724</td>
<td>59.6</td>
<td>62.7</td>
</tr>
<tr>
<td></td>
<td>2003-2007</td>
<td>121,803</td>
<td>62.5</td>
<td>65.6</td>
</tr>
</tbody>
</table>

### Directly standardised3

<table>
<thead>
<tr>
<th>Age group</th>
<th>Period</th>
<th>Number of cases analysed</th>
<th>Observed survival (% at 1 yr)</th>
<th>Relative survival (% at 1 yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-74</td>
<td>1983-1987</td>
<td>69,701</td>
<td>54.5</td>
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<tr>
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<td>1993-1997</td>
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<td>62.9</td>
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<td>62.7</td>
</tr>
<tr>
<td></td>
<td>2003-2007</td>
<td>121,803</td>
<td>62.5</td>
<td>65.6</td>
</tr>
</tbody>
</table>

---

1 Cases diagnosed in 2005-2007 do not have 5 years' follow-up and cases diagnosed in 2000-2007 do not have 10 years' follow-up.

2 Cases diagnosed in 1983-1996 are coded to ICD-9 scheme and cases diagnosed in 1997-2007 are coded to ICD-10 scheme.

3 These rates are standardised to the European Cancer Patient Population (EUROCARE-4).

---

### Trends in Cancer Survival 1983-2007

Source: Scottish Cancer Registry, ISD

Data extracted: June 2010
This paper aims to summarise the key points in the full paper. The relevant paragraph in the full paper is referenced against each point.

<table>
<thead>
<tr>
<th>Point</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Health inequalities are systematic, unfair differences in the health of the population that occur across social classes or population groups. Addressing health inequalities is a priority for the NHS and partner agencies.</td>
<td>3.1</td>
</tr>
<tr>
<td>• Health inequalities are underpinned by wider social inequalities, so multi-agency action is needed to address these and much of this work is already being led within Community Planning Partnerships. The NHS Lothian strategy focuses more narrowly on actions that NHS Lothian itself can take.</td>
<td>3.1</td>
</tr>
<tr>
<td>• A draft strategy was consulted on over the summer, was subjected to impact assessment, and revised accordingly.</td>
<td>6.1, 7.1</td>
</tr>
<tr>
<td>• The strategy identifies that tackling health inequalities requires commitment across NHS Lothian. This includes: actions that use the potential of the NHS as a large employer and through procurement; ensuring services are available and accessible to all and delivered proportionate to need, to reverse the ‘inverse care law’; increasing the priority given to primary and community services, early years and preventative interventions relative, as the most disadvantaged groups benefit most from these; addressing the social issues that impact on patients’ health and ability to use healthcare; developing partnerships with voluntary sector; raising awareness of underlying causes and advocating for policies and interventions that reduce inequalities in income, wealth and power.</td>
<td>3.3</td>
</tr>
<tr>
<td>• A detailed action plan has been developed for the next three years that identifies actions relating to: Procurement, NHS as Employer; Clinical Services; Partnership and Monitoring.</td>
<td>3.5</td>
</tr>
</tbody>
</table>
NHS LOTHIAN HEATH INEQUALITIES STRATEGY

1 Purpose of the Report
1.1 The purpose of this report is to seek Board approval for the NHS Lothian Health Inequalities Strategy. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

2 Recommendations
The Board is recommended to:
2.1 Approve the Health Inequalities Strategy and action plan.

3 Discussion of Key Issues
3.1 Health inequalities are systematic, unfair differences in the health of the population that occur across social classes or population groups. Scottish Government identifies addressing health inequalities as a priority for the NHS and partner agencies. Health inequalities are underpinned by wider social inequalities, so multi-agency action is needed to address these and much of this work is already being led within Community Planning Partnerships. The NHS Lothian strategy focuses more narrowly on actions that NHS Lothian itself can take.

3.2 The strategy document includes:
- A profile of the most vulnerable populations in Lothian who have the poorest health
- A summary of the policy context and literature on the causes of health inequalities and types of interventions most likely to be effective
- An outline of current actions that NHS Lothian is taking to reduce health inequalities
- A description of the overall approach to health inequalities
- An action plan for 2014-17
- How the plan will be monitored and reviewed

3.3 The strategy identifies that within the NHS the overall approach to mitigate and tackle health inequalities should recognise the gradient in ill health across socio-economic groups. Providing services in ways that disproportionately benefit more affluent groups and failing to invest appropriately to address inequalities has an opportunity cost as it will result in poorer health and social outcomes relative to the investments made. The strategy highlights that the overall approach should include the following high level actions that require long term commitment across NHS Lothian:
• Using the potential of the NHS as a large employer and through procurement to provide employment, education and training opportunities with fair terms of employment for all staff.

• Ensuring services are available and accessible to all and delivered proportionate to need, to reverse the ‘inverse care law’. This means increasing provision of geographically based primary and community services in the areas with highest needs.

• Increasing the priority given to primary and community services relative to secondary and tertiary services, as the most disadvantaged groups benefit most from these.

• Increasing the priority given to early years and preventative interventions relative to interventions in later life, as the most disadvantaged groups benefit most from these.

• Ensuring the social issues that impact on patients’ health and ability to use healthcare are viewed as legitimate issues for health professionals to consider, are systematically recognised, patient management reflects these needs and patients are referred or signposted to appropriate support.

• Investing in partnerships with voluntary sector and other organisations that are better placed to address social issues that affect patients’ health.

• Working with partners to raise awareness of underlying causes and to advocate for policies and interventions that reduce inequalities in income, wealth and power.

3.4 The strategy also identifies more specific short term actions for the three years 2014-17. Priority actions were proposed in the consultation draft and the strategy group has reviewed these following the consultation and the combined impact assessment (summary of the impact assessment findings is given in section 6). The group has now prepared a more detailed action plan with milestones and measures to review progress for each. The group acknowledges that some of this work will require to be developed further over time.

3.5 Each of the priority actions has an identified working group or service that is leading its implementation. Some are established groups, some have been, or are being, newly set up specifically to deliver the actions. The strategy group itself will continue to meet quarterly to review progress against the actions and will agree any changes to the action plan as the work develops further. It is proposed that the strategy group should report overall progress to the Strategic Planning Committee on a six monthly or annual basis.

Table: Priority actions to mitigate, prevent or undo health inequalities, 2014-17

<table>
<thead>
<tr>
<th>Types of action</th>
<th>Priority actions 2014-2017</th>
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<tbody>
<tr>
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<tr>
<td>Actions relating to employment policies that support vulnerable people to gain employment or ensure fair terms and conditions for all staff</td>
<td>Develop, learn from and build on initiatives that seek to increase capacity in primary care to mitigate health inequalities and identify ways to sustain these if successful</td>
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<td>Actions to support staff to support the most vulnerable patients</td>
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<td>Identify patients at risk of financial insecurity and enable access to appropriate services</td>
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<td>Increase number of practices with welfare advice and income maximisation services</td>
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<td>Increase recruitment opportunities for young people and vulnerable groups through socially responsible recruitment programme</td>
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<td>Staff training to enable them to respond to social and economic circumstances affecting patients’ health. This should include cultural competence.</td>
<td>Use findings from Early Years Collaborative and implement identified best practice across NHS Lothian.</td>
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<td>Train staff in health literacy tools and techniques to improve patient safety, communication, self management and understanding and inform about available resources.</td>
<td>Implement Learning Disability Health Inequalities Plan to ensure NHS services can meet needs of people with learning disability</td>
</tr>
<tr>
<td></td>
<td>Ensure Health and Social Care Partnership Strategic Needs Assessments explicitly</td>
</tr>
</tbody>
</table>
assess significant inequalities in each area and identify opportunities to mitigate health inequalities

Ensure patient pathways in the Strategic Plan identify vulnerable groups and ways to improve their ability to access effective care

Continue routine use of impact assessment of new policies and plans

<table>
<thead>
<tr>
<th>Partnership</th>
<th>Ensure public health/health promotion input to community planning partnerships including economic partnerships</th>
</tr>
</thead>
<tbody>
<tr>
<td>Services in above categories that are delivered in partnership with others, or that we fund but are delivered by others</td>
<td>Work with local authority and voluntary sector partners to develop impact assessments that identify the impacts of their policies on health inequalities</td>
</tr>
<tr>
<td>NHS as advocate for wider actions by partners</td>
<td>Advocate for routine payment of at least the living wage</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th>Monitoring and evaluation</th>
<th>Develop measures of determinants of health inequalities and use these in monitoring the impacts of this and other strategies</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Review priority actions in three years</td>
</tr>
</tbody>
</table>

**4 Key Risks**

4.1 Health inequalities are a complex ‘wicked’ issue and require long term action by many partners. There is a risk that the large scope of the work needed inhibits action, or alternatively that unrealistic expectations are placed on strategies seeking to reduce health inequalities. This can be mitigated by developing clear actions and monitoring against realistic outcome indicators.

4.2 There is also a risk of ‘lifestyle drift’ – that strategies to reduce health inequalities focus on the easier downstream activities and ignore more difficult upstream factors. This can be mitigated by ensuring that strategies use a range of approaches to address both upstream and downstream factors.

**5 Risk Register**

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

**6 Impact on Inequality, Including Health Inequalities**

6.1 The Health Inequalities Strategy and Action Plan was subjected to Combined Impact Assessment in July 2014. The impact assessment identified mainly positive impacts from the policy, but also identified some potential negatives impacts, which were: potential increased workload and pressure associated with new roles and
approaches including the need to make time for staff training; actions may be less appropriate in rural settings where deprivation is more mixed; prioritisation of early years may disadvantage other groups, including teenage transitions.

6.2 A series of recommendations were made from the impact assessment to enhance the positive impacts and mitigate the potential negative impacts above. These actions have been agreed by the strategy document and will be monitored as part of its work. The actions include:

- Broadening the scope of some of the priority actions
- Making links with some other related areas of work
- Monitoring the effect of the actions on staff workloads
- Developing an Inclusive version of the document

7 Involving People

7.1 The Health Inequalities Strategy was formally consulted on as part of the Strategic Plan consultation. As part of this, groups with a particular interest in health inequalities were contacted directly and the strategy was discussed with Community Health Projects, other voluntary sector groups and the Health Improvement Partnerships.

7.2 Respondents to the consultation supported the approach proposed in the draft strategy. Actions relating to procurement and employment were particularly strongly supported. Other key themes in consultation responses were: the importance of partnership working; the potential for third sector organisations to deliver early intervention; perceived barriers between NHS and other services; the specific needs of people with mental health problems; the importance of linking to other relevant policies and strategies. Some specific suggestions were made that have been reviewed and discussed by the strategy group. Where relevant, these have been incorporated into the health inequalities strategy. Other issues raised in the consultation, such as concerns about transport and use of technology, are wider issues that form part of the Strategic Plan.

8 Resource Implications

8.1 The resources needed to implement the agreed priority actions will need to be identified as part of their further development.
# NHS Lothian Health Inequalities Strategy

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</table>
INTRODUCTION

Of all the challenges facing Scotland, the gaping health inequalities and high mortality rates are clearly our greatest.

*Health Scotland Overview for Ministerial Taskforce on Health Inequalities Nov 2012*

Health inequalities are ‘systematic, unfair differences in the health of the population that occur across social classes or population groups’.

In Scotland there are significant inequalities in health between people who are socially and economically well off, and those who are socially disadvantaged. In Lothian this means for example that people living in the most affluent communities in Lothian can expect to live twenty one years longer than people living in the most deprived communities. People living in the most deprived communities also have poorer physical and mental health throughout their lives.

Health inequalities do not just affect the most deprived communities and individuals. For almost every health indicator there is a clear gradient showing progressively poorer health with decreasing affluence and influence. Nor are health inequalities only related to socio-economic position. People who are disadvantaged by race, disability, gender and other factors also have poorer health.

This strategy sets out how NHS Lothian intends to respond to these inequalities and achieve greater equity in health for the Lothian population. It recognises that health inequalities reflect much broader societal forces that the NHS cannot address on its own. However, NHS services play an important role in mitigating the effects of these wider social inequalities on health, and NHS organisations can also work with partners to try to address the underlying influences.

Much of the work to achieve health equity forms part of community planning arrangements in the four Lothian local authorities. This strategy focuses more specifically on the role that NHS Lothian can play through its own services.

This document contains:

- A profile of the most vulnerable populations in Lothian who have the poorest health
- A summary of the policy context and literature on the causes of health inequalities and types of interventions most likely to be effective
- An outline of current actions that NHS Lothian is taking to reduce health inequalities
- A description of the overall approach to health inequalities
- An action plan for 2014-17
- How the plan will be monitored and reviewed
FUTURE PRIORITY ACTIONS

The following table summarises the areas of action that NHS organisations can take to mitigate and reduce health inequalities. It shows the priority actions that NHS Lothian will take over the next three years.

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<td>Staff training to enable them to respond to social &amp; economic circumstances affecting patients health. This should include cultural competence.</td>
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<td>Train staff in health literacy tools &amp; techniques to Improve patient safety, communication, self management &amp; understanding and inform about available resources</td>
</tr>
<tr>
<td><strong>Planning and delivery of Clinical services</strong></td>
<td></td>
</tr>
<tr>
<td>Actions to target universal services to the most vulnerable people in Lothian</td>
<td>Develop, learn from and build on initiatives that seek to increase capacity in primary care to mitigate health inequalities and identify ways to sustain these if successful</td>
</tr>
<tr>
<td>Actions to investigate and amend service provision to ensure appropriate for all groups – RIA, equity audit, deliver in other settings etc</td>
<td>Develop routine use of ‘work outcomes’ in patient recovery plans</td>
</tr>
<tr>
<td>Services that are universal but most needed by people in specific populations</td>
<td>Identify patients at risk of financial insecurity and enable access to appropriate services</td>
</tr>
<tr>
<td>Provision of support to access and use universal services</td>
<td>Increase number of practices with welfare advice and income maximisation services</td>
</tr>
<tr>
<td>Services that are only needed by particular population groups</td>
<td>Ensure evidence based vocational rehabilitation services available to support those with health conditions to return to/retain employment</td>
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<td></td>
<td>Use findings from Early Years Collaborative and implement identified best practice across NHS Lothian.</td>
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| Prioritisation of early years provision | Implement Learning Disability Health Inequalities Plan to ensure NHS services can meet needs of people with learning disability  
Ensure Health & Social Care Partnership Strategic Needs Assessments explicitly assess significant inequalities in each area and identify opportunities to mitigate health inequalities  
Ensure patient pathways in the Strategic Plan identify vulnerable groups and ways to improve their ability to access effective care  
Continue routine use of impact assessment of new policies and plans |
|---|---|
| **Partnership**  
Services in above categories that are delivered in partnership with others, or that we fund but are delivered by others  
NHS as advocate for wider actions by partners | Ensure public health/health promotion input to community planning partnerships including economic partnerships  
Work with local authority and voluntary sector partners to develop impact assessments that identify the impacts of their policies on health inequalities  
Advocate for routine payment of at least the living wage |
| **Monitoring and evaluation** | Develop measures of determinants of health inequalities and use these in monitoring the impacts of this and other strategies  
Review priority actions in 3 years |
POPULATION PROFILE

In 2012, 843,733 people lived in Lothian, 15.9% of the total Scottish population. Some groups of the population are more likely to experience poor health than others. The table below gives some demographic information showing the diversity of the population. It identifies some of the populations that differentially experience poor health, with some key issues to consider in providing healthcare.

<table>
<thead>
<tr>
<th>Population</th>
<th>Key issues for NHS Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Men and Women</td>
<td>Male life expectancy is 77 years, significantly lower than female life expectancy at 81.4 years. Men experience higher rates of most diseases eg lung and colorectal cancer, CHD and stroke. Young men more likely to commit suicide or be involved in accidents or violence. Women are more likely to suffer ill health particularly mental ill health, suggesting that women spend more years in poor health. Women are higher risk of domestic violence.</td>
</tr>
<tr>
<td>Older people</td>
<td>Approximately 7% of the Lothian population, around 60,000 people, is aged over 75 years. Women substantially outnumber men in older age groups. The population as a whole is ageing as people are living longer. However the average age in more deprived communities tends to be lower because life expectancy is lower. The risk of morbidity and mortality rises with age – but this rise occurs 10-15 years earlier in the most deprived populations. Isolation and poverty compound the health problems associated with old age.</td>
</tr>
<tr>
<td>Children and young people</td>
<td>Children and young people under 16 years make up approximately 17% of Lothian’s population. Socio-economic health inequalities are evident from a very young age, indeed from before birth. Early years experiences including poverty have a very significant impact on children’s lives and health into adulthood. Looked After children have particularly poor outcomes.</td>
</tr>
<tr>
<td>Lesbian, Gay and Bisexual people</td>
<td>In 2010 the Integrated Household Survey reported that 1.4% of respondents indentified as gay or lesbian and 0.55% as bisexual. Between 5% and 12% of people are estimated to have had a same sex experience or contact. Experience of homophobic abuse and violence is associated with high rates of mental illness and self-harming behaviour. Men who have sex with men are at risk of blood borne viruses.</td>
</tr>
</tbody>
</table>

1 Further information on these key issues is available in the Rapid Impact Assessment guidance at http://www.nhslothian.scot.nhs.uk/YourRights/EqualityDiversity/ImpactAssessment/Pages/default.aspx
<table>
<thead>
<tr>
<th>Population</th>
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<tr>
<td>Transgender people</td>
<td>Transgender people frequently experience discrimination, abuse and violence and are at increased risk of substance use and self harm.</td>
</tr>
<tr>
<td>People with physical disability</td>
<td>2011 census data suggest that 8% of Lothian residents’ day to day activities are limited a lot and 9% of residents’ activities are limited a little. These rates are higher among older people. People with a disability may find it more difficult to access services via public transport or walking, to retain employment, and may experience harassment.</td>
</tr>
<tr>
<td>People with learning disability and/or Autism</td>
<td>About 2% of the population has a learning disability but only a quarter to a fifth of these are identified to health and social care services. Based on national estimates, approximately 1700 people (children and adults) in Lothian are identified as having learning disabilities. People with learning disabilities have higher than population average rates of morbidity and mortality from all diseases with notably higher rates of death from respiratory disease, cardiovascular disease and some of the rarer forms of cancer such as gall bladder, stomach and gullet. Prevention and health promotion is not always effective with people with learning disabilities. Autism affects 1 in 100 people, so there are approximately 8,500 people in Lothian with autism. Autism causes difficulty with both verbal and non-verbal communication; difficulty with social interactions; and restrictive, reciprocal and stereotypical routines of behaviour.</td>
</tr>
<tr>
<td>People with mental health problems</td>
<td>Around 14% of the adult population has a mental health condition. This proportion is higher in women than men. Mental ill-health is often hidden – with stigma attached to accessing services. The risk of many physical conditions is also increased in people with mental health problems. Similarly, many people with multi-morbidity have poor mental health – among people from most deprived communities this is more common. People with protected characteristics related to race, disability, sexual orientation can experience discrimination and harassment which impacts negatively on mental health.</td>
</tr>
<tr>
<td>Minority ethnic people</td>
<td>Most Lothian residents (94.3%) identify as White (European (including 17,350 Polish people), British or Scottish); this is slightly lower than the Scotland average. There are 31,000 (3.7%) Asian Scottish people in Lothian; in Edinburgh 5.5% of the population identify as Asian. No other area in Lothian has a rate above the Scotland average of 2.7%. South Asians experience higher rates of diabetes and heart disease. Black Africans have a high rate of HIV diagnosis and are at higher risk of hypertension and glaucoma.</td>
</tr>
</tbody>
</table>
### Key issues for NHS Lothian

#### Gypsy Travellers
Gypsy Travellers experience high morbidity and have lower life expectancy.

#### Minority Ethnic Communities
Many people from minority ethnic communities experience difficulties accessing services related to language or cultural barriers, or lack of familiarity with services.

#### People with Different Religions or Beliefs
43% of the Lothian population identified as no religion, 47% Christian, 2% Muslim in the 2011 census.

#### People Living in Poverty
11% of the Lothian population is classified as income deprived by SIMD 2012

- Average pay is lower in West Lothian than the Scottish average. Pay for Midlothian residents and people who work in East Lothian is also low.
- Research suggests that between £350 and £550 per working adult is being lost in Lothian households as a result of welfare reform. Most of these financial losses will affect people already on low incomes, notably people with disabilities and lone parents with children.
- Poverty often clusters in certain geographical neighbourhoods, but most people who are income deprived do not live in the most deprived neighbourhoods. This is particularly the case for some minority ethnic groups.
- Poverty is a strong risk factor for poor health and lower life expectancy. For almost every health indicator there is a clear gradient showing better health with increasing affluence. Poverty compounds the impact of social inequalities, and often co-exists with other disadvantages.

#### Homeless People
Homeless people suffer substantially poorer physical and mental health than the rest of the population. Health starts to deteriorate within two weeks of homelessness and there is a high risk of substance misuse.

#### People Involved in the Criminal Justice System
Prisoners are predominantly young, male, white and from disadvantaged backgrounds. Three quarters (73%) of prisoners have an Alcohol Use Disorder, with 36% possibly alcohol dependent. When studied, 73% tested positive for illegal drugs on admission to prison and 17% tested positive on liberation. 76% of prisoners smoke. 1 in 5 are estimated to be Hepatitis C positive.

- The NHS is now responsible for Prison Health.

#### People with Low Literacy/Numeracy
Educational inequalities have a significant and independent impact on health. 27% of Scottish adults face occasional challenges and constrained opportunities due to literacy difficulties, but will generally cope with their day-to-day lives. 4% have problems that affect their ability to cope with day-to-day life.
Population  Key issues for NHS Lothian
Health literacy is the ability to obtain, read, understand and use healthcare information. People with poor health literacy have poorer outcomes but simple tools, eg Teachback, can mitigate this.

Carers  9% of Lothian adults provide unpaid care. 5% provide between 1 and 19 hours per week, 2% provide more than 50 hours.

Unpaid carers are disproportionately women and older. Being a carer can lead to isolation, loss of income and harm to the carer’s own health.

Children can also be carers, with adverse impacts on their own education, health and wellbeing.

NHS Lothian Staff  NHS Lothian is a large employer and directly employs over 23,000 people. 78% of the workforce is female, 5% is from a non-white ethnic group, 34% is aged over 50 years. Many will be carers, or have a long term condition or disability.

The inequalities gradient in Lothian
The graph below shows the gradient in health outcomes by deprivation, measured by the Scottish Index of Multiple Deprivation (SIMD). For almost any measure of health there is a gradient showing poorer outcomes with increasing deprivation. This has a significant human cost in suffering, mortality and morbidity.

There is also a financial cost, as increasing morbidity due to deprivation results in higher need for health care, with higher rates of outpatient attendances, hospital admissions and use of primary care services. The graph below shows the gradient in emergency hospital admissions.
EMERGENCY ADMISSIONS RATES: 2010/11
AGE-SEX STANDARDISED RATES PER 1,000 POPULATION

Least Deprived

Most Deprived
POLICY CONTEXT, CAUSES AND INTERVENTIONS

Policy context

Social injustice is killing people on a grand scale.


Health inequalities are recognised as a priority locally, nationally and internationally. The Scottish Government produced Equally Well, the report of the ministerial review of health inequalities, in 2008. This recognised the need for cross sectoral work to reduce health inequalities. It contained 78 recommendations across a range of policy areas including actions relating to the early years, improving physical environments, tackling poverty, addressing specific harms to health and support for vulnerable groups. Equally Well was reviewed in 2010 and again in 2012/13, with support from NHS Health Scotland which led a policy review to identify the areas to focus on.

In 2008 the World Health Organisation published the report on the Global Commission on the Social Determinants of Health, led by Sir Michael Marmot. This contained three overarching priority recommendations: improve daily living conditions; tackle the inequitable distribution of power, money and resources; measure and understand the problem and assess the impact of action. Michael Marmot has subsequently led a European review of health inequalities and a review for the English Department of Health that resulted in the Fair Society Healthy Lives report. This contained six strategic objectives:

- Give every child the best start in life
- Enable all children, young people and adults to maximize their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and developing sustainable places and communities
- Strengthen the role and impact of ill-health prevention.

Although these reports have been produced in different contexts for different audiences, they all recognise that health inequalities reflect wider social inequalities, and cannot be tackled by the health sector alone.
Understanding the causes of health inequalities

Put simply, the higher one’s social position, the better one’s health is likely to be…These serious health inequalities do not arise by chance, and they cannot be attributed simply to genetic makeup, ‘bad’, unhealthy behaviour, or difficulties in access to medical care, important as those factors may be. Social and economic differences in health status reflect, and are caused by, social and economic inequalities in society.’

Michael Marmot. Fair Society Healthy Lives, 2010

The existence and width of health inequalities cannot be attributed to a single clinical or behavioural risk factor. They are the result of social circumstances and reflect the underlying distribution of power and resources in the population.

It is now accepted that the underlying roots of health inequalities relate to the unfair distribution of power, money and resources. The social and political forces that maintain this unfair distribution are termed the ‘fundamental causes’ of health inequalities. These fundamental causes affect the distribution of wider environmental influences such as the availability of jobs, good quality housing, education and learning opportunities, access to services, social status. This results in differences in individual experiences of, for example, discrimination, prejudice, low income, poor opportunities. This is illustrated in the model below.

Figure: Fundamental Causes of Health Inequalities

These differences in individual experiences affect people’s health in three main ways:

- **Differential exposure** to environmental, cultural, socio-economic and educational influences that impact on health.

- The psychosocial consequences of **differences in social status**. There is now strong evidence that ‘status anxiety’ leads to psychological and physiological changes that affect health.

