Lothian NHS Board

Lothian NHS Board
Mainpoint
102 Westport
Edinburgh
EH3 9DN
Main Switchboard: 0131 242 100

www.nhslothian.scot

Date 20/06/2025
Your Ref
Our Ref 10137

Enquiries to Richard Mutch
Extension 35687
Direct Line 0131 465 5687
loth.freedomofinformation@nhs.scot
richard.mutch@nhs.scot

Dear

FREEDOM OF INFORMATION - MINUTES

I write in response to your request for information in relation to CMT and Healthcare Governance minutes.

Question:
1. Minutes of the most recent Corporate Management Team meeting (as at 21/05/2025), as well as minutes of all CMT meetings over the previous six weeks,

Answer:

Enclosed are the CMT Minutes from past 6 weeks:
- 22 April
- 06 May

I will not be able to provide 20 May CMT Minutes as not approved within the timescale of your request. These can be requested at a later date if still required.

Question:
2. Minutes (and any referenced documents including eg action logs) of the Healthcare Governance Committee meeting held in January 2025;
3. Minutes (and any referenced documents including eg action logs) of the Healthcare Governance Committee meeting held on 20/05/2025.

Answer:

The Healthcare Governance Committee minutes and actions from the January 2025 meeting are enclosed. The minutes (but not the action note) are also published with the board papers here: https://org.nhslothian.scot/lothiannhsboard/board-papers/ (16 April meeting).

This information is exempt under Section 25 of the Freedom of Information (Scotland) Act 2002 - Information otherwise accessible

(1) Information which the applicant can reasonably obtain other than by requesting it under section 1(1) is exempt information.

The papers going to the meetings have been provided with redactions – Section 38(1)(b) personal information. We have removed details of staff below a senior level and any patient identifiable information.

The minutes from the meeting on 20 May are not completed yet and will not be finalised until the next meeting in late July, they will be published with the Board papers before the August Board meeting and will be available via the following –
https://org.nhslothian.scot/lothiannhsboard/board-papers/

This detail is currently considered exempt under Section 27 of the Freedom of Information (Scotland) Act 2002 – future publication

(1) Information is exempt information if-
(a)it is held with a view to its being published by-
(i) a Scottish public authority; or
(ii) any other person at a date not later than twelve weeks after that on which the request for the information is made;
(b) when that request is made the information is already being held with that view; and
(c)it is reasonable in all the circumstances that the information be withheld from disclosure until such date as is mentioned in paragraph (a).

The papers for this meeting can be requested after the August Board Meeting.

I hope the information provided helps with your request.

If you are unhappy with our response to your request, you do have the right to request us to review it. Your request should be made within 40 working days of receipt of this letter, and we will reply within 20 working days of receipt. If our decision is unchanged following a review and you remain dissatisfied with this, you then have the right to make a formal complaint to the Scottish Information Commissioner within 6 months of receipt of our review response. You can do this by using the Scottish Information Commissioner's Office online appeals service at www.itspublicknowledge.info/Appeal. If you remain dissatisfied with the Commissioner's response you then have the option to appeal to the Court of Session on a point of law.

If you require a review of our decision to be carried out, please write to the FOI Reviewer at the email address at the head of this letter. The review will be undertaken by a Reviewer who was not involved in the original decision-making process.

FOI responses (subject to redaction of personal information) may appear on NHS Lothian's Freedom of Information website at: https://org.nhslothian.scot/FOI/Pages/default.aspx

Yours sincerely

ALISON MACDONALD
Executive Director, Nursing
Cc: Chief Executive

Healthcare Governance Committee

Tue 28 January 2025, 13:00 - 16:00

MS Teams

Agenda

Chair's Welcome and Introductions

1. Apologies for absence

Verbal *Andrew Cogan*

2. Declaration of interest

Verbal *Andrew Cogan*

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.

3. Patient Story

4. Committee Business

4.1. Committee 2024/25 Workplan

Information *Andrew Cogan*

4.1 HGC Workplan 2024-25 Master V14.pdf (8 pages)

4.2. Committee Assurance Questions

Information *Jill Gillies*

4.2 Key Governance Questions July 2022.pdf (2 pages)
4.2 Key Questions for HGC Members.pdf (1 pages)

4.3. Committee Cumulative Action Note and Minutes from Previous Meeting (19 November 2024)

Approval *Andrew Cogan*

HGC 28-01-25 Actions.pdf (1 pages)
HGC 19-11-24 Minutes.pdf (8 pages)

4.4. Revised Healthcare Governance Committee Terms of Reference

Decision *Jill Gillies*

4.4 Amendment to terms of reference Annual Review v0.1.pdf (6 pages)

5. Matters Arising

6. Emerging Issues

7. Mental Health Assurance Report, including inpatient services, psychological therapies risk, specialist services

Discussion *Tracey Mckigen*

- 7. REAS Assurance.pdf (20 pages)
- 7. Appendix 1- REAS Scope.pdf (4 pages)
- 7. Appendix 2- Assurance mapping appendix table REAS.pdf (4 pages)
- 7. Appendix 3- Outcome Measures.pdf (8 pages)
- 7. Appendix 4 - Supporting Data_.pdf (6 pages)

7.1. Out of Area Placements Monitoring Team Annual Update

Discussion *Tracey Mckigen*

- 7.1 Monitoring Out of Area Group Annual Report.pdf (6 pages)

7.2. REAS Risk Assurance Reporting

Discussion *Tracey Mckigen*

- 7.2 HGC risk assurance reporting - REAS_.pdf (6 pages)
- 7.2 Appendix 1 5510- Royal Edinburgh Bed Occupancy (2).pdf (4 pages)
- 7.2 Appendix 2 5785 Absence of Female High Secure Accommodation in the Estate.pdf (3 pages)
- 7.2 Appendix 3 5785- Inappropriate and inadequate Low Secure Accomodation in the Estate- REAS.pdf (2 pages)

8. Person Centred Care

9. Safe Care

9.1. Gender Identity Services

Verbal *Tracey Gillies*

9.2. Maternity Services update

Discussion *Michelle Carr*

- 9.2 Maternity Services Update 28.01.25 UPDATED.pdf (5 pages)

9.3. Patient Safety and Quality Annual Report

Discussion *Tracey Gillies*

- 9.3 Quality and Safety ReportJan24.v0.4.pdf (14 pages)
- 9.3 Appendix 1 Quality Directorate - Progress Report - Consolidated - Dec 2024 (Final) (2).pdf (90 pages)

9.4. Hospital Standardised Mortality Rate - Review final report

Discussion *Tracey Gillies*

- 9.4 HSMR Final Report HGC Jan 2025_final.pdf (5 pages)

10. Effective Care

11. Exception reporting only - reports provided

11.1. Tobacco Control Annual Report

Information *Dona Milne*

- 11.1 Tobacco Annual Report 2023-24.pdf (4 pages)
- 11.1 Tobacco Control Annual Report 2023-24 0.4.pdf (32 pages)

11.2. Tissue Governance Annual Report

Information *Tracey Gillies*

- 11.2 Tissue Governance Annual Report (Jan25).pdf (6 pages)
- 11.2 Appendix 1 - NRS Accreditation Certificate (Lothian).pdf (1 pages)
- 11.2 Appendix 2 - NRS Accreditaiton Annual Declaration (2024).pdf (2 pages)
- 11.2 Appendix 3 - Confirmation of ethical approval for Lothian NRS BioResource (June 2020).pdf (7 pages)

11.3. Scottish Trauma Audit Group Annual Report

Information *Tracey Gillies*

- 11.3 STAG Report & Major Trauma Peer Review.pdf (18 pages)

11.4. Resilience Annual Report

Information *Dona Milne*

- 11.4 Resilience Annual Report 2024.pdf (3 pages)
- 11.4 Appendix 1 Resilience Annual Report 2024 final for HCG_.pdf (14 pages)

11.5. Health Protection Team Annual Report

Information *Dona Milne*

- 11.5 HPT Anuual Report 2023.pdf (4 pages)
- 11.5 Appendix 1 Service scope appendix - Generic HSCP HPT.pdf (1 pages)
- 11.5 Appendix 2 Assurance mapping appendix table HSCP v1.4 HPT.pdf (3 pages)
- 11.5 Appendix 3 HPT Annual report 2023.pdf (17 pages)

11.6. Tissue Viability Annual Report

Information *Alison Macdonald*

- 11.6 Tissue Viability Annual Report.pdf (7 pages)
- 11.6 Appendix 1 Tissue Viability Service Provision.pdf (2 pages)

12. Minutes of management meetings and sub committees

12.1. Health and Safety Committee, 28 August 2024

Information

- 12.1 28.08.2024_NHSLHealth and Safety Cttee Mins.pdf (10 pages)

12.2. Clinical Management Group, 8 October 2024, 12 November 2024

Information

- 12.2 241008 Approved CMG minutes.pdf (11 pages)
- 12.2 241112 Approved CMG minutes.pdf (11 pages)

12.3. Policy Approval Group, 10 September 2024

12.3 PAG Meeting Notes 10 September 2024.pdf (3 pages)

13. Corporate Risk Register

Discussion *Tracey Gillies*

13. HGC Risk register paper 28 January 2025 v0.1.pdf (44 pages)

14. Reflections on the meeting

Verbal *Andrew Cogan*

14.1. Matters to be highlighted to the next Board

14.2. Matters to be highlighted to another board committee

15. Further meeting dates

- 18 March 2025
- 20 May 2025
- 22 July 2025
- 23 September 2025
- 18 November 2025
- 27 January 2026
- 17 March 2026

HEALTHCARE GOVERNANCE COMMITTEE - WORKPLAN 2024/25

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
Meeting 28 May 2024, deadline for papers 14 May 2024			
Service report - assurance focus			
Women's Services Assurance Report	MC	1/2/5/6/7/8	
Standing items			
Corporate Risk Register (every meeting)	TG	1/14	
Public Protection (twice per year)	AMcD	13	
Management and Learning from Adverse Events (twice per year)	TG	7/2	
Annual / scheduled items for discussion			
Involving People Update	AMcD	1/2	
Health and Safety – Clinical Governance and Performance Annual Report	TG	1/2	
Healthcare Governance Committee Annual Report	Chair	14	
MBRACE-UK Perinatal Deaths - Benchmarks perinatal outcomes for the Lothian population against the UK population (received March 2024)	TG	1/2/5	
4 Hour Emergency Access Risk Mitigation Plan (deferred to July 2024)	MC	1/14	
Hospital Bed Occupancy Risk Mitigation Plan (deferred to July 2024)	MC	1/14	
Delayed Discharge / Bed Occupancy Risk Mitigation Plan – Edinburgh HSCP	JP	1/14	
Access to Treatment Risk Mitigation Plan	MC	1/14	
Medicines Management Annual Report (deferred from March 2024)	TG	3	
Annual / Scheduled Reports for exception reporting			
Pregnancy and Newborn Screening Annual Report	DM	1/2/5	
Palliative Care Managed Clinical Network Annual Report (deferred from September 2023)	AMcD	1/2/5/6	

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
Cervical Cancer Screening Annual Report (for May 2025, deferred from November 2024)	DM	1/2/5	
Matters arising added to this meeting			
Meeting 23 July 2024, deadline for papers 9 July 2024			
Service report - assurance focus			
Children's Services	MC	1/2/5/6/7/8	
Standing items			
Corporate Risk Register (every meeting)	TG	1/14	
Annual / scheduled items for discussion			
Annual / Scheduled Reports for exception reporting			
Bowel Cancer Screening Annual Report	DM	1/2/5/6	
Abdominal Aortic Aneurysm (AAA) Screening Update	DM	1/2/5/6	
Litigation Annual Report	TG	1/2	
Blood Transfusion Annual Report	TG	1/2/5/6	
Matters arising added to this meeting			
Meeting 17 September 2024, deadline for papers 3 September 2024			
Service report - assurance focus			
Health and Social Care Partnerships Assurance Reports:	Chief Officers	1/2/5/6/7/8	

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
East Lothian Health and Social Care Partnership and hosted services: - Sexual health.	Chief Officers	1/2/5/6/7/8	
Edinburgh Health and Social Care Partnership and hosted services: - Hospital Based Complex Clinical Care - Palliative Care - Hospices - Astley Ainslie Hospital (to be transferred to another HSCP) - Robert Ferguson Unit at the Royal Edinburgh Hospital (to be transferred to another HSCP) - Cardiac Rehabilitation (to be transferred to another HSCP).	Chief Officers	1/2/5/6/7/8	
Midlothian Health and Social Care Partnership and hosted services: - Dietetics - Adults with Complex and Exceptional Needs Service.	Chief Officers	1/2/5/6/7/8	
West Lothian Health and Social Care Partnership and hosted services: - Podiatry	Chief Officers	1/2/5/6/7/8	
Standing items			
Annual / scheduled items for discussion			
GP Sustainability (Risk 3829 Sustainability of model of General Practice)	JL	1/14	
Oral Health Services Annual Report	JL	1/2/5/6/7/8	
General Practice Out of Hours Service (LUCS) Annual Report	JL	1/2/5/6/7/8	
Patient Experience Strategic Plan	AMcD	1/8	
Annual / Scheduled Reports for exception reporting			
Care Home Annual Report	AMcD		
Matters arising added to this meeting			

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
Meeting 22 October 2024, deadline for papers 8 October 2024			
Service report – assurance focus			
Acute Services Assurance Report – Acute Adult Sites and Outpatient Services	MC	1/2/5/6/7/8	
Standing items			
Corporate Risk Register (every meeting)	TG	1/14	
Annual / scheduled items for discussion			
Duty of Candour Annual Report	TG	2/7	
Annual Review of Committee Terms of Reference (to go to December Board)	AC		
Annual / Scheduled Reports for exception reporting			
Sexual Health and Blood Borne Virus Programme Board Annual Report (every second year, reported in 2023)	DM	1/2/5/6	
Viral Hepatitis Managed Care Network Annual Report (every second year, reporting in 2024)	DM	1/2/5/6	
Respiratory Managed Care Network Annual Report - Describes the work of the MCN in support of the management of this long term condition by primary and secondary care teams in delivery of the respiratory standards	AMcD	1/2/5/6	
Breast Cancer Screening Annual Report	DM	1/2/5	
Diabetic Eye Screening Annual Report	DM	1/2/5/6/	
Tissue Viability Annual Report (deferred to 28 January 2025)	AMcD	1/2/5/6	
Matters arising added to this meeting			
Meeting 19 November 2024, deadline for papers 5 November 2024			

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
Service report - assurance focus			
Acute Services Assurance Report – Diagnostics, Anaesthetics, Theatres and Critical Care (DATCC)	MC	1/2/5/6/7/8	
Standing items			
Corporate Risk Register (every meeting)	TG	1/14	
Public Protection (twice per year)	AMcD	13	
Management and Learning from Adverse Events (twice per year)	TG	1/2/7	
Annual / scheduled items for discussion			
Spiritual Care Annual Report (deferred to January 2025)	AMcD	1	
Safe and Effective Cancer Care	MC	1/2/5/6	
Stroke Care	TG	1/2/5/6	
External Providers Annual Report	MC	1/2/6/7/8	
Infected Blood Inquiry	TG	7/12	
Drug Related Deaths Annual Report	DM	1/2/7	
Scottish National Audit Programme	TG		
Annual / Scheduled Reports for exception reporting			
Edinburgh Transplant Service Annual Report (deferred to January 2025)	TG	1/2/5/6	
Scottish Cardiac Audit Programme (SCAP)	TG	1/2/5/6	
Scottish Stroke Care Audit (SSCA)	TG	1/2/5/6	
Scottish MS Register (SMSR)	TG	1/2/5/6	
Scottish Intensive Care Society Audit Group (SICSAG)	TG	1/2/5/6	
Scottish Hip Fracture Audit (SHFA)	TG	1/2/5/6	
Scottish Arthroplasty Project (SAP)	TG	1/2/5/6	
Scottish Renal Registry (SRR)	TG	1/2/5/6	
Scottish ECT Accreditation Network (SEAN)	TG	1/2/5/6	

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
Organ Donation Annual Report - This report describes the oversight of the organ donation process by NHSBT, the involvement of the teams who support donation and areas of improvement being addressed	TG	1/2/5/6	
Controlled Drug Governance Team Annual Report	TG	3	
Matters arising added to this meeting			
Meeting 28 January 2025, deadline for papers 14 January 2025			
Service report - assurance focus			
Mental Health Assurance Report, including inpatient services, psychological therapies risk, specialist services	CC	1/2//5/6/7/8	
Standing items			
Corporate Risk Register (every meeting)	TG	1/14	
Annual / scheduled items for discussion			
Patient Safety and Quality Annual Report	TG	1/2/7	
Annual / Scheduled Reports for exception reporting			
Out of Area Placements Monitoring Team Annual Update	Tracey McKinley	1	
Resilience Annual Report - Outlines the work of the resilience team to allow NHS Lothian to meet its obligation as a category 1 responder under the Civil Contingencies Act	DM	1/2	
REAS Accommodation Risk Mitigation Plan – High secure female	CC	1/14	
REAS Accommodation Risk Mitigation Plan – Low secure	CC	1/14	
Bed Occupancy Royal Edinburgh Hospital Risk Mitigation Plan	CC	1/14	
Tobacco Control Annual Report	DM		

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
Tissue Viability Annual Report (deferred from October 2024)	AMcD	1/2/5/6	
Tissue Governance Annual Report (deferred from November 204)- Describes the processes and required standards for the acquisition, storage and subsequent use of biological tissue including blood under the Human Tissue Act	TG	1/2/5/6	
Scottish Trauma Audit Group Annual Report (deferred from November 2024)	TG	1/2/5/6	
Edinburgh Transplant Service Annual Report (deferred from November 2024)	TG	1/2/5/6	
Matters arising added to this meeting			
Meeting 18 March 2025, deadline for papers 4 March 2025			
Service report - assurance focus			
Preparing for Healthcare Governance Committee Annual Report and Assurance Need	Chair	14	
Standing items			
Corporate Risk Register (every meeting)	TG	1/14	
Annual / scheduled items for discussion			
Equality and Human Rights Performance Report Outcomes	DM	12	
Research and Development Annual Report	TG	10	
Information Governance Annual Report	TG	11	
Medicines Management Annual Report	TG	3	
Immunisation Annual Report (moved to July 2025 to fit in with reporting)	DM		
Spiritual Care Annual Report (deferred from November 2024)	AMcD	1	
Healthcare Associated Infection	AMcD	1/2	
Annual / Scheduled Reports for exception reporting			
Voluntary Services Annual Report	AMcD	1	

Reporting Timetable	Exec Lead	Terms of Reference	Assurance Tracker
Clinical Policy and Documentation Annual Report - Summarises the work of the policy group including the consultation and approval process	AMcD	4	
Scottish Intercollegiate Guidelines Network Annual Report	TG	5	
Diabetes Managed Clinical Network Annual Report - Describes the work of the MCN in support of the management of this long term condition by primary and secondary care teams in delivery of the diabetes standards	AMcD	1/2/5/6	
Matters arising added to this meeting			

Service reporting will include where appropriate the impact of corporate risks on the delivery of person-centred safe effective care and actions being taken to mitigate these risks.

<u>Service Template</u> - Based on Health Improvement Scotland Quality of Care Reviews, those writing service reports for HCG are asked to set them out in the format below to address key governance questions aligned to HCG TOR

1. **Describe the scope of the services being reported**

2. **Management and Oversight of Quality**
    - How at a service level do you have oversight of quality?
    - How do you identify concerns about quality of care?
    - If issues are raised, how do you respond?
    - Do you have a clear escalation process to senior managers concerning quality of care issues?

3. **Service quality outcomes and the consequences of not meeting standards on person centred safe effective care:**
    - Clinical / Service Standards / Indicators / Targets
        - Internal
        - External
        - Service data/information and any local/national comparators

4. **Impact on people experiencing care; carers; family**
    - What are your mechanisms for gathering and responding to patient/carers/family feedback?
    - How are you learning from this feedback and using it to inform improvement and share learning?
    - How are you managing and learning from complaints, sharing learning and making improvement?

5. **Impact on staff**
    - What mechanisms do you have to hear and respond to staff experience and improve (to be reported through Staff Governance)

6. **Delivery of Safe Care**
    - How do you learn from adverse events?
        - How are you monitoring harms relating to service area, e.g. falls, infection
        - Improvement programme to reduce harm
7. **Equitable care**
    - Support for difficult to reach groups, translation support

8. **Workforce Management and Support (to be reported through Staff Governance)**
    - How do you examine the current workforce and future requirements to ensure quality of care
    - Training and development plans

9. **Quality Improvement-based Leadership**
    - Processes for staff development, training and learning for improvement

- Staff empowered to test ideas and improve and share lessons to deliver high quality care

10. Key Risks

- What are the key risks related to quality and how are they quantified?
- What information (data) is available to assess the risks. Are these risks being managed at an operational level or on the corporate risk register. Is there a plan in place to mitigate these risks?
- For all plans, they should answer the following questions:
    - How will you know that the action agreed has been implemented?
    - How will you know if the action has had any impact when it is implemented? (How will it be measured?)
    - Is the action strong enough to lead the change required?
    - Who is accountable for the delivery, monitoring and reporting of the progress and improvement against the actions agreed?

Is it clear how actions will support person-centred, safe, effective care?

Key Questions for Healthcare Governance Committee Members when considering papers and presentations at meetings

Extract from paper submitted to the Healthcare Governance on 9 July 2019:

For all papers the following questions are useful and focus on remedial actions to address key risks to quality, however, actions should also focus on learning and celebrate successes. Questions asked following presentations or papers do not need to be limited to these clearly, but this focus will support HCG in addressing its substantial agenda

Key Questions:

- What are the key risks related to quality and how are they quantified. What information (data) is available to assess the risks
- For all actions identified, they should answer the following questions:
  - How will you know that the action agreed has been implemented?
  - How will you know if the action has had any impact when it is implemented? (How will it be measured?)
  - Is the action strong enough to lead the change required?
  - Who is accountable for the delivery, monitoring and reporting of the progress and improvement against the actions agreed?
  - Is it clear how actions will support person-centred, safe, effective care?

NHS LOTHIAN

HEALTHCARE GOVENANCE COMMITTEE

CUMULATIVE ACTION NOTE

No.	Action	Point	Lead	Due date	Update
1.	It would be agreed when the next update on the Edinburgh Health and Social Care Partnership Bed Occupancy / Delayed Discharge risk mitigation plan would be brought to the Committee.	28/05/24 5.3.2	Tracey Gillies / Andrew Cogan	23/07/24	Completed. Discussed at the meeting on 19 November 2024.
2.	The outcome of the Cass report and any actions for NHS Lothian would be highlighted in the Board Committee Chairs' updates at the Board meeting following update from the Scottish Government. A further update on progress with the pathway for 17/18 year olds would be brought to the Committee.	28/05/24 10.1 19/11/24	Andrew Cogan / Tracey Gillies Tracey Gillies	23/07/24 28/01/25	An update report was discussed at the meeting on 19 November 2024. On agenda for the meeting on 28 January 2025.
3.	An update to be brought to the next meeting on the response to the national Infected Blood Inquiry recommendations, including blood tracking.	23/07/24 20.1.2	Tracey Gillies	19/11/24	A verbal update was given at the meeting on 19 November 2024. A full update on recommendations would be brought to the March or May 2025 meeting.
4.	A further update on the Edinburgh Health and Social Care Partnership Bed Occupancy Risk Mitigation Plan to be brought to the Committee.	19/11/24	Pat Togher	18/03/25	
5.	A further update on improvement work in Maternity Services would be brought to the Committee.	19/11/24	Michelle Carr	18/03/25	

Next Meeting: 28 January 2025

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 13.00 on Tuesday 19 November 2024 by video conference.

Present: Mr A. Cogan, Non-Executive Board Member (chair); Mr E. Balfour, Non-Executive Board Member; Cllr H. Cartmill, Non-Executive Board Member; Mr A. Fleming, Non-Executive Board Member; Mr P. Knight, Non-Executive Board Member.

In attendance: Ms E. Anderson, Associate Quality Improvement Advisor; Ms H. Cameron, Director of Allied Health Professionals; Ms M. Carr, Chief Officer, Acute Services; Ms S. Davidson, Talent Management Programme (observing); Ms F. Ewing, Consultant Radiologist (item 51); Mr S. Garden, Director of Pharmacy; Ms J. Gillies, Associate Director of Quality; Ms T. Gillies, Medical Director; Ms A. Goodfellow, Deputy Director of Public Health; Mr I. Gorman, Service Director, Diagnostics, Anaesthetics, Theatres and Critical Care (item 51); Ms S. Gossner, Chief Nurse, East Lothian Health and Social Care Partnership; Ms L. Guthrie, Associate Director, Infection Prevention and Control; Mr J. Hetherington, General Manager, Diagnostics (item 51); Mr G. Johnston, Non Executive Director, NHS Forth Valley (observing); Dr K. Kallirroi, Associate Medical Director, Anaesthetics, Theatres and Critical Care (item 51); Professor A. Khan, Non Executive Board Member (observing); Mr M. Massaro-Mallinson, Service Director, Edinburgh Health and Social Care Partnership (item 52.1); Ms J. McDonald, General Manager, Anaesthetics, Theatres and Critical Care (item 51); Ms J. McNulty, Associate Nurse Director, Theatres and Anaesthetics (item 51); Mr G. Mills, Talent Management Programme (observing); Ms J. Morrison, Head of Patient Experience; Ms R. Moss, Talent Management Programme (observing); Ms P. Murray, Child Health Commissioner (observing); Ms M. Odam, Talent Management Programme (observing); Dr F. Ogilvie, Consultant in Public Health (item 53.5); Ms C. Palmer, Associate Nurse Director, Western General Hospital (item 53.1); Ms B. Pillath, Committee Administrator (minutes); Dr C. Reid, Consultant in Palliative Care (item 53.1); Mr G. Stark, Talent Management Programme (observing); Ms F. Stratton, Chief Nurse, Midlothian Health and Social Care Partnership; Mr C. Stirling, Site Director, Western General Hospital (item 53.1); Mr D. Thompson, Board Secretary; Ms H. Wallace, Business Manager, Diagnostics, Anaesthetics, Theatres and Critical Care (item 51); Ms S. Walter, Service Manager, Capacity Development, Outpatients and Associated Services and Talent Management Programme (item 53.4 and observing); Ms J. Webster, Talent Management Programme (observing); Dr C. Whitworth, Medical Director, Acute Services; Mr P. Wynne, Director of Community Nursing; Ms L. Yule, Chief Nurse, West Lothian Health and Social Care Partnership.

Apologies: Mr J. Crombie, Deputy Chief Executive; Professor C. Hiscox, Chief Executive; Ms A. MacDonald, Executive Nurse Director; Ms D. Milne, Director of Public Health; Mr P. Togher, Chief Officer, Edinburgh Health and Social Care Partnership; Ms C. Wyllie, Director of Public Protection.

Chair's Welcome and Introductions

Mr Cogan 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.

50. Committee Business

51.1 Minutes from Previous Meeting (22 October 2024)

50.1.1 The minutes from the meeting held on 22 October 2024 were approved as a correct record.

50.1.2 The cumulative action note would be updated following discussion at the meeting and would be circulated with the papers for the next meeting.

51.2 Membership

51.2.1 This was Mr Cartmill's last meeting of this Committee. Mr Cogan thanked him for his input. Mr Khan would become a member of the Committee from the next meeting.

51. Acute Services Assurance Report – Diagnostics, Anaesthetics, Theatres and Critical Care

51.1 Ms Carr, Mr Gorman, Ms McNulty, Ms Ewing and Dr Kallirroi presented the previously circulated paper. In response to a question about professional and clinical leadership for healthcare scientists and allied health professionals, it was noted that the Chief Radiologist and Lead for Allied Health Professionals reported up through the management structure. There was also a professional lead for Healthcare Science. There was good communication and professional development opportunities for these groups of staff.

51.2 The thrombectomy service operated from 8am to 6pm seven days per week and also covered NHS Boards in the east region using a 'hub and spoke' model and St John's Hospital outwith the 5 day per week service there. The ambition would be to offer a 24/7 service, but this was resource dependent. NHS Lothian provided more hours of service than the other regions in Scotland which were 5 days per week.

51.3 During the temporary closure of the Eye Pavilion, all eye surgery was being provided at St John's hospital where staff had been transferred. Theatre space was being freed up by moving services that did not require anaesthetics. The move had been efficient and there was a focus on catching up on theatre lists to cover those delayed by the move.

51.4 Mr Gorman advised that there were good arrangements for getting diagnostics results to clinical teams in good time. Radiology dealt with 700,000 results per year. There was assurance through the diagnostic teams that there was compliance with the process. Any individual problems in getting results were considered by the Lothian Interface Group with clinicians from primary and secondary care. There was work to do on addressing communications when patients were delayed.

51.5 There were long standing delays in step down from the High Dependency Unit and Intensive Care Unit, readmission and night time discharge from the units. Delay of discharge from the Intensive Care Unit was a capacity issue but also resulted in a poor experience for patients delayed as this was not a good environment for recovery. One bed was always kept available for emergency admissions to the unit.

51.6 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

52. Safe Care

52.1 Edinburgh Health and Social Care Partnership Bed Occupancy / Delayed Discharge Risk Mitigation

52.1.1 The chair welcomed Mr Massaro-Mallinson to the meeting and he presented the previously circulated paper. Additional work ongoing between the four health and social care partnerships aimed at improving the situation. From May, the number of people waiting for a care home had doubled, but improvements had been made on availability of hospital at home places. Redesign work would focus on maximising internal home care services. Work was also being done with Social Work and Housing, but hospital at home was currently the highest impact area.

52.1.2 More work on care home places was needed. More beds had been made available in some areas but more recurring funding was needed to increase this further.

52.1.3 It was noted that it would be useful to see a longer time period in the delayed discharge chart in the paper in order to compare to previous years.

52.1.4 Ms T. Gillies noted that a high level of bed occupancy impacted the care of patients who were delated as well as those waiting for an acute or mental health bed. Patients not experiencing care in the most appropriate setting was detrimental to the quality of care even if where outcome was not impacted, for example the impact to patients and families when a patient died in an institutional setting rather than a homely setting.

52.1.5 Members accepted the recommendations laid out in the paper and accepted limited assurance. A further update would be given in March 2025. **PT**

52.2 Acute Access to Treatment Risk Mitigation

52.2.1 Ms Carr presented the previously circulated paper. The mitigation had been reported at the Strategic Planning and Performance Committee and some of the mitigations in place discussed. Waiting times were longer in NHS Lothian than in other large health boards. The reasons for this were being assessed, and there was also assessment of the clinical impact of these delays.

52.2.2 Dr Whitworth advised that the consequences of long waits for procedures included deterioration in conditions and delays in determining diagnosis or treatment plan. Processes were in place to identify these cases and to triage again to ensure urgent cases were treated sooner. The delays also lead to a change in behaviour of referrers and those carrying out triage, in referring more patients as urgent due a concern about the effect of delay.

52.2.3 Ms T. Gillies advised that there was no robust data on whether there were increased presentations at the emergency department due to long waits for procedures, but anecdotally unscheduled cancer presentations may be increasing.

The number of patients referred as urgent suspicion of cancer increased, but not all of these were considered urgent after assessment. Primary care referrals for CT scans and x-ray were open as an additional route for treatment referral. A regional piece of work was being considered on routine screening referrals and clinical outcomes. A further report would be brought to the Committee in March 2025 on the different routes for cancer treatment referral. **TG**

52.2.4 Members accepted the recommendations laid out in the paper and accepted limited assurance. A further update would be brought to the Committee in March 2025. **MC**

52.3 Update on national actions related to the Infected Blood Inquiry Oversight and Assurance Group

52.3.1 Ms T. Gillies gave a verbal update. The Scottish Government Oversight and Assurance Group was working on the recommendations from the national Inquiry. An update was being prepared which sent out the specific implications in Scotland. Some of the recommendations would be taken forward following appointment of a Patient Safety Commissioner in Scotland.

52.3.2 Clinical groups had met to consider the clinical recommendations. Some of the wording of the recommendations was not based on current appraised guidance, so work was being done on this. The GMC representatives talked about education in the use of blood. The Scottish Government had set up a group looking at the use of blood and the reduction of unnecessary use. One recommendation was for an end to end tracking system to be in place for blood. This was being considered nationally and the NHS National Services Scotland was preparing a business case to apply to the Scottish Government for funding.

52.3.3 A peer review had taken place at the Scottish Haemophilia Centre on current practice, and the recommendations from this were being worked on.

52.3.4 A paper would be brought to the Committee in March or May 2025 to update on the response to recommendations. **TG**

52.4 Gender Identity Services

52.4.1 Ms T. Gillies presented the previously circulated paper. The short life working group was working on the pathway for patients aged 17 and 18 years, as NHS Lothian had been an outlier in moving 17 year olds into adult services. An update on the outcome of this discussion would be brought to the meeting in January 2025. **TG**

52.5 Maternity Services Update

52.5.1 Ms Carr presented the previously circulated paper. Concerns had been raised regarding rota and safe staffing, as well as the process for escalating safe staffing risks. Maternity Services had now been brought into the process used elsewhere in acute services.

52.5.2 The Staff Governance Committee would oversee the whistleblowing complaint and the upheld complaints in this area. The action required to address the concerns

including managing patient flow and impact on outcomes for mothers and babies would be overseen by the Healthcare Governance Committee.

52.5.3 It was noted that the Healthcare Governance had previously taken a moderate level of assurance on Maternity Services, and this may represent the instability of the evidence on which this was based, but it was confirmed that the data seen was correct.

52.5.4 Work was ongoing with Organisational Development and an interim report would be brought to the Committee in March 2025 before the full Women's Services report in May 2025. **MC**

52.6 Public Protection Annual Report

52.6.1 Members accepted the recommendations laid out in the previous paper, and accepted moderate assurance.

52.7 Significant Adverse Events

52.7.1 Ms T. Gillies presented the previously circulated paper. Data on the proportion of incidents covered by the top three categories of harm was requested for the next report.

52.7.2 The data showed an increase in the number of all incidents. Ms T. Gillies advised that more information had been provided in the previous paper. In terms of maternity cases, because cases were considered together in themed groups the numbers reported as completed could fluctuate. The initial assessment of level of harm by the member of staff reporting the incident on Datix was not always the same as the level of harm agreed as the outcome following investigation and review.

52.7.3 There was a time lag in the reported data of 12 to 18 months from the incident. This was because of the time taking to investigate and to communicate with the families first. There had been no increase in reported avoidable harm outcome 3 and 4 events in maternity services after review.

52.7.4 It was important to encourage all incident reporting from staff even if this initially showed more cases. This ensure that all potential concerns were reviewed. There was less resource for investigation in detail for incidents of poor patient experience rather than incidents of avoidable harm, and different processes were used.

52.7.5 Members accepted the recommendations laid out in the paper.

53. Effective Care

53.1 Safe and Effective Cancer Care

53.1.1 The chair welcomed Mr Stirling to the meeting and he presented the previously circulated paper. It was noted that complaints in the category of 'communication' included complaints about not being able to get thought on the telephone, not receiving a call back when advised, being unable to communicate, or bad news

communicated in such a way that the patient and family did not understand the situation. Complaints about lack of compassion in communication were rare. Work had been done on releasing nurse time for phone calls but data had not been collected to see if this had reduced the number of complaints.

53.1.2 Ms T. Gillies advised that in the next report data would be included on what work was being done to improve performance on Quality Performance Indicators which were not being met.

53.1.3 It was noted that the annual cycle of QPI reporting was based on data, but that Healthcare Improvement Scotland reporting also had an element of peer review.

53.1.4 Mr Garden noted that the Cancer and Therapeutics Advisory Committee considered overall and individual patient therapeutics providing extra scrutiny on access to cost effective cancer medicines.

53.1.5 Incidents had been reported on missed results. Ms Palmer advised that this was a problem across Scotland and had been discussed at the Corporate Management Group meeting. Recent cases had been complex including more than one result, or unexpected results. All scans were considered at the multidisciplinary team meetings. There were a high number of blood results, all of which should be signed off. The CMG would continue to consider improvement measures.

53.1.6 Members accepted the recommendations in the paper and accepted moderate assurance.

53.2 Stroke Care

53.2.1 Ms T. Gillies presented the previously circulated paper and members accepted the recommendations laid out, accepting moderate assurance.

53.3 Organ Donation Annual Report

53.3.1 Ms T. Gillies presented the previously circulated paper. It was noted that work to increase organ donations was done at a national level along with the head of equalities with donations carried out locally.

53.3.2 Members accepted the recommendations laid out in the paper.

53.4 External Providers Annual Report

53.4.1 The chair welcomed Ms Walter to the meeting and she presented the previously circulated paper. External providers were no longer being used in Scotland. It was noted that capacity remained available, but the Scottish Government had not provided funding for this over the past year. The current policy was not to restart external provision.

53.4.2 Members accepted the recommendations laid out in the paper and accepted significant assurance.

53.5 Drug Related Deaths Annual Report

53.5.1 The chair welcomed Dr Ogilvie to the meeting and she presented the previously circulated paper. It was noted that Scotland had a higher drug deaths rate compared to the rest of the UK due to higher social deprivation and a historical drug using population.

53.2 Scoping work was being carried out with the City of Edinburgh Council Alcohol and Drugs Partnership on providing a safe space for drug use but this would not be funded locally unless external funding was available. Ms T. Gillies advised that this had not yet been discussed by the Corporate Management Team and health input would be required due to the need for healthcare staffing.

53.6 Scottish National Audit Programme

53.6.1 Ms T. Gillies presented the previously circulated paper. The nine audit reports were included as papers for exception reporting only. It was agreed that due to the large quantity of information in the audits reports, the important information for members would be included in other assurance reports in the future instead.

54. Exception Reporting Only

Members noted the following previously circulated reports for information:

54.1 Controlled Drug Governance Team Annual Report;
54.2 Pregnancy and Newborn Screening Annual Report;
54.3 Scottish Cardiac Audit Programme;
54.4 Scottish Stroke Care Audit;
54.5 Scottish Multiple Sclerosis Register;
54.6 Scottish Intensive Care Society Annual Report;
54.7 Scottish Hip Fracture Audit;
54.8 Scottish Arthroplasty Project;
54.9 Scottish Renal Registry;
54.10 Scottish ECT Audit Network;
54.11 Scottish Trauma Audit Group.

55. Minutes of Management Meetings and Sub Committees

Members noted the previously circulated minutes from the following meetings:

55.1 Health and Safety Committee, 28 August 2024;
55.2 Organ Donation Sub Group, 15 August 2024.

56. Corporate Risk Register

56.1 Members accepted the recommendations laid out in the previously circulated paper.

57. Reflections on the meeting

57.1 It was agreed that the update on Gender Identity Services would be highlighted at the Committee Chairs' Updates item on the agenda at the next Board meeting.

48. Date of Next Meeting

48.1 The next meeting of the Healthcare Governance Committee would take place at **1.00pm** on **Tuesday 28 January 2025** by video conference.

49. Further Meeting Dates

49.1 Meetings would take place on the following dates:
- 18 March 2025;
- 20 May 2025
- 22 July 2025
- 23 September 2025
- 18 November 2025
- 27 January 2026
- 17 March 2026.

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Amendment to committee Terms of Reference**
Responsible Executive:	**Tracey Gillies, Medical Director**
Report Author:	**Jill Gillies, Associate Director of Quality**

1 Purpose

This report is presented for:

Assurance	☐	Decision	☒
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☒
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☒	Performance / service delivery	☐
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☐
Primary Care	☒	Digital	☐
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to request that the committee agree an amendment to the Terms of Reference to address a recommendation from the internal audit of risk management 2024/25.

The Committee is recommended to approve the Healthcare Governance Committee Terms of Reference, as set out in appendix 1 for the next year.

2.2 Background

The Committee Terms of Reference were reviewed and agreed in October 2024 prior to presentation to the February 2025 Board for ratification. No changes to the current Terms of Reference were identified by the Chair or Executive Leads for the Committee at that time, so it was agreed that these were approved for the next year.

2.3 Assessment

The internal audit report on risk management 2024/25 was received after the annual scheduled review of the Terms of Reference and included the following recommendation:

- The terms of reference for the Healthcare Governance Committee is revised at the next scheduled review to make direct reference to the management of risks within the remit of the Committee or as a core function.

An additional point is included in section 2 c), core functions to address this recommendation as noted below:

The Committee shall seek assurance on the following:

c) Mitigation plans for those risks escalated to the Corporate Risk Register and assigned to the Committee

2.4 Recommendation

The Committee is recommended to approve the updated Healthcare Governance Committee Terms of Reference as set out in appendix 1.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Healthcare Governance Committee Terms of Reference.

Appendix 1

HEALTHCARE GOVERNANCE COMMITTEE

1. REMIT

1.1. The Healthcare Governance Committee (HGC) will provide assurance to the Board that the quality of all aspects of care in NHS Lothian is person-centred, safe, effective, equitable and maintained to a high standard.

1.2. The Committee will also provide assurance to the Board that NHS Lothian meets its responsibilities with respect to:

- National Standards for Community Engagement and Participation[1]
- Volunteers/Carers
- Information Governance
- Protection of Vulnerable People including children, adults, offenders
- Relevant Statutory Equality Duties

1.3. The Board authorises the Committee to investigate any activity within its terms of reference, to request any Board member or employee to attend a Committee meeting and request a written report or seek any information it requires. The Board directs all employees to co-operate with any Committee request.

1.4. The HGC may seek assurance from other Board committees, as required, in relation to any governance, risk or performance issue pertinent to the discharge of its remit. In turn, the HGC may provide assurance to other Board committees, from time to time.

1.5. The Board authorises the Committee to determine the processes for the approval of Board policies, except for the following types of policy:

- Policies that are reserved for approval by the Board through its Standing Orders.
- Human Resources Policies.
- Finance Policies.

2. CORE FUNCTIONS

2.1. The Committee shall seek assurance on the following:

a) The quality, effectiveness, and safety of care of services within NHS Lothian is regularly monitored, reported and reviewed and specifically:
   i. Clinical care delivered across NHS Lothian meets NHS, HIS and other relevant standards and that unacceptable clinical practice is detected and addressed
   ii. Effective quality assurance and quality improvement systems are in place covering all aspects of service delivery

b) Continuous improvement of clinical care drives decision-making about the provision, organisation, and management of services

c) Mitigation plans for those risks escalated to the Corporate Risk Register and assigned to the Committee

d) Medicines Management, including the management of Controlled Drugs

[1] As set out by Health Improvement Scotland – Community Engagement within *The Quality Framework for Community Engagement and Participation* (April 2023)

e) There is a systematic and documented approach for the production, implementation and evaluation of clinical policies

f) An open and transparent culture exists with respect to the reporting, investigation and corrective action taken following adverse events, reviews, fatal accident inquiries, ombudsman reports or other internal or external reports

g) Complaints and patient feedback are handled in accordance with national standards/guidance, and lessons learned from their investigation and resolution, including reports from the Scottish Public Sector Ombudsman and Mental Welfare Commission

h) All individuals engaged by the Board to carry out its functions and services are appropriately trained to develop the skills and competencies required to deliver the care needed; that continuing personal and professional development and lifelong learning are supported; and that there are mechanisms for developmental training and assessment where necessary (specific assurances will be sought from the Staff Governance Committee)

i) High-quality research and development, teaching and training are supported in partnership with other public or private sector bodies, and meet relevant guidance/governance standards, and complies with Research Framework for Health & Community Care.

j) Information governance across NHS Lothian meets NHS, HIS and other relevant standards, and that unacceptable practice will be detected and addressed, including Codes of Practice on openness and related strategy processes all applied and monitored

k) The Board's adherence to legislative requirements and the implementation of relevant directives and other instructions from Scottish Government with respect to equality, diversity and human rights, including addressing and responding effectively to health inequalities in the population (additionally, the HGC will seek assurance that Integration Joint Boards are taking appropriate account of equality, diversity and human rights matters when planning and commissioning services)

l) The protection of vulnerable adults (adults, children, offenders) complies with legislative requirements and national standards

m) The HGC's remit is addressed in a systematic and documented manner through clear policies and procedures, and adequate and effective systems of internal control.

2.2. In order to support the delivery of its remit and core functions, the HGC shall:

- Monitor and review outcomes and processes across NHS Lothian, seeking assurance that the appropriate structures, processes, and controls are in place and operating effectively.
- Encourage and support co-ordination and whole system learning activities across NHS Lothian, especially the sharing of good practice and the effective use of data, such as national clinical audits, to benchmark performance and delivery.
- Delegate any necessary authority to groups or sub-committees to undertake the detailed consideration and resolution of specific matters on behalf of the Committee.
- Ensure there is an annual workplan for the discharge of its remit, and that there is an annual report on its activities.

- Ensure that any required action is undertaken swiftly in order to provide reassurance to the Board and the public.
- Inform the development of relevant Board strategies.
- Monitor, review and inform updates to any relevant risk assurance and mitigation plans.
- Ensure that, where required, any item presented for decision-making is subject to an appropriate impact assessment process, in line with NHS Lothian policy.

3. MEMBERSHIP

3.1. The membership of the HGC will be:

- Five non-executive members of the Board, appointed by the Board (one of whom shall be the Chair of the Area Clinical Forum)
- Up to two staff side representatives, nominated from and by the NHS Lothian Partnership Forum

3.2. Should it choose to do so, the HGC may appoint up to two external members to represent the voice of patients and/or the public. Any such appointments will be made in accordance with a procedure approved by the Board.

3.3. The Chair of the HGC will be appointed by the Board from amongst the five non-executive members. If the Chair of the HGC is not present at a meeting, the members present may appoint one of the other non-executive board members present to preside.

3.4. All Board members have a right of access to the Committee's meeting papers and minutes.

In Attendance:

3.5. The Chair of the NHS Lothian Board should not be a member of the HGC but may attend meetings.

3.6. Officers and senior staff of the Board will be expected to attend meetings of the Committee when issues within their area of responsibility are being considered. The role of an attendee is to provide information and advice and to participate in discussions, either for the whole duration of the meeting or for particular agenda items. The Committee Chair will agree with the Lead Officer to the Committee which officers or senior staff should attend meetings, routinely or otherwise, and for which items. Attendance requirements will be based upon the HGC's Annual Work Plan. Notwithstanding this, the following staff will be in regular attendance at HGC meetings:

- The Chief Executive
- The Executive Medical Director
- The Executive Director of Nursing, Midwifery & AHPs
- The Director of Public Health & Health Policy
- The Director of Pharmacy
- The Associate Director for Quality Improvement

3.7. The Executive Medical Director shall serve as the Lead Officer to the Committee.

4. QUORUM

4.1. No business shall be transacted at a meeting of the HGC unless a quorum has been established. A meeting will be considered quorate when at least three of the five non-executive members are present.

4.2. There may be occasions when due to the unavailability of a non-executive member, the Board Chairman may ask any other non-executive members of Lothian NHS Board to act as members of the Committee so that a quorum is achieved.

5. VOTING

5.1. Should a vote need to be taken, only the non-executive members of the Board appointed to the HGC (or nominated to act as members of the HGC under 4.2 above) shall be entitled to vote, either by show of hands or a ballot.

6. FREQUENCY OF MEETINGS

6.1. The Committee will normally meet six times in each calendar year but may elect to have additional meetings, at the discretion of the Chair. The Committee will conduct its meetings in line with the Standing Orders of the Board.

7. REPORTING ARRANGEMENTS

7.1. The Committee will report to the Board by means of submission of its approved minutes to the next available Board meeting. The Board will provide a standing invitation to the Chair of the Committee to report verbally on any key issues which the Committee considers should be brought to the Board's attention and to identify any issues that may require to be addressed in the future.

7.2. The Committee Chair will provide an annual report on the Committee's discharge of these Terms of Reference to the Audit and Risk Committee, to inform the Board's annual review of the effectiveness of its systems of risk management and internal control. This will be a source of information and assurance for the preparation of the Board's Governance Statement, published within the annual accounts.

8. DATE OF APPROVAL OF THESE TERMS OF REFERENCE: 22 OCTOBER 2024

9. DATE BY WHICH THE TERMS SHOULD BE REVIEWED: JANUARY 2025

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Royal Edinburgh and Associated Services Update on Healthcare Governance Arrangements**
Responsible Executive:	**Tracey McKigen, Services Director**
Report Author:	**Danielle Shearer, Business Manager**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☒
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☒
Primary Care	☐	Digital	☐
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHS Scotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to provide the committee with an assessment of the quality and safety of care provided in the Royal Edinburgh Hospital and Associated Services (REAS) and work being undertaken to address risks and improve quality and safety.

The committee is recommended to accept overall moderate assurance that REAS have comprehensive systems in place to deliver safe, effective, person-centred care.

2.2 Background

REAS brings together staff employed by NHS Lothian, both within the Royal Edinburgh Hospital (REH) site, other acute sites including the St John's Hospital, Livingston (SJH) and the Royal Hospital for Children and Young People (RHCYP), in Edinburgh, off-site in community premises and co-located with other services and organisations e.g. Police Custody Suites and Prisons. There are delegated, non-delegated and hosted services. These services include but are not necessarily limited to:

- ECT
- Adult Acute Mental Health inpatients
- Adult Psychiatric Rehabilitation inpatients
- Older People's Mental Health (OPMH) inpatients
- Intensive Home Treatment Team (IHTT)
- Mental Health Assessment Team (MHAS)
- Rapid Response Team (RRT)
  Forensic Assessment, Support & Treatment (FAST)
  Mental Health Intensive Support Team (MHIST)
- Intellectual Disabilities inpatients
  ASD & ADHD Resource, Training and Support Team
- Child and Adolescents Mental Health Services (CAMHS) inpatients and community
- Prison Healthcare (primary care, mental health, and substance use) for two Lothian prisons
- Psychological Therapy Services: Pan-Lothian.
- Court Liaison Service
- Psychotherapy
- Art Psychotherapies
  Occupational Therapy
- Substance use and Alcohol Related Brain Disease (ARBD)

REAS provides the following services on a regional/National basis:

- Regional Medium Secure inpatients and Forensic community services
- Regional & National Specialist Services (Perinatal community services, Mother and Baby Unit, Eating Disorder Services inpatient and community and Scottish Mental Health Services for Deaf People)
- Two National Prisons
- Regional Police Custody Healthcare (primary care, mental health, and substance use)
- Regional Forensic Medical Examiner Service

3.1 Structures and Processes for Management and Oversight of Safety

3.1.1 Management and Governance Structures

3.1.1.1 A Patient Safety and Experience Action Group (PSEAG) is in operation and is co-chaired by the Chief Nurse and Associate Medical Director. The group meets on a weekly basis to review all newly reported significant adverse events (SAE), considers any immediate patient safety concerns, commissions the appropriate level of review and monitors any actions/improvements as a result of investigation recommendations.

3.1.1.2 A business meeting was convened in January 2024 to address barriers encountered during the SAER process. Due to staff absences, this meeting was paused but has been reestablished in January 2025. This includes assigning alternative and external reviewers as necessary, addressing outstanding action plans, and advancing reports requiring REAS Senior Management Team (SMT) approval.

3.1.1.3 Concerns about quality of care are managed through the NHS Lothian complaints process as appropriate. Patient concerns about staff employed by NHS Lothian are managed through Once for Scotland ER processes where necessary.

3.1.1.4 Clear lines of accountability and responsibility are established, cases of concern are escalated through the supervisory and line management structures.

3.1.1.5 The Mental Welfare Commission carries out both announced and unannounced visits and provides feedback and recommendations for management, where appropriate.

3.1.1.6 Regular meetings take place by means of SMT and 1:1 supervision which allow issues to be escalated appropriately. REAS undertake Quarterly Performance meetings which are chaired by the Deputy Chief Executive.

3.1.1.7 REAS have restructured their local quarterly performance meetings to align with the corporate quarterly performance cycle. This includes a monthly scorecard covering the

areas of Staffing, including overall absence and specific focus on Sickness, Quality, Employee Development, and Service Delivery.

A narrative document has also been introduced to be reported on quarterly basis to give context to the data and allow the General Managers to select an appropriate assurance level. These meetings are newly formed and will be developed over 25/26.

3.1.1.8 A monthly risk register report is issued to REAS SMT and extended to service leads to ensure that all risks are monitored and updated on a regular basis.

3.1.2 Complaints

3.1.2.1 REAS is committed to continually improving the services for the people of NHS Lothian and beyond and recognises complaints are an important source of valuable feedback. REAS have an established Assurance and Improvement (A&I) team who work closely with REAS senior managers and the Patient Experience Team (PET) to continue to deliver high performance for Stage 2 complaints.

3.1.2.2 REAS have implemented a local MS Planner which allows the complaints team to track local complaints and their process, allowing for timely follow-up and work closely with the PET for improved complaint responses. A weekly report is shared with the SMT to monitor complaint compliance and promptly action investigations and responses.

3.1.2.3 Complaints by Outcome and Type

Of the 286 stage 2 Complaints received between 1 January 2024 and 28 November 2024 when this report was written, 32 were upheld and 92 were partially upheld.

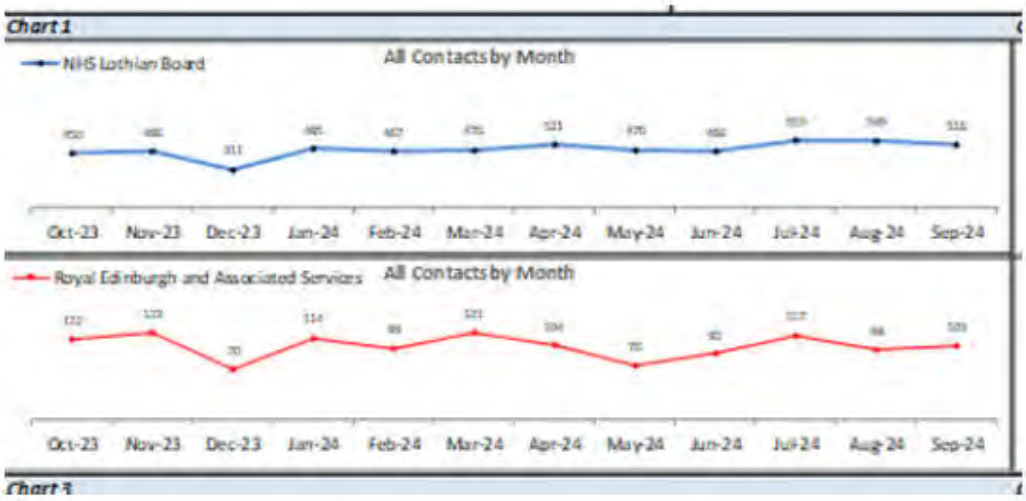
	Stage 1	Stage 2	Total
Upheld	121	32	153
Partly Upheld	74	92	166
Not Upheld	467	133	600
Total	665	286	951

3.1.2.4 The top 4 themes for stage 2 complaints are:

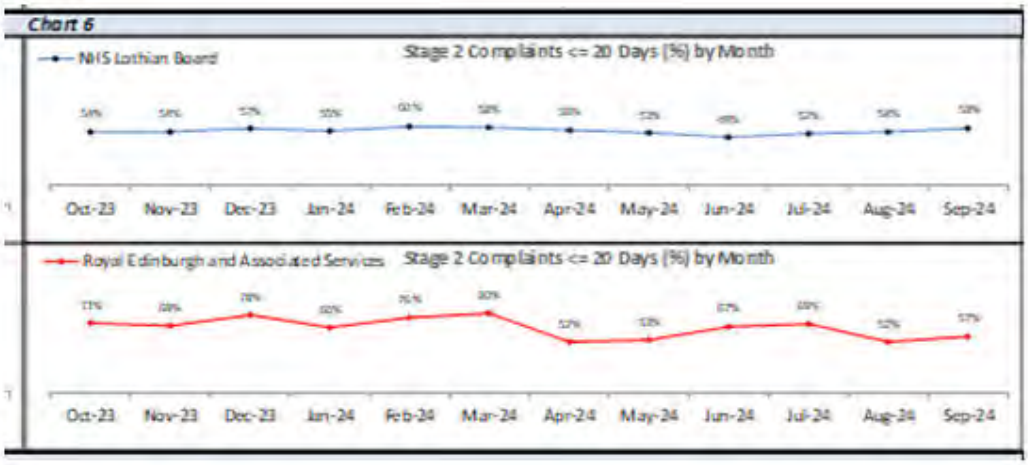
- Treatment – Inadequate/inappropriate treatment (119)
- Communication – Poor Communication (90)
- Delays – Delays in treatment (79)
- Access - Admission/appointment issues (74)

3.1.2.5 For the purposes of this report, the below graph is updated to October 2024 as the November 2024 data has not been published by PET at the time of writing this report. The number of contacts with NHS Lothian Complaints has remained stable. However, the

number that are associated to REAS has seen a fluctuation across the 2023/2024 between 70 and 122 contacts per month.



Significant efforts have been made with services to ensure 20-day compliance is improved. There has been a large amount of absence within the A&I team with only 1 member of staff available since April 2024 which has had a significant impact, evidenced by the drop in compliance. Staffing has increased in November 2024 and will improve the compliance again.



As of November 2024, REAS have [redacted] SPSO cases opened.

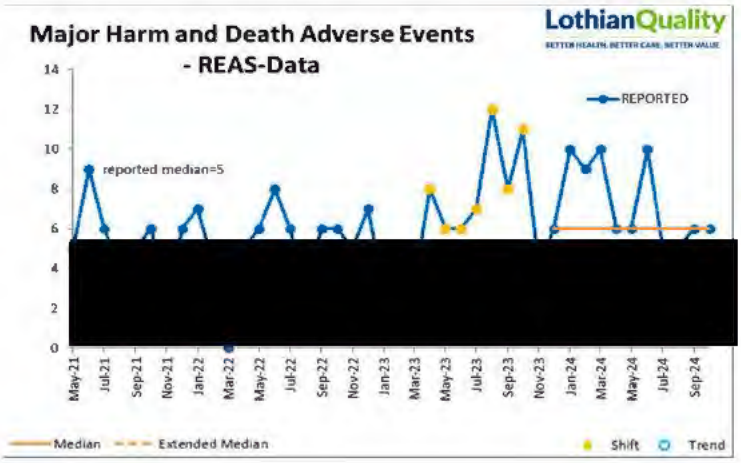
There were 27 SPSO cases closed during January – October 2024. 19 were not taken forward, [redacted] were closed as a premature complaint, the remaining 5 were closed at the pre-investigation request. As of November 2024, there are [redacted] open SPSO cases.

3.1.3 **Risk Management**

3.1.3.1 Adverse events in REAS are recorded on DATIX and the A&I team are responsible for ensuring that the SAER process is adhered to. There have been a number of issues with the REAS process which are being addressed. The main issues currently being faced are around the length of time to assign reviewers; for action plans to be developed by services on completion of the review; and the time for sign off from REAS

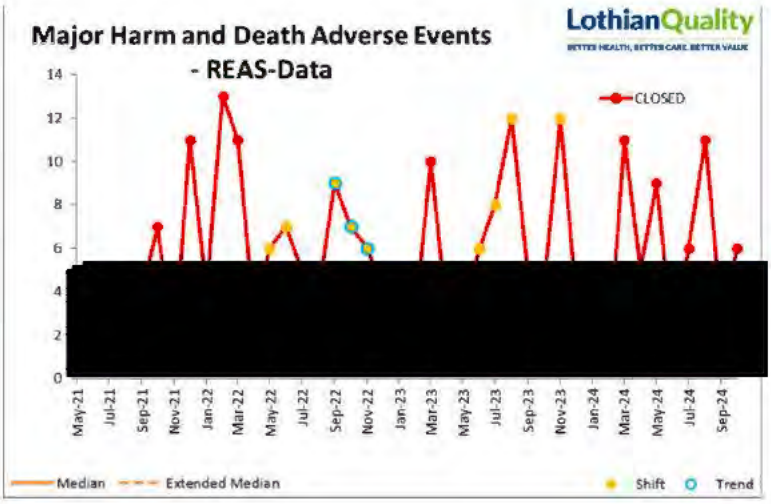
SMT, which is represented in the below table with current reviews exceeding KPI targets. This reflects the current overcapacity demand on all services.

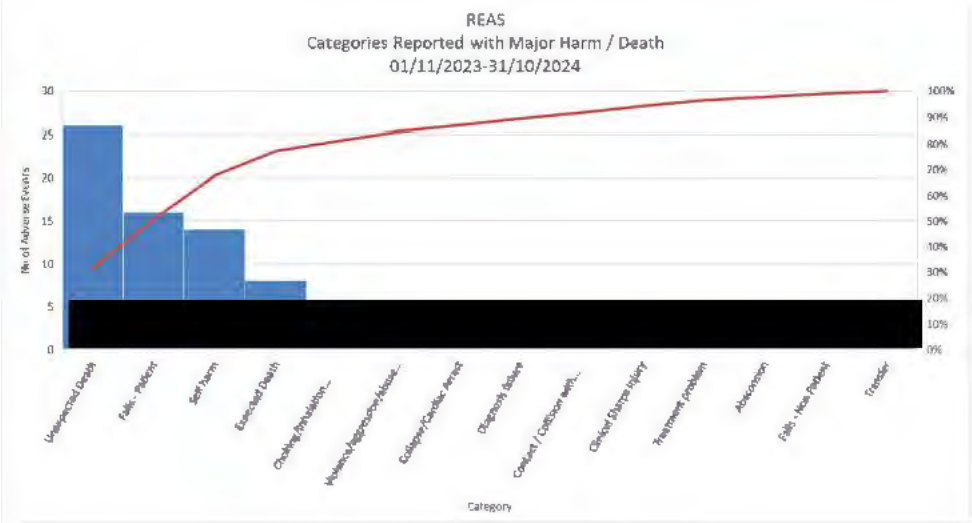
	Number open at (26/11/24)	Number exceeding Key Performance Indicator (KPI) at (26/11/24)	Key Performance Indicator (KPI)
Non-Level 1 Adverse Events	52	35	Non-level 1 events should be closed within 70 days
Level 1 Adverse Events	10	10	Level 1 events should be closed within 140 days



This chart highlights a shift in the median reported major harm and death adverse events from November 2023.

This chart highlights the inconsistency of Major harm and death adverse event closures, which is due to reviewers resource, service pressures and reduction in timely sign offs.





The above chart identifies unexpected death as the main reason category within the Major Harm and death adverse events with falls and self-harm following. Unexpected deaths have reduced from 2022/2023 and falls have increased. Out of the 26 unexpected deaths that occurred in 2024, 2 were inpatient deaths, 11 occurred in the two prisons and 13 occurred in the community. There is an established falls group which a member of the Assurance and Improvement team is working closely with, alongside the Quality Improvement team to identify themes of falls and improvement plans.

Level 1 Reviews Closed with outcomes	1	2	3	4	Total
May-23	0	0		0	
Jun-23	0	0	0		
Jul-23	0		0	0	
Aug-23	0				
Sep-23	0		0	0	
Oct-23	0		0	0	
Nov-23	0		0	0	
Dec-23	0	0		0	
Jan-24	0		0	0	
Feb-24	0	0	0	0	0
Mar-24	0	0	0	0	0
Apr-24	0	0		0	
May-24	0	0	0	0	0
Jun-24	0	0	0	0	0
Jul-24	0		0		
Aug-24	0			0	
Sep-24	0	0		0	
Total	0				20

The table above shows the number of outcomes for level 1 reviews per month May 2023 - October 2024.

3.2 Service Quality and Safety Assessment

3.2.1 Safe Care

The safecare system has been used across REAS since 2017, alongside the implementation of the Healthroster. The system allows clinical acuity to be assessed and recorded locally in ward areas. Nursing staff use a set criterion to rate the input each patient requires; the system then calculates what safe staffing should look like. There is flexibility around this to include professional judgement and the ability to mitigate of risk, giving a level of assurance staffing is safe and effective.

REAS have a local escalation process in place and use the system to lead our daily staffing huddle. At this we review staffing against clinical acuity this provides an opportunity to utilise resources better across the sites and mitigate risk as it is highlighted. Where staff have concerns, staff can “red flag” a shift, this initiates a conversation regarding mitigation of risk and potentially influences where staffing resources are better utilised.
The huddle is chaired by the Chief Nurse and Deputy Chief Nurse to provide professional oversight and provides an overview of clinical activity REAS wide.