- Accumulation of these effects over the **lifecourse**. The inequalities in health that are observed now will reflect not only current status but also differences in experiences at earlier stages in life. This is why interventions targeting families and the early years are so important.

**What should we do about health inequalities?**

*Tackling health inequalities is a matter of social justice. It’s unacceptable in 21st century Scotland that some people can expect to die earlier than others, simply due to an accident of birth or circumstances.*

*Scottish Government. Equally Well, 2008*

The description of the causes of health inequalities suggests that no single approach is sufficient to reduce health inequalities - concerted efforts are required across many partners at local and national levels.

There are three types of action that are needed:

- Actions that **mitigate** the health and social consequences of social inequalities. People who are socially disadvantaged have higher health needs and the level and intensity of service provision should reflect that. These actions target the effects - shown on the far right of Figure 1.

- Actions that help individuals and communities **resist** the effects of inequality on health and wellbeing. These include targeted health improvement activities, community development activities that increase social capital in deprived areas, improvements to
the physical environment in deprived areas. These are predominantly addressing individual experiences and environmental influences as shown in Figure 1.

- Actions that undo the underlying structural inequalities in power and resources. These are the most challenging to implement. They include provision of high quality universal services such as education, housing, employment and improved environments particularly in the most deprived areas. But ultimately undoing structural inequalities requires fundamental socio-economic and political measures. These may include economic policies that support social mobility and prevent high wage differentials; income maximisation services; reducing the democratic deficit across the social spectrum; increasing the number of people on the electoral roll. Key policy areas for action to reduce social and health inequalities are employment, income and education.

**Structural, population approaches – v- individual approaches**

Evidence from the scientific literature suggests that interventions that are most likely to be effective in reducing health inequalities are structural changes to the environment, legislation and regulatory controls, fiscal policies, reducing price barriers, income support, accessibility of public services, prioritising disadvantaged groups, and intensive support for vulnerable population groups.

Interventions least likely to reduce health inequalities include mass media campaigns, written materials, campaigns reliant on people opting in; messages designed for the whole population, or approaches that involve significant cost or other barriers.

**Health improvement – v - health inequalities**

It is important to distinguish between health improvement activities and actions to reduce health inequalities, as they are often confused. Health improvement includes policies, actions and interventions designed to improve health and prevent ill health. They target people who are currently well, rather than healthcare interventions for people who are, or perceive that they are, unwell. Health improvement activities are usually delivered to groups or whole populations rather than individuals. Health improvement activities do not necessarily reduce health inequalities unless specifically targeting disadvantaged groups. They may actually increase inequalities if affluent people are better able to act on them.
Actions to tackle health inequalities may include targeted delivery of healthcare to mitigate health inequalities; targeting of health improvement activities; and actions that seek to address the fundamental causes discussed above.

**Targeting of interventions**

A common approach to tackling health inequalities is to target support and interventions to the geographical areas identified as being deprived, most commonly the most deprived 15% areas measured by the Scottish Index of Multiple Deprivation (SIMD). There are several reasons why this approach cannot reduce health inequalities on its own:

- Many disadvantaged people do not live in these deprived areas – only about half of people who are income deprived live in the 15% most deprived areas by SIMD. So if an intervention is provided only to people living in targeted areas, other equally needy people will miss out.
- As noted earlier, health inequalities do not only affect the most disadvantaged groups of people but occur across the socio-economic gradient. Even if these targeted interventions could raise the level of health of the people in the targeted areas to that of people in the most affluent areas, there would still be a gradient in the rest of the population.
- Similarly, this approach is only concerned with socio-economic inequalities (using geography as a crude proxy) and misses inequalities relating to other characteristics such as race or disability.
- Actions that only target the most deprived communities implicitly situate the problem with those communities rather than with the fundamental causes and are unlikely to tackle these fundamental causes.
- Explicit targeting may actually exacerbate harm by labelling and stigmatising those communities.

Despite these caveats, targeting is appropriate for many situations. Clearly, interventions seeking to improve health and mitigate health inequalities should be provided in proportion to the level of ill health. And poor physical and social environments in some communities leads to poorer health in the people who live there. So it often makes sense to target environmental interventions geographically – examples would include improvements to greenspace or interventions to increase social capital, especially linking social capital that supports people to link with others in other groups and communities. But for the reasons above, it is important that individually focused interventions are provided universally, but with
greater quantity of service, and strong locality working, in the areas where the need is greatest. The Fair Society Healthy Lives report called this ‘proportionate universalism’.

**The role of healthcare organisations**

Although all the major policy documents identify that health inequalities requires a multi-sectoral response, some recent reports have considered the specific role of health organisations. The most obvious role is to mitigate and prevent health inequalities by providing healthcare and health improvement interventions in proportion to need.

High quality, universal healthcare that is available to everyone with no or minimal cost barriers is in itself important to mitigate and reduce health inequalities. But within the universal service there are often other barriers that prevent some disadvantaged groups of people from receiving care. These include physical, social, environmental and practical barriers such as mismatch between service design and patient need, cultural differences between patients and staff, low expectations, poor experience, transport costs and lack of capacity where the need is highest. These all contribute to what is termed the ‘inverse care law’ – that quantity and quality of care may be poorest for those with the highest needs.

The ‘Deep End’ group of general practices serving populations living in deprived areas has identified the increased workload for these practices and advocates that practices in deprived areas should have a package of additional support to meet the health needs of their populations. The package includes additional GP time; attached specialist workers; link workers to improve joint working with other services including the third sector.

A Canadian report identified the following priorities to ensure health services meet the needs of a culturally and linguistically diverse population:

- Develop health equity targets and plans in consultation with communities and community members.
- Improve health literacy.
- Increase equitable access to prevention and curative services for underserved populations.
- Develop inter-sectoral collaborative and knowledge exchange mechanisms.
- Increase the capacity of the health system to serve the needs of the diverse population.
The Institute for Health Equity identifies the following areas of work that NHS organisations can do to help reduce health inequalities:

- Workforce education and training – to build awareness of health inequalities and skills to work with all communities.
- Working with individuals and communities – build relationships of trust and respect, take a social history and use to tailor support to individuals’ needs, refer to services that address root causes.
- NHS organisations – ensure NHS provides good work for its staff, use purchasing power to support local community, culture of equality and fairness.
- Work in partnership
- Advocacy

This has been summarised further in a NHS Health Scotland document as follows:

- The quality of services the NHS plans and provides
- What the NHS does in partnership
- The NHS as an employer and procurer
- The advocacy role of the NHS

These reflect the mitigate/prevent/undo framework outlined above.
CURRENT ACTION IN NHS LOTHIAN

Reducing health inequalities requires effective partnership working across a range of organisations.


NHS Lothian has recognised health inequalities as a priority for many years. In 2006 the NHS Board approved a Strategic Framework that outlined its role to take forward three strands of work:

1. Work to ensure that mainstream services are accessible by and appropriate for all groups within the population. This includes use of impact assessment to ensure new services are planned to be equitable, and equity audits of service areas to identify and address inequalities in access or outcomes.
2. Work to provide additional support to ensure that specific disadvantaged groups can access NHS services. This includes provision of targeted services or advocacy that helps people access services.
3. Partnership work with other organizations to help address the determinants of health inequalities. NHS Lothian action with partners to address underlying causes of health inequality includes targeting of health improvement activities; provision of welfare advice in health settings; partnership with employability services and providing intensive support to vulnerable families.

Strands 1 and 2 are ways in which NHS Lothian can target its work to mitigate health inequalities, whereas strand 3 contributes to help prevent and undo inequalities. Since the strategic framework was approved, it has been used to structure health inequalities work. As a framework rather than a strategy, there was no overall action plan or separate monitoring framework but NHS Lothian has implemented a series of interventions to meet the needs of particular vulnerable populations. In addition, Rapid Impact Assessment is now used routinely to ensure new plans consider differential impacts.

The Board also has an Equality Outcomes Action Plan that details work to improve outcomes for people with protected characteristics as defined in the Equality Act. The group developing of this strategy undertook some scoping of the range of work that NHS Lothian is currently doing to mitigate, prevent, and undo health inequalities. This is summarised in the table below.
### Current NHS Lothian actions to address health inequalities

<table>
<thead>
<tr>
<th>Action on health inequalities</th>
<th>Mainstream Services</th>
<th>Specialist Services</th>
<th>NHS as employer</th>
<th>Procurement and capital planning</th>
<th>Wider Partnerships</th>
<th>Outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mitigate</strong> the severity of the health and social consequences of social inequalities</td>
<td>High quality universal primary care</td>
<td>Services that are specifically for disadvantaged populations such as Keep Well; Access Practice; MEHIS; Willow; advocacy support etc</td>
<td>Staff training and support to ensure staff understand impact of deprivation and respond appropriately</td>
<td>New NHS buildings meet the standards set out in the Healthy Built Environment strategy.</td>
<td>Social care/voluntary sector provision that is targeted according to need</td>
<td>Reduced mortality and morbidity in identified disadvantaged groups</td>
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<td></td>
<td>Amendments to mainstream services to ensure they are appropriate for all groups – eg communication support/transport/location of service/reminders etc</td>
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<td></td>
<td>Use of RIA, equity audit etc to assess whether services are equitable, with changes accordingly</td>
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<tr>
<td></td>
<td>Higher provision of mainstream community services in communities with higher needs</td>
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<tr>
<td></td>
<td>Prioritisation of the universal services</td>
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<tr>
<td>Prevent the effects of inequality on health and wellbeing.</td>
<td>Prioritisation of services for early years</td>
<td>Prioritisation of health promotion, preventive, community and primary care services – these all are needed most by the most disadvantaged</td>
<td>Health improvement initiatives that are targeted specifically to disadvantaged groups</td>
<td>HR policies that minimise job strain and increase job control</td>
<td>Implementation of actions in Sustainable Development Action Plan – to minimise future inequalities arising from climate change</td>
<td>Input to SOA indicators</td>
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<tr>
<td><strong>Undo</strong> the underlying structural inequalities in power and resources</td>
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<tr>
<td>Services within health settings that address poverty and inequality eg:</td>
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<td>Benefits and money advice</td>
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<tr>
<td>Health literacy support</td>
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<tr>
<td>HR policies that reduce social gradients</td>
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<td>Targeted recruitment/support to access employment for people furthest from the labour market</td>
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<td>Equal opportunities policies</td>
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<tr>
<td>Procurement policies that provide community benefit – particularly employment of groups that are furthest from the labour market</td>
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<tr>
<td>NHS as advocate:</td>
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<tr>
<td>Input to SOA indicators</td>
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<tr>
<td>Support for universal services/policy that reduces gaps - especially related to education, employment, income max etc</td>
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<tr>
<td>Reduced gap across population in resources/power/status</td>
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</tbody>
</table>
Health inequalities is a ‘wicked issue’ that needs concerted action and changes across many different organisations at different levels. Reducing the underlying inequalities in income, wealth and power needs actions to focus on income, employment and education. The NHS may have a more limited role in ‘undoing’ the underlying social inequalities but has an important role to mitigate the health consequences. Within the NHS, the overall approach to mitigate and tackle health inequalities should include:

- Using the potential of the NHS as a large employer and through procurement to provide employment, education and training opportunities with fair terms of employment for all staff.

- Ensuring services are available and accessible to all, and are delivered proportionate to need, to reverse the ‘inverse care law’. This means increasing provision of geographically based primary and community services in the areas with highest needs.

- Increasing the priority given to primary and community services relative to secondary and tertiary services, as the most disadvantaged groups benefit most from these.

- Increasing the priority given to early years and preventative interventions relative to interventions in later life, as the most disadvantaged groups benefit most from these.

- Ensuring the social issues that impact on patients’ health and ability to use healthcare are viewed as legitimate issues for health professionals to consider, are systematically recognised, patient management reflects these needs and patients are referred or signposted to appropriate support.

- Investing in partnerships with voluntary sector and other organisations that are better placed to address social issues that affect patients’ health.

- Working with partners to raise awareness of underlying causes and to advocate for policies and interventions that reduce inequalities in income, wealth and power.

Fully implementing these may be challenging and requires a long term commitment throughout NHS Lothian. This cannot be delivered by one service alone, or by a few projects or initiatives. The action plan below presents the detailed actions that are planned for the three years 2014-17, with some key measures of progress. In addition to these specific actions, NHS Lothian will continue to prioritise the areas noted above and recognise the responsibility of all parts of the organisation to support these in order to tackle health inequalities.
## NHS Lothian Health Inequalities Strategy Action Plan 2014-17

### Procurement

<table>
<thead>
<tr>
<th>Project</th>
<th>Lead</th>
<th>Milestones</th>
<th>Measure</th>
</tr>
</thead>
</table>
| Develop use of community benefit clauses in contract specifications and procurement strategies | Community Benefits Group | Community benefits tracking report – November 2014  
Agreed increase in targeted community benefits in project specifications – as new projects specified, review November 2015  
Realisation of agreed benefits – according to projects’ timescales | Numbers of training opportunities  
Numbers of apprenticeships  
Spend in Supported Businesses |

### NHS Lothian as employer

<table>
<thead>
<tr>
<th>Project</th>
<th>Lead</th>
<th>Milestones</th>
<th>Measure</th>
</tr>
</thead>
</table>
| Increase support and training for NHS Lothian staff on financial and IT literacy | Health Promotion/ Learning and Development | Review uptake of training currently in place - Expand and/or redesign current training | Number of people accessing training/support  
Self reported confidence with financial/IT literacy |
| Continue to pay all staff at least the living wage | HR | Currently in place  
Continue to monitor | Number of staff below living wage |
| Increase recruitment opportunities for young people and vulnerable groups through socially responsible recruitment programme | Socially Responsible Recruitment Group | Programmes identified for the following groups:  
School leavers  
Vulnerable young people, including those with a disability  
Graduates with a disability  
People with learning disabilities  
People with autism  
People who have been long term unemployed  
Women returning to work, education or training | Numbers of people from identified vulnerable groups offered placements/training  
Numbers of people recruited from identified vulnerable groups  
Number who sustain employment >6mths |
<table>
<thead>
<tr>
<th>Clinical services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project</strong></td>
</tr>
<tr>
<td>Staff training to enable them to respond to social &amp; economic circumstances affecting patients’ health. This should include cultural competence.</td>
</tr>
<tr>
<td>Train staff in health literacy tools &amp; techniques to improve patient safety, communication, self management &amp; understanding and inform about available resources</td>
</tr>
<tr>
<td>Develop, learn from and build on initiatives that seek to increase capacity in primary care to mitigate health inequalities and identify ways to sustain these if successful</td>
</tr>
<tr>
<td>Develop routine use of ‘work outcomes’ in patient recovery plans</td>
</tr>
<tr>
<td>Activity</td>
</tr>
<tr>
<td>---------</td>
</tr>
</tbody>
</table>
| Identify patients at risk of financial insecurity and enable access to appropriate services | NHS Lothian Welfare and Employability Advice Group | Prepare information for staff and patients on sources of advice and support – completed October 2014.
- Pilot use of screening questions in 2 settings - Sep 2015.
- Increased use of screening questions, with associated training and support – March 2015.
| Number of settings routinely asking about financial insecurity | Number of patients signposted to appropriate services |
| Increase number of NHS settings with access to and links with welfare advice and income maximisation services | NHS Lothian Welfare and Employability Advice Group | Brief prepared scoping current welfare advice services – Jan 2015.
- Plan to increase access to welfare services – developed by March 2015, implemented from April 2015.
| Number of NHS settings with access to and links with welfare advice service |
| Ensure evidence based vocational rehabilitation services available to support those with health conditions to return to/retain employment | Health Works Strategy Group | Business case for service prepared, will include agreement on future service and links with DWP service - March 2015.
| Number of patients seen by WHS
- Proportion of employed patients who retain employment at 3 and 6 months
- Proportion of previously out of work patients who gain employment, which is retained at 6 months |
| Use findings from Early Years Collaborative and implement identified best practice across NHS Lothian. | Early Years Collaborative Workstream groups | Use improvement methodology to increase documentation of Healthy Start eligibility and increase proportion of eligible women and children who receive vouchers. – March 2016.
- Increase access to other information and advice for vulnerable families through partnership with other agencies.
| Proportion of pregnant women with documentation of Healthy Start eligibility and recorded as being eligible for Healthy Start at booking
- Proportion of eligible women and children receiving vouchers
- Proportion of eligible women receiving Healthy Start vouchers by 16 week antenatal appointment |
<table>
<thead>
<tr>
<th>Implement Learning Disability Health Inequalities Plan to ensure NHS services can meet needs of people with learning disability</th>
<th>Learning Disability Health Inequality Group</th>
<th>Implementation the Learning Disability LDP guidance. Mainstream learning from test site work, developing social prescribing for people who may have a learning disability. Evaluate and use findings from LD Health Inequality enquiry events held in 2014. Ensure all public facing health information is delivered in accessible formats.</th>
<th>Number of people accessing social prescribing. Relevant measures to be developed to reflect findings from enquiry events. Number of information resources available in accessible formats.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ensure Health &amp; Social Care Partnership Strategic Needs Assessments explicitly assess significant inequalities in each area and identify opportunities to mitigate health inequalities</td>
<td>Public health/Health and Social Care Partnerships</td>
<td>Strategic needs assessments completed including identification of inequalities, vulnerable groups, and relevant actions – April 2015. Ensure needs assessments and commissioning plans prioritise prevention, early intervention, primary and community services and address inequalities across the lifecourse.</td>
<td>Explicit demonstration of inequalities issues within each needs assessment.</td>
</tr>
<tr>
<td>Ensure patient pathways in the Strategic Plan identify vulnerable groups and ways to improve their ability to access effective care</td>
<td>Public health/leads for each pathway</td>
<td>Impact assessment or inequalities report completed for each pathway. Recommendations included in pathway work.</td>
<td>Explicit demonstration of inequalities issues within each pathway.</td>
</tr>
</tbody>
</table>
IMPLEMENTATION AND MONITORING

The action plan above identifies a group or service to lead each of the actions. Some of these are existing groups but others have been established specifically to implement the actions in this strategy. These groups are responsible to deliver the actions and report back to the Strategy Group.

The Strategy Group will meet quarterly to review progress against these actions and identify and seek to address any problems or issues that arise in their implementation. The group will report to the NHS Lothian Strategic Planning Group.

As well as reviewing progress with the short term actions, the Strategy Group will also continue to raise awareness of health inequalities, influence other strategies and plans, and develop other areas of action to reduce health inequalities.

The group will review this strategy in three years.

SELECTED BIBLIOGRAPHY


Executive Summary

The Vale of Leven Hospital Inquiry Report

The Rt Hon Lord MacLean Chairman

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APS Group Scotland
DPPA23140/11/16

2.9
The Vale of Leven Hospital Inquiry Report

The Rt Hon Lord MacLean Chairman

Executive Summary
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Chairman’s letter to the Cabinet Secretary

The Vale of Leven Hospital Inquiry

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Cabinet Secretary for Health and Wellbeing
St Andrew's House
Regent Road
EDINBURGH
EH1 3DG

November 2014

Dear Cabinet Secretary

On 21 August 2009, I was appointed by the then Cabinet Secretary for Health and Wellbeing to hold a public inquiry into the occurrence of Clostridium difficile infection at the Vale of Leven Hospital from 1 January 2007 onwards, in particular between 1 December 2007 and 1 June 2008, and to investigate the deaths associated with that infection.

The Terms of Reference were very wide-ranging and I have addressed these, I hope, comprehensively, as can be seen from the Report which I now present to you.

Yours sincerely,

Rt Hon Lord MacLean
Chairman
Foreword

The evidence adduced by the Inquiry was concluded on 28 June 2012. In July 2012 I entered hospital for what was then regarded as a fairly routine operation. The operation itself was concluded successfully but shortly thereafter my condition began to deteriorate as a result of an infection of unknown aetiology which necessitated a prolonged period of intensive care and hospitalisation for a total of five months. I may say that the irony of this was not lost on me during the time I remained in hospital. The experience did, however, enable me better to understand the plight of those who suffered from \textit{C. difficile} infection and in some cases died from it, in the Vale of Leven Hospital.

I narrate all this, not in anyway to evoke sympathy for myself but in order to pay tribute to the Inquiry team who responded so superbly to the crisis they then had to face, namely carrying on the work of the Inquiry effectively without its Chairman. A central core of the staff, made up of the Secretary, leading Counsel to the Inquiry, and its Principal Solicitor, visited me regularly in hospital, consulted me there, and received instructions from me. After my discharge from hospital the same work was carried on during my convalescence at home. In order to ensure that Mr Neil, the Cabinet Secretary who succeeded Ms Sturgeon, was aware of the predicament I was in, I wrote a personal letter to him on 17 January 2013. He replied to this letter on 21 March 2013 and from the terms of that letter I believe he ultimately came to understand the problems I had had.

On 29 July 2009 I met the then Cabinet Secretary for Health and Wellbeing, Ms Nicola Sturgeon, in Glasgow. She thanked me for taking over from Lord Coulsfield. We discussed the terms of the remit. She was very keen on a time limit because, as she said, she wanted a short and sharp inquiry. She expected a report and recommendations on her desk by October 2010. In light of my previous experience as Chairman of two other Inquiries and membership of another (none of which had any time restriction) I demurred to such a time limit and explained that I did not consider it possible to fulfil the terms of such a wide remit within that time scale. I preferred a time limit of “as soon as possible”. The Cabinet Secretary, however, insisted, with the qualification that the Inquiry could always apply for an extension. I am clear that this was a mistake, for the reasons that are given more fully in the Report itself and summarised in the Introduction.
The result was that, as each so-called deadline approached and was not fulfilled, there
was a familiar chorus of criticism from certain quarters. Significantly, none of it came
from any representatives of Core Participants. Nevertheless, the Inquiry team had
to face this criticism and respond to it as best they could, when, in my opinion, they
were absolutely blameless.

If anything, the whole experience shows the futility of imposing time constraints on
an Inquiry like this, simply because one cannot at the outset know what lies ahead
of an Inquiry’s investigation. My illness was just one aspect of this. Indeed, I doubt
whether, unless in wholly exceptional circumstances, an Inquiry set up under the
Inquiries Act should be limited in point of time.

I should add that, in my not inconsiderable experience, it is very rare to have such
a cohesive and united unit as the entire Inquiry team. That is probably due to the
quite exceptional skills of leadership demonstrated by the Secretary, Julie-Anne
Jamieson who kept the show on the road, as it were, and maintained in the face of
considerable difficulties, the high level of morale which has persisted to the end. She
was exceptional.

I take this opportunity to express my gratitude to my single-minded and devoted
Inquiry team. I am grateful to all those in the team who so faithfully assisted me.

R.N.M. MacLean

Lord MacLean
November 2014
Introduction
Summary

Serious failures

Between 1 January 2007 and 1 June 2008, 131 patients who were or had been patients in the Vale of Leven Hospital (VOLH) tested positive for Clostridium difficile Infection (CDI). Of that number, 63 patients tested positive in the period from 1 December 2007 to 1 June 2008. During that particular period 28 of those 63 patients died with CDI as a causal factor in their deaths, either as the underlying cause of death or as a contributory cause of death. Another three patients who died in the course of June 2008 also had CDI as a causal factor in their deaths. In the period 1 January 2007 to 31 December 2008 the total number of deaths identified by the Inquiry in which CDI was a causal factor was 34. These figures are particularly damning when considered in the context of the VOLH, a hospital with around 136 beds in 2008.

CDI can be a devastating illness, particularly in the frail and elderly. It can lead to malnutrition and dehydration unless carefully managed. The frequency of diarrhoea, the impact upon patient dignity, and the challenges presented to staff are some of the factors that highlight the absolute necessity of treating CDI as a serious illness. Sadly, for reasons I set out in detail in this Report, there were deficiencies in medical and nursing care at the VOLH that seriously compromised the care of this group of patients. Furthermore, the infection prevention and control practices and systems were seriously deficient.

Governance and management failures resulted in an environment where patient care was compromised and where infection prevention and control was inadequate. The important principle of Board to ward and ward to Board means that there must be an effective line of reporting, accountability, and assurance. This was lacking for the VOLH. There were failures by individuals but the overall responsibility has to rest ultimately with NHS Greater Glasgow and Clyde (NHSGGC).

It is highly likely that there were a number of undeclared outbreaks of CDI transmission in the VOLH between 1 January 2007 and 1 June 2008. Many patients were exposed unnecessarily to CDI and had to suffer the humiliation and distress often associated with the infection.

Scottish Ministers have a duty to promote the improvement of the physical and mental health of the people of Scotland. The Scottish Government is the executive branch of government in Scotland. The duty to promote the health of the people of Scotland is discharged through Health Boards, particularly within the context of healthcare acquired infections such as CDI. There was a failure to have in place an inspection regime that could provide the necessary assurance that infection prevention and control was being properly managed and important policies and guidance implemented.

Inadequate attention was given by the Scottish Government and NHSGGC to the reports about other outbreaks in the United Kingdom. These identified failures similar to many of the failures at the VOLH discovered in the course of the Inquiry. Repeated warnings over a number of years about the importance of prudent antibiotic prescribing had no apparent impact. The Scottish Government failed to monitor the implementation of the prudent prescribing message and to remedy the failure by NHSGGC to implement that message.

Prolonged uncertainty over the future of the VOLH had damaging effects on recruitment, staff morale, and the physical environment of the VOLH. The hospital environment was not conducive to good patient care. It is hardly credible that in 2007 and 2008 a care environment existed in which gaps in floor joints were covered in adhesive tape. There was a lack of wash-hand basins in wards and toilets, and commodes were not fit for purpose.