Healthcare Improvement Scotland are developing a Scottish specific tool that will be rolled out nationally and will include the professional judgement tool that is currently done separately. This system is linked to and used to report figures related to the Health and Care (Staffing) (Scotland) Act 2019.

The provisions in the Health & Care (Staffing) (Scotland) Act 2019 which were imposed on 1 April 2024 with a purpose to include a duty to seek clinical advice. This is to ensure that operational management have a professional perspective to support appropriate decision making and actions that will ensure the health, wellbeing and safety of patients, the provision of high-quality care and the wellbeing of staff.

The Act aims to enable high quality care and improved outcomes for people using services in both health and care by helping to ensure appropriate staffing. The duties under the provisions of the Act set in statute states; “that at all times suitably qualified and competent individuals from such a range of professional disciplines as necessary are working in such numbers as are appropriate for the health, wellbeing and safety of patients or service users and the provision of high-quality health care.” The process we have in place ensures this is the case.

3.2.2 Mental Welfare Commission Visits

3.2.2.1 In 2024, the Mental Welfare Commission conducted 13 visits, 3 unannounced and 10 announced. Notably, four of these visits resulted in either one or no recommendations, the visits which received no recommendations occurred on Blackford Ward (IPCU), Redwood Ward within the Orchard Clinic, MBU at SJH, and the William Fraser Centre received only 1 environmental recommendation, highlighting the exceptional work of the clinical staff and the quality of the service environments. Using the standards in these areas we are sharing learning across all other services and replicating processes. However, ten visits did yield recommendations, with themes focusing on the following areas:

- Documentation
- Care Planning
- Physical Environment

- Medication
- Staffing
- Training

SMART action plans have been put forward to address these recommendations, and the services are diligently working to implement these improvements however capital restraints are impacting on the ability to make any significant investment to upgrade physical environments.

Audits now implemented in relation to management of medications and care plans to ensure consistency and learning.

As previously discussed at committee the Melville Unit MWC was very poor, and a specific action plan is being overseen by REAS SMT around this. A recent proposal to CMT has agreed that progress should be made in splitting the current unit into two distinct patient pathways. The work on this is ongoing and will conclude later in the year.

3.2.3 Service Challenges and Mitigations

3.2.3.1 Bed Occupancy

Table 3.2.3.1 Adult Acute Bed Occupancy

	Apr-23	May-23	Jun-23	Jul-23	Aug-23	Sep-23	Oct-23	Nov-23	Dec-23	Jan-24	Feb-24	Mar-24	Apr-24	May-24	Jun-24	Jul-24	Aug-24	Sep-24	Oct-24	Nov-24
Bed Occupancy Rate	112.8%	111.5%	106.7%	104.1%	102.9%	102.7%	103.2%	106.1%	105.1%	106.2%	104.2%	105.8%	105.5%	104.8%	102.8%	103.9%	104.2%	107.4%	111.4%	110.2%

Bed pressures remain a significant risk, with demand consistently surpassing capacity across inpatient services. This creates a risk that inpatient services may be unable to provide an acute mental health bed within an acceptable timescale, despite current measures to mitigate this risk. Adult Acute beds are capped at a maximum capacity of 105 beds, with an additional 5 beds (1 per ward) available, bringing the total capacity to 110 beds. However, in recent months, this capacity has been regularly exceeded, reaching up to 125 beds.

To address this surge, a winter surge capacity of an additional 12 beds for three months has been approved by the REAS Senior Management Team (SMT) and Clinical Management Team (CMT). These opened on 6th January. This issue is currently listed on the NHS Lothian Corporate Risk Register. Continued collaboration with Edinburgh Health and Social Care

Partnership (HSCP) aims to address the demand levels on inpatient services. Efforts are focused on reducing non-health delays and reviewing interface pathways to streamline patient flow and improve bed availability. The “Discharge without Delay” (DwD) programme is being implemented across adult acute and older people’s mental health wards. This initiative aims to expedite the discharge process, ensuring that patients who are ready to leave the hospital can do so without unnecessary delays. The programme reports to the Lothian DwD Programme Board.
Despite these controls and initiatives, they are currently insufficient to mitigate the ongoing high demand. Occupancy rates remain above 100%, and patients are experiencing longer wait times which causes pressure to other services, including the Emergency Department at the Royal Infirmary. This situation underscores the need for continued efforts to enhance capacity, improve patient flow, and ensure timely access to care. There is a need to review the number of commissioned beds Edinburgh require for its population

3.2.3.2 Prison Healthcare Staffing

Within Prison healthcare, the primary focus has been on ensuring adequate staffing to meet the demands of the service while reducing reliance on supplementary staff. Clear evidence indicates that Prison healthcare has historically depended heavily on both bank and agency supplementary staff. Efforts have been made to recruit and collaborate with the staff bank to develop a larger pool of personnel to support the service. However, these efforts have faced challenges, particularly due to the training requirements and the necessity for approval of prison entry by the Scottish Prison Service (SPS).

To address these issues, systems have been implemented to ensure rosters are reviewed and approved by the prison healthcare senior team. These rosters are subject to regular audits, monitoring, and quarterly reporting to maintain accountability and effectiveness.

3.2.3.3 Melville Unit

The CAMHS Melville Regional Inpatient Unit has faced significant challenges since relocating to the Royal Hospital for Children and Young People (RHCYP) from the Young Person’s Unit (YPU) at the Royal Edinburgh Hospital (REH) campus. These challenges include increased admissions for eating disorders, higher clinical acuity, and staffing issues.

The current operational model and environment do not adequately meet the needs of patients or staff. Despite a 100% retention rate of newly qualified nurses over the past year, high turnover among experienced staff remains a concern. Since January 2023, the Melville Unit has reported 209 violence and aggression (V&A) incidents, including 168 episodes of self-harm and 92 incidents of patient-to-staff violence. These incidents resulted in 85 minor injuries, 7 moderate injuries, and [redacted] RIDDOR reportable events, including two staff fractures. These figures highlight the challenging environment and the need for urgent re-evaluation of the operational model and environment.

Senior teams from the Melville Unit, CAMHS, REAS, and Corporate Management Team agree that the current service configuration is unsustainable and requires reconsideration to ensure patient safety and staff wellbeing.

A Short Life Working Group (SLWG) was formed to review potential service model options. Option 3, a split model of care across two units, emerged as the preferred option, though it requires further development.

1. **Eating Disorder and Mental Health Split:**
   In this scenario, all patients with an eating disorder would remain at the Melville Unit, co-located with other children's services at the RHCYP. This arrangement would facilitate easy access to physical health services for these patients.

   Patients aged 12–18 with functional mental health conditions like mood disorders or psychosis, would be relocated to the vacant YPU at the REH, better suited for managing complex mental health needs.

2. **Acute and Community Integration Model:**

   The Melville Unit would serve as an acute care area for patients with urgent needs requiring intensive medical oversight, while the REH would provide a supportive environment for patients transitioning back into the community, taking advantage of the Morningside location's resources and integration opportunities.

A paper was presented at CMT on 14th Jan and asked for:

- **Discussion**: Examine and consider the implications of a matter.
- **Decision**: Approval of preferred option 3: Split defined models of care over two Units: Melville Unit and Royal Edinburgh Hospital Young Patient Unit and proposed next steps after the consideration of options.

It was agreed to progress with option 3 and further work up the staffing models required.

3.2.3.4 Veterans 1st Point

This service has been provided using matched funding for a number of years. Due to the significant ongoing financial challenges CMT agreed that it could no longer fund its share and that the service should reduce into the financial envelope provided by SG.

Based upon the reduced funding, a proposed model of service delivery was presented to the REAS SMT on 15th January. Whilst some clarification is still required around the level of psychiatry time, the delivery of service has been agreed. This was based upon surveys completed with service users and staff members who highlighted the key functions of a Veterans service to be the delivery of evidence-based treatment and access to a workforce with knowledge and understanding of the specific challenges veterans face. The new model proposed focuses on a Clinical Liaison team that can provide specific training and supervision to those within general mental health services working with this population as well as retaining a limited amount of direct clinical capacity for those who would most benefit from a greater level of clinical expertise (e.g. where war pensions assessments are required).

The new model will require an impact assessment to be completed and taken to CMT in February with an expected start date of April 2025

3.2.3.5 FAI

There have been 4 FAI determinations related to REAs services in the last year. £ where the Sherriff has made no recommendations. However there is one where individuals have been criticised and there are 4 main recommendations which will be taken forward via an action plan

Work is also ongoing across the multi-disciplinary team with several improvements workstreams underway;

Structures, Workforce, and Governance

- Development of Nursing Workforce and Leadership: This encompasses induction, skills/competencies, training, Personal Development Plans (PDPs), clinical supervision, and effective line management.
- Education and Training: Implementation of a Continuous Development Program (CDP) and reflective practice sessions across the Multi-Disciplinary Team (MDT).
- Standard Operating Procedures (SOPs): Comprehensive review and development of SOPs within the unit.
- Governance Structure Review: Enhancing audit and assurance processes to improve governance.
- Process Streamlining: Reducing duplication and optimising processes to maximise care delivery time.
- MDT Staffing Structure Review: Evaluating and optimising the staffing structure to deliver an agreed model of care, ensuring effective utilisation of clinical expertise across Tier 4.

Service/Care Delivery Model and Developments

- SOP for Admission to Discharge: Development of a clear clinical pathway tailored to different mental health diagnoses (e.g., Eating Disorder, Psychosis, Depression, Neurodevelopmental disorders).
- Clinical Pathways Review: Continuous review and improvement of clinical pathways.
- Person-Centred Care Planning: Integration of both mental and physical health in care planning.
- Risk Assessment and Safety Planning: Enhancing skills in risk assessment, safety planning, and the application of continuous interventions.
- Transition Pathways: Establishing clear transition pathways for admissions and discharges, including transition to adult services.
- Therapeutic Group Work: Development and implementation of a therapeutic group work program.

Communication and Engagement

- Promoting Collaborative MDT Working: Encouraging effective and collaborative working within the MDT.
- Implementation of AMBIT (Adaptive Mentalisation Based Integrative Treatment): 4 days training by Lothian trainers, with supervision from Anna Freud centre. AMBIT is an approach that aims to maintain effective practice despite the inevitable impact that high levels of risk and complexity can have on team and system functioning. AMBIT will provide a foundation for improvements in clinical pathways, communication and staff support and wellbeing.
  AMBIT Training for Children and Young People Crisis Professionals | Anna Freud
- Meeting Processes: Reviewing clinical and business meeting processes to ensure staff inclusion, transparency, and information sharing.
- Engagement with Young People and Families: Strengthening communication and engagement with young people and their families.
- Parental and Carer Communication: Developing carers bulletin, facilitating face-to-face sessions, and enhancing engagement in the young person's care.

- Welcome Pack and Advocacy: Providing a comprehensive welcome pack, advocacy services, and carers sessions.

Eating Disorder Care and treatment

- Model of Care Review: Reviewing and redefining the model of care for eating disorders.
- Therapeutic Meal Support: Implementing guidelines for therapeutic meal support, developing meal support champions, and coordinating mealtime training.
- Evidence-Based Care: Utilising evidence-based care and treatment approaches to guide treatment options, including behavioural approaches to meal/food exposure.
- SOP for ED Treatment: Developing SOPs for the treatment of eating disorders, including the use of nasogastric (NG) feeding.
- Promoting an ED Culture: Embedding a supportive culture for eating disorder management within the Inpatient Unit (IPU).
- Therapeutic Meal Support Culture: Promoting a culture where meal support is recognised and implemented as a therapeutic intervention by the MDT.

3.2.4 Service Improvement Work to Address Safety Issues

3.2.4.1 Recent discussions have focused on updating the capital investment business case for anti-ligature inpatient door upgrades across Lothian Mental Health, including General Managers for the Royal Edinburgh Hospital (REH) and St. John's Hospital (SJH).

3.2.4.2 Trauma-informed practice continues to be a key focus within broader strategic plans. Recent changes to Trauma Services will enable wider access to trauma-informed supervision and consultation for staff across services starting January 2025, aligning with the ongoing work provided by the Trauma Training Coordinator.

3.2.4.3 Senior Psychology staff have received training in the Significant Adverse Event Review (SAER) process, resulting in an increasing number of professionals now able to contribute to reviews commissioned by the Patient Safety and Experience Advisory Group (PSEAG).

3.2.4.4 Within the CAMHS Service, high performance continues across all areas related to training in all services. Competency frameworks have been developed for staff in leadership roles, tailored to individual needs. The Newly Qualified Nurse (NQN) Induction Programme, developed by the Nurse Consultant, has proven beneficial, with the Melville Unit retaining all NQNs.

3.2.4.5 Within the Forensics Services trauma-informed practice training is being rolled out to all staff cohorts within prisons. An induction programme for all new starts has been developed, which has positively impacted recruitment and retention.

3.2.4.6 The Orchard Clinic recently underwent its first full in-person review by the Quality Network for Forensic Mental Health Services through the Royal College of Psychiatrists. The review team included clinicians from medium secure units in Leicester and Norfolk, a patient representative, and a college representative. The visiting team was highly impressed with our Forensic Community Mental Health Team (FCMHT) – particularly the work they accomplish as a small team and their extensive remit. Our focus on wellbeing was commended, and the family room was praised for its excellent activity options, along with Cypress and our Occupational Therapy (OT) model. The team also noted our promotion of patient activities, including the gyms on the wards. Feedback

indicated that staff felt well-supported following incidents, with access to reflective practice and support from the nurse therapist. Additionally, the integration of See Think Act training into staff perspectives on delivering care was highlighted positively.

3.2.4.7 REAS works closely with Police Scotland to improve processes surrounding missing Persons. There has been a substantial decrease in missing persons reporting to police Scotland from the Royal Edinburgh site and is currently sitting at 149 persons reported in 2024 (excluding December). This has been gradually decreasing since 2014, as seen in the table below.

Misper Inc from REH (MH Hosp)											
	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
January	33	24	23	36	14	17	12	15	9	14	13
February	26	30	27	33	20	19	10	12	10	16	14
March	46	40	42	48	28	34	10	11	11	10	15
April	31	42	33	38	16	25	0	12	17	11	15
May	43	26	39	31	38	32	7	21	20	14	7
June	56	39	34	35	22	23	10	13	12	11	17
July	65	27	24	41	29	25	14	22	25	21	9
August	50	39	45	30	17	38	17	19	17	15	16
September	39	48	27	17	20	19	15	18	18	15	17
October	32	34	43	18	21	26	19	12	17	14	13
November	31	35	33	24	30	14	16	16	19	11	13
December	31	24	39	23	15	17	17	11	11	18	
Total	483	408	409	374	270	289	147	182	186	170	

3.2.5 Effective Care

3.2.5.1 Work to review both Length of Stay and Discharge without Delay is ongoing reflecting the national programme recommendations roll out and impact of local demand requirements.

3.2.5.2 A SLWG has been set up to review the use of Trak and meaningful outcome data for psychological therapies. Until now the focus has been on compliance with the mandatory data set however we are reviewing the ability of Trak to report on broader treatment outcomes to support effective treatment.

3.2.5.3 A Trauma training plan has been developed to guide the skill development of psychologists and psychological therapists post-qualification. This is in recognising that the complexity of the clinical work has increased and the prevalence of complex trauma across mental health presentation is high. The training plan reflects the current evidence-base for psychological treatment and will inform the long-term development of the workforce.

3.2.5.3 The Clinical Governance and Standard Board for Psychological Therapies meets 6 weekly and has the function of reviewing training plans for all psychological therapies services. This has supported cross-service cpd planning to support both efficient use of funds to train staff and sustainable training plans to develop the workforce in the long-term. This Board also serves the function of reviewing innovative service developments to ensure safe and evidence-based practice.

3.2.6 Person Centred Care

3.2.6.1 Continued work with Edinburgh HSCP to address levels of demand on inpatient

services aimed at maintaining the reduction in non-health delays and reviewing interface pathways.

3.2.6.2 This is an area that requires further development within psychological therapies. There are pockets of patient-centred care, e.g. Veterans First Point has until recently had a service-user group and AGM to involve them at a decision-making level. Patient satisfaction surveys have also been used within the general AMH services to gather feedback on changes in practice, e.g. increased pre-assessment questionnaires. However, there is a recognition of a need to take a more consistent and embedded approach to incorporating patient views in the long-term.

3.2.6.3 Patient satisfaction surveys are used in most services. Datix and complaints information is reviewed on a regular basis to review themes and agree actions for reducing reasons for complaints. A Datix learning form has been developed within HMPs to ensure consistent feedback to staff groups. This was picked up by HIS as excellent practice and they are keen to work with us to rollout nationally. Work continues to refine this and will be considered for rollout locally.

3.2.6.4 Peer support workers are now fully established in a number of our services including Perinatal Orchard Clinic and ATRC and proving highly beneficial, with good feedback from patients, their families and third sector organisations. An area to consider for next year would be to further evaluate and expand into other services with peer support posts either on a voluntary or paid basis.

4.0 Nursing Workforce

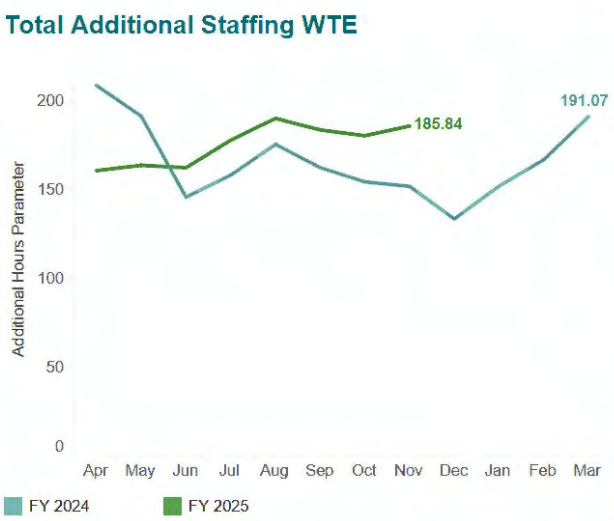
4.1 Establishment Gap

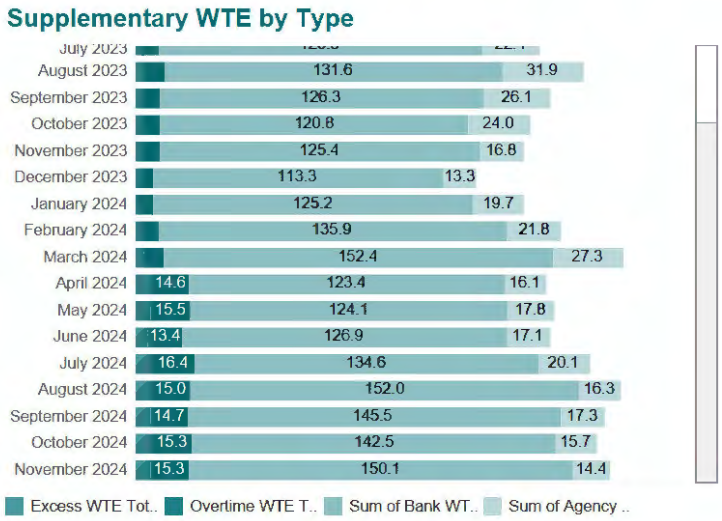
Establishment Gap

Shows the total Funded Establishment for each month compared to the total WTE of staff in post per month. The Establishment Gap is the percentage difference.

	ɟ 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
WTE	034	1,052	1,048	1,067	1,069	1,069	1,080	1,075	1,080	1,087	1,092	1,086	1,087	1,101	1,129	1,133
Sum of FE	161	1,163	1,164	1,164	1,164	1,164	1,167	1,168	1,168	1,167	1,179	1,178	1,173	1,174	1,176	1,177
Establishme..	.99	9.53	9.98	8.36	8.14	8.19	7.44	8.02	7.56	6.87	7.39	7.80	7.33	6.21	4.01	3.79

4.1.2 Supplementary Staffing





Total WTE by Financial Structure

Hover over HealthBoard/Division and Press [+] to expand the table.

Division	g 23	Sep 23	Oct 23	Nov 23	Dec 23	Jan 24	Feb 24	Mar 24	Apr 24	May 24	Jun 24	Jul 24	Aug 24	Sep 24	Oct 24	Nov 24
Reas	5.56	162.50	154.46	151.97	133.62	152.09	166.88	191.07	160.79	163.77	162.42	177.85	190.14	183.67	180.40	185.84
Grand Total	5.56	162.50	154.46	151.97	133.62	152.09	166.88	191.07	160.79	163.77	162.42	177.85	190.14	183.67	180.40	185.84

4.1.3 Over the last 5 years the following actions have been taken to attempt to mitigate the risks related to the reduced nursing workforce which has seen some beneficial effects:

- Provision of 6 final year student nurse Practice Learning placements from University of Stirling which has enabled REAS to recruit small numbers of NQN graduates from Stirling each year.

- The development in 2019 of a local Return to Nursing course in partnership with QMU targeting previously registered mental health nurses, offering employment at Band 2 level during their course – this has not generated any new registered nurses for Lothian but continues to be advertised periodically.

- In-reach to universities to meet with final year student nurses annually since 2019. It is proposed this would be done with 1st and 2nd year students from 2022 onwards

- Guaranteed substantive employment for NQNs upon completion of nurse training without formal interview process was introduced in 2020 (23 recruited). In 2022 REAS recruited 66 NQNs, 63 of whom will take up employment. This increase in local uptake is reflective of the efforts that have bene made to attract staff into posts.

- Creation of better career pathways and new roles for registered nurses (Clinical Academic Senior Nurse roles x 2 – one of which is now in partnership with Stirling University, the other continues with ENU; Advanced Nurse practitioner roles; deputy chief nurse role; Nurse Consultant roles – new roles in Perinatal Mental Health and CAMHS during this reporting period). These roles highlight the diverse roles available in REAS, provide opportunity to have nurses in local Universities to increase recruitment and offer

non-managerial roles to experienced nursing staff allowing us to keep hold of the knowledge and experience.

- REAS participating in NQN pilot - final year consolidation nurse students were matched with Band 5 Registered Nurse vacancies at the point of their final placement commencement in May 2021. Upon qualification they were automatically commence as Registered Nurses in those same clinical areas. A B6 Clinical Educator role was recruited to support the NQNs, and outcomes have confirmed that retention has significantly improved with only 3 NQNs having left REAS in this reporting period during the first 10 months of employment compared with 13 in the preceding year. This demonstrates a retention figure of 89% in the first year and 96% retention in the second year.

- Introduction of a new role of Assistant Practitioner to the nursing workforce at AfC Band 4. The first cohort of Assistant Practitioners for REAS commenced a 12-month training programme with Edinburgh College in September 2021. A further 2 rounds of external recruitment have not proved as lucrative as expected however between internal candidates and external adverts, there was a total of 10 fully qualified B4 Assistant practitioners in REAS by the end of 2023 with the current numbers are 26 with continued efforts to recruit a target of 30 across service areas. These roles will provide invaluable support and provision for delegated aspects of the Registered Nurse responsibilities.

- The most recent initiative is a partnership between REAS and the Open University to directly recruit Trainee Mental Health Nurses who are employed whilst supported to undertake the BSc Hons over 4 years and will be guaranteed an RMN post upon completion. 17 Trainees are in post from September 2022. A further 23 Trainees were employed in September 2023. This is a pilot with the OU that only REAS and 2 nurses in Lochgilphead are participating in This “earn as you learn” model was recognised nationally by the Mental Heal Nursing Forum for Scotland and was awarded prizes for *Innovation in Education and* the Excellence in Mental Health Nursing Overall Winner 2023. The Scottish Government gave a commitment to expanding this model across Scotland, with other Universities, with the view to increasing uptake of Student Nurse numbers. Unfortunately, this pilot has not been reintroduced and the OU advised they required a period of time to restructure to accommodate any further cohorts of students. The Chief Nurse for education and Executive Nurse Director have met with the SG to discuss the reintroduction of this pilot.

- REAS has successfully implemented and maintained a significant reduction in the use of contract agencies. The Melville unit remains the only consistent user of agency staff, with Adult Acute requiring some input when bed capacity becomes an issue.

- A clear process is in place for escalating any agency shifts via the Chief Nurse. We hold daily staffing huddles, utilising SafeCare, to discuss clinical acuity, bed capacity impacts, and ensure staffing is safe and effective. Following these discussions, requests for agency staff are submitted to Nurse Directors for approval.

- REAS has introduced a nursing resource system where staff can book shifts and be allocated to areas needing additional support due to increased clinical acuity or unfilled bank shifts. Recently, we implemented a 9am to 2pm shift to accommodate parents’ schedules, allowing them to drop off and pick up their children from school. This shift has proven to be very useful.

4.1.4 Reduction in the Mental Health Outcome Framework has seen our WTE reduce in 2024 and will continue to present challenges across, CAMHS, Perinatal and Eating Disorders, with service reviews currently being scoped in order to meet financial targets.

5.0 Financial

5.1 Financial Forecast

5.1.1 REAS is forecasting a breakeven position for the end of 2024/25 financial year including 2.4% efficiencies.

5.2 Financial Pressures

5.2.2 The Enhanced MH Outcomes Framework allocation for 2024/25 was reduced by 4.5% in comparison to the prior year and the impact of this for REAS services was a reduction of £0.8m. The areas impacted are CAMHS, Psychology, Perinatal and Eating Disorders

5.2.3 The main areas of financial pressures are Adult Acute inpatient wards and the CAMHS Melville unit. Both have increased spend on continuous interventions and constant observations through nursing bank and agency use. In addition, prescribing of Buvidal in prisons is also forecasting a £400k spend for 24/25. Funding was allocated for this in 2021 on a non-recurring basis and no further funding has been received since then.

5.2.4 There is a significant overspend in Psychology due to previous commitments to reduce long waits for therapy and recruit permanent staff to do this. This has resulted in a permanent workforce without substantive funding, particularly affecting the 4 AMH general teams and administration. Many Psychology services rely on delegated budgets and non-recurring funding, complicating long-term planning. Recent funding reductions have halted direct clinical work in the Psychological Staff Support Service and Veterans First Point.

6.0 Risk Assessment/Management

6.1 Current Risk Management

6.1.1 Bed pressures remain a key risk with demand outstripping capacity across the majority of inpatient services. Risk of inpatient service being unable to provide an acute mental health bed within an acceptable timescale, noting current measures to reduce this risk. Adult Acute beds are capped at 105 beds as maximum capacity with an additional 5 beds (1 per ward) being available to bring total capacity to 110 beds. In recent months this has been regularly exceeded leading to up to 125 and as a result some winter surge capacity of an additional 12 beds for 3 months has been approved by REAS SMT and CMT. This is currently on the NHS Lothian Corporate Risk Register.

6.1.2 In October 2023, there were 2 new risks added to the Corporate Risk Register for REAS

which was around inappropriate and inadequate accommodation in the secure estate. There is a risk that female patients who require high secure accommodation or any patient requiring low secure accommodation will be inappropriately placed because there is a lack of female high secure accommodation in Scotland and a lack of low secure accommodation for any patient in NHS Lothian including for ID.

6.1.3 There is a risk associated with the capital projects to re-provide rehabilitation services and intellectual disability services. Both were prioritised as category A but are unlikely to proceed in the next few years and the master planning group for the site will now come back together to consider what is possible within the current estate.

6.1.4 There is also a risk to patient safety from outdated standards of anti-ligature inpatient doors with a capital case to upgrade these undertaking a prioritisation exercise .

6.1.5 With a significant reduction in capacity due to the need for financial balance, this will Impact access to Psychological Therapies significantly. Other key areas have also been identified as risks due to gaps in service.

6.1.6 Melville Unit remains a high-risk area, with a recent review and options appraisal undertaken around future provision of the unit. A paper has been developed and this will be presented to the corporate management team.

7.0 Risk Register

There are no implications of this paper for the NHS Lothian risk register other than the risks already mentioned.

8.0 Equality and Diversity, including health inequalities

8.1 Current Impacts on Equality and Diversity

8.1 Lack of sufficient beds has an impact on equality of access.

8.2 It was highlighted within the Equality and Diversity Impact Assessment that the reduction in funds for the Veterans First Point service would have a likely impact on access to services for this population.

9.0 Other impacts

9.1 An impact assessment on this paper has not been carried out

10 Communication, involvement, engagement, and consultation

The Board has carried out its duties to involve and engage external stakeholders, including patients and members of the public, where appropriate:

There are a number of forums used to engage and consult with people who use our services including the patients' council, service specific programmes and wider consultation on policy changes. Patient Feedback is also formally obtained through commissioned work.

11 Recommendation

- **Assurance** – The Board/Committee is asked to agree and accept a specific level of assurance on the matter, based on the evidence presented (a standard assurance level must be recommended and clearly evidenced).

12 List of Appendices

The following appendices are included with this report:

- Appendix 1: Site/ Service/Group of Services Scope
- Appendix 2: Assurance Mapping Appendix Table
- Appendix 3: Outcome Measures
- Appendix 4: Process Measures

Appendix 1 – Scope of Royal Edinburgh and Associated Services

Service Name	Royal Edinburgh and Associated Services
What does REAS do?	The Royal Edinburgh Hospital and Associated Services (REAS) provides mental health care in Edinburgh and the surrounding regions. It provides comprehensive mental health and Intellectual Disabilities services to individuals of all ages, from children and adolescents to adults and the elderly. It also provides primary care and substance use services in the two Lothian Prisons and the nine policy custody areas REAS is committed to delivering high quality, patient-centred care that addresses a wide range of mental health needs. The hospital aims to provide a holistic approach, integrating medical treatment with psychological support and social care to ensure that patients receive well rounded and effective care. One of the key strengths of REAS is its multidisciplinary teams, which include but is not limited to, Psychiatrists, Psychologists, Nurses and Allied Health Professionals. These professionals work collaboratively to develop personalised treatment plans tailored to the unique needs of each patient. This team based approach ensures that all aspects of a patient's mental health are addressed, from diagnosis and treatment to rehabilitation and ongoing support. REAS also places a strong emphasis on research and education. The hospital is involved in numerous research projects aimed at advancing the understanding of mental health conditions and developing new and innovative treatments. Additionally, REAS serves as a training ground for future mental health professionals, providing education and hands-on experience to medical, nursing and other healthcare trainees. Overall, REAS is dedicated to improving the mental health and wellbeing of its patients through compassionate care and innovative treatment. REAS provides the following services for patients in NHS Lothian: • Adult Mental Health inpatients • Adult Rehabilitation inpatients • Older People Mental Health (OPMH) inpatients • Intensive Home Treatment Team • Mental health Assessment Team • Rapid Response Team • Intellectual Disabilities inpatients • Child and Adolescents Mental Health Services (CAMHS) inpatients and community • Prison Healthcare (primary care, mental health, and substance use) for two Lothian prisons • Psychological Therapy pan Lothian. • Court Liaison Service

<table>
<tr><td></td><td>

Psychotherapy
Veterans Services
Art Therapy
Substance Use and ARTC

REAS provides the following services on a regional basis:

Regional Medium Secure inpatients and Forensic community services
Regional & National Specialist Services (Perinatal community services, Mother and Baby Unit, Eating Disorder Services inpatient and community and Scottish Mental Health Services for Deaf People)
Regional Police Custody Healthcare (primary care, mental health, and substance use)
Regional Forensic Medical Examiner Service
Two National Prisons

</td></tr>
<tr><td>What facilities does REAS use?</td><td>
REAS

REAS total Bed Capacity across all services is 330.
Two beds remain closed for clinical capacity in Melville Inpatient Unit (CAMHS).
Seven beds remain closed for refurbishment in Redwood (Forensic Psychiatry).
There are currently 12 additional beds open for 12 weeks to provide additional inpatient capacity

<table>
<tr><th>Location</th><th></th><th>Type of Facility</th><th>Total Number of Beds in Facility</th></tr>
<tr><td>ACUTE</td><td>Meadows Female</td><td>Adult Mental Health</td><td>16</td></tr>
<tr><td></td><td>Merchiston</td><td>Adult Mental Health</td><td>16</td></tr>
<tr><td></td><td>Hermitage</td><td>Adult Mental Health</td><td>16</td></tr>
<tr><td></td><td>Balcarres Male</td><td>Adult Mental Health</td><td>16</td></tr>
<tr><td></td><td>Craiglockhart</td><td>Adult Mental Health</td><td>16</td></tr>
<tr><td></td><td>Braids</td><td>Adult Mental Health</td><td>15</td></tr>
<tr><td></td><td>Blackford</td><td>Adult Mental Health IPCU</td><td>10</td></tr>
<tr><td></td><td></td><td>TOTAL</td><td>105</td></tr>
<tr><td>CAMHS</td><td>Melville Inpatient Unit</td><td>CAMHS</td><td>12</td></tr>
<tr><td></td><td></td><td>TOTAL</td><td>12</td></tr>
<tr><td>ATRC</td><td>RITSON</td><td>SMD Addictions</td><td>12</td></tr>
<tr><td></td><td></td><td>TOTAL</td><td>12</td></tr>
<tr><td>REHAB</td><td>North Wing</td><td>Rehabilitation (Mental Health)</td><td>15</td></tr>
</table>
</td></tr>
</table>

	Craiglea	Rehabilitation (Mental Health)	15
	Myreside	Rehabilitation (Mental Health)	15
	Cramond	Rehabilitation (Mental Health)	15
	Margaret Duguid	Rehabilitation (Mental Health)	4
		TOTAL	**64**
OPMH	Fairmile	Psychiatry of Old Age	15
	Harlaw	Psychiatry of Old Age	15
	Eden	Psychiatry of Old Age	15
	Cannan	Psychiatry of Old Age	15
		TOTAL	**60**
SJH	Mother & Baby Unit	perinatal	6
	WD 2 REDU	Eating Disorders	12
		TOTAL	**18**
FORENSIC	Redwood	Forensic Psychiatry	15
	Hawthorn	Forensic Psychiatry	11
	Cedar	Forensic Psychiatry	14
		TOTAL	**40**
William Fraser Centre	Culzean	Learning Disability Service	4
	Rannochmore	Learning Disability Service	4
	Strathaird	Learning Disability Service	4
		TOTAL	**12**
Islay Centre	Barra	Learning Disability Service	4
	Rum	Learning Disability Service	3
	Harris	Learning Disability Service	3
	Camis Tigh	Learning Disability Service	6
		TOTAL	**16**
		REAS TOTAL	**339**

How many staff does this site/service/group of services have (WTE)?	Staffing information correct as at [insert date]		
		Establishment	In Post
	Nursing	1176	1129
	AHPs	122.3	127.8
	Doctors (excluding doctors in training)	109.49	111.2
	Doctors in training	67.60	64.96
	Other		

Appendix 2 - Assurance Mapping Appendix Table– REAS

[redacted]

Evidence	HCG	Service SMT's	REAS SMT	REAS Clinical Governance and Assurance Group	REAS performance Meetings	Comments Standardised agendas across services are being developed to ensure consistency of approach so some of this is in place and some in progress
[redacted]						
Number of adverse events reported per month.	Annual	Monthly	Monthly via performance meeting	Monthly	Monthly	Each service has a performance score card with a number of these measures which is completed monthly
Number of adverse events with an outcome 3 or 4 reported per month.	Annual	Monthly	Monthly via performance meeting	Monthly	Monthly	See section 7, page 8 of the Adverse Event Review Template for definitions of review outcomes.
Themes identified from adverse events.	Annual	Quarterly	Quarterly	Quarterly	Quarterly	
Safety themes identified from complaints	Annual	Quarterly	Quarterly	Quarterly	Quarterly	
[redacted]						
Number of SAEs not closed within 6 months	Annual	Quarterly	Monthly via performance meeting	Monthly	Monthly	
Number of complaints	Annual	Monthly	Monthly via performance meeting	Monthly.	Monthly	
% Complaints closed within 20 working days	Annual	Monthly	Monthly via performance meeting	Monthly	Monthly	
% staff who have completed all mandatory training (corporate)	Annual	Monthly	Monthly	Not currently discussed	Monthly	
% of staff with live PDP in place	Annual	Monthly	Monthly	Not currently discussed	Monthly	

Ratio of nursing staff in post: establishment	Annual	Monthly	Monthly via performance meeting	Not routinely discussed	Monthly	

Mortality Indicators						
	Frequency and location of routine reporting & review					
Evidence	**HCG**	**Service SMT**	**REAS SMT**	**REAS Clinical Governance and Assurance Group**	**REAS Performance**	**Comments**
Outcome measures						
Number of Deaths per month	Annual	Not currently discussed	Monthly via performance meeting	Discussed weekly at REAS PSEAG	Monthly as part of review of SAERs	

Morbidity Indicators						
	Frequency and location of routine reporting & review					
Evidence	**HCG**	**Service SMT**	**REAS SMT**	**REAS Clinical Governance and Assurance Group**	**REAS Performance committee or sub committees**	**Comments**
Outcome measures						
Number of patient falls with harm per month	Annual	Monthly	Not currently discussed	Discussed via weekly PSEAG	Discussed via falls group	

					which feeds into CG&AG	
Number of Self Harm per month	Annual	Not routinely discussed but trends would be	Not routinely discussed	Discussed weekly at PSEAG	Not routinely discussed	
Number of Violence and Aggression reported per Month	Annual	Monthly	Discussed Quarterly via H&S	Monthly	Monthly	
Missing Person Data REH	Annual	Monthly	Not routinely discussed	Not routinely discussed	Monthly via police liaison meeting	
Process measures						
Bed Occupancy	Annual	Monthly	Not routinely discussed	Not routinely discussed although clinical concerns resulting from high occupancy will be	Monthly	
Delayed Discharges per Month	Annual	Monthly	Discussed via performance.	Not routinely discussed	Monthly	
CAMHS Patients seen per Month	Annual	Monthly via CAMHs SMT	Discussed via performance.	Not routinely discussed	Monthly	
CAMHS Waiting Times per Month	Annual	Monthly via CAMHs SMT	Discussed via performance.	Not routinely discussed	Monthly	

Psychological Therapies Patients seen per Month	Annual	Monthly via Psychology SMT	Discussed via performance.	Not routinely discussed	Monthly	
Psychological Therapies Waiting Times	Annual	Monthly via Psychology SMT	Discussed via performance.	Not routinely discussed	Monthly	

Evidence	**HCG**	**REAS SMT**	**REAS PSEAG**	**Other Service SMT(s)**	**Comments**
Healthcare Environment Inspectorate reports	N/A	N/A	N/A	N/A	
HIS Inspection reports	New to MH	New to MH	New to MH	New to MH	
Scottish Public Services Ombudsman reports	Annual	As required but none upheld for 3 years +	As required but none upheld for 3 years +	As required but none upheld for 3 years +	
All relevant national audit reports	Annual and as required	As available	As required	As required	
MWC	Annual and as required	Quarterly via performance	Not routinely discussed	Quarterly and as required specific to service	

Appendix 3: Outcome Measures

Table 1.0: Number of Patient Falls with Harm per Month, per Service.

	Harm to a person - Minor	Harm to a person - Moderate	Harm to a person - Major	Harm to a person - Death	Total
HMP Addiewell	**0**	**0**	**0**		
December 2024	0	0	0		
Admin & Clerical Staff		**0**	**0**	**0**	
July 2024		0	0	0	
Adult Mental Health - Acute	**22**			**0**	
January 2024		0	0	0	
February 2024		0	0	0	
March 2024		0	0	0	
May 2024		0		0	
June 2024		0	0	0	
July 2024		0	0	0	
August 2024		0		0	
September 2024			0	0	
October 2024		0	0	0	
December 2024		0	0	0	
Adult Mental Health - Community Psychiatry		**0**	**0**	**0**	
June 2024		0	0	0	
Adult Mental Health - Rehab	**21**		**0**	**0**	
January 2024		0	0	0	
February 2024		0	0	0	
March 2024		0	0	0	
April 2024		0	0	0	
May 2024			0	0	
June 2024		0	0	0	
July 2024		0	0	0	
August 2024		0	0	0	
October 2024			0	0	
November 2024			0	0	
CAMHS Tier 4		**0**	**0**	**0**	
June 2024		0	0	0	
HMP Edinburgh	**0**		**0**	**0**	
October 2024	0		0	0	
Forensics		**0**		**0**	
February 2024		0	0	0	
April 2024	0	0		0	
June 2024		0	0	0	
Learning Disabilities - Inpatient Services			**0**	**0**	**6**

January 2024	0	[redacted]	0	0	[redacted]
June 2024	[redacted]	0	0	0	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
December 2024	[redacted]	0	0	0	[redacted]
Lothian Perinatal and Infant Mental Health Service	[redacted]	**0**	**0**	**0**	[redacted]
December 2024	[redacted]	0	0	0	[redacted]
Psychiatry of Old Age	**69**	[redacted]	**12**	[redacted]	**83**
January 2024	7	[redacted]	[redacted]	0	11
February 2024	[redacted]	0	[redacted]	0	6
March 2024	[redacted]	0	[redacted]	0	[redacted]
April 2024	8	0	0	0	8
May 2024	[redacted]	0	[redacted]	0	[redacted]
June 2024	7	0	[redacted]	0	[redacted]
July 2024	8	0	0	0	8
August 2024	10	0	[redacted]	0	[redacted]
September 2024	[redacted]	0	[redacted]	0	7
October 2024	[redacted]	0	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
December 2024	[redacted]	0	0	[redacted]	[redacted]
Substance Misuse	[redacted]	**0**	**0**	**0**	[redacted]
May 2024	[redacted]	0	0	0	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
October 2024	[redacted]	0	0	0	[redacted]
December 2024	[redacted]	0	0	0	[redacted]
Totals:	**127**	**8**	**16**	[redacted]	[redacted]

Table 2.0: Number of Self-Harm Per Month, Per Service

	Harm to a person - Minor	Harm to a person - Moderate	Harm to a person - Major	Harm to a person - Death	Total
HMP Addiewell					[redacted]
November 2024	0	0	0	[redacted]	[redacted]
Adult Mental Health - Acute	**115**	**22**	[redacted]	[redacted]	**142**
January 2024	11	[redacted]	[redacted]	[redacted]	15
February 2024	6	0	0	[redacted]	[redacted]
March 2024	[redacted]	[redacted]	0	0	[redacted]
April 2024	[redacted]	[redacted]	0	0	[redacted]
May 2024	9	[redacted]	0	0	[redacted]
June 2024	19	[redacted]	0	0	[redacted]
July 2024	23	[redacted]	0	0	[redacted]
August 2024	12	[redacted]	0	0	[redacted]
September 2024	6	[redacted]	0	0	[redacted]
October 2024	10	[redacted]	0	0	[redacted]

November 2024	[redacted]	[redacted]	0	[redacted]	7
December 2024	8	[redacted]	[redacted]	0	10
Adult Mental Health - Community Psychiatry	**0**	[redacted]	**0**	**0**	[redacted]
September 2024	0	[redacted]	0	0	[redacted]
Adult Mental Health - Rehab	**9**	[redacted]	**0**	**0**	[redacted]
January 2024	[redacted]	0	0	0	[redacted]
March 2024	[redacted]	0	0	0	[redacted]
April 2024	[redacted]	0	0	0	[redacted]
May 2024	0	[redacted]	0	0	[redacted]
July 2024	[redacted]	0	0	0	[redacted]
October 2024	[redacted]	0	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
CAMHS Tier 3	[redacted]	[redacted]	[redacted]	**0**	[redacted]
February 2024	0	0	[redacted]	0	[redacted]
March 2024	0	0	[redacted]	0	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
October 2024	0	[redacted]	0	0	[redacted]
CAMHS Tier 4	**127**	**14**	[redacted]	**0**	[redacted]
January 2024	12	0	0	0	12
February 2024	11	0	0	0	11
March 2024	15	[redacted]	0	0	[redacted]
April 2024	23	[redacted]	0	0	[redacted]
May 2024	10	0	0	0	10
June 2024	10	[redacted]	0	0	[redacted]
July 2024	7	[redacted]	[redacted]	0	13
August 2024	6	[redacted]	0	0	7
September 2024	6	[redacted]	0	0	[redacted]
October 2024	12	0	0	0	12
November 2024	[redacted]	0	0	0	[redacted]
December 2024	10	0	0	0	10
Eating Disorders	**15**	**0**	**0**	**0**	**15**
February 2024	[redacted]	0	0	0	[redacted]
September 2024	[redacted]	0	0	0	[redacted]
October 2024	[redacted]	0	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
December 2024	[redacted]	0	0	0	[redacted]
Forensics	[redacted]	[redacted]	**0**	[redacted]	[redacted]
March 2024	[redacted]	0	0	0	[redacted]
July 2024	[redacted]	0	0	0	[redacted]
September 2024	0	[redacted]	0	0	[redacted]
October 2024	0	0	0	[redacted]	[redacted]
IHTT	**0**	**0**	**0**	[redacted]	[redacted]
January 2024	0	0	0	[redacted]	[redacted]
September 2024	0	0	0	[redacted]	[redacted]
November 2024	0	0	0	[redacted]	[redacted]
Learning Disabilities - Community	[redacted]	**0**	[redacted]	**0**	[redacted]
April 2024	[redacted]	0	0	0	[redacted]
October 2024	[redacted]	0	0	0	[redacted]

November 2024	0	0	[redacted]	0	[redacted]
Learning Disabilities - Inpatient Services	**10**	**0**	**0**	**0**	**10**
January 2024	[redacted]	0	0	0	[redacted]
February 2024	[redacted]	0	0	0	[redacted]
June 2024	[redacted]	0	0	0	[redacted]
July 2024	[redacted]	0	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
Lothian Perinatal and Infant Mental Health Service	[redacted]	[redacted]	**0**	[redacted]	[redacted]
February 2024	0	0	0	[redacted]	[redacted]
May 2024	0	[redacted]	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
MH Assessment Service	[redacted]	**0**	**0**	**0**	[redacted]
June 2024	[redacted]	0	0	0	[redacted]
Psychiatry of Old Age	[redacted]	[redacted]	**0**	[redacted]	[redacted]
March 2024	[redacted]	0	0	0	[redacted]
May 2024	0	[redacted]	0	0	[redacted]
June 2024	0	0	0	[redacted]	[redacted]
December 2024	0	[redacted]	0	0	[redacted]
Psychology Department	**0**	**0**	**0**	[redacted]	[redacted]
June 2024	0	0	0	[redacted]	[redacted]
Substance Misuse	[redacted]	**0**	**0**	**0**	[redacted]
May 2024	[redacted]	0	0	0	[redacted]
Totals:	**286**	**44**	[redacted]	**11**	**347**

Table 3.0: Number of Violence and Aggression Reported Per Month, Per Service

	No known adverse effect at this time	Harm to a person - Minor	Harm to a person - Moderate	Harm to a person - Major	Total
HMP Addiewell	**9**	[redacted]	[redacted]	**0**	[redacted]
January 2024	[redacted]	0	0	0	[redacted]
March 2024	0	[redacted]	[redacted]	0	[redacted]
May 2024	[redacted]	0	0	0	[redacted]
July 2024	[redacted]	0	0	0	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
September 2024	0	[redacted]	0	0	[redacted]
October 2024	[redacted]	0	0	0	[redacted]
Admin & Clerical Staff	[redacted]	**0**	**0**	**0**	[redacted]
September 2024	[redacted]	0	0	0	[redacted]
Adult Mental Health - Acute	**304**	**121**	**18**	[redacted]	**446**
January 2024	33	[redacted]	0	[redacted]	37
February 2024	14	[redacted]	[redacted]	0	23
March 2024	17	9	[redacted]	0	[redacted]
April 2024	31	12	0	0	43

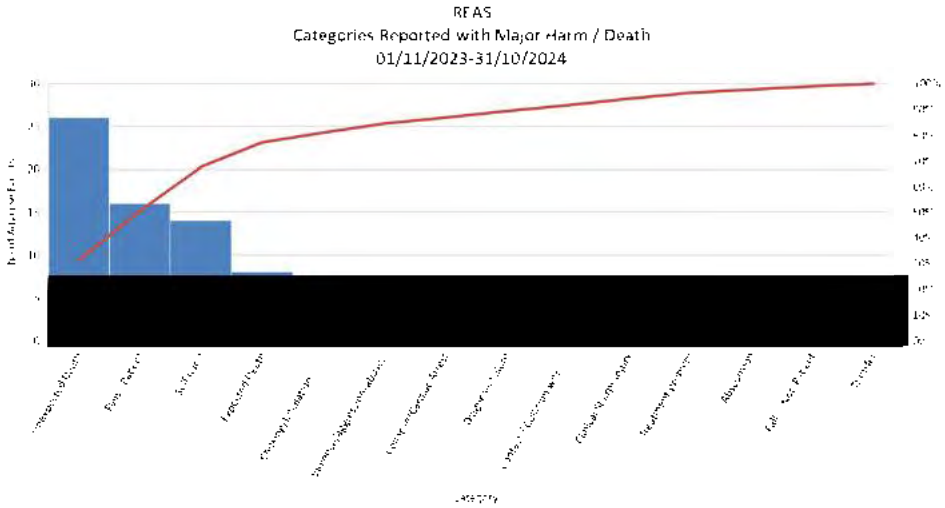
May 2024	24	12	[redacted]	[redacted]	[redacted]
June 2024	24	14	[redacted]	0	[redacted]
July 2024	44	22	[redacted]	0	[redacted]
August 2024	31	12	[redacted]	0	[redacted]
September 2024	11	[redacted]	[redacted]	0	[redacted]
October 2024	22	12	[redacted]	0	[redacted]
November 2024	22	7	[redacted]	0	[redacted]
December 2024	31	12	[redacted]	[redacted]	47
Adult Mental Health - Community Psychiatry	[redacted]	**0**	[redacted]	**0**	[redacted]
June 2024	[redacted]	0	0	0	[redacted]
July 2024	[redacted]	0	0	0	[redacted]
October 2024	0	0	[redacted]	0	[redacted]
November 2024	1	0	0	0	[redacted]
Adult Mental Health - Rehab	**183**	**58**	**8**	**0**	**249**
January 2024	23	9	[redacted]	0	[redacted]
February 2024	17	[redacted]	[redacted]	0	[redacted]
March 2024	15	8	[redacted]	0	[redacted]
April 2024	13	[redacted]	0	0	[redacted]
May 2024	20	[redacted]	[redacted]	0	[redacted]
June 2024	9	6	0	0	15
July 2024	20	[redacted]	0	0	[redacted]
August 2024	8	[redacted]	0	0	[redacted]
September 2024	10	6	[redacted]	0	[redacted]
October 2024	10	[redacted]	0	0	[redacted]
November 2024	19	0	0	0	19
December 2024	19	[redacted]	0	0	[redacted]
CAMHS Tier 2	[redacted]	**0**	**0**	**0**	[redacted]
March 2024	[redacted]	0	0	0	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
CAMHS Tier 3	**15**	**7**	[redacted]	**0**	[redacted]
January 2024	[redacted]	0	0	0	[redacted]
February 2024	[redacted]	0	0	0	[redacted]
March 2024	[redacted]	[redacted]	0	0	[redacted]
April 2024	[redacted]	[redacted]	[redacted]	0	[redacted]
May 2024	[redacted]	0	0	0	[redacted]
July 2024	[redacted]	[redacted]	0	0	[redacted]
August 2024	0	[redacted]	0	0	[redacted]
September 2024	[redacted]	0	0	0	[redacted]
October 2024	[redacted]	[redacted]	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
CAMHS Tier 4	**135**	**72**	**7**	[redacted]	[redacted]
January 2024	12	[redacted]	0	0	[redacted]
February 2024	[redacted]	[redacted]	0	0	[redacted]
March 2024	14	14	[redacted]	0	[redacted]
April 2024	13	9	0	[redacted]	[redacted]
May 2024	20	9	[redacted]	0	[redacted]
June 2024	9	[redacted]	0	0	[redacted]

July 2024	[redacted]	[redacted]	0	0	7
August 2024	[redacted]	7	0	0	[redacted]
September 2024	[redacted]	[redacted]	0	0	8
October 2024	28	7	[redacted]	0	[redacted]
November 2024	14	6	[redacted]	0	[redacted]
December 2024	6	7	[redacted]	0	16
HMP Edinburgh	**11**	[redacted]	**0**	**0**	**13**
February 2024	[redacted]	0	0	0	[redacted]
March 2024	[redacted]	0	0	0	[redacted]
April 2024	[redacted]	0	0	0	[redacted]
May 2024	[redacted]	0	0	0	[redacted]
June 2024	[redacted]	0	0	0	[redacted]
August 2024	0	[redacted]	0	0	[redacted]
September 2024	[redacted]	0	0	0	[redacted]
November 2024	[redacted]	[redacted]	0	0	[redacted]
December 2024	[redacted]	0	0	0	[redacted]
Forensics	**24**	**6**	[redacted]	**0**	[redacted]
January 2024	0	[redacted]	0	0	[redacted]
February 2024	[redacted]	0	0	0	[redacted]
March 2024	[redacted]	[redacted]	0	0	[redacted]
April 2024	[redacted]	[redacted]	0	0	[redacted]
June 2024	[redacted]	0	0	0	[redacted]
July 2024	8	0	0	0	8
September 2024	[redacted]	[redacted]	0	0	[redacted]
October 2024	[redacted]	0	[redacted]	0	[redacted]
December 2024	[redacted]	2	0	0	[redacted]
Learning Disabilities - Community	**8**	**8**	**0**	**0**	**16**
January 2024	[redacted]	[redacted]	0	0	[redacted]
February 2024	[redacted]	0	0	0	[redacted]
April 2024	[redacted]	[redacted]	0	0	[redacted]
May 2024	0	[redacted]	0	0	[redacted]
June 2024	[redacted]	[redacted]	0	0	[redacted]
July 2024	0	[redacted]	0	0	[redacted]
September 2024	[redacted]	[redacted]	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
Learning Disabilities - Inpatient Services	**323**	**51**	**7**	**0**	**381**
January 2024	42	[redacted]	[redacted]	0	[redacted]
February 2024	57	[redacted]	0	0	[redacted]
March 2024	34	[redacted]	0	0	[redacted]
April 2024	36	[redacted]	0	0	[redacted]
May 2024	17	[redacted]	0	0	[redacted]
June 2024	15	[redacted]	0	0	[redacted]
July 2024	22	7	[redacted]	0	[redacted]
August 2024	27	[redacted]	0	0	[redacted]
September 2024	20	[redacted]	[redacted]	0	[redacted]
October 2024	27	[redacted]	[redacted]	0	[redacted]
November 2024	17	13	0	0	30

December 2024	9	[redacted]	[redacted]	0	[redacted]
Lothian Perinatal and Infant Mental Health Service	[redacted]	[redacted]	[redacted]	**0**	**7**
March 2024	0	[redacted]	0	0	[redacted]
August 2024	[redacted]	[redacted]	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
December 2024	[redacted]	0	[redacted]	0	[redacted]
MH Assessment Service	**7**	[redacted]	**0**	**0**	**11**
January 2024	[redacted]	0	0	0	[redacted]
March 2024	[redacted]	[redacted]	0	0	[redacted]
April 2024	[redacted]	0	0	0	[redacted]
May 2024	[redacted]	0	0	0	[redacted]
June 2024	[redacted]	[redacted]	0	0	[redacted]
July 2024	0	[redacted]	0	0	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
October 2024	0	[redacted]	0	0	[redacted]
Psychiatry of Old Age	**239**	**117**	[redacted]	**0**	**359**
January 2024	10	7	0	0	17
February 2024	18	8	0	0	26
March 2024	25	9	[redacted]	0	[redacted]
April 2024	32	12	0	0	44
May 2024	30	10	[redacted]	0	[redacted]
June 2024	16	15	0	0	31
July 2024	24	10	[redacted]	0	[redacted]
August 2024	11	9	0	0	20
September 2024	26	[redacted]	0	0	[redacted]
October 2024	27	8	0	0	35
November 2024	13	13	0	0	26
December 2004	7	12	0	0	19
Psychology Department	[redacted]	**0**	**0**	**0**	[redacted]
October 2024	[redacted]	0	0	0	[redacted]
Psychological Therapies	[redacted]	**0**	**0**	**0**	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
December 2024	[redacted]	0	0	0	[redacted]
Substance Misuse	**9**	[redacted]	[redacted]	**0**	[redacted]
February 2024	0	[redacted]	[redacted]	0	[redacted]
April 2024	[redacted]	0	0	0	[redacted]
May 2024	[redacted]	0	0	0	[redacted]
July 2024	[redacted]	0	0	0	[redacted]
August 2024	[redacted]	0	0	0	[redacted]
September 2024	[redacted]	0	0	0	[redacted]
October 2024	[redacted]	0	0	0	[redacted]
November 2024	[redacted]	0	0	0	[redacted]
December 2024	[redacted]	0	0	0	[redacted]
Totals:	**1283**	**451**	**49**	[redacted]	**1787**

Table 4.0: Number of Deaths per Month

***Please note, these are all deaths reported under REAS - not necessarily inpatient deaths or suicides.**



Appendix 4: Process Measures

1.0 Bed Occupancy

Table 1.1: Adult Acute Mental Health Bed Occupancy

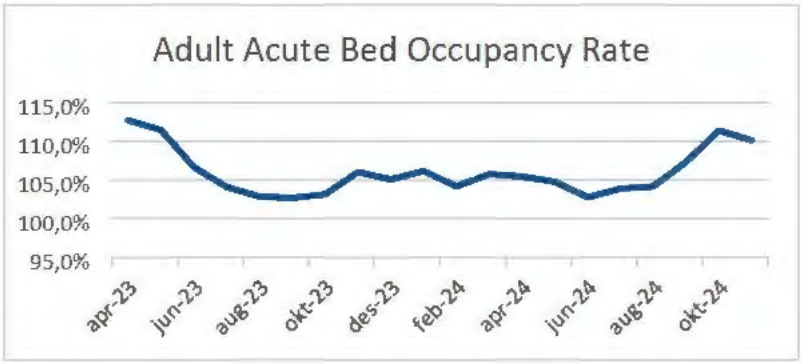


Table 1.2: Older People's Mental Health Bed Occupancy

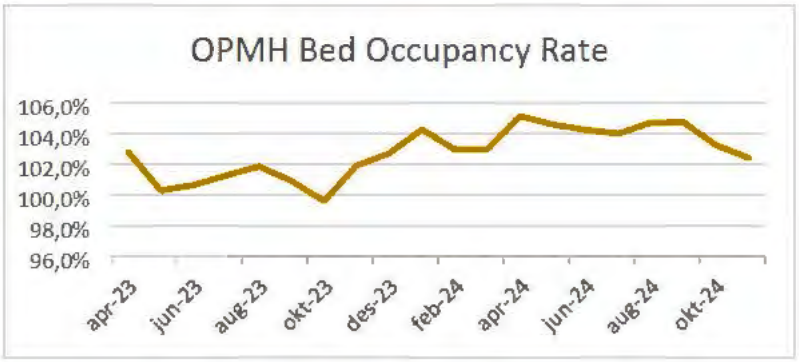


Table 1.3: Adult Mental Health Rehab Bed Occupancy

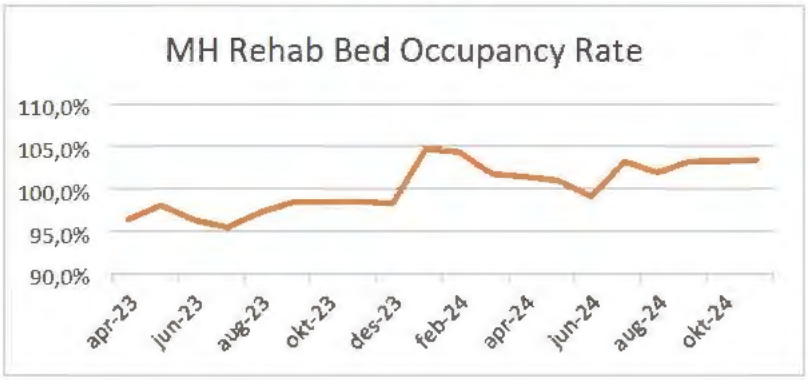


Table 1.4: Learning Disability Service Bed Occupancy

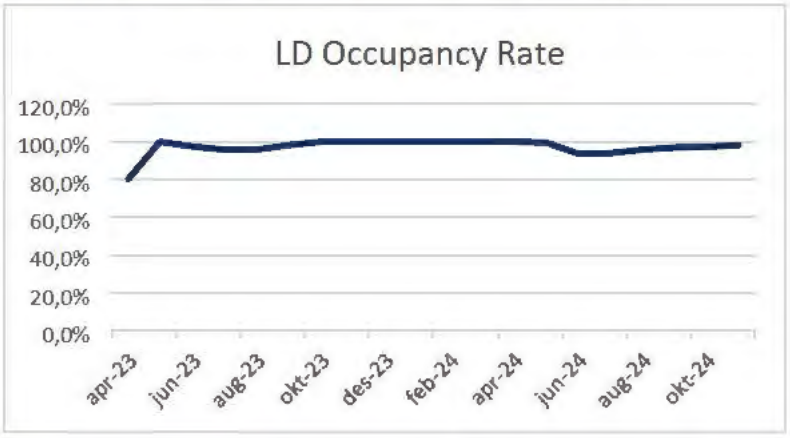


Table 1.5 Orchard Clinic Bed Occupancy (This is based on 7 beds closed).