A lack of strong management as well as personal and system failures contributed to the development of a culture in the VOLH that had lost sight of what is of the very essence of a hospital – a caring and compassionate environment dedicated to the provision of the highest possible level of care.
Background to the Inquiry

Creation of the Inquiry

On 22 April 2009 the then Cabinet Secretary for Health and Wellbeing, Nicola Sturgeon, announced to the Scottish Parliament that a Public Inquiry would be held into the “outbreak” of *Clostridium difficile* at the VOLH. She explained that this would commence at the conclusion of ongoing investigations by the police and the Health and Safety Executive, and of any prosecutions resulting from those investigations. At the same time the Cabinet Secretary announced that the Rt Hon Lord Coulsfield had agreed to chair the Inquiry.

The C.diff Justice Group, which represents a number of surviving and deceased patients, was influential in the establishment of the Inquiry. In January 2009 the Group lodged a petition with the Scottish Parliament Public Petitions Committee calling for a public inquiry to ensure that lessons were learned across the NHS and that further deaths from *C. difficile* were minimised. The petition was considered by the Petitions Committee on 27 January 2009 and formally closed on 1 November 2011.

The Group’s determination to have a public inquiry has been fully vindicated by the Inquiry’s findings of significant failures from which important lessons must be learned.

In June 2009 the Lord Advocate intimated that there would be no criminal proceedings and steps were then taken to establish an Inquiry Team and define its Terms of Reference. The statements obtained by the police were passed on to the Inquiry Team.

Lord Coulsfield subsequently withdrew from the Inquiry for health reasons, and my appointment was announced in his place on 21 August 2009.

The Inquiry was formally set up on 1 October 2009. The procedure of the Inquiry was subject to the Inquiries Act 2005 (the 2005 Act) and the Inquiries (Scotland) Rules 2007 (the 2007 Rules).

No other person was appointed to sit with me. The important task of fulfilling the Terms of Reference has therefore been my sole responsibility. In carrying out that responsibility I have been greatly assisted by my Assessors and the members of the Inquiry Team.

Appointment of Assessors

To assist me in my task I appointed two Assessors, under a power granted to me under section 11 of the 2005 Act. A summary of their qualifications and experience is set out in Appendix 2. The purpose behind their appointment was that of providing me with advice on matters within their own areas of professional expertise, which included nursing and medical expertise and also expertise in infection prevention and control.

The Assessors were appointed on 14 October 2009. They participated in the preparations for the oral hearings and attended the oral hearings, and I was able to rely on their advice in the course of the drafting of the Report. Their joint contribution to the Inquiry process proved invaluable, as nursing and medical matters and issues of infection prevention and control became central to the work of the Inquiry. I am extremely grateful to them for that contribution and for the commitment they continued to make to an Inquiry process that took longer than anticipated.

Meeting with NHS Greater Glasgow and Clyde Board members

Lord Coulsfield and the Secretary to the Inquiry met with NHSGGC Board members on 11 June 2009. That was an informal meeting and was not part of the evidence gathering process. It was agreed at that meeting that there could be a single point of contact within the Board for the Inquiry. I, however, did not consider it necessary to have a further meeting with Board members.

Meeting with patients/relatives

Lord Coulsfield met patients and relatives on 12 June 2009, and following my own appointment as Chairman I decided that it would also be appropriate for me to have a similar meeting. That meeting took place on 25 September 2009, and was attended by one former patient and 17 relatives of
patients. I found the meeting to be highly productive, and I gained the clear impression that the patient and relative group as a whole was anxious to be as helpful as possible to the Inquiry. Quite understandably they wanted to find out why CDI became such a problem in the VOLH.

The scope of the Inquiry

Terms of Reference

The Terms of Reference agreed with the Cabinet Secretary were in the following terms:

a) To investigate the circumstances contributing to the occurrence and rates of *C. difficile* infection at the Vale of Leven Hospital from 1 January 2007 onwards, and any increases in such rates during that period and in particular between 1 December 2007 and 1 June 2008, with particular reference to the circumstances which gave rise to deaths associated with that infection.

b) To investigate the management and clinical response at the Vale of Leven Hospital to the *C. difficile* infection rates during that period and to any such increases, and the steps taken to prevent or reduce the risk of spread or recurrence of the infection.

c) To investigate the systems in place at the Vale of Leven Hospital to identify and notify cases, increased rates of infection outbreaks and deaths associated with *C. difficile* infection, including the action taken to inform patients, their relatives and the public and the steps taken at the Vale of Leven and in NHSScotland generally for recording such incidents including for the purposes of death certification.

d) To investigate the actions of NHS Greater Glasgow and Clyde in response to the occurrence of *C. difficile* infection at the Vale of Leven Hospital, including informing patients and their relatives of the risks of such infection and the measures that should be taken to assist prevention and control.

e) To investigate the governance arrangements of NHS Greater Glasgow and Clyde in relation to, and the priority given to, the prevention and control of the infection.

f) With reference to experience within and beyond Scotland of *C. difficile*, to establish what lessons should be learnt and to make recommendations.

g) To report by 30 September 2010 unless otherwise provided by the Cabinet Secretary for Health and Wellbeing.

The Cabinet Secretary granted several extensions to the reporting date in accordance with paragraph (g) of the remit.

The breadth of the Terms of Reference

What is significant about the Terms of Reference is their breadth. I have already made the point in the Foreword that I did not consider it possible to report by a specified date, initially 30 September 2010. The Cabinet Secretary’s response was the addition of the provision in paragraph (g) for extending the time limit. That did not allay my concerns. While it is readily understandable that the responsible Minister should wish an inquiry to report at the earliest reasonable opportunity, until the work of an inquiry is well under way any prediction about a time limit cannot be accurate and may be totally unrealistic. The Inquiry Team must conduct an initial investigation. Only once that initial stage is substantially complete will it become apparent what further investigation is necessary. A further factor that could not have been foreseen at the outset was that of the problems encountered in the recovery of documents, discussed later in the Report. These problems became a running sore that bedevilled the work of the Inquiry even into 2012.

For reasons set out in this Report, including the nature and extent of the Terms of Reference and the size of the task that emerged, the successive deadlines were impossible to meet. When that was apparent to me, I notified the Cabinet Secretary at the
earliest opportunity. As it turned out, because of the amount of work involved in the initial investigation, the first phase of oral hearings did not take place until June 2010, just four months before the original latest reporting date of September 2010.

The first application for an extension of time was in fact made on 10 December 2009, and following that the reporting date was extended to 31 May 2011. Subsequent extensions were necessary to allow the Inquiry to carry out as thorough an investigation as possible into the terms of the remit. The final phase of oral hearings was not completed until June 2012.

The lesson to be learned from this experience is that, except in circumstances where the issue is clear and the remit is a relatively narrow one, specific deadlines should not be imposed on public inquiries of this kind. A formula “as soon as possible” or even “as soon as practicable” should be seen as a much better option. No inquiry Chairman would fail to respond to that form of remit in a timeous manner. Unrealistic deadlines of the kind contained in the Terms of Reference create unrealistic expectations in the minds of those waiting for the Report to be published. They also create undue and unfair pressure on the Inquiry Team.

The broad nature of the remit as set out in paragraphs (a) to (g) of the Terms of Reference reflects the Cabinet Secretary’s intention, when the setting up of the Inquiry was announced in the Scottish Parliament on 22 April 2009, that relevant lessons “must be learned by everyone in the NHS”.

**Interpretation of the Terms of Reference by NHS Greater Glasgow and Clyde**

On 11 May 2011 the NHS Central Legal Office (CLO), acting on behalf of NHSGGC, delivered a Note to the Inquiry intimating an objection to evidence being led on aspects of the quality of nursing care provided to patients covered by the remit. That Note was revised on 12 May 2011. The principal thrust of the objection was in the following terms:

“On the ground of fairness specified in s.17 of the Inquiries Act 2005 (“the 2005 Act”), and also in reference to the need (s.17(3) of the 2005 Act) to avoid any unnecessary cost (whether to public funds or to witnesses or others), GGHB respectfully submits that no evidence should be allowed or taken into account concerning various aspects of the quality of nursing care (“the aspects objected to”) at the Vale of Leven Hospital in the period to date, namely hydration of patients; preparation of fluid balance charts and completion of these; nutrition of patients; completion of nutrition assessments and food charts, and the need to involve a dietician; weighing of patients; guarding against and dealing with skin and pressure damage, and taking tissue viability precautions; carrying out manual handling risk assessments; carrying out falls risk assessments; avoiding patients being injured through falling; providing proper pain relief; completion of care plans (except for care plans relevant to the contraction of Clostridium difficile illness or the mortality rate there from); assessing the mental state of patients and meeting their mental health needs; the quality of the personal care given to patients; Do Not Attempt Resuscitation (“DNAR”) decisions; and providing end of life care pathways”.

**Ruling on NHS Greater Glasgow and Clyde’s objection**

With little hesitation I repelled the objection taken on behalf of NHSGGC. The solicitor to NHSGGC was advised of my ruling and my reasons by letter dated 12 May 2011. I concluded that the issues of concern raised in the nursing expert reports were in areas of nursing care which might be directly relevant to the circumstances contributing to the occurrence and rates of CDI at the VOLH. It has to be emphasised that good nursing care lies at the very heart of the appropriate management of patients who contract CDI. That care does not just begin when the diagnosis of CDI has been confirmed. Patient care has to be seen as a dynamic
process that involves regular assessment and reassessment. A patient who develops CDI may require to be managed not just for the direct effects of the infection itself, for example by the administration of antibiotics, but also for other aspects of care on which CDI might have an impact, such as hydration, nutrition, pressure management, and the risk of falls and impaired mobility due to the debilitating nature of the condition. While Do Not Attempt Resuscitation (DNAR) decisions may be only indirectly linked, these decisions can be relevant to the care of patients suffering from CDI.

Renewal of the objection
At the oral hearing on 23 August 2011 Counsel for NHSGGC renewed the objection to the leading of evidence on certain aspects of care. By this time almost all the evidence of the nursing experts had been led. At this point the challenge was more restricted in nature, with the focus now only on some aspects of care. For example, it was not now being suggested that the nursing management of hydration and nutrition was not relevant to the issues that I required to examine.

Having heard the argument on this renewed objection I again refused to sustain it. It was in principle the objection that had been taken earlier and repelled, and no good reason was advanced for its renewal after almost all the nursing evidence had been led. It had been clear in advance from the nursing expert reports what evidence was going to be led. As I have already explained, there are aspects of nursing care that cannot be divorced from consideration of how a patient suffering from CDI is being managed. Hydration and nutrition are clear examples, and no doubt that is why NHSGGC did not renew its objection to those aspects of care at the oral hearing. Counsel for NHSGGC argued that the Inquiry should focus only on the care planning relevant to the contraction or persistence of CDI, but the fallacy underlying that argument is the assumption that the care planning for a patient who is suffering from CDI can be properly managed without regard to all that patient’s problems.

Furthermore, I was satisfied that the issue of whether any aspects of patient management were outwith the Terms of Reference was a matter that could be determined at the end of the evidence without causing any material delay to the progress of the Inquiry. In addition, most of the nursing expert evidence having been led, I was of the view that, in fairness to nurses whose standard of care had been criticised, they should be given the opportunity to respond to that criticism.

The focus and early period division
The Terms of Reference stipulate in paragraph (a) that the starting date for my investigation of the circumstances contributing to the occurrence and rates of CDI is 1 January 2007. There is no specified end date, but that same paragraph does provide that particular attention is to be directed to the period from 1 December 2007 to 1 June 2008. This period had been looked at by other Inquiries. In this Report I have labelled the period from 1 January 2007 to 30 November 2007 the “early period”, and the period from 1 December 2007 to 1 June 2008 the “focus period”.

Clostridium difficile infection

Clostridium difficile

Clostridium difficile (C. difficile) is a bacterium that can cause infection in the colon. Up to 4% of healthy adults carry C. difficile in the colon. That percentage may increase to 50% in hospital, particularly in the elderly and newborn infants. These patients may not have the infection, but clearly the risk of the infection developing increases significantly in a hospital environment. There are numerous different strains of C. difficile, and some strains are said to be more virulent than others. These strains are normally referred to as “hypervirulent” strains because they produce high levels of toxins. It has to be stressed, however, that any strain of C. difficile has the potential to cause severe infection.

To acquire the organism, spores must enter the mouth and be swallowed. Many people are exposed to spores, but C. difficile generally does not colonise in healthy people and

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cause infection. This is because the normal healthy bacteria in the colon protect against the development of the infection. It is when these protective mechanisms are disrupted that *C. difficile* can colonise in the colon and result in infection. This disruption is usually caused by the administration of antibiotics in the treatment of another infection, for example, a urinary tract infection. This is particularly so when patients are treated with broad spectrum antibiotics, because these antibiotics eradicate many normal bacteria in the colon, making the colon more susceptible to the development of CDI. This is why prudent antibiotic prescribing is so important in patient management. An infected patient will normally develop diarrhoea, and in a hospital there is the risk of the environment being contaminated, with other patients being put at risk. Good hand hygiene is important as a preventative measure.

From an infection prevention and control perspective, the isolation of a symptomatic patient from other patients is important. Unfortunately, as set out in the Report, the general practice in the VOLH was not to isolate patients until the infection was actually diagnosed by means of a positive laboratory result. This practice meant that other patients continued to be placed at risk of cross infection.

**CDI symptoms**

There are a variety of symptoms associated with CDI. I have already mentioned diarrhoea, which when caused by CDI is often described as “explosive”. Symptoms can also include abdominal pain, fever and nausea. In some cases the colon can become severely inflamed, a condition known as pseudomembranous colitis. This can become acute, resulting in toxic megacolon - acute distension of the colon. CDI must therefore be regarded as a serious illness that can be life-threatening, and I have already set out the number of patients covered by my remit who died with CDI involved in the death. The elderly are particularly vulnerable. Professor George Griffin, Professor of Infectious Diseases Medicine at St George’s University, London, whose evidence is considered later, provided the following graphic description of the impact of CDI:

“*C. difficile* is very unpleasant for patients. It is exceedingly unpleasant and distressing for relatives to see an old, loved patient in a bed in a pool of faeces. It is very difficult for nursing staff to have to clean a patient nine, ten times a day who is demented, immobile, (and) can’t help the nurse with moving”?

For a patient to contract CDI in a hospital setting, a setting where the patient expects to be protected and safe, is especially tragic. CDI can deny an elderly patient a peaceful and uncomplicated death, and that is one particular reason, among others, why what was allowed to happen in the VOLH should never be allowed to happen again.

**The Vale of Leven Hospital**

**Changes in hospital management**

The Vale of Leven District General Hospital (this is its full title) is one of the smaller hospitals in the National Health Service in Scotland. It is located in the town of Alexandria, West Dunbartonshire. In 2002 the VOLH delivered a broad range of acute hospital services, and the bed complement was in the region of 234, but by 2008 this had been reduced to around 136.

Prior to 1 April 2006 the VOLH was managed by NHS Argyll and Clyde. By 2005 NHS Argyll and Clyde had incurred a cumulative budget deficit of £82 million, and on 19 May 2005 the then Minister for Health and Community Care announced in a statement to the Scottish Parliament that NHS Argyll and Clyde was to be dissolved. The administrative boundaries of Greater Glasgow Health Board (GGHB), also then known as NHS Greater Glasgow, and of NHS Highland were to be changed to allow them to take over responsibility for managing the delivery of the health services in Argyll and Clyde.

Following upon an integration process NHS Argyll and Clyde was dissolved on 1 April 2006. From that date a number of hospitals, including the VOLH, became the full responsibility of GGHB, which became known as NHS Greater Glasgow and Clyde (NHSGGC).
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Full integration of services did not, however, take place immediately, and a Clyde Acute Directorate was created to manage services in the former Argyll and Clyde hospitals now managed by NHSGGC, including the VOLH. Mrs Deborah den Herder was appointed as the Director of the Clyde Acute Directorate, although she did not take up her post formally until 1 October 2006.

Reduction in services
In the years up to 2007 and 2008 a significant reduction in the services provided at the VOLH had taken place. These are set out in Chapter 8. By then the future of the hospital had been uncertain over a prolonged period of time. This uncertainty had a damaging impact on recruitment and morale as well as on the hospital’s physical environment. It also compromised patient care.

CDI at the VOLH
Discovery and extent of the problem
The problem with CDI in the VOLH was not apparent until May 2008. Those who worked in the VOLH did not appear to identify CDI as a particular problem over the period from 1 January 2007 to May 2008, even although a significant number of patients suffered from the illness during that period. As set out in the Report, the discovery of the extent of the problem was partly due to a press enquiry by a local newspaper requesting information on the number of cases of CDI at the VOLH in the six months prior to June 2008. Dr Brian Cowan, Medical Director and Acute Services Division Medical Director of Greater Glasgow and Clyde described his understanding of the position in the following way:

“Here was an outbreak which raged, or a series of outbreaks that raged, for a long period of time with a significant, highly significant, number of deaths”.8

In the period from 1 January 2007 to June 2008 there were 199 positive test results for C. difficile toxin from 131 patients in the VOLH, and in different wards at different times throughout that period there were patients suffering from CDI who were linked in time and place. Outbreak Policies in force during that period9 made it clear that an outbreak consisted of two or more linked cases of the same illness, yet no outbreak was declared. The reasons for the failure to identify a problem include the dysfunctional nature of the Infection Control Team, the inadequacy of reporting systems and the failure of committee structures. Nevertheless, it is surprising that such a problem could effectively remain undiscovered for so long even in the face of such failures.

Levels of infection and fatality rates
As I set out at the beginning of this summary, in the period from 1 January 2007 to 1 June 2008 131 patients who were or had been in the VOLH tested positive for CDI. Although the focus of the Inquiry has been on the period up to 1 June 2008, patients continued to suffer from CDI until the end of 2008, but the rate was lower. The total number of patients covered by the Inquiry’s remit who contracted CDI between 1 January 2007 and 31 December 2008 was 143.

I did not engage in a comparative exercise of CDI rates in Scottish hospitals, for such an exercise was outwith my remit. It is perfectly clear, however, that for a hospital the size of the VOLH the number of patients infected reveals that CDI had become a serious problem in the VOLH, even although that problem was not identified. The problem was compounded by the number of patients who died with CDI as the underlying cause or a contributory factor. In the six-month period from 1 December 2007 to 1 June 2008, CDI played a role in the deaths of 28 patients.

Death certification
Accuracy
Accuracy in death certification is important because it provides an understanding of the health needs of the population. There is also a personal need for family members to know why a relative has died. Of the 28 patients who died between 1 December 2007 and 1 June 2008 with CDI as the underlying cause or contributory factor, CDI was not mentioned in the death certificates of seven of these patients.
Death certification involves the exercise of professional judgement. Yet although in 2007 and 2008 the available guidance provided that it was “best if a consultant, general practitioner or other experienced clinician certifies the death”, it seems that in practice in Scotland consultants were rarely involved in death certification at that time. Certainly in the cases examined from the VOLH the majority of the death certificates were signed by junior doctors without any recorded consultation with more senior medical staff.

**New guidance**

New guidance was issued on death certification after the emergence of the CDI problem at the VOLH. The most up-to-date guidance provides that death certificates for patients who have died in hospital should only be completed after discussion with a consultant. Ideally this should be the patient’s named consultant. Boards also have to ensure that there are systems in place to identify *C. difficile* associated deaths.

Scotland should not have developed the practice of consultants generally not being involved in the death certification of their patients. Consultants are best placed to accurately assess why a patient has died. I certainly endorse the mandatory duty now imposed to involve consultants. Furthermore, if a patient dies with CDI either as a cause of death or as a contributing condition, relatives should be provided with a clear explanation about the role played by CDI in the patient’s death.

**Patient records**

**Examination of patient records by experts**

In the interpretation of my remit I took the decision that the patient records of the patients who suffered CDI in the focus period should be subjected to careful scrutiny. This scrutiny had not been carried out during other investigations into the VOLH CDI problem. From that exercise it became apparent to me, with the assistance of members of the Inquiry Team and my Assessors, that certain recurrent themes emerged. In order to explore those issues more fully, experts were commissioned in a number of disciplines so that the Terms of Reference could be properly complied with. The timescales involved in that process are set out in Chapter 2. I have already set out my reasoning for the division of cases into the early period and the focus period. Accordingly, expert reports were instructed on 1. medical care; 2. nursing care; 3. the prescription of antibiotics; 4. infection prevention and control; and 5. death certification for all patients who fell within the focus period. Patients for whom expert reports were obtained are listed in Appendix 1. Those patients and relatives who were core participants had an opportunity through their legal representatives to see these detailed reports.

A more restricted approach was taken in the early cases, but I still considered it necessary that, insofar as patient records were available, a nursing expert should examine these records to see whether trends apparent in the course of the focus period also existed in that early period.

Detailed examination of patient records, expert reports and all other evidence relevant to each patient’s care was undertaken during the Inquiry’s work in preparation of this Report. This approach reflected the approach taken during the oral hearings which involved detailed examination of patient care.

The results of that whole exercise are discussed in the Report. Suffice to say at this point that the unacceptable levels of care discovered were not the levels of care which I would have expected to find in any hospital in Scotland. That is why I have made firm recommendations in the Report which should be seen as fundamental to patient care. Ultimate responsibility for patient care in Scotland rests with the Scottish Ministers. To discharge that duty the necessary inspection and implementation systems must be capable of providing real assurance that patient care in Scotland is not at any risk of being compromised.
NHS Greater Glasgow and Clyde’s position on the examination of patient records

In the course of submissions made on behalf of NHSGGC at the oral hearing on 13 June 2011 in connection with the legal representation of nurses, an issue addressed in Chapter 2, Counsel for NHSGGC made the following statement in connection with the reports of the nursing experts:

“The content of the reports came as somewhat of a surprise to Greater Glasgow Health Board.”

As discussed in Chapter 17, the remit of the Internal Investigation set up by NHSGGC in June 2008 did not cover an examination of patient care with particular reference to the medical records. Nor did the Independent Review chaired by Professor Cairns Smith, Professor of Public Health at the University of Aberdeen. That was not part of the remit of either investigation.

Limited reviews of patient records were undertaken during the Internal Investigation. A case note review of 45 patient records was also carried out by senior nurses as part of the Outbreak Control Team’s investigations that commenced in June 2008 to obtain certain data in relation to matters such as age, date of admission and to which wards patients were admitted. So far as the Outbreak Control Team report discloses, the purpose of that review was to make a comparison between the status of the patients who died and the status of patients who survived. The report’s conclusion was that patients who died were, on average, older than those who survived. In addition, on 16 June 2008 two senior Consultant Physicians from outwith the Clyde division undertook a case review of 15 patient records where *C. difficile* had appeared on the death certificates to consider whether the death certification was appropriate. The Outbreak Control report describes this as a “brief review”.

I was surprised that NHSGGC had not taken steps to examine the patient records to evaluate the nature of care afforded to CDI patients, particularly the records of patients who died with CDI as a cause, or contributory cause, of death, in order to satisfy itself that there were no apparent deficiencies in care. I would regard such an examination as one that should be at the forefront of the thinking of any Health Board in the circumstances that had emerged in the VOLH by June 2008. Mr Robert Calderwood, Chief Executive of NHSGGC, did explain in his evidence that once the Independent Review was set up on 18 June 2008 NHSGGC was invited to assist with that Review and discontinue its own investigation, but as already mentioned the Independent Review did not examine patient care in any detail.

Management

The importance of questioning

It was surprising how managers at different levels within an organisation like NHSGGC failed in one of the most fundamental aspects of management, namely to ask questions.

The culture

Quite apart from a number of individual failures to investigate and be aware of what was actually happening in the VOLH, it became apparent that there was a systemic failure. Ultimately this can only be described as a management culture that relied upon being told of problems rather than actively seeking assurance about what was in fact happening. To take an example from the evidence, a manager who has a responsibility to ensure the delivery of high quality care cannot fulfill that duty simply by relying on being told when a specific problem emerges and then reacting to the problem. Some managers with responsibilities for the VOLH also had responsibilities for other hospitals operated by NHSGGC, but the Inquiry’s focus, of course, was only on the VOLH, and in consequence I cannot comment on their broader performance. Nor do I know how prevalent this style of management would be generally within NHSScotland. Nevertheless, the clear lesson to be learned is that an
important aspect of management is to be proactive and obtain assurance that systems and personnel are functioning effectively.

Patients and families

Full co-operation

A Chapter in the Report has been devoted to the views of patients and families and their experiences at the VOLH. The oral evidence at the hearings from this group of witnesses was given in a measured and unexaggerated way. Those who provided written statements but were not called to give oral evidence co-operated fully with the Inquiry. These witnesses recognised the importance of having a local hospital and as a group wanted to support its continued existence.

The Inquiry’s oral hearings began with the evidence of this group of witnesses. I was anxious that they should have an opportunity as early as possible to have their views expressed publicly. Much of the Inquiry’s work was still to be done at that time, and that meant that when they gave their evidence they were not aware of the extent and range of criticisms that were to be made subsequently by the experts.

A common theme

A common theme from this group’s evidence was the desire to have answers to what went wrong at the VOLH. A significant number of this group of witnesses had been actively engaged in a campaign for a public inquiry, and it became clear during the evidence that fundamental to their thinking was the desire that others should not be made to suffer in the same way that patients suffered in the VOLH as a result of contracting CDI. Although this group of witnesses was reluctant to be critical of the care provided to patients, many of the descriptions provided did show that there were failures in basic nursing care. Some witnesses attributed poor care to the nursing staff being too busy to render the necessary quality of care. Being busy is not an excuse. If the right kind of care requires more staff, then arrangements should be in place to have an adequate number of staff available.