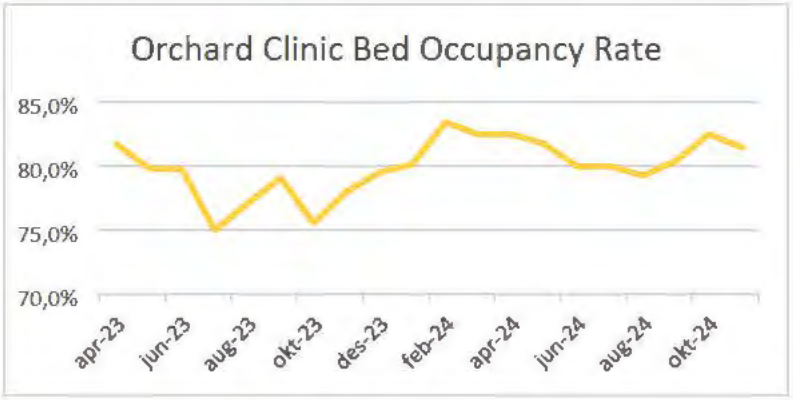


Table 1.6: Ritson Clinic Bed Occupancy

Table 1.7: Regional Eating Disorder Unit Bed Occupancy

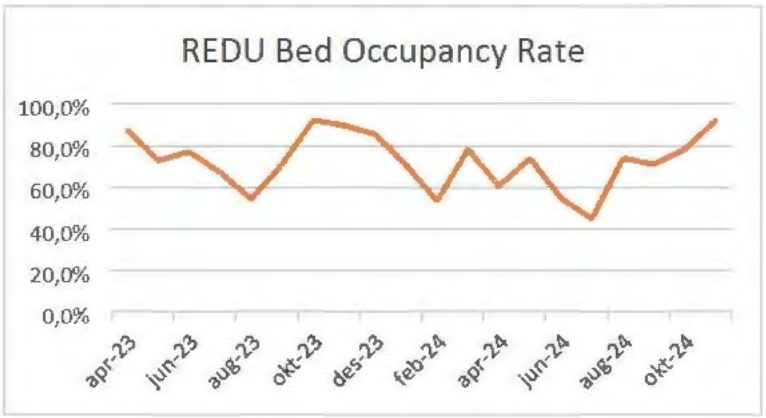


Table 1.8 Mother and Baby Unit Bed Occupancy Rate

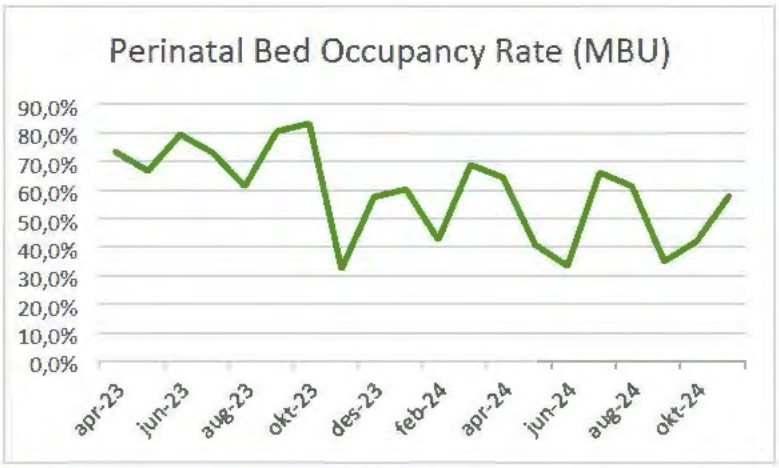
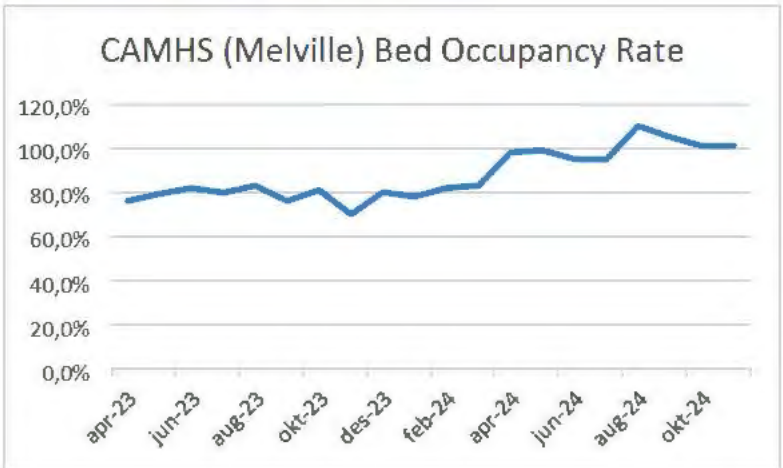
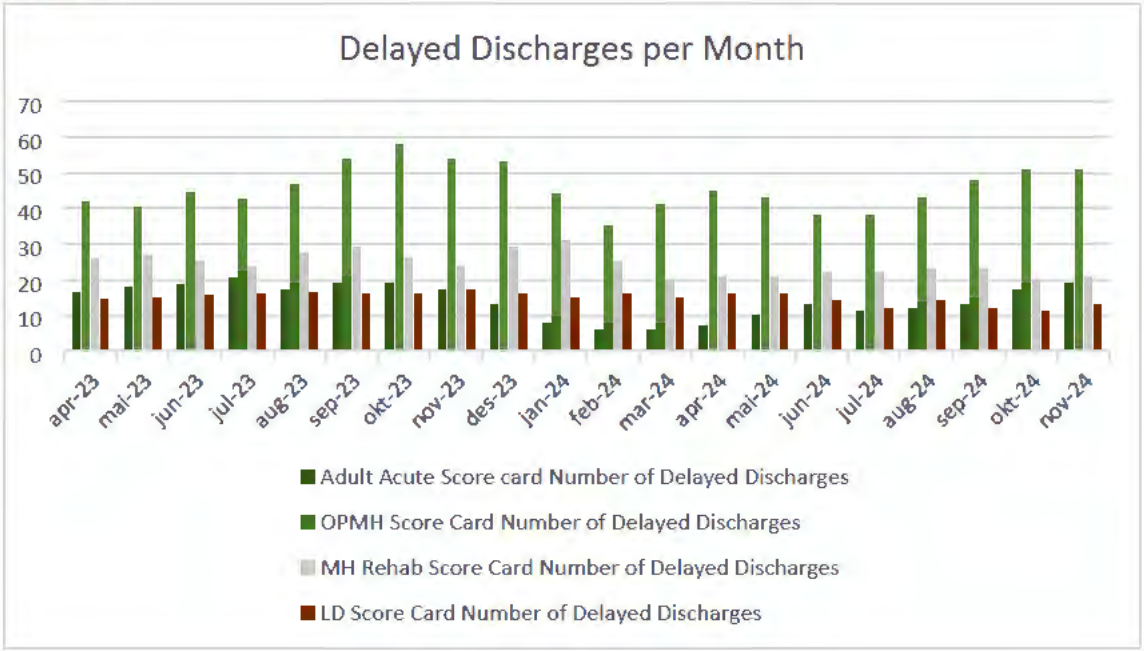


Table 1.9 Melville Unit Bed Occupancy



2.0 Number of Delayed Discharges

Table 2.0



3.0 CAMHS

Table 3.0: % of Patients seen <18 weeks

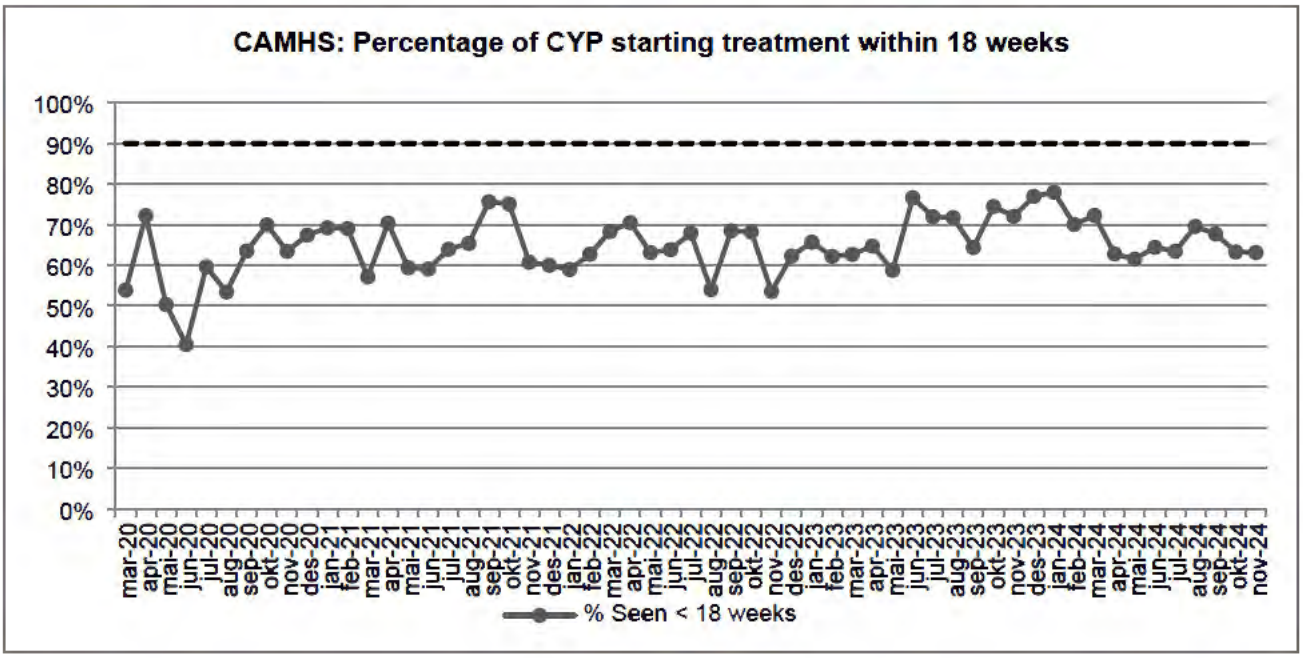
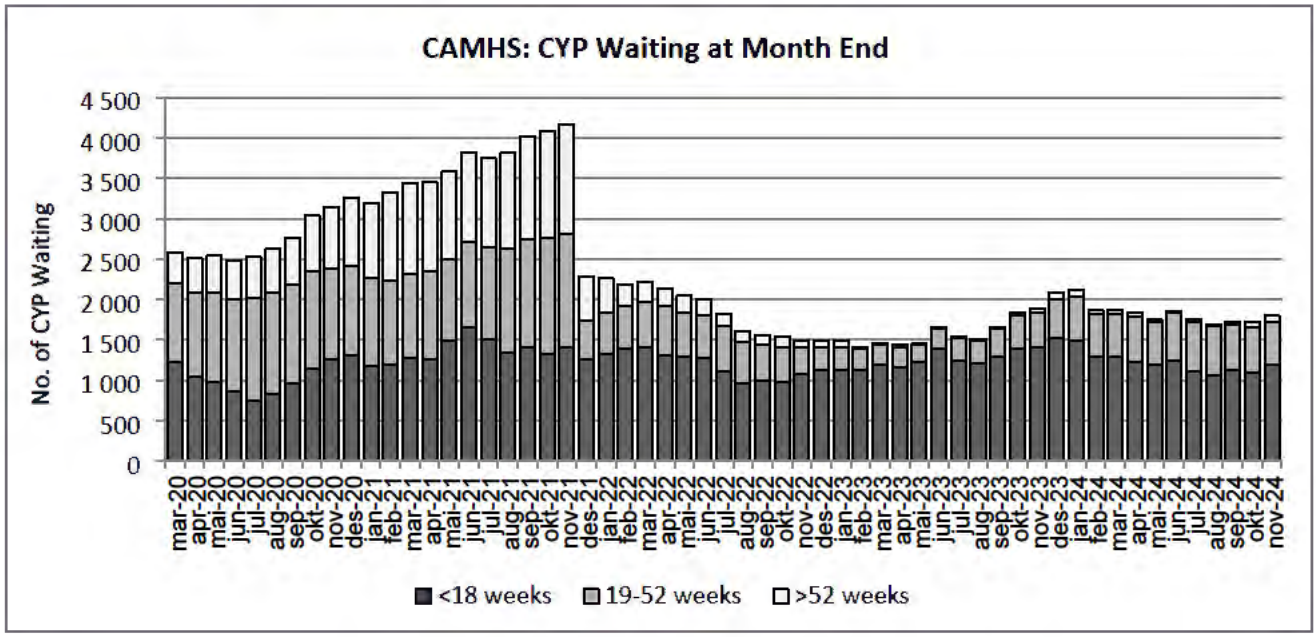


Table 3.1: CYP Waiting at Month End



4.0 Psychological Therapies

Table 4.0: % of Patients seen <18 weeks

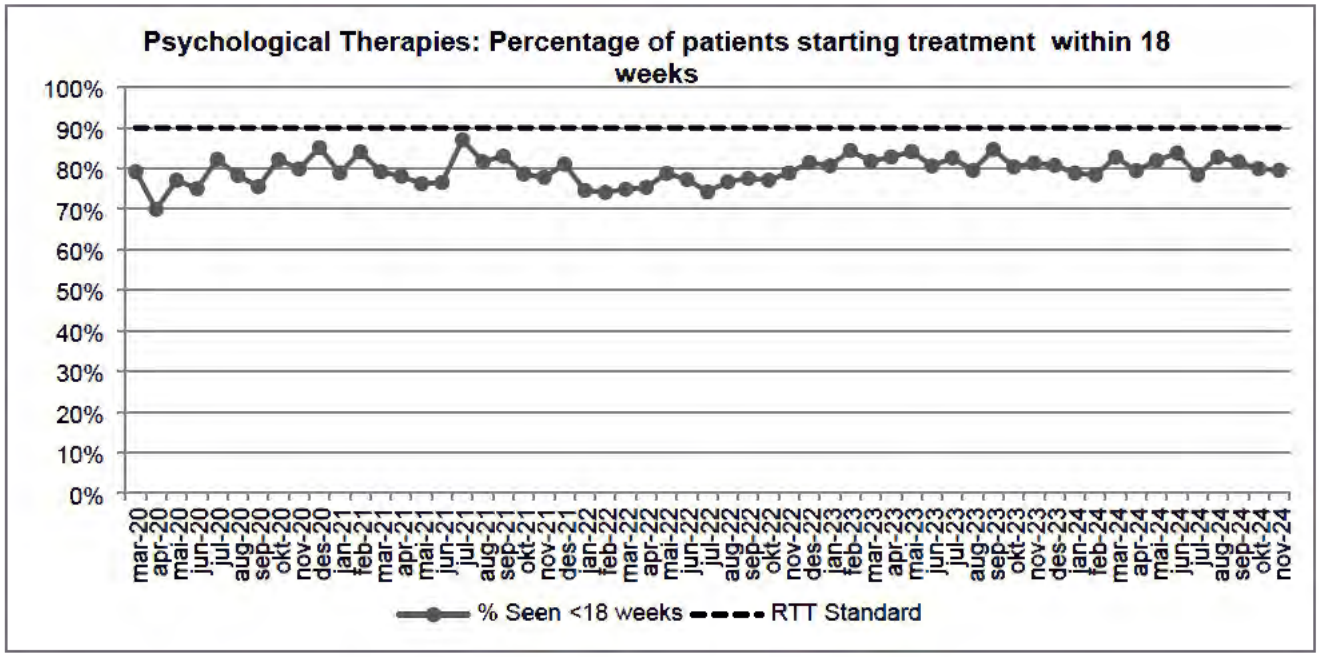
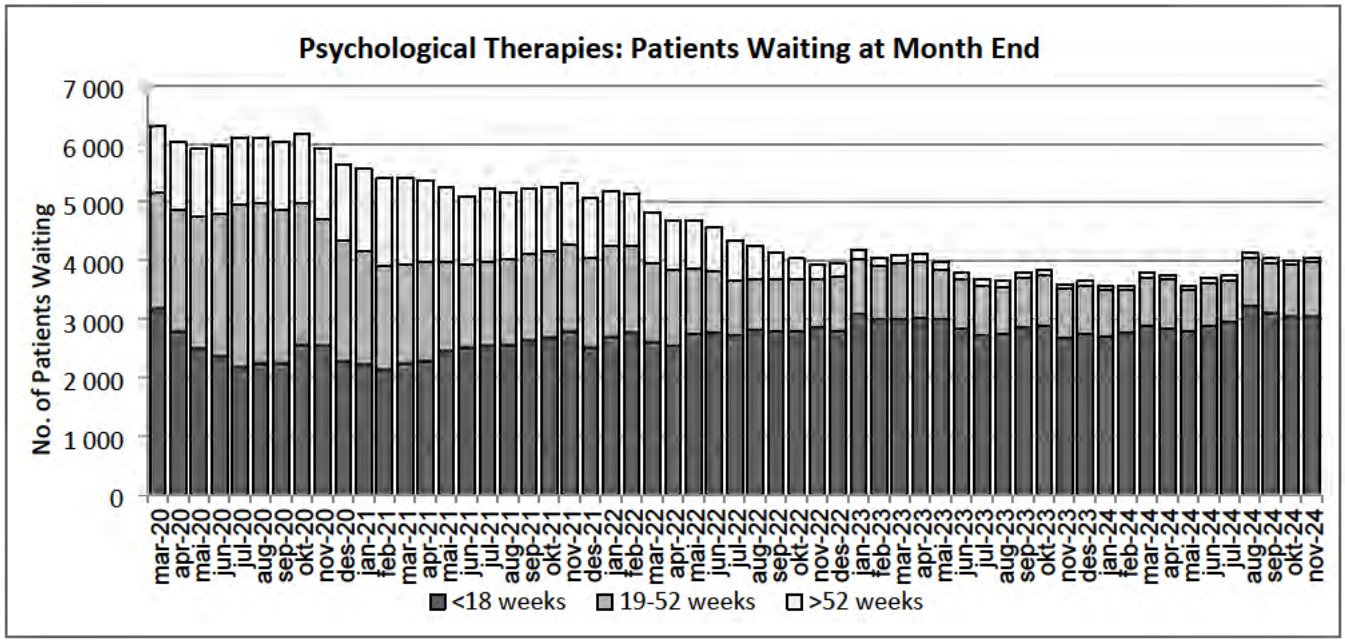


Table 4.1 Patients Waiting at Month End



NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Monitoring Out of Area Group (MOOAG) Annual Report**
Responsible Executive:	**Tracey Mckigen**
Report Author:	**Emily Hollinshead, Finance Manager**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☒	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHS Scotland quality ambition(s):

Safe	☒	Effective	☐
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

To present the annual update from the Monitoring Out of Area Group (MOOAG).

The committee is recommended to accept moderate assurance that MOOAG and the independent sector partners have comprehensive systems in place to deliver safe, effective and person - centred care.

2.2 Background

Scope of Services

MOOAG is made up of senior operational managers, clinicians and senior managers with commissioning responsibility to agree and review the appropriateness of all out of area placements for mental health and learning disabilities patients.

Due to the lack of low secure provision in NHS Lothian, MOOAG contracts a block booking for low secure mental health beds with two independent sector providers, Shaw Healthcare and The Priory Group. The previous block contracts finished June 2024 and new contracts were agreed with both providers and will be in place until 31 March 2027. This guarantees access to 15 low secure mental health beds with ability to flex capacity upwards or downwards depending on bed availability within both units.

2.3 Assessment

Structures and Processes for Management and Oversight of Safety

Management and governance structures

MOOAG met six times during 2023/24. The group oversees NHS Lothian mental health and learning disabilities patients who are being treated out of area. The group also considers applications for new out of area referrals and is responsible for financial oversight of out of area placements.

Management and governance processes

At each meeting MOOAG considers new applications from clinicians who wish to refer a patient out with Lothian for a specialist placement. All applications are required to have been endorsed by the management team of the referring clinician. Existing placements for patients who are currently placed out of area are reviewed on a rolling basis at each meeting with the Lothian link clinician updating the group. Forecast expenditure against the £6.6m MOOAG budget is also presented at each meeting to ensure the group are apprised of the impact on the budget of any decisions that are being considered.

Healthcare Inspectorate reports for out of area providers are considered by MOOAG with Lothian link clinicians required to report any concerns about clinical practice and the suitability, or otherwise of the placement.

The number of out of area placements decreased by two in 2023/24 compared to the previous year. However, due to the previous block contracts (16 beds), we continued to pay for an empty bed in the Ayr Clinic for most of the year.

The Mental Welfare Commission noted that NHS Lothian was one of the few systems that had a robust mechanism of oversight for out of area placements.

Development of Local Provision

Following the Scottish Budget on 19 December 2023 all NHS Boards were instructed to stop any project development spend. Given the challenging financial environment the Scottish Government do not anticipate starting any new projects for at least the next two years. The initial agreements will remain on hold for the medium term. If the Mental Health Rehabilitation case was progress to completion it would allow all but one individual currently placed out of area to return to Lothian.

2.3.1 Financial

Table 1 below shows the cost of out of area placements only across the last three financial years. These figures **exclude** the cost of assessments and emergency out of area admissions which are also overseen by MOOAG and are charged to the out of area budget.

	2021/22		2022/23		2023/24	
	No of patients	£m	No of patients	£m	No of patients	£m
Mental Health	25	5.3	26	5.7	25*	5.6
Learning Disability	[redacted]	0.2	[redacted]	0.2	[redacted]	0.2
Totals	[redacted]	**5.4**	[redacted]	**5.9**	[redacted]	**5.8**

Table 1: out of area placement costs (excludes emergency and assessment costs)
** This included a void bed within the Ayr Clinic block contract.*

The number of patients shown are the total number of patients who were placed out of area across the financial year. Most placements were for treatment not currently available in NHS Lothian, primarily low secure mental health.

The overall MOOAG budget was underspent by £0.9m in 2023/24, the budget position in table 2 below **includes** all emergency out of area admissions as well as assessment costs.

	2023/24 £m
Budget	6.6
Expenditure	5.6
Under/(Overspend)	**0.9**

Table 2: Year End MOOAG budget 2023/24

2.3.2 Risk Assessment/Management

Demand for low secure mental health provision increases.

Impact of the current economic conditions resulting in significantly increased costs for out of area placements.

The lack of available capital funding for the next 5-10 years preventing local provision of low secure mental health beds.

2.3.3 Equality and Diversity, including health inequalities

This is an update report and therefore no impact assessment is required.

2.3.4 Other impacts

Not applicable.

2.3.5 Communication, involvement, engagement, and consultation

MOOAG does not include patient representation given the need to protect patient confidentiality and the sensitive nature of the small number of cases that are overseen by the group.

2.4 Recommendation

- **Assurance** – The Board/Committee is asked to agree and accept a significant assurance level.

2 List of appendices

The following appendices are included with this report:

- Appendix 1, External Placement Providers 2023/24
- Appendix 2, MOOAG membership 2023/24

Appendix 1

External Placement Providers 2023/24

Unit	Organisation
Aberbeeg Hospital, Aberbeeg	Elysium Healthcare
Ayr Clinic Priory, Ayr	Priory Group
Cygnet Hospital, Bury	Cygnet Health Care
Cygnet Hospital, Clifton	Cygnet Health Care
Cygnet Hospital, Maidstone	Cygnet Health Care
Cygnet Wallace Hospital, Dundee	Cygnet Health Care
Kemple View Priory, Blackburn	Priory Group
Roseberry Park Hospital, Middlesbrough	Tees, Esk and Wear Valleys NHS Foundation Trust
St Magnus Hospital, Haslemere	St Magnus House
St Mary's Hospital, Warrington	Elysium Healthcare
Surehaven, Glasgow	Shaw Healthcare

Appendix 2

MOOAG membership List 2023/24

Tracey Mckigen	Services Director, REAS (Chair)
Dr Andrew Watson	Associate Medical Director, REAS
Hamish Hamilton	Chief Finance Officer, West Lothian HSCP
Jacquie Balkan	General Manager, REAS
Angela Dixon	General Manager, REAS
Dr Jo Brown	Clinical Director, Consultant Forensic Psychiatrist
Dr Ganesan Rajagopal	Clinical Director, Learning Disabilities, REAS
Anna Duff	Mental Health Operational Lead, Edinburgh HSCP
Guy Whitehead	General Manager, East Lothian HSCP
Mike Reid	General Manager, West Lothian HSCP
Karen Darroch	Service Manager, Midlothian HSCP
Joe Badji-Churchill	MOOAG Administrator
Emily Hollinshead	Finance Manager

NHS Lothian

Meeting: **Healthcare Governance Committee**

Meeting date:

Title: **REAS risk assurance reports**

Responsible Executive: **Caroline Hiscox, Chief Executive**

Report Author: **Tracey McKigen, Services director, REAS**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other Corporate risk register	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to set out the risk mitigation plans to manage three risks on the corporate risk register (CRR):

5510: Royal Edinburgh Bed Occupancy
5785: Absence of Female High Secure Accommodation in the Estate
5784: Inappropriate and Inadequate Low Secure Accommodation in the Estate

2.2 Background

Details of the three risks related to REAS are set out below.

5510 Royal Edinburgh Bed Occupancy
Accepted onto the corporate risk register December 2022
Last reviewed by committee - January 2024 - Limited assurance accepted

Risk description
There is a risk that patients do not receive safe and effective care due to high levels of bed occupancy, leading to increased risk of harm, poor patient and staff experience and impacting on flow, leading to overcrowding, patients having to be boarded overnight in other specialities, being placed out of area, or sleeping in areas within wards not designed for this purpose.

Current grading: Very High 25 (Likelihood: Almost Certain (5), Impact: Extreme (5))

5785 Absence of Female High Secure Accommodation in the Estate
Accepted onto the corporate risk register March 2023
Last reviewed by committee - January 2024 - Limited assurance accepted

Risk description
There is a risk that female patients who require high secure accommodation will be inappropriately placed because there is a lack of female high secure accommodation in Scotland. This could potentially lead to harm to patients themselves, other patients, and staff as well as the potential for legal challenge against the level of security which is a risk to the organisation.

Current grading: High 12 (Likelihood: Possible (3), Impact: Major (4)

5784 Inappropriate and Inadequate Low Secure Accommodation in the Estate

Accepted onto the corporate risk register March 2023
Last reviewed by committee - January 2024 - Limited assurance accepted

Risk description
There is a risk that patients who require low secure accommodation will be inappropriately placed because there is a lack of low secure accommodation for any patient in Lothian. This could potentially lead to harm to patients themselves, other patients, and staff as well

as the potential for legal challenge against the level of security which is a risk to the organisation.

Current grading: High 15 (Likelihood: Almost Certain (5), Impact: Moderate (3)

2.3 Assessment

Risk mitigation plans for each of the three risks are attached at appendices 1-3.

Implementation of the Plans

5510 Royal Edinburgh Bed Occupancy

Performance and plans are reviewed every 2 weeks at REAS SMT. Adequacy of controls are currently assessed as weak - the controls in place are not currently adequate to mitigate the risk as demand is outstripping capacity and the level of risk cannot be reduced.

Additional spaces which are not designated as bedroom areas within the hospital are used to accommodate overflow. Patients may be admitted to hospitals out of area for care and treatment where additional space is exhausted locally.

The corporate management team has agreed plans to open 12 additional beds for a 3 month period to ease pressures over the winter period. These are available now. Work continues with EHSCP to develop services as alternative to inpatient admission.

5785 Absence of Female High Secure Accommodation in the Estate

The Executive leadership team (ELT) has direct accountability for oversight of this risk and operational management is through REAS SMT.

The CEO, Medical Director and Mental Health Service Director manage specific instances on a case-by-case basis, with use of out-of-area placements if required.

The responsibility for delivery of female high secure care sits with Scottish Government and the mitigations in place for both untried and convicted woman are held by NHS Lothian.

Adequacy of controls: Weak - The controls in place are not adequate to mitigate the risk and the level of risk cannot be reduced

Short-term accommodation would be sourced from Rampton High Secure Female Hospital, England where necessary if outstanding court appearances are not required and if they are patients are required to be looked after in isolation in medium secure

A National programme of work is in place with State Hospital Chief Executive leading on plans to create a high secure on the state hospital campus.

5784: Inappropriate and Inadequate Low Secure Accommodation in the Estate

The Executive leadership team (ELT) has direct accountability for oversight of this risk and operational management is through REAS SMT

The CEO, Medical Director and Mental Health Service Director manage specific instances on a case-by-case basis, with use of out-of-area placements.

Adequacy of controls: Satisfactory: all controls are working and can be demonstrated through measurement.

We continue with the contracts for out of area placements and are reviewing some of those patients to see if they are now able to be safely managed on REH campus.

A block booking contract is in place with Ayr Clinic and Surehaven for three years from 1st July 2024 of accommodation with Shaw Healthcare (Surehaven) and Partnerships in Care (Ayr Clinic) for 8 low secure mental health beds each (16 total).

The mitigations are managing the risk although there is an increased financial impact of block booking

There had been a business case for provision of low secure accommodation within NHS Lothian, which is not going ahead at this time due to the freeze on capital spending from the Scottish Government.

2.3.1 Quality/ Patient Care

Successful implementation of the risk mitigation plans will positively impact on quality of care.

2.3.2 Workforce

The resource implications are directly related to the actions required to mitigate against each of the risks.

Successfully mitigating the outlined risks will ensure that multi-disciplinary teams possess the appropriate skillsets to care for patients in the correct level of accommodation, whether high secure or low secure, as required. Additionally, effectively managing bed occupancy will help maintain optimal patient-to-staff ratios, thereby improving patient outcomes and resource allocation. This will ultimately lead to better overall patient care and reduced pressure on staff. Furthermore, mitigating these risks can significantly enhance workforce health and wellbeing by reducing stress and burnout, resulting in higher job satisfaction and retention.

2.3.3 Financial

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

Following the Scottish Budget on 19 December 2023 all NHS Boards were instructed to stop any project development spend. Given the challenging financial environment the

Scottish Government do not anticipate starting any new projects for at least the next two years.

2.3.4 Risk Assessment/Management

As described in this paper, these risks are on the corporate risk register and as such, risk mitigation plans are monitored through corporate risk register reporting arrangements through CMT, Healthcare Governance committee and the Board.

2.3.5 Equality and Diversity, including health inequalities

This paper does not consider developing, planning, designing services and/or policies and strategies therefore the statutory duties do not apply.

2.3.7 Communication, involvement, engagement and consultation

This paper does not consider developing, planning, designing services and/or policies and strategies therefore the statutory duties do not apply.

2.3.8 Route to the Meeting

In line with CRR reporting arrangements, the Chief executive and REAS Services Director (owner and handler for these risks) provide updates every 2 months which are considered by the CMT who make recommendations to the Board. Following Board review, the updates are routinely shared with Audit and Risk and Healthcare Governance Committees.

Operational management groups e.g. CMT, FIG, IC committee, H&S

2.4 Recommendation

- **Assurance** – The committee is asked to agree and accept levels of assurance for the three risks as noted below:

  5510 Royal Edinburgh Bed Occupancy – limited- The mitigations are not adequate to eliminate the risk

  5785 Absence of Female High Secure Accommodation in the Estate – limited -The mitigations are not adequate to eliminate the risk. Note this is a national issue.

  5784: Inappropriate and Inadequate Low Secure Accommodation in the Estate – moderate – The mitigations are currently adequate to mitigate the risk

3 List of appendices

The following appendices are included with this report:

- Appendix 1: Risk mitigation plan 5510 Royal Edinburgh Bed Occupancy
- Appendix 2: Risk mitigation plan 5785 Absence of Female High Secure Accommodation in the Estate

- Appendix 3: Risk mitigation plan 5784: Inappropriate and Inadequate Low Secure Accommodation in the Estate

Risk Mitigation Plan for Corporate Risks

Name and ID of risk: 5510 Royal Edinburgh Bed Occupancy		Owner: Caroline Hiscox	
Associated corporate objective: Mental health, illness, and wellbeing			
Description/Grading/Risk response	**How will the impact of plans be measured?**	**Which Governance Committee assures the risk?**	**Date last reported, level of assurance and committee response**
There is a risk that patients do not receive safe and effective care due to high levels of bed occupancy, leading to increased risk of harm, poor patient and staff experience and impacting on flow, leading to overcrowding, patients having to be boarded overnight in other specialities, being placed out of area, or sleeping in areas within wards not designed for this purpose. New risk approved by Board December 2022. **Risk Response:** Treat **Current grading:** Very High 25 (Likelihood: Almost Certain [redacted], Impact: Extreme [redacted])	• Reduced number of delayed discharges. • Reduced number of patients in inappropriate areas either contingency beds or other services on REH site (daily) • Reduced number of patients from Edinburgh in West Lothian (daily) • Reduced number of occupied beds (daily) • Reduced length of health delays of patients waiting for transfer to REH (daily)	Healthcare Governance Committee	January 2024 Limited assurance accepted

Risk Mitigation Plan

Current controls: Provide details of current controls and comment on whether these are functioning as expected		
Description	**ADP Workstream/Programme**	**Impact/current data**
12 week opening of 12 extra in-patients in additional ward	REAS ADP in draft	Opened 6th Jan, full capacity 13th. Initially allowed safe admission of all patients.
Use of additional spaces in psychiatric wards at REH for overflow – contingency rooms	REAS ADP in draft	Wards have added additional rooms used to increase capacity – these are not ensuite, require additional safety checks (in place) but do have full beds. Used as part of day to day capacity throughout 2024. Environmental checks of these spaces are included in agreed governance for managing in-patient wards. In-patient risk assessment explicitly covers ligature risk.
Divert procedures	REAS ADP in draft SLWG REAS/RIE	Agreed procedure that if no longer capacity to admit into MH beds (including no capacity in Lothian and in any other Health Board in Scotland) Edinburgh, East and Mid patients will wait in RIE ED. W/L patients wait in SJHs as part of long established pathways. Significant period of use of procedure for sustained period in Autumn 2024. Clinical governance procedures agreed through group chaired by AMD. Escalation procedures and communication developed. Ongoing challenge to develop alternatives to using RIE ED capacity for patients waiting for MH beds.
Use of W/L HSCP commissioned beds in SJHs		Significant use of adult and IPCU beds in SJHs for patients from elsewhere in Lothian.

		This provides additional capacity for the whole system but impacts on the staffing resources available in W/L for work elsewhere in the pathway
Day to day managing demand for beds that outstrip capacity		AMD chaired meeting 7/1/25. Will take framework for prioritisation of people waiting beds to REAS SMT in Feb/25. Largely an endorsement of current procedures.
Clinical governance of patients waiting for MH beds in other speciality beds	REAS ADP in draft SLWG	TRAK procedures being developed to create dashboard to fully track delays – currently relies on REH bed managers to maintain lists of demand. Work led by Strategy Lead for MH. Nurse Director for Mental Health confirming procedures for accessing increased staffing across NHS Lothian week of 13/1/25 Support for acute services based teams discharging to community MH services being improved – complex services across HSCPs have significant impact on timely access, particularly for discharges from non-MH wards.
Discharge facilitation work	REAS ADP in draft LSDF	Escalation procedures to support senior involvement from HSCP in discharge issues but housing remains the most challenging issue to resolve. Intensive community support pathways are in place but only open to people who have a tenancy or family support. TRAK development for MH in 2024 has improved functionality for documenting outstanding tasks and then communicating these effectively – ongoing work to improve reliability of completeness Challenges with community staff's ability to in-reach to establish criteria for discharge continue. Case

		loads and acuity in specialist community teams impact on availability
Clozapine titration. Currently inpatient clozapine titration have not been possible due to more acute issues being prioritised. Clozapine can reduce in-patient days over time, alongside wider health benefits.		Whilst there is a community escalation pathway for clozapine some people have clinical and/or support needs that currently lead to in-patient requests. A review of the community escalation pathway is ongoing – this will lead to more people being suitable Plans for those people who still need an in-patient trial are not so developed
OOA patients in Lothian MH beds 6-8 AMH inpatient beds are, on average, used by people not from Lothian		Procedures, in particular the Mental Health Act, lead to significant waits for people to move to their 'home' area. Engagement with the SG team has not led to improvements in the timeliness of the process. Local work to support clinicians complete the process of gaining approval from SG for transfers is ongoing.

Planned/proposed controls					
Description	**ADP Workstream / Programme**	**Anticipated Impact**	**Who is Actioning**	**Due Date**	**Completed Date**
REAS/EHSCP are reviewing key parts of the pathway for supporting people at risk of admission – CMHT and IHTT		Reduced use of inpatient beds.	REAS General Manager and Head of Health Edinburgh Health and Social Care Partnership.	End June 2025	Ongoing
Review impact of additional beds		Evaluate need for additional in-patient capacity	REAS/EHSCP	28/2/25	

Risk Mitigation Plan for Corporate Risks

Name and ID of risk: 5785 Absence of Female High Secure Accommodation in the Estate		Owner: Caroline Hiscox	
Associated corporate objective: Mental health, illness, and wellbeing			
Description/Grading/Risk response	**How will the impact of plans be measured?**	**Which Governance Committee assures the risk?**	**Date last reported, level of assurance and committee response**
There is a risk that female patients who require high secure accommodation will be inappropriately placed because there is a lack of female high secure accommodation in Scotland. This could potentially lead to harm to patients themselves, other patients, and staff as well as the potential for legal challenge against the level of security which is a risk to the organisation. New risk approved by Board December 2022. **Risk Response:** Tolerate **Current grading:** High 12 (Likelihood: Possible[redacted], Impact: Major[redacted]	The number of female high secure patients requiring to be looked after in medium secure or Rampton will reduce	Healthcare Governance Committee	July 2024 Limited assurance accepted.

Risk Mitigation Plan

Current controls: Provide details of current controls and comment on whether these are functioning as expected		
Description	**ADP Workstream/Programme**	**Impact/current data**
Short-term accommodation would be sourced from Rampton High Secure Female Prison, England for those with no outstanding court appearances or within isolation in medium secure estate.	Via NSS / TSH / Forensic Network	Pathway has been accessed but significant LOS to facilitate. Rampton was deemed inadequate by Inspectors in 2024 – this is now resolved but risk of reoccurrence, with even longer LOS in MSU in NHS Lothian remains
Management oversight • •The Executive leadership team (ELT) has direct accountability for oversight of this risk and operational management is through REAS SMT • The CEO, Medical Director and Mental Health Service Director manage specific instances on a case-by-case basis, with use of out-of-area placements if required.		Mitigations (procedural and relational security focused) of admission to NHS Lothian managed medium secure care (one of only 2 wards offering this in Scotland) of women who require High Secure Care has been well supported by NHS Lothian management teams.

Planned/proposed controls					
Description	**ADP Workstream / Programme**	**Anticipated Impact**	**Who is Actioning**	**Due Date**	**Completed Date**
This is a National programme with State Hospital Chief Executive leading on plans to create a high secure on The State Hospital campus. The responsibility for delivery of female high secure care sits with Scottish Government but the mitigations in place for both untried and convicted woman are the responsibility of NHS Lothian.	National Programme of Work.	Availability of Female High secure Risks.	State Hospital Chief Executive		

Risk Mitigation Plan for Corporate Risks

Name and ID of risk: 5784: Inappropriate and Inadequate Low Secure Accommodation in the Estate		Owner: Caroline Hiscox	
Associated corporate objective: Mental health, illness, and wellbeing			
Description/Grading/Risk response	**How will the impact of plans be measured?**	**Which Governance Committee assures the risk?**	**Date last reported, level of assurance and committee response**
There is a risk that patients who require low secure accommodation will be inappropriately placed because there is a lack of low secure accommodation for any patient in Lothian. This could potentially lead to harm to patients themselves, other patients, and staff as well as the potential for legal challenge against the level of security which is a risk to the organisation. **Risk Response:** Treat **Current grading:** High 15 (Likelihood: Almost Certain [redacted], Impact: Moderate [redacted]	The number of patients waiting on low secure accommodation and unable to be place appropriately will reduce	Healthcare Governance Committee	July 2024 Moderate assurance accepted.

Risk Mitigation Plan

Current controls: Provide details of current controls and comment on whether these are functioning as expected		
Description	**ADP Workstream/Programme**	**Impact/current data**
•We continue with the contracts for out of area placements and are reviewing some of those patients to see if they are now able to be safely managed on REH campus. •Mitigations remain as previous with block booking contract in place with Ayr Clinic and Surehaven for three years from 1st July 2024.		The mitigations are managing the clinical risk despite the increased financial impact of needing access independent beds v local NHS beds. More flexibility has been added to the contracts – 14 beds block booked but 2 at the same rate with flexible use
Management of OOA Group provides clinical and financial governance of all placements. Mental Welfare Commission noted function and membership of group as a good practice recommendation for all of Scotland		Number of patients and spend on OOA MH in-patient care is significantly lower than previous arrangements

Planned/proposed controls					
Description	**ADP Workstream / Programme**	**Anticipated Impact**	**Who is Actioning**	**Due Date**	**Completed Date**
Full business case for new build at REH to end need for OOA low secure care completed and assigned category A by NHS Lothian	Business Case for provision of low secure provision.	End OOA low secure care	Tracey Mckigen		No capital at SG level to progress currently

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Maternity Services Update**
Responsible Executive:	**Michelle Carr, Chief Officer (Acute)**
Report Author:	**Allister Short, Service Director**
	Dr Corinne Love, Associate Medical Director
	Mercedes Perez-Botella, Director of Midwifery

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☒	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☒	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☐
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

Over the previous12 months, several issues and concerns have been raised relating to Maternity Services within NHS Lothian. This has included a Stage 2 whistleblowing which was raised in Feb 24, RTC May 24, feedback from a series of staff engagement events and externally by Healthcare Improvement Scotland (HIS) through their Responding to Concerns process. It should be noted that a copy of the whistleblowing report was provided to the BBC which resulted in a significant amount of press coverage relating to the current situation within the service. This paper seeks to provide a further update to HGC on the improvement work underway.

2.2 Background

Following the response to the HIS 'Responding to Concerns' from NHS Lothian in October, HIS acknowledged how seriously NHS Lothian were taking concerns and recognised our continued focus on providing safe care for women, their babies and ensuring a safe maternity workforce. HIS also sought update on the development and implementation of our delivery programme in response to the concerns raised and a further update was provided on 16 December.

As previously reported to Healthcare Governance Committee, the service submits data to the Perinatal Network, Public Health Scotland, NNAP and MBRRACE relating to safety and outcomes. Our services are not outliers within any of the safety indicators, performing above average in some of the indicators. The service also provides an annual assurance report to the Committee, which accepted a moderate level of assurance in May 2024.

The service has also had a virtual visit by SPSP (Scottish Patient Safety Programme) Perinatal Programme on the 21 November 2024. Our local improvement programme is focusing on reducing avoidable harm in maternity services by achieving safe and person-centred care spanning a person's entire maternity journey and our workstreams are aligned with Healthcare Improvement Scotland SPSP's Perinatal Programme. The meeting was attended by our Director of Midwifery, Clinical Director in Obstetrics, Neonatal Clinical Director, Associate Director of Midwifery, Service Manager and Quality Improvement leads who presented our latest data across all our areas of targeted improvement. Although SPSP does not look at standards of care or the clinical environment for assurance purposes, feedback received following the virtual visit noted a comprehensive and detailed description of ongoing SPSP Perinatal work was provided and that the Perinatal Programme was encouraged to see the level of collaboration within the Boards perinatal team.

2.3 Assessment

To support the improvement work being progressed within Maternity Services, processes were put in place to provide support, scrutiny and oversight. These are detailed below:

- Establishment of a Short Life Working Group (chaired by the Deputy Chief Executive) to oversee progress against the agreed improvement plan to address

issues and concerns have been raised relating to Maternity Services within NHS Lothian.

- Detailed improvement plan now being implemented and reports to the above group.
- Establishment of the Professional Midwifery Leadership Group which includes two external expert midwives to provide expert advice and an impartial view on the on-going delivery of recommendations.
- Additional nursing leadership through the secondment of the Acute Nurse Director in an Improvement Director role with a primary focus on Safe Delivery of Care (see below).

2.3.1 Quality/ Patient Care

The key focus of the Improvement Director role has been set out by the Executive Leadership Team and an intense programme of work has been established to ensure the delivery of the essentials of safe care: Safe Environment, Safe Care and Safe Staffing using an intelligence led approach. Whilst ensuring the pace of change is realised, fundamental will be a system for embedding improvement through business as usual and existing leadership roles. This work will align with aspects of the quality improvement programme previously established to reduce avoidable harm.

As reported to HGC in November, and in response to the specific feedback received from staff which highlighted concerns regarding the midwifery rotational process and the escalation of staffing and safety concerns, the actions below have since been delivered:

- Full review of the rotational programme underway ensuring that the programme reflects the development needs of staff, clarity on purpose, transparency of decision making and a sustainable model that addresses explicit issues identified across site based and community settings.
- Implementation of a revised twice daily safety and capacity meeting to further strengthen reporting and escalation processes so that staffing concerns are appropriately highlighted within the service and wider organisation. The output and escalations from these meetings now report through to the Pan-Lothian Capacity meeting, with clear lines of escalation to ensure increased transparency and support.
- Staffing concerns continue to be addressed if escalated at the daily Executive Nurse Directors staffing meeting which is attended by the Director of Midwifery or Associate Midwifery Director. This ensures compliance with the The Health and Care (Staffing) (Scotland) Act 2019 the 12Ia; Duty to ensure appropriate staffing.

In order to address the upheld concerns in the whistleblowing report and subsequent action plan, and following a Quality-of-Care review, we also undertook a deep dive into our Obstetric Triage area to understand the activity and the demands in that service, the patient pathways for improvement and the associated optimum staffing model. The Staff Bank has taken forward work to increase the number of Midwives with the necessary BSOTS training and in the interim, Staff Bank is being utilised to provide an additional midwife and support worker during times of peak activity each day.

2.3.2 Workforce

Staff have highlighted concerns about staffing levels through various HR routes and directly through engagement sessions with clinical leaders and managers. This was also an upheld concern in the whistleblowing investigation. There were also concerns raised by staff that fiscal concerns were being prioritised over care delivery. Following a series of such concerns an independent professional quality of care review was commissioned to consider the findings from all the investigations that had been carried out. These were considered by the Professional Midwifery Leadership Group as part of their remit to provide the professional oversight for the Nursing & Midwifery Workforce Review across the entire service using the Common Staffing Methodology / Establishment HealthCheck.

The initial output from this group identified that the current funded establishment available to deliver the Midwifery services does not enable staffing levels that align with national guidance, recommendations and statutory requirements or adequately meeting the needs of our staff, patients and their families. An interim workforce paper has been submitted to NHS Lothian CMT to highlight these immediate pressures. There have also been immediate actions put in place to address some of the staffing pressures, with an additional two midwifery staff and three healthcare support workers available each day through staff bank.

There are specific actions aligned to addressing organisational cultural issues identified and upheld through a whistleblowing investigation, feedback received from a series of staff engagement events and externally by Healthcare Improvement Scotland:

- Working with external OD input and support, a staff survey has been circulated focusing on culture and exploring what it feels like to work in and to engage with the team. The survey is due to close on 27 January and at the time of writing, 437 responses (37% of staff) had been received. A further communication is due to go out to encourage further responses.
- To support the survey process, 25 stakeholder interviews have been held with staff and key stakeholders. Alongside this, 18 focus group sessions are planned for late January, with capacity for up to 200 frontline staff, across different groups and sites, facilitated by the external OD company.
- The finalised report from the above work will be ready by the end of February and the recommendations from this report will inform future actions.
- As previously reported, the OD Team within NHS Lothian are supporting team development work within the Women's Services Clinical Management Team (CMT), with the first session held on 12 November and the next session planned for March. Other organisational development work that now underway is a development programme for Band 6 staff based on feedback and identified needs – this 12-month programme had its first session on 15 January.
- We continue to promote the Speak Up service for staff to raise any issues or concerns through Team Briefings, safety huddles, staff newsletters and staff noticeboards.

2.3.3 Financial

Any emergent concerns requiring financial investment are being managed through the service budgets.

2.3.4 Risk Assessment/Management

The current risks associated with this work are being directly managed through the Directorate and, where appropriate, being escalated through Acute Services.

2.3.5 Equality and Diversity, including health inequalities

There are no immediate equality and diversity implications arising from this report.

2.3.6 Other impacts

2.3.7 Communication, involvement, engagement and consultation

There has been extensive engagement with staff as part of this process to ensure that all staff are fully appraised and involved in this process. To date, this has included staff engagement events across hospital sites and community settings. We have also engaged with the Maternity Voices Partnership (MVP) and given an overview of the improvement work we are undertaking.

2.3.8 Route to the Meeting

2.4 Recommendation

The purpose of this paper is to provide awareness to the Healthcare Governance Committee on the actions being progressed to address these concerns.

- **Awareness** – For Members' information only.

3 List of appendices

None

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28th January 2025**
Title:	**Quality and Safety Annual Report 2024**
Responsible Executive:	**Tracey Gillies, Executive Medical Director**
Report Author:	**Jill Gillies, Associate Director of Quality**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☒	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☐
Primary Care	☒	Digital	☐
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☐
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to provide assurance that systems and processes are in place to support the ongoing implementation of the NHS Lothian Quality Strategy (2018-2027), and to demonstrate progress in improving patient safety. This includes capturing lessons from adverse events, identifying themes, and implementing improvements through planned programmes such as the Scottish Patient Safety Programmes (SPSP) across Acute Adult, Primary Care, Mental Health, Paediatrics, Neonatology, and Maternal Health in Lothian.

The Healthcare Governance Committee (HGC) is asked to:

Review the range of work undertaken to improve patient safety across NHS Lothian that contribute to reducing mortality, preventing harm, and improving experience and outcomes of care.

Accept **moderate assurance** regarding the systems, processes, and progress of safety improvement programmes included in this paper.

Accept **moderate assurance** on the infrastructure supporting NHS Lothian's Quality Strategy, highlighting Quality Improvement (QI) teams' local improvements, the Quality Directorate's capacity-building initiatives, and progress in strengthening links between assurance and improvement.

2.2 Background

NHS Lothian's Quality Strategy (QS) aims to embed Quality Management (QM)—encompassing Quality Planning, Improvement, Control, and Assurance—throughout the organisation. The Quality Directorate (QD) works to integrate assurance and improvement, with a focus on strengthening connections between these functions across service areas.

This paper provides examples of how the QM system is applied to reduce harm by learning from adverse events, identifying themes, and implementing targeted improvement programmes.

A focus of the QD has been supporting sites and services with Quality Planning (QP). This involves triangulating data from adverse events, patient complaints, and Lothian Accredited Care Assurance Standards (LACAS). The QD supports services in identifying themes and translating them into improvement programmes with a driver diagram and aims for improvement.

A detailed report on site and service improvement activities can be accessed **here**. This paper provides a summary of key patient safety improvement programmes, including those within the Scottish Patient Safety Programme—a national quality improvement programme aimed at improving the safety and reliability of care and reducing avoidable harm.

2.3 Assessment

Reducing avoidable harms

The aims of the Acute Adult Safety programme are to reduce the Hospital Standardised Mortality Ratio (HSMR) across Scottish hospitals (no national target set) through the reduction in common healthcare associated harms, the details of which will follow in this report.

HSMR

The HSMR for NHS Lothian is currently 0.98 (a combined figure for three sites), and no Lothian sites were beyond the control limits for the indicator, as shown in the funnel plot in Appendix 1. However, the HSMR for the Royal Infirmary of Edinburgh (RIE) has been above the warning limit. Over the past year, a series of reports have been presented to the committee to investigate any evidence of avoidable mortality at RIE. An overview of this work will be provided as a separate item on the agenda for this meeting.

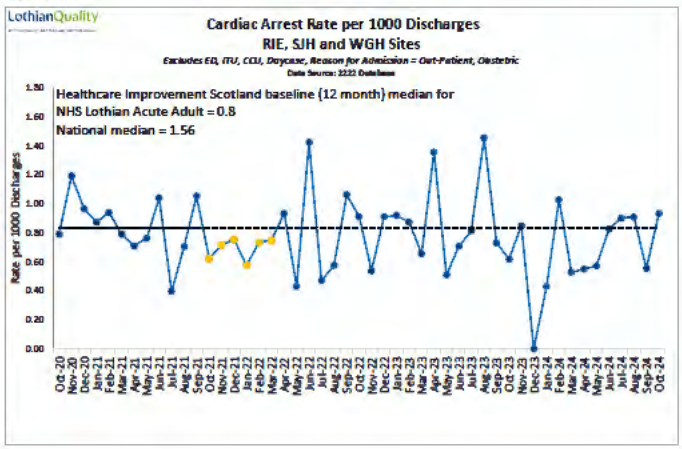
Patient Safety Improvement Programmes

Management of Deteriorating Patients

NHS Lothian has prioritised improvements in the care and management of patients who deteriorate and has committed to participating in Healthcare Improvement Scotland's Deteriorating Patient Collaborative. The aim has been to sustain the current Cardiac Arrest rate reduction (national aim) and reduce the number of SAEs related to deterioration (NHS Lothian aim). Using a quality management approach, a review of the current deteriorating patient programme has been performed to inform the planning of the next phase of improvement work. To support this, the QD has appointed a Clinical Lead for the Deteriorating Patient Programme, and the improvement plans for the three Acute sites have been presented to Acute CMG earlier this year.

The national median cardiac arrest rate is 1.56 per 1,000 discharges. NHS Lothian's Acute Adult median rate is lower, at 0.8 per 1,000 discharges, as shown in Chart 1 below.

Chart 1



Ongoing improvement activity across the three acute adult sites includes:

- Maintaining the reduction in cardiopulmonary resuscitation rate in acute care.
- Developing and implementing an NHS Lothian NEWS escalation policy.

- Achieving a reduction in medical emergencies with preceding deterioration.
- Understanding the barriers to timely *score to door* [1]time and achieving a reduction in *score to door* time for unplanned Critical Care admissions.
- Implementing Treatment Escalation Plans (TEPs), including alignment of previously documented future care plans.

Reducing Falls

Falls remain the most frequently reported adverse event in Lothian. The National Falls Improvement Programme originally aimed to achieve a 20% reduction in all falls and a 30% reduction in falls with harm by September 2023. While these aims were not fully met, every site has shown a decrease in falls compared to their baseline median. The Falls data is outlined in Appendix 3.

Nationally, there has been a 9% reduction in the rate of falls in acute hospitals. Starting in January 2025, NHS Lothian will work with Healthcare Improvement Scotland (HIS) as one of the volunteer boards to test a new national definition for falls and falls with harm.

Data on Falls (per 1000 Occupied Bed Days):

- **National Comparator:** currently at 7.0, down from 7.7 a 9% reduction – from March 2023.
- **Lothian Overall:** 7.89, reflecting a 13% reduction since September 2022.
- **Royal Infirmary of Edinburgh (RIE):** 7.0, with a 13% reduction since March 2023.
- **St. John's Hospital (SJH):** has seen an increase in falls from Jan 2024 with a new temporary median of 9.9 but still below their baseline median of 10.3.
- **Western General Hospital (WGH):** 8.05, achieving a 19% reduction since September 2023.

Work continues across sites to make further improvements to reduce falls, including:

- Providing focused QI support to wards identified through data triangulation and analysis as having the greatest potential for improvement.
- Testing changes using QI methods (Plan-Do-Study-Act (PDSA)), such as cohorting high-risk patients in a designated "Baywatch" area. Teams will capture data on 'saves', which are instances where patients are prevented from falling through the Baywatch approach.
- Sharing learning across sites, for example promoting good practice such as WGH's emphasis on the collaborative role of the multidisciplinary team in reducing falls.
- Implementation of the NHS Lothian Falls Strategy due to be published early 2025, through providing ongoing support for the strategy to align efforts across the system, particularly through utilising the *Falls Dashboard*.
- Partnering with Healthcare Improvement Scotland (HIS) to test the draft national definition of a fall and a fall with harm. Detailed planning for this initiative will commence in January 2025.
- The QD is also working to revise the template used for conducting adverse event reviews following a fall, with the aim of improving our falls learning system.

These efforts aim to build on current progress and strengthen fall prevention measures across NHS Lothian.

[1] Score to door time refers to the time from a NEWS (National Early Warning Score) being calculated to the time of admission to critical care.

Maternity & Neonatal Services Improvement Programme including the SPSP – Perinatal Improvement Programme

In September 2023, HIS launched the SPSP Perinatal Programme, which NHS Lothian used as an opportunity to conduct quality planning. This process involved reviewing, theming, and learning from significant adverse events (SAEs) and complaints, as well as implementing improvements from within the SPSP programme. This process informed the improvement activities for the Maternity and Neonatal Improvement Programme, which aims to reduce avoidable harm in maternity and neonatal services by March 2025.

The Maternity & Neonatal Improvement Programme is overseen by a Programme Board, co-chaired by the Medical and Nursing Directors. The programme is delivered using improvement methods, guided by a driver diagram that identifies the primary areas of focus and outlines the change ideas being tested to achieve the overall improvement aims. Further details can be found in Appendix 3.

In addition, analysis of the 2023 Scottish data shows that NHS Lothian is close to the Scottish average for Stillbirth rates (Appendix 3 – Stillbirth Funnel Plot). However, reducing stillbirth rates remains a national priority, as Scotland strives to achieve rates comparable with the best-performing countries, such as those in Scandinavia.

Reducing Pressure Ulcers

For the past two years, the committee has provided limited assurance regarding improvements in reducing pressure ulcers (PU), partly due to the absence of a dedicated improvement programme, as reflected in the data in Appendix 4. To address this, the Nursing and Midwifery Care Assurance Oversight Board has commissioned a Pan-Lothian, whole-system collaborative approach to reducing PUs. An oversight group has been established, co-chaired by a Chief Nurse and an Associate Nurse Director, with contributions from LACAS, EiC, and the Quality Directorate. Quality Planning activities are currently underway across acute sites and Health and Social Care Partnerships (HSCPs), aligning these plans with the National SPSP Pressure Ulcer Change Package. The PU Collaborative will provide regular reports to the Nursing and Midwifery Care Assurance Oversight Board.

Paediatric Services

The Royal Hospital for Children and Young People (RHCYP) is participating in the SPSP Paediatric Programme (SPSPP). The aim is to reduce harm caused by clinical deterioration by improving the recognition, response, and review processes for deteriorating children and young people.

A summary of activities includes establishing a dedicated database to track and analyse 2222 emergency calls, performing routine Paediatric Early Warning Score (PEWS) audits to ensure compliance with scoring protocols. There has also been a focus on enhancing staff awareness of non-PEWS indicators of deterioration, such as family and staff concerns, and identifying learning points from unplanned critical care admissions to inform multidisciplinary training.

Mental Health Services

The aim of the Mental Health safety programmes is to reduce avoidable harm and enhance the delivery of safe, effective, and person-centred care within the Royal Edinburgh Hospital and Associated Services (REAS) by March 2025.

A review of Significant Adverse Events (SAEs), Local Case Reviews, Mental Welfare Commission recommendations, and complaints identified areas for improvement. An initial focus of improvements will be on:

- Enhancing care planning and risk assessment to support ward staff in delivering therapeutic activities and mitigating harm risks.
- Strengthening multidisciplinary team working within wards to foster patient engagement and reduce harm to both patients and staff.

The QD continue to monitor and provide data on recorded incidents of physical violence, restraint, and self-harm, aligning with the identified SPSP mental health harm priorities.

SPSP - Primary Care Services

The Safety Enhanced Service Programme (SESP) aims for at least 80% of QI projects undertaken by GP practices to achieve an IHI score of 3.0 or higher, indicating significant progress toward improvement. The maximum possible score is 5.
A summary of achievements includes:

- 101 practices signed up for the SESP, with 98 attending the Launch Workshops (202 attendees total) held in hybrid formats.
- 100 project proposals and 98 Project Charters, including baseline data, were submitted; 79 practices completed a PDSA cycle.
- 53 coaching clinics held with 88 attendees; 100% of participants reported the sessions were valuable, addressing critical project-related queries.
- Progress reported includes modest improvement (IHI score 3.0) or better in 10 practices; scores will be updated at project completion.
- Participants appreciated the practical application of QI methods in workshops and the focused guidance during coaching clinics, which simplified setting aims and managing project goals within realistic parameters ensuring workload feasibility.

Reducing Medicine related Harms

In November 2023, the Medicines Safety and Risk Group was established with the responsibility for optimising medicines safety within NHS Lothian. The group has supported a range of activities including Quality Planning, supported by the Quality Directorate. This work has involved theming medicine-related adverse events and triangulating these with other relevant data sources. The next steps for the group include the organisation of a workshop to develop a Pan-Lothian Driver Diagram for Medicine-Related Harms, which will inform an improvement programme with identified aims and priorities. This work will both inform and be informed by the National SPSP Medicines Programme, which is currently under development.

The QD have also identified medicine-related harms through site-based quality planning and are currently supporting improvement work in these areas.

Infrastructure Support

SPSP Executive Leadership Walkrounds

Leadership WalkRounds provide an opportunity for Executive and Non-Executive leaders to engage directly with staff in clinical areas to discuss their ideas and issues related to safety. A summary of the aims and process for undertaking Leadership WalkRounds are outlined in Appendix 5.

From January to December 2024, a total of 10 Leadership WalkRounds were conducted. All members of the Executive Team and 9 Non-Executive Directors participated. The WalkRounds took place across the following specialties and areas:

- Paediatric Intensive Care Unit (PICU)
- Stroke Service
- Rehabilitation Unit (REAS)
- Magnetic Resonance Department
- Acute Medical Unit (AMU)
- Laboratories
- Perinatal Mental Health Service
- Surgical Services
- Medical Day Case

Feedback from participants has been overwhelmingly positive, with comments including:

- "Great to hear about all the improvements."
- "An excellent opportunity to meet and explain the service to senior management external to our department."

Quality Academy

The Quality Academy aims to enhance NHS Lothian staff's skills in quality planning, improvement, and assurance. This will be achieved by giving participants the essential knowledge, tools, and methodology to lead, plan, and deliver a focussed piece of improvement work in their own service area and by providing participants a system of understanding of healthcare and how quality improvement tools can be used to improve these systems and measure their progress.

Summary of activities:

- **QI Skills Course:** Six sessions held; cohorts 25 and 26 completed, 27 and 28 underway.
- **Bitesize & QI Essentials:** Three sessions delivered; with a centralised booking process in development.
- **Public Engagement Training:** Initial session delivered; high demand prompted a further session in October 2024.
- **QI Coaching:** Coaching framework established; active coaches identified.
- **SAE Reviewer Training:** In-house training reviewed; NES pilot training currently underway.
- **Recruitment to NES Taught Courses:** Communication plan implemented; course links available on the Quality Academy website.
- **Programme Alignment:** Courses aligned to service needs and reducing adverse events.
- **Joy in Work (JiW) Training:** Existing programmes reviewed; JiW and workforce well-being training completed.

Next steps for the Quality Academy include delivering three QI Skills Courses and two Bitesize sessions in 2025, hosting a public engagement masterclass, and evaluating the QI coaching process. Additional priorities involve completing NES train-the-trainer SAE Reviewer Training, refining NHS Lothian's recruitment to NES courses, and establishing a Joy in Work steering group to plan and test future activities.

2.3.2 Workforce
Not applicable for this report.

2.3.3 Financial
This is not **relevant** for this report.

2.3.4 Risk Assessment/Management
The programmes of work set out in this paper are linked to a number corporate objectives and as a result will contribute to plans to mitigate a number of the risks on the corporate risk register.

2.3.5 Equality and Diversity, including health inequalities.
This paper outlines the delivery of the NHS Lothian Quality Improvement Strategy and does not in itself require an impact assessment.

2.3.6 Other impacts
This is not applicable for this report.

2.3.7 Route to the Meeting
This is not applicable for this report.

2.4 Recommendation

2.4.1 The Healthcare Governance Committee (HGC) is asked to:

Review the range of work undertaken to improve patient safety across NHS Lothian that contribute to reducing mortality, preventing harm, and improving experience and outcomes of care.

Accept **moderate assurance** regarding the systems, processes, and progress of safety improvement programmes included in this paper.

Accept **moderate assurance** on the infrastructure supporting NHS Lothian's Quality Strategy, highlighting Quality Improvement (QI) teams' local improvements, the Quality Directorate's capacity-building initiatives, and progress in strengthening links between assurance and improvement.

3 List of appendices

The following appendices are included with this report:

Appendix 1 –HSMR Table and Funnel Plot NHS Lothian
Appendix 2 – Reducing Falls Data
Appendix 3 – Maternity and Neonatal Programme DD and Stillbirth Funnel Plot
Appendix 4 – Pressure Ulcer Data
Appendix 5 – SPSP Executive Leadership Walkrounds - Synopsis

Appendix 1 - HSMR Table and Funnel Plot NHS Lothian

Royal Infirmary of Edinburgh, Western General Hospital and St John's Hospital

Hospital Standardised Mortality Ratio

Publication Date: 12th November 2024

Latest Hospital Standardised Mortality Ratio

Please note that as of August 2019, HSMR is presented using a 12 month reporting period when making comparisons against the national average. This will be advanced by three months with each quarterly update.

Crude mortality values presented here are reflective of the latest 12 month HSMR reporting period. For crude mortality trends by individual quarter please refer to **Crude Trends (Overall)**.