Poor communication

Relatives were critical of poor levels of communication. This was particularly the case in relation to the presence and nature of CDI. One witness only became aware that his mother had been diagnosed with CDI when he saw *C. difficile* mentioned on her death certificate. Some relatives were told that it was a “wee bug”. That is not an apt description of what can be a life-threatening infection. Mixed messages were provided to relatives who took patients’ soiled laundry home to wash. Good communication and candour are important aspects of care.

Nursing and medical care

Nursing failures

In the Report it has been necessary to mention nursing failures. There were individual failures caused by a number of factors, including pressures of work, lack of training, and inadequate support. Poor leadership also contributed to an inadequate standard of nursing care. The individual nurses concerned may have been doing their best. What I have sought to identify is how, in a care environment that does not promote good quality care, nursing standards can deteriorate and become unacceptable. The message to be conveyed on this issue is one of the absolute importance of good quality nursing care.

There were a significant number of cases in which there were delays of over 24 hours between the taking of a specimen for laboratory analysis and the commencement of treatment. What was totally unacceptable were the delays in the commencement of treatment after the ward was aware of the positive result. Delay in the commencement of treatment in such circumstances represents an inexcusable level of patient care. Such failures would inevitably compromise patient care.

Medical care

The deficiencies that existed in relation to medical staffing are set out in Chapter 14. In effect, there was a layer of middle grade medical staffing missing, with the result that the brunt of the day to day care had to be borne by inexperienced junior doctors and that consultants were overstretched.
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medical review of patients suffering from CDI was inadequate, and for many patients there was no evidence that a proper clinical assessment of the patient's condition had been made. Scrutiny of antibiotic prescribing disclosed that many aspects of practice were poor. There were instances of antibiotics being prescribed when no antibiotic was necessary, and of the continued prescribing of antibiotics in cases where a laboratory test demonstrated that the organism was resistant to that choice of antibiotic.

Overall it is likely that patient care was compromised by the inadequate standard of medical care.

Infection prevention and control

Significant failures

Clearly infection prevention and control practices and systems had to be fully investigated by the Inquiry. Again experts were commissioned to assist the Inquiry in this task. The Chapter in the Report on infection prevention and control is one of the major Chapters, and there can be little doubt that the significant deficiencies in infection prevention and control practices and systems discovered by the Inquiry had a profound impact on the care provided to patients in the VOLH.

Local failures

There were personal failures by the senior nurse responsible for infection prevention and control in the VOLH. The failure not to consider as a real possibility that the number of cases with CDI was a result of cross infection was inexplicable. Over the period from 1 January 2007 to 1 June 2008 there were a number of opportunities presented when cross infection should have been actively considered.

The Infection Control Doctor

Dr Elizabeth Biggs was the Infection Control Doctor for the VOLH at least from 1 January 2007 up to early February 2008. Dr Biggs was based at the Inverclyde Royal Hospital (IRH) but was responsible as Infection Control Doctor for that hospital, the Royal Alexandria Hospital (RAH) and the VOLH. The main thrust of the evidence was that she did not attend the VOLH during that period.

Dr Biggs was under a duty to take a lead role in the effective functioning of the Infection Control Team. It is clear that Dr Biggs was unhappy with her general position and lacked professional line management support, but that does not excuse her attitude. Dr Biggs' attitude to her role as Infection Control Doctor for the VOLH was wholly inappropriate and professionally unacceptable.

Failure to address Dr Biggs' behaviour

Dr Biggs had raised issues in a number of emails and failure to address these, and to ensure an effective leader of the Infection Control Team was in place, was a serious management failure. One witness described Dr Biggs' behaviour as “accepted behaviour”. Such an attitude is to be deplored. Accepted behaviour that puts patients at risk has no place in any Health Board’s philosophy.

System failures

The failure to meet of committees within the infection control structure meant that the structure became unfit for purpose. This was compounded by the fact that the reporting systems within the infection control system itself and under the clinical governance arrangements in place at the time were inadequate. Adequate reporting systems must ensure that there is ward to Board and Board to ward accountability. Appropriate systems would have identified the local failures at the VOLH and the failure of Dr Biggs to carry out her duties. That in turn would have identified the problem with CDI in the VOLH much sooner and saved many patients from suffering from the infection and its consequences.

National structures and systems

Structures

In order to orientate the reader of the Report, some information is provided in Chapter 6 on how the National Health Service in Scotland has been structured. In summary, ultimate responsibility for the promotion and improvement of the physical and mental
health of the people of Scotland rests with the Scottish Ministers. The Scottish Ministers discharge that duty through Health Boards. The Scottish Government is the executive branch of government in Scotland. There are a number of organisations that provide support including NHS National Services Scotland (NSS) of which Health Protection Scotland (HPS) forms part. The Scottish Government Health Directorate (SGHD) provides the central management of the NHS in Scotland. The Cabinet Secretary for Health and Wellbeing is the Minister responsible for the SGHD.

**Systems**

The impact of healthcare acquired infections (HAIs) on patients has been well recognised since at least the 1990s. The HAI Task Force was created in January 2003 in recognition of the ongoing challenges presented by HAI. Its primary responsibility is to advise on the development and delivery of Scottish Government policy in order to minimise HAIs. There is no doubt that the HAI Task Force has carried out some excellent work, including the implementation of the system of mandatory reporting of all positive tests for *C. difficile* toxins to HPS on a weekly basis since September 2006. This is in effect a national surveillance system in Scotland that provides information on the extent of CDI at a national level and allows a comparison to be made of trends and data over time and between Health Boards. It is to be emphasised that the system is not designed to identify the prevalence of CDI in a particular hospital.

The Scottish Government also set performance targets that Health Boards are expected to meet. These are known as Health Improvement, Efficiency, Access and Treatment (HEAT) Targets. In November 2006 the Scottish Government announced a HEAT Target for *Staphylococcus aureus* bacteraemia (including MRSA and MSSA). The target was an overall reduction of 30% in such cases by 2010, and that target was achieved by September 2009.

The importance of the HEAT Target system lies in the fact that it places an onus on Health Boards to meet the targets by having, for example, effective infection prevention and control methods in place. CDI was only made a HEAT Target in 2009 in response to the discovery of the CDI problem at the VOLH. Had CDI been a HEAT Target earlier, that might have raised awareness of the infection, but it is to be stressed that the HEAT Target system was not designed to be a surveillance system of the kind that Boards had to have in place. Although there was no evidence that in the period prior to 1 June 2008 any consideration was being given to making CDI a HEAT Target, that is not a criticism because it was necessary to have adequate data available for comparative purposes, and as I have already indicated the system for mandatory surveillance did not come into operation until September 2006. The introduction of CDI as a HEAT Target in 2009 was an appropriate response by the Scottish Government to the emergence of the CDI problem at the VOLH.

**Healthcare Environment Inspectorate**

Prior to June 2008 there was no system of independent inspection dedicated to the infection prevention and control of HAI. Following upon the discovery of the CDI problem in VOLH the Cabinet Secretary had a number of meetings with family members of patients who had contracted CDI who made clear to her the view that there should be an independent inspectorate in place to review the actions taken in hospitals in relation to HAIs. This led to the establishment of the Healthcare Environment Inspectorate (HEI) in April 2009. The HEI carries out announced and unannounced inspections and publishes inspection results on its website. The inspection team measures hospitals against standards that are designed to minimise the risk of infection to patients, visitors and staff, based on evidence, best practice and expert opinion. The Health Board concerned must respond to any issues raised by the inspection process.

**Inspections of the VOLH in 2011 and 2012**

It is worthy of note that an announced inspection of the VOLH took place on 10 and 11 August 2011, and that an unannounced inspection took place there on 7 June 2012. The unannounced inspection in June 2012 concluded that the hospital was clean and
well maintained and that education in infection prevention and control was being well promoted. There is no doubt that had there been an inspection regime of that kind in 2007 and 2008, and had an inspection of the VOLH been carried out over that period, the conclusions would have been very different to the conclusions arrived at in 2012.

The absence of an inspection system – a failure
Since devolution the SGHD and other agencies have produced a significant amount of material for Health Boards on HAIs. For example, the Scottish Infection Manual published in July 1998 sent out a clear message on the importance of good infection prevention and control. Furthermore, the importance of prudent antibiotic prescribing had been well known at least since the 1990s. There was no doubt that the message on the importance of having sound systems in place to combat HAIs was a message that had been repeated many times over the years because of the importance attached to it. In such circumstances it is surprising and indeed regrettable that an effective inspectorate system had not been put in place prior to 1 June 2008. This is dealt with in detail in the Report, and represents a failure on the part of the Scottish Government.

Antibiotic prescribing
Prudent prescribing
The importance of prudent antibiotic prescribing had been recognised in Scotland for many years prior to 2007 to 2008. In a letter dated 21 May 1999 addressed to a number of people, including Health Board General Managers and Chief Executives, the Scottish Office Department of Health included prudent antibiotic prescribing as an important goal in the reduction of ill health from hospital acquired infection. That message was subsequently repeated over a number of years. An Action Plan published in 2002 by the then Scottish Executive again emphasised the importance of prudent antimicrobial use. A guide on the prudent use of antibiotics published in 2005 highlighted as a challenge the inadequate supervision of prescribing and the inappropriate choice of antibiotics by junior doctors. Even as late as March 2008, shortly prior to the emergence of the problem with CDI at the VOLH, another Action Plan was launched by the then Cabinet Secretary for Health and Wellbeing. This echoed the theme that had emerged in Scotland at least by 1999, and had been repeated over the years, that antibiotic prescribing was not being carried out in a prudent way.

Inadequate response to the prudent prescribing message
Reference has already been made to the failures in the prescribing of antibiotics in the VOLH, failures that persisted until the emergence of the CDI problem in May 2008. The repeated messages on prudent prescribing had not had an effective impact in the VOLH by June 2008. Dr Andrew Seaton, a Consultant Physician in Infectious Diseases and General Medicine in NHSGGC, said in evidence that what was happening in the VOLH in relation to antibiotic prescribing “was applicable to all our hospitals in Greater Glasgow and Clyde and, indeed, almost certainly all our hospitals in Scotland”. It is not within my remit to consider the position of other hospitals in Scotland, but what was perfectly apparent to me was that there had been what I describe in the Report as a mismatch between expectation and implementation. There are two targets for criticism here – NHSGGC for failing to respond to the messages being sent on the importance of prudent prescribing, and the Scottish Government for failing to identify and remedy the failure to comply with the prudent prescribing messages.

Outbreaks elsewhere
Paragraph (f) of the Terms of Reference did permit the Inquiry to see what lessons could be learned from experience of CDI in and beyond Scotland. I was, however, of the view that that paragraph did not provide...
an open ended platform from which to look at the detail of how outbreaks of CDI were handled in other hospitals. That would have been an enormous task. In light of the Terms of Reference as a whole I was of the clear view that it would be outwith their scope to embark upon a critical analysis of the infection control policies of other organisations, the governance arrangements of such organisations and the handling of any outbreaks. What I did find useful was to have regard in particular to the available reports on CDI outbreaks in England, and compare the conclusions arrived at with the conclusions I have arrived at in connection with the VOLH. What was striking was the similarity of the problems identified in these reports and the problems identified by this Inquiry. Lessons had not been learned from these reports. This is considered in Chapter 18.

Scrutiny of other hospitals

There was regular traffic of patients to the VOLH from other hospitals. In particular, patients covered by the remit were transferred from the RAH, or transferred from the VOLH to the RAH. For that reason it became necessary for the Inquiry to examine some aspects of the treatment of those patients at the RAH. As discussed later in the Report, I concluded that the prescription and administration of antibiotics to patients prior to admission to the VOLH were relevant to my remit whether that occurred at another hospital or in the community under the authorisation of general practitioners. That did not mean, however, that I considered it to be within my remit to conduct an examination of practices, policies and patient care at any other hospital, or in the community.

The proceedings

Inquisitorial proceedings

In Scotland, legal proceedings are generally conducted by way of adversarial process. For example, in a civil litigation the parties to the litigation identify the issues that are of concern to them and decide what evidence to lead in support of their respective positions. Generally a witness led by one party can then be cross-examined by the other party and, if necessary, re-examined. The judge presiding over the case has no direct part to play in that process. The judge’s role is to ensure that parties conduct the case in accordance with the rules and the judge only intervenes in the evidence to seek clarification or further explanation. At the end of a case parties make submissions on the facts and the law to advance their respective positions and, ultimately, the judge decides the case by making findings in fact and law.

The purpose of an inquiry of this kind is quite different. The process is an inquisitorial one. Section 17 of the 2005 Act provides as follows:

“(1) Subject to any provision of this Act or rules under Section 41, the procedure and conduct of an inquiry are to be such as the Chairman of the inquiry may direct.

“(3) In making any decision as to the procedure or conduct of an inquiry the Chairman must act with fairness and with regard also to the need to avoid any unnecessary cost (whether to public funds or to witnesses or to others)

In an inquiry of the kind that I have conducted it was for me to decide who would give evidence to the Inquiry and what areas should be subject to investigation, all within the parameters of the Terms of Reference. It was not in any way part of my function to resolve issues as a judge might resolve issues between parties in a litigation. The role of Core Participants is quite different to the role played by parties to litigation. Indeed their role should be seen as being one where they are under a duty to assist the Inquiry in responding to its Terms of Reference.

As I said at the preliminary hearing on 1 February 2010, the focus of the Inquiry was on investigating, and the Inquiry’s questions were to be about finding out what happened, why it happened and, importantly, how to make a difference for the future.

Furthermore, the extent to which Core Participants may question witnesses is significantly constrained by the 2007 Rules. Rule 9 provides:
“(1) Subject to paragraphs (2) to (5), where a witness is giving oral evidence at an inquiry hearing, only –
(a) the inquiry panel;
(b) counsel to the inquiry;
(c) if counsel has not been appointed, the solicitor to the inquiry; or
(d) persons entitled to do so under paragraphs (2) to (4), may examine that witness.

(2) Where a witness, including a Core Participant, is being examined at an inquiry hearing, the Chairman may direct that the recognised legal representative of that witness may examine the witness”.

There are other provisions in the 2007 Rules regulating the examination of witnesses, but the clear message is that it is for the Chairman to decide whether a witness should be examined by a Core Participant or any other party representing a person.

**Expert assistance**

The contribution made by all the experts commissioned by the Inquiry cannot be overstated. An inquiry of this kind, with Terms of Reference that required investigation of a range of different factors leading to the development of the problem with CDI, could not perform its function without expert input from a number of different disciplines. I am extremely grateful to all the experts who assisted the Inquiry. Details of the experts are provided in Appendix 4.

**Standard of proof**

The 2005 Act and the 2007 Rules are silent on the standard of proof an inquiry under the 2005 Act should apply when making its findings. I have already mentioned Section 17, which provides that the procedures and conduct of the Inquiry are to be such as I may direct. Furthermore, as I have explained, I must act with fairness. It is worth pointing out that Section 2 of the 2005 Act provides that “an inquiry panel is not to rule on and has no power to determine, any person’s civil or criminal liability”. It is not the function of an inquiry under the 2005 Act to determine the rights and obligations of any parties. In the light of these provisions I considered it to be appropriate to apply the civil standard of proof, a standard of proof on the balance of probabilities.
Conclusion
Conclusion

This was a lengthy and complicated Inquiry. It was necessary to examine a wide range of topics in order to comply with the terms of the remit. I was determined to carry out as comprehensive an investigation as possible so that a full account could be provided of why the CDI problem at the VOLH was so persistent and devastating. Patients and families had to relive painful experiences in providing statements and giving oral evidence and then had to wait for some considerable time for the publication of the Report. I consider that wait to be highly regrettable but I do firmly believe that the timescales identified throughout the Inquiry process were unrealistic. The extent of the work required to undertake a thorough examination of the many relevant issues cannot be overemphasised. In the event the Inquiry has unearthed serious personal and systemic failures. Patients who suffered from CDI at the VOLH were badly let down by people at different levels of NHSGGC who were supposed to care for them. The Scottish Ministers bear ultimate responsibility for NHSScotland and even at the level of the Scottish Government the systems were simply not adequate to tackle effectively an HAI like CDI. The major single lesson to be learned is that what happened at the VOLH to cause such personal suffering should never be allowed to happen again.

The Report and the recommendations are informed by all the relevant documentation gathered by the Inquiry, the evidence contained in written statements, and the evidence at the oral hearings, including the evidence of the experts who were commissioned to assist the Inquiry. The lessons to be learned are contained within the narrative of the Report and reflected in the recommendations.

Some of the recommendations are directed to aspects of basic nursing care, for example fluid monitoring, care planning, and the prevention and management of pressure damage. I note from the important inspection work being carried out by Healthcare Improvement Scotland that these aspects of care still feature as sources of criticism, and I make no apology for including recommendations on these issues to reinforce how critical they are to good quality care. Such basic care is integral to compassionate care. The recommendations are not directed against individuals although they will have an impact on individual behaviour. Nevertheless, it is important for individuals such as nurses and doctors to realise that they have a professional responsibility to comply with what is laid down as proper practice by their professional bodies.

There may be some recommendations that have been overtaken by events. For example, as set out in Chapter 15, NHSGGC did introduce more effective reporting systems for CDI after June 2008, but again the message should be reinforced that systems must ensure that important information is relayed from ward to Board.

I am convinced that the adoption of the recommendations proposed will result in a significantly improved focus on patient care, and in particular on the care of patients who contract a hospital infection such as CDI. CDI has been the focus of the Inquiry, but I am in no doubt that, although it was the failures in how CDI was managed at the VOLH that governed the work of the Inquiry, the recommendations should have a more far-reaching impact. Indeed the express intention of the Cabinet Secretary when announcing the setting up of the Inquiry was that lessons should be learned across Scotland. The recommendations are designed to encapsulate a concept of patient care that includes skilled and considerate medical and nursing care, transparency, candour, effective systems of infection prevention and control, and strong and dedicated leadership.
Key findings
Key findings

The key findings are short summaries of issues identified in the main body of the Report. For a proper understanding of these issues the reader should read the main text.

The numbering of the introductory and subsequent headings identifies the Chapter and Section numbers upon which the findings are based.

3. Healthcare Associated Infection and \textit{C. difficile}

3.1 Healthcare Associated Infection
Healthcare Associated Infection (HAI) is an infection acquired as a result of a healthcare intervention either in hospital or in the community. HAIs are a major public health problem. Good infection prevention and control practices can prevent HAIs.

3.2 Antibiotics and the bowel flora
The undoubted potential therapeutic benefit of antibiotics in certain circumstances has to be balanced against the risks associated with antibiotic use. Antibiotics can affect the bacteria that make up the normal bowel flora of humans. Because it is unusual for a specific antibiotic to be active only against one particular bacterial species or group of species, treatment of a specific infection with an antibiotic will be likely to have an effect on other bacteria in the bowel.

3.3 \textit{C. difficile} – what is it?
\textit{C. difficile} is an organism carried in the bowel of up to 4% of healthy adults. Under normal circumstances it does not cause symptoms because it is in relatively small numbers and constrained by other bacterial flora that make up the normal bowel flora of the healthy adult. Multiplication of the organism can be triggered by the use of broad spectrum antibiotics administered for some other suspected bacterial infection. \textit{C. difficile} produces toxins that set in motion a process that causes \textit{C. difficile} associated diarrhoea (CDAD). In severe cases the infection can be life-threatening.

3.4 How \textit{C. difficile} is spread
\textit{C. difficile} is able to remain in the environment in the form of resistant spores, a vast number of which can be shed by a symptomatic patient. Ingestion of spores by a patient who is receiving antibiotics can result in infection. Although any antibiotic may result in CDAD the particular antibiotics associated with CDAD are the cephalosporins, co-amoxiclav (and other broad spectrum penicillins) clindamycin and ciprofloxacin (and other fluoroquinolone antibiotics).

There are hypervirulent strains of \textit{C. difficile} that produce high levels of toxins. The 027 strain has been described as a hypervirulent strain but any strain of \textit{C. difficile} can produce severe CDAD.

3.5 Laboratory diagnosis of \textit{C. difficile} infection
There are a number of tests presently available for laboratory testing for CDAD. It is important to appreciate, however, that there is no test that is both 100% sensitive and also 100% specific. The laboratory must be aware of the risk of false positive and false negative results.

3.6 Precautions against occurrence and spread of \textit{C. difficile} infection
Because \textit{C. difficile} can be transmitted to individuals by a number of routes, including direct hand to mouth spread, good and appropriate hand hygiene is essential. So too is good maintenance of the healthcare environment. The main way to prevent cross-contamination is to isolate the potentially infectious patient in a single room. Cohorting of infected patients under strict infection control conditions must be seen as a last resort where single rooms are not available.

An unexplained incident of loose stools should be assumed to be infectious until an alternative cause is confirmed. In the VOLH in 2007 to 2008 a potential outbreak could include two cases of potentially infectious diarrhoea linked in time and place.
3.7 Treatment of *C. difficile* infection
Treatment includes the administration of the antibiotics metronidazole or vancomycin, depending upon the duration or severity of the infection. Any existing antibiotic treatment must be reviewed urgently. Good hydration is essential. The importance of ensuring that the patient’s comfort and dignity are preserved cannot be overemphasised.

3.8 Conclusion
CDAD is a significant cause of morbidity and mortality in the elderly, the immunosuppressed and severely ill patients on broad spectrum antibiotic chemotherapy. Diarrhoea in these groups of patients must be taken seriously and urgent steps taken to establish whether or not infection is involved. Patients with diarrhoea must be isolated as soon as possible. As soon as the diagnosis is confirmed appropriate antibiotic treatment must be started. Other antibiotics must be reviewed and stopped unless there are overriding clinical reasons to continue with them.

4. The number of patients with *C. difficile* and those who died

4.1 Discovery of the problem
The ongoing problem with CDI in the VOLH began to emerge in mid-May 2008. Following a press enquiry in early June 2008, a look-back exercise covering the six-month period from 1 December 2007 to 31 May 2008 disclosed that there had been a persistent CDI problem and associated deaths during that period. That exercise identified 55 patients who had suffered from CDI and 18 CDI associated deaths. Those figures were an underestimate of the true position. The CDI problem was identified as a result of a combination of external factors including a coincidental research project and the press enquiry.

4.2 Number of CDI cases
In the period from 1 January 2007 to 31 December 2008, 143 patients who were or had been patients in the VOLH tested positive for CDI.

In the period from 1 January 2007 to 30 November 2007 (the early period) 68 patients tested positive for CDI. In the period from 1 December 2007 to 1 June 2008 (the focus period) there were 63 patients who tested positive for CDI.

In the period from 1 June 2008 to 31 December 2008 a further 12 patients at the VOLH tested positive for CDI. Furthermore, in addition, a number of patients who had tested positive prior to 1 June 2008 tested positive again after 1 June 2008.

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**Figure 4.1 Patients with CDI**

<table>
<thead>
<tr>
<th>Period</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>1/01/07 – 31/12/08</td>
<td>Total 143</td>
</tr>
<tr>
<td>01/01/07 - 30/11/07</td>
<td>68 patients</td>
</tr>
<tr>
<td></td>
<td>“Early period”</td>
</tr>
<tr>
<td>01/12/07 - 01/06/08</td>
<td>63 patients</td>
</tr>
<tr>
<td></td>
<td>“Focus period”</td>
</tr>
<tr>
<td>01/06/08 - 31/12/08</td>
<td>12 patients</td>
</tr>
</tbody>
</table>
4.3 Number of *C. difficile* deaths

Many of the patient records of the 68 patients who contracted CDI in the early period (1 January 2007 to 30 November 2007) were not available. It was possible to conclude that CDI played a part in the deaths of at least six patients during that period.

In the focus period (1 December 2007 to 1 June 2008) 28 patients died with CDI as a causal factor in their deaths either as the underlying cause of death or as a contributory cause of death.

Ten patients died after 1 June 2008. CDI was a causal factor in five of those deaths. Three of those five patients died in June 2008.

Of the patients considered by the Inquiry, CDI was a causal factor in the deaths of 34 of those patients. In addition an examination of the death certificates of patients who died prior to 30 November 2007 revealed that CDI was mentioned in the death certificates of three of those patients. The figure for the number of deaths is an underestimate, since many patient records for the early period (1 January 2007 to 30 November 2007) were unavailable. Most of the patients who died were elderly and suffered from other conditions. These were patients who were clinically very vulnerable and in whom an infection such as CDI could have profound effects. What CDI caused was unnecessary suffering and lack of dignity to patients and enormous distress to relatives.

Figure 4.2 Deaths related to CDI

![Diagram of deaths related to CDI]

- **Total Deaths**: 43
- **Deaths related to CDI**: 34

**01/01/07 – 30/11/07**
- 2 deaths (full analysis of deaths not possible)
  - 1 confirmed CDI related
  - (3 further references on death certificates)

**01/12/07 – 01/06/08**
- 31 deaths
  - 28 related to CDI

**01/06/08 – 31/12/08**
- 10 further deaths
  - 5 related to CDI
4.4 Conclusion
The fact that many of the patients were vulnerable and frail made the suffering inflicted by CDI particularly devastating. The lack of dignity suffered by patients in the final period of their lives and the enormous distress caused to relatives underline the importance of recognising CDI as a serious infection.