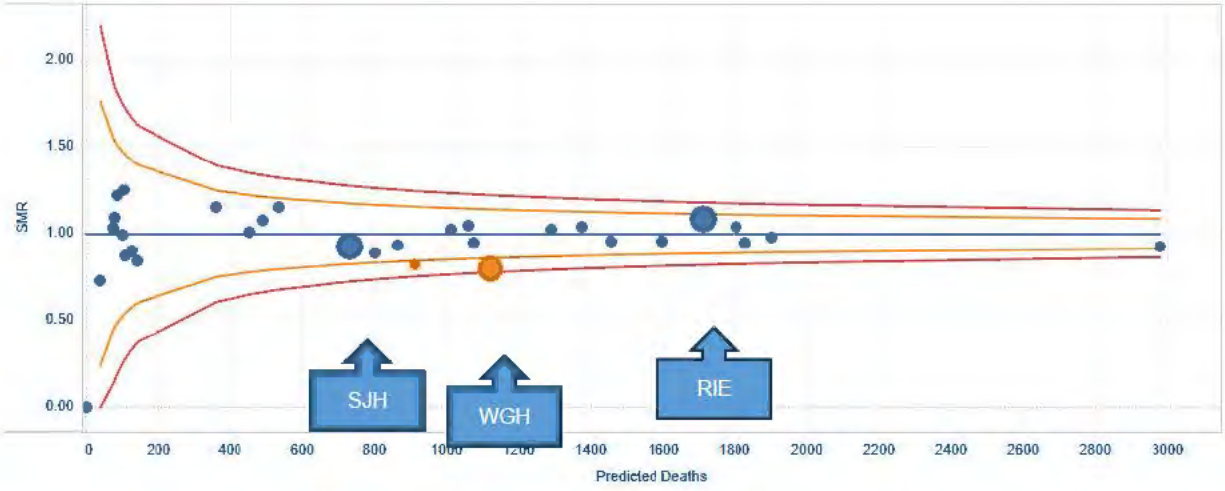
Health Board of Treatment:
NHS Lothian

Period:
July 2023 to June 2024

Location	Observed Deaths	Predicted Deaths	Patients	Crude Rate (%)	HSMR	Comparison to Scotland on the Funnel Plot
Scotland	**27,234**	**27,234**	**676,123**	**4.0%**	**1.00**	**n/a**
NHS Lothian	3,552	3,625	92,472	3.8%	0.98	n/a
Royal Infirmary of Edinburgh at Little France	1,855	1,711	38,703	4.8%	1.08	●
St John's Hospital	674	732	21,686	3.1%	0.92	●
Western General Hospital	887	1,120	17,802	5.0%	0.79	▼

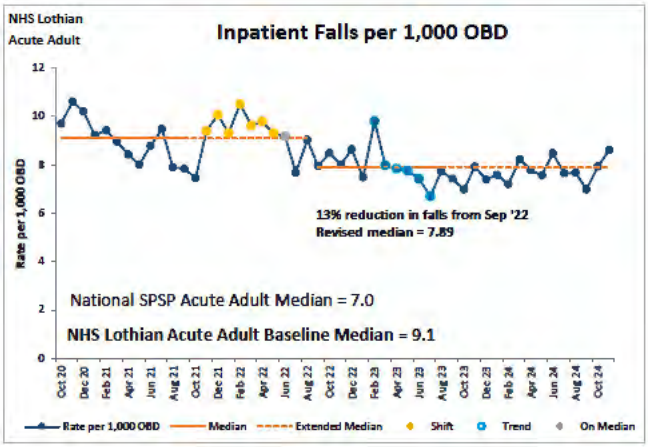
Funnel Plot by Hospital: July 2023 to June 2024

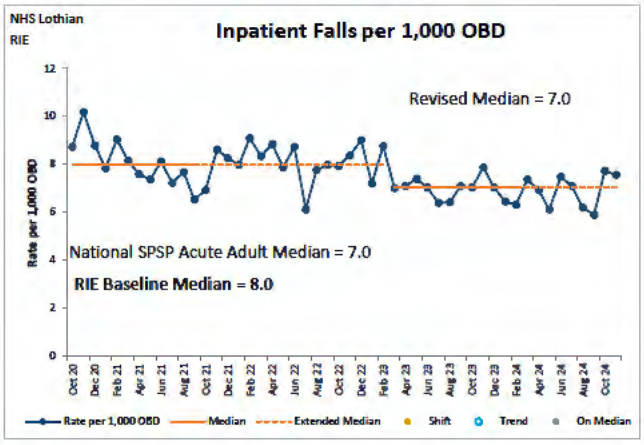
Allows comparisons to be made between each hospital and the average for Scotland for a particular period.

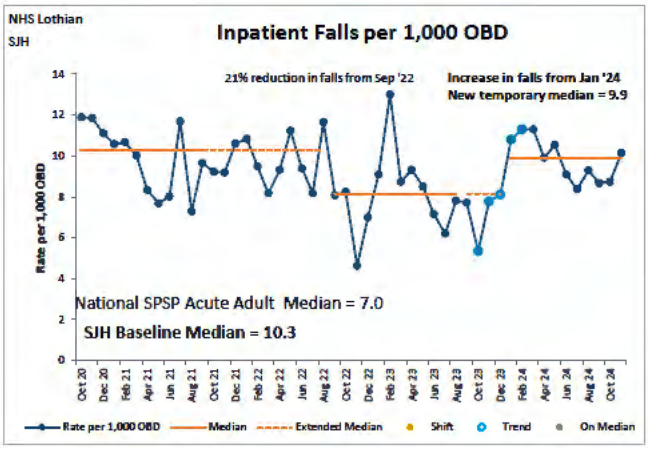


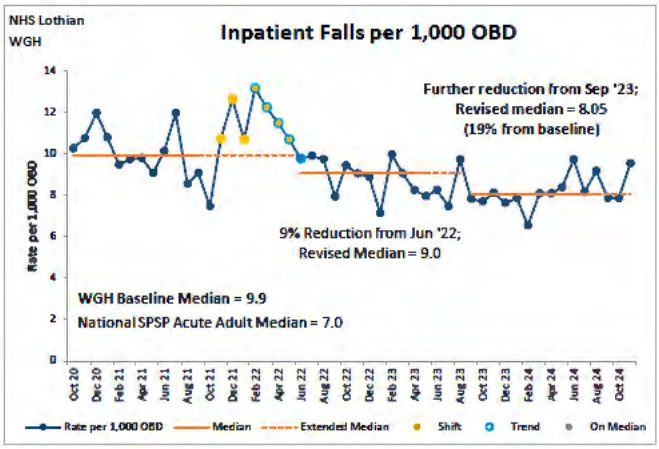
Appendix 2 - Falls Data

Monthly Falls data is submitted to HIS SPSP Acute Adult on a Quarterly basis.

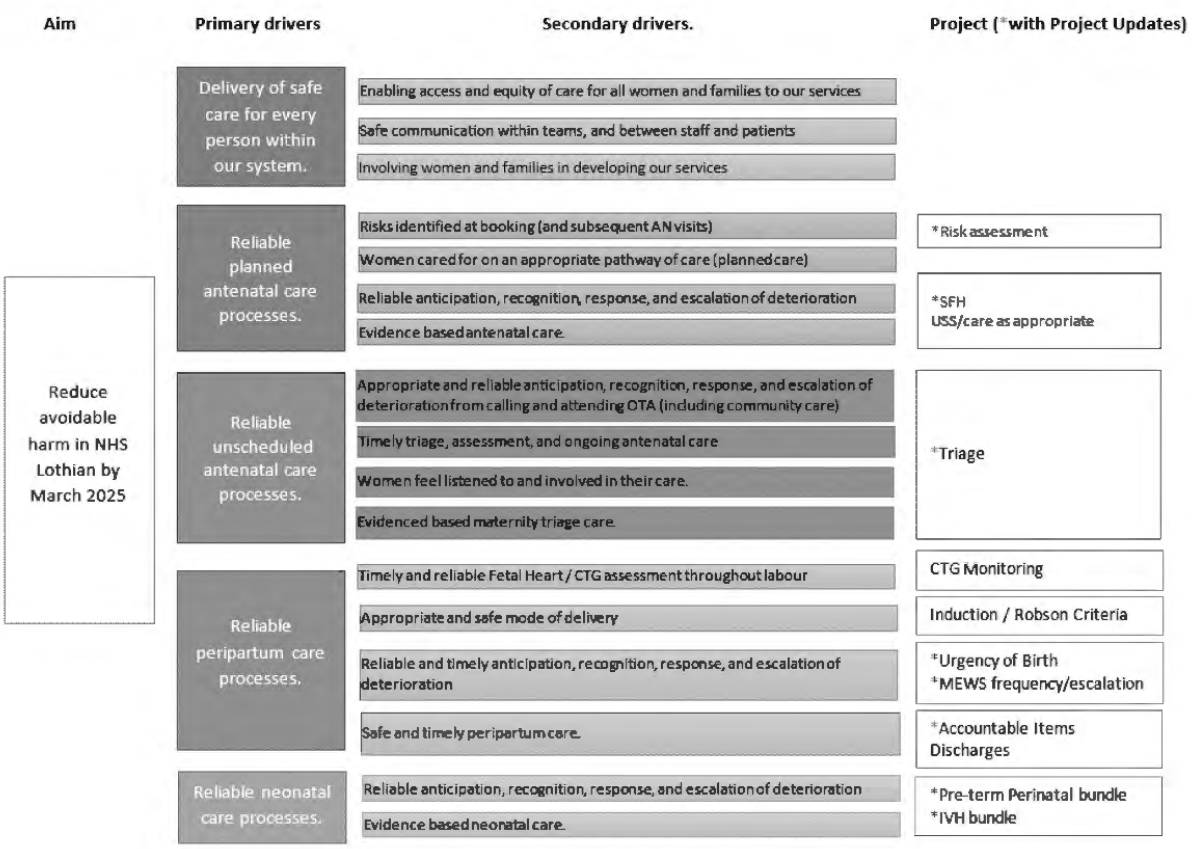




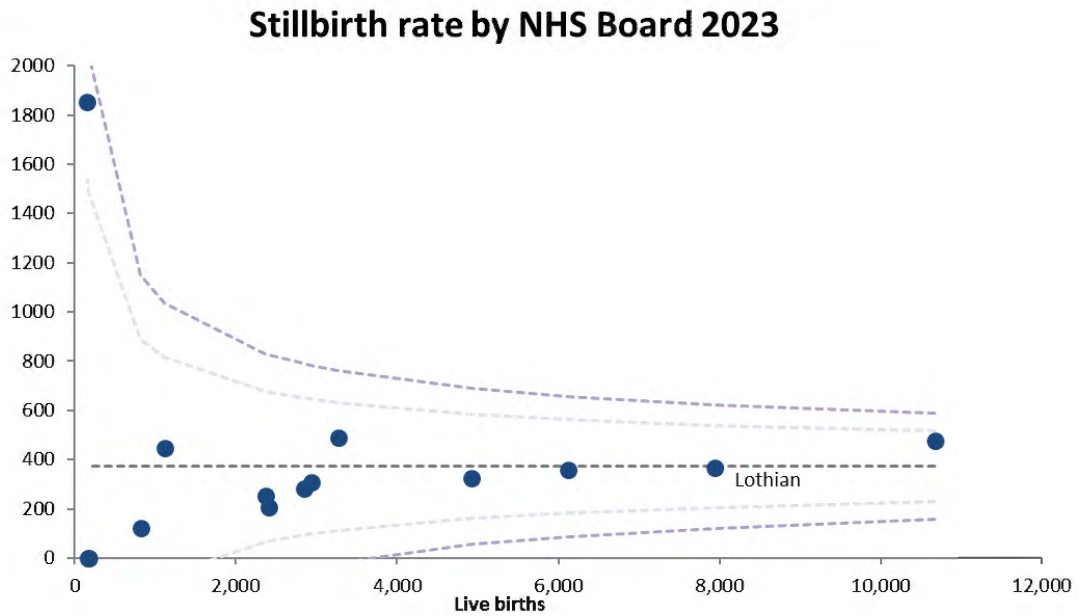




Appendix 3 – Maternity and Neonatal Improvement Programme Driver Diagram and Stillbirth Funnel Plot

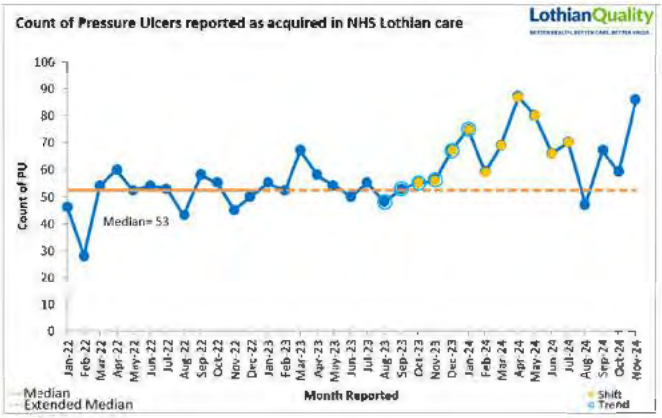


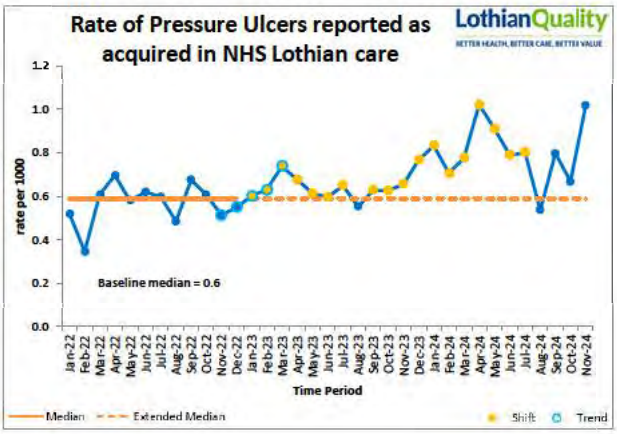
Stillbirth rates by NHS Board 2023, National Records of Scotland data



Appendix 4 - Pressure Ulcer Data

All Grades of Pressure Ulcers reported
Includes those developed in this ward, this hospital, or another hospital in NHS Lothian, at Home under District Nursing Care





Appendix 5 - Synopsis: Executive Leadership WalkRounds and Promoting a Culture of Patient Safety

1. **WalkRounds as a Tool for Safety Culture**:
   - Definition of Safety Culture: A culture of safety requires systems that allow staff to learn from errors and near misses to prevent recurrence (AHRQ PS Net Safety Culture, 2014).
   - Purpose of WalkRounds: These Patient Safety WalkRounds involve leadership asking thoughtful questions to understand the barriers clinical staff face, with a focus on improving patient safety.

2. **Key Elements of a Positive Safety Culture** (NHS England):
   - A positive safety culture is collaboratively crafted, ensuring safety through:
     - Continuous learning and safety risk improvement
     - Supportive, psychologically safe teamwork
     - Empowerment for all staff to speak up.

3. **Emotional Impact of Errors**:
   - Errors leading to patient harm are distressing for healthcare staff. Supporting staff emotionally is vital for maintaining a culture of safety (American College of Healthcare Executives).

4. **Leadership's Role**:
   - Leadership is crucial for fostering a safety culture. It drives the continuous improvement of safety practices and ensures psychological safety for staff (Healthcare Improvement Scotland's Essentials of Safe Care).

5. **Key Characteristics of WalkRounds**:
   - Enables staff to raise concerns in a safe, open, and informal setting.
   - Not an inspection: WalkRounds are a tool for understanding and removing barriers to safety, not for evaluating management.
   - Focused on clinical staff, not just leadership or management.

6. **NHS Lothian's Commitment to WalkRounds**:
   - NHS Lothian conducts monthly WalkRounds with the aim to:
     - Connect the ward to the board, ensuring senior staff engage with clinical staff.
     - Listen to staff on the front lines, gaining insights on patient safety.
     - Offer guidance and support to remove barriers and foster improvements in safety practices.
     - Spread improvement initiatives throughout the organization.
     - Reinforce patient safety as a strategic priority across all levels of the organization.

Conclusion: Executive Leadership WalkRounds are integral to fostering a culture of safety in healthcare. Through open communication, emotional support, and strategic leadership, WalkRounds enable continuous improvement, empower staff, and keep patient safety at the forefront of organisational priorities. NHS Lothian's commitment to these WalkRounds reflects a broader commitment to patient safety and continuous learning.

Processes and Support

The structured processes supporting Executive Leadership WalkRounds ensure effective engagement, transparency, and continuous improvement in patient safety. Through consistent leadership involvement, detailed reporting, and development opportunities, NHS Lothian fosters a culture of safety and accountability.

1. **Organisation and Leadership**:
   - The Quality Directorate oversees the organisation and facilitation of Executive Leadership WalkRounds.
   - Each WalkRound is led by one executive and accompanied by two non-executives.
   - Quality Directorate members are present to facilitate the WalkRound and document any follow-up actions.

2. **Reporting and Communication**:
   - Post-WalkRound reports are shared with clinical teams, Site Clinical Management Groups (CMGs), and the Executive Patient Safety and Experience Action Group (PSEAG).
   - This ensures transparent communication and action on identified issues.

3. **Commitment to Consistency**:
   - Cancellation of WalkRounds is discouraged to prevent disruption to the visiting area and maintain consistent engagement. These WalkRounds are highly valued by staff.

4. **Engagement and Development Opportunities**:
   - Executives and non-executives can sign up for WalkRounds by emailing loth.spspwalkrounds@nhs.scot
   - The current timetable can be seen here: SPSP Executive Leadership WalkRounds™
   - Although a slide-set is also available on request, the Quality Directorate can offer a one-hour development session for the Board in 2025 to enhance understanding of WalkRounds, refine processes, and assess their impact on patient safety.

Carolyn Swift
Head of Quality & Safety, NHS Lothian
Quality Directorate

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate

Improvement Programmes

2024-2025

Progress Report

November 2024

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Contents Page

1)	**Quality Academy**
2)	**Adverse Events**
3)	**Assurance Framework**
4)	**Western General Hospital**
	4.1 Surgical Assessment Unit 4.2 Uro-oncology prostate postal service 4.3 Building capacity and capability for quality management systems 4.4 Front Door Medicine 4.5 Prostate cancer pathway improvement 4.6 Breast pre-operative assessment improvement 4.7 Endourology Pathway
5)	**The Royal Infirmary of Edinburgh**
6)	**St John's Hospital** • Gentamicin • Frailty • Missed Medications • Deteriorating patient collaborative • QI in Medicine • Building a QI network in St John's Hospital

7)	**Royal Hospital for Children and Young People** 7.1 Deteriorating Patient Programme 7.2 Paediatric at home IV Ceftriaxone - Ambulatory IV Cef 7.3 Support RHCYP QIT meetings and site priority coaching 7.4 Bereavement Pathway
8)	**Primary Care**
9)	**Mental Health**
	9.1 Capacity and capability 9.2 Reducing Falls: Older People Mental Health (OPMH) 9.3 Readiness Response - Adult Mental Health (AMH) 9.4 Safe Care - Adult Mental Health (AMH)
10)	**Maternity and Neonatal**
	10.1 Improving patient/family communication in Maternity and Neonatal Significant Adverse Event Reviews (SAERs) 10.2 Maternity Services Improvement Programme • Planned Antenatal Care • Unscheduled Antenatal Care • Peripartum Care

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

Quality Academy

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Quality Academy	**Period**	April – September 2024
Project/Programme Title	Quality Academy		
Team Involved	Quality Academy		
Programme Lead	Ricky Samson / Cheryl Tudor		
Project Manager	Maryam Hanif / Burcin Meltem		

1. Aim:

1. QI Skills Course: Review content and revise content based on stakeholder feedback. Deliver 2 QI Skills Courses.
2. Bite sized &QI Essentials: Review content of both bitesize and local essentials. Agree with IAs (core content) Co-ordinate and centralise booking process on the Quality Academy website.
3. Public Engagement Training: Design a high-level awareness raising session for staff in relation to public engagement activities.
4. Manage & Enhance QI Coaching: Review current coaching resources and recruitment process for coaches. Identify all planned coaching sessions for 2024-2025.
5. SAE Reviewer Training: Carry out a need assessment gap between what is currently being delivered and what is required to meet organisational needs.
6. Manage NHS Lothian recruitment to NES Taught Courses: Establish current NES taught courses and recruitment cycle for the year.
7. Quality Academy Programme Board: Establish Quality Academy Programme Board.
8. Joy in Work Training: Scoping of JiW improvement projects taking place in Lothian.

2. Background and Purpose (Why?):

The Quality Academy exists to build and support the understanding, capability, and capacity of NHS Lothian staff in all aspects of Quality planning, improvement, and assurance.

This will be achieved by giving participants the essential knowledge, tools, and methodology to lead, plan, and deliver a focussed piece of improvement work in their own service area and by providing participants a system of understanding of healthcare and how quality improvement tools can be used to improve these systems and measure their progress.

3. Key Actions and Improvements to Date:

1. QI Skills Course: 6 Academy Days held. Cohorts 25 & 26 completed. Cohorts 27 &28 commenced (Day 4-5 to be delivered by the end of December 2024). Content review undertaken at the end of each cohort.

2. Bite sized &QI Essentials: 3 Bitesize sessions have been delivered by the Academy. The development of a centralised booking process is ongoing. Content review undertaken at the end of each bitesize session.
3. Public Engagement Training: Session has been successfully delivered with demand for a further session which is planned for 31st October 2024.
4. Manage & Enhance QI Coaching: All active coaches have been identified and a coaching development framework is now available for new coaches.
5. SAE Reviewer Training: In house training has been reviewed. NES are producing their training offerings at the end of October 2024. A gap analysis will take place then with the possibility of a combined in house / NES model.
6. Managed NHS Lothian recruitment to NES Taught Courses: Communication plan with NES is in place with links to the appropriate courses on the QI Academy website.
7. Quality Academy Programme Board: Future academy courses will be aligned to services needs and reducing significant adverse events.
8. Joy in Work Training: Review of existing JIW programmes undertaken and engagement with JiW events delivered via Q community. IHI Creating Workforce Joy and Well-Being course completed.

4. Measures/Impact/Data:

Staff Trained Numbers:
QI Skills Course: 82
QI Bitesize Sessions and Local Training: 46
Public Engagement: 49

Summary of Survey Responses/Impact:
The QI Skills course was generally well-received, with participants appreciating the structure, support, and practical application of QI tools. However, there were some recurring themes in the feedback:

What Worked Well:
- **Clear Structure and Guidance:** Participants valued the step-by-step approach, clear explanations, and the support provided by coaches and facilitators.
- **Practical Application:** The opportunity to work on real-world projects and receive feedback was highly beneficial.
- **Interactive Learning:** The combination of online modules and live sessions provided a flexible and engaging learning experience.
- **Supportive Community:** The cohort model fostered a sense of community and peer support.

What Didn't Work Well:
- **Online Delivery:** While online delivery offered flexibility, some participants expressed a preference for face-to-face sessions, particularly for group discussions and building relationships.
- **Time Constraints:** The limited timeframe and the need to balance work commitments with course requirements were challenges for many.
- **Overwhelming Information:** Some participants felt overwhelmed by the volume of information, especially during the initial sessions.

Suggestions for Improvement:
- **Hybrid Delivery:** A combination of online and face-to-face sessions could provide the best of both worlds.
- **More Practical Examples:** More practical examples and case studies would be helpful, especially for those new to QI.
- **Flexible Timeframes:** Consider offering more flexible timelines to accommodate individual schedules.
- **Focused Feedback Sessions:** More focused feedback sessions on individual projects would be beneficial.

Overall, the QI course was a valuable learning experience for most participants.

5. Reflections/Learning Points:

- Very disappointing response from other boards for the SAE training survey need to consider a different means of communication going forward.
- Not as strong an uptake on the bite sized sessions this year need to consider the value of delivering them going forward.
- Very good uptake on the places for SAE training and QI Skills.
- Managing NES training application processes has worked well.
- Scope of Joy in Work workstream needs defined – this could be implemented as a cross-system improvement initiative, or a focused training / coaching offer hosted within the Academy portfolio of courses. Needs discussed with key stakeholders and an options appraisal undertaken to inform next steps.

6. Next Steps (Summary):

1. QI Skills Course: Deliver 3 QI Skills Courses.
2. Bite sized &QI Essentials: Deliver 2 QA Bitesize sessions. Ongoing evaluation and revisions.
3. Public Engagement Training: Delivery 1 in-depth masterclass on engagement.
4. Manage & Enhance QI Coaching: Evaluate the new process and adapt as required.
5. SAE Reviewer Training: Review and evaluate in house SAE Reviewer Training sessions and deliver further sessions as required.
6. Manage NHS Lothian recruitment to NES Taught Courses: Review and evaluate the process and further improvement if needed. Work with NES for potential collaborative projects.
7. Quality Academy Programme Board: Review and revise the vision and strategic direction of the QAPB for the next year and align them with service requirements.
8. Joy in Work Training: Identify / recruit to steering group to define scope of the work, and plan development and testing.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

Adverse Events

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Adverse Events	**Period**	April-October 2024
Project/Programme Title	Adverse Events Improvement Programme		
Team Involved	Carolyn Swift, Sue Gibbs, Cheryl Tudor, Ricky Samson, Sharon Gill, Catriona Wilson, Elli-Noora Salo, Robert Pritchard, Thomas Murray, Vasudha Singh, Maryam Hanif		
Programme Lead	Jill Gillies, Liz Bream		
Improvement Lead	Vasudha Singh		

1. Aim:

Improve learning from and management of Significant Adverse Events (SAE) resulting in unexpected harm or death to enhance patient and staff safety.

Increase staff satisfaction with the SAE process.

Increase compliance with review process related Key Performance Indicators (KPI).

Reduce dependence of Process users on Quality Directorate (QD) Adverse Events (AE) team.

Timely and reliable provision of necessary data around AE to sites and services.

2. Background and Purpose (Why?):

NHS Lothian has an open reporting system for adverse events, including unexpected events across all services where a person has suffered major harm or death. Although this has continued to ensure visibility of unexpected harm, there are challenges in achieving a balance and proportionality in resource invested in review against the opportunity for learning and improvement. This is particularly true in many situations where initial reporting usually reflects an unexpected serious outcome rather than a clear adverse event. Under such circumstances, efficient management of SAE processes and effective learning from SAE reviews becomes crucial to increase patient and staff safety and satisfaction.

3. Key Actions and Improvements to Date:

- Quality planning using data and extensive process mapping across NHS Lothian stakeholder groups including variation, risks and feedback
- Programme PID and Driver Diagram created
- Data on variation in SAE approval process and review commissioning decisions
- Improvement priorities refined
- Adverse Events Toolkit schematic created
- Proposal on revising and improving review templates and processes based on data and feedback

- SMRT template revised and Local Case Review guidance updated.
- SBARs created for improving HAI reviews and non-clinical reviews
- SAE Training opportunities made available online
- Programme's Outcome Map, Logic Model and Measurement plan drafted to help with programme evaluation
- Ongoing training and stakeholder engagement and support by QA Facilitators to embed and promote SAE processes
- Six-monthly papers for Healthcare Governance Committee (HGC) on AE- including a paper on evaluation of changes made in April 2023 to SAE review process
- Assurance framework data around Adverse Events for Services
- Mock dashboard for Adverse Events with Measurement plan

Other work that has also been carried out/ supported:

- Mortality and Harm related processes and projects:
  - Mortality Screening Tool published
  - Stroke Mortality Case Reviews conducted
  - Learning from Harm flowchart developed
  - Mortality and Morbidity meeting guidance and sample Terms of Reference developed
- SNAP Audits process
  - Supported as an ongoing activity to ensure timely, reliable and quality submission of Board response to SNAP Audit outlier status.
  - Papers to Acute CMG (3 in 2024) and annual paper on SNAP Audits to HGC.

4. Measures/Impact/Data:

Copies of the Adverse Events Measurement Plan and Dataset can be made available on request by emailing loth.qist-admin@nhs.scot

5. Reflections/Learning Points:

- Helpful having access to the senior management by way of the Programme Management group to keep projects well-aligned with business needs
- Helpful keeping the project activity well-documented for management and reporting
- Helpful having a project plan agreed and documented with the team which is then used for tracking activity along with action logs.
- Measurement plans and regular data collection very helpful for ongoing evaluation
- Challenges with changes in team leadership and membership

6. Next Steps (Summary):

- Falls and Pressure Ulcer reviews- quality planning and improvement
- HAI and Non-Clinical Template Improvement projects
- Dashboard build with Quantium and Quality Analytics team
- Complete the Adverse Events Toolkit
- Continue to support and report on SNAP Audits to Acute CMG and HGC

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

Assurance Framework Reporting

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Assurance Framework Reporting	**Period**	April – October 2024
Project/Programme Title	Assurance Reporting		
Team Involved	Liz Bream, Associate Medical Director for Quality and Safety Jill Gillies, Associate Director of Quality Mary Stewart, Specialty Registrar in Public Health Elaine Anderson, Associate Quality Improvement Advisor		
Programme Lead	Jill Gillies		
Improvement Lead	Liz Bream and Jill Gillies		

1. Aim:

The aim for this programme is that by the end of 2025/2026 all areas of clinical care which the Healthcare Governance Committee has oversight of and governance responsibility for, will be using an agreed assurance framework for their reports. The assurance framework will outline the relevant evidence the HGC needs to determine what level of assurance it can take for safe, person-centred and effective care.

2. Background and Purpose (Why?):

This work supports the NHS Lothian corporate objective "Working towards safe and quality service delivery resulting in safe and effective person-centred care" by strengthening healthcare governance through reliable reporting of person centred and effective care in annual reports from services. (1)

Effective governance in a healthcare organisation exists "when the appropriate issues are considered by the right people, the relevant information is reviewed in the most useful format at the right time, and the level of scrutiny produces rigorous challenge and an effective response." (2)

The purpose of an assurance framework is to provide a clear articulation of, and system for, assurance in an organisation so that there is an "effective and comprehensive process in place to identify, understand, monitor and address current and future risks." (3)

An assurance framework does this by providing "a structured means of identifying and mapping the main sources of assurance in an organisation, and co-ordinating them to best effect." (4)

(1) NHS-Lothian-Corporate-Objectives-2023-24-Final-21.06.23.pdf (nhslothian.scot)
(2) https://www.gov.scot/publications/blueprint-good-governance-nhs-scotland-second-edition/
(3) https://nhsproviders.org/media/1182/board-assurance-a-tool-kit.pdf
(4) https://www.gov.uk/government/publications/assurance-frameworks-guidance#:~:text=Details-,This%20guidance%20advises%20on%20how%20assurance%20can%20best%20support%20accounting,meeting%20their%20corporate%20governance%20obligations

3. Key Actions and Improvements to Date:

This is a 2-year programme. Work undertaken in 2024/25 is focusing on safety. In 2025/26, the assurance framework will incorporate reporting on person centred and effective care.
A suite of generic templates has been developed and tested:

- A report document to
  - provide the committee with information about the structures and processes for management and oversight of safety in the service
  - provide detail of how the service use data and evidence, to allow an assessment of the quality and safety of care provided in the service, and outline work being undertaken to address risks and improve quality and safety
- A service scope appendix (orientating HGC to the service that the report covers)
- An assurance mapping template appendix (providing evidence that the service is reviewing evidence about safety in appropriate fora)

The templates can be amended to suit the needs of the service.

To date, the following sites and services have submitted reports and associated appendices in the revised format to the committee:

- **May**: Women's Services (moderate assurance accepted).
- **July**: Children's Services (moderate assurance accepted).
- **September**: East, Edinburgh, Mid and West Lothian HSCPs (moderate assurance accepted). GP Out of Hours and Oral Health Services (moderate assurance accepted).
- **October**: Acute Services - Edinburgh Royal Infirmary, Western General, St John's Hospital and Outpatients (moderate assurance accepted, noting that there are pressures in some areas of the service).

4. Measures/Impact/Data:

A meeting with HGC non-executive members of the committee was held in July to obtain feedback on the reports submitted to date and the updated approach. They advised that new format was helpful and that a full analysis should be undertaken once all services had submitted a report using the new templates.

Feedback will be sought from all services and HGC members to evaluate the effectiveness of the new approach early in 2025 and any updates required implemented before the 2025/26 reporting period.

5. Reflections/Learning Points:

Engagement with services:

- The quality of submissions to date has been varied. Ongoing collaboration between members of the quality directorate team and services is required to facilitate completion of the report in alignment with the principles of the revised assurance framework approach. The expectation is that services will lead on completing the report.

Report content:

- It is helpful to committee members if services talk to the paper vs. giving a separate presentation.
- Provide succinct information in the body of the report, with a brief outline of areas that are performing well. Where data indicates an outlying position, ensure the supporting data is included in the body of the report with clear action of activities being undertaken to address the risk.

6. Next Steps (Summary):

The following services will present reports using the new framework to the committee in the coming months:

- **November**: Diagnostics, Anaesthetics, Theatres and Critical Care (DATCC) and Cancer Services
- **January**: Royal Edinburgh and Associated Services (REAS)

Creation of measures of person centred and effective care for inclusion in the assurance framework report and templates.

As outlined above, the report format and approach will be reviewed and updated as appropriate following feedback from committee members and services.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

Western General Hospital

Projects / Workstreams:

1. Surgical Assessment Unit
2. Uro-oncology prostate postal service
3. Building capacity and capability for quality management systems
4. Front Door Medicine
5. Prostate cancer pathway improvement
6. Breast pre-operative assessment improvement
7. Endourology Pathway

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	WGH Surgical Assessment Unit	**Period**	April-September 2024
Project/Programme Title	SAU flow		
Team Involved	Jenny Fleming, Vicki Stewart, Danielle Collins, Terri Kinnell, Charisse Wallace, Carole White, Karen Sewell, Jenifer Holt		
Programme Lead	Jenny Fleming		
Improvement Lead	Thivya Jevanesan		

1. Aim:

To improve SAU 4-hour performance to 75% by April 2025. The key focus is to:

- ensure SAU is seeing the right patients by reducing return patients at the right time.
- focus on patient flow.

2. Background and Purpose (Why?):

In recent years, there has been a significant increase in the number of patients who were seen in the surgical assessment unit at the WGH. This increase in demand has led to delays in patients getting their first assessment and senior review, leading to breaches, queues at the front door and lower staff and patient experience. While there is some ongoing improvement work to reduce the number of inappropriate referrals into SAU via the flow centre, this project aims to explore other improvement opportunities to increase flow within SAU.

3. Key Actions and Improvements to Date:

Improvements to date:

- Special cause variation in the 4-hour performance
- Sustained reduction in the weekly number of return patients attending SAU
- Sustained reduction in the weekly number of 4- and 8-hour breaches

Value-added activities that lead to the above-mentioned improvements:

- Completion of 2 PDSA cycles of 4 weeks each to reduce the number of return patients attending SAU
- Continuation of the abscess pathway which is now an embedded pathway via Daybed Suite, which has contributed to the sustained reduction in weekly return patients attending SAU
- Continuation of scheduled CT slots to reduce return patients which has contributed to the sustained reduction in weekly return patients attending SAU

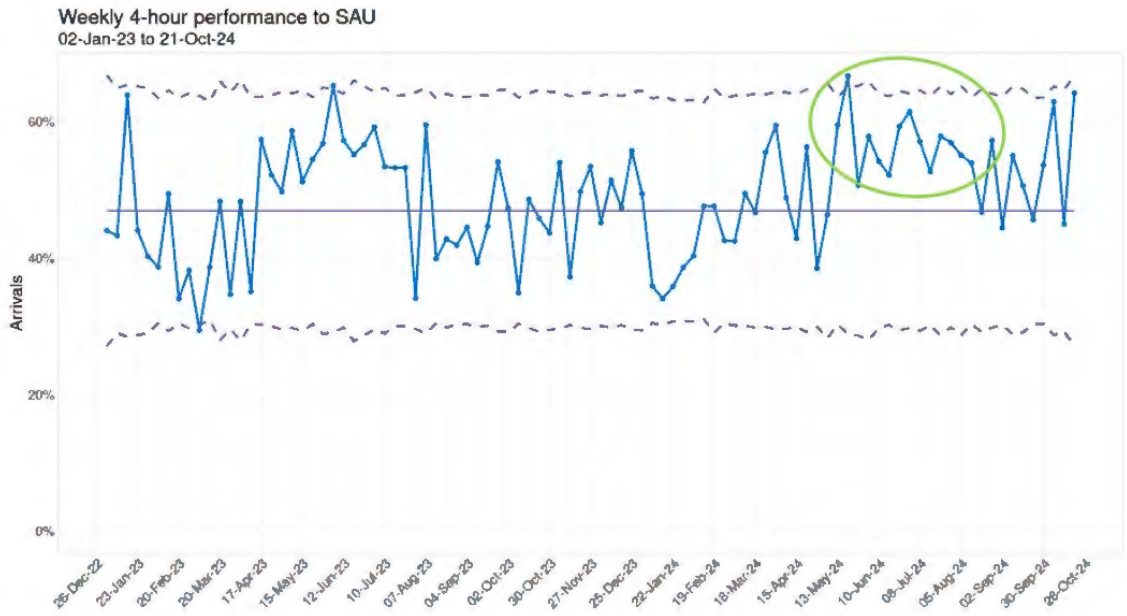
Other value enabling actions:

- Continued data collection and analysis to monitor progress

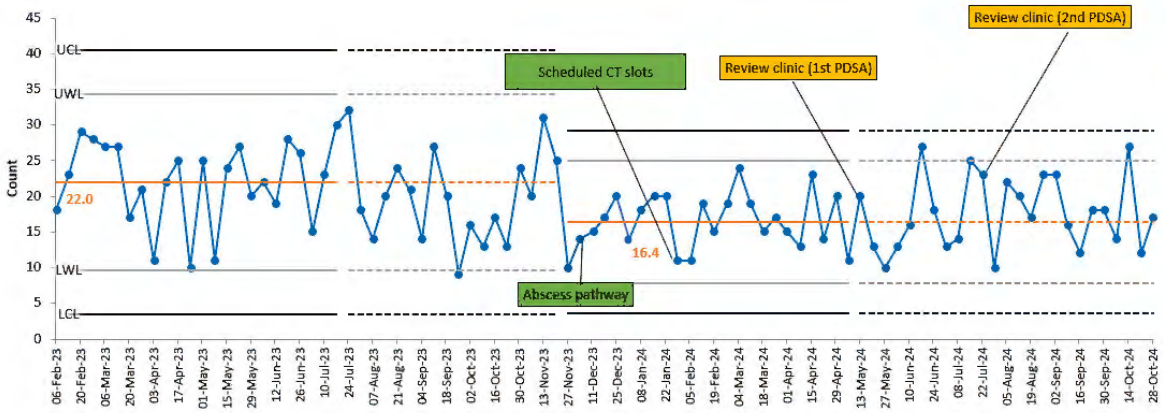
4. Measures/Impact/Data:

The main measures include:

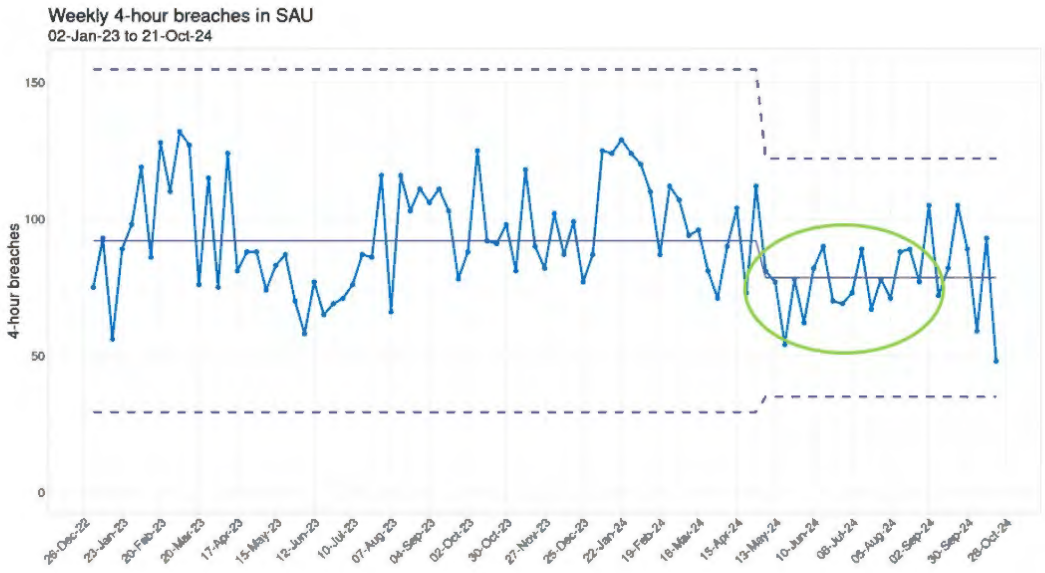
- **Weekly 4-hour performance (outcome measure)**

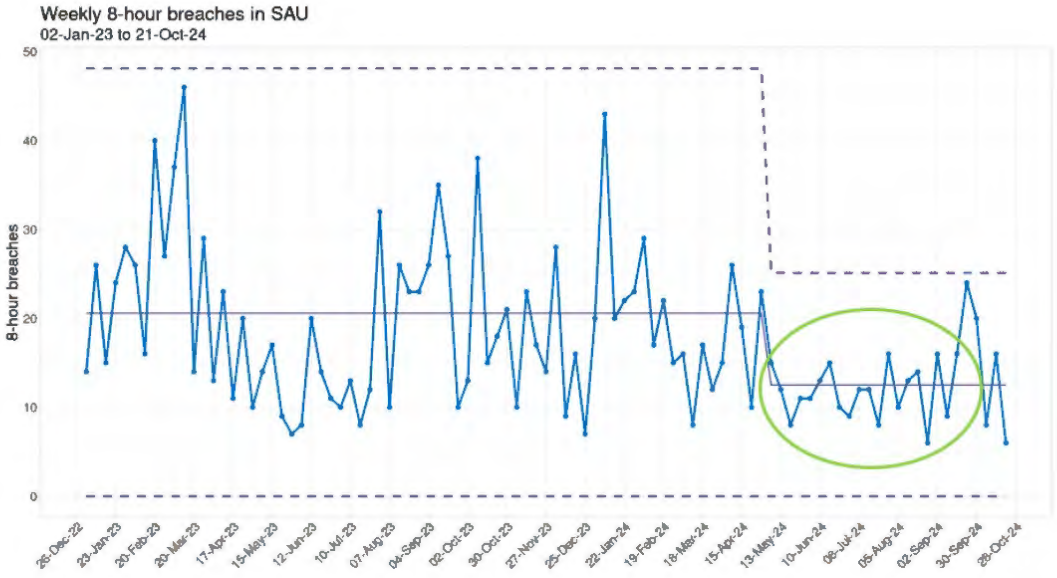


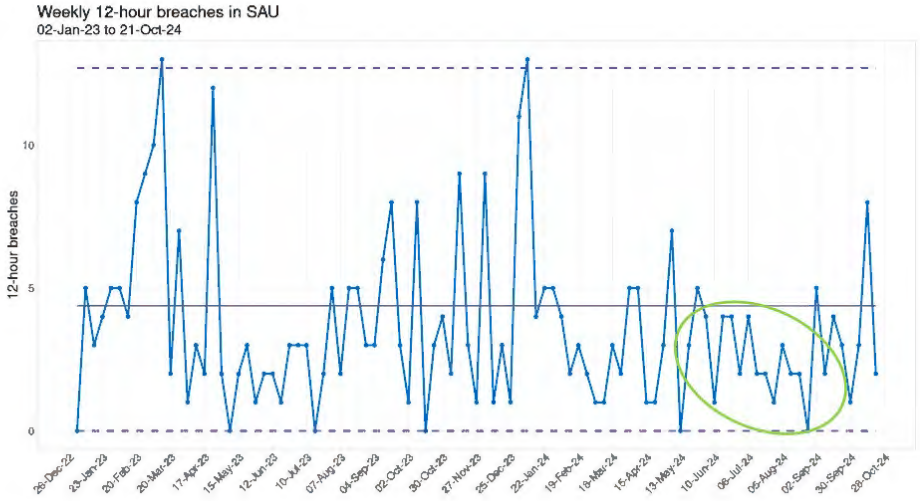
- **Weekly number of return patients (process measure)**



- **Number of weekly 4, 8 and 12-hourly breaches (outcomes measure)**







5. Reflections/Learning Points:

While the focus on return patients has led to a sustained reduction in the weekly number of return patients, this project has yet to focus improvement efforts on patients who should not have been referred to SAU (i.e. catheter-related or where the refHelp guidelines were not followed). In addition, SAU's medical model is a significant contributing factor in seeing patients in a timely manner. These two factors will need to be explored to improve SAU's capacity.

On reflection the timing of the 2nd PDSA cycle of the review clinic was not idea as this was done during the summer period with annual leave in the service team. In addition, the doctors in training rotation happened during the 4-week PDSA which added challenges to the service.

6. Next Steps (Summary):

Carry out a time in motion study to better understand the capacity challenges within SAU, especially around the medical model and limited footprint of the department.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	WGH Cancer Services	**Period**	April – September 2024
Project/Programme title	Uro-oncology prostate postal service		
Team involved	Uro-oncology clinical nurse specialists, oncology administrative teams		
Programme lead	Lyndsay Cameron – General Manager for Cancer Services		
Improvement Lead	Elise O'Leary – Improvement Advisor		

1. Aim:

To reduce the time spent by nursing and administration on the uro-oncology prostate cancer postal service by January 2025.

2. Background and Purpose (Why?):

The uro-oncology prostate postal service contacts and advises on the care of patients who are not on active oncological treatment for their prostate cancer. On average, 350 letters are posted monthly. This requires significant nursing and administrative resource to manage. The current resource allocation does not match the workload. The team believe there are opportunities for improvement in this service.

3. Key Actions and Improvements to Date:

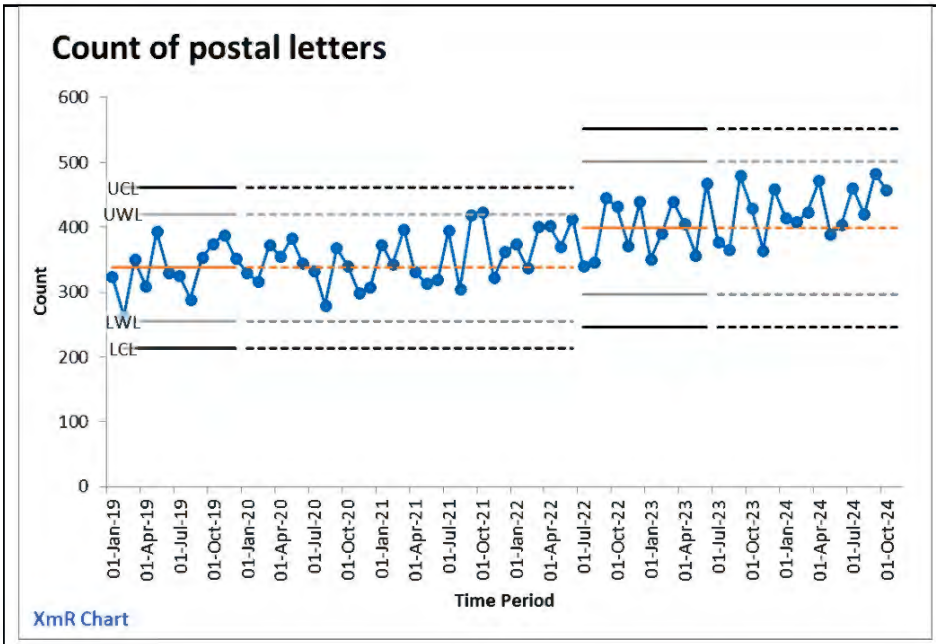
Key actions to date include:

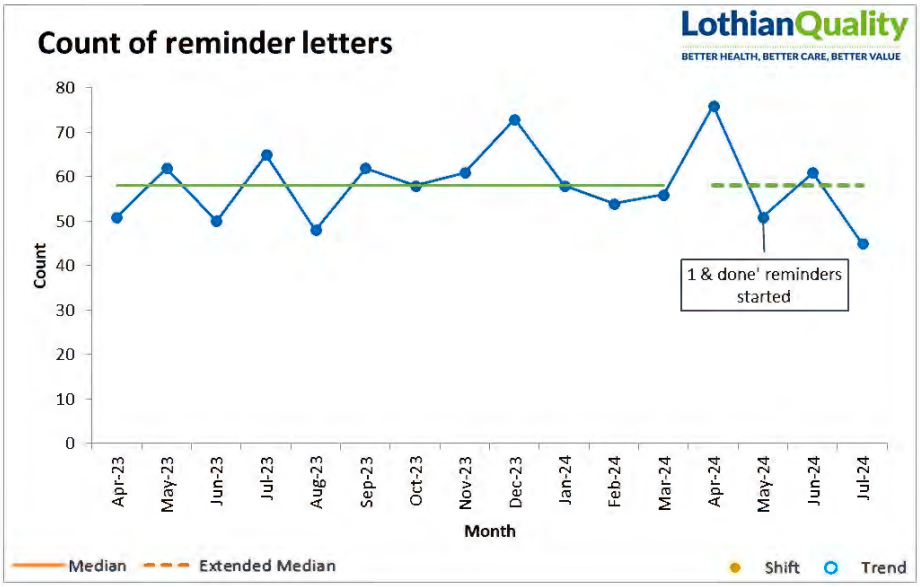
- Team development
- Key change ideas identified; including digital solutions

Change ideas implemented include:

- One reminder letter only (from up to 3 per patient), reducing administrative burden
- Improved letter with signposting, improving communication to patients
- Automated reporting of blood test results, reducing administrative waste
- Surgical patients moved to surgical team for follow up, appropriately allocating work
- Electronic signatures approved, reducing administrative waste.

4. Measures/Impact/Data:





It has been difficult to quantify time taken, despite this being the key aim of the project. The project team estimates that prior to changes being made this process takes 87 hours per week across 4-5 staff members. They estimate that the changes should see this reduce to approximately 57 hours (a 33% decrease). These changes will not impact the quality of care that patients receive.

5. Reflections/Learning Points:

Improvement ideas have come from a variety of levels and have included stopping activity, automating activity, reallocating activity to more appropriate teams, making better use of existing technology. Due to the number of opportunities for improvement identified, it has been important to use tools including driver diagrams and action trackers to keep track of all changes. Using these tools have provided valuable opportunities to review, update and increase the number of improvement ideas within this project.

While most involved have been eager to make changes, some team members have required time and support to agree to them, particularly administrative team members worried these changes may impact on the viability of their role.

It has been particularly important to make use of available technology to simplify the existing process.

6. Next Steps (Summary):

Key change ideas of removing additional paperwork to commence in January 2025. Clinicians wanted to inform patients of upcoming change and, as patients are contacted on average 6 monthly, the change was agreed to be started in January 2025.

Another key change idea is to use Connect Me to enable communication with patients and reduce time spent on monitoring for this cohort. This is being supported and managed by John Wallace, a Programme Manager for the Edinburgh Cancer Centre.

Cancer National Pathways for prostate cancer are scheduled to be published in early 2025. This may impact on eligibility criteria for inclusion/discharge from postal follow up services.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	WGH - Capacity and Capability	**Period**	April – September 2024
Project/Programme title	Building capacity and capability for quality management systems		
Team involved	WGH Quality Directorate		
Programme lead	-		
Improvement Lead	Elise O'Leary		

1. Aim:

To deliver local QI training in a flexible and agile manner, acknowledging current service pressures (Quality Strategy Interim Review 2023).

2. Background and Purpose (Why?):

Building capacity and capability for improvement is a key requirement for a high functioning health system and an essential component of Quality Management. At WGH this is directly supported through staff training and improvement coaching.

Improvement training equips staff/teams with the skills and tools to understand the complex care environment, apply a systematic approach to problem solving, design, test and implement changes using real measurement to improve experience and outcome of care.

The aim of the QI coaching programme is for individuals and teams to have local access to a QI Coach, to increase the confidence and participation in improvement work across NHS Lothian: QI Coaching — Lothian Quality (scot.nhs.uk).

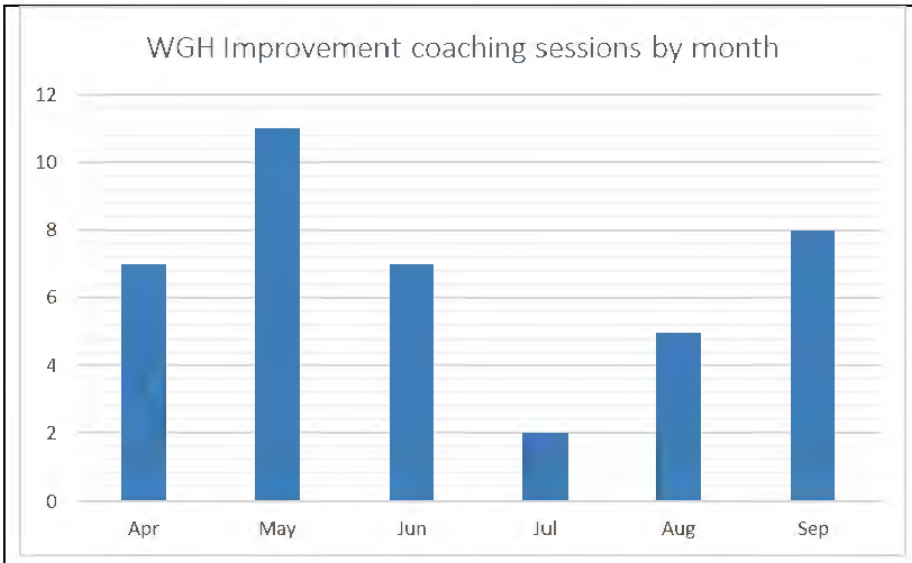
These activities sit within the overarching quality management system infrastructure.

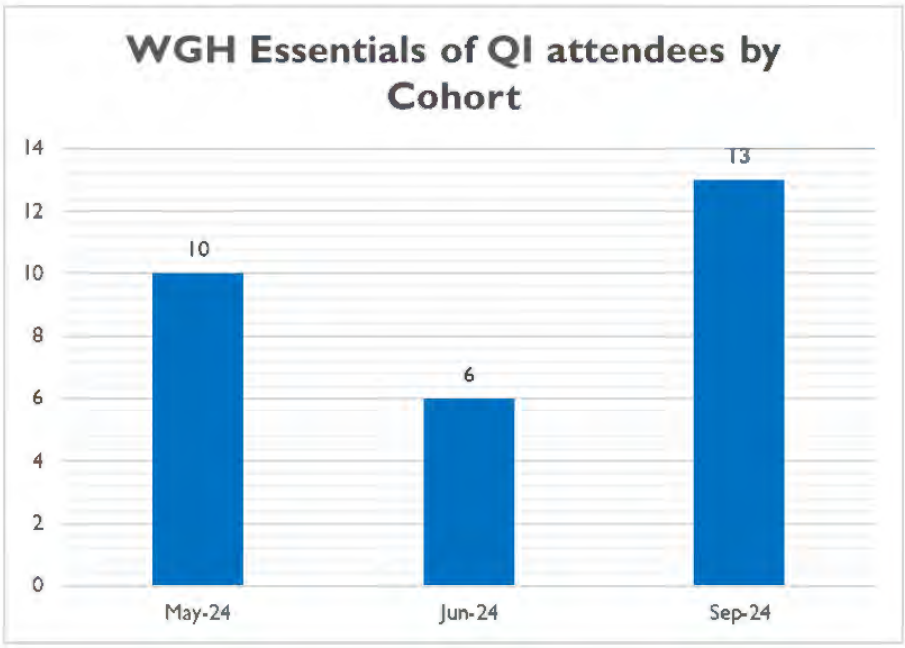
3. Key Actions and Improvements to Date:

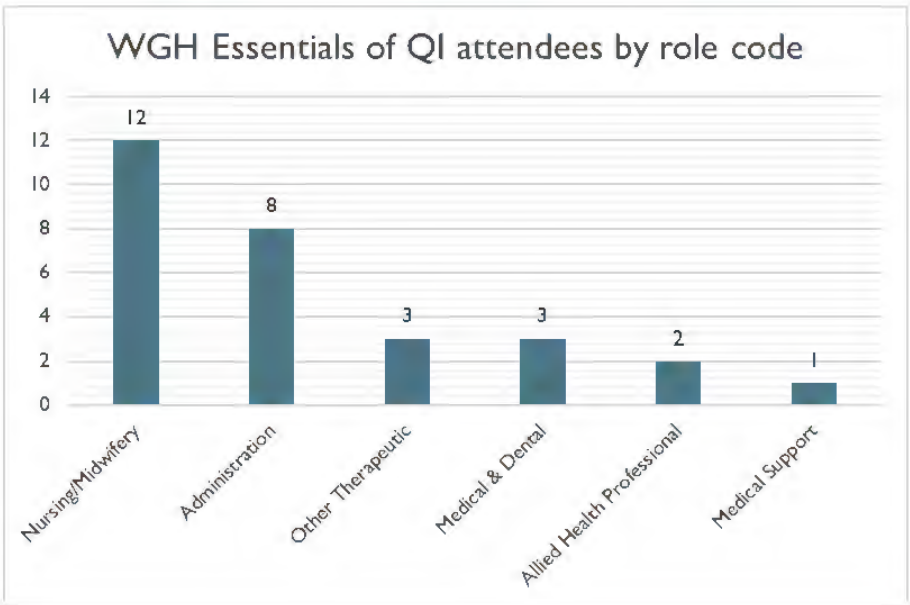
Three 'Essentials of QI' sessions were run over this period. These included two 'projects' days focusing on developing aim statements, theory of change, testing changes and measurement for improvement, and one 'planning' day focusing on building conditions for change, understanding systems, and measurement.

Over this period, 40 staff members engaged in coaching with the improvement team.

4. Measures/Impact/Data:







Copies of supporting documentation (Quality Improvement Summaries) can be made available on request by emailing loth.qist-admin@nhs.scot

5. Reflections/Learning Points:

Continuing to adapt the Essentials of QI is beneficial for both staff attending and for staff leading the session.

Testing clinical examples worked well in September 2024 and will continue to be used and improved in further 'planning' sessions.

6. Next Steps (Summary):

Essentials of QI will commence again in early 2025. These will be planned to avoid winter pressures to maximise the impact of the learning.

Coaching clinic sessions will continue into the next six months and onwards.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	WGH - Acute Medicine	**Period**	April– October 2024
Project/Programme Title	Front Door Medicine		
Team Involved	Dr. Weerakoon, Dr. Crane, Dr. Gordon, Penny Clarke		
Programme Lead	David Z Walker		
Improvement Lead	Thivya Jevanesan, Dr. Malvika Bhatia		

1. Aim:

To enhance patient flow and optimize care delivery for acute medical presentations at WGH front door by providing safe, high-quality, timely, and equitable care across varying levels of urgency and clinical needs, while advancing clinical governance through continuous quality monitoring, accountability, transparency, and a commitment to excellence in clinical practice.

2. Background and Purpose (Why?):

The escalating demand for unscheduled care and emergency services is increasingly surpassing the available local and national capacity, leading to increased instances of avoidable harm. Lothian's Strategic Development Framework and The National Urgent and Unscheduled Care Collaborative Programme outlines supporting access to unscheduled care as a key priority. Through continuous improvement, we can reduce unwarranted variation in our processes and systems and ensure the right care at the right time and place for our patients.

3. Key Actions and Improvements to Date:

- Winter bid project - Rapid Assessment and Treatment or Redirection qualitative and quantitative data analysis completed and presented. New combined working model for MAU and RACU trialled at front door in lieu.
- Driver diagram for Medicine created to identify priorities, link projects, and identify areas of improvement across all areas and specialities.
- Clinical Governance Group set up with QI support.
- Supporting ongoing work in Medicine to ensure their processes robustly capture, learn from, and prevent harm.
- Gap analysis undertaken in MAU and RACU to understand compliance with existing standards.
- 47 highest priority SOPs identified to be updated and linked for safer clinical practice.
- Self-presenters project data collection and analysis conducted for quality planning at the front door.
- Patient engagement project reports generated every 4 months to incorporate patient voices into ongoing improvement work.

- Medicine QIT successfully revamped to be more structured, improve attendance, and increase commitment to quality initiatives.
- Medicine QIT linked to Clinical Governance Group as actioning arm.
- Staff feedback collected across various staff groups in MAU beds and trollies via a detailed questionnaire. Feedback was themed to identify areas for improvement.
- Driver diagram created for staff wellbeing in MAU and change ideas collected from staff across seniority. First round of actions for improvement identified and progress being communicated back to staff.
- Manchester triage system data analysis conducted in 3 rounds after 6 months of trial at the front door. Baseline data established and ongoing data support provided to guide improvement in patient flow.
- Frailty model adapted from ED at RIE and being trialled at WGH front door. QI to support the service in using data to understand if the change is an improvement and understand the variables in the process.
- Deep dive ongoing into areas of avoidable harm in medicine – unread results project.

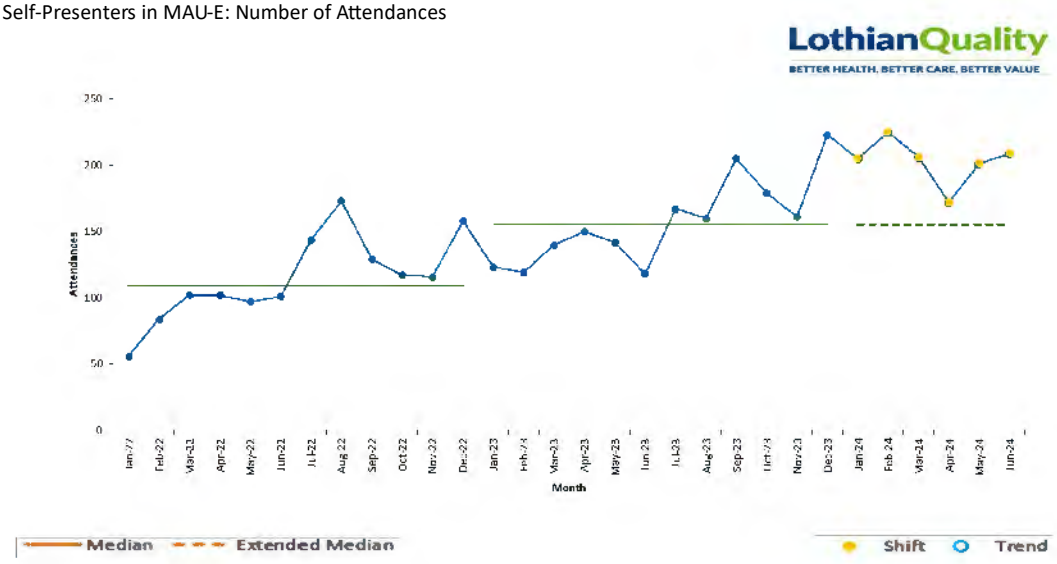
4. Measures/Impact/Data:

Clinical Governance Group: Compliance with Standards (Society of Acute Medicine)

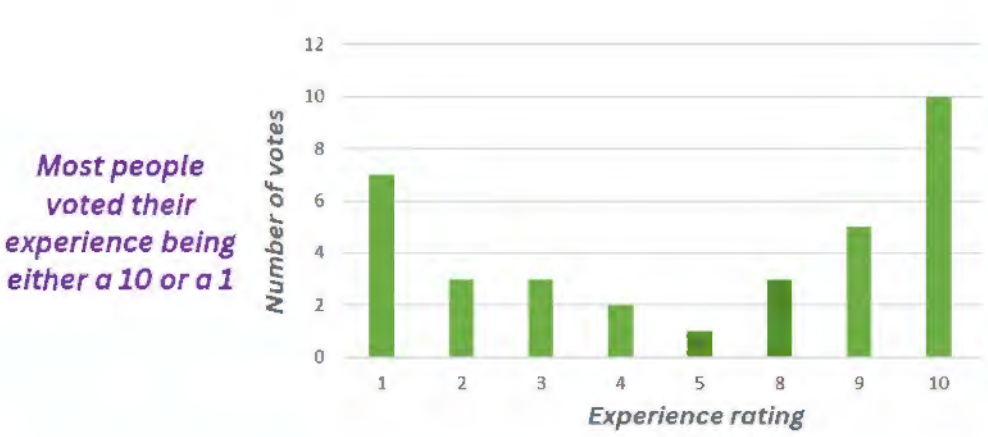
A copy of the Compliance with Standards (Society of Acute Medicine) can be made available on request by emailing loth.qist-admin@nhs.scot

Self-presenters: Number of patients self-presenting to WGH front door, self-presenter patient experience

Self-Presenters in MAU-E: Number of Attendances



Patient Engagement: Qualitative and quantitative patient experience

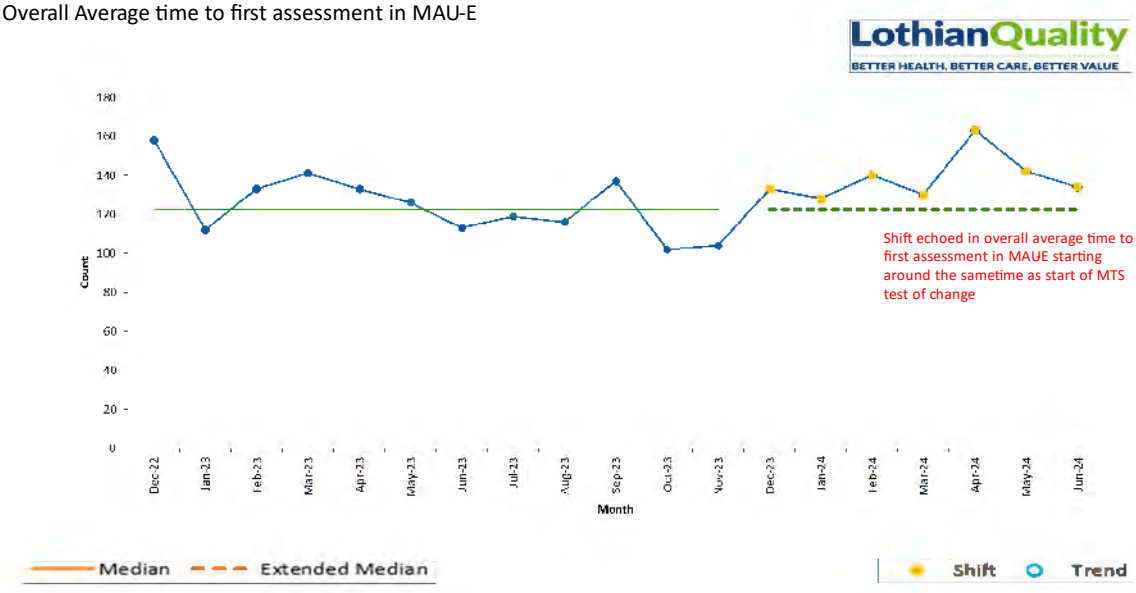


MAU Staff feedback: Qualitative and quantitative staff experience

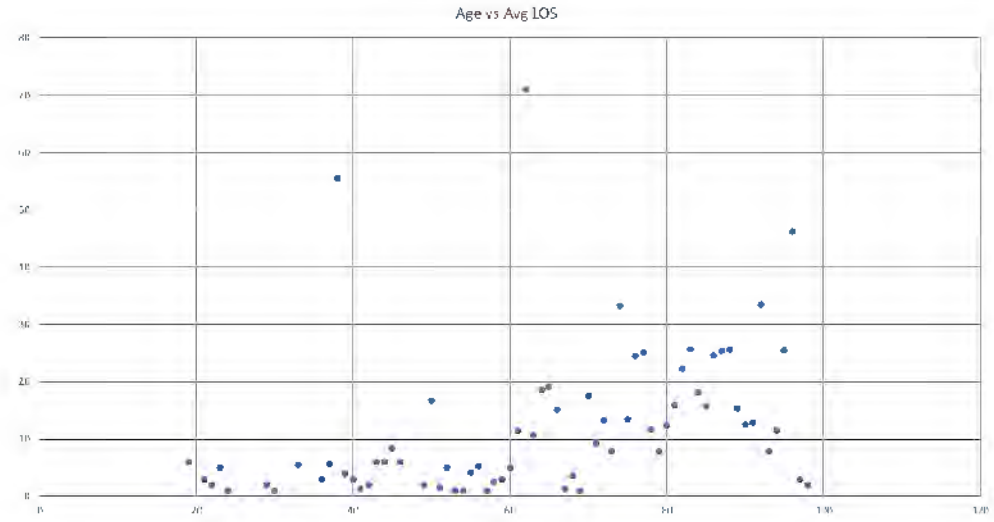
A copy of the MAU Staff feedback: Qualitative and quantitative staff experience can be made available on request by emailing loth.qist-admin@nhs.scot

Patient flow at front door: Number of patients per MTS category, Time to triage per MTS category, Time to first assessment per MTS triage category, Admission rate per MTS triage category, Number of Breeches and reason.

Overall Average time to first assessment in MAU-E



Frailty at the front door: Number of admissions avoided by frailty team, Admission rate for patients aged over 65, Average LOS for patients aged over 65, patient experience, Admission rate for patients aged under 65, Average LOS for patients aged under 65, 30-day readmission rate.



5. Reflections/Learning Points:

- Importance of having clear measures, continuous data collection and analysis, and making evidence-based adjustments regularly throughout the improvement journey.
- Qualitative data collection from all stakeholders affected by a test of change has been very influential to decide if change was an improvement.
- Driver diagrams recognized to be a powerful visual tool to align multiple stakeholders to a common cause and identify areas for improvement.
- Governance group involvement prompted the team to discuss and learn about clinical governance and existing assurance frameworks.
- Hugely beneficial to follow a quality management systems approach and involve the QI team at the quality planning phase rather than bringing them in at the end of a test of change to do an evaluation.
- Follow-through is essential to ensure that improvements are not only implemented but also sustained over time, reinforcing accountability and engagement across the team.

6. Next Steps (Summary):

- **Clinical Governance Group:** Set up of meeting successful. Handover to admin resources to continue supporting the meeting while the QI team to continue to attend and support relevant projects.
- **SOPs for governance project:** Continue to coordinate SOPs for 47 most important SOPs based on risk.
- **Self-presenters:** Project paused for senior decision making at local level.
- **Patient Engagement:** Continue reporting, but collection and analysis of data to be streamlined for efficiencies.
- **MAU Staff feedback:** Planned QI coaching with the service and via the Medicine QIT to enable to service to undertake the improvement actions.
- **Patient flow at front door:** Continue to support the service in using data to monitor if the change is an improvement.

- **Frailty at the front door:** Continue to support the service in using data to monitor if the change is an improvement.
- **Avoidable harm:** Currently scoping the extent of the problem. Stakeholder engagement and quality planning to follow.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	WGH – Urology	**Period**	April – September 2024
Project/Programme title	Prostate cancer pathway improvement		
Team involved	WGH Quality Directorate		
Programme lead	Jenny Fleming		
Improvement Lead	Elise O'Leary		

1. Aim:

To reduce time taken from referral to diagnosis of prostate cancer at WGH by October 2023.

2. Background and Purpose (Why?):

The Urology service has been experiencing significant challenges across the pathway from referral to diagnosis. The 31-day pathway is expected to worsen as the current waiting time adjustments for non-standard treatment associated with robotics has come to an end in May 2022.

The current patient waiting times from referral to diagnosis are well over the target days. Quality planning conducted in 2022 has identified areas for improvement.

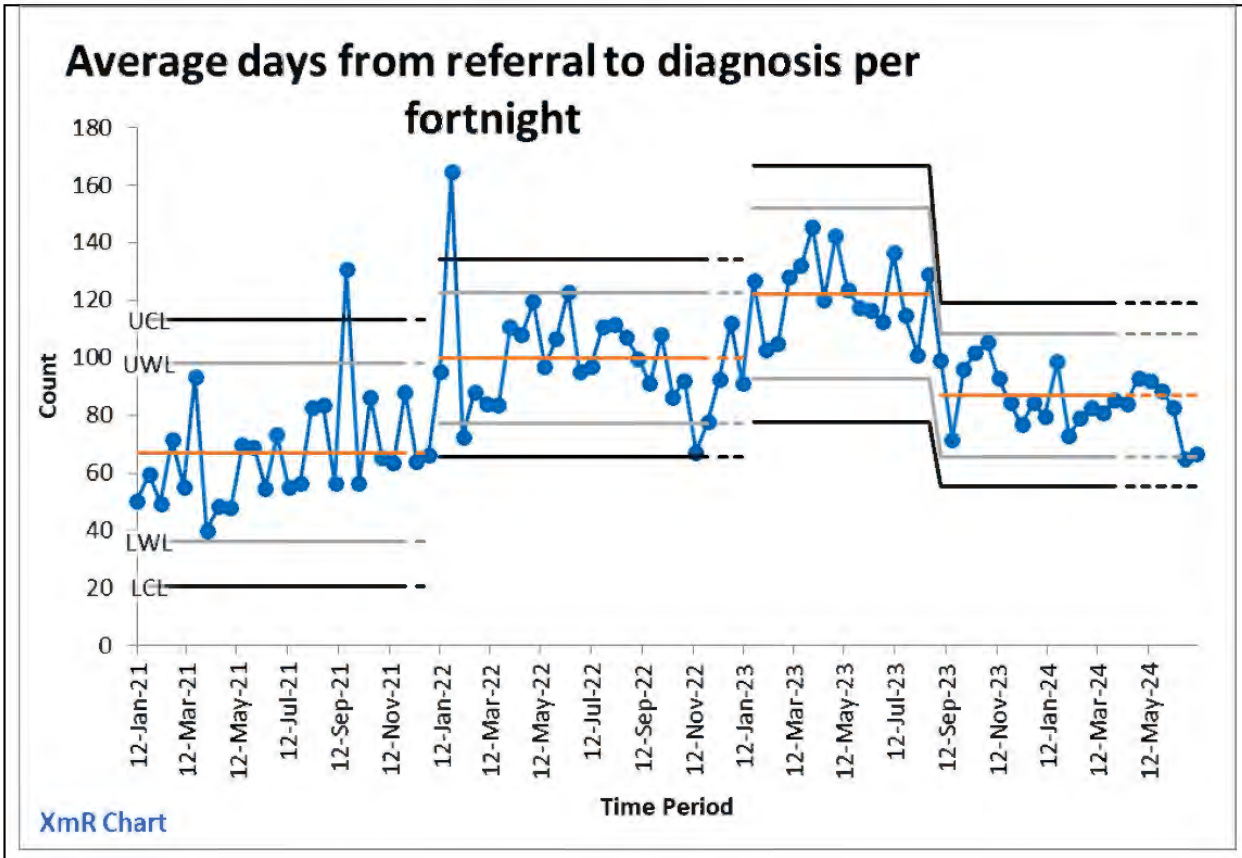
3. Key Actions and Improvements to Date:

Key actions took place over 2023, with a key change idea triaging whether a patient was required to attend for an appointment or whether the referral included sufficient information to direct the patient to MRI.

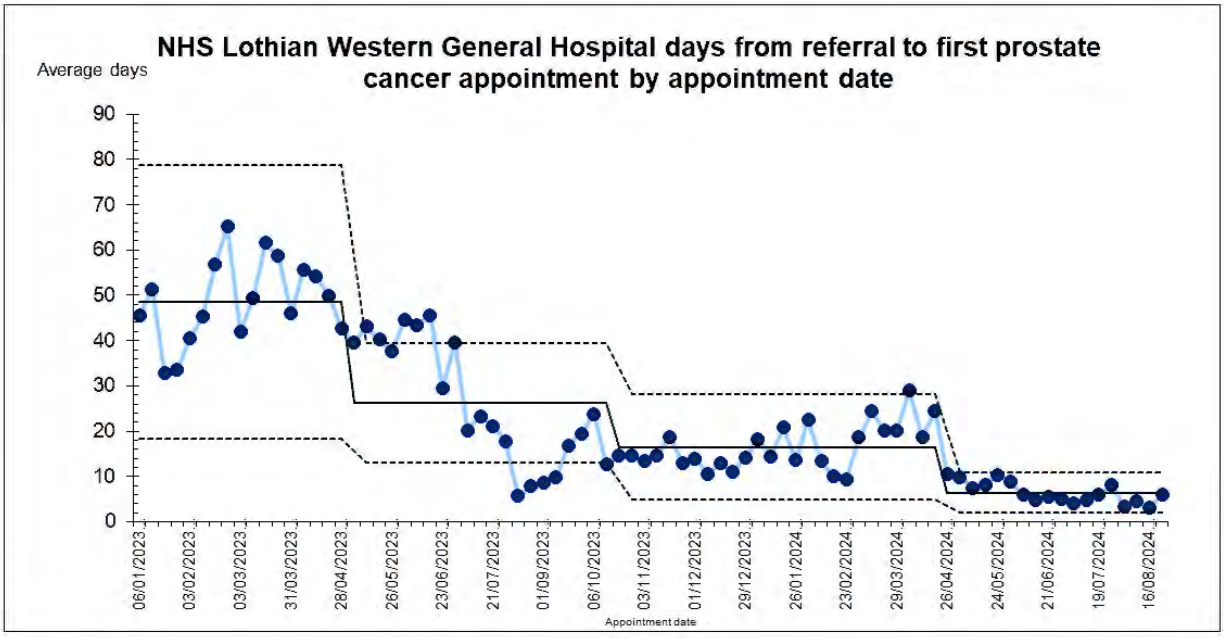
A key action within this project was developing the measurement plan and maintaining up-to-date data.

The average time for diagnosis has decreased from 122 days to 87 days. The average time to first appointment has progressively decreased from an average of 49 days at the beginning of the project to 6 days at the end of September (please see the charts below).

4. Measures/Impact/Data:



The average time for diagnosis has decreased from 122 days to 87 days.



The average time to first appointment has progressively decreased from an average of 49 days at the beginning of the project to 6 days at the end of September.

More measurement information on Prostate cancer pathway improvement can be made available on request by emailing loth.qist-admin@nhs.scot

5. Reflections/Learning Points:

Continuing to maintain the data despite not being in active improvement has been vital to see whether the change idea has resulted in an improvement, especially due to the length of this pathway.

At times, even pragmatic change ideas are not initially accepted by teams, however improvement teams should continue to persevere with creating the conditions for change and testing.

Engaging all stakeholders is vital in making improvements. For this project, working with radiology from the beginning made the change more acceptable.

6. Next Steps (Summary):

There is continued interest in this pathway and looking to improve the time to diagnosis. There are considerable challenges facing radiology capacity in coming months which will impact on this.

The project team are planning to renew this work in the new year.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	WGH Cancer Services	**Period**	June – September 2024
Project/Programme title	Breast pre-operative assessment improvement		
Team involved	Breast pre-operative assessment nurses, Breast Surgeons		
Programme lead	Jo Henderson – Clinical Service Manager Oncology		
Improvement Lead	Elise O'Leary – Improvement Advisor		

1. Aim:

By January 2025 to increase the number of patients completing pre-operative assessment per week by 10%.

2. Background and Purpose (Why?):

Breast surgery have insufficient pre-operative assessment clinic slots to match the demand. This may be impacting on breast surgery's ability to maximise usage of theatre capacity.

Pre-operative assessment clinics are scheduled providing the same amount of time for all patients, regardless of their individual factors. There is a thought that some patients are receiving more resource than is required, i.e. patients who do not have comorbidities, may be fit and otherwise well could benefit from streamlined processes and shorter appointments. Over-resourcing some patients may impact on their experience (e.g. having to come into hospital for an appointment that does not add significant value).

3. Key Actions and Improvements to Date:

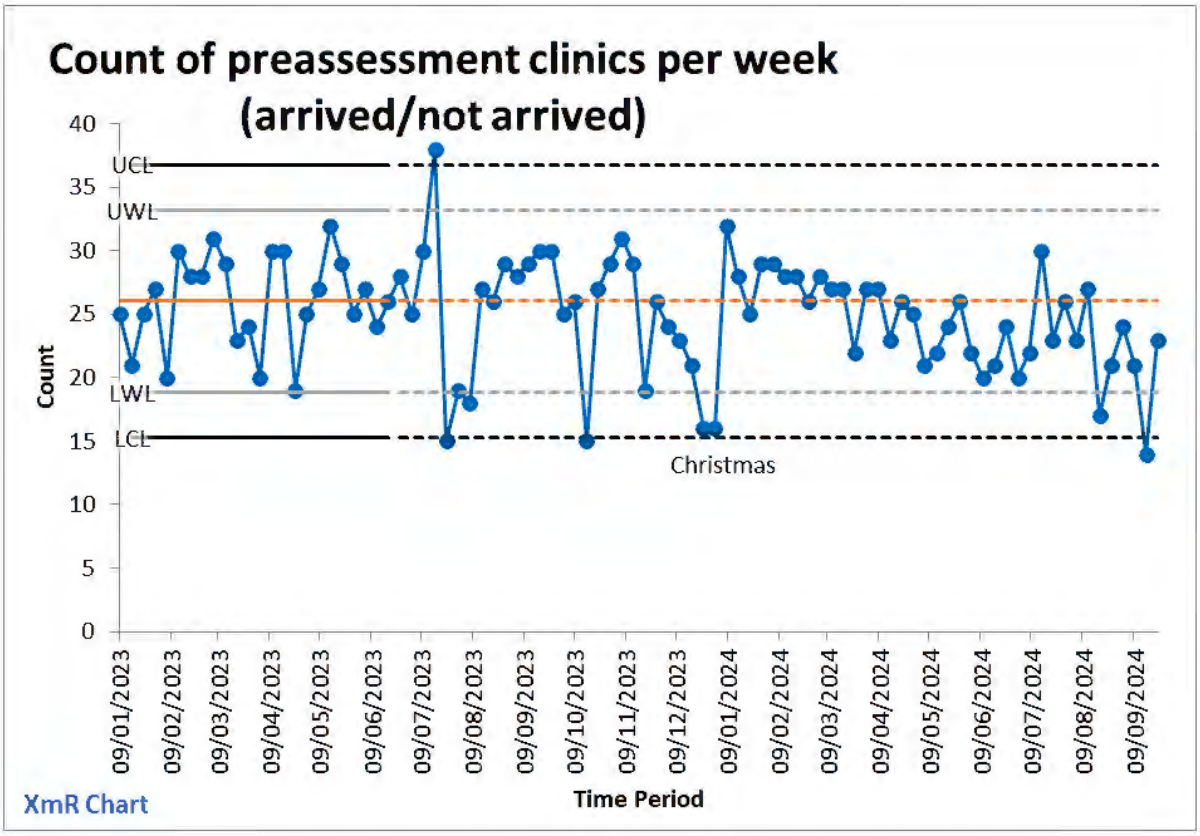
A key change idea has been identified and began testing. This idea involves patients filling in a questionnaire before attending the appointment with information relating to their medical history. This allows for nurses to determine whether patients are suitable for a phone appointment and can also allow nurses to focus on vital areas of the patient's history.

Further change ideas have been identified and will be tested in future.

In addition, the breast pre-operative assessment cohort has been identified to be a part of a NHS Lothian digital solution pilot.

4. Measures/Impact/Data:

Initial testing of the idea found that appointments were reduced by a minimum of 15 minutes (up to a 25-minute reduction for a straightforward patient).



(Count is impacted by staffing).

5. Reflections/Learning Points:

Activity and improvements have been propelled by engaged staff who know that improvements can be made.

Measurement and data collection has been inconsistent, so the team are working to determine a method to improve reliability.

A digital innovation has been discussed that would improve this service, however the group agreed to progress with non-digital interventions in the interim. This was intended to progress improvements as well as help staff to be increasingly comfortable with the concept. This has proved wise, as unexpected changes at the digital front may mean the innovation will not be introduced in Lothian for quite some time.

6. Next Steps (Summary):

To continue testing change ideas and expanding the project including

- expanding the cohort of patients included in the test
- testing changes to scheduling to increase capacity
- embed agreed upon change ideas
- determine whether this idea can be spread to other pre-operative assessment teams.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	WGH - Surgery	**Period**	June – September 2024
Project/Programme title	Endourology Pathway		
Team involved	Endourology		
Programme lead	N/A		
Improvement Lead	Sandra Ross		

1. Aim:

The aim is to identify opportunities within the pathway to reduce unnecessary appointments, save clinical and administrative time. As well as improve the patient experience and reduce risk from delayed procedures.

Project to have initial scoping before review of QI input: Planning for Improvement Phase.

2. Background and Purpose (Why?):

Within the endourology pathway there are concerns that there is unnecessary duplication (clinic visits, repeat diagnostics, return patients) that extends the pathway and puts pressure on the urology and radiology services.

Improvement of the pathway, including opportunities to streamline or reduce input from the services, would improve the care and experience of the patient.

Potential return on investment/better use of resources have been identified as:

- Reduction in admin time by reducing the number of activities [Efficient]
- Reduction in clinical time by removing unnecessary repeat clinics or diagnostics [Efficient]
- Timely escalation of patients

3. Key Actions and Improvements to Date:

- Understand the current systems and processes
- Review SAERs
  - 2 SAERs identified between 1 June 2022 – 30 June 2024
  - Review of DATIX within Lithotripsy department
- Detailed Process Map with data and timescales
  - Endourology pathway
  - Lithotripsy pathway – on day of appointment
- Staff Experience Survey - thematic analysis
- Identification and analysis of data – demand, activity and queue

4. Measures/Impact/Data:

Planning for Quality Data:

- Endourology MDM identified as key step, data from 1 July 2023 – 30 June 2024 identified 1993 new patients
  - Referral Source – ward 0.2%, outwith HB area 13%, other Lothian Hospital 0.8%, within the trust 64%, GP 22%, outpatient dept 0.05%
  - Other HBs - 32% Borders, 15% D&G, 13% Tayside, 12% FV, 11% Fife, 10% Highland, 3% AA, 2% WI, 1% GGC, 1% England/Wales/N.Ireland
  - Outcomes - 25.2% Discharge, 14.4 % Return App, 2.5% Diagnostic Test, 24.9% Review Results, 4.8% WL Day case surgery, 8% WL Inpatient Surgery, 0.2% Watchful wait, 10.4% NA, 0.3% PSA Follow Up, 0.6% WL Flexible cystoscopy, 8.6% WL Lithotripsy, 0.3% Refer to other Urology speciality
  - Time between referral and MDT meeting – average 6 days

- Review of 36 random patients on Endourology pathway – identified on daily urology WL report
  - Time between referral and MDM meeting – average 8 days
  - Time between MDM meeting and PACS – average 282 days
  - Time between PACS and planned operation - average 107 days

- Review of 20 random patients on Lithotripsy pathway – identified from Endourology MDM appointments between 9 January – 10 September 2024
  - Referral source – GP 45%, within trust 30%, other HB 25%
  - Other HBs – Borders 10%, Fife 5%, FV 10%, Lothian 55%, Tayside 20%
  - Time between referral and MDT meeting - average 6.7 days
  - Time between MDT meeting and Lithotripsy - average 27.55 days
  - Outcomes from lithotripsy appointment - 5% Cancelled – FU imaging, 10% Cancelled – FU URS, 5% Cancelled – new date, 5% Discharge, 40% FU – imaging, 20% Further Litho, 5% - NA, 5% Not required – stone passed, 5% Transferred – pt infection

- Staff experience themes
  - What works well?
    - Team working and good, open communication
    - Clear referral pathway to MDM
    - Quick appointments for patients
    - Everything is handled by ourselves in the department, very streamlined process
    - Having all the information concerning the patient on the day
  - What would be even better if?
    - Difficult to access URS on CEPOD
    - Patient letters done more often
    - Quicker results from diagnostic tests
    - More capacity for procedures, reduce wait times for patients
    - Additional staff to manage workload
  - Any ideas for improvements?
    - More training for CEPOD staff re URS and laser. They happen so sporadically, competence can be difficult
    - Increasing capacity for endourology cases
    - Improve timeliness of results being communicated, reduce patient telephone calls

Copies of the Endourology Pathway Process Map and Dataset can be made available on request by emailing loth.qist-admin@nhs.scot

5. Reflections/Learning Points:

We were asked to support this project and it was approved at the WGH QI Programme Board for a 4-week scoping period. However, we spent a period of time looking for the initial data which would have been good to have prior to discussing at QI Programme Board and seeking approval.

Due to the summer period, it was difficult to engage with staff timeously due to annual leave, as well as sick leave, which did have an impact on the timeline.

Referrals into the pathway are dealt with extremely quickly and generally discussed at the MDM meeting within 1 week. When patients are on the lithotripsy pathway they are dealt with 'in-house' by staff and it is felt that due to these patients experience a safe, quick and effective pathway. However, it is noted that there are also additional patients that are not seen via the MDM meeting that are within this pathway that are harder to track.

6. Next Steps (Summary):

Discussion with Clinical Service Manager in September to share findings and to agree the potential next steps:

- Direct project support has ended, and potential support is via coaching as requested.
- CSM and Urology Lead to determine potential next steps from highlighted areas:
  - The patients seen at the MDT meeting with an operation outcome, due to the long timescales between waitlist, pre-assessment, and operation date.
  - Lithotripsy pathway - those patients that bypass the MDT meeting, additional diagnostic imaging following the appointment.
  - Referrals from other health boards (non-lithotripsy patients).

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

The Royal Infirmary of Edinburgh

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	RIE	**Period**	April – September 2024
Project/Programme Title	RIE Site Quality Programme		
Team Involved	Liz Bream, AMD Quality & Safety Lesley Morrow, Quality & Safety Lead Elli-Noora Salo - IF Vasudha Singh - IA		Emma Ford, Det Pat AIA Emma Hearn, IA Sally Dowie, Administrator Ife Ajalam AIA
Programme Lead	Lesley Morrow		
Improvement Lead	Lesley Morrow / Vasudha Singh		

1. Aim:

The aim of the RIE site priority planning is provide information to the leadership team to enhance & support quality management on the RIE site, to enable teams to lead data-driven, effective and robust improvement through the establishment of a site quality improvement programme which will contribute to patient safety/patient outcomes.

Det Pat:

- The aims are to sustain the current Cardiac Arrest rate reduction (national aim) and reduce the number of SAEs related to deterioration (NHS Lothian aim).
- To improve observation frequency to align with the national SPSP collaborative aim of having 95% compliance with all aspects of recognition of deterioration of deterioration by June 2025

QI Bitesize/QI Essentials:

- To provide introductory QI training locally to teams undertaking QI work across the site.

2. Background and Purpose (Why?):

The RIE site has not had an improvement programme before. Establishing a programme guided by the data provided in the prioritisation plan will support the site to target improvement work to reduce the risk of adverse events which will contribute to better patient outcomes and improve levels of assurance.

Det Pat; The Scottish Patient Safety Programme (SPSP) Deteriorating Patient Programme focuses on improving the recognition, response, review, and reassessment of deteriorating patients in acute care setting. The primary aim of the programme is to reduce harm and mortality by ensuring timely and effective care for patients showing signs of deterioration. The programme uses an evidence-based approach. The 2 projects on the site are focusing on:

- Achieving an organisational learning system to learn from adverse events such as cardiac arrests and medical emergencies
- Improvement in frequency of observation – scale up and spread approach to reach all 24 wards by June 2025 – starting with 4 wards s in each cohort about to start cohort 2.

QI Bitesize/QI Essentials:

- A training resource was devised that could be delivered as 6 x 30-minute session or 1 x 3-hour session with small groups of staff to allow for interactive teaching using worked examples. These sessions were devised for staff who may not have the capacity to attend the QI Academy due to unpredictability of staffing levels. The sessions could also be tailored to the local areas needs.

3. Key Actions and Improvements to Date:

Data has been gathered from Datix and Stakeholder meetings to identify where to focus improvement work. The data was triangulated with data from the LACAS RIE Inpatient Quality Report July 2024 and key areas of focus were identified. The information was collated into a prioritisation plan which was presented to site leadership team for agreement. The Focused improvement activity in specific areas identified through data are:

- Falls
- Pressure Care
- Medicines Safety
- Deteriorating Patient – projects already established

The improvement work will be done with the ward teams identified using the data. Where appropriate this work will be delivered in collaboration with the LACAS team. Work has started to:

- Identify key stakeholders in each focus area
- Discuss any barriers to engagement and address
- Identify teams in each area of focus to work alongside
- Agree improvements aims, and discuss change ideas
- Agree measures for each programme of work and produce measurement plans
- Provide summary of QD plans in flash report format to site Management Team at the beginning of each month.

4. Measures/Impact/Data:

No measurement plans in place yet.

Det Pat - data widely shared in site reports.

5. Reflections/Learning Points:

Quality Planning Phase has taken a lot longer than was intended – should have presented to site leadership team in July 2024.

Staffing challenges.

Takes a lot of time and effort to pull together – lots of moving parts, data sources etc.

Know more now than I did at the beginning about Datix but a lot more to learn.

Providing data and discussing its validity with teams has been good for relationship building.

Collaborative working with LACAS has strengthened relationships with wards as we present a united front – more trusted because we are working with the LACAS nurses.

6. Next Steps (Summary):

A Quality Plan for each of the 4 work programmes will be pulled together. Have started meetings with the selected ward teams to go through their data and establish project teams.

- Implement Tests of Change
- Coach teams on QI methods
- Capture data - Provide data workbooks for each ward as appropriate
- Pull data reports from TRAK where possible
- Produce monthly flash reports

Det Pat:

- Implementation of use of NEWS2 Overview boards in RIE site processes including site safety huddles, safety meetings and out of hours working models.
- Cohort 2 wards have now been identified – 4 more wards – to meet with cohort 1 wards to share learning and get cohort 2 started with their improvement work.

QI Bitesize/QI Essentials:

- The QD team will continue to build capacity and capability in improvement methodology to support both Quality and Service Redesign programmes across the site.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

St John's Hospital

Projects / Workstreams:

1) Gentamicin
2) Frailty
3) Missed Medications
4) Deteriorating patient collaborative
5) QI in Medicine
6) Building a QI network in St John's Hospital

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	St John's Hospital	**Period**	April – September 2024
Project/Programme Title	St John's Quality Improvement Programme		
Team Involved	St John's Hospital		
Programme Lead	Susi Paden		
Improvement Lead	Susi Paden		

1. Aim:

1) **Gentamicin**
Draft Aim: By February 2025, there will be an *x% reduction in errors recorded in Datix for Gentamicin on St John's Hospital site – * *to be confirmed.*

2) **Frailty**
Draft aim: To improve patient experience and communication around frailty plans for frail patients assessed by the frailty team at St John's Hospital.

3) **Missed medications**
Draft aim: To reduce the number of missed doses of analgesia and aperient medications for patients, who lack capacity, in Ward 25 St John's Hospital.

4) **Deteriorating patient collaborative**
Recorded observations for all patients to meet the national standard of 95%, for wards in the deteriorating patient collaborative by February 2025.

5) **QI in Medicine**
To improve quality improvement capability, capacity and recording for the St John's medical teams by June 2025

6) **Building a QI network in St John's Hospital**
To improve the capability, capacity, and engagement of staff in Quality Improvement across St John's site.

2. Background and Purpose (Why?):

1) **Gentamicin**
The process for the prescribing, administering, and monitoring of Gentamicin (Gent.). is complex. Improving these processes, has the potential to save time, be more efficient and reduce avoidable harms. Errors associated with Gent. are related to patient safety concerns. If levels are too high this can result in Acute Kidney Injury (AKI) and/or ototoxicity (vestibular or hearing loss). If levels are too low this can mean infection is not treated and potential for further deterioration.

2) **Frailty**
The frailty team recognise that the recommendations within the frailty assessments are not routinely acted on which can result in unnecessary delays, duplication of steps and lack of continuity of care for frail patients. They wanted to improve the overall patient experience by testing out case loading.

3) **Missed medications**
Missed medications can lead to distressed behavior for patients who lack capacity due to living with dementia or delirium. To improve patient outcomes and experience it is imperative to ensure that they receive all prescribed medications or to ensure covert pathways are considered. It is evident that some patients with incapacity are frequently missing medicines which leads to a poor experience for both patients and their carer's.

4) **Deteriorating patient collaborative**
A deteriorating patient collaborative has been developed to co-ordinate and share learning around processes and practice in relation to observation frequency. This is in line with the Scottish Patient Safety Programme, which aims to reduce mortality and harm for people in acute hospitals by reliable recognition and response to acutely unwell patients. This collaborative involves 6 ward areas.

5) **QI in Medicine**
The newly appointed medical QI leads recognised the need for improved pathways and processes to support Doctors in Training to engage with quality improvement projects. This encompasses knowledge and skills to engage, sharing of results and learning and ensuring clear handover at the end of rotation. This project will ensure continuity of projects, less duplication and reduce waste and ensure more efficient use of resources.

6) **Building a QI network in St John's Hospital**
Over the last 4 years the Associate Quality Improvement Advisor (AQIA) has focused on developing a QI network in St John's. The network development involved establishing positive working relationships across the site and crucially with site management. Increasing knowledge and skills of staff in relation to QI aimed to support their meaningful engagement in QI projects and initiatives. This was supported by the provision of Bitesize, Introduction to QI courses, coaching support for local projects and QI leadership on projects where required.

3. Key Actions and Improvements to Date:

1) **Gentamicin**
- Multi-disciplinary project team developed with regular meetings.
- Extensive multi-disciplinary process mapping completed.
- Staff experience survey
- Snapshot audit data to identify common errors in processes.
- Measurement plan developed.
- Tests of change identified, to be agreed.

2) **Frailty**
- Process mapping completed.
- Staff experience data collected.
- Patient journey data collected and to be collated.
- Test of change to be identified.

3) **Missed Medications**
   - Multi-disciplinary project team developed.
   - Process map developed.
   - Staff experience data collection commenced.
   - Qualitative data in form of patient stories collected.
   - Tests of change to be identified.

4) **Deteriorating patient collaborative**
   - Data collection for 6 ward areas (5 patients per week/20 per month)
   - Data charted and shared with ward team at QI huddles and with senior nursing leadership team.
   - Ward process maps developed.
   - Ward specific fishbones developed.
   - Tests of change to be identified across all 6 wards.

5) **QI in Medicine**
   - MEDAS QIT re-designed and commenced meeting.
   - 'How to get started with a QI project' guide developed
   - Medicine specific project charter developed for testing.
   - SJH Medicine QI page on Lothian QI website established.
   - Database for collation and co-ordination of projects developed.
   - Celebration event of projects to be planned.

6) **Building a QI network in St John's Hospital**
   - Regular Bitesize QI sessions delivered.
   - QI coaching to teams and clinicians
   - Leading on quality planning
   - Active project support
   - Relationship building and development.
   - Representing QI at local site management meetings
   - QI presence in SJH newsletter

4. Measures/Impact/Data:

Copies of the undernoted supporting documentation can be made available on request by emailing loth.qist-admin@nhs.scot

1) **Gentamicin**
   - Measurement Framework
   - Project Driver Diagram
   - Learning from Process Mapping and Tests of Change
   - Process Map

2) **Frailty**
   - Process Map
   - Quality Planning

3) **Missed medications**
   - Process Map

- Project Plan and Data Presentation

4) Deteriorating patient collaborative

- MAU Data

> Data for MAU –collected routinely since November 2021. Performance compliance reduced following the introduction of NEWS on Trak

- Ward 18 Data

> Data for ward 18 – collected weekly from July 2024. This is a surgical ward with a tight routine which is demonstrated in their compliance data.

- Barriers and Change Ideas (Driver Diagram)

> Barriers to observations being carried out at the correct time, as identified by collaborative wards.

5) QI in Medicine

- Medical (Driver Diagram)

6) Building a QI network in St John's Hospital

- Coaching – 68 coaching sessions held April-Oct 2024
- Bitesize – 32 attendee's April – Oct 2024
- Awarded 'Team of the Month' for September, nominated by Lead Pharmacist Lynne Merchant.

➢ Teaching and training: e.g. delivering bite size QI sessions

➢ Support: e.g. offering coaching clinics and direct to service support

➢ Project support, with reporting through SJH CMG. Current project list includes:

- Deteriorating patient site report
- Deteriorating patient collaborative
- Gentamicin
- Omitted meds on W25
- Frailty
- Medical QI infrastructure

This nomination is being made to specifically recognise the input Susi has given to developing QI infrastructures in the Pharmacy department and latterly in the medical team.

5. Reflections/Learning Points:

1) **Gentamicin**

a) This pathway is complex with multiple touch points for communication and documentation. The process from patients being assessed in the Emergency Department (ED) to transfer to MAU creates many opportunities for this to go wrong and negatively impact on the patient.

b) It is essential to take a multi-disciplinary approach to this work and ensure we identify the correct areas to focus our improvement work.

c) Creating a measurement framework that is not too arduous on clinical staff is essential.

2) **Frailty**

The frailty team are enthusiastic and keen to progress to testing changes however the discharge landscape and assessment process at the front door has become more challenging due to a number of pilots from the HSCP. This has impacted on their ability to progress with this project as they waited to see how these would develop and the impact they would have on their team. This, alongside staffing challenges has resulted in the project being paused until the team feel ready to re-engage.

3) **Missed medications**

The engagement at a ward level has been sporadic which has led to several delays, this may reflect the number of different improvement projects that the ward is involved in. The multi-disciplinary project team are all new to QI and it requires a clear sense of direction and leadership going forward.

4) **Deteriorating Patient Collaborative**

Taking a collaborative approach to this project has ensured clear leadership at a nursing level. This has made a positive impact on the renewed sense of focus and communication to nursing staff. The teams have required considerable support to engage in quality planning and identifying potential tests of change. It is interesting to note that the data for compliance around observations has deteriorated since the introduction of NEWS on Trak. The teams are currently exploring why this may be and generating change ideas to improve performance.

5) **QI in Medicine**

This work has led to the refreshed MEDAS QIT being re-established after a break of over 4 years. This will allow an appropriate forum for discussion, agreement, and support for QI projects in medicine. The meeting is open to all disciplines working in medicine, to ensure a multi-disciplinary approach.

It is hoped that the website presence will bring the QI experience for medics at St John's up to date and give a more relevant feel. The database and project charter will allow for better co-ordination of efforts and ensure continuity of projects.
The QI medicine leads are enthusiastic and keen to make a difference.

6) **Building a QI network in St John's Hospital**

The progression of building a QI network in St John's has made steady progress over the years and is in a positive place currently. Staff are engaged and motivated to consider projects and work toward improvements. The AQIA is a member of key meetings such as the Quality, Risk and Governance meeting, the Pharmacy Improvement and Innovation Group, the Site CMG, QIT meetings. A presence in these meetings has allowed for further relationship development, raise awareness of QI methodology and the ability to provide QI leadership. St John's is a tight knit community and staff work hard to make a difference and do their jobs well. I've learned that relationships are vital here and the key to successful engagement.

6. Next Steps (Summary):

1) **Gentamicin**
This project has been temporarily paused in recognition of fluctuating conditions for change within focus ward and the absence of a key member of the project team. A review meeting is scheduled for 7/11/2024. Due to the AQIA leaving post there will be a gap in QI leadership within this project.

2) **Frailty**
This project has been paused at the request of the frailty team until their staffing levels stabilise. They are keen to continue with it and are connected with the HIS Frailty Learning System online.

3) **Missed medications.**
This project is being handed over to the Lead Nurse for LACAS as the new project lead. The recommendation is to complete staff experience to understand and highlight the barriers, engage more with medical team and pharmacy, and develop an overarching driver diagram to aid the flow of this project and support it to keep on track.

4) **Deteriorating Patient Collaborative**
Due to potential gap in QI leadership the CNM will take this forward with ward staff. Key members of the ward team will be trained in the audit and data gather processes. The team will still require QI support with this on an ongoing basis.

5) **QI in Medicine**
The MEDAS QIT should continue to meet to identify, discuss and co-ordinate improvement projects. The database will need to be kept up to date to be relevant and helpful. On going QI coaching support will be required for medical staff.

6) **Building a QI network in St John's Hospital**
The AQIA is leaving post and cover arrangements have not yet been decided.
Training will be paused at this current time due to this.
Coaching may be provided centrally by others in the QI team.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

Royal Hospital for Children and Young People

Projects / Workstreams:

1) Deteriorating Patient Programme
2) Pediatric at home IV Ceftriaxone - Ambulatory IV Cef
3) Support RHCYP QIT meetings and site priority coaching
4) Bereavement Pathway

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	RHCYP	**Period**	November 2024
Project/Programme Title	SPSPP Deteriorating Patient Programme		
Team Involved (DetPat/Resus Group)	Laura Fraser CD, Wendy Ford AQIA, David Armstrong Cons, Lewis Doult CNM, Sarah Archibald CSM, Karen Burke Pharmacy Lead, Paul Leonard Cons, Stephen Hartley Lead RO, Joni Wilson RO, Emma Hearn QIA, Andras Husz Cons, Lindsay Reid Cons, Mairi Stark Cons, Alistair Baxter Cons		
Programme Lead	[redacted] Laura Fraser CD, Peter Campbell AD,		
Improvement Lead	Anne Porter AQIA		

1. Aim:

To reduce harm from deterioration by improving the recognition, response and review of the deteriorating child and young person. (Date not yet confirmed by the RHCYP team)

2. Background and Purpose (Why?):

As part of the HIS SPSPP programme RHCYP along with 13 other boards across Scotland are taking part in this collaborative to improve the recognition, response and review of the deteriorating child and young person.

3. Key Actions and Improvements to Date: Taken from last HIS submission (Oct 31, 2024)

1. Setting up a dedicated database to record 2222 activity and themes to inform future improvement activity.
2. PEWS routine weekly ward audits to include compliance against local ward documented frequency requirement with fully correct scoring.
3. Backslash for PET calls form now live on TRAK and in use to enable clinicians to effectively record PET calls. Quality Directorate to monitor frequency of use of the form against PET calls made. PET call information obtained via BOXI reports and followed up on TRAK.
4. Ongoing work relating to trending PEWS and outreach reviews following escalation.
5. Improving recognition of Deteriorating patient, PEWS score not the only indicator, staff & carer concern very important. 125 previously audited CHIs from the 5 inpatient wards to be reviewed to identify signs of early staff or family concern. Learning points from potential near misses to be shared with the Det Pat /Resus group and used to inform PET training.

6. Systematic review of unplanned admissions from RHCYP wards to Crit Care have identified evolving themes. Learning points from these events have been incorporated into MDT PET training and have informed a change of a SOP at ward level.

7. Introductory PET sessions have been held with a view to some of these colleagues joining the faculty over the next reporting period. Learnings from these sessions have been documented and circulated via everyone email throughout RHCYP.

   Copies of the learning points from these sessions can be made available on request by emailing loth.qist-admin@nhs.scot

8. Progress has been made with identifying additional nursing and medical colleagues to join the MDT PET faculty.

9. Local agreement and sign off on a policy for frequency of routine blood pressure recording to be confirmed.

10. Setting up a toolkit for Structured Review of Deterioration Response. Current tool used in adults has been submitted to RHCYP for consideration and suitability for paediatrics.

11. PEWS on TRAK now live in the 5 in scope inpatient wards. PEWS on TRAK project team still visible on site for ongoing support as required. A summary of the initial feedback collected by the PEWS on TRAK team has been positive and is included below.

What works well with PEWS on TRAK?

Useful and clear to see all observations in PEWS Graph. It is useful to see the PEWS trend. PEWS value on floor plan useful.

Useful to have escalation and re-escalation recorded in escalation notes and clinical notes – this will improve the clarity of communications across teams.

Functionality is straightforward, self-explanatory & user friendly.

Automatic escalation notes will be good for audit purposes.

Observations paused functionality is easy to use for patients moving to PCCU.

Consultant in SJH Child Ward was very happy to have PEWS on Trak.

What doesn't work so well with PEWS on TRAK?

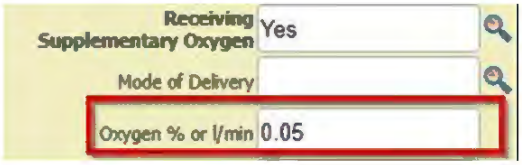
It was more time consuming to record observations initially, but this improved throughout the week. Being on the computers will mean spending less time with patients.

Challenging when using the split screen on laptop to review PEWS Graph and update clinical notes simultaneously.

ED specific - It would be useful to not have to use the ED Triage screen as well as PEWS on Trak.

Even better if?

Work is underway to allow this field to go to two decimal places.



12. Hybrid joint DET PAT/RESUS group meetings at frequency of 6 per annum. Optimum time slot to maximise MDT attendance not yet established.

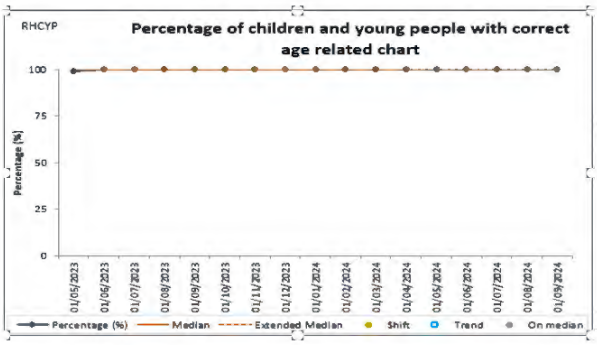
13. Escalation boards to be finalised and placed in the inpatient wards.

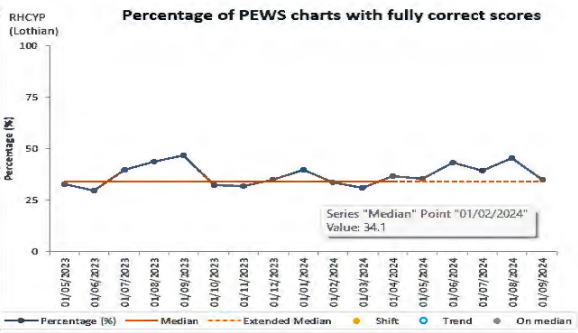
14. Structured reviews are carried out and to be included in medic job plans. (Some system changes may be needed depending on number of outreach reviews, watcher status numbers, recording of reviews, and the time needed to formalise this) Some short codes also require reviewing.

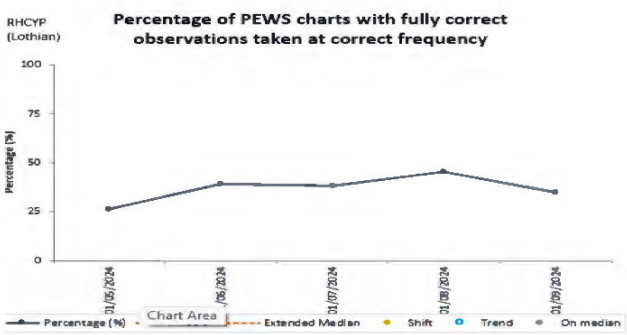
4. Measures/Impact/Data:

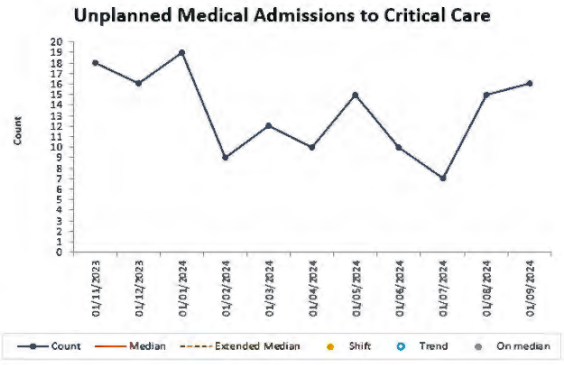
Copies of the supporting documentation / additional measurement data can be made available on request by emailing loth.qist-admin@nhs.scot

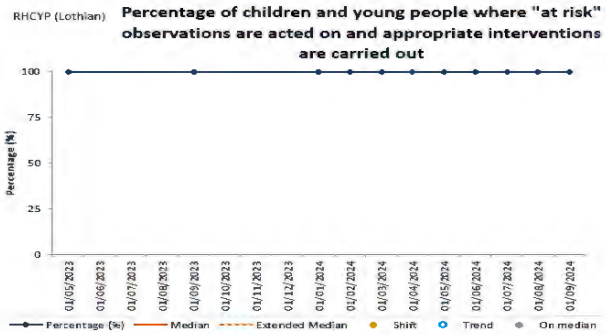
Charts are compiled from the weekly PEWS audits and submitted quarterly to meet the requirements of the collaborative.











5. Reflections/Learning Points:

Good engagement from the RHCYP ward teams and medics especially following the establishment of the joint DetPat/resus group. The lack of local documented BP policy is challenging, BP frequency appears to be an issue across all the boards. Some clarity at local or national level would be helpful. PEWS on TRAK is an excellent tool, the downside being the loss of the regular weekly contact with the wards.

6. Next Steps (Summary):

Continue to audit 25 patients per week across the 5 in scope wards using PEWS on TRAK.

Work with the 5 in scope wards to ensure accountability for missed BP is documented correctly on PEWS on TRAK. BP is the most frequently missed parameter.

Continue to engage, work with and support actions generated via the DetPat/Resus meetings. Have interim meetings with Laura Fraser (CD PICU) to ensure continuity of any actions.

Continue to collect information and submit quarterly update reports to HIS.

Collect PEWS on TRAK user feedback from the 5 inpatient wards to include with the Jan 25 SPSPP submission. Use the 3QI questions. Information gained will be shared with the Det Pat/RESUS group & may also be used to inform future training.

Record all 2222 activity and themes via newly established database. Monitor themes to inform potential improvement work.

Following the recent HIS SPSP learning session agree format for Structured Review of Deterioration Toolkit. Commence use of Toolkit for Structured Review of Deterioration Response. Current tool used in adults has been submitted to RHCYP for consideration and suitability for paediatrics.

Monitor use of the PET backslash form completion compared to actual PET calls made.

125 previously audited CHIs from the 5 inpatient wards to be reviewed by medic to identify signs of early staff or family concern. Learning points from potential near misses to be shared with the Det Pat /Resus group and used to inform PET training.

Plan to attend RHCYP huddles.

Note - Local BP frequency policy has not yet been finalised. (For PEWS Audits BP frequency is measured against ward documented frequency).

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	RHCYP	**Period**	November 2024
Project/Programme Title	Paediatric at home IV Ceftriaxone - Ambulatory IV Cef		
Team Involved	Jenny Gallagher CNM and the community nursing teams, Karen Burke Pharmacy, Laura Jones Cons, Angie Hood SCN,		
Programme Lead	Sonia Joseph CD, Nicola Davidson CNM		
Improvement Lead	Anne Porter AIQA		

1. Aim:

Paediatric OP IV Therapy – reducing numbers of children under the age of 16 attending hospital for Ambulatory IV CEF by introducing a home IV CEF service in the community.

2. Background and Purpose (Why?):

Progressing the work on home IV administration is an essential part of better patient experience. The hospital is experiencing significant bed pressures, the provision of administration of home IV antibiotics would release capacity within the Dirleton ward (Mon to Thu) and the 5 inpatient wards that provide the service over the weekend.

Given the systems pressure the hospital is experiencing, looking at home IVs is to be prioritised as a piece of important work for the hospital.

The government have allocated some money to look at hospital at home programmes/improvement work, funding has been secured and used to purchase the BRAUN syringe drivers required.

3. Key Actions and Improvements to Date:

Draft Administration of Intravenous Antibiotics (Children Community) Policy and Single Checking Procedure has been written which will regenerate further considerations and comments.

Drafted Community Children's Nursing specific SOP and SCP, discharge checklists and patient information leaflets; these will need further review once there is clarity on the service NHSL are going to provide.
BRAUN syringe drivers have been purchased and adjusted to suit the paediatric population.

Community team allocated work schedules that now include future home IV fixed timeslots.

IV CEF project presented at the RHCYP Senior Management Team meeting. Approval given to proceed with SIM testing and testing on 1 patient in the home. (Suggested that the PDSA template be used)

4. Measures/Impact/Data:

IV Cef Family Feedback Summary and Ambulatory IV Cef Data can be made available on request by emailing loth.qist-admin@nhs.scot

5. Reflections/Learning Points:

Project has been slow to progress despite having strong support from the RHCYP site. Availability of staff to attend meetings and proceed work contributed to the delay.

As this is a project to introduce a new service a case was built to support the need for it. (please see slide pack and feedback in section 4) The learning from this was the extent of the data required, time commitment to collect it and the MDT involvement needed.

6. Next Steps (Summary):

IV CEF project presented (by Programme Leads) and approved at the RHCYP Senior Management Team meeting.

Provisional Community Nurse onsite training dates in place (attendance for training dependent on IV CEF patient availability on site) Training carried out by RHCYP Dirleton team.

Full SIM training currently being considered. Possibly tabletop SIM as an alternative.

Pharmacy IV monograph draft completed. (No additional pharmacy provision for this project).

In progress – confirming frequency of IV CEF extravasation injury as this would require admittance to RHCYP.

Community nurse work diaries prepopulated with home IV 2-hour time slots in advance of introduction of home IV.

2 nurses to attend initial appointments. Possibility of 1 nurse only remaining for duration of future appointment.

Family/carer/patient feedback continues to be collected via JISC.

Consider using PDSA template with 1st cohort of home IV CEF patients.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	RHCYP	**Period**	November 2024
Project/Programme Title	Support RHCYP QIT meetings and accommodate site priority coaching requests		
Team Involved	RHCYP Medics, AD, AMD, CNMs, SCNs, AHP, Pharmacy as available to attend		
Programme Lead	Sonia Joseph QIT Chair, Nicola Davidson Co Chair		
Improvement Lead	Anne Porter AQIA		

1. Aim:

To support, inform, communicate, and work closely with the RHCYP QIT Chair and Co-Chair to ensure that reporting of all active site priority activity is timely and correct.

2. Background and Purpose (Why?):

Following the move to the new site the QIT was paused.

With an updated TOR the RHCYP QIT was restarted and meets monthly in person and on TEAMS.

QI project updates are provided, and new work is discussed to ensure it aligns with site priorities.

This is a joint surgical/medical QIT as the site was deemed too small to accommodate 2 separate QITs.

3. Key Actions and Improvements to Date:

Built and maintained strong relationships across the RHCYP site. Excellent feedback from QIT chair in relation to project teams previously supported by QI.

Ensure timely project updates are available in advance of each QIT.

Maintain and share a database of all the projects, audits and service improvement work on the site.

The database is currently (work in progress) being updated to be a more automated tool that can be updated and shared between the Business Team and the Quality Directorate. New projects, audits and service evaluation forms once completed will populate the database and generate progress reminder requests.

Coaching RHCYP Quality Academy attendees when required. Accommodating ad hoc coaching requests and supporting smaller projects. e.g. ANTT compliance audit/project in Lochranza ward. *Note – also currently coaching 3 x RIE Quality Academy projects for Cohort 28.*

4. Measures/Impact/Data:

Since its inception in March 2021 the project database currently has 186 recorded QI activities. 48 Audits, 22 Service Evaluations and 116 QI projects.

The business team as part of the modernisation of the project database are currently following up on all the projects, audits and service evaluations. Historically replies to requests for updates has been poor due to staff turnover, FY rotation or project work stopping/stalling due to time pressures and clinical demands.

The distribution of the coaching flyer via everyone email was very successful but has currently been paused (the coaching register stands at 114 hours of coaching since Sept 2022).

One off ad hoc coaching requests received directly by email continue to be offered by TEAMS or in Person.

5. Reflections/Learning Points:

The QIT is a useful and valuable meeting that quickly provides a good summary of activity across the site and an excellent opportunity to engage with the senior team.

Although the QIT is agenda led it provides a good opportunity to ask questions and make suggestions.

The learning points gained from each QIT are due to the input from the cross section of MDT that attend and contribute.

6. Next Steps (Summary):

Continue to work with and contribute to the QIT by attending the monthly meetings and supporting QI activity and coaching requests on the RHCYP site.

Home IV and the Bereavement projects are coming close to an end. Sonia has circulated a scoping email to the site for suggestions for future QI work.

Early suggestions include a return to the earlier theatres project, ward flow from ED to Castle Mey and a national project related to patient transfer between hospitals over the weekend.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	RHCYP	**Period**	November 2024
Project/Programme Title	Bereavement Pathway		
Team Involved	Jennifer Pyper, Bereavement Lead Nicola Robertson, Bereavement Admin Support		
Programme Lead	Nicola Davidson CNM		
Improvement Lead	Anne Porter AQIA		

1. Aim:

Improving the patient, family, carer and staff experience of death and bereavement at RHCYP by streamlining the bereavement process.

2. Background and Purpose (Why?):

With frequent changeover of staff, new ward layouts and the move to a new site it was felt that in the case of a child death here was no clear pathway for teams to follow.

A Bereavement Lead (2-year post, June 23-June 2025) position was advertised and successfully recruited.

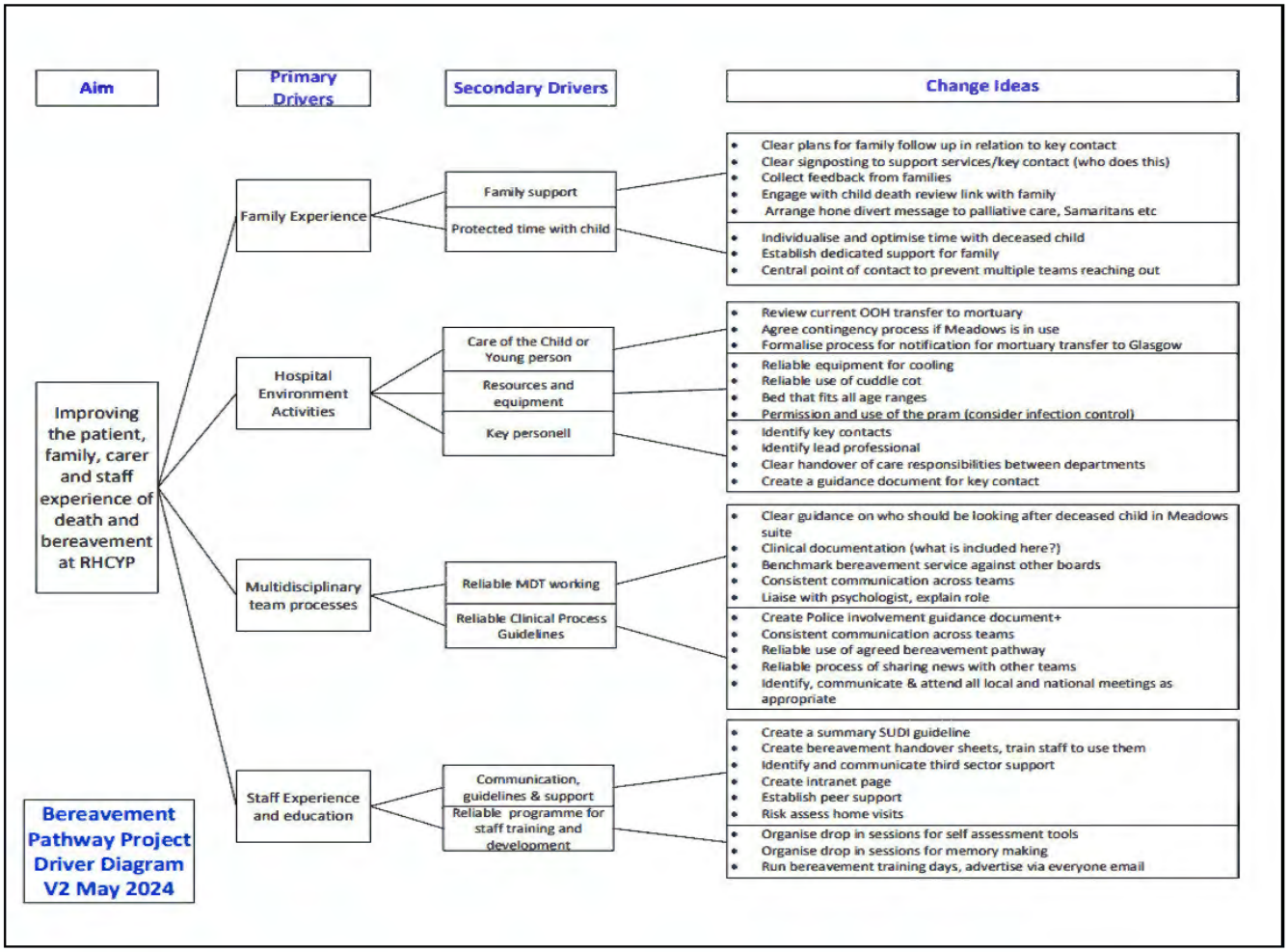
Part of the remit was to streamline the bereavement pathway and improve the family, carer and staff experience. The first process map illustrated the lack of flow in the bereavement pathway. To ensure coaching continuity (following mat leave within the QI team) the bereavement team attended the Quality Academy.

Process mapping continues with input from ED, Lochranza, Crit Care, Calareidh and Sunndach as these are the areas where most deaths are expected.

3. Key Actions and Improvements to Date:

Substantial progress has been made in implementing the change ideas included in the driver diagram (below).

Those related to Hospital Environment Activities when dependent on equipment or infrastructure are proving to be more challenging.



4. Measures/Impact/Data:

The bereavement team conducts regular bereavement training days to increase staff knowledge and confidence.

New paperwork that accompanies the patient has been introduced by the bereavement team & made available to ward teams, saving time and uncertainty. Letter templates have also been created.

Staff experience has been collected via JISC to inform future training.

Copies of the Staff Feedback - Bereavement Feedback Summary of Themes, can be made available on request by emailing loth.qist-admin@nhs.scot

*Currently collecting data relating to time the bereavement team spends on each death, to include e.g. family visits, phone calls, police involvement, ad hoc requests, procurator fiscal, transfer for postmortem, letters to the family, community support teams and emails.

5. Reflections/Learning Points:

This has been a challenging piece of work due to the nature and sensitivity of the work.

Every aspect of this project took significantly longer than expected. The ward teams are extremely time pressured and requests for input to the work were slow to return.

The bereavement team consists of 2 people and despite the death rate being low on the site the time demand from some of the families is high. Time spent with a family can exceed a duration of 1 year due to the wait for a postmortem result.

The Bereavement Team lead presented a summary of their project at a recent QIT and were able to demonstrate the benefit of using QI methodology. Excellent feedback was given following the presentation.

6. Next Steps (Summary):

Continue to support the bereavement team using the QI tools as appropriate, particularly the development of the final process map.

*Demonstrate the value of having a dedicated bereavement team by collecting data to quantify the value they bring.

Bereavement team to continue offering in person training opportunities.

Note - Nicola Robertson, Bereavement Admin Support was nominated for Team Member of the Year 2024

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

Primary Care

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Primary Care	**Period**	April – October 2024
Project/Programme Title	Quality Improvement & Safety Network - Includes the QI & Safety Enhanced Service (SESP), QI training and Cluster Quality Lead Support		
Team Involved	Rebecca Green, Clinical Lead for Primary Care Quality and Safety Sue Perkins, Quality Improvement Advisor Sarah Bennie, Associate Quality Improvement Advisor Elaine Anderson, Associate Quality Improvement Advisor Jo Edmiston, Project Officer		
Programme Lead	Sue Perkins		
Improvement Lead	Rebecca Green & Sue Perkins		

1. Aim:

SESP - At least 80% of QI projects carried out by GP practices as part of the QI & Safety Enhanced Service have an IHI score of 3.0 or above.

CQL support - To enhance & support quality management, leadership, & change management knowledge to enable CQLs to respond to and lead data-driven, effective and robust improvement.

QI Essentials training - To train at least 10 participants per cohort in QI who report an increase in QI knowledge and at 6 months post-training have used QI tools to support improvement.

2. Background and Purpose (Why?):

This programme supports the sustainable development of a strong culture of continuous and measurable quality improvement across all Primary Care services in Lothian. Our aim is to ensure care is safe, effective, patient-centred, timely, efficient and equitable with associated improved patient outcomes.

3. Key Actions and Improvements to Date:

We continue to offer the Quality Improvement and Enhanced Service to all GP practices annually as mechanism to support practices to undertake quality improvement projects supporting safe care, improved patient outcomes and practice resilience.

We also have a programme of Cluster Quality Lead support which consists of coaching sessions (focused on leadership and QI skills), a CQL Handbook plus quarterly facilitated pan-Lothian meetings. Within Clusters we established a Practice Quality Lead network last year, with an associated Handbook and Teams Channel. The team also provide regular QI training for primary care staff called 'QI Essentials' with cohorts running twice a year for 4 x 90 minute sessions, as well as adhoc coaching, QI training and support.

1. **Quality Improvement and Safety Enhanced Service (SESP):**
   - 101 practices signed up to the SESP.
     - *"Think this is a really valuable enhanced services option which TBH will likely make us do something this year which we've been putting off for 3 years! And to do it properly."*
   - 98 practices attended a Launch Workshop – 202 attendees in total. We offered one face-to-face Workshop targeted at those new to QI and/or the ES and a further 3 Workshops held online.
     - *"Using a project [at the Launch Workshop] to show how to apply all the/many QI methods was great."*
   - 100 project proposals submitted.
   - 98 Project Charters submitted (including planning tool and baseline data)
   - 79 practices have submitted a written Plan, Do, Study, Act cycle.
   - 53 coaching clinics have been held with 88 attendees (each practice must attend at least one coaching clinic). 100% of attendees agreed this was a good use of their time and addressed questions and topics that are important to the project.
     - *"[The coaching clinic] helped formulate clear objectives re next steps, data to be measured, deadlines for what needs to be submitted when and how to access help with poster development."*
     - *"Our take home messages were keep the goal as simple as possible, do not set the bar too high and keep the workload feasible in order not to discourage the team's effort, try to understand the process and its components first instead of trying to "deliver" at all cost."*
   - IHI scores at coaching clinics held to date are:
     - 0.5 intent to participate – 4 practices.
     - 1.5 planning for the project has begun – 4 practices.
     - 2.0 activity but no changes – 11 practices.
     - 2.5 changes tested but no improvement – 18 practices.
     - 3.0 modest improvement – 9 practices.
     - 3.5 improvement – 1 practice.
   - IHI scores will be updated at the end of projects.
   - To date 100% of coaching clinic attendees agree their participation in the ES has increased their knowledge of QI.