5. C. difficile infection rates and undeclared outbreaks

5.1 Definition of an outbreak
An outbreak of CDI includes two or more linked cases of CDI, by which is meant that the patients are suffering from the same strain of C. difficile toxin due to cross contamination. Different C. difficile strains can be identified by ribotyping, and if the strain of C. difficile is the same in two linked patients then that would indicate that a single ribotype was being transmitted between patients. The Infection Control Nurses in the VOLH were well aware of what constituted an outbreak.

When an outbreak is suspected, a number of people including the Medical Director have to be notified and, if an outbreak is confirmed, an Outbreak Control Team requires to be set up. An NHSGGC requirement is that the Chief Executive and/or the Chairman need to be informed.

5.2 The number of CDI results
In the period from 1 January 2007 to 1 June 2008 there were 199 positive results for C. difficile toxin at the VOLH. Ninety of these positive results were in the focus period. For a hospital the size of the VOLH (136 beds in 2008) this represents a significant level of activity.

5.3 Wards with CDI patients – the early period
In the early period (1 January 2007 to 30 November 2007) there were several occasions when the number of patients suffering from CDI in different wards in the VOLH should have been fully investigated. As early as February 2007 there were two patients in ward 6 who tested positive for C. difficile toxin within a day of each other.

In April 2007 there were several patients who tested positive in ward 14 over a period of three to four days. In March 2007 two patients were positive in ward F on the same day, and around two days later another patient tested positive. These are examples of early opportunities in 2007 for full investigation of the real possibility of cross-contamination. Although no ribotyping of specimens took place during that period because the nature of the problem was not properly identified, it is inconceivable that there were not a number of outbreaks. The C. difficile problem was not confined to one ward. A number of the wards in the VOLH were affected.

5.4 Wards with CDI patients – the focus period
There were several occasions during the focus period (1 December 2007 to 1 June 2008) when at least two patients were suffering from CDI in the same ward in the VOLH. In ward 6 there were patients closely associated in time and place who tested positive in December 2007 and February 2008. In ward F the ward was aware of five patients testing positive between 9 and 25 January 2008. Several patients remained positive in ward F in February 2008.

5.5 Conclusion
If the outbreaks that occurred in 2007 had been identified at the time, and the proper procedures followed, the persisting CDI problem that continued up to June 2008 would have been significantly reduced and many patients would have been spared the devastating impact of the infection. CDI would not have been a causal factor in so many deaths. The omissions to identify potential outbreaks represented serious failures.

6. National structures and systems

6.1 Relevant parties and agencies
Scottish Ministers have ultimate responsibility to promote the improvement of the physical and mental health of the people of Scotland. It is through Regional and Special Health Boards that Scottish
Ministers discharge many of their duties. The Scottish Government is the executive branch of government in Scotland. Healthcare Improvement Scotland (HIS) has a general duty of furthering improvement in the quality of healthcare in Scotland. There are other agencies such as NHS National Services Scotland (NSS) and Health Protection Scotland (HPS), a division of NSS, that provide strategic support and expert input. HPS has a particular responsibility for HAIs.

NHSScotland is a generic description that encompasses the Health Boards and HIS.

The central management of the NHS in Scotland is undertaken by the Scottish Government Health Directorate (SGHD). The Cabinet Secretary for Health and Wellbeing is the Minister responsible for the SGHD.

6.2 Systems
The recognition of the growing challenges around HAI led to the creation of the HAI Task Force in January 2003. This is a multi-agency body responsible for advising on the development and delivery of Scottish Government policy to minimise HAIs. The Task Force membership is drawn from a wide range of expertise including medical directors, nurse directors and consultant microbiologists. Much of the HPS work on HAIs is carried out in conjunction with the Task Force.

The Task Force and HPS were instrumental in the development of a mandatory reporting system of *C. difficile* toxin specimens. Since 1 September 2006 specimens of diarrhoea from patients aged 65 years or over have to be tested for *C. difficile* toxin and the results of all positive results have to be sent to HPS on a weekly basis. From 1 April 2009 surveillance for CDI has included the collection of data for those aged 15 and over. This regime provides a national surveillance system for CDI in Scotland. The system is not designed to monitor the prevalence of CDI in a particular hospital. As part of the work of the Task Force, since November 2007, the Scottish Salmonella, Shigella and *C. difficile* Reference Laboratory at Stobhill Hospital, Glasgow, has been able to ribotype isolates to identify outbreaks and the emergence of new strains of *C. difficile*.

6.3 Accountability and monitoring
The system of direct accountability of Health Boards to the Scottish Government included monthly meetings, two-monthly meetings, and an Annual Review. The Annual Review is of particular importance, and is attended by the Cabinet Secretary, senior officials and Board members. There is a public session, and members of the public have the opportunity of questioning the Cabinet Secretary and the Chair of the Health Board. In the course of the Annual Reviews in August 2006 and October 2007 the Cabinet Secretary did receive assurances from the NHSGGC regarding compliance with infection prevention and control standards.

As part of the Scottish Government’s annual auditing process of Health Boards, Chief Executives are required to sign a Statement of Internal Control to confirm that effective processes are in place for clinical governance, including appropriate mechanisms in place for HAI.

6.4 Health Improvement Efficiency, Access and Treatment (HEAT) Targets and CDI guidance
The Scottish Government sets performance targets, Health Improvement, Efficiency, Access, and Treatment (HEAT) Targets that Health Boards are expected to meet. CDI was not a HEAT Target in 2007 and 2008. In November 2006 MRSA was made a HEAT Target with a 30% reduction target by 2010, one that was in fact achieved by September 2009. CDI was made a HEAT Target in 2009 in the aftermath of the discovery of the problem with CDI at the VOLH. It was only then that the reporting regime set up in September 2006 had produced adequate data that could be used for comparative purposes.

6.5 The review system
The Clinical Standards Board for Scotland (CSBS) (later subsumed under NHS QIS, and since 1 April 2011 under HIS), was established as a Special Health Board in April 1999 to develop and run a national system of quality assurance of clinical services. In December 2001 CSBS published standards designed to ensure that the risk of infection was controlled. A revision of these standards was published in March 2008.
Following the publication of the standards, CSBS undertook a process of review of all Trusts and Boards. The Argyll and Clyde Acute Hospitals NHS Trust was reviewed in July 2002. The Trust met only 24 out of 69 criteria. An update review on 12 May 2004 disclosed that 27 out of 69 criteria were met. No further reviews or assessments took place prior to June 2008.

The review process conducted by CSBS did include an investigatory process but it was not an inspection system. Nonetheless, in 2002 and 2004 significant failures in infection prevention and control were identified in the former Argyll and Clyde Trust.

6.6 Healthcare Environment Inspectorate

In 2007 and 2008 there was no inspection system to provide independent scrutiny of the state of the healthcare environment in hospitals, including infection control, cleanliness and hygiene. An inspection regime was introduced by the establishment of the HEI in April 2009 in response to the emergence of the VOLH CDI problem. It was a highly appropriate response. The focus of the HEI is on reducing the HAI risk to patients through a rigorous inspection framework that includes unannounced inspections of hospitals across NHSScotland. In the years since its establishment the HEI has identified a number of hospitals where there were deficiencies in infection prevention and control.

6.7 Conclusion

The introduction of CDI as a HEAT Target in 2009 was an appropriate and timely response by the Scottish Government to the disclosure in June 2008 of the CDI problem at the VOLH.

A rigorous inspection system of infection prevention and control should have been in place prior to 1 June 2008. This represents a failure on the part of the Scottish Government. Had such a system existed in the period from 1 January 2007 to 1 June 2008, its existence would at the very least have raised awareness of HAI throughout Scotland. If the VOLH had been inspected during that period the CDI problem would have been identified.

7. National policies and guidance

7.1 National guidance on the prevention and control of *C. difficile* before 2008

There was a considerable range of policies and guidance on HAI available to Boards in Scotland from the 1990s onwards. The Scottish Government and national organisations regarded infection prevention and control as an important priority. UK national guidance on the prevention and management of *C. difficile* was published in 1994. Launched in September 2003 the Cleanliness Champions Programme was designed to provide education in the basic principles of infection prevention and control with hand hygiene at the heart of the programme.

7.2 The role of Health Protection Scotland in developing guidance on *C. difficile*

Health Protection Scotland (HPS) was charged with delivering many aspects of plans devised to address HAI. This included the issuing of guidance on HAI. The publication by HPS of the *Clostridium difficile* associated disease (CDAD) bundle in March 2008 was guidance directed at CDI.

7.3 Developments from June 2008 onwards

A number of *C. difficile* related guidance documents were being developed in early 2008 but were not available prior to 1 June 2008. This included Scottish guidance on CDI and a checklist for preventing and controlling *C. difficile* associated disease.

7.4 Was the guidance on HAI adequate?

On 27 June 2008, after the VOLH CDI problem emerged, the Director General and Chief Executive of NHSScotland wrote to Health Board Chief Executives reminding them of their responsibilities for HAI. The six-page Appendix to that letter lists guidance relevant to HAI, a clear indication of the extent of the information available. There was adequate guidance available and the message on the importance of managing HAI had been repeated over several years.

Guidance in the form of a checklist was issued by HPS in August 2008. The first version of national guidance on CDI
was not published until October 2008. Notwithstanding the absence of specific *C. difficile* guidance there were policies in place which informed Health Boards of how to respond to cases and outbreaks of CDI. The guidance issued in October 2008 strengthened aspects of the guidance that already existed.

### 7.5 The provision of *C. difficile* guidance
Specific Scottish guidance on *C. difficile* was not available until October 2008. The publication of that guidance was originally planned for 2009 as part of a two year programme. Publication was brought forward as a result of emerging 027 outbreaks.

### 7.6 The monitoring of the implementation of guidance
Although there was a range of guidance available at national level, the persisting CDI problem at the VOLH showed that not enough attention was paid to the implementation of guidance.

After the discovery of the CDI problem at the VOLH in June 2008 a more prescriptive approach was adopted by SGHD with a specific action plan produced for NHSGGC and a more general action plan for all Health Boards.

### 7.7 Conclusion
The considerable range of policies available on HAI and *C. difficile* from the 1990s showed that the Scottish Government and national organisations took the threat of HAIs seriously. The weakness in the system was inadequate external scrutiny.

### 8. Changes in services at the Vale of Leven Hospital from 2002

#### 8.1 Prolonged uncertainty
For some years there was real uncertainty over the range of services to be provided at the VOLH and indeed over the future of the hospital itself. Attempts had been made to develop a sustainable strategy for the VOLH, and between 2002 and 2004 a significant service reconfiguration took place in Argyll and Clyde resulting in services, including A&E services, being transferred from the VOLH to the RAH. This reduction in services meant that the anaesthetic service was not sustainable beyond the short term, because the volume of work available was not sufficient to allow anaesthetists to maintain their skills or provide a basis to sustain training accreditation. This state of affairs cast doubt on the sustainability of unscheduled admissions at the VOLH. This prolonged uncertainty had a damaging effect on staff morale, equipment and on the physical environment of the hospital.

#### 8.2 Shaping the Future
In 2004 NHS Argyll and Clyde produced a public consultation paper, “Shaping the Future”, setting out proposals for the reconfiguration of services substantially to be carried out by the end of April 2007. Significant changes were proposed across the whole Argyll and Clyde area. The proposals proved to be highly controversial, and there was no final strategy before the announcement in May 2005 that NHS Argyll and Clyde was to be dissolved.

#### 8.3 The Lomond Integrated Care Model
The Lomond Integrated Care Model was developed as a specific measure to address the fragility of the anaesthetics service and to manage emergency admissions at the VOLH without the support of anaesthetists. This model envisaged that 85 to 88% of medical admissions would continue. On the dissolution of NHS Argyll and Clyde on 1 April 2006 this model had not been fully implemented. On-site anaesthetic cover was still available at the VOLH. The Board of NHSGGC intended to fully implement the model, but medical consultants in the Clyde sector concluded that providing unscheduled care at the VOLH without anaesthetic cover would not be a safe system of work. This meant that the model could not proceed as originally conceived. The Health Minister was made aware of this at a meeting in September 2006. At a subsequent meeting in October 2006 attended by Health Department representatives and the Chief Executive of NHSGGC, the Chief Executive was told to carry out a full option appraisal of the proposed change.
Executive Summary

8.4 A new strategy
In June 2007 NHSGGC produced a paper: “Clyde Health and Service Strategies: Outcome of Reviews and Proposals for Consultation”. The extensive programme for change set out in that paper included the withdrawal of the Lomond Integrated Care Model at the VOLH and the transfer of unscheduled medical care to the RAH. At its meeting on 26 June 2007 the NHSGGC Board approved the proposals set out in the paper as the basis for formal public consultation and external review. The need for public consultation and external review arose because of the policy of independent scrutiny and public consultation introduced by the new Scottish Government elected in May 2007.

The external review was carried out by an Independent Scrutiny Panel. In its report published on 30 November 2007 the Independent Scrutiny Panel put forward a number of options for public consultation including the retention of the status quo. Subsequently, having initially rejected the need for public consultation at a Board meeting on 18 December 2007, NHSGGC reversed its previous decision under instruction from the Cabinet Secretary and, at a meeting on 22 January 2008, agreed to initiate a period of public consultation as soon as possible.

That consultation process was still ongoing in June 2008 when the CDI problem at the VOLH emerged. In June 2008 the Cabinet Secretary for Health and Wellbeing commissioned an Independent Review into the sustainability of anaesthetic services at the VOLH. That review concluded, as had been the conclusion in 2006, that anaesthetic services were not sustainable at the VOLH, but that selected unscheduled admissions could be retained at the VOLH with unscheduled medical admissions diverted to a suitably equipped hospital such as the RAH.

8.5 The Vision for the Vale
In September 2008 NHSGGC approved and published its consultation document “Vision for the Vale of Leven Hospital”, with the consultation period running from 31 October 2008 to 30 January 2009. The recommendations of the Independent Review were adopted as the model for unscheduled medical admissions. At a meeting on 24 February 2009 the NHSGGC Board approved a plan that retained unscheduled medical admissions at the VOLH at a level of about 70% of the current level without the need for anaesthetic cover. The uncertainty surrounding the level of unscheduled medical care and the level of services necessary was therefore resolved after many years.

8.6 Conclusion
Prolonged uncertainty over the range of services to be provided at the VOLH, including anaesthetic cover, and over the future of the VOLH itself, had a damaging effect on recruitment, on staff morale and on the physical environment of the hospital. This state of affairs should not have been permitted to continue for as long as it did.

9. The creation, leadership and management of the Clyde Directorate

9.1 The dissolution of NHS Argyll and Clyde
Financial mismanagement in NHS Argyll and Clyde resulted in the then Minister for Health and Community Care announcing on 19 May 2005 in a statement to the Scottish Parliament that NHS Argyll and Clyde was to be dissolved. The administrative boundaries of NHS Greater Glasgow and NHS Highland were to be changed to allow these Boards to take over responsibility for managing the delivery of health services in the relevant areas of Argyll and Clyde.

NHS Argyll and Clyde was dissolved on 1 April 2006. From that date NHS Greater Glasgow took over responsibility for a significant part of the Argyll and Clyde area, including the VOLH, the IRH and the RAH. Since then the Board has used the descriptive name of NHS Greater Glasgow and Clyde (NHSGGC).

9.2 Integration
The options open to NHS Greater Glasgow were either full integration when NHS Argyll and Clyde was dissolved or phased integration. NHS Greater Glasgow was itself already in the process of restructuring, and the decision was made that full integration
should not be completed for a further three years. Acute Services within the Argyll and Clyde area that were to be the responsibility of NHSGGC were therefore initially incorporated as a single directorate of the Acute Division of Greater Glasgow.

The integration process after April 2006 was managed by the Clyde Transition Steering Group, chaired by the Chief Executive. The final meeting of this Group took place in November 2006.

The creation of the Clyde Acute Directorate was a sound decision. A significant amount of planning and expertise was involved in ensuring that the transition of the Argyll and Clyde Board’s responsibilities to NHSGGC was as smooth as possible. Nevertheless, integration took place against a background of mismanagement of NHS Argyll and Clyde and of glaring deficiencies in infection prevention and control previously identified in Argyll and Clyde. Extensive transitional arrangements had been put in place for what was a major organisational change. Given this history, and notwithstanding the care taken in the planning of the integration process and the appropriateness of the establishment of the separate Clyde Acute Directorate as part of that process, it would have been desirable for a post-implementation audit or review by an independent party to have been carried out.

9.3 Impact of integration on the Vale of Leven Hospital (VOLH)

Although no criticism is made of the decision to establish the Clyde Acute Directorate, the decision did mean that infection prevention and control management within that Directorate initially remained separate from the rest of Greater Glasgow. Full integration at an earlier stage would have resulted in earlier recognition that the Clyde infection prevention and control system was defective.

As part of the continuing process of integration, in September 2007 the rehabilitation and assessment areas of the Clyde Acute Directorate were integrated into NHSGGC Rehabilitation and Assessment Directorate (RAD) but line management for infection prevention and control for the rehabilitation and assessment areas in the VOLH did not change.

9.4 Leadership of the Clyde Directorate

The new Clyde Acute Directorate required highly experienced leadership and strong management in order to achieve successful integration. Yet the recruitment process for the appointment of the Director was delayed. Mrs den Herder was not interviewed for the post until 19 June 2006 and only took up the post formally on 1 October 2006. From 1 April 2006 to 31 July 2006 an interim Director was appointed. After 31 July 2006, responsibilities for the Clyde Directorate were passed to individual Directorate General Managers until Mrs den Herder was in post.

9.5 The leadership of Mrs den Herder

The Clyde Acute Directorate was not directly comparable with other directorates within NHSGGC, as it was geographically defined rather than service-based. The range of services for which Mrs den Herder was responsible proved to be a considerable burden for her, and it is not surprising that Mrs den Herder did not initially give priority to infection prevention and control at the VOLH. Nevertheless in the course of 2007 she should have been in a position to acquaint herself with the outstanding deficiencies in the management of infection prevention and control.

Mrs den Herder failed to give sufficient priority to infection prevention and control. There is no doubt that in this, as well as in other aspects of her work, Mrs den Herder was let down by other members of her management team, but given her responsibility for infection prevention and control she should have exercised greater scrutiny of the structures that were in place. She should have been in a position to identify that there were system failures. She resigned her post in July 2008, at least in part because of “stress and burnout”.27 There can be little doubt that her stress levels would have impacted upon her performance as Director of the Clyde Acute Directorate.

9.6 Other managers in the Clyde Directorate

Other managers in the Clyde Directorate were insufficiently proactive, with the result that system failures, and in particular the failure

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of the Infection Control Doctor to fulfil her duties, were not identified.

The management approach to infection prevention and control in the Clyde Directorate was a manifestation of a culture that viewed infection prevention and control as being of low priority. NHSGGC has to bear ultimate responsibility for the existence of this culture notwithstanding the difficulties it encountered in inheriting the problems of NHS Argyll and Clyde and in the integration process.

9.7 Conclusion
The decision to establish a separate Clyde Acute Directorate was, in principle, a sound one. A post-implementation audit or review would have been desirable. There was a lack of continuity of leadership in the initial stages, although it is by no means certain that the clinical governance and infection prevention and control issues would have been recognised at an early stage given Mrs den Herder’s failure to identify them in the months after she took up post. Generally, infection prevention and control was viewed as low priority by other managers.

10. Clinical governance

10.1 National policy
Clinical governance is the system through which NHS organisations across the UK are accountable for continuously monitoring and improving the quality of their services and safeguarding high standards of patient-focused care and services. Monitoring is a key element of effective clinical governance.

10.2 Clinical governance in NHS Greater Glasgow and Clyde
In December 2006 NHSGGC produced its own Clinical Governance Framework in recognition of the importance of having effective arrangements in place to improve public and staff confidence in the safety and quality of the healthcare provided. That Framework document also recognised the importance of monitoring arrangements to improve the quality of healthcare provided. Clinical governance responsibilities were a specific part of the role of senior staff, directors and other general managers, with the Chief Executive having overall responsibility. NHSGGC also produced more detailed guidance on clinical governance in December 2006 in recognition of its importance.

10.3 Clinical governance structures at divisional level
In NHSGGC an appropriate clinical governance committee structure was in place at divisional level. A Clinical Governance Committee (CG Committee) had responsibility to oversee the Clinical Governance Framework and assure NHSGGC that it was working effectively. There was a reporting line from the infection prevention and control committee structure through the Board Infection Control Committee (BICC) to the CG Committee.

The infection prevention and control reporting line to the BICC did not, however, identify the system and personal failures that resulted in the infection prevention and control system for the VOLH becoming dysfunctional. The CG Committee did not become aware of the CDI problem in the VOLH prior to June 2008.

10.4 Clinical governance in the Clyde Acute Directorate
At the level of the Clyde Acute Directorate (after 1 October 2006) Mrs den Herder, as Director, bore responsibility for leading the clinical governance agenda. That responsibility included ensuring the achievement of the highest possible quality of care. That responsibility for high quality care included HAI. As Director, Mrs den Herder chaired the senior committee in the Directorate with responsibility for clinical governance.

Mrs den Herder failed to ensure that the clinical governance arrangements for infection prevention and control were operating effectively. The clinical governance arrangements for which she has to bear ultimate responsibility were not geared to ensuring the highest possible quality of patient care in relation to HAI, and in particular CDI. She was not provided with routine infection prevention and control
information. Infection prevention and control was largely ignored as an element of importance to clinical governance.

Had clinical governance within the Clyde Acute Directorate been effective, the infection prevention and control failings set out in this Report would have been identified. Although the precise impact of earlier detection cannot be measured, the identification of these failings would have prevented many cases of CDI.

10.5 Clinical governance in the Rehabilitation and Assessment Directorate

The rehabilitation and assessment areas of Clyde were fully integrated with NHSGGC in September 2007. Ms Anne Harkness, the Director of the Greater Glasgow Rehabilitation and Assessment Directorate (RAD), became the Director of the extended RAD, with wards 14, 15 and F at the VOLH being included in her responsibilities. Ms Harkness was responsible for leading the clinical governance agenda in the RAD, as was Mrs den Herder for the Clyde Acute Directorate.

Prior to June 2008 Ms Harkness was not aware of the CDI problem at the VOLH. There were patients suffering from CDI in wards for which she was responsible, particularly in ward F in January/February 2008. The clinical governance arrangements were not sufficiently effective to alert her to the problem.

10.6 Reporting from the Clyde Sector

The NHSGGC CG Committee was unaware of the persistent CDI problem in the VOLH notwithstanding appropriate links being in place in the Clyde Sector. This was due to a lack of focus in the Clyde Sector on infection prevention and control as an integral part of clinical governance.

10.7 The Clinical Governance Committee and NHS Greater Glasgow and Clyde

Above the level of the Clyde Sector, clinical governance committee structures were in place, with a reporting line on infection prevention and control from the Board Infection Control Committee (BICC) to the CG Committee. Input on infection prevention and control issues was provided to the CG Committee from other sources, but because of the size of NHSGGC the information made available to the CG Committee was limited to issues deemed to be of importance. The CG Committee should have been alerted to the CDI problem in the VOLH, but the clinical governance arrangements within the Clyde Sector were not sufficiently effective to provide the necessary assurances that the infection prevention and control arrangements at the VOLH were operating properly.

10.8 Changes in clinical governance since 2008

Important changes in reporting practices have been put in place by NHSGGC since June 2008. Infection prevention and control is now a standing item on the CG Committee’s agenda. The Board Infection Control Committee reports to each meeting of the CG Committee instead of annually.

10.9 No non-executive director for Clyde

The membership list for the CG Committee discloses an intention to appoint a designated non-executive director for Clyde to the committee. That did not happen. It would have been highly desirable to have a non-executive director on that committee with a specific responsibility for Clyde during a period of extensive organisational change.

10.10 Conclusion

NHSGGC’s clinical governance system was not operating effectively. An effective clinical governance system would have identified the infection prevention and control failures that occurred in connection with the VOLH.

11. The experiences of patients and relatives

11.1 Sources of evidence

A total of 71 patients and relatives provided written statements to the Inquiry, eight of whom were patients.

The patients and relatives who gave oral evidence to the Inquiry were asked to recall events that for many had been highly
distressing. They gave their evidence with candour and with great dignity. In the oral evidence and in the evidence provided in statements to the Inquiry many witnesses did not directly criticise the care given by nursing staff. They described care that was deficient but that they believed could be explained by the nursing staff being overworked and understaffed. The evidence of these witnesses was provided prior to the evidence of the nursing and medical experts and the criticisms made by these experts.

11.2 The patients’ and relatives’ expectations
A common theme in the evidence of the patient and relative group was a desire for answers to two questions: firstly, why there were so many deaths in which CDI was implicated, and secondly, why the problem with CDI was not identified prior to June 2008. The other main theme that emerged from their evidence was the desire that others should not be made to suffer in the way that patients suffered in the VOLH.

11.3 Patient care
While many of the patients and relatives did not criticise the nursing staff directly, incidents described by them did represent examples of failures in basic nursing care. Patients in different wards were described by relatives as having dirty fingernails. Faeces were found under fingernails. One patient, whose catheter bag was seen to be full at visiting times, had puddles at the side of the bed on the floor in the vicinity of the catheter bag. The catheter bag was strapped to the patient’s leg, and the patient developed sores on her leg where the bag was located. There were unacceptable failures in basic nursing care.

11.4 The patients’ and relatives’ view on staffing
The clear impression gained by these witnesses was that there was a shortage of staff on the wards and that the nurses were overworked. It was that belief that convinced them that members of the nursing staff were doing the best they could in difficult circumstances. Staff morale was perceived as low.