2. **Cluster Quality Lead Support**
   - Annual summary of Cluster extrinsic and intrinsic improvement collated for 2023-2024. Copies of the Annual Summary of Cluster Improvement Work, can be made available on request by emailing loth.qist-admin@nhs.scot
   - 5 coaching clinics provided to Cluster Quality Leads.
   - Two pan Lothian CQL meetings held with average 65% attendance, focused on respiratory prescribing and high risk prescribing.

3. **QI Essentials**
   - Cohort 12 (May 2024)
     - 12 attendees completed ≥3 out of 4 sessions.
     - Average self-reported knowledge across the different topics increased by 88% from 1.8/5 to 3.3/5 where 1 = no knowledge/awareness and 5 = expert, could teach on this.
     - *"It was the first time a lot of these things made sense to me! It was really useful to discuss the ideas using practical and realistic scenarios. Both the instructors were really great."*
   - Cohort 13 (September 2024)
     - 21 attendees completed ≥3 out of 4 sessions.
     - Tested an additional optional session on run charts with positive feedback.
     - Average self-reported knowledge across the different topics increased by 140% from 1.4/5 to 3.4/5 where 1 = no knowledge/awareness and 5 = expert, could teach on this
     - *"I do find your style, pace and presentation very appropriate for a non-specialist audience, with clear examples and continued offers of support. Finding teams and personnel that are actively looking outward to support others is hard to come across in the NHS just now!"*

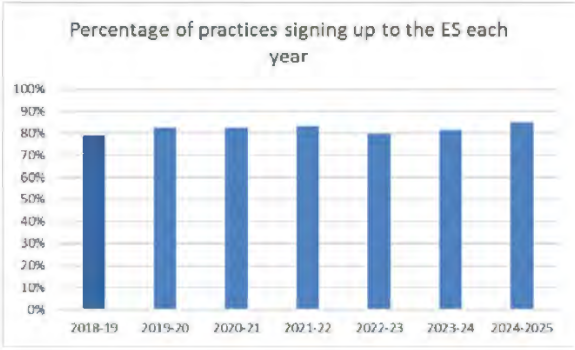
- *"I really enjoyed/appreciated it very much, and the trainers are so knowledgeable about their subject. I've learnt a lot, and really loved how well organised you guys are and the quick follow ups."*

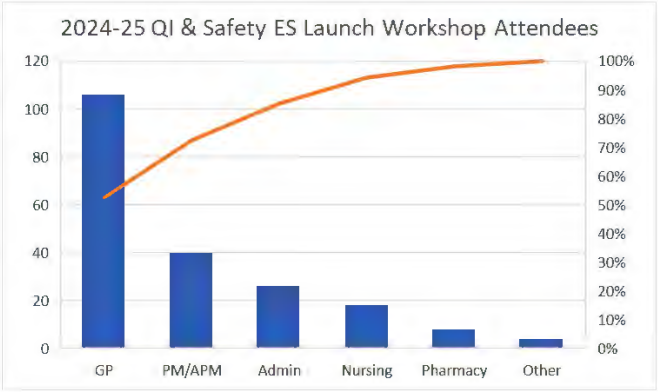
4. Other

- 22 hours of coaching provided to primary care colleagues in addition to ES coaching. Two visits to practices to provide hands on QI support for non ES practice QI work.
- Adhoc training session on Demand, Capacity, Activity and Queue delivered in May with 27 attendees.
- Two service resilience meetings facilitated with in-hours and out of hours primary care services (CQLs and LUCS) to support more informed data-driven decisions, improvements to transfers of care for patients and demand management.
- Two QI breakout training sessions delivered as part of LUCS 20th anniversary event on 10th October.

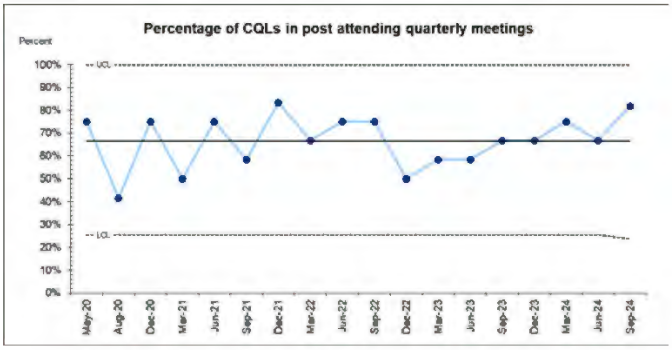
4. Measures/Impact/Data:

1. Quality Improvement and Safety Enhanced Service (SESP)

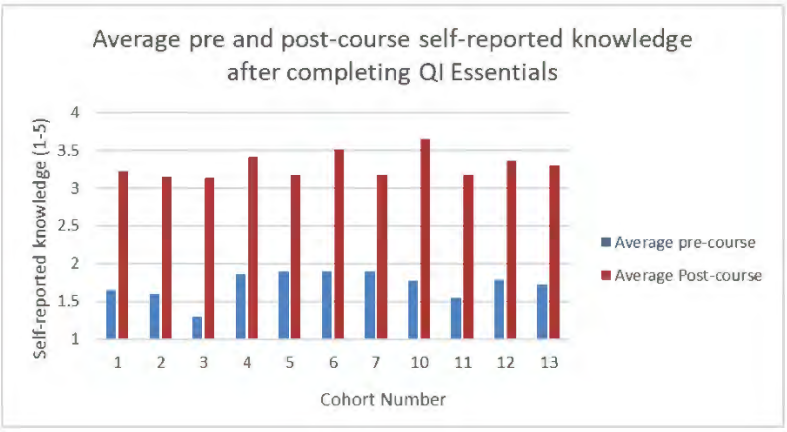




2. Cluster Quality Lead Support

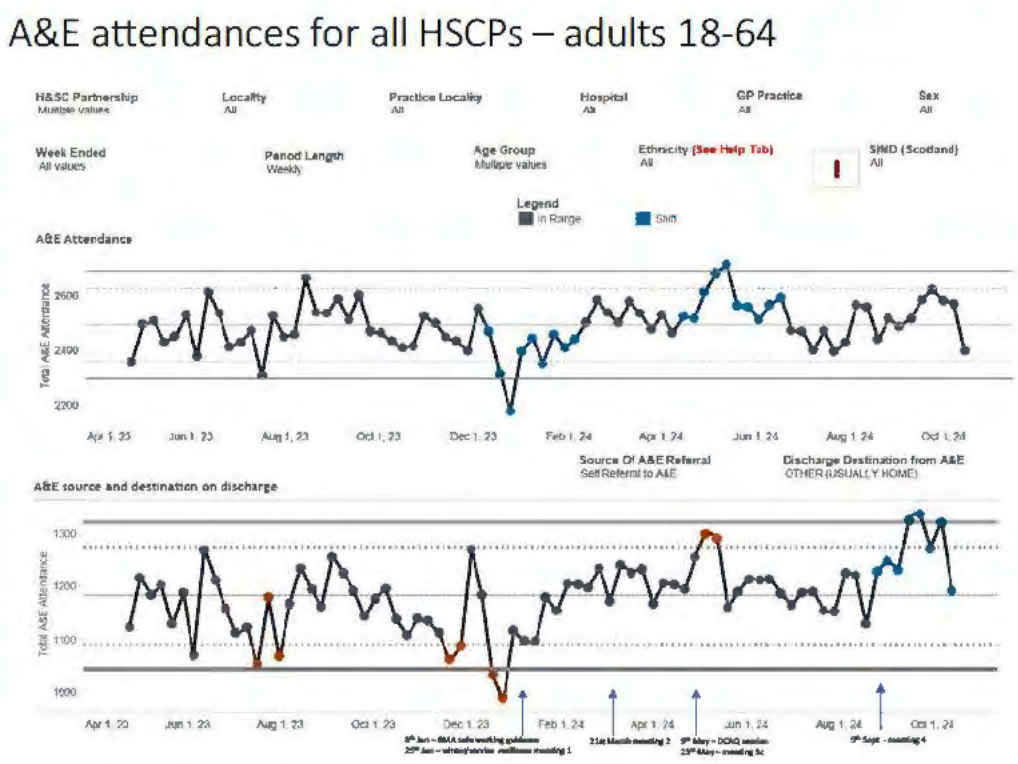


3. QI Essential Training



4. Other

There were concerns that BMA safe working guidance recommending GPs limit contacts to 25 per day issued in Jan 2024 would lead to an increase in patients self-referring to A&E. This has been a focus of discussions in the winter/service resilience meetings and DCAQ training sessions, stressing a joint approach across in-hours and out of hours care to safely manage demand. Data did not show an increase in patients self-referring to A&E who are discharged home, although there has been a shift in the data from Sept onwards.

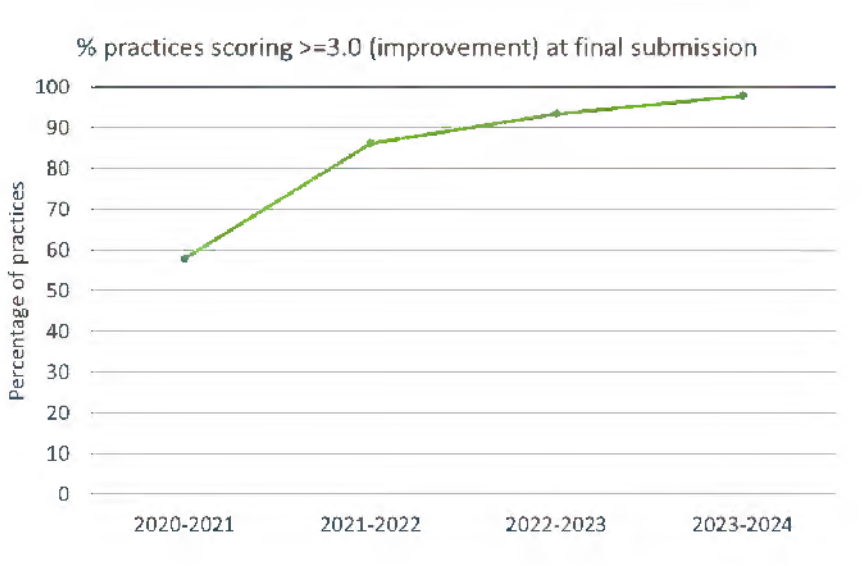


5. Reflections/Learning Points:

- Although engagement with the SESP has remained consistent there are challenges with the use of improvement methodology, particularly with data collection, analysis and display.
- CQLs understanding of data for improvement purposes is limited; CQL reporting needs to be amended to encourage the use of data over time in order to apply and benefit from run chart rules and SPC.
- There is variation in how much practices engage with cluster quality work and how much time is protected for Practice Quality Leads despite this being set out in the nGMS contract.
- There is still siloed working even for specific cohorts of patients who are a priority across the system (frail patients, those with long term conditions) which limits the impact improvements within primary care can have on patient outcomes.
- There continues to be a risk of duplication of funding for the QI & Safety ES with primary care prescribing schemes and other ES; this should reduce in 2025-2026 with the ES review and subsequent changes (see below).

- The revision of Enhanced Services means that several discontinued ES will be 'folded into' the QI and Safety ES in 2025-2026 and the requirements for the QI & Safety ES will change. Practices will be eligible for a performance payment for projects which score 3.0 or above on the IHI scale. We need to have early conversations with GP practices to ensure they are aware of this change in requirements. To date we have not shared IHI scores with practices.

- The % practices achieving IHI 3.0 or above has increased over time and therefore we may need to increase our improvement aim to reflect the maturity of the system and competence/capability in QI.



- The QI team have had limited engagement with primary care teams who are not GP practices which has mainly been through Academy and adhoc coaching.

- There are some difficulties in establishing responsibilities for supporting QI between the central primary care QI team and HSPCs.

6. Next Steps (Summary):

1. **QI & Safety ES:**
   Continue with coaching clinics are due 28th March 2025. IHI scoring will be completed after end of project requirements have been submitted including data, patient/staff experience, a poster. Participating practices are also required to send at least one team member to an end of project shared learning event.

2. **Cluster Quality Lead support:**
   Facilitate 26th November pan-Lothian CQL meeting. Revise reporting template for 2024-2025 to encourage more robust data collection and analysis. Provide coaching support to three CQLs appointed in 2024 (one CQL vacancy remains).

3. **QI Essentials:**
   Revise content for delivery of Cohort 14 in 2025. Agree whether to repeat optional run chart session or combine this with the core modules.

4. Other:

Deliver QI training session to newly qualified Practice Nurses on 7th November. Facilitate the next in-hours and out of hours service pressures meeting on 14th November. Hold coaching clinic with Edinburgh HMP.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE
MENTAL HEALTH QUALITY IMPROVEMENT NETWORK

NHS Lothian

Improvement Programme:

Mental Health

Projects / Workstreams:

1) Capacity and capability
2) Reducing Falls - Older People Mental Health (OPMH)
3) Readiness Response - Adult Mental Health (AMH)
4) Safe Care - Adult Mental Health (AMH)

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE
MENTAL HEALTH QUALITY IMPROVEMENT NETWORK

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Mental Health	**Period**	March - November 2024
Project/Programme Title	Capacity and capability		
Team involved	Mental Health		
Programme lead	Rebecca Fyffe		
Improvement lead	Susan Marr		

1. Aim:

Empower services to be self-sufficient in QI capability.

2. Background and purpose (why?):

To encourage engagement with Quality Improvement within Mental Health Services the QD supports individuals, wards and teams with small scale quality improvement projects, prioritising those projects that sit within the Mental Health programme areas.

The aim of supporting individual projects through 1-hr clinics is to provide coaching in QI tools and methodology, providing a basic understanding of QI, develop a workforce that identifies QI as a useful tool and build enthusiasm for using QI, as well identify projects with potential to share, scale up and spread to other MH service.

3. Key actions and improvements to date:

The QD continue to support individual QI clinics across MH services as well as ward-based projects.

From SAER review, clinics have been held with teams looking at different components of the Falls work

- Increasing Physiotherapist referrals and assessment.
- Reducing falls in OPMH wards.

Providing coaching for Practice Development and Improvement nurses to support improving quality and consistency of patients notes / care plans.

Supporting the Senior Management Team with bed capacity escalation, to identify key projects to scope and plan improvement.

Identify individual projects* with potential to deliver improved patient safety and potential cost savings.

- Reducing wastage of medicines due to expire on Braids ward – this has expanded and now includes identifying alternative medications and potential savings across multiple wards.
- Improving access to reports on HEPMA for Senior Clinical Staff during out of hours shifts allows for quicker access to medication needed at short notice.

- Creating a safe handover – Resident doctor project to improve handover reducing errors and improving patient safety – reduced inefficiency of handover.
- Improve community engagement with IHTT / MHAS – IHTT to review community referral process to identify areas of potential change and improvement – reduce admissions
- Improved communication between IPCU and Adult Acute wards – improving safe transitions of care between IPCU and main Adult Acute wards.

4. Measures / impact / data:

Outcome:

- No of projects identified that are linked to a priority programme or objective.
- QI clinics held.

Process:

- Number of clinics held Mar–Sep 2024 – 103 individual clinics (40 Academy coaching).

Balancing:

- Attendance at MH QI CI Forums
- Feedback on clinics held – 100% of those who completed the feedback stated that they had found the clinics beneficial to them and their project.
- SPSP Harms:
  - Physical violence
  - Restraint
  - Self-harm
  - Falls

5. Reflections / learning points:

The QI team continues to see engagement from teams keen to work with us to drive small scale improvement projects within wards or services.

Copies of a document with Project outlined, demonstrates some of the identified benefits or progress to date, and this can be made available on request by emailing loth.qist-admin@nhs.scot

Clear leadership required from SMT to ensure engagement with projects amongst frontline staff.

The current bed capacity and staffing challenges within REAS have impacted on staff capacity to work with the team on QI projects.

6. Next steps (summary):

- Continuing to provide access to QI clinics and identify those that link to MH programmes of work.
- Reviewing existing projects for impact on MH Services.
  - Orchard Clinic – Screening tool for patients taking part in physical activity – ensuring patients within a locked door environment have capability to take part in physical activity within the clinic.
  - Reducing medication wastage on Adult Acute ward – Initial project to reduce wastage has developed into a number of projects looking at medicines management across the site.
- Develop measurement plan for building capacity and capability across MH services.

What went well with QI Clinics:

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE
MENTAL HEALTH QUALITY IMPROVEMENT NETWORK

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Mental Health	**Period**	March - November 2024
Project/Programme Title	Reducing Falls - OPMH		
Team involved	Older People Mental Health (OPMH)		
Programme lead	Karen Ritchie, Clinical Nurse Manager for OPMH		
Improvement lead	Susan Marr		

1. Aim:

Reduce avoidable harm and improve safe, effective, person-centred care within the Royal Edinburgh Hospital and Associated Services (REAS) by March 2025.

2. Background and purpose (why?):

The comprehensive review of SAERs (see report "MH Safe Care") identified falls and falls with harm within Older Peoples Mental Health as the one of the largest contributors to harms data.

The Royal Edinburgh Hospital and Associated Services (REAS) Falls group discussed improvements in OPMH.

The group have a number of ideas around risk assessment/management and documentation and have identified a potential project with OPMH Physios to increase awareness of patients falls risk with nursing staff to actively reduce falls.

3. Key actions and improvements to date:

The QD provided further data e.g. times of falls in the OPMH areas, and a ward has been identified with most falls recorded, to target interventions.

A REAS 'Task and Action group' has been set up to address gaps in documentation of risk assessment and recording with an aim to increase staff awareness of patients requiring additional physio or OT input.

Physio project to increase visibility of patients at risk of falls.

4. Measures / impact / data:

Outcome:

- Number of falls
- Number of falls with harm.

Process:

- Completed risk assessments
- Number of patients with OT / Physio referral and/or assessment
- (These will be developed further as the project progresses)

Balancing

- Number of pressure ulcers
- Increase in frailty

5. Reflections / learning points:

Clear leadership required from SMT to ensure engagement with projects amongst frontline staff.

Datix recording is poor with the area of fall not recorded, making tracking hot spots challenging.
Focus on improving risk assessment and paperwork.

6. Next steps (summary):

Measures and change ideas for each project need to be identified to monitor whether changes are an improvement.

The data in REH does not yet show where falls are happening on the unit – the group will investigate how to identify hot-spots on wards.

The QD team will build an improvement team which includes physios and nursing team to start building the will to change.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE
MENTAL HEALTH QUALITY IMPROVEMENT NETWORK

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Mental Health	**Period**	March - November 2024
Project/Programme Title	Readiness response		
Team involved	Adult Mental Health (AMH)		
Programme lead	Jacquie Balkan, General Manager – AMH, Older Peoples Mental Health, Rehabilitation and Learning Disability		
Improvement lead	Susan Marr		

1. Aim:

Robust service escalation due to bed occupancy (readiness response), and the introduction of prep stat, to ensure safer management of patient flow.

2. Background and purpose (why?):

This workstream is in response to the service's needs to introduce this within the improvement programmes that the QD staff support.

Royal Edinburgh Hospital is experiencing consistent over-capacity in Adult Mental Health beds. The team has been asked to support planning work to reduce overcrowding and improve the Senior Management Team response.

Increased bed occupancy can heighten the risks to both staff and patients of incidents of harm. Staff capacity to address gaps in performance or safety concerns within their own area is hampered by the immediate needs of patients.

The QD team provides Quality Control data on admissions, discharges, mean length of stay, delayed discharges, occupied bed days and occupancy rates for both Adult Mental Health and Older Peoples mental health services. The team also provides data on recorded incidents of physical violence, restraint and self-harm as identified SPSP harms within mental health.

3. Key actions and improvements to date:

Development of escalation poster and cards for management – understand which parts of the process can be tested and developed as change ideas.

Support to develop a structured response when over-capacity within AMH services and identify changes to system – this will help to reduce the occupancy rate across adult acute inpatient services to agreed safe levels.

Continue to provide QC control data at this time to support understanding of the situation.

4. Measures / impact / data:

Outcome:

- Reduce bed occupancy rate
- Reduce Mean length of stay of ward discharges
- Reduce delayed discharges

Process:

- Number of pts identified for discharge at RRD.
- Number of RRD held.
- % of actions from daily huddle completed.
- Further measures will be determined, including methods of collecting staff feedback.

Balancing:

- Occupied bed days
- Increased staff wellbeing
- Reduced staff absence
- Increased staff retention

SPSP harms:

- Physical violence,
- Restraint,
- Self-harm
- Falls

5. Reflections / learning points:

Ward teams are keen to improve safety within their wards, however they struggle to find time to collect baseline data or consider improvement ideas whilst the adult acute wards are over capacity, which then has a knock-on effect across all wards on the site.

6. Next steps (summary):

Improving rapid rundowns on wards to inform discharges – Introduction of a revised Standard operating procedure for rapid rundowns – QI team to support data collection once rolled out.

Identify change ideas from readiness response to test.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE
MENTAL HEALTH QUALITY IMPROVEMENT NETWORK

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Mental Health	**Period**	March - November 2024
Project/Programme Title	Safe Care		
Team involved	Adult Mental Health (Adult Mental Health)		
Programme lead	Lynda Lumley, Clinical Nurse Manager for AA		
Improvement lead	Susan Marr		

1. Aim:

Reduce avoidable harm and improve safe, effective, person-centred care within the Royal Edinburgh Hospital and Associated Services (REAS) by March 2025.

2. Background and purpose (why?):

A comprehensive review and theming were conducted of SAEs, Local Case Reviews, Mental Welfare Commission recommendations, and complaints.

A copy of the Safe Care Review document can be made available on request by emailing loth.qist-admin@nhs.scot

Each of the 5 reviews, and core standards, highlights the need for improvements within the themes of:

- ✓ *Care planning and risk assessment.*
- ✓ *Case notes quality and documentation.*
- ✓ *Multidisciplinary team working and communication.*
- ✓ *Care at transitions.*

- Access to reliable care planning and risk assessment allows ward staff to plan and safely engage with patients to improve therapeutic activities and reduce the risk of harm to both staff and patients.
- Multi-disciplinary team working within wards, gives staff additional support structures to improve engagement with patients and reduce the risk of harm to both staff and patients.
- The QI team provides data on recorded incidents of physical violence, restraint and self-harm as identified SPSP harms within mental health.

3. Key actions and improvements to date:

The above paper was submitted to the Mental Health SMT, and it was agreed that that these themes would be a focus within existing MH improvement programmes e.g. Discharge, USC and Safety.

The team has sought existing clinical projects initially and to start to work with engaged teams.

Project 1

Supporting improvement with patient notes and care-planning. – To improve quality of patient notes and care-planning by March 2025. Increased compliance with Guiding Principle 1 of clinical Documentation SOP will ensure that all relevant risks and associated management are documented and mitigated for.

Project 2

Improving rapid rundowns on wards to inform discharges – Introduction of a revised Standard operating procedure for rapid rundowns – QI team to support data collection once rolled out (Not started).

4. Measures / impact / data:

Measures will include monitoring outcomes of harms:

- Physical violence,
- Restraint,
- Self-harm

Each project (1. And 2. Above and new projects) will have a measurement plan.

Project 1 (Balcarres and Craiglockhart)

Outcome:

- 100% of patients admitted to Balcarres and Craiglockhart wards will have a person-centred care plan in place within 48hrs by 30 March 2025.

Process:

- % of case notes expected completed
- % of case note principals completed

Balancing:

- TBC

Project 2

Outcome:

- Number of patients identified as ready for discharge over next 48hrs

Process:

- Number of MDT roles at RRD
- No of pt discharges discussed at RRD
- % of tasks identified / completed at RRD

Balancing:

- Length of RRD
- Readmission rate for Adult Acute wards

5. Reflections / learning points:

Data collection has been person dependent.

Lack of understanding within teams in interpreting data – may benefit from providing modular teaching of QI foundation training, - Challenges around staff being able to leave wards to attend training on site.

6. Next steps (summary):

Improving the identification patients ready for discharge from wards with the introduction of the SOP. QI team to support data collection of the process measures once the SOP has been rolled out. The wards will be approached to identify change ideas to reduce variation and improve engagement with the RRD once rolled out.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Improvement Programme:

Maternity and Neonatal

Projects / Workstreams:

1) **Improving patient/family communication in Maternity and Neonatal Significant Adverse Event Reviews (SAERs)**

2) **Maternity Services Improvement Programme**
   - **Planned Antenatal Care**
   - **Unscheduled Antenatal Care**
   - **Peripartum Care**

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Maternity & Neonatal Services	**Period**	April - October 2024
Project/Programme Title	Improving patient/family communication in Maternity and Neonatal Significant Adverse Event Reviews (SAERs)		
Team Involved	Sue Perkins, Quality Improvement Advisor Liz Bream, Associate Medical Director for Quality and Safety Jill Gillies, Associate Director of Quality Women's and Children's Risk Management Team Senior clinical management team maternity and neonatology		
Programme Lead	Sue Perkins		
Improvement Lead	Sue Perkins and Liz Bream		

1. Aim:

To improve patient/family communication in maternity and neonatology Significant Adverse Event Reviews by April 2025, so that patients/families report a positive experience of their involvement at the end of the review process.

2. Background and Purpose (Why?):

There have been several complaints made from patients and families involved in a Significant Adverse Event Review about the review process, including:

- A lack of proactive and compassionate communication about the review
- The length of time the review takes
- The review report containing errors
- Not receiving a sufficient apology for incident which prompted the review

Quality planning, including feedback from 3 families who have been part of a Review and from Maternity Voices Partnership also demonstrates that:

- SAERs do meet the 140 working day timeline
- The letters used to communicate with families do not contain an apology
- Key Contacts have not often received any training in this role and do not always feel well equipped to support families
- There are mismatched expectations about how the review will run and what it can cover between patients/families and healthcare professionals
- Other processes including clinical follow up, Perinatal Mortality Review Template (PMRTs) and the bereavement pathway are not co-ordinated
- Feedback from patients/families involved in a review about the process and how they were communicated with is not collected
- There have been several cases where the SAER process has compounded harm caused to patients/families by the initial SAE

3. Key Actions and Improvements to Date:

Three initial Project Delivery Group meetings were held to inform the Project Plan for this work and a PID was signed off by the Maternity and Neonatal Programme Board.

Quality Planning took place from April to October to understand where there are opportunities for improvement in the process including:

- Process mapping from the point of a SAE occurring through to the patient/family receiving a copy of the review report and meeting with the service (if they opt to do so).
- Analysis of complaints received that specifically mention concerns with the SAER process.
- Use of the last 10 patients tool to understand how long the most recently closed 10 cases took, which steps in the process took the longest and how far these reviews were from meeting the 140 working day target.
- Feedback from Maternity Voices Partnership about the letters used to communicate with patients/families.
- Surveys and interviews with Key Contacts, members of the Risk Management Team and senior clinicians to identify what works well and where improvements could be made.
- A review of best practice and research from within Scotland and the UK to map gaps against best practice.

The Quality Planning was presented at the Risk Operations Group on the 6 September 2024 and the Women's Services Clinical Governance & Risk Management Meeting on the 25 October 2024.

Copies of the SAERs Quality Planning Project document can be made available on request by emailing loth.qist-admin@nhs.scot

A further Project Delivery Group meeting was held on 29 October 2024 to review actions proposed from the quality planning. This group agreed to set up a Short Life Working Group which will include patient/family representatives and meet over the next 6 months to carry out practical actions for improvement.

Copies of the SAERs Workplan for the short life working group can be made available on request by emailing loth.qist-admin@nhs.scot

4. Measures/Impact/Data:

Not yet available.

5. Reflections/Learning Points:

- Quality Planning takes time but is crucial to identify and gain buy-in for improvement
- It is difficult to balance the power of individual patient/family stories against a wish to have experience from a 'representative' cohort of people
- There are competing priorities and service pressures within maternity services which make this specific programme of work challenging
- Understanding the mechanisms/levers/existing groups and structures that can provide momentum for improvement is difficult when you are not familiar with a service
- Where improvements are practical actions that need to happen as a matter of urgency it can be tricky to balance supporting a service against encouraging them to take ownership of changes

6. Next Steps (Summary):

Convene Short Life Working Group to action agreed workplan by April 2025.

LothianQuality
BETTER HEALTH, BETTER CARE, BETTER VALUE

NHS Lothian

Quality Directorate Mid-Year Reporting

Service/Area/Programme	Maternity	**Period**	March-November 2024
Project/Programme Title	Maternity Services Improvement Programme		
Team Involved	Multidisciplinary team across RIE, SJH and community		
Programme Lead	Dr. N Mary, Dr. Doubal, K Ruggeri Dr. Chiswick, Dr. Armstrong		
Improvement Lead	C Swift, R Davies, A Redpath		

1. Aim:

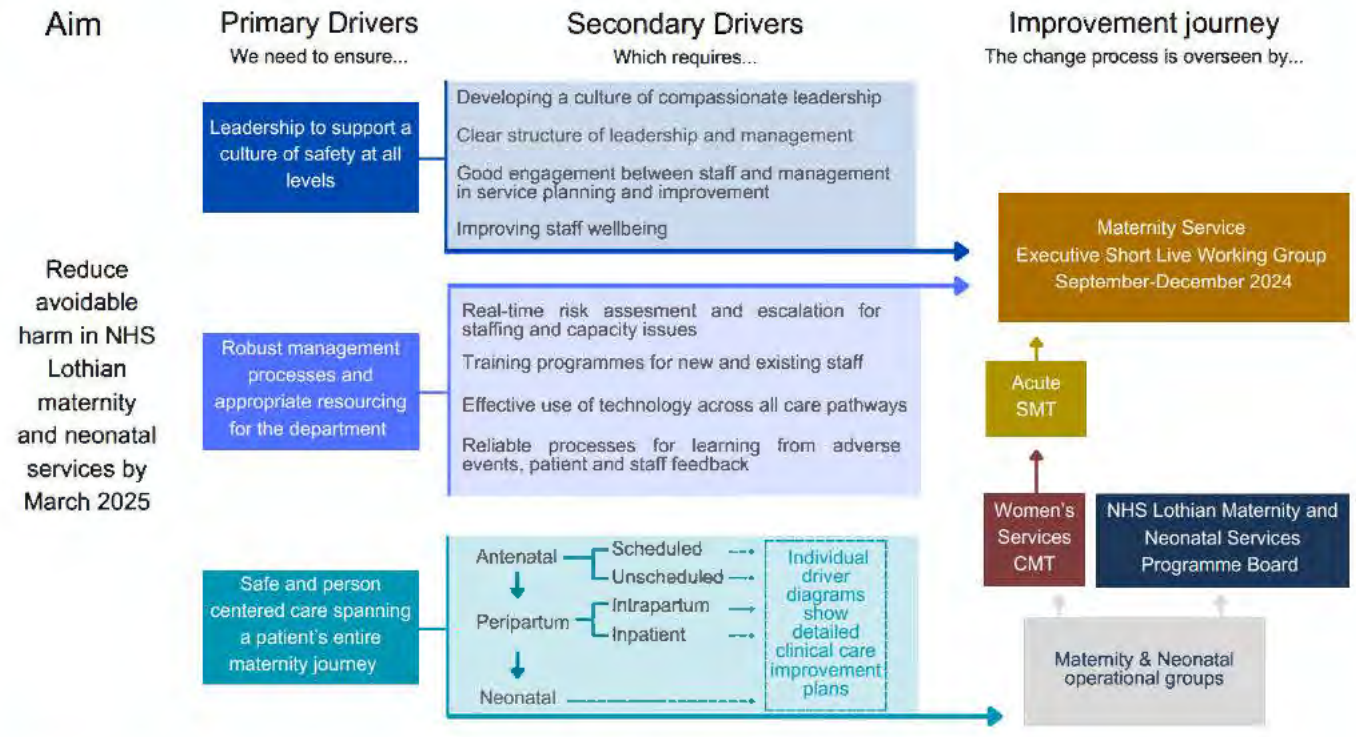
The aim of the improvement programme for maternity services is to reduce avoidable harm, by March 2025.

This is achieved through the delivery of clinical primary drivers:

1. Reliable planned antenatal care processes.
2. Reliable unscheduled antenatal care processes.
3. Reliable peripartum care processes.

This can be seen in the following diagram which incorporates leadership and management with clinical improvement.

Chart 1



Information on the clinical primary drivers is included in this mid-year report.

2. Background and Purpose (Why?):

Quality planning was undertaken which included reviewing, theming, and learning from SAEs, complaints, and compliments. This allowed us to focus improvement activity.

1. Reliable planned antenatal care processes.

   - Standardising the antenatal booking risk assessment process

   Why: Midwives in different localities may have different ways of checking that they have acted on all risks identified booking questionnaires and risk assessments on Trak. Women who have higher risk pregnancies (e.g. because of high BMI) therefore may not reliably be put on the correct pathway for antenatal care resulting in missed opportunities to reduce risk for mother and baby.

   - Small for Gestational Age Improvement Project

   Why: SGA babies need to be identified by reliable fetal growth monitoring (for most cases this is by measuring Symphysial Fundal Height (SFH) regularly) so that changes can be made to antenatal care to reduce the risk of babies being stillborn.

2. Reliable unscheduled antenatal care processes.

   Why: Significant adverse events (SAEs) may occur because of delays and failure to reliably recognise a escalate key conditions that need timely obstetric care (e.g. preterm labour). This may mean women and babies do not receive the care they need.

3. Reliable peripartum care processes.

   Why: Significant adverse events (SAEs) may occur because of:

   - lack of recognition and escalation of deteriorating CTGs
   - delays in performing caesarean section deliveries resulting in brain injury for babies.
   - leaving items in place unintentionally. These cause complications for women (e.g. infection, readmission, pain & distress).

3. Key Actions and Improvements to Date:

The whole programme is supported by an infrastructure of frequent meetings from project and improvement delivery to operational delivery and managerial governance and support. As seen in chart 1, this is overseen by an executive group.

Project Initiation Documents (PIDs) and Project Plans were developed with the service that maximises the current maternity services structure. Robust programme management supports the timely delivery of the programme and risks.

1. Reliable planned antenatal care processes

   - Covering all community areas and teams, the antenatal booking risk assessment has been standardised to reduce variation in practice and is being spread across Lothian. The use of the assessment is being audited to monitor reliability.

     The aim is to develop the use of TRAK to remove the need for the paper checklist, however this is longer term.

- With correct risk assessment, identification, and management of SGA we aim to achieve delivery before 40 weeks.

  An awareness campaign is underway and practical changes include where plotting documentation is held.

  There has been an initial focus on training, individual feedback, and clarity within the guideline for midwives, including a flowchart, on referral process following SFH measurements.

2. Reliable unscheduled antenatal care processes.

   Comprehensive quality planning to understand the system has been undertaken in the triage stage of women's care to enable a focus for improvement. Understanding the system continues.
   There has been consistent improvement in time to triage and it is hardest to achieve at busiest times of day.

   Practical changes continue to be embedded e.g. handovers, twice daily huddles (also ensure staff breaks and wellbeing), triage rooms identified by signage, 2nd triage room in use.

   Continue implementing the use of the Birmingham Symptom-specific Obstetric Triage System (BSOTS) which is a standardised way to assess women presenting with unexpected pregnancy related problems or concerns, ensuring they are prioritised in order of clinical urgency.

   We will better record time of medical review to understand the data and the changes required. The team are focussing on ensuring that medical staff review appropriate women, rather than the majority. At busy times available medical staff will be in theatre, labour wards, inpatient wards, clinics and seeing other patients in triage.

3. Reliable peripartum care processes.

   - Fetal Wellbeing

     One senior midwife is dedicated to supporting staff across RIE and SJH with ensuring safe recognition, interpretation, and escalation of fetal concerns.

     Data is monitored weekly, and all adverse events are reviewed by the senior midwife for fetal wellbeing practice.

     We have ascertained, through audit, the reasons for 'fresh eyes' not being done every hour and plan to address that.

     Various change ideas have trialled and implemented e.g. using a sticker on the CTG trace that provides a checklist for staff to review fetal trace, physiology, and maternal health.

     A structured method of assessing characteristics of a CTG was introduced (features are contractions, FHR, variability, decelerations, accelerations, and overall classification) – this is now embedded in practice.

     A revised Partogram (documentation) is in place and includes risk assessment and the escalation guidance (RAG based) that enables staff to escalate appropriately and empowers staff to escalate to senior staff.

     Training and individual feedback continues and is refined regularly.

- Urgency of Birth

  Comprehensive Quality Planning to understand the system and issues, including detailed process mapping, case note reviews and observational data, were completed.

  The use of stickers in this part of the project will be reviewed when we consider all the documentation in use. Documentation on paper is to be rationalised to reduce duplication and enable staff to document clearly and in a timely manner.

  Data has shown us that Cat1 sections that are delivered >30mins are done so appropriately, although we continue to aim to improve the service for women.

  Additional elective theatre capacity has been provided to improve outcomes and data on Cat 2 sections is directing us to focus on specific groups of sections.

  The aforementioned detailed process mapping and staff feedback have allowed us to identified efficiencies from the decision to deliver to delivery. These allow gains in time in LW and help to improve the 'pebbles in the shoes' for MWs and doctors, while the team also continues to add theatre lists and look at workforce and wellbeing.

  Detailed map is available on request by emailing loth.qist-admin@nhs.scot

- Accountable Items

  Initial stages have been to determine current practice. Observational data is encouraging although further data is required.

4. Measures/Impact/Data:

At time of reporting
(Copies of charts can be made available on request by emailing loth.qist-admin@nhs.scot)

1. Reliable planned antenatal care processes.

   - Aim - >99% of antenatal booking appointments have all risks identified by June 2025.
     Current median - ~75%.
   - Aim - Reduce % of SGA singleton babies born at or after 40 weeks' gestation by December 202
     Current median - 54%.
   - Aim - >90% patients with all SFH measurements plotted on growth chart (from case note sample) by December 2024
     Current median - 67% (from 43%)
   - Aim - >90% correct follow up if growth is static or failing (from case note sample) by March 2024
     Current median – 64%

2. Reliable unscheduled antenatal care processes.

   - Aim - >80% of women have initial "triage" assessment within 15 minutes of arrival by December 2024.
     Current – 71% (increase from 52%) - 78% were seen within 20 minutes.
   - Aim - >90% of women allocated a triage category (red/orange/yellow/green).
     Current median sustained at 92%.

- Aim - >90% women are allocated to the correct triage category according to the BSOTS algorithm by December 2024.
  Current – 90-100%
- Aim - Women get ongoing midwifery care within the appropriate BSOTS defined timescale by December 202 a.100% Red (immediate) b. >90 % Orange (15 mins) c. >75% Yellow (60 mins)
  Current - 81% of Orange Cases were seen within 15 mins; 80% of Yellow within 60 mins.
- Aim - >90% women triaged to orange or red receive medical review when required by March 2025 (immediate for red; within 15 minutes or sooner if more urgent concerns arise for orange)
  Current - Patients requiring medical review should receive it in a timely manner and those in order of clinical priority. Times are not mandated by BSOTS and there is no agreed consensus. Orange cases with abnormal MEWS or fetal concerns - average time to medical review 38 minutes (target is <15 minutes).
- Patient experience of care
  Current – collated face-face and via a QR Code survey
- Staff experience of care
  Verbal feedback this far

3. <u>Reliable peripartum care processes.</u>

- Fetal Wellbeing
  - Aim - 95% of women should have the correct frequency & interpretation of CTG monitoring by December 2024
    Current - Median 99% at RIE and 100% at SJH sustained.
  - Aim - 95% of 'fresh eyes' reviews should be completed by December 2024
    Current - Median 85% at RIE and 81% at SJH
  - Aim - 95% of CTGs requiring escalation are escalated appropriately by December 2024
    Current - Median 100**%** at RIE and SJH sustained.

- Urgency of Birth
  - >95% of category 2 deliveries should have prompt sticker in place by December 2024
    Current median - 83%
  - 95% of category 1 deliveries on both sites, should have a time of decision to delivery of less than 30 mins by March 2025 and have reason for delay documented.
    Current median - 57% at RIE and 85% at SJH
  - 95% of category 2 deliveries on both sites, should have a time of decision to delivery of less than 75 mins by March 2025 and have reason for delay documented.
    Current median - 61% at RIE and 78% at SJH
  - Staff experience of care

- Accountable Items
  - Aim - Achieve no further retained accountable items in RIE/SJH from September 2024.
    Last SAEs at RIE Oct 2023 and SJH June 2024
  - Aim: 95% Accountable items form in notes by December 2024.
    Current median - 88% at RIE LW (increase from 55%), 100% at RIE LBC and 80% at SJH LW.

5. Next Steps (Summary):

<u>Overall</u>

- Communication and engagement with all staff groups is essential. We will build on this to enhance transparency and conditions for improvement.

- We will also develop sharing information on the improvement programme with patients and seek further feedback and learning.

Within community areas

- We will ensure standardised booking and will develop ideas to improve follow-up after plotting.
- Training will continue.
- The team will input to TRAK developments to support the programme.

Within the Triage area

- Develop midwife-led discharge protocols from Triage areas.
- Explore development of locally agreed targets for time to medical review in Triage which should be aligned with agreed existing escalation advice according to MEWS.
- Continue audits and close monitoring of data, whilst ensuring that all staff are aware of progress and successes.

Within Labour ward areas (peripartum)

- Optimise current pathways.
- Develop Birth Bundle (documentation).
- Improve the flow of communication, and role responsibility.
- Request information from other NHS Scotland boards on their processes and ideas for change.

NHS Lothian

Meeting: Healthcare Governance Committee

Meeting date: 28th January 2025

Title: Hospital Standardised Mortality Ratio

Responsible Executive: Tracey Gillies, Executive Medical Director

Report Author: E. Bream, Consultant in Public Health, Associate Medical Director for Quality and Safety

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☒	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☐
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

2.1.1 The purpose of this report is to provide a routine update on the Hospital Standardised Mortality Ratio (HSMR). This follows the detailed investigation conducted in 2023 and 2024 because of the increased HSMR at RIE reported in August 2023.

2.1.2 The committee is asked to note that:

The latest HSMR for NHS Lothian is 0.98 and that none of the three acute sites are out with the warning limits. These data were published in November 2024 and reflect data for July 2023 to June 2024.

2.1.3 A planned update on HSMR will be submitted to the committee in January 2026, unless the HSMR diverges further or there is other emerging evidence of avoidable mortality.

2.2 Background

2.2.1 HSMR is a statistic routinely reported quarterly by Public Health Scotland (PHS) and is the ratio of observed deaths and 'expected' deaths (as calculated by the HSMR statistical model). It includes all adult acute and day case admissions and takes account of deaths that occur within 30 days of admission (irrespective of place of death). Obstetric and psychiatry deaths are not included. Deaths occurring in the ED are also not included as patients are not admitted. An HSMR of more than 1 means that more deaths occurred than predicted by the model. It does not necessarily mean that the deaths were avoidable, unexpected or attributable to failings in care. It is intended to trigger further investigation. [1]

2.2.2 For four consecutive 12 month reporting periods (April 2022 – March 2023, July 2022 – June 2023, October 2022-September 2023, January 2023-December 2023), the HSMR for the RIE breached the 2 standard deviation upper warning limit (UWL). Note that there is an overlap in the reporting periods. The overall NHS Lothian HSMR was between 0.99 and 1.01 during this period. The results of the investigation of this were presented to the committee in January (case reviews), March (coding and epidemiological analyses), May (Stroke), September (Sub Arachnoid Haemorrhage) and November 2024 (Stroke, as part of wider Stroke paper). Although quality of care issues were identified as part of the targeted case reviews undertaken, no consistent evidence of avoidable mortality was found. Possible alternative explanations for the increased HSMR were identified and detailed in the March and November reports.

2.2.3 The recommendations detailed in the individual reports are summarised in Appendix 1.

2.3 Assessment

For the reporting periods April 2023-March 2024 and July 2023- June 2024 (as above) none of the three acute sites have been out with the warning limits.

[1] HSMR - FAQs - 2022 (isdscotland.org)

The recommendations which are most likely to have the most impact on the HSMR are 4, 5 and 8.

Recommendation 4 – addressing use of symptom codes and under-coding of comorbidities

Work on this has commenced and initial data shows a reduction in the use of the R29.6 symptom code (falls not specified) which was found to have been over-used in the original report.

Recommendation 5 – guidance for clinical staff on recording diagnoses
This has been completed by working with the medical staff in the Acute Medical Unit (AMU) at RIE which reflects the highest volume area for admissions. This has included education to staff about the importance of clear documentation of the primary diagnosis and comorbidities at the post-admission ward wound and in the Immediate Discharge Letter (used by the clinical coding team).

Recommendation 8 – feedback to PHS
The full report has been shared and PHS have indicated that they plan to report on updates to the HSMR model in 2025.

2.3.2 Workforce

Not applicable for this report.

2.3.3 Financial

This is not **relevant** for this report.

2.3.4 Risk Assessment/Management

Future HSMR data published may show RIE as an outlier. The latest data reflect the period to June 2024 and do not reflect full implementation of internal recommendations following the outcome of the work undertaken in workstreams 2 and 3. There has also been no change to the national statistical model.

There is an ongoing risk that an HSMR within the warning limits may fail to detect clinical quality of care issues.

2.3.5 Equality and Diversity, including health inequalities

This is not relevant for this report.

2.3.6 Other impacts

This is not relevant for this report.

2.3.7 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- RIE PSEAG
- Acute Clinical Management Group

2.4 Recommendation

2.4.1 The committee is asked to note:

2.4.2 A planned update on HSMR will be submitted to the committee in January 2026, unless the HSMR diverges or there is other emerging evidence of avoidable mortality.

3 List of appendices

The following appendices are included with this report:

Appendix 1 – Summary of recommendations

Appendix 1 Summary of recommendations from HSMR reports

	Report	Status
	Report 1 – workstream 1 – targeted case note review	
1	The outcome 3 cases will be fed back to the relevant teams for consideration of further review and other thematic learning will be shared with relevant improvement programmes.	Complete
2	Await the outcome of work streams 2 and 3 *(coding & epidemiological analyses)* as detailed above. Further HSMR case review should not be considered until these are concluded and the recommendations acted on.	n/a No further case reviews undertaken
3	Incorporate and share methodological learning from this exercise into any future case note reviews both internally and with others.	Complete
	Report 2 – workstream 2 & 3 – coding & epidemiological analyses	
4	Work is undertaken by the NHS Lothian coding team to address the issue identified with use of symptom codes and under-coding of co-morbidities. This should include implementation of processes to monitor this prospectively by Lothian Analytical Services.	Ongoing
5	Guidance on the content of clinical documentation in casenotes during the first episode of care is provided to key staff groups in admission areas.	Complete for AMU (largest number of emergency admissions for RIE site)
6	Work as detailed above *(further investigation for ischaemic stroke and subarachnoid haemorrhage)* is concluded and reported to PSEAG by the Stroke and Neurosurgical teams.	See 9-15
7	The full report is shared internally and with PHS and HIS with a view to sharing learning about the application of the HSMR model and the methodology used to investigate an SMR for a hospital which is above the warning limit.	Complete
8	Specific feedback is provided to PHS in relation to findings from this investigation which may be relevant to future HSMR model reporting and development. This includes the interpretation of hospital-specific SMRs in the context of: models of service provision which diverge substantially in one hospital/health board from models of service provision in the remainder of Scotland, such as increasing community provision of COPD services which result in admission avoidance; local models of service provision which concentrate illness acuity on one site; and limitations of the HSMR statistical model in relation to groupings of diagnoses with differing mortality (e.g. influenza with upper respiratory tract diagnoses) when these vary between hospitals.	Full report shared which covered this context
	Stroke report 1 – case reviews for acute stroke unit	
9	Case review for stroke deaths out with the stroke unit are completed and, along with analyses from SSCA, are included into the Stroke report to HCG in November to complete this work.	Complete
10	The Stroke team consider and test a revised approach to mortality and morbidity review/governance processes which aligns more clearly to SSCA measures/SQIB.	Complete
	Stroke report 2 - case reviews for deaths out with acute stroke unit	
11	The findings from this work feed into existing workstreams in relation to flow across the RIE site. This should include specific consideration of how to prioritise admission to the Acute Stroke Unit for patients with a diagnosis of acute stroke.	Discussed at RIE PSEAG
12	The Stroke team consider review of relevant referral pathways for specialist stroke review.	Complete
13	The Stroke team consider and test a revised approach to mortality and morbidity review/governance processes which aligns more clearly to SSCA measures/SQIB.	Complete
	Stroke report 3 – Scottish Stroke Care Audit (SSCA) analyses	
14	This report is shared with PHS HSMR and SSCA teams.	Complete
	SAH report	
15	No recommendations	n/a

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**NHS Lothian Tobacco Control Annual Report, 2023-24**
Responsible Executive:	**Dona Milne, Director of Public Health and Health Policy**
Report Author:	**Martin Higgins, Head of Healthy Places**

1 Purpose

[Please check the boxes for all items that apply in each section]

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☐	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The report summarises NHS Lothian tobacco control team performance with specific reference to the Annual Delivery Plan target for smoking cessation and outlines actions across the service to reduce harms from tobacco among the Lothian population.

The committee is recommended to accept moderate assurance that the tobacco control service has comprehensive systems in place to deliver safe, effective and person-centred care.

2.2 Background

Tobacco control is one of the key NHS Lothian public health objectives:

- Reduce harm from tobacco by reducing smoking prevalence across NHS Lothian with a specific focus on women and children, implementing our tobacco control policy and increasing the number of people who successfully stop smoking.

The NHS Lothian Tobacco Control Action Plan 2024-25 outlines the Board's approach to reduce the harms caused by smoking. Tobacco control work focuses mostly on smoking cessation (delivered under the national Quit Your Way branding) and tobacco protection (for example, reducing exposure to smoking or second-hand smoke).

This report outlines the trends underpinning the performance data and the actions that have been implemented to improve smoking cessation outcomes. It is important to note that overall prevalence of smoking in Scotland and Lothian has been declining for many years. Remaining smokers (and those in the Annual Delivery Plan (ADP) target population) are more likely to be those who face wider adverse circumstances, and or co-morbidities such as mental health problems, that make it more difficult to quit.

The harms caused by tobacco consumption are among the largest preventable causes of ill-health and early death. The most recent available data show that (in 2020-2021) there were more than 6,000 hospital admissions of people aged 35 and over living in Lothian attributed to smoking. Over 1,100 deaths among people aged 35 and over in Lothian during 2020-21 were wholly or partially attributable to smoking. Smoking prevalence is significantly higher among adults than children and notably patterned by socioeconomic position.

Smoking cessation performance is measured against an Annual Delivery Plan (ADP) target of 1,181 successful 12 week quits from people living in the 40% most deprived Scottish Index of Multiple Deprivation (SIMD) datazones within Lothian. During 2023-24, 49% of this target was achieved, an increase from 42% the previous year. The Quit Your Way service is organised around two delivery mechanisms: non-pharmacy (delivered by

community specialist teams and an acute specialist team) and community pharmacy. The report highlights that the performance of the specialist aspects of the service has been improving steadily in recent years, with the exception of the Edinburgh community team, where improvement has been slower. The community pharmacy elements of the service have more room for improvement.

The highest priority local action for tobacco protection is the implementation of the NHS Lothian smoke free policy.

2.3 Assessment

Structures and Processes for Management and Oversight of Safety

Management and governance structures

Tobacco Control sits within the Population Health division of Public Health. A Public Health Consultant has oversight for the service and the Head of Healthy Places is the strategic lead. After a recent organisational review, the tobacco control function is managed by an Assistant Programme Manager who reports to the Head of Healthy Places.

The Population Health Senior Leadership Team has recently agreed to support a proposal for quality improvement work in Edinburgh and community pharmacy Quit Your Way services in 2025.

2.3.1 Quality/Patient Care

The Quit Your Way service seeks to implement the national service specification for smoking cessation and the recommendations from the 2023 Review of Smoking Cessation Services in Scotland.

2.3.2 Workforce

Acknowledgement should be given to the ongoing work that frontline staff carry out to support people who use tobacco in Lothian to reduce their risk of harm.

2.3.3 Financial

There are no new financial implications.

2.3.4 Risk Assessment/Management

There are no implications for the Board's Corporate Risk Register.

2.3.5 Equality and Diversity, including health inequalities

There is no requirement for an ECRIA to be conducted on this Annual Report of data.

2.3.6 Other impacts

No other relevant impacts.

2.3.7 Communication, involvement, engagement and consultation

The Board has carried out its duties to involve and engage external stakeholders, however patients and members of the public were not engaged on this report.

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- NHS Lothian Public Health Population Health SLT 14 January 2025
- NHS Lothian Public Health and Health Policy SMT 27 January 2025

2.4 Recommendation

- **Awareness** – For Members' information only.

2.4 Recommendation

[State the action(s) sought. Use one of the following directions for the meeting. No other terminology should be used. This must match the "Purpose" section above.]

- **Awareness** – For Members' information only.
- **Assurance** – The Board/Committee is asked to agree and accept a specific level of assurance on the matter, based on the evidence presented (a standard assurance level must be recommended and clearly evidenced).
- **Decision** – Reaching a conclusion after the consideration of options.
- **Discussion** – Examine and consider the implications of a matter.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, NHS Lothian Tobacco Control Annual Report 2023-24

Tobacco Control Annual Report 2023-24

Public Health and Health Policy

Report Authors:
Martin Higgins, Head of Healthy Places, Public Health and Health Policy,
Flora Ogilvie, Consultant in Public Health, Public Health and Health Policy
Robbie Preece, Health Improvement Lead (Tobacco Control), Public Health and Health Policy

Date: December 2024

Acknowledgements: With thanks to colleagues in the NHS Lothian tobacco control team who contributed to this report.

Summary

This report summarises NHS Lothian's tobacco control activity during the period from 01 April 2023 to 30 September 2024. Smoking cessation data covers the period to the end of 31 March 2024. The focus of the report is smoking cessation but there is some coverage of tobacco protection and prevention work also.

Smoking cessation performance is measured against an Annual Delivery Plan target of 1,181 successful 12 week quits from people living in the 40% most deprived datazones within Lothian. During 2023-24, 49% of this quits target was achieved, which was an improvement from 42% the previous year. This report outlines the trends underpinning these data and the actions that have been implemented to improve smoking cessation outcomes.

Public Health and Health Policy

The Public Health and Health Policy directorate consists of over 150 people working in 4 main divisions. We work to improve and protect the health of the people of Lothian.

Our underpinning principles for our work:

- Work in Partnership locally to reduce health inequalities and improve population health.
- Ensure that prevention is prioritised with a focus on strengthening communities.
- Ensure public health practice is evidence informed with resources and activity deployed proportionate to population need.
- Recognise the climate emergency as a public health priority and embed the UN Sustainable Development Goals/Scottish Climate Plan in public health activity.
- Nurture and support well-trained and motivated staff.
- Embed equality and human rights into our work, including trauma informed practice, The Promise and the UNCRC.
- Set and maintain a culture of continuous evidence-based improvement.

The Tobacco Control service is part of the Population Health division of the directorate of Public Health and Health Policy. The Population Health division work with partners and communities to improve population health and health inequalities by focusing on the social determinants of health.

Introduction and context

In November 2023, the Scottish Government published its *Tobacco and Vaping Framework: Roadmap to 2034.* The new framework reviewed progress on tobacco control work in Scotland since the 'tobacco-free' by 2034[1] target was adopted in 2013[1] and also included an update on tobacco control research and evidence informed policy. The framework adopts a three-pronged focus on people, product and place (which broadly map as the previous themes of cessation, prevention and protection) with priorities for two year implementation phases. The first national implementation plan, which will run until November 2025, has the following areas of focus:

People:

- Improving cessation services and routes for support
- A media campaign to deter youth vaping

Product:

- Restrictions on the age of sale
- Further restrictions on vaping

Place:

- Review of smoke free places
- Development of tobacco and nicotine vapourising product register

The allocation of NHS Lothian tobacco control resource aligns well with the focus on improving cessation services and routes for support through the provision and improvement of the Quit Your Way smoking cessation service. Wider product and place activity is part of our tobacco control effort but much of that work is led by national government and local government partners, except for our ongoing commitment to full implementation and continual monitoring of our smoke free hospitals policy. The framework also contains more detail about future plans to address vaping with a notable focus on regulation and enforcement relating to restricting the supply and sale of vapes to under 18s.

This annual report includes updates on key smoking cessation and tobacco control activity in Lothian. The overarching public health objective for tobacco control work in Lothian is as follows:

[1] 'Tobacco-free' is defined as a smoking prevalence among the adult population of 5% or lower.

- Reduce harm from tobacco by reducing smoking prevalence across NHS Lothian with a specific focus on women and children, implementing our tobacco control policy and increasing the number of people who successfully stop smoking
- Smoking cessation services are delivered under the national brand, Quit Your Way (QYW). There are especially close work ties between the smoking cessation programme of work in acute settings and the smoke free places implementation. As most prevention and protection work is led by public sector partners, the tobacco control effort in NHS Lothian is mostly focused on smoking cessation.

Our Tobacco Control Action Plan 2024-25 (see Appendix Two) is split into two main topic areas:

i. People: Smoking cessation (delivered as part of the national Quit Your Way service); and
ii. Product and Place: Prevention and protection work.

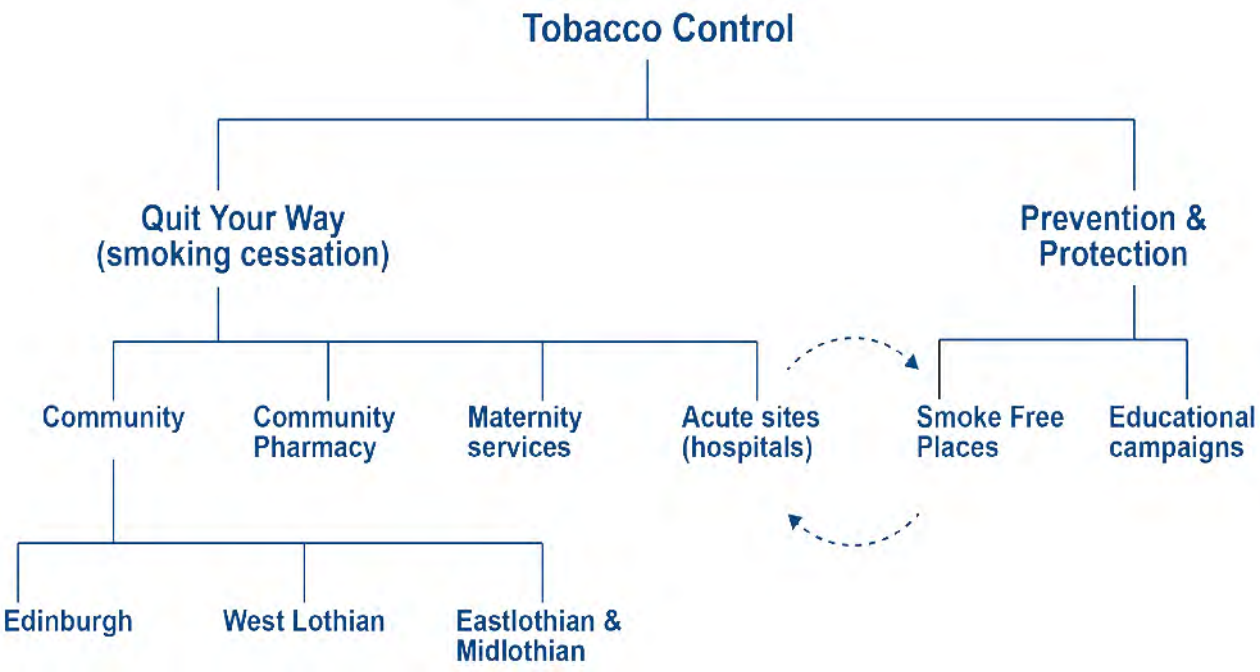


Figure 1: NHS Lothian tobacco control operational arrangements

Tobacco Control Action Plans 2023-25

Since 2023, the NHS Lothian tobacco control action plans have been focused on delivering the public health objectives of delivering the Annual Delivery Plan target[2] for smoking cessation, reducing smoking rates among pregnant women and supporting work on tobacco protection and prevention. The action plans have been based on applying quality improvement principles across the service.

Declining cessation numbers were identified as a problem in Lothian in 2019 and performance has been consistently below national averages for a number of years. Cessation services were remotely delivered during most of 2020, 2021 and 2022 which had a further negative impact of quit rates across Scotland.

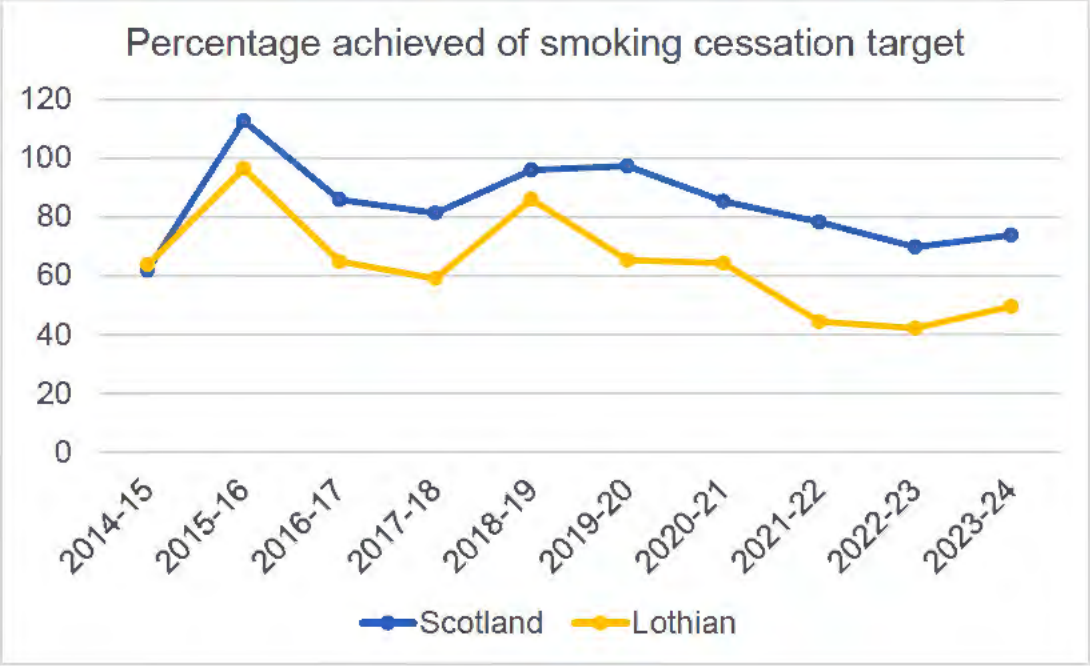
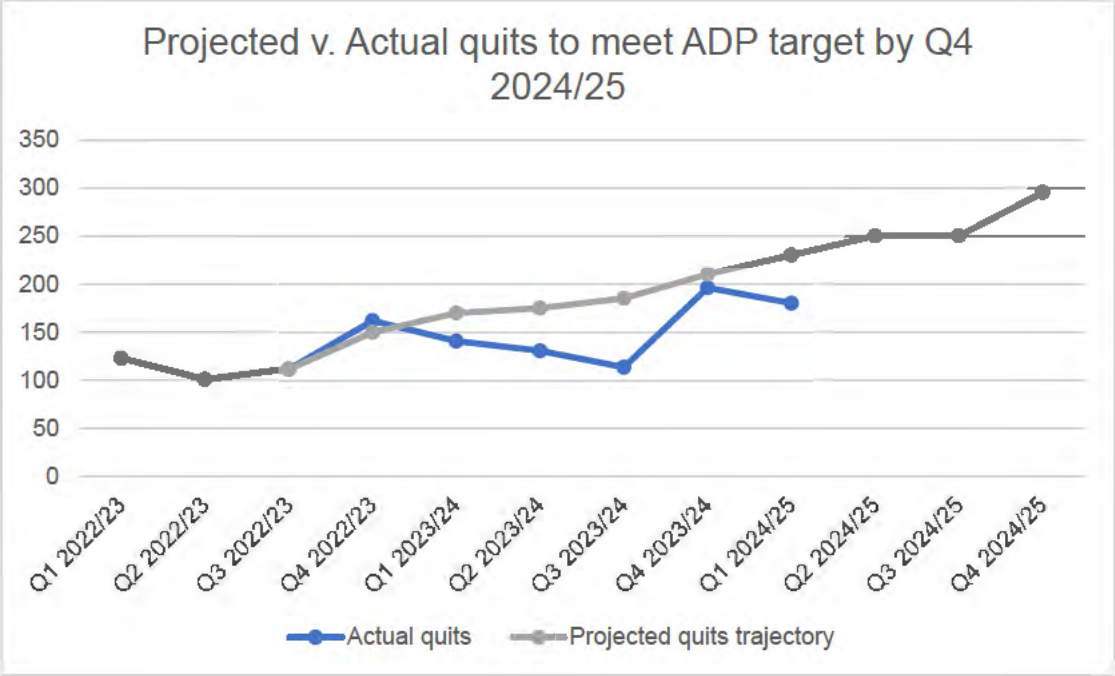


Figure 2: Percentage of smoking cessation target achieved, Lothian and Scotland, 2015-2024

In early 2023, a commitment was made to meet the Annual Delivery Plan target within two years. Figure 3 shows the trajectory and current performance. There is a seasonal trend in quit numbers so that cessation rates are typically highest in quarter four. But the current trend, while improving, means it is unlikely that the quarter four (January to March 2025) cessation numbers will meet the target.

Figure 3: NHS Lothian Tobacco Control Action Plan 2023-24 proposed trajectory for improving successful Annual Delivery Plan quits to meet target by end 2024-25

[2] The ADP target is nationally set for each NHS Board, focussed on the two most deprived quintiles within that Board area, based on (historic) modelled rates of smoking.



During the first half of 2023-24, the service underwent an internal audit of administrative processes. The recommendations from the audit have now been addressed except for the introduction of a Quit Your Way Trak module to manage patient records. Although scoping work has been undertaken with e-Health colleagues, the project has not currently been prioritised by e-Health for completion. A number of public health programmes, including Quit Your Way, require e-Health support and there are efforts ongoing to secure additional e-Health support for this work.

.

Table 1: Main elements of the Lothian Tobacco Action Plan, 2023-25

Smoking cessation			**Protection and Prevention**	
Community	**Acute**	**Community Pharmacy**	**Protection**	**Prevention**
Increase the number of successful 12 week quits from 2021-22 baseline (307/65% of target) in Community settings	Develop an integrated care pathway to provide a whole (hospital) system approach to smoking cessation in hospitals to improve 12 week quit rate	Increase the number of successful 12 week quits from 2021-22 baseline (171/29% of target) in Community Pharmacy	Develop clear public health messaging about smoking and vaping for use in a variety of settings	Explore opportunities to support trading standards to reduce access to tobacco, including action on: • Illegal sales • Proxy purchases
Improve links between other services and QYW	Increase 12 week quits among pregnant women from 2021-22 baseline (37) who smoke at first booking appointment		Implement new NHS Lothian Smoke Free Policy	Support wider public health campaigns about tobacco harm

Equalities and Human Rights

Who we support

The epidemiology of smoking

Although smoking rates have declined significantly in recent years, the harms caused by tobacco consumption are among the largest preventable causes of ill-health and early death. Smoking increases the risks of cancers, heart disease, respiratory diseases, strokes, and diabetes. Second hand smoke is also a health risk particularly for pregnant women and young children. The most recent data shows, there were more than 6,000 hospital admissions of people aged 35 and over living in Lothian attributed to smoking (2020-2021). Over 1,100 deaths among people aged 35 and over in Lothian during 2020-21 were wholly or partially attributable to smoking.[2] Smoking prevalence is significantly higher among adults than children and young people, and notably patterned by socioeconomic position.

The most recent Scottish Health Survey estimate of adult smoking prevalence in Lothian is 15%.[3] For children and young people, the rate is 2.4% with a higher rate at S4 than S2.[4] But population prevalence masks significant variation in smoking trends. The 2023 Scottish Health Survey reported that 26% of people living in the most deprived areas smoke compared with 6% in the least deprived areas across Scotland.[3] A similar socioeconomic gradient is evident among women recorded as smoking during pregnancy.

At the current rate, it is forecast that smoking prevalence rates in the most deprived section of society will be more than double the national target for a Tobacco Free Generation by 2034,[1] which is why smoking cessation services must continue to target smokers who live in the most deprived communities. Similarly, while smoking rates are low among children, it is important to retain a focus on smoking prevention to ensure young people are discouraged from starting.

Removing discrimination, advancing equality of opportunity and fostering good relations.

- See the Spotlight in community services for an example of a lifecourse approach to smoking cessation work

What we achieved this year

Support people to stop smoking

Our smoking cessation effort is delivered under the national Quit Your Way (QYW) branding.

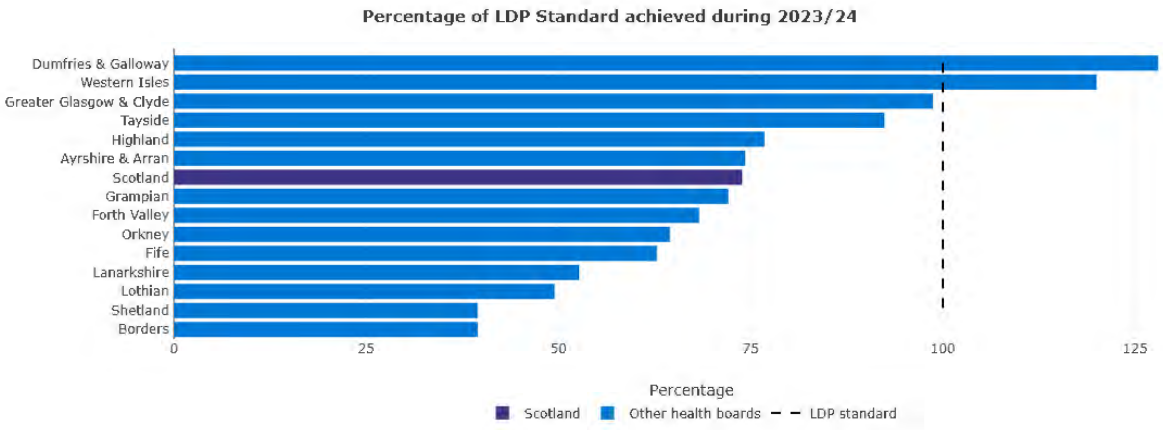
The NHS Lothian Quit Your Way team provides specialised smoking cessation support in community and hospital settings with separate teams for Edinburgh and West Lothian and a combined team for East Lothian and Midlothian as well as a team in hospitals.

Quit Your Way branded services are provided in community pharmacies as part of the nationally agreed public health pharmacy contract with specialist smoking cessation and administrative and training support provided by the Lothian QYW staff.

Our progress this year:

Smoking cessation performance is measured against a Scottish Government Annual Delivery Plan target of 1,181 successful 12 week quits from people living in the 40% most deprived datazones within Lothian. During 2022-23, Public Health Scotland reported that 49% of this quits target was achieved in Lothian. (Note that each NHS Board area has a different quits target calculated with reference to its own 40% most deprived datazones).

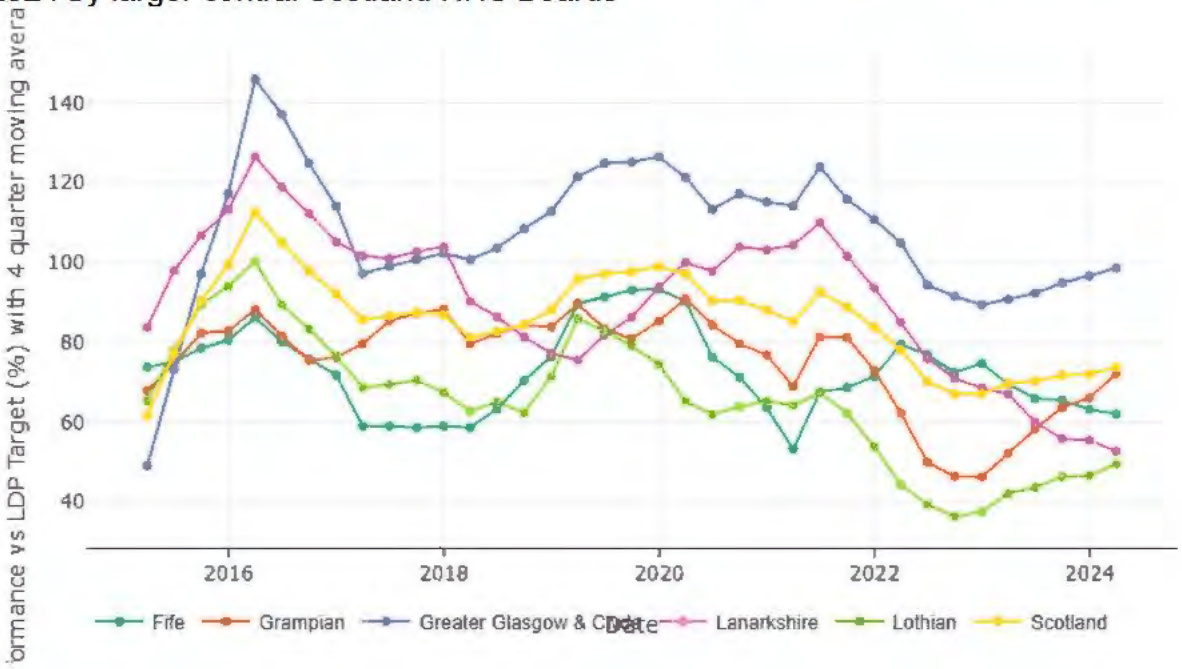
Figure 4: Percentage of Annual Delivery Plan target achieved in 2023-24 by NHS Boards in Scotland



Lothian smoking cessation performance is significantly below the level achieved by other large NHS Boards. Unfortunately, this underperformance has been happening for a number of years as illustrated in Figure 5. Other NHS Boards in central Scotland achieve higher smoking cessation numbers. In the lats three years there

has been a consistent improvement in cessation performance from the community specialist service in Lothian but community pharmacy quit numbers remain significantly below target.

Figure 5: Percentage of Annual Delivery Plan target achieved between 2016 and 2024 by larger central Scotland NHS Boards



The Annual Delivery Plan successful quits target is broken down locally within Lothian so that different aspects of the service have clear targets:

Table 2: Successful 12 week quits target from 40% most deprived datazones within Lothian, 2023-24

Area	Acute	Community	Pharmacy	Grand Total
East Lothian and Midlothian	27	108	135	**270**
Edinburgh	60	239	299	**598**
West Lothian	32	126	158	**316**
Grand Total	**119**	**473**	**592**	**1,184**[3]

During 2023-24, the achieved successful quit numbers were as follows.

[3] The actual target is 1,181 but rounded to 1,184 to avoid fractions

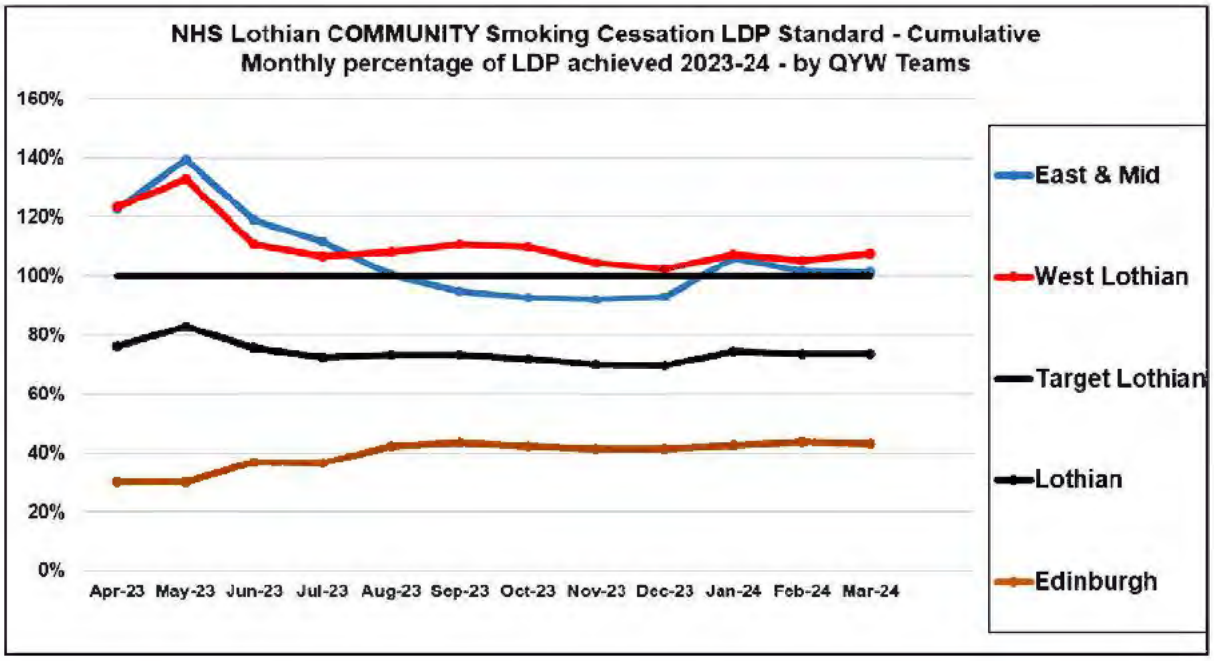
Table 3: Successful 12 week quits from 40% most deprived datazones within Lothian, 2023-24

Successful 12 week quits percentage of target achieved, 2023-24				
Area	Acute	Community	Pharmacy	Total
East Lothian and Midlothian	74	100	27	**61**
Edinburgh	60	44	28	**38**
West Lothian	75	107	21	**61**
Total	**67**	**74**	**26**	**49**

Supporting people in the community

Overall, the specialist community service delivered 349 Annual Delivery Plan quits or 74% of its target (making up 30% of the total NHS Lothian Annual Delivery Plan target). The graph below highlights performance of each of the specialist community teams as a percentage of their target.

Figure 6: Percentage of Annual Delivery Plan quits achieved by NHS Lothian QYW specialist community teams in 2023-24



The lack of successful quits in Edinburgh has a significant impact on overall Lothian performance due to the higher number of expected quits within the City of Edinburgh. The teams has been rebuilding referral pathways with all community partners e.g. GPs, district nurses, community psychiatric nurses and health visitors as well as community and voluntary sector partners. A mid-year review in 2024-25

has identified the need for a more focused improvement plan to increase Edinburgh numbers.

Spotlight: word of mouth, peer support and Quit Your Way support

Quit Your Way teams run a series of one-to-one and group support sessions for patients across Lothian. Peer support has been identified as one of the most effective ways to help a person maintain their quit attempt. Patient A was a heavy smoker of 30 plus years and was very unsure of her ability to quit. After initial contact with a Tobacco Control Practitioner in our West Lothian team, she joined a peer support session and started her journey. Towards the eighth week of her quit journey, she asked if her daughter could come along as she was also a long-term heavy smoker. The daughter had reported having witnessed her mother's quit journey, that she felt more motivated for her own.

Although the daughter has a small child and no childcare, with support from the West Lothian Quit Your Way team, she too has started her cessation journey. Both grandmother and the mother attend a face-to-face peer group session and they bring along the child as our sessions are suitable and child friendly. Patient A has completed her 12 weeks successfully. Her daughter is six weeks into her journey.

This effort captures the ethos of what it means to achieve a smoke free generation. It demonstrates how good outcomes can be shared and the more we achieve for our adult population the better the health of our children. All referrals are welcome, motivated referrals are the best and word of mouth is a very powerful thing.

Future Plans:

The area with potential for most improvement is the Edinburgh community specialist service. After a period of staff turnover, there is more stability within the team and resources are more closely aligned to the areas with highest population need. An Edinburgh Quit Your Way Improvement Plan is being developed to ensure clarity on team activity during 2024-25. This will focus on generating more quits attempts. Key to this will be a programme of engagement with key referral stakeholders, more focused engagement with priority GP practices and community venues and an emphasis on maintaining a higher quit rate across the team.

Supporting people as inpatients (Acute services)

Successful quits initiated in Lothian hospitals are intended to deliver approximately 11% of the Annual Delivery Plan target.

In 2023-24, the acute team achieved 80 successful quits or 67% of this target, which reflects the implementation of a reconfigured service which allows Quit Your Way staff to support people from the agreement of a quit date all the way to the end of their cessation journey. This approach means that the acute team relies on targeting people in hospital who are motivated to quit. In turn this means referrals to Quit Your Way within the hospital need to be appropriate.

There is evidence, however, across the Lothian health and care system of significant variation in referrals to Quit Your Way between hospitals and clinical specialties. To address this, the acute team has devised an updated integrated care pathway which will be the basis for future work with hospital colleagues.

The purpose of an integrated tobacco dependence treatment pathway across all acute sites in Lothian is to ensure that all patients are offered a comfortable hospital stay to manage nicotine withdrawal symptoms from point of admission via a front door area, the Emergency Department and Acute Medical and Surgical Admissions Units. The pathway then outlines clearly the steps that need to be taken within the hospital to facilitate a successful quit attempt. This work can be a cornerstone of the new NHS Lothian wide approach to prevention.

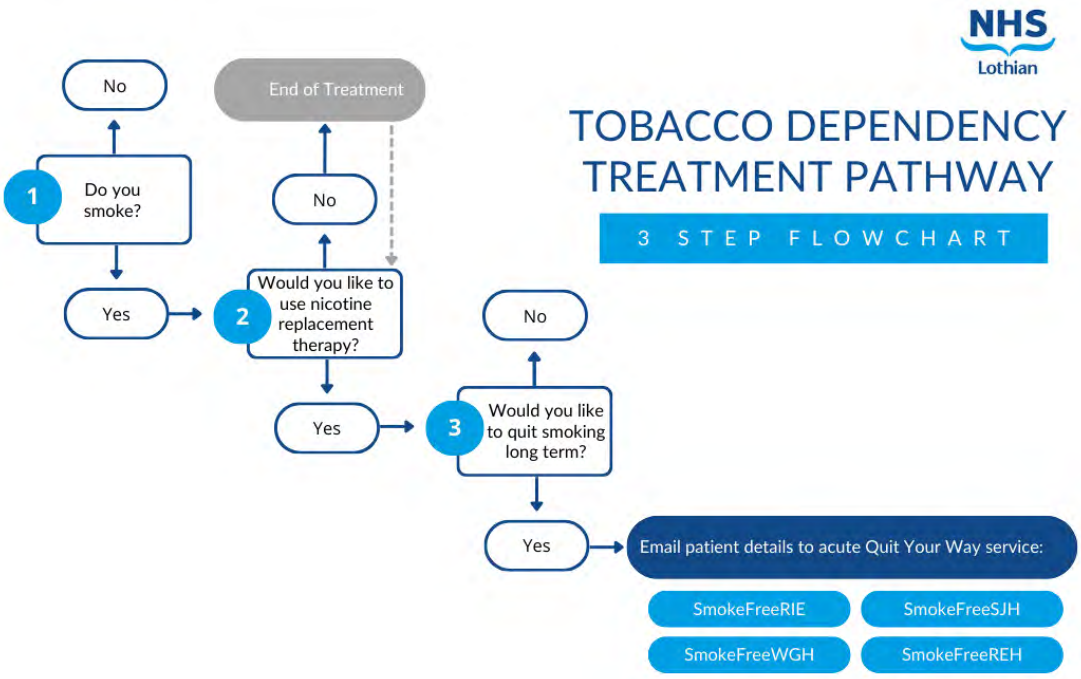


Figure 7: NHS Lothian Tobacco Dependency Treatment Pathway

Future Plans:

There remain some barriers to a slick, automated referral – notably no automated Trak referral – but by improving messaging about the pathway and targeted work with hospitals, wards, clinical specialties and staff, it is hoped the updated referral process will be better understood by clinical staff, leading to a proportionate spread of referrals from across the system rather than the current variation within the system.

Supporting people who smoke while they wait for scheduled for inpatient procedures will be a focus for work in 2024-25 as NHS Lothian's work on Waiting Well develops.

Supporting Community Pharmacies

During 2023-24, community pharmacies achieved 153 quits as part of the Annual Delivery Plan target, which accounted for 26% of their expected quits (or 13% of the total NHS Lothian Annual Delivery Plan target). This represented a slight increase on the previous year's figures and signals a reverse of a negative trend that started in Q2 (July to September) 2021-22.

Although community pharmacies nationally have a range of challenges at present (including store closures), Lothian performance is still below that seen in other NHS Board areas.

But the increase in 2023-24 is attributable to work being done with community pharmacies by the new Pharmacy Assist Team. This small team works with pharmacies to encourage them to complete tasks including four week follow up reports, and provides Patient Care Record support, CO monitoring equipment support and administration of training events. It is also important that staff in community pharmacies are confident that they have the skills to support a smoking quit attempt.

Spotlight: The Pharmacy Assist Team

The Quit Your Way Pharmacy Assist Team have been supporting pharmacies since January 2023. As the team was newly formed all processes and work plans needed to be created. To date the team have supported pharmacies by:

- Awareness-raising about the team: Just over a third of the 180 pharmacies in Lothian have been visited by the team (predominantly pharmacies with a higher number of smokers in the local area) and 131 community pharmacies have requested and received resources to advertise and provide smoking cessation. Future work will prioritise pharmacies in communities with the highest estimated smoking populations.
- Organising training sessions for community pharmacy staff. The current training session is three hours long. Future training needs have been identified and plans are being developed with pharmacy colleagues to focus on the Patient Care Records (PCR) system (for recording quit attempts) and Varenicline Patient Group Directive (PGD) information.

Future Plans:

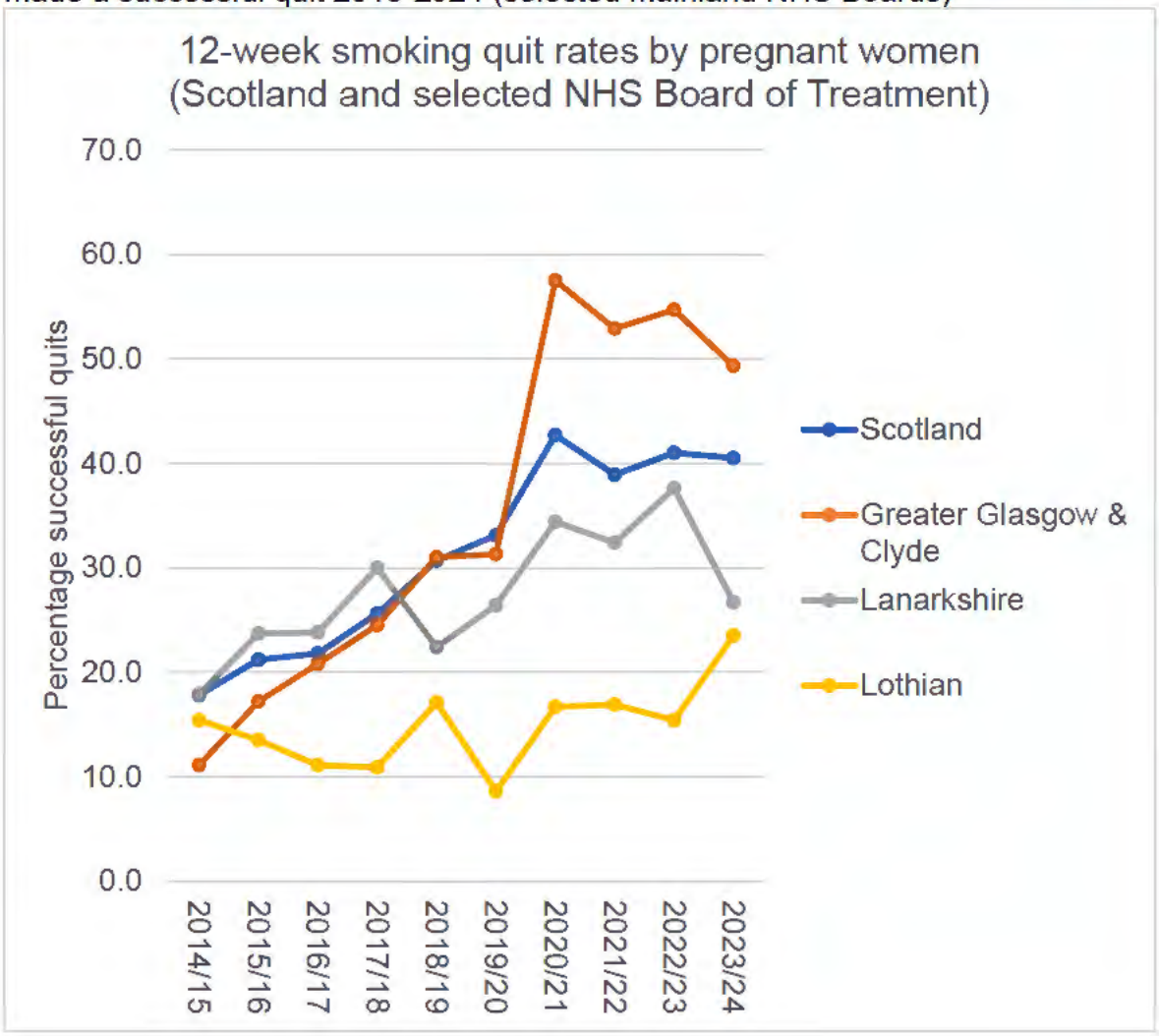
The Pharmacy Assist Team will be working more closely with QYW practitioners targeting the pharmacies located in areas where more smokers are likely to live. We will be developing an Improvement Plan to ensure a consistent, repeatable approach to support for community pharmacies. The plan will consider whether additional specialist smoking cessation staff support is required to improve community pharmacy quit numbers.

Maternity

Pregnant women smoking is a major risk factor for premature births, low birthweight and other negative maternal and child health outcomes. Reducing smoking prevalence among pregnant women has the potential for huge population health benefit. Although there is not currently a national target for quits in pregnant women, it is an NHS Lothian public health objective to increase the number of 12 week quits among pregnant women who smoke at first booking appointment.

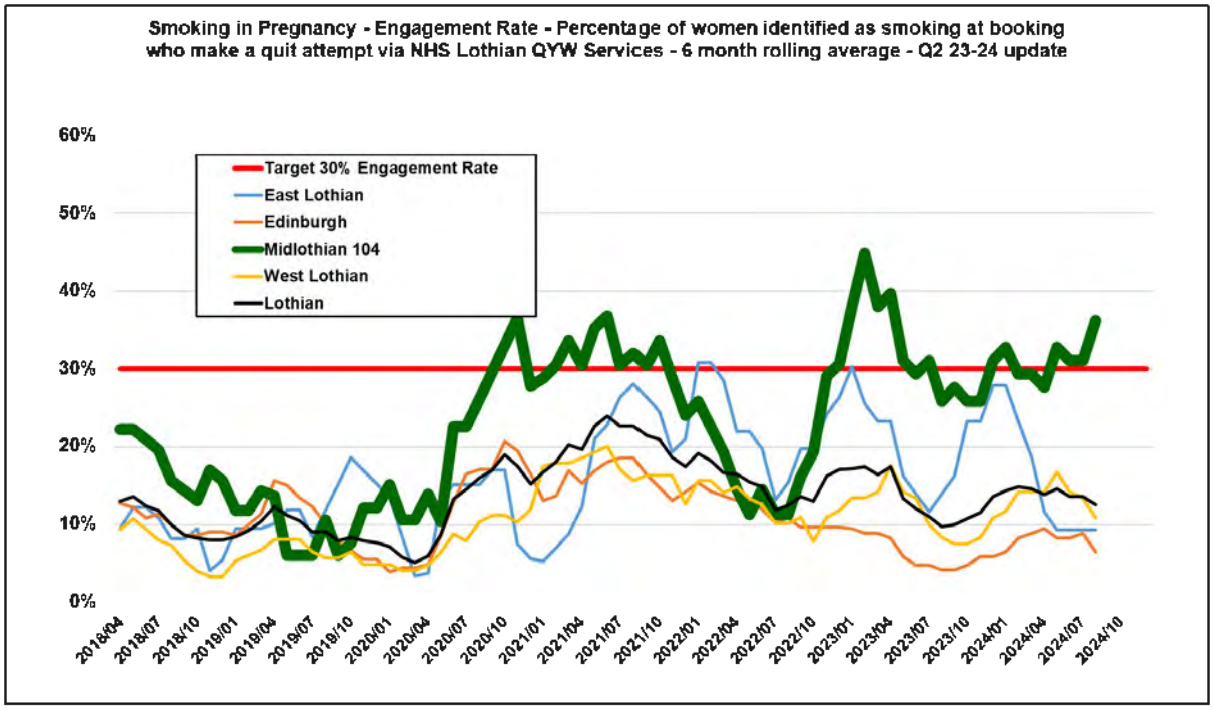
In recent years, the numbers of pregnant women making smoking quit attempts has been very low across Scotland. In 2014-15, 2,805 pregnant women made a quit attempt whereas only 859 women made an attempt in 2023-24. The comparable numbers for Lothian were 521 and 98. Although Lothian has a lower percentage of smokers than Scotland averages, 98 women represent approximately 11% of the total number of women recorded as smokers at their first pregnancy booking appointment. As a result of the decline in attempted quits, the number of successful 12 week quits in Scotland was below 300 in 2023-24. But even with small numbers, there is still notable variation in performance across NHS Boards (see Figure 8). A key objective in Lothian is to increase the number of quit attempts (engagement) and the number of successful 12 week quits among pregnant women (outcomes).

Figure 8: Percentage of pregnant women smoking recorded at first booking who made a successful quit 2015-2024 (selected mainland NHS Boards)



The local approach to improving pregnancy smoking outcomes involves increasing the number of women starting a quit attempt and then providing bespoke support for these women from that initial engagement point. Our work has started with a Midlothian pilot project for which engagement at 30% is the target. Maternity staff have been supported to have effective conversations at booking visit around smoking. The supply of Carbon Monoxide monitors and training in their use has been prioritised and an automated referral from Maternity Trak to Quit Your Way is now in place. The positive impact on the number of women referred to smoking cessation report in Midlothian can be seen in the chart below.

Figure 9: Percentage of women across Lothian identified as smoking at booking appointment who made a quit attempt, 2018-2024



The starting point for this work is recording carbon monoxide readings at first booking appointment. A sustained effore from community midwifery teams with support from the Tobacco Control Project Manager and Practitioner working on maternity shows the effect of an improvement focus. The chart below shows how monitoring rates are now clustered closer to the target of 98% compared to the variation when these numbers were first recorded in November 2022.

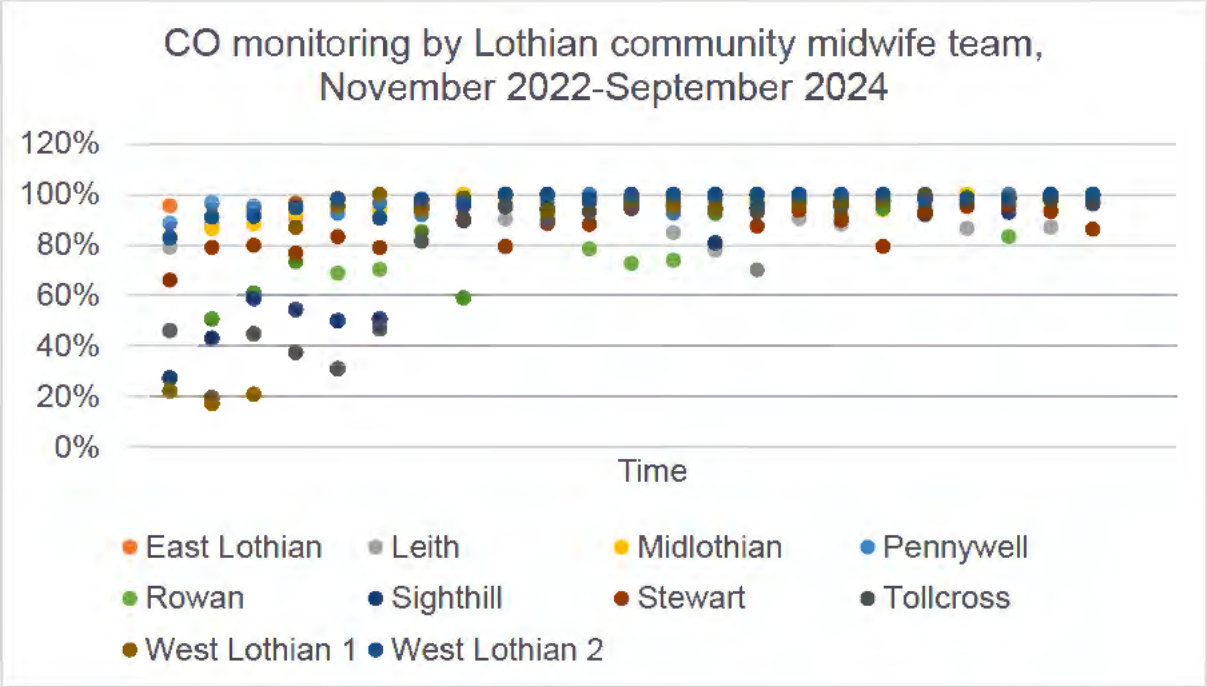


Figure 10: CO monitoring at first booking by NHS Lothian community midwifery teams,

Future Plans:

- Continue to monitor Carbon Monoxide readings and increase referrals to QYW.
- The next phase of maternity smoking cessation work involves taking lessons from Midlothian and improving engagement and outcomes across Lothian.

Protection and Prevention from Tobacco Harms

Updating the NHS Lothian Smoke Free Policy

NHS Lothian as a health promoting organisation is committed to providing a smoke free environment for staff, service users and their families or carers by reducing exposure to second-hand smoke. During 2022, the smoke free policy was updated to ensure compliance with changes in legislation but also to support a renewed focus on tobacco control across the Lothian health and care system.

The policy needed to be updated to comply with legislation changes in September 2022 which mean it is now an offence to smoke within 15 metres of an NHS hospital building. Local authority environmental health staff now have the authority to issue £50 fines to people caught smoking within 15 metres of a building footprint.[4] NHS Boards can also be fined up to £1,000 for failing to implement the smoke free policy properly.

A key aspect of the renewal of the smoke free policy is the implementation plan. An NHS Lothian Tobacco Monitoring group has been established to provide advice, oversight, and decision-making structure for the successful implementation of Smoke Free Grounds across NHS Lothian Board area hospitals.

One of the most important tasks for the smoke free hospitals work has been establishing a robust measure of smoking activity at Lothian hospitals.

Hospital grounds smoking activity data

Since 2023, there have been a number of site surveys assessing the local rate of smoking at the following NHS Lothian sites: Western General Hospital, Little France Campus, St John's Hospital, Astley Ainslie, East Lothian Community Hospital and Midlothian Community Hospital. At pre-agreed points, an assessor recorded a count of the numbers of smokers and attempted to categorise each smoker as one of staff, patients, contractors or other.

The data collected in 2023 highlighted a number of trends. There is more smoking at the Western General Hospital, the hospitals at Little France and St John's Hospital than at the other sites. Staff represented approximately 40% of all people who were observed smoking. And more people smoked than vaped. The monitoring group has therefore focused on reducing staff smoking numbers for 2024.

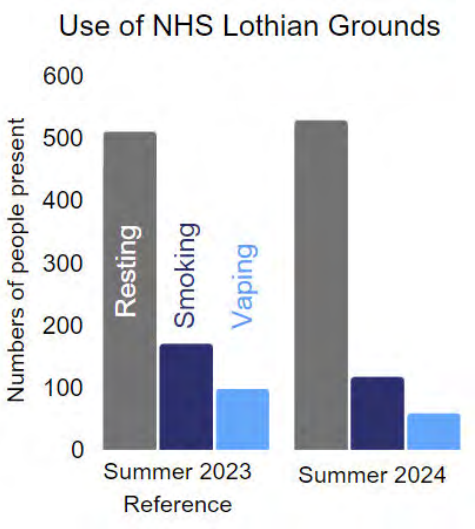
There has now been data collected at the six sites over a fifteen month period between May 2023 and August 2024. There has been lots of work publicising the smoke free policy and reiterating the role of NHS staff. There is new publicity material, staff and patient communications, new signage, information sessions about

[4] Note that the footprint is drawn from the furthest point at which building canopies extend from the main structure

the smoke free policy and changes to sites such as removal of old ‘smoking shelters’ and relocation of bins away from building entrances. During 2024, the new Fire Incident Response Team at the Royal Infirmary of Edinburgh undertook a bespoke induction that covered smoke free policy among other subjects pertaining to fire safety at the site.

Overall, there has been a slight decline in the number of people observed smoking at hospital sites when comparing summer 2023 and summer 2024.

Figure 2: Breakdown of observed smokers by category at NHS Lothian hospitals during summer 2023 and summer 2024



What is more noticeable is the shift in locations where people smoke on sites. The data from the Little France campus are indicative of this but similar patterns are evident at the Western General Hospital and St John’s Hospital. At the Royal Infirmary, smoking has shifted from the main entrance area and there is less vaping at the maternity unit. There is, however, more smoking at the edge of the site.

Figure 10: Little France Smoke Free Grounds areas of activity, summer 2023 and summer 2024.

There needs to be a continued focus on monitoring smoking activity across the hospitals. The emphasis on staff compliance with the policy also needs to be maintained. While information on smoking cessation options is made available to staff, this is not a primary outcome of the smoke free places work, in recognition of evidence base that successful quit attempts require internal motivation. It would not be appropriate to use smoke free training, signage and conversations to try to generate quit attempts.

Future Plans 2024-25:

- Review of the NHS Lothian Smoke Free Policy
- A smoke free tannoy will be piloted at St John's Hospital
- Continued focus on reducing smoking among staff
- More emphasis on changing environments at locations on hospital campuses where smoking continues
- Continued provision of smoke free information sessions and targeted communication campaigns

Conclusion

There have been signs of progress across all aspects of tobacco control work during 2023-24. The health harms from tobacco mean that there needs to be consistent, high quality work across our smoking cessation services and our prevention work. It is work that is not always glamorous nor is it without challenges. Our priorities for 2024 onwards will be to maintain improvements in smoking cessation performance while increasing efforts to denormalise smoking across NHS Lothian sites.

1. Scottish Government, *Tobacco Control Strategy - Creating a Tobacco-Free Generation*, H.a.S. Care, Editor. 2013, Scottish Government Edinburgh.
2. Scottish Public Health Observatory. *Online Profiles Tool*. 2023 [cited 2023 27 November]; Available from: https://www.scotpho.org.uk/comparative-health/profiles/online-profiles-tool/.
3. Scottish Government, *The Scottish Health Survey 2023 edition: main report*, in *Scottish Health Survey*, V. Wilson, H. Biggs, and S. Reid, Editors. 2023, Scottish Government: Edinburgh.
4. Scottish Government, *Health and Wellbeing Census Scotland 2021- 2022*, H.a.S.C. Education, Editor. 2023, Scottih Government: Edinburgh.

Appendix 1: Tobacco Control work plan 2024-25 (April 2024)

Overarching aim/focus:	Increase the number of people who successfully stop smoking and move closer to achieving the NHS Lothian Annual Delivery Plansmoking cessation target. Increase the number of pregnant women who successfully stop smoking

Ref	Objective	Success Measurement	Lead	Timescale	Update	Level of Assurance
1.1	Show sustained improvement in 12 week quit rate towards Annual Delivery Plan smoking cessation target (1,181 quits from people living in Lothian's 40% most deprived datazones)	a) On target to achieve 295 quits by end Q4 2024-25 b) Improve upstream recording so that QYW referrals can be tracked	Head of Healthy Places	a) End Q4 2024-25 b) End Q2 2024-25		
1.2	Increase the number of successful 12 week quits from 2021-22 baseline (171/29% of target) in Community Pharmacy	a) Identification of individual community pharmacies for quality improvement activity based upon agreed inclusion criteria b) Systematic programme of training provision on an ongoing basis for community pharmacy staff delivering	Head of Healthy Places/Service Manager	a) End Q1 2024-25 b) End Q1 2024-25 c) End Q2 2024-25		

		smoking cessation. In addition to support for brief advice and follow-up of clients, this will also focus on data input and reporting. c) Analysis of local prescribing data to inform local planning.				
1.3	Increase the number of successful 12 week quits from 2021-22 baseline (307/65% of target) in Community settings	a) Monitor primary care referrals b) Dashboard provides up-to-date information on GP referral patterns	Head of Healthy Places/Service Manager	a) End Q2 2024-25 b) End Q2 2024-25		
1.4	Implement the nicotine treatement pathway to provide a whole (hospital) system approach to smoking cessation in hospitals to improve 12 week quit rate	a) Implementation of nicotine treatment pathway	Head of Healthy Places/Service Manager	a) End Q2 2024-25		
1.5	Increase 12 week quits among pregnant women from 2021-	a) Work with Maternity services and community midwives to refine smoking	Head of Healthy Places/Service Manager	a) End Q2 2024-25 b) End Q1		

	22 baseline (26) who smoke at first booking appointment	component of booking appointment b) QYW staff trained to support pregnant women c) Phased roll-out of full QYW maternity service		2024-25 c) End Q2 2024-25		
1.6	Improve links between other services and QYW	Information on referral pathways provided for key staff working in: - SHBBV - Substance Use		TBC		
1.7	Implement QYW Internal Audit action plan to improve business and administration processes in the service	TBC	Head of Healthy Places/Service Manager	TBC		

Overarching aim/focus:	Implement the NHS Lothian Smoke Free Policy					
Ref	Objective	Success Measurement	Lead	Timescale	Update	Level of Assurance
2.1	Maintain Smoke Free Policy monitoring and enforcement group	a) Bi-monthly meetings b) Maintain monitoring system for tracking compliance with smoke free places legislation within hospital grounds.	Head of Healthy Places/Service Manager	Ongoing		
2.2	Implement Smoke Free Hospitals Plan	a) Staff smoking focus b) Targetted work on hospital sites (environmental change)	Head of Healthy Places/Service Manager	a) End Q3 2024-25 b) End Q4 2024-25		
2.3	Deliver information sessions for staff to understand i. the importance of having a smoke free hospital environment, and ii. how to signpost/refer to QYW.		Head of Healthy Places/Service Manager	Ongoing		

2.5	Develop guidance material on the ‘Care of patients who smoke’, linked with objective 1.4 above.	Guidance for staff and patients in mental health settings	Head of Healthy Places/Service Manager	End Q2 2024-25		

Overarching aim/focus	Develop a prevention work programme in line with recommendations in the new National Tobacco Strategy					
Ref	Objective	Success Measurement	Lead	Timescale	Update	Level of Assurance
3.1	Support development of clear public health messaging about smoking and vaping for use in a variety of settings	Identify/develop a suite of materials about the impacts of smoking and vaping that form the basis of public health advice from NHS Lothian about these topics especially in relation to children and young people	Head of Healthy Places/Service Manager	Ongoing		
3.2	Support wider public health campaigns about tobacco harm	Support and amplify the reach of ASH/PHS/SG/WHO educational campaigns	Head of Healthy Places/Service Manager	Ongoing		

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Tissue Governance Annual Report**
Responsible Executive:	**Tracey Gillies**
Report Author:	**Craig Marshall – Tissue Governance Manager**

1 Purpose

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other: Research	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to provide the committee with an update on the activity of Tissue Governance and the work undertaken to regarding the safe and effective use of patient samples for research, development and innovation.

It is recommended that the Committee review and give continued support to the systems in place for Tissue Governance.

2.2 Background

Research involving the use of human tissue, or information derived from human tissue, is a fundamental cornerstone of cutting edge translational, medical research. Translational research, both in academia and industrial settings, is integral to advance the understanding of disease and to improve the diagnosis and treatment of patients. It is necessary to create and sustain an environment that fosters research, in the interests of patients and the public.

Tissue Governance, via the Lothian NRS BioResource (Biorepository), continues to provide a governance infrastructure and ethical framework that facilitates collection, storage and use of patient tissues (including blood and urine), surplus to diagnosis, for research, development and innovation projects within NHS Lothian, and other institutions and organisations including Universities of Edinburgh and St Andrews. This ensures that samples are collected and retained with all the appropriate ethical approvals and patient consents required. Furthermore, this ensures that all such research complies with current legislation, guidelines for best practice, and recommended criteria for NHS Research Scotland (NRS) Accreditation.

We continue to promote a culture of support for research and innovation ,and to provide NHS Lothian Health Board with oversight of the use of patient tissue samples collected and used for research. Patient care, safety and confidentiality are paramount at all stages in the process.

We oversee the use of patient-derived tissue and fluid samples in academic research, commercial research, and clinical trials, and continue to receive many requests for Tissue Governance approval for tissue related projects and associated de-identified clinical data. The Tissue Governance Unit operates under a single ethics permission (D Harrison is named PI) and NRS Accreditation.

Scope of Services

The provision and use of patient samples, surplus to diagnostic requirement, for research and education purposes.

2.3 Assessment

Structures and Processes for Management and Oversight of Safety

Management and governance structures

Prof. David Harrison, (named lead in the ethics opinion) and Dr Hannah Monaghan continue jointly as clinical leads for Tissue Governance, with support from Prof. Tim Kendall, Pathology, University of Edinburgh, Prof. Matt Reed, Emergency Medicine, RIE, and Dr Kate Kirkwood, Pathology, WGH.

Dr Craig Marshall is the Tissue Governance Manager supported by Mr Vishad Patel, Tissue Governance Biomedical Scientific Officer and Dr Lisa-Marie Butt who has joined as Tissue Governance Officer.

Management and governance processes

[The Tissue Governance management committee have meetings scheduled each month. Any issues arising during this period are discussed and actioned accordingly. If necessary, a risk assessment is conducted. If further escalation is required, these are discussed with R&D management in the first instance and then escalated to the executive lead, where necessary.

There have been no significant issues during this reporting period.

2.3.1 Service Quality and Safety Assessment

Safe Care

Current evidence about safety

Accreditation:

Accreditation of the Lothian NRS Bioresource was awarded on the 01-Feb-2023 (Appendix 1). This is valid until 31-Jan-2026. This is subject to the submission of an annual declaration of compliance (Appendix 2), with the next annual declaration due for submission on 01-Feb-2025. There have been no significant changes during this period that affect our accreditation status.

The next accreditation cycle is due to start later this year. To prepare for this we will continue with an audit programme of ongoing tissue collections and will liaise with Research Tissue Banks and identified collections within Lothian to ensure that they continue to work to the level of accreditation standards.

Ethics:

Lothian NRS BioResource has Research Tissue Bank ethical approval from East of Scotland Research Ethics Services (ref: 20/ES/0061) which permits the provision and use of patient samples to research projects, subject to certain conditions (Appendix 3).

This approval must be renewed every 5 years as standard, with the current approval due for renewal in July 2025. We will begin the process of applying for this in February 2025 to ensure continuity of approval/service.

Pathology Archive:

Access to the Pathology Archive to retrieve tissue samples for clinical trials and other research studies is restricted to NHS Laboratory Medicine or Tissue Governance staff only. Local researchers who request material must submit a application to Tissue Governance. Tissue Governance record the release of any material retrieved via this means.

Tissue held within the Pathology Archive forms part of patient medical records and only surplus material may be released. Use of this resource is restricted to prevent misuse, misplacement or depletion of tissue blocks, thus protecting the archive and ensuring that material is available for potential future clinical testing. Where possible, blocks are retained with de-identified sections provided. All material is de-identified at the point of release to protect individuals' anonymity (unless the appropriate approvals permit otherwise) and ensure compliance with REC approval.

Data:

Tissue samples are of much more value for translational research when linked to clinical data. Tissue Governance/BioResource provides a minimal, de-identified dataset with tissue samples where requested. All data released by ourselves is de-identified to the research group.

We also continue to liaise with DataLoch and groups such as Cancer Informatics for support with requests which involve large or complex data. In such instances, researchers are directed to DataLoch.

Tissue Collection Registration:

An updated version of "Tissue Governance Arrangements in NHS Lothian" and accompanying letter is due to be sent out to all consultants in Q3 of 2025. Previously this has been issued by the Medical Director and the University of Edinburgh Executive Dean of Research and Strategy. This will be the fifth iteration of these documents and will direct researchers to register existing collections with Tissue Governance.

The national biorepository management platform, created by the Health Informatics Centre, University of Dundee, should provide a daily management tool for the BioResource and be used to create a central register of other tissue collections within NHS Lothian and University of Edinburgh.

This platform was due go live in 2024, however this has been further delayed due to developmental issues. HIC are now finalising the system and aim to launch this in the coming months. Once this is live, we will roll this out to research groups who will be

directed to register locally held collections on this system. The primary focus of this will be collections where project-specific REC and R&D approval has ended. The BioResource will not seek to assume custody of any collections but will have oversight of their existence and will work with all parties involved to ensure that they are compliant with applicable regulation. This registration will also facilitate the transfer of 'responsibility' or 'accountability' to the BioResource should the researchers leave or the collection become obsolete.

2.3.2 Workforce

In November 2024, a new Tissue Governance Officer post was established and appointed (Dr Butt) who will undertake an audit programme of ongoing tissue collections and will liaise with Research Tissue Banks and identified collections within Lothian to ensure that they continue to work to the level of accreditation standards.

2.3.3 Financial

CSO continue to fund us at a level of 70% of our core operating costs for the year 2024/2025. This level of funding has not increased over the past 8 years. The BioResource operates on a cost-recovery model and continues to successfully recover funds to meet the shortfall.

The CSO also issues Aims and Objectives as a condition of continued funding. We continue to work towards fulfilling these.

2.3.4 Risk Assessment/Management

There is a regulatory requirement for governance to be in place for research conducted using patient samples (Chief Medical Officer Letter of 27th September 2011). The existence of the Tissue Governance team and the BioResource has markedly reduced the risk of unregulated tissue being collected within Lothian and/or used in research within NHS Lothian, the University of Edinburgh and other organisations, by overseeing and supporting this type of work, and ensuring compliance with legal and regulatory requirements as far as possible.

We provide a governance infrastructure and ethical cover for a large number of research projects via the BioResource, receiving an average of 179 sample requests per year for the past 4 years, and will continue to work to ensure that tissue is collected, stored and used appropriately and in accordance with best working practice. We will continue to audit tissue collections over the coming year to reassure the Health Board that the programme is safe, ethical, and that patient confidentiality is observed.

The introduction of the registration component of the national tissue platform should also improve oversight of tissue collections held within NHS Lothian and the University of Edinburgh. The primary focus of this will be collections where project-specific REC and R&D approval has ended.

2.3.5 Equality and Diversity, including health inequalities

Not applicable.

An impact assessment was carried out in July 2011 at the time of our first report. The main findings were that the activities of the Tissue Governance will have no negative impact upon inequalities.

2.3.6 Other impacts

Not applicable

2.3.7 Communication, involvement, engagement, and consultation

Not applicable – we are not proposing any change to service or policies.

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Tissue Governance Management Committee, 10 January 2025

2.4 Recommendation

- **Awareness** – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix 1 – NRS Accreditation Certificate
- Appendix 2 – NRS Accreditation Annual Declaration (2024)
- Appendix 3 – Confirmation of ethical approval for Lothian NRS BioResource

NHS SCOTLAND
NHS RESEARCH SCOTLAND

CENTRAL MANAGEMENT TEAM

NHS Research Scotland (NRS) Lothian

CERTIFICATE OF ACCREDITATION

01/02/23-31/01/26

We confirm NRS Lothian Biorepository working on behalf of NHS Lothian has met the NRS Accreditation Standards. The Accreditation period lasts for 3 years and is subject to an Annual Declaration of Compliance.

Stephen Kelly PhD,
Science Manager, NRS-CMT

Professor James Ironside,
Chair, Independent Expert Panel

Human Tissue legislation in Scotland differs from that in the rest of the UK. The NRS Biorepositories are therefore accredited by an Independent Expert Panel using criteria comparable to those for research tissue bank licensing in England, Wales and Northern Ireland by the Human Tissue Authority.

NHS SCOTLAND
NHS RESEARCH SCOTLAND
CENTRAL MANAGEMENT TEAM

NRS Biorepositories Annual Self-Certification: 1st February 2023 – 31 January 2024

Please complete and return a signed copy to bioaccreditation@nrs.org.uk.

Before signing, please use the table below to inform us of any events or instances that altered or had the potential to alter the ability of the human tissue bank to meet the Quality Standards for NRS Biorepository Accreditation.

Examples of such events/instances that could affect your accreditation status include (this list is not exhaustive):

- Moving premises
- Long term absence of key tissue bank staff
  e.g., sabbatical, parental leave, sick leave, retirement, resignation
- Significant event/incident:
  e.g., equipment failure, damage to premises, a breach in the consent policy
- IT system failure affecting or compromising data relevant to the tissue collected
- Changeover of senior staff
  e.g., R&D Director, tissue bank manager
- Significant amendment to your existing ethics approval

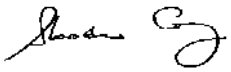
Event / Instance	Impact to performance
e.g., change of Manager	*Minimal impact, new manager transitioned from existing staff and is very experienced*

Regional Human Tissue Banks Annual Self-Certification:

1st February 2023 – 31 January 2024

NHS Board	NHS Lothian
Address	Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Chief Executive Name	Calum Campbell
Chief Executive Signature	
Date	13 March 2024

R&D Director / RD&I Director Name	Alasdair Gray
R&D Director / RD&I Director Signature	
Date	13/03/2024

By signing this declaration, you are confirming that your human tissue bank will meet the Quality Standards of Operation required to maintain your accreditation status. Return of the completed document is a condition of your accreditation.

If you have any queries, please contact:
bioaccreditation@nrs.org.uk

Amended 16/07/2020

NHS SCOTLAND

East of Scotland Research Ethics Service *(EoSRES)*

Research Ethics Service

TAyside medical Science Centre
Residency Block Level 3
George Pirie Way
Ninewells Hospital and Medical School
Dundee DD1 9SY

Professor David J Harrison
NHS Lothian
Laboratory Medicine
Royal Infirmary of Edinburgh
51 Little France Crescent
EH16 4SA

Date: 23 June 2020
Your Ref:
Our Ref: LR/**20/ES/0061**
Enquiries to: Mrs Lorraine Reilly
Direct Line: 01382 383878
Email: eosres.tayside@nhs.net

Dear Professor Harrison

Title of the Research Tissue Bank: **Lothian NRS Bioresource**
REC reference: **20/ES/0061**
Designated Individual: **Professor David Harrison**
IRAS project ID: **281531**

The Research Ethics Committee reviewed the above application at the meeting held on 19 June 2020. Thank you, Mrs Frances Rae and Dr Craig Marshall for attending via Zoom teleconferencing to discuss the application.

Ethical opinion

The members of the Committee present gave a favourable ethical opinion of the above research tissue bank on the basis described in the application form and supporting documentation, subject to the conditions specified below.

The Committee has also confirmed that the favourable ethical opinion applies to all research projects conducted in the UK using tissue or data supplied by the tissue bank, provided that the release of the tissue or data complies with the attached conditions. It will not be necessary for these researchers to make project-based applications for ethical approval. They will be deemed to have ethical approval from this committee. You should provide the researcher with a copy of this letter as confirmation of this. The Committee should be notified of all projects receiving tissue and data from the tissue bank by means of an annual report.

This application was for the renewal of a Research Tissue Bank application. The previous REC Reference number for this application was 15/ES/0094.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the Research Tissue Bank.

Number	Conditions
1.	Provide clarification with regards to the EBAT procedures as it included a request for tissue from back operations as stated in the letter of invitation (appendix 24). However, the PIS and consent form (appendix 23) did not include mention of the

	operation site and there was also no statement in the consent form explicitly requesting consent to tissue being taken.
2.	Review and amend the following wording on the ERTBB script for website (appendix 28) to include less authoritative wording; for example, 'you should have read this sheet' to read 'Please read this sheet' and 'You should keep the Patient Information Sheet' to read 'Please keep the Patient Information Sheet'.
3.	The Committee noted that in all the invitation letters; for example, appendix 43, it stated 'I am willing/not willing to take part in the Regenerative Neurology Tissue Bank' and requested that the statements were amended to 'I am willing/not willing to receive information about xxxxxxxx'.
4.	Review and amend the SRNTB consent form (appendix 53) as there was no explicit statement requesting permission to have a blood sample taken.

You should notify the REC once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers. Revised documents should be submitted to the REC electronically from IRAS. The REC will acknowledge receipt and provide a final list of the approved documentation for the Research Tissue Bank, which can be made available to host organisations to facilitate their permission for the Research Tissue Bank. Failure to provide the final versions to the REC may cause delay in obtaining permissions.

Research governance

Under the UK Policy Framework for Health and Social Care Research, there is no requirement for NHS research permission for the establishment of research tissue banks in the NHS. Applications to NHS R&D offices through IRAS are not required as all NHS organisations are expected to have included management review in the process of establishing the research tissue bank.

Research permission is also not required by collaborators at tissue collection centres (TCCs) who provide tissue or data under the terms of a supply agreement between the organisation and the research tissue bank. TCCs are not research sites for the purposes of the RGF.

Research tissue bank managers are advised to provide R&D offices at all TCCs with a copy of the REC application for information, together with a copy of the favourable opinion letter when available. All TCCs should be listed in Part C of the REC application.

NHS researchers undertaking specific research projects using tissue or data supplied by the research tissue bank must apply for permission to R&D offices at all organisations where the research is conducted, whether or not the research tissue bank has ethical approval.

Assessment of site suitability is not a requirement for ethical review of research tissue banks.

Registration of Research Tissue Banks

It is a condition of the ethical approval that all Research Tissue Banks are registered on the UK Clinical Research Collaboration (UKCRC) Tissue Directory. The Research Tissue Bank should be registered no later than 6 weeks after the date of this favourable ethical opinion letter or 6 weeks after the Research Tissue Bank holds tissue with the intention to provide for research purposes. Please use the following link to register the Research Tissue Bank on the UKCRC Directory: https://directory.biobankinguk.org/Register/Biobank Registration is defined as having added details of the types of tissue samples held in the tissue bank.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment or when submitting an annual progress report. We will monitor the registration details as part of the annual progress reporting process.

Publication of Your Research Summary

We will publish your research summary for the above study on the research summaries section of our website, together with your contact details, no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, make a request to defer, or require further information, please visit: https://www.hra.nhs.uk/planning-and-improving-research/application-summaries/research-summaries/

For research studies related to COVID-19, we are fast-tracking the publication of research summaries. During this public health emergency, it is vital that everyone can promptly identify all relevant research related to COVID-19 that is taking place globally. If you have not already done so, please register your study on a public registry as soon as possible and provide the HRA with the registration detail, which will be posted alongside other information relating to your project. We are also asking sponsors not to request deferral of publication of research summary for any projects relating to COVID-19. In addition, to facilitate finding and extracting studies related to COVID-19 from public databases, please enter the WHO official acronym for the coronavirus disease (COVID-19) in the full title of your study. Approved COVID-19 studies can be found at: https://www.hra.nhs.uk/covid-19-research/approved-covid-19-research/

Duration of ethical opinion

The favourable opinion has been renewed for five years from the end of the previous five year period provided that you comply with the standard conditions of ethical approval for Research Tissue Banks set out in the attached document. You are advised to study the conditions carefully. The opinion may be renewed for a further period of up to five years on receipt of a fresh application. It is suggested that the fresh application is made 3-6 months before the 5 years expires, to ensure continuous approval for the research tissue bank.

Research Tissue Bank Renewals

The previous five year period ran from 14 July 2015 to 14 July 2020. This Research Tissue Bank may be renewed for further periods of five years at a time by following the process described in the above paragraph.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Covering letter on headed paper [Appx 63 Cover letter]		01 June 2020
IRAS Checklist XML [Checklist_03062020]		03 June 2020
Other [Appx 4 Bioresource PIS GI]	1.5	09 October 2019
Other [Appx 9 Bioresource Consent skin tracked changes]	1.3	28 May 2020
Other [Appx 10 Bioresource PIS Skin tracked changes]	1.3	28 May 2020
Other [Appx 15 Surgery consent generic]	2.0	
Other [Appx 16 Accreditation certificate]		01 February 2020
Other [Appx 18 Bioresource protocol clean]	6.0	01 June 2020

Other [Appx 19 SCOTRRCC protocol tracked changes]	5.0	24 April 2020
Other [Appx 21 SCOTRRCC ICF tracked changes]	4.0	24 April 2020
Other [App 22 EBAT protocol]	6	05 March 2020
Other [Appx 23 EBAT PIS and Consent]	8	02 April 2020
Other [Appx 3 Bioresource consent GI]	1.4	09 October 2019
Other [Appx 24 EBAT letter neurosurgeon]	1.0	02 April 2020
Other [Appx 25 EBAT letter kidney]	1.0	05 March 2020
Other [Appx 30 ERTBB online consent Covid]	1.0	22 May 2020
Other [Appx 34 SRNTB cover letter]	1.0	27 May 2020
Other [Appx 35 SRNTB GP letter clean]	2.0	27 May 2020
Other [Appx 37 SRNTB thank you letter clean]	2.0	27 May 2020
Other [Appx 38 SRNTB thank you letter tracked changes]	2.0	27 May 2020
Other [Appx 39 SRNTB partner carer letter clean]	2.0	27 May 2020
Other [Appx 43 SRNTB Neuro letter clean]	2.0	27 May 2020
Other [Appx 45 SRNTB Neuro PIS clean]	2.0	27 May 2020
Other [Appx 49 SRNTB Relative PIS clean]	2.0	27 May 2020
Other [Appx 58 Prof Harrison CV]		
Other [Appx 59 List of appendices]		
Other [Appx 60 Biorepositories network approval form]	2.0	12 November 2015
Other [Appx 31 ERTBB online consent form Covid-19 highlighted changes]	1.0	22 May 2020
Other [Appx 5 Bioresource consent gynae]	1.3	09 October 2019
Other [Appx 6 Bioresource PIS Gynae]	1.3	09 October 2019
Other [Appx 7 Bioresource Consent liver]	1.1	09 October 2019
Other [Appx 8 Bioresource PIS liver]	1.1	09 October 2019
Other [Appx 11 Bioresouce Consent stem cell]	1.4	09 October 2019
Other [Appx 12 Bioresource PIS stem cell]	1.4	09 October 2019
Other [Appx 13 Bioresource Consent Xenograft]	1.4	09 October 2019
Other [Appx 14 Bioresource PIS Xenograft]	1.4	09 October 2019
Other [Appx 20 SCOTRRCC PIS]	4.0	24 May 2016
Other [Appx 26 Fife SOP]	2.0	05 July 2019
Other [Appx 27 ERTBB protocol]	2.0	25 May 2020
Other [Appx 28 ERTBB Covid script]	1.0	22 May 2020
Other [Appx 29 ERTBB PIS QR code Covid]	1.9	06 March 2019
Other [Appx 32 SRNTB guidelines clean]	2.0	27 May 2020
Other [Appx 33 SRNTB guidelines tracked changes]	2.0	27 May 2020
Other [Appx 36 SRNTB GP letter tracked changes]	2.0	27 May 2020
Other [Appx 40 partner carer invitation letter tracked changes]	2.0	27 May 2020
Other [Appx 41 SRNTB partner PIS clean]	2.0	27 May 2020
Other [Appx 42 SRNTB partner PIS tracked changes]	2.0	27 May 2020
Other [Appx 44 Neuro letter tracked changes]	2.0	27 May 2020
Other [Appx 46 Neuro PIS tracked changes]	2.0	27 May 2020
Other [Appx 47 SRNTB relative letter clean]	2.0	27 May 2020
Other [Appx 48 SRNTB Relative letter tracked changes]	2.0	27 May 2020
Other [Appx 50 SRNTB Relative PIS tracked changes]	2.0	27 May 2020

Other [Appx 51 SRNTB Sample form clean]	2.0	27 May 2020
Other [Appx 52 SRNTB Sample form tracked changes]	2.0	27 May 2020
Other [Appx 53 SRNTB Consent form clean]	2.0	27 May 2020
Other [Appx 54 SRNTB Consent form tracked changes]	2.0	27 May 2020
Other [Appx 55 SRNTB Data Collection Proforma]	1.0	27 May 2020
Other [Appx 56 SRNTB Flow chart clean]	2.0	27 May 2020
Other [Appx 57 SRNTB Flow chart tracked changes]	2.0	27 May 2020
Other [Appx 61 Terms of reference TG committee]	1.5	23 May 2020
Other [Appx 62 HTA/NRES Joint statement]		01 July 2009
Participant consent form [Appx 1 Bioresource Consent Form generic]	1.6	09 October 2019
Participant information sheet (PIS) [Appx 2 Bioresource PIS generic]	1.6	09 October 2019
Protocol for management of the tissue bank [Appx 17 Bioresource protocol tracked changes]	6.0	01 June 2020
REC Application Form [RTB_Form_03062020]		03 June 2020

Membership of the Committee

The members of the Ethics Committee who were present at the meeting are listed on the attached sheet.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review: Reporting requirements

The attached standard conditions give detailed guidance on reporting requirements for research tissue banks with a favourable opinion, including:

- Notifying substantial amendments
- Submitting Annual Progress reports

The latest guidance on these topics can be found at https://www.hra.nhs.uk/approvals-amendments/managing-your-approval/.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website: http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Learning

We are pleased to welcome researchers and research staff to our HRA Learning Events and online learning opportunities– see details at: https://www.hra.nhs.uk/planning-and-improving-research/learning/

Yours sincerely

pp
Dr Robert Rea
Chair

E-mail: eosres.tayside@nhs.net

Enclosures: List of names and professions of members who were present at the meeting and those who submitted written comments
(RTB) Conditions of Approval

Copy to: NHS Lothian R&D Department

East of Scotland Research Ethics Service REC 1

Attendance at Committee meeting on 19 June 2020

Committee Members:

Name	Profession	Present	Notes
Dr Robert Rea	Business Development Manager	Yes	Chair
Dr Joshua Agbogidi	Senior Registrar	Yes	
Dr Ian Barker	Retired Anaesthetist	Yes	
Mrs Johan Bennie	Medical Secretary	Yes	
Mrs Katherine Coll	Trial Manager	Yes	
Mr Jonathan Feeney	Bank Healthcare Assistant	No	Apologies received
Ms Lisa MacLeod	Lecturer in Clinical Pharmacy	Yes	
Dr Joel Rocha	Lecturer in Physical Activity and Public Health	No	Apologies received
Dr Douglas Scott	GP	Yes	
Miss Emma Wilson	Trainee Health Psychologist	No	Apologies received

Also in attendance:

Name	Position (or reason for attending)
Dr Bannin De Witt Jansen	Scientific Officer/Regional Manager
Mrs Susan Hewer	Observer
Mrs Lorraine Reilly	REC Manager

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28th January 2025**
Title:	**2024 STAG Report & Major Trauma Peer Review**
Responsible Executive:	**Tracey Gillies Executive Medical Director**
Report Author:	**Wendy Parkinson Clinical Service Manager Major Trauma, Dean Kerslake Clinical Director Major Trauma, James Powell Associate Medical Director Surgical Services RIE**

1 Purpose

[Please check the boxes for all items that apply in each section]

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

Report summary

1.0 Situation

The purpose of this report is to provide the committee with an update on the 2024 Scottish Trauma Audit Group (STAG) report published by Public Health Scotland and an overview of the outcomes and recommendations from the 2024 STN peer review.