11.5 Communication
Relatives expressed a real concern about a general lack of communication by nursing and medical staff. Difficulties were encountered in speaking to nursing staff and in obtaining information from medical staff. The fact that the nursing shift change coincided with evening visiting caused a particular problem. One area where there was a lack of proper discussion was that of decisions not to resuscitate patients in the event of cardiac arrest.

There was also a lack of communication over CDI. A number of witnesses were not aware of relatives having contracted CDI until the relative had died. One witness only became aware that a patient had been diagnosed with CDI when he saw “C. difficile” on the death certificate.

Good communication should be seen as an important element of patient care so that patients, and where appropriate relatives, can be involved in decisions about care.

11.6 Ward fabric and cleanliness
It was obvious to patients and relatives that the VOLH was run down. There was some evidence that the hospital environment was not particularly clean. Storage was an obvious problem, with items stored within patient bays. Faeces were seen on items of patient clothing. Urine on the floor of one ward had not been properly cleaned and produced a stench that was described as “disgusting”. Commodes were seen to be dirty.

11.7 Infection prevention and control issues
In a number of wards inadequate information was given on hand washing, and many visitors were not advised of the importance of using soap and water when a patient was diagnosed with CDI. Heavily soiled laundry was taken home by some relatives of patients suffering CDI with inadequate and conflicting information on how the laundry should be managed. Most witnesses said that nursing staff did wear aprons and gloves when dealing with patients, but a number of witnesses did not recall seeing a notice.

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outside an isolation room when a patient was suffering from CDI. Isolation practices were seen to be carelessly managed, with doors of isolation rooms left open.

11.8 Conclusion
The patient and relative group pressed for a public inquiry because they wanted a full examination of why the CDI problem had persisted for as long as it did and why there were so many deaths in which CDI was implicated. The descriptions of care provided did identify serious failures in patient care.

12. Nursing care

12.1 The Nursing and Midwifery Council Code of Conduct
The Nursing and Midwifery Council (NMC) sets standards for nurses and midwives for the provision of safe and appropriate care.

The NMC, through its Code of Conduct and other advice, emphasises that record keeping is an integral part of nursing care. If widespread failures in record keeping are identified there can be little doubt that care has been compromised.

12.2 Use of nursing experts
Seven independent nursing experts were commissioned by the Inquiry to provide professional opinions on the quality of nursing care given to patients who suffered from CDI during the focus period (1 December 2007 to 1 June 2008). They were instructed to review the patient records and Infection Control Cards and asked to use the professional standards of the NMC as a benchmark for the standard of care expected from nursing staff. Cases from different wards were allocated to each expert. An infection control nursing expert was asked to review some aspects of nursing care in that period. The available patient records for the early period (1 January 2007 to 30 November 2007) were also reviewed by one of the nursing experts.

12.3 Overall view of nursing experts
There was a catalogue of failures in fundamental aspects of nursing care. Deficiencies in nursing care were not restricted to one particular ward or limited to a particular period of time. It was apparent that standards of nursing care had been permitted to lapse over a period of time.

12.4 Record keeping
The record of a patient’s stay in hospital is an essential clinical tool. Nursing is not a memory game. The standard of record keeping by the nursing staff in the VOLH was poor. It was clear that a culture had developed in which record keeping was not considered to be a priority. Nurses maintained in evidence that with small wards they were fully aware of the needs of the individual patients without having detailed and complete records. This was a seriously flawed approach and must have contributed to failures in patient care.

The NMC Guidance emphasises that auditing plays a vital part in ensuring that good quality care is being provided to patients. Deficiencies identified through auditing can be responded to by staff training and development. No auditing of records was carried out from 1 January 2007 to April or May 2008. Peer audits of patient records had taken place in the past, but none had been carried out in the VOLH since 2003.

12.5 Nursing aspects of infection prevention and control
Nurses are at the frontline of the delivery of care. To deliver care to an acceptable standard to patients with CDI nurses must have the relevant knowledge and skills.

Prior to June 2008 the majority of nursing staff in the VOLH had no formal training on CDI. Some nurses in the VOLH had completed the Cleanliness Champions Programme prior to 1 June 2008 but the uptake was poor. Infection Control Nurses at the VOLH did visit wards to provide advice, but there was little evidence in the nursing records on the advice given because generally no record was made.

Evidence of the nurses’ knowledge of the seriousness of CDI as an infection was somewhat mixed. There was evidence that it was seen as a serious infection, but there was also evidence of a lack of awareness of the significance of the infection. A review
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of nursing records disclosed that there was little to suggest that nurses were aware of the seriousness of CDI as an illness. The importance of fundamental aspects of care, including fluid balance management and nutrition, was not recognised. Delays in the administration of antibiotics for patients who tested positive for CDI represented a wholly unacceptable level of care for patients who in the main were elderly and vulnerable and exposed to serious risk by contracting CDI.

Although the Loose Stools Policy quite rightly provided that a patient who could contaminate the environment with faeces should be isolated unless the patient was clinically unsuitable for isolation, the practice in the VOLH was not to isolate patients until a positive laboratory result of the diagnosis was obtained. This practice was to an extent influenced by a shortage of isolation rooms but because it was usually possible to isolate once the diagnosis was confirmed it was clear that isolation could have occurred earlier. The practice was an unsafe one and put asymptomatic patients at risk.

12.6 Isolation issues specific to ward F

The admission of a patient to ward F in February 2008 was badly managed. The patient was not symptomatic for CDI, but was admitted into a bay where there was at least one symptomatic patient. This patient later contracted CDI. The investigation into a complaint by this patient’s family was poorly carried out with the result that the Chief Operating Officer was misled and provided inaccurate information in response to the complaint.

12.7 Nursing assessments and care planning in the focus period

Effective patient assessment on admission to hospital is integral to the safety, continuity and quality of patient care. The assessment provides baseline information on which to plan care.

In the admission assessment documentation available in the VOLH many basic details were often not recorded. Some sections were not completed at all. Important information such as the patient’s weight, assessment of the risk of pressure damage, and the baseline observations of temperature, pulse, respiration and blood pressure, was regularly omitted from the assessments.

Pro forma nutritional assessment documentation was available but had not been distributed to all wards. Where available there were deficiencies in the assessments including a failure to regularly reassess the position and delays in patients being referred to a dietician. Other assessments like moving and handling and falls risks assessments were often either not completed at all or incorrectly completed with no evidence of reassessment.

Care planning is a term used to describe the process of assessing a patient’s needs. It is a prescription for care. The ability to prepare an appropriate care plan is a core skill, and the absence of an appropriate care plan makes it difficult for nurses and other members of the healthcare team to deliver consistent and coordinated care. Care planning should be seen as a mandatory professional responsibility.

Care plans were poorly completed and did not reflect all of the patient’s problems. In one ward the well recognised nursing model for care planning had been abandoned in favour of a medical model that simply consisted of listing the medical instructions on the care plan documentation. This was a wholly inappropriate model of care planning. For many of the patients who contracted CDI no care plans had been prepared.

12.8 Nursing notes and charts in the focus period

The nursing evaluation records are an important part of the patient records and are the direct responsibility of the nurses caring for the patients.

There were serious failures in the recording of patient information in the nursing evaluation records. There were unacceptable gaps in some records. The handover practices adopted at the VOLH included information obtained by the nurse during the shift being noted on a handover sheet for use during handovers. On many occasions this information had not been entered into the
There were serious failures in the recording of observations in patients who were ill with CDI and in the nursing management of pain. In general there was no proper recording of stools in patients with unexplained diarrhoea and also when there had been a diagnosis of CDI. The recording of fluid balance, of obvious importance to patients suffering from CDI and at real risk of dehydration, was poor.

12.9 Pressure damage in the focus period
Immobile, sick and weak patients are unable to move effectively and are dependent upon their carers to assist them. They are at particular risk of sustaining pressure damage. Patients who are suffering from CDI with profuse diarrhoea are particularly vulnerable to skin damage. That is one reason why moving and handling techniques are important in the management of these patients.

Effective nursing care should prevent pressure damage where possible. Early assessment of the risk to the patient is imperative so that appropriate measures can be put in place to prevent pressure damage or at least reduce the risk.

In the VOLH the intention was that the risk of pressure damage should be assessed on admission by using the established criteria contained in the Waterlow Scoring system. The appropriate documentation for the implementation of this system was available to nurses in the VOLH. The Waterlow Scoring system documentation was not, however, being used in ward 6.

There were serious deficiencies in pressure management. There were failures to assess patients and failures in documentation of the risk which included incorrect scoring. In cases where initial assessments were made, there were failures to review assessments appropriately and to prepare appropriate care plans. On the whole pressure and tissue management at the VOLH was poor. Inevitably this would have had an impact on care. So far as the Inquiry can ascertain at least 37 patients in the focus group of 63 patients suffered pressure damage, although it is not possible to say how many patients might have suffered some pressure damage prior to admission.

Between January 2007 and June 2008 the VOLH did not have a dedicated Tissue Viability Nurse (TVN). That task was being carried out by one of the Senior Charge Nurses (SCNs), which placed her in a very difficult position because of her responsibility for a busy medical ward. Given the importance of tissue viability a nurse who was an SCN on a busy ward should not have been selected as the TVN for the VOLH.

12.10 Nursing care in the early period
The nursing expert who examined the patient records for the early period (1 January 2007 to 30 November 2007) had access to 33 sets of patient records out of a total of 68 patients who tested positive for CDI. The trends evident on basic aspects of nursing care in the focus period were also present in the early period.

12.11 Staffing issues and care
Adequate staffing of nurses on wards is dependent not only on having the correct number of nurses, but also on having the correct skill mix to carry out the care appropriate to the level of patient dependency. Adequate nursing staffing levels are important for ensuring patient safety and quality of care. The staffing ratios for all the wards in the VOLH were acceptable for the number and nature of patients for these wards. Similarly the ratio of registered/trained to untrained staff on the medical wards was appropriate. The use of bank and agency staff was at an expected level.

What the staffing ratios do not do, however, is take account of a number of patients becoming unwell with profuse diarrhoea and requiring additional nursing input. Nor do the ratios for the Rehabilitation and Assessment wards take account of the fact that some patients in those wards may be medically unwell and may require nursing rather than rehabilitation care. The nurses’ evidence was that they were extremely busy on the wards, and that was regularly advanced as a reason why nursing records were incomplete. It is highly likely that, with patients in a
rehabilitation ward being acutely unwell and patients in different wards suffering from CDI, staffing levels were inadequate at times between January 2007 and June 2008. Activity levels on wards may very well at least partially explain why the nursing records were not kept as they should have been, but that does not in any way excuse the significant deficiencies found. Having regard to the serious failures identified, it is simply not tenable to maintain, as nurses did in evidence, that the care was in fact given.

12.12 Overall conclusions on nursing care
There were failures in fundamental aspects of nursing care of patients who suffered CDI. The SCNs must be primarily to blame for the deficiencies in their own wards.

Nursing Management was unaware of the extent of the problem with fundamental aspects of care. A functioning system of audit would have identified failures of the kind identified here and would have allowed remedial action to be taken. Effective Nursing Management would have identified the deficiencies in nursing care.

Ultimately NHSGGC must accept responsibility for the failures in nursing care identified in Chapter 12 of the Report.

13. Antibiotic prescribing
13.1 Antimicrobial policy and prudent prescribing
By letter dated 21 May 1999 addressed to Health Board General Managers and Chief Executives of NHS Trusts, among others, the Scottish Office Department of Health set out a wide range of actions aimed at reducing the emergence and spread of antimicrobial resistance and its impact on the treatment of infection. One of the key elements identified was prudent antimicrobial use.

In the years that followed this message was repeated. In 2002 the then Scottish Executive produced the “Antimicrobial Resistance Strategy and Scottish Action Plan” (the 2002 Action Plan). This was a three-year plan with aims that included the reduction of unnecessary and inappropriate use of antibiotics. Subsequently in 2005 a guide on the use of antibiotics for NHSScotland: “Antimicrobial Prescribing Policy and Practice in Scotland” (the 2005 guide) highlighted the challenges faced in antimicrobial prescribing, including concern about inadequate supervision of prescribing and inappropriate choice, duration of treatment and records of administration by junior doctors. One of the key recommendations of the 2005 guide was that a multi-disciplinary Antimicrobial Management Team (AMT) should be formed by each Health Board to be responsible for implementing antimicrobial policy and practice.

13.2 The 2008 Action Plan
In March 2008 the then Cabinet Secretary for Health and Wellbeing launched the “Scottish Management of Antimicrobial Resistance Action Plan” (the 2008 Action Plan) which was to replace the 2002 Action Plan. The 2008 Action Plan echoed the theme that had emerged in Scotland at least by 1999, and had persisted over the years, that it was known that antibiotic prescribing was not being carried out in a prudent manner.

13.3 Significant failures in implementation and monitoring
Prior to June 2008 the message on the importance of prudent antibiotic prescribing had certainly not reached the VOLH, where prescribing was far from prudent. The discovery of the CDI problem in the VOLH in May and June 2008 was a catalyst for change, but change in antimicrobial practices should have happened long before that time. Furthermore, reports into CDI outbreaks at the Stoke Mandeville and Maidstone and Tunbridge Wells hospitals published in 2006 and 2007 should have prompted an examination of antibiotic prescribing practice. A culture had developed in which clinicians, were using broad spectrum antibiotics in situations where they were no more effective against those infections that were sensitive to narrow spectrum antibiotics.

The recognition at national level of the need for prudent antibiotic prescribing and implementation of that policy produced an ineffective response by NHSGGC over a period of several years. The failure to
implement the prudent prescribing message should have been identified and remedied at an earlier stage by the Scottish Executive and later the Scottish Government. There was an obvious mismatch between expectation and implementation.

13.4 The Antimicrobial Management Team
The recommendation that Antimicrobial Management Teams (AMTs) should be set up was contained in the 2005 guide available to Health Boards from 5 September 2005. The NHSGGC AMT was not established until June 2007, but in circumstances that involved planning and financial support there was no undue delay by NHSGGC in setting up the AMT. A number of other Boards had not set up AMTs prior to June 2008, and were instructed by the Scottish Government to do so immediately after the problem with CDI at the VOLH came to light.

The NHSGGC AMT reacted swiftly and effectively to the emergence of the CDI problem at the VOLH. Steps taken to improve prudent prescribing had a dramatic impact on the number of CDI cases in the NHSGGC area even in the relatively short term.

13.5 Conclusion
The importance of prudent antibiotic prescribing had been recognised in Scotland for many years prior to June 2008. Important guidance was available but there was a mismatch between expectation and implementation that should have been addressed prior to June 2008.

14. Medical care
14.1 Inquiry medical experts
Medical experts commissioned by the Inquiry were given the patient records and Infection Control Cards of the patients allocated to them. Patient records from different wards were considered by each medical expert. The professional standards issued by the General Medical Council (GMC) were used by the medical experts as a benchmark for the standard of care expected from medical staff.

14.2 Record keeping
The GMC’s “Guidance for Doctors” effective from 13 November 2006 provided that doctors should keep clear, accurate and legible records, reporting the relevant clinical findings, the decisions made, information given to patients, and any drugs prescribed or other investigation or treatment. The message for doctors who want to show that care of the necessary quality has been given is to make an accurate and complete record of that care. As with nurses, good record keeping by doctors is an integral aspect of good care.

Records made by the consultants at the VOLH were generally adequate, but the recording of a patient’s condition and assessment made by junior doctors was poor. There was a real problem in identifying from some of the records why a particular antibiotic was being prescribed.

14.3 Medical staffing
Years of uncertainty over the future of the VOLH had a significant impact upon the recruitment of medical staff.

The departure of different specialist services from the VOLH over the years meant that the VOLH was regarded less and less as a potential source of senior education. Between January 2007 and June 2008 there were no middle grade doctors such as registrars in the VOLH. As a result a significant burden of managing patients was borne by junior doctors and added to the pressures on the senior medical staff. There was a lack of continuity of care. The pressure imposed upon one senior doctor because of his on-call duties had a significant impact upon his ability to conduct ward rounds.

The rehabilitation wards should have been mainly geared towards rehabilitation and not to looking after acutely ill patients. Between January 2007 and June 2008, however, acutely ill patients were in these wards, which increased the pressure on the doctors with responsibilities for these wards and impacted on care. This was recognised to an extent by management, and by at least February 2008 steps were being taken to monitor the provision of care at the VOLH while a decision on the future of the VOLH was awaited. Morale was low because of the uncertainty over the future of the hospital.
On inheriting the VOLH, NHSGGC took over a hospital that for a number of years had suffered losses of services and serious mismanagement. Uncertainty over the future of the VOLH and recruitment problems placed NHSGGC in a difficult position.

14.4 Medical management of CDI
A patient who tests positive for CDI should be reviewed that same day. That review should include a clinical assessment of the patient’s condition to assess the severity of the condition. The patient records disclosed, however, that there were delays in medical intervention with patients who had tested positive for CDI, suggesting that the severity of CDI as an illness was not properly recognised. Subsequent review should also be regular, which could mean on a daily basis. Even if it is accepted that there might have been more regular reviews than have been recorded in the patient records, it is clear that there were a significant number of instances where there was no review. Because junior doctors were at the forefront of care, their inexperience resulted in failures to notify senior medical staff when senior medical involvement was necessary.

The inadequacy of medical reviews and assessment compromised patient care. The lack of proper supervision of junior doctors was simply the result of the uncertain future of the VOLH as a hospital. Senior medical staff were exposed to pressures that limited their ability to provide the necessary supervision. It may not be easy for a Board to scrutinise the levels of medical care provided but assurance can be obtained that the quality and safety of care meet the requisite standard through appropriate systems. Ultimate responsibility for standards of care not being adequate rests with NHSGGC.

14.5 Do Not Attempt Resuscitation orders
A Do Not Attempt Resuscitation (DNAR) order is a written record of a decision that if the patient suffers a cardiac arrest he or she will not be resuscitated. A significant number of DNAR orders had been incorrectly completed, for example by failure to record a date for review. There was no evidence that the auditing envisaged by the DNAR Policy ever took place.

14.6 Antibiotic prescribing
In the period from 1 January 2007 to 1 June 2008 a variety of guidelines on antibiotic prescribing was being used at the VOLH. In the main there was consistency among the junior medical staff in the use of antibiotic prescribing guidelines. There was, however, a lack of uniformity in the use of guidelines among the senior medical staff, and there were some differences between the guidelines. This situation should not have developed. In a hospital like the VOLH clinicians should have been following one common agreed policy.

The patient records disclose that 60 of the 63 patients in the focus group did receive antibiotics while in the VOLH. At least 24 of those patients received antibiotics in the community which may have predisposed them to CDI, and at least three further patients had been prescribed predisposing antibiotics at the RAH before admission to the VOLH and before receiving antibiotic treatment in the VOLH. Nevertheless, more than half of the patients in the focus group were first prescribed antibiotics which predisposed them to CDI while they were in the VOLH. The antibiotics involved in the VOLH included third generation cephalosporins, quinolones and broad spectrum penicillins such as amoxicillin and co-amoxiclav (Augmentin). The prescribing of antibiotics in the VOLH therefore played a significant role in many of the patients in the focus group contracting CDI.

Poor documentation of the reasons for the choice of certain antibiotics made it difficult to ascertain whether or not the choice was appropriate. There were many examples of appropriate prescribing for conditions other than CDI. Nevertheless, it was evident that there were instances where the choice of antibiotic was inappropriate or where antibiotics were prescribed when unnecessary. There were also instances of the continued prescription of antibiotics in cases where a laboratory test demonstrated the organism was resistant to that antibiotic. After stricter controls were introduced in June 2008 there was a significant reduction in the use of co-amoxiclav in hospitals in NHSGGC, including the VOLH.
In most cases of CDI, once the treatment was started, appropriate antibiotic treatment by the prescription of metronidazole or vancomycin was given, although there were instances where ongoing monitoring should have led to a reassessment of treatment with greater input from a microbiologist.

14.7 The process for testing for *C. difficile* toxin

Delay in the prescription and administration of appropriate antibiotic therapy for CDI can have a significant impact on the management of the condition, and tends to make the outcome worse, particularly if the patient continues to receive broad spectrum antibiotics. The general practice adopted in the VOLH (with few exceptions) was that treatment for CDI was not started until a positive result was communicated by the Laboratory. This was in accordance with normal practice, but it does mean that there must be no undue delay between the taking of the specimen and the commencement of treatment.

There were a significant number of cases where there were either delays in the processing of specimens or delays in the commencement of treatment after the ward was aware of the result. There were also cases where there was a combination of processing and treatment delays, and these combined delays resulted in treatment being delayed for periods ranging from two to seven days. The delays identified in the commencement of treatment after positive results were known by the ward were inexcusable. The patients concerned continued to be unnecessarily exposed to any existing antibiotic treatment that they were receiving and to an untreated serious and potentially life-threatening infection.

No doubt there were failures by individuals in relation to antibiotic prescribing and for the delays in the treatment of CDI patients, but the ultimate responsibility for standards having become unacceptable must rest with NHSGGC.

14.8 Conclusion

The medical care of patients suffering from CDI was inadequate. Poor record keeping, failures in carrying out proper medical assessments and review, inappropriate prescribing and unacceptable delays in the commencement of appropriate antibiotic treatment after positive results were available, compromised patient care.

15 Infection prevention and control

15.1 The constitution of an Infection Control Team

Clear guidance has been in place on the constitution of an Infection Control Team (ICT) since 2001. The ICT should include an Infection Control Doctor (ICD) and properly trained Infection Control Nurses (ICNs). The ICD should be the leader of the ICT. NHSGGC had ICTs in place for the sectors that made up the NHSGGC area. The VOLH was in the Clyde Sector as was the RAH and the IRH.

15.2 The Infection Control Team for the VOLH

During most of the period from 1 January 2007 to 1 June 2008 there were two Infection Control Nurses based at the VOLH. The senior Infection Control Nurse, Mrs Jean Murray, became interim Lead Nurse for infection control for the Clyde Directorate in July 2007, which involved taking on additional responsibility for infection prevention and control outwith the VOLH. She began a period of phased retirement in January 2008 and stopped work on 17 March 2008. The other Infection Control Nurse, Mrs Helen O’Neill, did not have a qualification in infection prevention and control. Particularly during Mrs Murray’s phased retirement Mrs O'Neill bore the brunt of the infection prevention and control duties at the VOLH.

The ICD for the Clyde Sector for the period from 1 January 2007 to early February 2008 was Dr Elizabeth Biggs. She was based at the IRH. Dr Biggs was under a duty to take a lead role in the effective functioning of the Infection Control Team. Dr Linda Bagrade took over as ICD in February 2008.

No formal appraisals of the Infection Control Team members were carried out in the period 1 January 2007 to 1 June 2008. At that time there was no functioning formal system of
appraisals in place at the VOLH, a situation that had existed for several years.

15.3 The infection prevention and control management structure
Ms Marie Martin had been the General Manager of Diagnostic Services for the Clyde Sector since April 2006, with a remit that also included responsibilities for infection prevention and control. Within the infection control structure for the Clyde Sector Ms Martin was the designated line manager for Dr Biggs and for Dr Biggs’ successor, Dr Bagrade. Ms Martin had a duty to ensure that there was adequate staff in place and that the staff had the resources and assistance in place to allow them to do their job. Ms Martin reported to Mrs den Herder. Within the Clyde Directorate Mrs den Herder had overall line management responsibility for infection prevention and control, with a reporting line to the Chief Operating Officer of the Acute Services Division.

Ms Martin failed to address the obvious and significant gap created by Mrs Murray’s phased retirement, particularly when Mrs O’Neill was an unqualified ICN and required supervision. This was at a time when a significant problem with CDI had developed in the VOLH.

15.4 Implementation of policies and training
The Infection Control Manual available in the VOLH contained appropriate policies relevant to infection prevention and control. Medical staff had not received training in infection prevention and control (other than as part of their undergraduate training) and had little awareness of the policies contained in the Infection Control Manual. Nursing staff did have an awareness of the Infection Control Manual. The relatively small number of nurses who had undertaken the Cleanliness Champions Programme would have gained some insight into aspects of infection prevention and control. Evidence from the nurses, however, suggested that prior to June 2008, they had received no formal training in CDI.

Important policies contained in the Infection Control Manual included the Outbreak Policy, the Loose Stools Policy and the *C. difficile* Policy. The Outbreak Policy defined the action to be taken if an outbreak was suspected or confirmed. The Loose Stools Policy identified the importance of patients suffering from loose stools being placed in a single room. In the main this was not the practice in the VOLH prior to 1 June 2008, with the result that the risks of cross-contamination were greatly increased. In a significant number of cases delays in isolation after the result was known increased the risks of cross-contamination even more. The *C. difficile* Policy highlighted the importance of hand hygiene and the fact that soap and water had to be used in conjunction with alcohol hand rub before and after direct patient contact.

The message contained in guidance issued by the Scottish Executive and subsequently by the Scottish Government that infection control was everyone’s business had not reached the medical staff at the VOLH, and was not practised by the nursing staff in a number of respects, including the failure to isolate potentially infectious patients, and failures in stool charting and care planning.

15.5 The Infection Control Manager
Mr Thomas Walsh, the Infection Control Manager for NHSGGC from 25 June 2007, did not have any operational or line management responsibilities for infection prevention and control. The reference to management in his job description related to “management of the processes rather than the management of human resources involved …”. The Infection Control Manager’s role was based on the then Scottish Executive Health Department guidance, but after June 2008, and following upon the events at VOLH, in January 2009 the role of the Infection Control Manager was changed so as to incorporate operational and line management responsibilities. That was a highly desirable change as the role created by NHSGGC for the Infection Control Manager, as understood by Mr Walsh, was not one that produced a system providing effective leadership of infection prevention and control.

15.6 The Nurse Consultant
The Nurse Consultant for Infection Control in the period from 1 January 2007 to 1 June 2008, Ms Sandra McNamee, had a
job description that required her to provide “strong strategic and clinical leadership across NHSGGC”. Like the Infection Control Manager, the Nurse Consultant did not have line management or operational responsibility for the Infection Control Teams. Ms McNamee did take over managerial and operational responsibility for the Infection Control Nurses of NHSGGC from 2009 as Assistant Director of Nursing for Infection Prevention and Control, and again this was an important change of remit that could only serve to strengthen the infection prevention and control system. If the Nurse Consultant had had more operational responsibility for the infection prevention and control structures, she would have been in a better position to identify deficiencies in those structures.

15.7 The infection control committee structure

NHSGGC had in place a committee structure designed to report infection control issues from the VOLH to the Board.

Within the VOLH itself, there was a link nurse system in place. There was no reporting line from the meetings of this Group, its apparent purpose being to increase awareness of infection prevention and control issues at ward level. The meetings of this Group were poorly attended, and there was no evidence before the Inquiry that it made any effective contribution to infection prevention and control in the VOLH in the period from 1 January 2007 to 1 June 2008.

The VOLH Infection Control Working Group (the Working Group) was also a local Group based at the VOLH, and was chaired by Mrs Murray. Meetings of the Working Group were also poorly attended, and the meeting planned for December 2007 did not take place because so many apologies for non-attendance were received. The next meeting should have been in March 2008, but again no meeting took place.

The Working Group had a reporting line to the Clyde Acute Infection Control Support Group (the Support Group). The Support Group was supposed to be the main Group within the Clyde Sector for identifying, responding to and reporting infection prevention and control issues. It was chaired by Dr Biggs. At the meeting of the Support Group of 10 July 2007 Dr Biggs indicated that she felt that the ICD should not be the person to chair the Support Group. The next planned meeting on 9 October 2007 therefore did not take place, and indeed the Support Group did not meet again. The combined failures of the Support Group and the Working Group resulted in a significant gap in the reporting chain that was designed to report from ward to Board.

The reporting line for the Support Group was to the Acute Control of Infection Committee (ACIC). In the period from 1 January 2007 to 1 June 2008 the ACIC was chaired by Dr Robin Reid, Associate Medical Director Diagnostics. In addition to the Clyde Sector, all other NHSGGC areas reported to the ACIC. The ACIC reported to the NHSGGC Board Infection Control Committee (BICC) chaired by Dr Syed Ahmed, Consultant in Public Health Medicine. The BICC reported to the Chief Executive and also to the Board CG Committee. Dr Biggs was a member of the BICC but did not attend any meeting from January 2007 to 1 June 2008.

15.8 Reporting within the infection control committee structure

From 1 January 2007 to June 2008 the reporting of issues about infection prevention and control was carried out within an established system of “exception reporting” designed to control the flow of information through the hierarchy of committees. This meant that at the levels of the ACIC and the BICC an issue would only be reported if, for example, there was a concern that it was outwith normal parameters. An outbreak of CDI would qualify for exception reporting, although in practice any outbreak ought to be identified and responded to before any meeting took place.

The system of exception reporting provided an important filter of information within an organisation as large as NHSGGC. It was important that senior management was not inundated with matters that could be managed adequately at levels further down the chain. Such a system, however, does depend upon individuals recognising and reporting exceptional events. Because
there were significant individual failures within the Infection Control Team for the VOLH, important information on the nature and extent of the CDI problem in the VOLH was not being transmitted to the ACIC. Consequently there was no discussion at the ACIC level about the prevalence of CDI in the period from January 2007 to June 2008. Similarly, the BICC was not made aware of the persisting problem with CDI at the VOLH.

The exception reporting system therefore failed to identify the CDI problem that existed in the VOLH throughout most of 2007 and up until its discovery in May 2008. It is undoubtedly the case that, if the infection control structure had worked in the way it was intended to work, the problem with CDI at the VOLH would have been discovered and responded to.

Infection prevention and control is a core part of patient safety, and senior management ought to have been made aware of the rates and trends of a hospital associated infection such as CDI. The principle of Board to ward and ward to Board means that there must be an unbroken line of reporting, accountability and assurance. The failure to have a system in place whereby rates and trends of CDI in hospitals such as the VOLH were being made available at least to meetings of the ACIC and subsequently reported to the Board, was a system failure and one that contributed to the CDI problem persisting up to June 2008. This is a failure for which NHSGGC has to bear ultimate responsibility.

15.9 The failure of the committee structure
As the chair of the Working Group, Mrs Murray was directly responsible for its failure to meet after 28 September 2007. Dr Biggs was directly responsible for the failure of the Support Group to meet after 10 July 2007. Ms Martin knew the Support Group had ceased to meet and had direct responsibility to tackle the problem created by Dr Biggs’ failure to convene the Support Group. Ms Annette Rankin, Infection Prevention and Control Head Nurse, was aware that the Support Group had ceased to meet and failed to raise this issue at meetings of the ACIC that she attended. Mrs Murray, as a member of the Support Group, was also aware that it had ceased to meet. She too had opportunities to raise the issue, particularly at meetings of the ACIC at which she was in attendance. Although Mrs den Herder has maintained in correspondence that she did not know the Support Group had ceased to meet, she did receive the minutes of the Support Group and it should have become apparent to her that that Group had stopped functioning.

The respective chairs of the BICC and the ACIC, Dr Ahmed and Dr Reid, were not made aware of the failure of the Support Group. Nor was the Infection Control Manager, Mr Walsh.

15.10 Surveillance systems
Effective surveillance is a necessary prerequisite of a properly functioning infection prevention and control system.

In the VOLH the Infection Control Nurses operated a T-card monitoring system. This system involved identifying a patient who had been diagnosed with CDI by entering information onto a yellow T-card which was then placed in a rack by reference to the ward in which the patient was accommodated. If there were two or three CDI cases in a particular ward at the same time there would be two or three yellow cards in a line to display that information. In that way the system could provide contemporary information on the number of positive cases and alert the Infection Control Nurses to a potential problem with CDI. As disclosed by an examination of the T-cards, the Infection Control Nurses’ record keeping was totally inadequate.

The VOLH also had an Access database system. The Infection Control Nurses entered information into the system on patients who tested positive for CDI. It was then possible to access data in different forms from the database and extract those data to create reports and identify trends.

The Infection Control Nurses at the VOLH should have been able through regular visits to wards to identify the extent of the CDI problem that persisted in the VOLH during the period from 1 January 2007 to 1 June...
2008. In any event the systems available were themselves perfectly adequate to enable the Infection Control Nurses to discover the existence of potential outbreaks of CDI.

15.11 Failure to identify outbreaks

The failures at local level to appreciate the nature of the persisting CDI problem at the VOLH were serious and had a profound effect on patient care. At different points in time during the period from 1 January 2007 to 1 June 2008 it was apparent in different wards that there were patients suffering from CDI who were linked in time and place. The medical staff seemed oblivious to the persisting CDI problem. Any focus given to CDI patients by nursing staff was influenced by Mrs Murray’s perspective that the problem could be explained by factors other than cross-contamination.

At the meeting of the Support Group on 9 May 2007 a report was presented by Dr Biggs containing important information on the status of CDI patients in the VOLH. The report disclosed that in April 2007 there were 22 positive results for CDI in the VOLH. Another source of evidence in that report disclosed that four patients tested positive for CDI in ward 14 in the week beginning 13 April 2007. This was a relatively early opportunity to identify the extent of the problem with CDI in the VOLH, but it was an opportunity that was completely missed. An appropriate response to the information contained in the report would almost certainly have identified the CDI problem and saved a significant amount of further suffering. Dr Biggs’ response, as Infection Control Doctor, was totally inadequate and professionally unacceptable.

In the period from 1 January 2007 to 1 June 2008 there were a number of opportunities to carry out a proper investigation into why there were patients suffering from CDI in different wards in the VOLH. Because no proper investigations were carried out no ribotyping of the positive C. difficile toxin samples was conducted which would have established whether the same strain of infection was involved. However, it is inconceivable that there were no outbreaks during that period.

Mrs Murray, as the Senior Infection Control Nurse at the VOLH, repeatedly failed to recognise that the most likely explanation for the presence of two or more patients suffering CDI in the same ward and closely linked in time was cross infection. She excluded cross infection because in her view there were other risk factors that could lead to patients developing C. difficile diarrhoea. Her position was completely illogical, particularly when the great majority of the cases of CDI were described in the Access database system as “hospital related”. Her failures were serious failures and contributed in a significant way to the persisting CDI problem at the VOLH. The failures meant that the outbreak procedures contained in the Infection Control Manual were never invoked. If they had been, other levels of management within the infection control structure would have been alerted to the CDI problem.

15.12 Role of the Microbiologists

By 2005 there was real concern about the number of vacant microbiology posts in Argyll and Clyde, with two out of the five positions being vacant. The resident microbiologist in the VOLH had resigned in 2002 and another microbiologist had left her post at the RAH in 2005, with neither post being filled. Arrangements were made to provide some microbiology cover for the VOLH which were intended as a stopgap pending the appointment of additional microbiologists. Dr François de Villiers, Consultant Microbiologist at the IRH, and Dr Barbara Weinhardt, Consultant Microbiologist at the RAH, were involved in these arrangements, under which limited on-site clinical microbiology cover was provided at the VOLH by Dr de Villiers. Difficulties in recruitment meant that the vacant posts were not filled until early 2008, with the result that the staffing arrangements for consultant microbiologists in the Clyde Sector were unsatisfactory throughout the period from January 2007 to January 2008. The unsatisfactory nature of the arrangements was compounded by Dr Biggs’ failures in her duty as ICD.

C. difficile toxin positive results required to be authorised by a consultant microbiologist. Although on occasion that did not happen, the
number of positive reports being authorised in December 2007 and into early 2008 did make consultant microbiologists in Clyde aware of an increased incidence of CDI. One of these consult microbiologists raised the issue with Dr Biggs, suggesting that she should investigate the position in hospitals for which she was the Infection Control Doctor. There is no evidence that Dr Biggs carried out any investigation into the prevalence of CDI at the VOLH. In December 2007 and January 2008 there were patients suffering from CDI in a number of wards in the VOLH, and an investigation at that time would have disclosed the likelihood of an outbreak.

Prior to the appointment of the two additional microbiologists in early 2008, the system in place meant that a co-ordinated, integrated microbiology service was not being provided to the VOLH.

**15.13 The Infection Control Doctor**

Dr Biggs was the designated ICD for the Clyde Sector, which included the VOLH. This was a responsibility that certainly spanned the period from 1 January 2007 to early February 2008, when Dr Bagrade took over as ICD. Dr Biggs was unable on health grounds to provide a written statement or give oral evidence to the Inquiry.

Professional line management has an important role to play in providing advice and support, but there seems to be some confusion over who was Dr Biggs’ professional line manager after April 2006. Dr Elizabeth Jordan, the Associate Medical Director, should have been Dr Biggs’ professional line manager until she left her post in August 2007, and there was a suggestion in the police statement Dr Biggs provided in September 2009 that Dr Jordan was her line manager at least up to May 2007. In any event there is no evidence that any real professional line management support was provided to Dr Biggs in 2007, and this is a factor that must be taken into account when considering Dr Biggs’ attitude to her role as ICD. She was unhappy with her role and with changes implemented by NHSGGC, and a higher level of support should have been available to her.

Although Dr Biggs did not receive a job description providing details of her role until 19 September 2007, she could have been under no misapprehension as to what her duties were as Infection Control Doctor. She did not question the terms of the job description once she received it.

Ms Martin had line management (non-professional) responsibilities for infection prevention and control and was the line manager for Dr Biggs and Dr de Villiers. The suggestion by her that Dr de Villiers was to cover Dr Biggs’ ICD responsibilities at the VOLH when he went there is not accepted by the Inquiry. This simply highlights the dysfunctional nature of the arrangements for infection prevention and control at the VOLH. In a series of emails in 2007, mainly to Ms Martin, Dr Biggs raised a number of issues in relation to her position as ICD. Dr Biggs made it clear that she had no intention of carrying out her responsibilities as ICD, an attitude that demanded a prompt and effective response.

Dr Biggs’ attitude to her role as ICD so far as the VOLH was concerned was inappropriate and professionally unacceptable. She was the leader of the Infection Control Team. She was not performing her duties as ICD at the VOLH. She had minimal contact with the Infection Control Nurses there and provided little support or leadership. Her attitude to Ms Annette Rankin, Head Infection Control Nurse for NHSGGC, was unprofessional.

Dr Biggs’ self-imposed restriction on her role as ICD for the VOLH was without justification, whatever reservations she may have had over changes to the infection control structure. Her failure to carry out her duties as ICD for the VOLH was a serious failure on her part and would have contributed significantly to the ongoing CDI problem there and to unnecessary suffering to patients.

**15.14 Knowledge of Dr Biggs’ failure as Infection Control Doctor**

Clearly Mrs Murray and Mrs O’Neill knew that Dr Biggs was not attending to her ICD responsibilities at the VOLH. Mrs Murray had discussions with Ms Rankin about Dr
Biggs’ failure to carry out her ICD duties, and Ms Rankin did pass on her concerns about Dr Biggs to Mr Walsh. Mr Walsh may not have been aware of the extent of the problem, but he could not avoid being aware that there was a problem, and he should have conducted some enquiries to see if the problem had been resolved.

Ms Martin knew that Dr Biggs did not attend the VOLH. She had no proper basis in fact to believe that Dr de Villiers was covering as ICD for Dr Biggs. As Dr Biggs’ line manager (non-professional) Ms Martin failed to deal with the problems created by Dr Biggs in her attitude to her role as ICD. Mrs den Herder did not know that Dr Biggs was not fulfilling her role as ICD, but she ought to have been made aware of the problem. Ms Martin in particular ought to have made her aware of the problems with Dr Biggs. Ms Martin’s failure to address the problems created by Dr Biggs was a serious failure.

The reality is that in the latter part of 2007 no-one was prepared to tackle the issues associated with Dr Biggs. By then there was a plan to replace Dr Biggs after the appointment of the two new consultant microbiologists but that does not excuse the failure to deal at the time with an ICD who was not carrying out her infection prevention and control responsibilities for the VOLH.

15.15 The secondment issue
Ms Martin claimed that she was on full-time secondment to the Picture Archiving Communication Systems (PACS) project from August 2007 to April 2008 and that when on secondment her responsibilities for infection prevention and control ceased.

Both these claims are incorrect. In September 2007 there had been some discussion about the possibility of early integration through which managerial responsibility for infection prevention and control for the Clyde Sector would be integrated within Greater Glasgow and Clyde but that was not pursued. The position in fact is that Ms Martin did remain responsible for infection prevention and control. Mrs den Herder recognised that Ms Martin would require support to provide her with sufficient time to undertake the PACS work. That support was not adequate and

Ms Martin complained to Mrs den Herder about the pressure she was under due to the extent of her responsibilities. Mrs den Herder should have responded positively to these complaints but she failed to do so. Ms Martin’s complaints of overwork should have alerted Mrs den Herder to the real possibility that the management of infection prevention and control was being neglected.

15.16 The reporting of C. difficile data to Health Protection Scotland and the Public Health Protection Unit
Mandatory reporting of C. difficile toxin positive cases was required as part of the national surveillance system from 1 September 2006. Reports providing details of C. difficile toxin cases are sent to Health Protection Scotland (HPS). This reporting system was never designed to be a surveillance tool; it is simply a method of identifying how many patients had been diagnosed with CDI as part of the national surveillance programme. The system of national surveillance was not intended to replace effective systems of local surveillance and reporting.

Copies of the reports sent to HPS were also sent to the NHSGGC Public Health Protection Unit (PHPU) on a weekly basis. This system of reporting did allow the PHPU to perform a surveillance function in connection with certain diseases in the community, but this did not constitute a surveillance system of CDI that was hospital acquired. The PHPU could not have been expected to identify the CDI problems at the VOLH.

15.17 Statistical Process Control Charts
The Statistical Process Control (SPC) Chart is a surveillance tool that can provide retrospective information on a monthly basis on the number of C. difficile toxin positive patients and trends. Although available in 2007 in some NHSGGC areas, SPC Charts were not introduced to the VOLH until April or May 2008.

Had the SPC Charts been in place in 2007, an increased level of awareness would have been generated in relation to rates of CDI at the VOLH and the CDI problem would have been discovered sooner. That having been said, the
dissolution of NHS Argyll and Clyde and the commencement of the process of integration with GGHB only took place in April 2006, and the preparation for the introduction of the SPC chart system to the VOLH was going to take some time. It was therefore not unreasonable that the introduction of the SPC chart system to the Clyde Sector, and the VOLH in particular, suffered some delay in comparison to other areas of NHSGGC. In any event, SPC Charts are not a substitute for acute observation in real time. The surveillance systems in place at the VOLH should have alerted the Infection Control Team to the extent of the problem with CDI.

15.18 The VOLH Laboratory accreditation
Following an inspection by the accrediting body in January 2003 the VOLH laboratory was granted conditional approval. That remained the position until another inspection on 18 and 19 September 2007. The September 2007 inspection produced a list of 43 non-compliances, although the inspectors’ overview report described the laboratory as well managed and well led. The numerous document control issues disclosed by the inspection were explained by the fact that the laboratory was in a transitional phase of migrating to an electronic system. The inspectors concluded that despite the number of non-compliances the quality of the service being provided was not being compromised.

Despite the conclusion of the overview report the extent of non-compliances shows that the general management of the microbiology service did need to be improved.

15.19 Risk registers
Risk registers are an important strategy for the management of risk in the delivery of healthcare. The creation and maintenance of a risk register ensures that risks relevant to a particular area of healthcare have been identified. Where possible risks are removed, but otherwise the risk register ensures that appropriate controls and precautions are in place to prevent those risks materialising.

The key to the creation of a risk register is risk assessment. Within an organisation such as NHSGGC, risk registers should be maintained at different levels including hospital level. NHSGGC implemented a risk register policy on 1 April 2006, acknowledging that the continuing development of a comprehensive risk register was a core part of risk-management activity.

A risk register specifically for infection prevention and control for the Acute Services Division was first discussed at a meeting of the ACIC on 26 November 2006. Subsequently there was some further discussion at meetings of the ACIC, but the risk register for infection prevention and control was not approved until the ACIC meeting held on 3 December 2008. Reference to CDI did not feature in earlier drafts of the risk register and it was only at the meeting of 3 December that the decision was taken to include CDI. Having regard to a timescale that first began in November 2006 the approval of the risk register in December 2008, just over two years later, represents undue delay. Account does, however, have to be taken of the fact that when that process began it was one of the many issues facing NHSGGC at a time of significant change. Furthermore, the emergence of the VOLH CDI problem did increase the level of attention paid to infection prevention and control.

15.20 Hygiene, environment and audits
National C. difficile guidance published in 1994 emphasised the importance of personal and environmental cleanliness in the prevention and control of CDI. Hand hygiene in particular is of extreme importance in the prevention of an infection like CDI but so too are environmental factors. Damaged surfaces make cleaning more difficult because it is harder to remove micro-organisms from damaged or irregular surfaces than from smooth surfaces.

The Cleanliness Champions Programme (CCP) was launched as part of the first HAI Task Force Plan in September 2003, and was viewed as an important aspect of infection prevention and control. The programme’s two main themes were safe practice and safe environment.

In a letter dated 18 March 2005 addressed to Chief Executives, NHS Boards and Nursing Directors, the Chief Nursing Officer reinforced
the importance of the CCP by requiring all G grade sisters/SCNs to undertake the CCP “forthwith” while adding that account should be taken of workload and available access to the required IT resources.

By 15 May 2007 NHSGGC was underperforming generally on completion of the CCP, an issue raised at the ACIC meeting of that date. In the VOLH the completion rate for the CCP in the period prior to June 2008 was extremely slow. The CCP did not receive the priority it should have received, and a more determined attitude to infection prevention and control would have provided more impetus to the implementation of the programme.

In the period leading up to June 2008 the fabric of the VOLH was in a poor state. Areas of flooring were damaged and covered in adhesive tape. Inspections carried out in May 2008, when the problem with CDI was emerging, identified an unsatisfactory hospital environment that included a lack of wash-hand basins, commodes that were not fit for purpose and required urgent replacement, and storage problems. At the dissolution of NHS Argyll and Clyde in April 2006 NHSGGC inherited a hospital in which underinvestment in maintenance and infrastructure had existed for a number of years. The environmental deficiencies had existed in the years prior to dissolution and persisted afterwards without resolution. There was an acceptance that because of the lack of investment, improvements were not going to happen until a decision on the VOLH’s future could be made.

The infection control audit process did identify key areas of persistent non-compliance, but there was no effective process of ensuring managerial awareness at a level where appropriate action could be taken. Environmental issues that had a clear impact on infection prevention and control were not addressed. Patients were put at risk. Staff morale was affected. Uncertainty led to the acceptance of the unacceptable from the perspective of patient safety.

15.21 Changes after June 2008
The NHSGGC Board responded promptly to the discovery of the failures that had occurred in the VOLH prior to June 2008. A single management structure, with the Board Medical Director as the accountable executive officer reporting to the Chief Executive has been put in place. The Board Medical Director is required to bring infection control and HAI reports to every Board meeting. New posts have been created to strengthen the management structure so that the principle of ward to Board and Board to ward accountability is as effective as possible.

The infection prevention and control committee structure has been changed, with the VOLH now under the jurisdiction of the North West Sector of NHSGGC. Governance, accountability and reporting arrangements have been significantly changed with the aim of producing an effective monitoring and reporting system of HAIs such as CDI.

Infection prevention and control education and training programmes have been implemented for all staff. NHSGGC pursues a policy that treats patient experience and involvement as an important element in the infection prevention and control programme. NHSGGC has also established an inspection regime in which multi-disciplinary teams inspect hospitals following methodology adopted by the Healthcare Environment Inspectorate.

Between June 2008 and June 2012 a sum in excess of £4.5m was invested in improving healthcare and the general environment at the VOLH. This improvement programme included the provision of additional wash-hand basins and the creation of more single rooms. After years of neglect there has been significant investment in the VOLH by NHSGGC.

15.22 Conclusion
The personal and system failures in infection prevention and control identified in Chapter 15 had a profound effect upon the care provided to patients at the VOLH. NHSGGC must bear ultimate responsibility for these failures. NHSGGC did learn lessons from the failures by introducing significant changes after 1 June 2008.
16. Death certification

16.1 Form of death certificate

The section of the death certificate which is devoted to the cause of death is divided into two parts. Part one deals with the direct cause of death and any conditions giving rise to that direct cause. Part two deals with other conditions which have contributed to death but are not part of the main sequence of events leading to death.

Death certification is a matter of professional judgement. The doctor needs to make a judgement as to what is the direct or immediate cause of death for entry into Part 1 of the death certificate and also a judgement as to which of the illnesses suffered by the patient are relevant for entry in Part 2 of the death certificate.

16.2 The 1999 guidance on death certification and VOLH practice

Guidance on the completion of death certificates was issued by the Registrar General for Scotland in January 1999. That guidance provided that it was “best if a consultant, general practitioner or other experienced clinician” certified the death. The guidance went on to provide that for a death in hospital an inexperienced doctor should only certify the death if closely supervised and if the experienced clinician was content that the causes of death were accurately recorded.

Notwithstanding the guidance, in practice consultants in Scotland were rarely involved in death certification in 2007 and 2008. That practice was reflected in the VOLH where, of the 33 extracts from the register of deaths examined, none of the death certificates had been signed by a permanent consultant and in the majority of cases the death certificate was signed by junior doctors. There was some evidence in the patient records that in some instances junior doctors did contact a consultant, but in the majority of cases the death certificate was signed by a junior doctor without any recorded consultation with senior medical staff.

Before issuing a death certificate the doctor concerned is obliged to consider whether or not the death should be reported to the Procurator Fiscal. Guidance issued by the Crown Office and Procurator Fiscal Service (COPFS) in November 1998 set out certain categories of death that were to be reported to the Procurator Fiscal but did not make any explicit reference to HAI or *C. difficile* infection. That guidance was updated in October 2008 to include HAI.

16.3 Accuracy in death certification in the VOLH

Accuracy in death certification is crucial in order to allow collation of data to enable the identification of trends and the establishment of public health measures to prevent diseases. At a more personal level it is very important for family members to know the cause or causes of death of a family member. A number of patients who died in the VOLH did not have CDI mentioned on their death certificates when in fact CDI should have been mentioned.

16.4 Updated guidance

Guidance issued in September 2009 and in October 2011 by the Chief Medical Officer (CMO) of the Scottish Government emphasised the important role to be played by consultants in death certification.

16.5 Collation, analysis of data and future changes

In the guidance issued in September 2009 the CMO envisaged that the reporting of HAI related deaths to the Procurator Fiscal would allow the local Area Procurator Fiscal to identify any clusters of HAI related deaths. The COPFS does not in fact collate information on HAI related deaths. The function of the COPFS is to investigate, and it does not have a surveillance function of the kind envisaged by the CMO. The Scottish Government should identify a national agency to monitor HAI mortality rates, and CDI deaths in particular.

16.6 Conclusion

The guidance on death certification in place in 2007 to 2008 had been issued in January 1999 and was inadequate and outdated. Death certification was viewed as a low priority despite the important role it plays.
The Inquiry's examination of the manner in which the deaths were certified in the VOLH disclosed that there was a lack of understanding of the way in which death certification should be carried out. Doctors need to be trained in the completion of death certificates.

17. Investigations from May 2008

17.1 The Independent Review

In June 2008 the Cabinet Secretary for Health and Wellbeing announced an Independent Review of the cases of *C. difficile* infection at the VOLH. That was led by Professor William Cairns Smith, OBE, Professor of Public Health at the University of Aberdeen. The report was published in August 2008, and an audit in December 2008 of the implementation of its recommendations concluded that rapid and very significant progress had been made in the VOLH.

17.2 Vale of Leven Internal Investigation report

An Internal Investigation was commissioned by Mr Calderwood, then the Chief Operating Officer, in June 2008 when he became aware of CDI cases and associated deaths.

The remit of the Internal Investigation was a narrow one and concerned with who knew about the *C. difficile* cases, what action was taken, and to whom matters were reported. The Internal Investigation team did not in fact limit its investigation to the terms of its remit; the Internal Investigation report proposed, for example, that each Directorate's Clinical Governance Committee should have a standing item on “Control of Infection”. In response to its specific remit the Internal Investigation did not identify any knowledge of the VOLH CDI problem within management.

The setting up of the Internal Investigation was an important and appropriate step, and identified some learning opportunities at an early stage. It did not identify errors or failures which must have been present to allow outbreaks to occur and to go unnoticed, but its remit was limited and its work was overtaken by the Independent Review.

17.3 Outbreak Control Team Investigation

The second investigation conducted by NHSGGC was in the form of an Outbreak Control Team (OCT) Investigation that began in June 2008 and reported in October 2008. It had a broader remit that involved investigating all aspects of the “outbreak” and ensuring that all control measures were in place.

The OCT’s report identified the outbreak period as 1 December 2007 to 31 May 2008. The number of cases of CDI in that period was identified as 55, with CDI identified as having caused or contributed to the death of 18 of 28 patients who died. These were underestimates of the numbers of patients and deaths.

The OCT concluded that the number of cases of CDI at the VOLH in the period examined was more than expected, and that the fatality rate appeared to be higher than reported from elsewhere.

The OCT report identified the T-card system as the surveillance system in place at the time, but failed to mention the Access database that was capable of providing regular surveillance reports.

As was the case with the Internal Investigation, the OCT’s investigation was somewhat truncated by the appointment of the Independent Review. Nevertheless the OCT report did make a number of valuable recommendations, including the review of roles and responsibilities and the communication chain for HAI, the commencement of a programme of work to improve the structural environment of the VOLH, the auditing of antimicrobial policy, and education on infection control and HAI issues.

17.4 Conclusion

The Internal Investigation and the OCT investigation did not examine the nursing and medical care given to patients who contracted CDI for the simple reason that their respective remits did not cover this issue. The setting up of the Internal Investigation was an appropriate step in the circumstances that emerged in May/June 2008.
18. Experiences of *C. difficile* infection within and beyond Scotland

18.1 The 027 strain
At the time of the Stoke Mandeville and Maidstone and Tunbridge Wells outbreaks, and in the aftermath of those outbreaks, the 027 strain was seen as a “hypervirulent” strain because it caused more severe disease and more deaths. The hypervirulent nature of the 027 strain was recognised by Health Protection Scotland in 2006, before the discovery of the CDI problem at the VOLH, as a strain capable of causing very severe disease and death.

18.2 The Stoke Mandeville and Maidstone and Tunbridge Wells reports
In July 2006 the Healthcare Commission in England published a report into two outbreaks of CDI at the Stoke Mandeville Hospital, the first between October 2003 and June 2004 and the second between October 2004 and June 2005. Many of the cases of CDI were due to the 027 strain. The report identified many failures in the management and care of patients suffering from CDI which were similar to the failures identified by the Inquiry at the VOLH. It highlighted the poor state of repair of the buildings, failures to isolate patients with diarrhoea, lack of facilities for hand washing and low priority afforded to infection control. There were nursing failures where fluid balance was given little attention and poor care planning and nursing assessments. At the time of its investigations the Healthcare Commission did, however, discover that the hospital policy on the use of broad spectrum antibiotics had already been changed in response to the cases of CDI.

In October 2007 the Healthcare Commission produced a report into outbreaks of *C. difficile* at Maidstone and Tunbridge Wells NHS Trust. That report identified a significant number of issues similar to the issues identified by the Inquiry at the VOLH, including the unnecessary administration of broad spectrum antibiotics, inadequate fluid management and an inadequate level of training on infection control.

System failures were also identified. The report’s recommendations, as with the recommendations of the Stoke Mandeville report, were of UK-wide relevance.

18.3 The NHS Greater Glasgow and Clyde response to Stoke Mandeville and Maidstone and Tunbridge Wells
Within NHSGGC a number of people were aware of the Stoke Mandeville report, in particular those with some responsibility for infection prevention and control. The Infection Control Manager, Mr Walsh, discussed the Maidstone and Tunbridge Wells report with the Nurse Consultant, and that report was influential in CDI being considered for the SPC Chart system.

In the VOLH itself there was also a response to the Stoke Mandeville report. On 16 February 2007 a meeting took place to discuss facilities services. Several concerns, including storage issues, poor housekeeping and poor maintenance of fabric and equipment were identified. A further review in February 2008 concluded that a number of those problems had not been resolved. There were also presentations early in 2007 and in May 2007 on infection prevention and control by Dr Weinhardt and Mrs Murray. These presentations covered what were poor infection prevention and control practices and the importance of prudent antibiotic prescribing.

18.4 NHS Quality Improvement Scotland response
No guidance appears to have been issued, or review conducted, by NHS QIS specifically in light of the Stoke Mandeville or Maidstone and Tunbridge Wells reports.

18.5 The response to the Stoke Mandeville and Maidstone and Tunbridge Wells reports by Health Protection Scotland
The work of Health Protection Scotland (HPS) in connection with HAIs is overseen by the HAI Task Force. In the Project Initiation Document produced in July 2007 for the development of a programme for reduction of healthcare associated CDI in Scotland, the HAI Taskforce did refer to the Healthcare Commission’s recommendations contained in
the Stoke Mandeville report. In October 2007, shortly after the publication of the Maidstone and Tunbridge Wells report, the HAI Taskforce considered that report. Thereafter the Chief Nursing Officer wrote on 8 November 2007 to Board Chief Executives asking each Board to undertake an immediate and thorough review of its local infection control policies. His expectation was that each Board would make sure that the systems and processes were in place for effective infection prevention and control, although that expectation was not spelled out in his letter.

National guidance on the prevention and control of CDI was published by HPS in October 2008. The production of national guidance of that kind can take time. HPS also developed a checklist as a support tool to check control measures were in place, prompted by the Stoke Mandeville and Maidstone and Tunbridge Wells reports. Although production of the checklist was accelerated following discovery of the CDI problem at the VOLH it was not in fact produced until June 2008. If the publication of the Stoke Mandeville report is taken as a starting point, it took some two years for the checklist to be produced.

18.6 The Scottish Government response

The Scottish Government did not take any action to draw the Stoke Mandeville case to the attention of Health Boards. Prior to June 2008 Scottish Government had not received any advice from any source that any action was required.

18.7 The Northern Health and Social Care Trust, Northern Ireland

The Regulation and Quality Improvement Authority for Northern Ireland (RQIA) published a review in August 2008 of the circumstances contributing to the rates of CDI in the Northern Health and Social Care Trust in 2007 and early 2008. The report of a Public Inquiry into the outbreak of CDI in Trust hospitals was published on 21 March 2011. The RQIA review identified failures similar to failures identified in this Report including structural reorganisation putting the monitoring of health infection prevention at risk, shortage of isolation beds, inappropriate use of antibiotics, poor quality of nursing notes and general lack of care plans and needs assessments.

The RQIA review and the Public Inquiry report suggest that there was also a lack of preparedness for an outbreak of CDI. This simply reinforces the need for lessons to be learned from other inquiries.

18.8 Ninewells Hospital, Dundee

In October 2009 an outbreak of CDI was declared at Ninewells Hospital, Dundee in one ward following upon two patients testing positive for CDI where the 027 strain was identified. Measures were taken in response to the outbreak including a visit by HPS. In total, between 31 July 2009 and 6 November 2009 seven patients who had been in the ward concerned were found to be infected with the 027 strain. CDI caused or contributed to the deaths of five of those patients.

The Ninewells outbreak occurred after discovery of the CDI problems at the VOLH in an environment where there was an increased awareness of the importance of infection prevention and control. The identification of the outbreak and subsequent management appeared to be in accordance with good infection prevention and control practice.
18.9 Comparison between the VOLH and Stoke Mandeville and Maidstone and Tunbridge Wells

At least 20 issues identified in the Stoke Mandeville and Maidstone and Tunbridge Wells reports were also identified by the Inquiry as relevant to the VOLH. This included the failure to isolate patients, the inappropriate prescribing of antibiotics, and failures in basic nursing care.

The findings in the Stoke Mandeville and Maidstone and Tunbridge Wells reports contained important lessons on how the management of CDI could go wrong and how it should be effectively managed. The recommendations in both reports provided valuable guidance which was available in the one case from July 2006 and in the other from October 2007.

18.10 Conclusion

There was a failure at national and NHSGGC level to utilise the Stoke Mandeville and Maidstone and Tunbridge Wells reports as a basis for timely guidance and for audit and review. There was undue delay on the part of HPS in producing the kind of advice set out in the checklist.

The findings and recommendations of the Stoke Mandeville report should have been considered by NHSGGC in a more thorough and systematic way prior to 2007, and practices and implementation of policies should have been reviewed in the light of these findings and recommendations. Had that happened, many of the factors contributing to the outbreaks at the VOLH would have been eliminated or at least reduced by June 2008.

It is important that effective systems are in place to enable lessons learned elsewhere to be applied in Scotland in a timely manner.
Recommendations
Chapter 6 National structures and systems

Recommendation 1: Scottish Government should ensure that the Healthcare Environment Inspectorate (HEI) has the power to close a ward to new admissions if the HEI concludes that there is a real risk to the safety of patients. In the event of such closure, an urgent action plan should be devised with the Infection Prevention and Control Team and management.

Chapter 7 National policies and guidance

Recommendation 2: Scottish Government should ensure that policies and guidance on healthcare associated infection are accompanied by an implementation strategy and that implementation is monitored.

Recommendation 3: Health Boards should ensure that infection prevention and control policies are reviewed promptly in response to any new policies or guidance issued by or on behalf of the Scottish Government, and in any event at specific review dates no more than two years apart.

Recommendation 4: Scottish Government should develop local Healthcare Associated Infection (HAI) Task Forces within each Health Board area.

Chapter 8 Changes in services at the Vale of Leven Hospital from 2002

Recommendation 5: Scottish Government should ensure that where any uncertainty over the future of any hospital or service exists, resolution of the uncertainty is not delayed any longer than is essential for planning and consultation to take place.

Recommendation 6: Scottish Government should ensure that where major changes in patient services are planned there should be clear and effective plans in place for continuity of safe patient care during the period of planning and change.

Chapter 9 The creation, leadership and management of the Clyde Directorate

Recommendation 7: In any major structural reorganisation in the NHS in Scotland a due diligence process including risk assessment should be undertaken by the Board or Boards responsible for all patient services before the reorganisation takes place. Subsequent to that reorganisation regular reviews of the process should be conducted to assess its impact upon patient services, up to the point at which the new structure is fully operational. The review process should include an independent audit.

Recommendation 8: In any major structural reorganisation in the NHS in Scotland the Board or Boards responsible should ensure that an effective and stable management structure is in place for the success of the project and the maintenance of patient safety throughout the process.

Chapter 10 Clinical governance

Recommendation 9: Health Boards should ensure that infection prevention and control is explicitly considered at all clinical governance committee meetings from local level to Board level.

Chapter 11 The experiences of patients and relatives

Recommendation 10: Health Boards should ensure that patients diagnosed with CDI are given information by medical and nursing staff about their condition and prognosis. Patients should be told when there is a suspicion they have CDI, and when there is a definitive diagnosis. Where appropriate, relatives should also be involved.

Recommendation 11: Health Boards should ensure that patients, and relatives where appropriate, are made aware that CDI is a condition that can be life-threatening, particularly in the elderly. The consultant in charge of a patient’s care should ensure that the patient and, where appropriate, relatives have reasonable access to fully informed medical staff.

Recommendation 12: Health Boards should ensure that when a patient has CDI patients and relatives are given clear and proper advice on the necessary infection control precautions, particularly hand washing and laundry. Should it be necessary to request relatives to take soiled laundry home, the laundry should be bagged appropriately and clear instructions about washing should be
given. Leaflets containing guidance should be provided, and these should be supplemented by discussion with patients and relatives.

Chapter 12 Nursing care

**Recommendation 13:** Health Boards should ensure that there is a clear and effective line of professional responsibility between the ward and the Board.

**Recommendation 14:** Health Boards should ensure that the nurse in charge of each ward audits compliance with the duty to keep clear and contemporaneous patient records. Health Boards should ensure that there is an effective system of audit of patient records, and that there is effective scrutiny of audits by the Board.

**Recommendation 15:** Health Boards should ensure that nursing staff caring for a patient with CDI keep accurate records of patient observations including temperature, pulse, respiration, oxygen saturation and blood pressure.

**Recommendation 16:** Health Boards should ensure that the nurse in charge of each ward reports suspected outbreaks of CDI (as defined in local guidance) to the Infection Control Team.

**Recommendation 17:** Health Boards should ensure that where there is risk of cross infection, the nurse in charge of a ward has ultimate responsibility for admission of patients to the ward or bay. Any such decision should be based on a full report of the patient’s status and full discussion with site management, the bed manager, and a member of the Infection Control Team. The decision and the advice upon which the decision is based should be fully recorded contemporaneously.

**Recommendation 18:** Health Boards should ensure that there is an agreed system of care planning in use in every ward with the appropriate documentation available to nursing staff. Where appropriate they should introduce pro forma care plans to assist nurses with care planning. Health Boards should ensure that there is a system of audit of care planning in place.

**Recommendation 19:** Health Boards should ensure that where Infection Control Nurses provide instructions on the management of patients those instructions are recorded in the patient notes and are included in care planning for the patient.

**Recommendation 20:** Health Boards should ensure that where a patient has, or is suspected of having, *C. difficile* diarrhoea a proper record of the patient’s stools is kept. Health Boards should ensure that there is an appropriate form of charting of stools available to enable nursing staff to provide the date, time, size and nature of the stool. Stool charts should be continued after a patient has become asymptomatic of diarrhoea in order to reduce the risk of cross infection. Health Boards should ensure that all nursing staff are properly trained in the completion of these charts, and that the nurse in charge of the ward audits compliance.

**Recommendation 21:** Health Boards should ensure that a member of nursing staff is available to deal with questions from relatives during visiting periods.

**Recommendation 22:** Health Boards should ensure that any discussion between a member of nursing staff and a relative about a patient which is relevant to the patient’s continuing care is recorded in the patient’s notes to ensure that those caring for the patient are aware of the information given.

**Recommendation 23:** Health Boards should ensure that a nurse appointed as Tissue Viability Nurse (TVN) is appropriately trained and possesses, or is working towards, a recognised specialist post-registration qualification. Health Boards should ensure that a trainee TVN is supervised by a qualified TVN.

**Recommendation 24:** Health Boards should ensure that where a TVN is involved in caring for a patient there is a clear record in the patient notes and care plan of the instructions given for management of the patient.
Recommendation 25: Health Boards should ensure that every patient is assessed for risk of pressure damage on admission to hospital using a recognised tool such as the Waterlow Score in accordance with best practice guidance. Where patients are identified as at risk they must be reassessed at the frequency identified by the risk scoring system employed. Compliance should be monitored by a system of audit.

Recommendation 26: Health Boards should ensure that where a patient has a wound or pressure damage there is clear documentation of the nature of the wound or damage in accordance with best practice guidance, including the cause, grade, size and colour of the wound or damage. The pressure damage or wound should be reassessed regularly according to the patient’s condition. Compliance should be monitored by a system of audit.

Recommendation 27: Health Boards should ensure that where a patient requires positional changes nursing staff clearly record this on a turning chart or equivalent. Compliance should be monitored by a system of audit.

Recommendation 28: Health Boards should ensure that all patients have their nutritional status screened on admission to a ward using a recognised nutritional screening tool. Where nutritional problems are identified further assessment should be undertaken to determine an individual care plan. Appropriate and timely referrals should be made to dieticians for patients identified as being in need of specialist nutritional support.

Recommendation 29: Health Boards should ensure that there is appropriate equipment in each ward to weigh all patients. Patients should be weighed on admission and at least weekly thereafter and weights recorded. Faulty equipment should be repaired or replaced timeously and a contingency plan should be in place in the event of delays.

Recommendation 30: Health Boards should ensure that where patients require fluid monitoring as part of their clinical care, nursing staff complete fluid balance charts as accurately as possible and sign them off at the end of each 24-hour period.

Recommendation 31: Health Boards should ensure that the staffing and skills mix is appropriate for each ward, and that it is reviewed in response to increases in the level of activity/patient acuity and dependency in the ward. Where the clinical profile of a group or ward of patients changes, (due to acuity and/or dependency) an agreed review framework and process should be in place to ensure that the appropriate skills base and resource requirements are easily provided.

Recommendation 32: Health Boards should ensure that there is a straightforward and timely escalation process for nurses to report concerns about the staffing numbers/skill mix.

Recommendation 33: Health Boards should ensure that where a complaint is made about nursing practice on a ward this complaint is investigated by an independent senior member of Nursing Management.

Chapter 13 Antibiotic prescribing

Recommendation 34: Health Boards should ensure that changes in policy and/or guidance on antimicrobial practice issued by or on behalf of Scottish Government are implemented without delay.

Recommendation 35: Scottish Government should monitor the implementation of policies and/or guidance on antibiotic prescribing issued in connection with healthcare associated infection and seek assurance within specified time limits that implementation has taken place.

Chapter 14 Medical care

Recommendation 36: Health Boards should ensure that the level of medical staffing planned and provided is sufficient to provide safe high quality care.

Recommendation 37: Health Boards should ensure that any patient with suspected CDI receives full clinical assessment by senior medical staff, that specific antibiotic therapy
for CDI is commenced timeously and that the response to antibiotics is monitored on at least a daily basis.

**Recommendation 38:** Health Boards should ensure that clear, accurate and legible patient records are kept by doctors, that records are seen as integral to good patient care, and that they are routinely audited by senior medical staff.

**Recommendation 39:** Health Boards should ensure that medical and nursing staff are aware that a DNAR decision is an important aspect of care. The decision should involve the patient where possible, nursing staff, the consultant in charge and, where appropriate, relatives. The decision should be fully documented, regularly reviewed and there should be regular auditing of compliance with the DNAR policy.

**Recommendation 40:** Health Boards should ensure that the key principles of prudent antibiotic prescribing are adhered to and that implementation of policy is rigorously monitored by management.

**Recommendation 41:** Health Boards should ensure that there is no unnecessary delay in processing laboratory specimens, in reporting positive results and in commencing specific antibiotic treatment. Infection control staff should carry out regular audits to ensure that there are no unnecessary delays in the management of infected patients once the diagnosis is confirmed.

### Chapter 15 Infection prevention and control

**Recommendation 42:** Health Boards should ensure that all those working in a healthcare setting have mandatory infection prevention and control training that includes CDI on appointment and regularly thereafter. Staff records should be audited to ensure that such training has taken place.

**Recommendation 43:** Health Boards should ensure that Infection Control Nurses and Infection Control Doctors have regular training in infection prevention and control, of which a record should be kept.

**Recommendation 44:** Health Boards should ensure that performance appraisals of infection prevention and control staff take place at least annually. The appraisals of Infection Control Doctors who have other responsibilities should include specific reference to their Infection Control Doctor roles.

**Recommendation 45:** Health Boards should ensure that where a manager has responsibility for oversight of infection prevention and control, this is specified in the job description.

**Recommendation 46:** Health Boards should ensure that the Infection Control Manager has direct responsibility for the infection prevention and control service and its staff.

**Recommendation 47:** Health Boards should ensure that the Infection Control Manager reports direct to the Chief Executive, or at least to an executive board member.

**Recommendation 48:** Health Boards should ensure that the Infection Control Manager is responsible for reporting to the Board on the state of healthcare associated infection in the organisation.

**Recommendation 49:** Scottish Government should re-issue national guidance on the role of the Infection Control Manager, stipulating that the Infection Control Manager must be responsible for the management of the infection prevention and control service.

**Recommendation 50:** Health Boards should ensure that there is 24-hour cover for infection prevention and control seven days a week, and that contingency plans for leave and sickness absence are in place.

**Recommendation 51:** Health Boards should ensure that any Infection Control Team functions as a team, with clear lines of communication and regular meetings.

**Recommendation 52:** Health Boards should ensure that adherence to infection prevention and control policies, for example the *C. difficile* and Loose Stool Policies, is audited at least annually, and that serious non-adherence is reported to the Board.
Recommendation 53: Health Boards should ensure that surveillance systems are fit for purpose, are simple to use and monitor, and provide information on potential outbreaks in real time.

Recommendation 54: Health Boards should ensure that the users of surveillance systems are properly trained in their use and fully aware of how to use and respond to the data available.

Recommendation 55: Health Boards should ensure that numbers and rates of CDI are reported through each level of the organisation up to the level of the Chief Executive and the Board. Reporting should include positive reporting in addition to any exception reporting. The Chief Executive should sign off the figures to confirm that there is oversight of infection prevention and control at that level.

Recommendation 56: Health Boards should ensure that infection prevention and control groups meet at regular intervals and that there is appropriate reporting upwards through the management structure.

Recommendation 57: Health Boards should ensure that the minutes of all meetings and reports from each infection prevention and control committee are reported to the level above in the hierarchy and include the numbers and rates of CDI, audit reports, and training reports.

Recommendation 58: Health Boards should ensure that there is lay representation at Board infection prevention and control committee level in keeping with local policy on public involvement.

Recommendation 59: Health Boards should ensure that attendance by members of committees in the infection prevention and control structure is treated as a priority. Non-attendance should only be justified by illness or leave or if there is a risk of compromise to other clinical duties in which event deputies should attend where practicable.

Recommendation 60: Health Boards should ensure that programmes designed to improve staff knowledge of good infection prevention and control practice, such as the Cleanliness Champions Programme, are implemented without undue delay. Staff should be given protected time by managers to complete such programmes.

Recommendation 61: Health Boards should ensure that unannounced inspections of clinical areas are conducted by senior infection prevention and control staff accompanied by lay representation to examine infection prevention and control arrangements, including policy implementation and cleanliness.

Recommendation 62: Health Boards should ensure that senior managers accompanied by infection prevention and control staff visit clinical areas at least weekly to verify that proper attention is being paid to infection prevention and control.

Recommendation 63: Health Boards should ensure that there is effective isolation of any patient who is suspected of suffering from CDI, and that failure to isolate is reported to senior management.

Recommendation 64: Health Boards should ensure that cohorting is not used as a substitute for single room isolation and is only resorted to in exceptional circumstances and under strict conditions of dedicated nursing, with infected patients nursed in cohort bays with en-suite facilities.

Recommendation 65: Health Boards should ensure that appropriate steps are taken to isolate patients with potentially infectious diarrhoea.

Recommendation 66: Health Boards should ensure that the healthcare environment does not compromise effective infection prevention and control, and that poor maintenance practices, such as the acceptance of non-intact surfaces that could compromise effective infection prevention and control practice, are not tolerated.
Recommendation 67: Health Boards should ensure that, where a local Link Nurse system is in place as part of the infection prevention and control system, the Link Nurses have specific training for that role. The role should be written into job descriptions and job plans. They should have clear objectives set annually and have protected time for Link Nurse duties.

Chapter 16 Death certification
Recommendation 68: Health Boards should ensure that where a death occurs in hospital the consultant in charge of the patient’s care is involved in the completion of the death certificate wherever practicable, and that such involvement is clearly recorded in the patient records. Regular auditing of this process should take place.

Recommendation 69: Health Boards should ensure that if a patient dies with CDI either as a cause of death or as a condition contributing to the death, relatives are provided with a clear explanation of the role played by CDI in the patient’s death.

Recommendation 70: Crown Office and the Procurator Fiscal Service (COPFS) should review its guidance on the reporting of deaths regularly and at least every two years.

Recommendation 71: Scottish Government should identify a national agency to undertake routine national monitoring of deaths related to CDI.

Chapter 17 Investigations from May 2008
Recommendation 72: Health Boards should ensure that a non-executive Board member or a representative from internal audit takes part in an Internal Investigation of the kind instigated by NHSGGC.

Recommendation 73: Health Boards should ensure that OCT reports provide sufficient details of the key factors in the spread of infection to allow a proper audit to be carried out, as recommended in the Watt Group Report.

Chapter 18 Experiences of C. difficile infection within and beyond Scotland
Recommendation 74: Scottish Government (whether through HPS, HIS, the HAI Task Force or otherwise) should as a matter of standard practice ensure that reports published in the United Kingdom and in other relevant jurisdictions on infection prevention and control and patient safety are reviewed as soon as possible, and that, as a minimum, any necessary interim guidance is issued within three months.

Recommendation 75: Health Boards should review such reports to determine what lessons can be learned and what reviews, audits or other measures (interim or otherwise) should be put in place in the light of these lessons.
The Vale of Leven Hospital Inquiry Report

The Rt Hon Lord MacLean Chairman

Executive Summary