The committee is recommended to accept assurance that the major trauma service has comprehensive systems in place to deliver safe, effective and person-centred care.

2.0 Background

2.1. Scottish Trauma Network

Trauma remains the fourth leading cause of death in western countries and is the leading cause of death for people under 40. In May 2016, the Cabinet Secretary for Health and Sport set out a commitment, to implement a bespoke Scottish Trauma Network (STN) comprising of an inclusive network of hospitals, four major trauma centres (MTCs) and integrated network infrastructure.

The purpose of the National Network is to ensure that those who experience Major Trauma receive quick access to high-quality, multi-speciality care and rehabilitation irrespective of geography.

Major Trauma care starts from the point of injury and the Scottish Ambulance Service plays a vital role in the delivery of the major trauma service. Pre-hospital teams deliver initial life-saving care as well as ensuring patients are appropriately triaged to the right hospital in the network, by using the Major Trauma Triage Tool (MTTT).

Each regional network is comprised of several sites who deliver acute care and rehabilitation. Regional networks are often comprised of Major Trauma Centres (MTCs), Trauma Units (TUs) and Local Emergency Hospitals (LEHs).

Major Trauma Centres are specialised hospitals that can deliver 24/7 access to consultant delivered care for patients who have sustained the most serious injuries. Trauma Units and Local Emergency Hospitals provide most of the care and treatment for trauma patients who do not require the specialist care of an MTC but who do require access to highly skilled specialists. These sites also provide care and resuscitation for patients who are injured over a 45-minute drive away from the MTC and require initial care and resuscitation before being transferred to the MTC.

The four regions within the Scottish Trauma Network are:

- **North of Scotland** (MTCs - Aberdeen Royal Infirmary and Royal Aberdeen Children's Hospital) established in 2018.
- **East of Scotland** (MTC - Ninewells Hospital) established in 2018.
- **South East of Scotland** (MTCs at Royal Infirmary of Edinburgh and Royal Hospital for Children and Young People) established in 2021.

- **West of Scotland** (MTCs – Queen Elizabeth University Hospital and Royal Hospital for Children) established in 2021.

2.2. South East of Scotland Trauma Network

The South East of Scotland Major Trauma Network was launched on 30th August 2021 and receives approximately 30% of trauma in Scotland. The Boards which participate in the South East Trauma Network are NHS Borders, NHS Fife, NHS Forth Valley, NHS Lothian and the Scottish Ambulance Service. Within these Health Boards there are three Trauma Units (based in Borders, Fife & Forth Valley), two Major Trauma Centres (for adult and paediatric patients in Lothian) and one Local Emergency Hospital (St John's Hospital Livingston in NHS Lothian).

The adult Major Trauma Centre (MTC) is located at the Royal Infirmary of Edinburgh and is based across two sites on the Little France campus. There is a dedicated 12-bedded major trauma ward in the Royal Infirmary of Edinburgh for polytrauma patients and eight funded beds within the Department of Clinical Neurosciences for patients with head injuries. The Paediatric Major Trauma Centre is based within the Royal Hospital for Children and Young People (RHCYP).

Hospitals within the South East Trauma Network have access locally to community based rehab facilities. The region is also served by a number of specialist rehabilitation units. These are Astley Ainslie Hospital (NHS Lothian, level 1), Bellfield Centre at Stirling Community Hospital (NHS Forth Valley, level 2B) and Sir George Sharp Unit at Cameron Hospital (NHS Fife, level 2B) as described here.

The South East of Scotland has developed comprehensive pathways with the key aim of not only saving lives but also giving life back through effective, coordinated rehabilitation. Pathways include repatriation pathways; secondary transfer protocols; head injury pathways and patient rehabilitation plans.

Management and governance processes

The Scottish Trauma Audit Group (STAG) is one of a number of audits within Scottish National Audit Programme (SNAP) and hosted within Public Health Scotland.

STAG was established with the aim of improving the quality of care, experience, and outcomes of patients with severe trauma injuries through measuring compliance against standards of care to support local quality improvement.

The STAG steering group has responsibility for the oversight of the audit including maintenance of reporting standards, adherence to aims, objectives and reporting of results. The STAG steering group is comprised of multi-disciplinary representation from NHS Health Boards across Scotland and includes patient representation.

The steering group meet regularly throughout the year to review the progress and direction of the audit in achieving aims and objectives.

STAG publish an annual report each year to report back on each trauma network's activity and compliance with a series of agreed key performance indicators.

3. Scottish Trauma Audit Group Report 2024

3.1. Assessment

The 2024 STAG Audit focuses on the calendar year 2023. The report published by Public Health Scotland, includes details of compliance with Scottish Trauma Network key performance indicators, mortality, and patient related outcome measures. It also provides a comprehensive summary of injuries and the patient journey for both adults and paediatrics.

It is the second annual STAG publication focusing on the STN as a whole and is the most complete picture to date of the epidemiology, service performance and patient outcome in those who suffer severe traumatic injury. The 2024 annual STAG national report presents detailed information of the care of 8368 adults (aged 16 and over) and 229 children and young people (under the age of 16 years) with severe injury (trauma), who have been treated in Scotland's NHS hospitals.

This is the most complete dataset to date and covers 99% of Emergency Department (ED) attendances from 29/30 of Scotland's Emergency Departments.

The Scottish Trauma Audit Group (STAG) uses the Injury Severity Score (ISS) as a measure to define major trauma. The ISS is a scoring system which calculates an injury severity score by looking at the number and severity of injuries sustained. The ISS can range from 1 which is a minor injury to 15 or above which is classified as major trauma. 75 represents a fatal injury.

The STAG audit collects data on all trauma patients (those with injuries classified as minor to major trauma), who have presented with injuries and fulfil one of the below criteria:

- Have a length of stay of 3 days or more (date of attendance is counted as day '0' and trauma patients who are transferred in/out of a hospital whose combined stay across multiple sites is 3 days or more).
- Trauma patients admitted to critical care (ITU or HDU), or Spinal Injury Unit (SIU) regardless of length of stay or admission specialty.
- Trauma patients (who would have been included in the audit) who die in the hospital, including the Emergency Department.

In 2019 STAG updated their inclusion criteria to include patients admitted under a medical ward if other inclusion criteria were met. Prior to 2019, only patients admitted under surgical wards were included in the audit. The change in inclusion criteria has increased the scope of the STAG Audit.

It should be highlighted that to be included in the audit patients have been injured severely enough to spend a minimum of three days in hospital, be admitted to critical care or die in hospital because of their injuries. Trauma patients who remain in hospital for over three

days due to a delay in their discharge would also be included in the audit. There are many more trauma admissions to hospitals out with these criteria, however the STAG audit focuses on the most severely injured patients. The full inclusion/exclusion criteria can be viewed here.

3.2. Key Findings

3.2.1. Scottish Trauma Network Summary

- This report, as with previous years, shows that the vast majority of severe trauma in Scotland is caused by falls, most commonly a fall on the same level rather than from a height. Trauma related to moving vehicles was the next most common cause of severe trauma.

- Falls and moving vehicle injuries accounted for 45% and 35% of all injuries respectively in paediatric patients.

- The report illustrates a changing demographic shift in the trauma patient group, with a rise in the median age from 55 years in 2013, to 60 years in 2018 and now 69 years in 2023. Falls accounted for 76% of traumatic injuries across all ages, rising to 90% in those over the age of 65 years.

- In response to this demographic change the STAG group has introduced clinical frailty scoring to their dataset. This change in demographic poses a potential challenge for all networks. The South East of Scotland Major Trauma Centre has a dedicated Medicine of the Elderly Consultant led team who input and oversee the care of elderly trauma patients. Multiple major trauma staff members from across the South East Network have also completed the HECTOR trauma course which delivers specialist training on the management of elderly trauma.
- KPI 2.8 stipulates that patients who have suffered major trauma (ISS >15) should be taken to an MTC and admitted under the care of the major trauma service rather than a single-specialty service. Across the STN there was an increase in compliance with this KPI, increasing from 11% in 2021 to 21% in 2023 nationally.
- 47% of the patients 65 years and over assessed using the Clinical Frailty Score (CFS). Of those assessed 37% were frail and 17% were mildly frail.
- 31% of patients aged 65 years and over were assessed by a specialist in medicine of the elderly (MOE). 66% of these patients were assessed as having a clinical frailty score of 5-9 which indicates frailty. The remaining 34% had a clinical frailty score of 4 or less which means no clinical frailty was indicated.
- Length of stay (LOS) showed a median stay of 9 days for adults and 5 days for paediatrics.
- Most patients in both adults (65%) and paediatrics (92%) were discharged home within 30 days.
- Patient Reported Outcome Measures (PROMS) data showed less patients reported moderate to extreme problems with pain, mobility, and self-care in 2022-23. Please see table below:

	Jun 2018 – Aug 2021	Sep 2022 – Aug 2023
Reported moderate to severe issues with mobility	39.6%	31.7%
Reported moderate to severe issues with pain	45.2%	42.4%
Reported moderate to extreme problems with self-care	22.3%	16.6%

- Using the Glasgow Outcome Scale (GOS), patients who reported "lower severe disability", requiring dependence on others for care, reduced from 7% in 2018-2021 to 3% in 2022-2023.
- 79% of patients in full or part time employment at the time of their injury returned to work in 2022-2023 compared to 66% in 2018-2021. It should be noted that this data is collected via PROMs and only reflects the experience of those who have chosen to or been able to participate in PROMs. Employment data was collected for fewer patients in 2022-2023 than in 2018-2021.
- Adult patients injured in moving vehicle injuries (MVI), were most commonly the driver (28%) followed by motor cyclists (20%) and pedal cyclists (17%). Paediatric patients involved in moving vehicle injuries were predominantly pedestrians (44%) and pedal cyclists (27%).
- The most severe injuries in adults showed a predominance of chest, limb and head injury. In paediatrics severe injuries were most likely in the limb, head and abdomen.
- Patients from the most deprived areas were more likely to have a severe injury however there was no associate between deprivation and survival in this dataset.
- Most major trauma adult patients were taken directly to an MTC in 2023 (58%).
- 119 adult patients had a severe injury whilst an inpatient in hospital.
- 10% of adult patients were transferred for definitive care with the most common reasons being for trauma and orthopaedic (32%) and neurosurgical care (21%).
- 70% of adult patients transferred for definitive care did so within 24 hours.
- This was the first year that QEUH is the busiest receiving trauma hospital in Scotland.

3.2.2. NHS Lothian Summary

- Across all three NHS Lothian STAG Hospitals (Royal Infirmary of Edinburgh, St John's Hospital Livingston and Royal Hospital for Children and Young People there was 100% data completion and submission to the STAG audit.
- 1130 Adults were admitted to RIE following a severe injury, an increase of 25 (2.3%) since 2022. There was an increase in trauma patients whose injuries were classified as major trauma (ISS > 15) with the number of patients increasing from 240 to 246. The median age in adults remained static at 68 years for RIE. 10% of patients with injuries classified as major trauma in RIE self-presented.

- 148 Adults were admitted to or through SJH following a severe injury, an increase of 47 (42%) since 2022. [redacted] children were admitted to SJH. There was a decrease in absolute number of major trauma patients from 26 to 21. Median age in adults increased at SJH (68-75). 43% of patients with major trauma in SJH self-presented.
- 34 Children were admitted to the Royal Hospital for Children and Young People.
- The RIE was >3 standard deviations (SD) above the national average for compliance with one KPI; Patients with a suspected head injury with a GCS<13 (or intubated) receives a CT head scan within one hour of arrival in ED,
- All other reported KPIs for all three NHS Lothian sites were within the expected national mean.
- Case mix adjusted mortality for all three sites in Lothian was within the expected statistical process control limits when compared to Scotland. The RIE performed 2 standard deviations above the national average for the number of expected survivors in this period (see figure 1).
- Survival in all three NHS Lothian hospitals (RIE, RHCYP and SJH) is within 2 standard deviations.

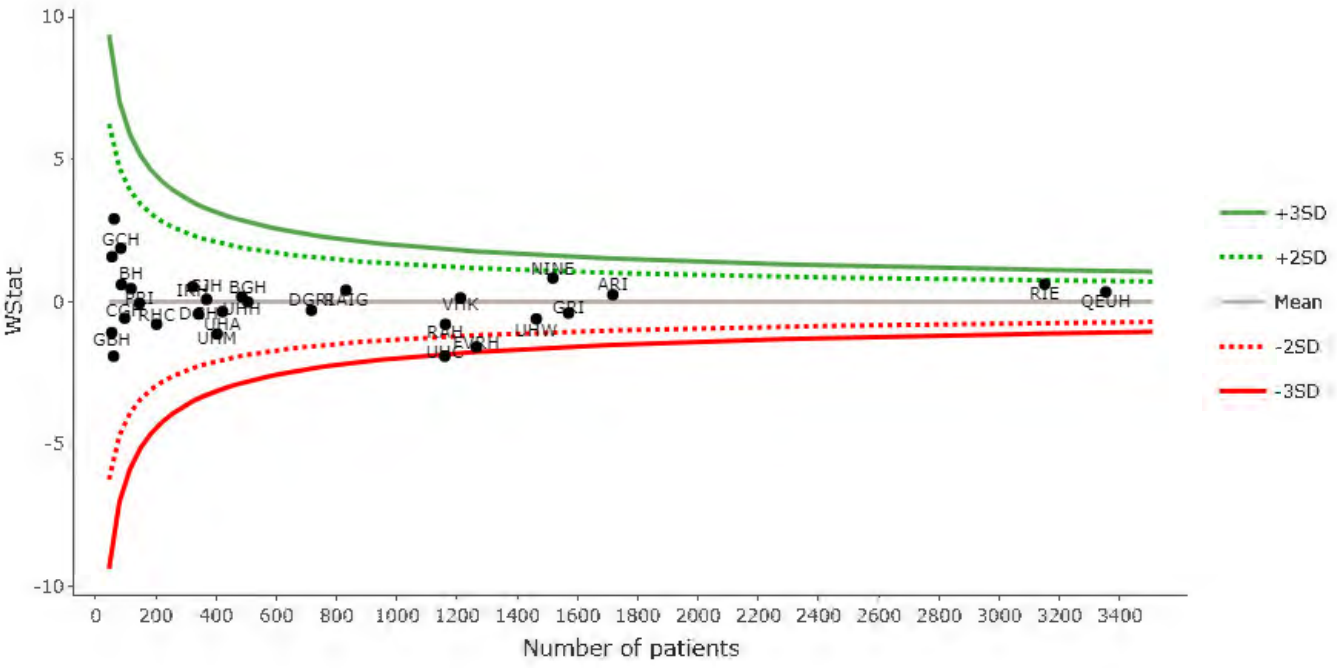


Figure 1: Case mix adjusted mortality.

3.2.3. South East of Scotland Compliance with Key Performance Indicators (KPI)

- The South East of Scotland was identified in the report as performing three standard deviations above the national average for two KPIs (3.1.1 – Assessment of Rehab Needs and KPI 3.2 – PROMs).
- The Royal Infirmary of Edinburgh was identified as performing >3SD above the national average for compliance with KPI 2.4.3: Patients with a suspected head injury with a GCS<13 (or intubated) receives a CT head scan within one hour of arrival in ED.

- The Royal Hospital for Children and Young People was identified as performing >2SD above the national average for compliance with KPI. 2.4.3: Patients with a suspected head injury with a GCS <13 (or intubated) receives a CT head scan within one hour of arrival in ED.
- The South East of Scotland was noted to be performing in line with the Scottish average for all other KPIs.

South East of Scotland's compliance with Scottish National Audit Programme (SNAP) Key Performance Indicators

	2022	2023
KPI 2.5. MTC care for patients with a severe head injury	67.9%	64.3%
KPI 2.6. Patients with open long bone, mid or hind foot fractures receive IV antibiotics within three hours	69.0%	73.1%
KPI 2.7 Administration of TXA in patients with severe haemorrhage	71.4%	82.6%
KPI 3.1.1. Assessment of rehab needs	92.8%	95.5%
KPI 3.1.2 Time to assessment of rehabilitation needs	86.3%	93.8%
KPI 3.2 Functional outcome using PROMs	73.8%	89.4%

South East of Scotland Compliance with SNAP Governance – CT KPI's.

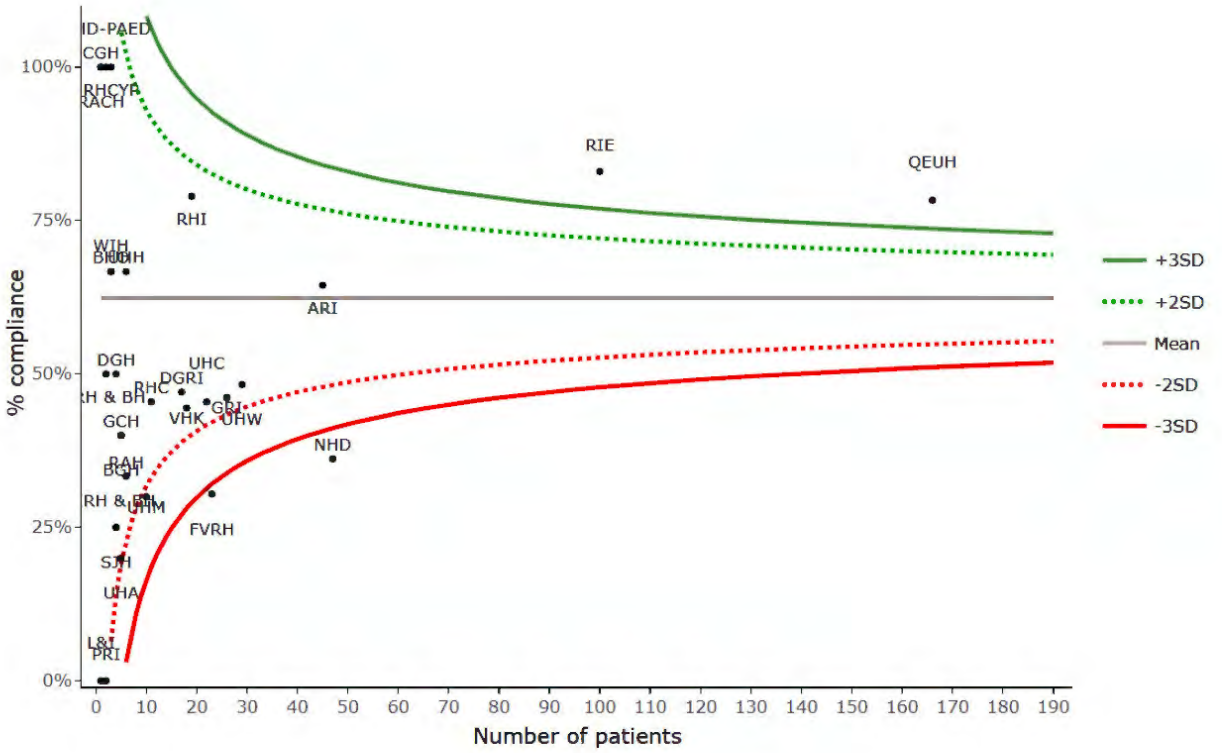


Figure 2: Compliance with KPI: 2.4.3 – Time to CT Head GCS <13

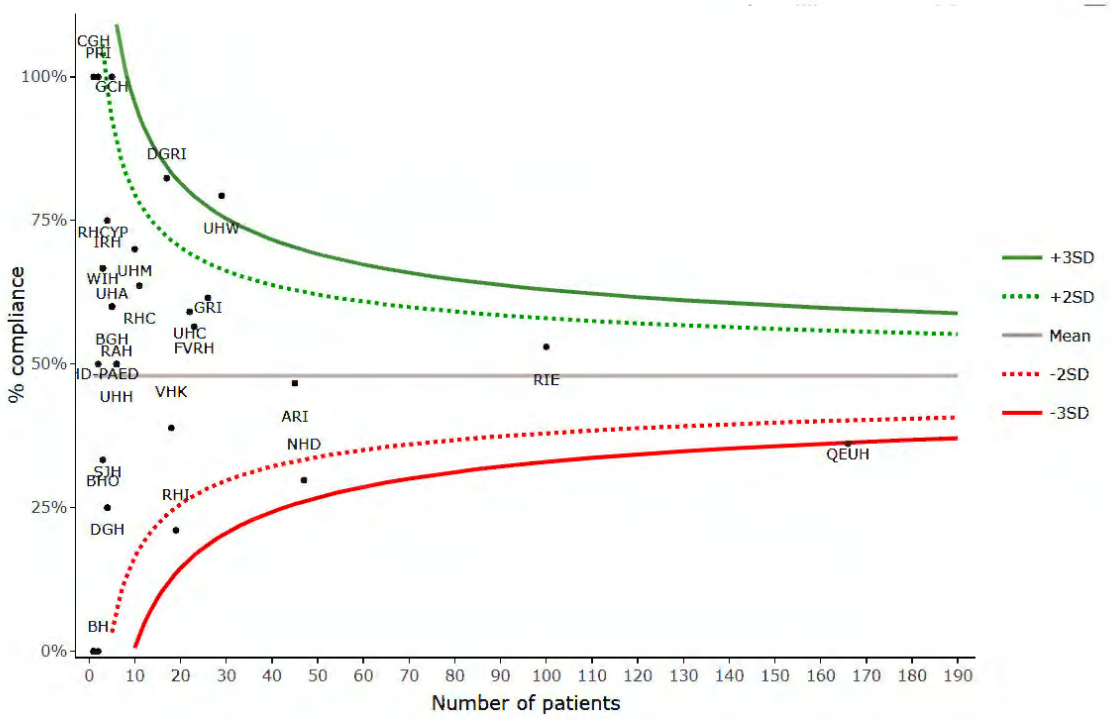


Figure 3: Compliance with KPI: 2.4.4 – Time to CT Head Report GCS <13

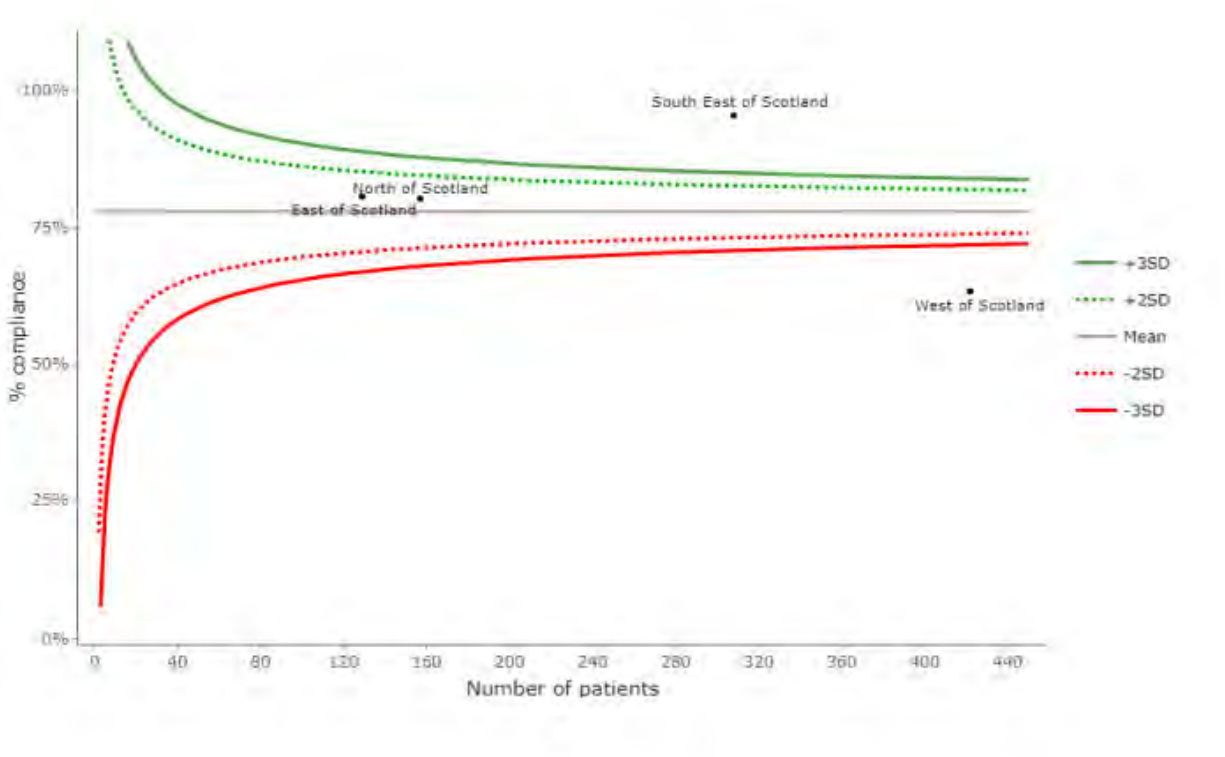


Figure 4: KPI 3.1.1 Assessment of rehabilitation needs

Excellent compliance with KPI 3.1.1: Assessment of rehab needs has been achieved with the following processes that have been implemented:

- Establishment of good relationships between rehab teams and Scottish Trauma Audit groups.
- Use of a TRAK workbench to ensure early identification of trauma patients and maximise opportunity to highlight patients and start rehabilitation assessment and Rehabilitation Plan.
- The multi-disciplinary team take a shared responsibility for completion of the Rehabilitation Plan.
- The trauma network has a seven-day rehabilitation service which ensures that Rehabilitation Plans can also be completed at weekends.

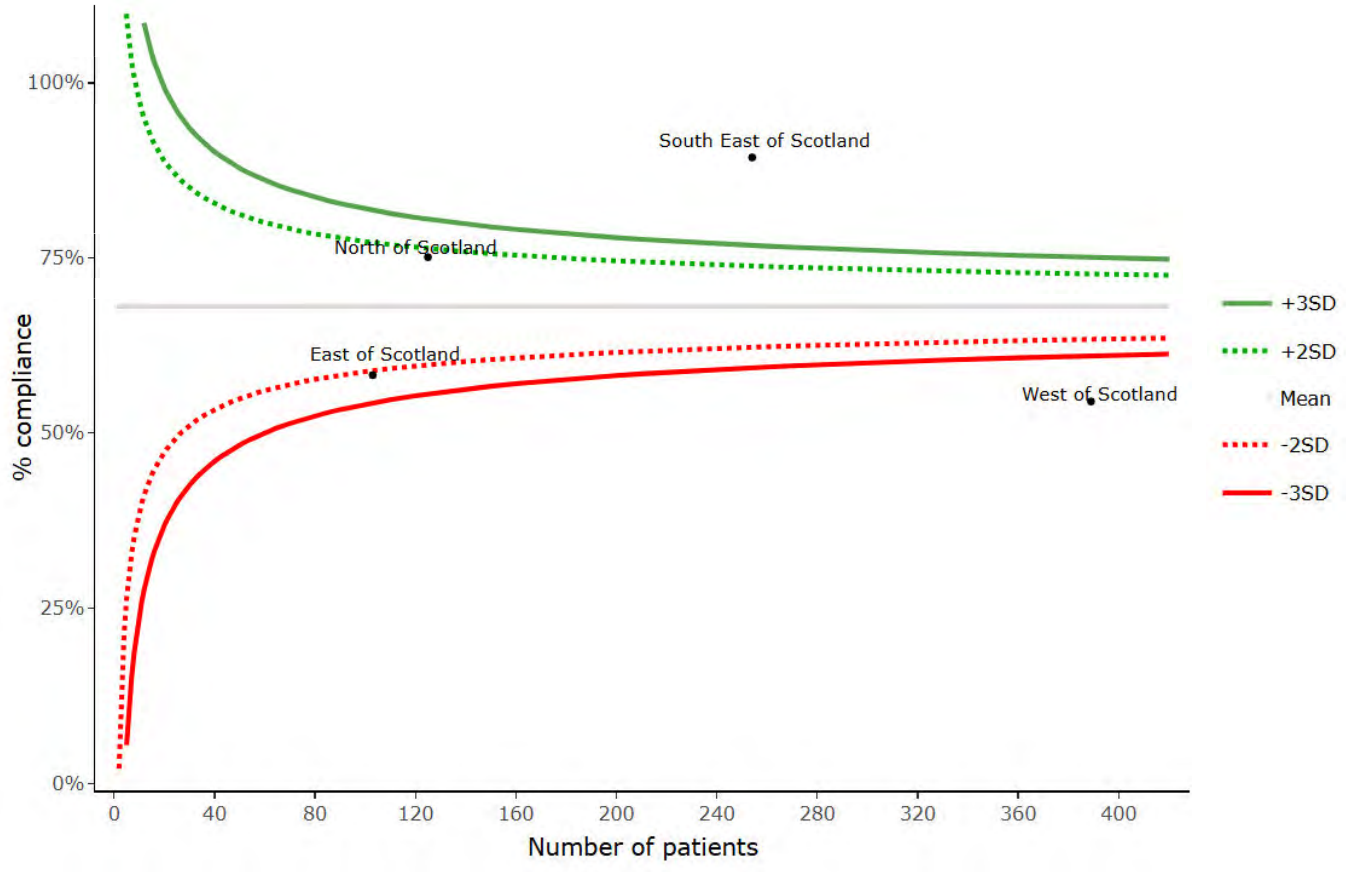


Figure 5: KPI 3.2: PROMS

Excellent compliance with KPI 3.2: Assessment of rehab needs has been achieved the following processes have been implemented:

- A local standard operating procedure for PROMs collection has been developed and is consistently followed.
- Teams benefit from co-location of the STAG LACs with the rehabilitation coordinators on the major trauma ward which ensures early identification of eligible patients (oversight from STAG LACs).
- The MTC has widened the team of staff who participate in PROMs issue/collection. This now includes all rehabilitation assistants who are trained and involved in approaching patients, as well as rehabilitation coordinators.
- The team monitor and scrutinise weekly PROMs compliance report from STAG LAC for patients not approached/missed and whether they can be followed up for collection by the team.
- Continuing to foster a sense of 'team' in terms of a collective responsibility to meet the PROMs KPI across the therapy staff, rehab coordinators and STAG LACs.

3.1.5. Future Audits

In the coming years, the following KPIs will be included within the STAG SNAP Governance process and the network will be measured on these KPIs.

- KPI 2.1.1. Patients with major trauma (ISS >15) that are taken to an MTC are received by a consultant led trauma team. The RIE does not currently have access to 24/7 onsite Emergency Department (ED) Consultant cover, and it is therefore unlikely that the service will be able to meet this KPI. This risk is described further in section 3.5.
- KPI 2.2. - Major trauma patients who are not taken directly to a MTC and are later transferred to a MTC are transferred within 24 hours.

4. SETN Peer Review

4.1. Assessment

The need for a peer review of trauma services in Scotland was identified by an internal National Services Division review of the Scottish Trauma Network (STN) in 2022/23.

The aim of the peer review was to allow regions to benchmark themselves against the STN minimum requirements. The process was designed to be a collaborative and supportive improvement process which was led by the regions and services themselves.

The process for this peer review was modelled on similar reviews of trauma services in England and Wales. The review involved the submission of a comprehensive evidence paper which demonstrated whether regions were meeting each minimum requirement. The process then consisted of a two-day site visit, including a walk round of the patient pathway at the adult and paediatric major trauma centres, presentations from all sites and a Q&A sessions with major trauma teams from across the South East Trauma Network.

The peer review panel responsible for assessing the regions was comprised of five clinical and managerial leads from across the Scottish and English Trauma Networks.

4.2. Peer Review Recommendations

Outcomes from the peer review process were largely positive. Figure 6 below illustrates the number of positive comments the South East received against the number of concerns identified.

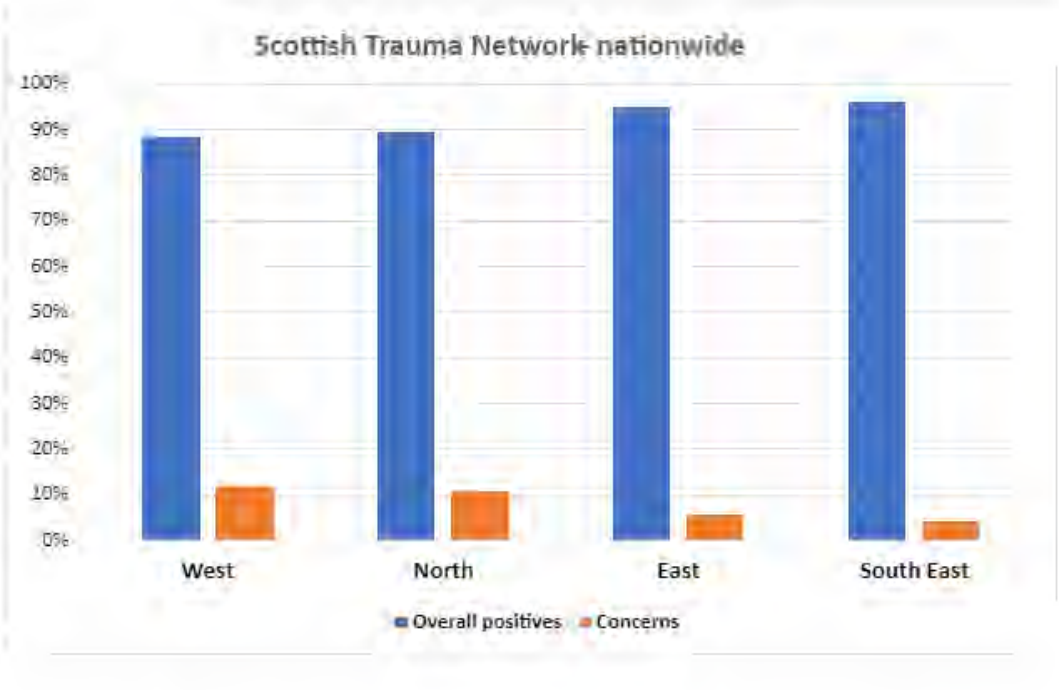


Figure 6: Overall positive ratings versus concerns for each region

The above graph also illustrates that the South East is currently meeting the vast majority of STN minimum requirements. During the peer review process the panel also highlighted several areas of significant achievement. These included:

- Excellent Clinical Leadership team.
- Establishment of passionate, committed, and person-centred teams across the network.
- Good pathways and cross-specialty working.
- The excellent facilities within the Major Trauma Centre ward.
- The adult Major Trauma Centre's Consultant of the week model and input from variety of specialties including orthopaedics; general surgery; plastic surgery; cardiothoracic; emergency medicine; critical care and neurosurgery.
- Participation in the STAG audit.
- Head injury pathways and dedicated MTC team based within DCN.
- Rehab Coordinator, Rehab and Mental Health Teams who provide an invaluable service to patients, ensuring they receive access to the right medical and rehabilitative care at the right time.
- The establishment of the SEoS Major Trauma Guidelines app which houses major trauma guidelines; resources and service directory which allows clinicians across the network to easily access up-to-date information.

The published report also outlined a series of recommendations for the service to progress. A regional action plan has since been established to take forward these recommendations. A summary of the recommendations and progress made to date is provided below:

Peer review recommendations

1. *Improving access to theatres and delivery of combined ortho-plastic surgery:*

   Since the peer review, the service has begun delivering ad-hoc combined ortho-plastic theatre sessions. A regular fortnightly combined ortho-plastic outpatient clinic has also been established.

   The Major Trauma Centre is continuing ongoing discussions with RIE Orthopaedics to explore the delivery of scheduled ortho-plastic theatre sessions.

2. *It is recommended that negotiations around 24/7 onsite ED Consultant cover are completed to provide the cover detailed in the minimum requirements.*

   The delivery of 24/7 onsite ED Consultant cover is identified as a minimum requirement for all major trauma centres operating within the Scottish Trauma Network (STN). NHS Lothian has recruited an additional 6.0 WTE ED Consultants to support the delivery of 24/7 onsite ED Consultant cover although this is yet to be implemented.

   The Major Trauma Centre and Clinical Management Teams presented the peer review recommendations to the RIE Hospital Management Group on 13th November 2024 and RIE Clinical Management teams on 10th December 2024. The risks and impact that the lack of onsite 24/7 ED consultant cover poses were communicated to Directors and Service Managers. These are also described in section 3.5.

   The lack of onsite 24/7 ED consultant cover was escalated to the STN Steering Group in December 2024.

3. *Explore establishment of a multidisciplinary meeting for all disciplines. Additionally, the MTC should consider holding the morning meeting on Microsoft Teams, which would allow the Trauma Units to join to get feedback on patients who've been transferred to the MTC.*

   A Microsoft Teams link has now been established to allow Trauma Units and Local Emergency Hospitals to attend MTC weekly MDTs to discuss appropriate patients as required.

   The Paediatric Major Trauma Centre (MTC) and adult MTC leads have agreed to explore opportunities for specialty input into morning meetings. It has been noted that the morning meetings clash with existing specialty meetings, and it therefore may be challenging to obtain engagement from specialties. Feedback from a recent major trauma staff experience survey suggests that the major trauma team largely feel that there is already good engagement and communication established between single specialty teams and the major trauma service.

4. *The SEoS should endeavour to ensure all staff have appropriate time to complete training.*

   The Major Trauma Centre team intend to liaise with the Emergency Department Clinical Nurse Manager, Clinical Service Manager and Nurse Educator to develop an

action plan to ensure Emergency Department nurses who receive major trauma patients are allocated time to complete essential training.

The South East intends to undertake a review of all externally run courses currently being offered to staff within the South East Trauma Network in 2025. The aim of this is to ensure that courses remain beneficial to staff working within the network; are made available to all staffing groups and levels, and to make sure that learning and knowledge is disseminated and shared among teams following participation in courses.

5. *To review major trauma care and pathways for major trauma patients who are admitted under a single specialty, rather than the MT Ward or DCN.*

   Most major trauma patients who are not admitted to the MTC are those whose injuries have been identified at a later stage in their patient journey. All major trauma patients, including outliers (those not admitted to the ward) are screened by the major trauma rehab coordinator team who have oversight of the care of these patients.

   The rehab teams have begun undertaking audits to compare therapy input for patients admitted into single specialty wards vs major trauma ward. An initial audit focused on the pathway for patients admitted under cardiothoracic showed that patients admitted under cardiothoracic largely had their therapy needs met and there was no impact on patient length of stay. A more detail review into the pathway for outliers is planned to take place.

6. *Explore provision of follow-up rehabilitation for major trauma patients discharged directly home.*

   Within the Trauma Units, both Fife and Borders have community-based rehab teams who can provide rehab to individuals within a community setting. Forth Valley's major trauma rehab team is based within the Specialist Rehab Centre in the Bellfield Centre.

   Major Trauma patients who reside in NHS Forth Valley, NHS Borders or NHS Fife all receive telephone follow-up calls post-discharge. These telephone calls allow the Rehab Coordinators to check-in on a patient's recovery and signpost them to any additional services if required. At the time of the peer review there was not sufficient capacity for the MTC Rehab Coordinators to deliver follow-up telephone calls for all patients. The MTC has since successfully secured funding for an additional fixed term 1.0 WTE Rehab Coordinator for one year. With this additional capacity the team have since begun delivering follow-up telephone calls to all patients.

   The MTC has also submitted an SBAR to request funding to recruit to a supported discharge team. This would allow the MTC to begin delivering some follow-up rehabilitation to patient's post-discharge. This is currently sitting with NHS Lothian finance for consideration.

   The MTC Mental Health and Psychiatry teams deliver continuous support to patient's post-discharge from hospital.

7. *The PMTC to deliver educational outreach to teams in the Trauma Units and Local Emergency Hospital*

The Paediatric Major Trauma Centre (PMTC) delivered the STN Paediatric Learning Event on 12th June 2024. Over 200 people attended the course from across the UK Trauma Networks, either online or in person. Feedback from the event was extremely positive.

The Paediatric Major Trauma Educator along with the wider PMTC Leadership team delivers outreach sessions to each Trauma Unit or Local Emergency Hospital Site each year. This includes discussions of case reviews as well as simulation exercises.

The STN is currently undertaking a review of the agreed minimum requirements to ensure that these remain fit for purpose post network implementation. The STN expects to commission another peer review process within the next five years.

5.0 Risk Assessment/Management

- There is a risk that KPI 2.1.1. "Access to a Consultant upon arrival" may not be met due to the current lack of onsite 24/7 ED Consultant cover. This poses a clinical risk as Consultants have the required clinical knowledge and expertise to appropriately assess and manage these severely injured patient's upon their arrival. It also ensures there is robust cover to support junior teams onsite.

The delivery of 24/7 onsite ED Consultant cover is identified as a minimum requirement for all major trauma centres operating within the Scottish Trauma Network (STN). The STN has allocated funding for an additional 6.0 WTE ED Consultants to deliver onsite overnight cover since 2018. This ensures the ED is up to the establishment recommended by the Royal College for Emergency Medicine's guidance to deliver a sustainable 24/7 ED Consultant rota. The Major Trauma Centres in Aberdeen and Glasgow who also applied for funding to deliver 24/7 cover have now successfully implemented this.

The RIE currently has a Consultant on-site each day from 07.30 until 02.00. The ED Consultant is then available on-call from home between 02.00 and 07.30am. An ST4+ is on site overnight with relevant escalation processes in place.

The risks associated with not delivering 24/7 cover are heightened by the current absence of a dedicated pre-hospital red team within the South East of Scotland. This has led to a deficit for early Consultant level advanced care for major trauma patients in Edinburgh and the South East of Scotland compared to other regions pre-hospital and Emergency Department services.

The lack of overnight ED Consultant cover despite recruiting to the posts has been escalated within NHS Lothian on several occasions since 2020 but no progress or plans to implement on site cover have been established by the Board. Identifying a suitable

solution to delivering this was identified as a key recommendation within the STN peer review. Since the peer review this recommendation and the associated risks have been communicated to relevant managers and directors within the Health Board including the RIE Hospital Management Group on 13th November 2024 and the Acute Clinical Management Group on 10th December 2024.

6. Recommendation

The Healthcare Governance Committee is asked to take **moderate** assurance from the outcomes of the 2024 STAG Report and 2024 Peer Review. These reports highlight the ongoing work of the South East Trauma Network to improve the care of trauma patients in Lothian and the South East of Scotland. In particular it should be noted:

- The South East of Scotland is currently meeting almost all STN minimum requirements. A regional action plan has been established to progress all other recommendations from the peer review. Progress has already been made in advancing these actions, as outlined in section 4.2.
- The South East of Scotland is performing three standard deviations above the national average in two Key Performance Indicators (3.1.1 – Assessment of Rehab Needs and 3.2 PROMs).
- The Royal Infirmary of Edinburgh is performing three standard deviations above the national average for KPI 2.4.3 CT scan within one hour for patients with a GCS <13 or intubated.
- The Royal Hospital for Children and Young People is performing two standard deviations or above in its compliance with KPI 2.4.3 CT scan within one hour for patients with a GCS <13 or intubated.
- The South East Trauma Network and all Lothian sites are performing in line with the Scottish average in its achievement of all other KPI's.

7. List of appendices

The following appendices are included with this report:

- Appendix 1: Scottish Trauma Audit Group Dashboard 2024
- Appendix 2: Scottish Trauma Audit Group Annual Report 2024
- Appendix 3: STAG Inclusion/Exclusion Criteria
- Appendix 4: STN Peer Review Report

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Resilience Annual Report 2024**
Responsible Executive:	**Dona Milne, Director of Public Health, and Health Policy**
Report Author:	**Ian Orr, Head of Resilience**

1 Purpose

The purpose of this report is to update the committee on the performance of the NHS Lothian Resilience Team, summarise the work undertaken in 2024 look to at future developments.

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☐

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The Civil Contingencies Act (2004), Contingency Planning (Scotland) Regulations 2005, Preparing Scotland 2008), and Preparing Emergencies (2023 sets out the framework on how NHS Lothian should deliver its obligations under the Civil Contingencies Act (CCA).

The principle of Integrated Emergency Management (IEM) identified in Preparing Scotland highlights the importance of "The development of flexible response planning based on responders' day to day activities defined as functions under the CCA". This overall approach is supported by focusing on five main functions, *assessment, prevention, preparation, response, and recovery*.

A key underlying principle of this approach is the integration of Emergency Planning (EP) and Business Continuity Management (BCM) functions across NHS Lothian. This ensures reduced duplication and increased capacity to respond to major incidents and infrastructure failures when they arise.

This must be seen in the context of significant additional duties for Category 1 Responders, organisational and service development, and NHS Lothian and partners who deliver integrated health and social care services.

2.2 Background

The Resilience Team was established to deliver the work programme for the Strategic Resilience Group (SRG) and support improvement in organisational resilience.

The Annual Report in Appendix 1 summarises the work undertaken in 2024.

2.3 Assessment

The Resilience Team co-ordinate and provide advice to NHS Lothian in delivering its responsibilities as a Category 1 responder under the Civil Contingencies Act 2004:

- Safeguards our responsibilities under the Civil Contingencies Act 2004 and Contingency Planning (Scotland) Regulations 2005 for example Emergency Planning, Business Continuity Management (BCM), Pandemic Influenza Planning, and additional areas such as Counter Terrorism (CONTEST/PREVENT), security awareness.
- Co-ordinates our ongoing organisational planning, giving due consideration to our partner agencies and taking cognisance of the work of the East of Scotland Regional Resilience Partnership (EoSRRP) and Lothian Local Resilience Partnership (LRP).
- Regularly reviews and maintains emergency and associated plans.
- Ensures a jointly owned and agreed annual work plan that details shared priorities, agreed responsibilities and accountability for the delivery of our organisational demands from the top down and from the bottom up throughout the organisation.
- Has a robust evaluation of effectiveness for our resilience duties that is tangible, explicit, and meaningful.
- Keeps abreast of all good practice, locally and nationally in order that we can benefit from others experience.
- Ensures that there is appropriate capacity and resources available for staff to discharge their organisational responsibilities.

- Reviews high level risks to the organisation in the form of the EoSRRP Risk Register and Corporate Risk Register and ensure appropriate actions are in place to mitigate those risks.
- Develops a robust training, exercise, audit, and review regime to stimulate a culture of continuous quality improvement across the organisation for contingency planning.

2.3.1 Quality/ Patient Care
Not applicable.

2.3.2 Workforce
In 2024 the team had significant absence which reduced capacity to deliver the resilience workplan. Temporary funding was agreed for a fixed term Resilience Officer post for one year. The successful candidate came into post on 13 January 2025.

2.3.3 Financial
None at this stage.

2.3.4 Risk Assessment/Management
Resilience risks are managed through the EoSRRP Risk Register and NHS Lothian Risk Registers thereby ensuring appropriate actions are in place to mitigate identified risks.

2.3.5 Equality and Diversity, including health inequalities
There is no requirement to assess the equality impact on people who share relevant protected characteristics because this report does not propose any new or revised policies or practices. It is a report about our performance and the paper does not propose a new or revised strategy, policy, or service change.

2.3.6 Other impacts
None at this stage.

2.3.7 Communication, involvement, engagement, and consultation
The NHS Lothian Strategic Resilience Group oversee the work of the resilience work of the organisation. The Group meets quarterly with Executive Director and Senior Management level membership. The Group is Chaired by the Director of Public Health.

2.3.8 Route to the Meeting
This report will go through the Strategic Resilience Group at their next meeting on 03 February 2025.

2.4 Recommendation

The Committee is asked to agree and accept moderate assurance on the work of the Resilience Team

List of Appendices

The following appendix is included with this report:

- Appendix 1, Resilience Annual Report 2024 (separate attachment)

Resilience Annual Report

NHS Lothian Resilience Annual Report

2024

Prepared by	Head of Resilience Business Support Officer, Resilience Team
Category/Level/Type	RT Annual Report
Version	v1.0 [d]
Approved by	Strategic Resilience Group
Date	

Contents

1. Emergency Planning & Resilience 2
1.1 Introduction 2
1.2 Aims and Objectives 2

2. Governance 2
2.1 Committees/Groups 2

3. Emergency Planning and Resilience Team 3

4. Key Work Activities (2022-2023) 4
4.1 Plan development 4
4.2 Support/Training/Exercises 4
4.4 Action Tracker 10
4.4 Action Tracker 11
4.7 Safety Advisory Group support ..... **Error! Bookmark not defined.**
4.8 NHS Standards for Organisational Resilience 11

5. Summary 11
5.1 Areas of Good Practice 11
5.2 Identified issues and potential solutions 12
5.3 Future areas of work and potential service developments 12

6. Next Review Date 12

1. Resilience

1.1 Introduction

Within NHS Lothian, the Resilience Team are part of the Public Health & Health Policy Directorate. Executive Director responsibility sits with the Director of Public Health.

The Resilience Team co-ordinate and provide advice to NHS Lothian in delivering its responsibilities as a Category 1 responder under the Civil Contingencies Act 2004.

1.2 Aims and Objectives

As detailed within NHS Lothian's Resilience Framework, the Resilience Team aim to:

1. Safeguard our responsibilities under the Civil Contingencies Act 2004 and Contingency Planning (Scotland) Regulations 2005 for example Emergency Planning, Business Continuity Management (BCM), Pandemic Influenza Planning, and additional areas such as Counter Terrorism (CONTEST/PREVENT) and security awareness.
2. Co-ordinate our ongoing organisational resilience planning, giving due consideration to our partner agencies, and taking cognisance of the work of the East of Scotland Regional Resilience Partnership (EoSRRP) and the Lothian and Borders Local Resilience Partnership (LRP).
3. Regularly review and maintain emergency and associated plans.
4. Ensure an agreed annual work plan that details shared priorities and agreed responsibilities for the delivery of our organisational resilience priorities.
5. Have a robust approach to evaluation of effectiveness for our resilience duties that is tangible, explicit, and meaningful.
6. Keep abreast of all good practice, locally and nationally in order that we can benefit from others experience.
7. Ensure that there is sufficient capacity and resources available for appropriate staff to discharge their organisational responsibilities.
8. Review high level risks to the organisation and where relevant include in the RRP Risk Register and NHS Lothian Corporate Risk Register and ensure appropriate actions are in place to mitigate those risks.
9. Develop a robust training, exercise, audit, and review regime to stimulate a culture of continuous quality improvement across the organisation for contingency planning.

2. Governance

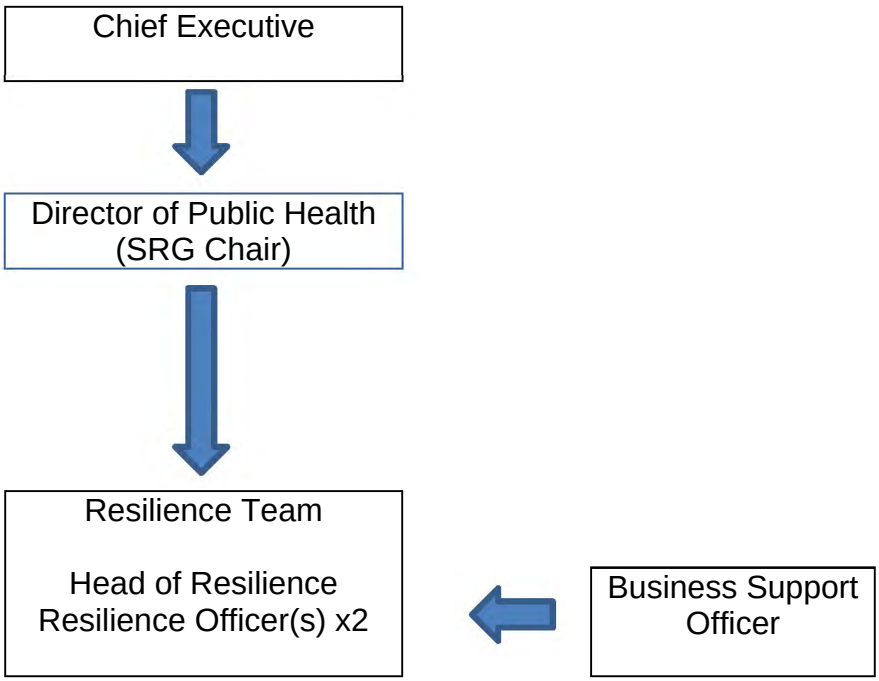
2.1 Committees/Groups

The Strategic Resilience Group (SRG) has overall governance responsibility for emergency planning and resilience.

The SRG meet every three months to provide NHS Lothian with a forum and structure to bring together responsible managers and practitioners in order that the organisation can progress the development, implementation, monitoring, and review of responsibilities under the Civil Contingencies Act 2004, Contingency Planning (Scotland) Regulations 2005 in terms of Emergency Planning and Business Continuity Management (BCM) and resilience matters.

The group also reviews and contributes to the annual resilience workplan at each SRG meeting ensuring the team works with services to ensure a state of resilience preparedness. This group also considers national guidance that may affect NHS Lothian resilience and requests updates from national/local forums on relevant issues via the Local Resilience Partnership, Regional Resilience Partnership and Scottish Government Emergency Planning Preparedness and Response Division (EPRR).

2.2 Responsibilities



The Director of Public Health is the designated Executive Lead and is responsible for the leadership and co-ordination of all resilience matters on behalf of NHS Lothian and who also fulfils the role of Chair of the SRG.

All Managers will be responsible for the operational delivery of resilience issues within their service areas and ensuring staff are aware of their respective roles and duties.

All staff are responsible for familiarising themselves with their individual roles as set out in Resilience Plans, for example NHS Lothian Major Incident Plan, Service Business Continuity Plans etc.

3. Resilience Team

The Resilience Team includes a Head of Resilience, two Resilience Officers and support from a Business Support Officer from Public Health. During 2024 there was significant absence within the team, and this has impacted on the delivery of the workplan.

4. Key Work Activities (2024)

4.1 Plan development

During 2024, the following plans were produced/updated:

Plan	Approved
Patients of Interest to Media or Security	January 2024
Plan Maintenance	October/November 2024

4.2 Support/Training/Exercises

NHS Lothian Resilience Framework
Service Operational Resilience Plans and Tactical Plans formed part of the assurance submission in October 2024. The current process of assurance relies on services annually completing returns confirming their resilience procedures, signed off by CMT members before submission to the Resilience Team. From January 2025 work will commence to replace Operational Resilience Plans with Business Continuity Plans (BCPs). Although there will be additional initial effort on services to transfer the information over to Business Continuity Plan templates, the review requirement and future reporting burden will be reduced for many service areas in the longer term.

The SRG welcomed the proposal to introduce a new Resilience Framework at their meeting on 11 November 2024. This will be coordinated by the Resilience Team with input from sites and services across acute and REAS sites. Small groups will be invited to attend meetings to assist with the development.

Exercise Safe Hands
Exercise Safe Hands was a National Exercise that tested most of the NHS Scotland Boards, focusing on a Major Incident Mass Casualty event within the North of Scotland.

NHS Lothian focused on how we would respond to such an event given the time delay it would take for patients to arrive at our Accident & Emergency departments whether this be by Scottish Ambulance or Air Ambulance. This tested the Sites, Services & Command structures around capacity creation, response and support to other Territorial Boards as well as dealing with business-as-usual operations within the hospitals.

The Scottish Government published a post exercise report with recommendations. All of the recommendations will be included in the development of new plans and the review and updating of existing plans.

NHS Lothian Operation Unicorn Plan
The NHS Lothian Operation Unicorn Plan has been updated and is intended to supplement other national plans and procedures.

Control Room Exercises/Awareness Sessions delivered across Acute and REAS Sites

RIE	Fri 26 January 2024	RHCYP	Tue 23 January 2024
RIE	Fri 23 February 2024	RHCYP	Tues 19 March 2024
RIE	Fri 22 March 2024	RHCYP	Tues 24 September 2024
RIE	Fri 17 May 2024	Women's	Wed 26 November 2024
RIE	Fri 19 July 2024	RHCYP	Thurs 28 November 2024
RIE	Fri 23 August 2024	SJH	Tues 6 February 2024
RIE	Fri 25 October 2024	SJH	Tues 18 June 2024
RIE	Fri 25 November 2024	SJH	Tues 20 August 2024
RIE	Fri 13 December 2024	WGH	Thurs 18 April 2024
RIE	Fri 22 November 2024	REAS	Thurs 22 February 2024
RIE	Fri 13 December 2024	REAS	Thurs 22 August 2024

Control Room Exercises are open to new staff members who may be required to function in one of the following roles: Hospital Medical Coordinator, Site Director, Senior Manager, Site & Capacity/Bed Coordinator, on-call staff and Administrative Loggist. Management teams will also have a training package in place within their own areas for staff joining the on-call rotas.

Major Incident – Call Out Exercises

Call out tests across Acute and REAS sites were conducted by switchboard staff at the request of the Resilience Team. This was to test the switchboard process when contact is made following a Major Incident standby/declaration and staff responses to this. These exercises tested how quickly calls were answered for control rooms that could be set up at short notice.

Telecoms Call Out Tests			
SJH	24 January 2024	RIE	05 June 2024
RHCYP	28 February 2024	REAS	17 July 2024
RHCYP	26 March 2024		

PREVENT

NHS Lothian PREVENT awareness sessions were delivered in June and December by Police Scotland Counter Terrorism and the Prevent Delivery Unit. Forty-six staff members attended from across NHS Lothian/H&SCPs. The sessions helped to signpost staff should they have a concern about an individual being drawn into or supporting terrorism.

Patients of Interest to Media or Security (PIMS)

In October Police Scotland Close Protection Officers and Royalty/VIP team attended a "Live Play" PIMS exercise to test the reception and transfer of a patient from ED to Critical Care. Following "live Play" the plan requires minor amendments.

Disaster Victim Identification (DVI) at RIE Walkthrough

Police Scotland participated in a walkthrough process on Friday 25 October 2025, for use of RIE mortuary.

Support to Others

COMAH Exercises

The Resilience Team continue to be involved with Torness Emergency Planning through a Resilience Officer and Public Health Consultant. The last exercise was Exercise Puma, held on 19 June 2024 at Penston House, Midlothian.

The purpose of the exercise was to test a Level 2 multi-agency response in the event of an off-site nuclear release from Torness. It allowed the Resilience Team along with the new East Region Health Protection Service to work through a scenario and evaluate our response to such an incident. This led to very constructive conversations in relation to Radiation Monitoring Units (RMU's) and pharmaceutical distribution in such an event. The Resilience Team will work with East Lothian Council to develop response arrangements.

The Resilience Team supported Port Health Exercise Blue Eagle on Tuesday 10 December 2024 at Norton Park Conference Centre. The purpose of this multi-agency exercise was to test a Port Health response to a potential infectious disease outbreak onboard an incoming flight to Edinburgh Airport. This allowed the Resilience Team along with Public Health colleagues to work through and review the current Port Health Plan and evaluate the response to ensure a greater effective response moving forward.

Other Activities

PageOne Integrated Messaging and Communication

An automated system (PageOne) has been developed to manage the response to incidents within NHS Lothian and to activate NHS Lothian's major incident response procedures. The system is currently being piloted with three small groups before being rolled out to the RIE Site followed by all Acute Sites by March 2025.

PageOne would replace the current onerous manual process which involved switchboard operators using a call out card to call individuals for each Acute/REAS Site(s).

Resilience Risk Assessment App

The Strategic Resilience Group approved a request in March 2023 to change the Assurance Risk Assessment Reporting point from April to October. The Resilience Team have been working with the eDigital Innovation Team to develop the Resilience Risk Assessment App. The App will replace the Risk Assessment Spreadsheet which sites and services complete to provide Assurance on Risk Assessment.

The App is in the final stages of development however due to staffing issues within the teams, Resilience and E-Health have delayed the roll out until early 2025.

Decontamination

The provision of decontamination facilities has progressed with St John's Hospital being identified as the preferred location for the Decontamination Container which has been financially approved and is currently going through the procurement process with delivery expected in Spring 2025.

Currently a temporary solution is provided at the RIE and RHCYP in the shape of a Decontamination tent. This tent is in the final years of service. Plans are being progressed to purchase a decontamination container for these sites. An overarching Decontamination plan will be created by Spring 2025 outlining the requirement for both units and sites.

Clinical teams within the ED, with assistance from the Resilience Team are developing a CBRN/Decontamination Plan outlining procedures for ED's. This is currently progressing through local governance, with dialogue also taking place between clinical teams and facilities in relation to tent maintenance.

4.3 Incidents

Table 1 describes the various levels of response to an incident, the potential requirements for mutual aid and Scottish Government reporting.

Table 1

Incident Response Levels	Health Board Response	Multi-Agency Regional Response	NHS/SG National Response	Multi-Agency National Response	Reporting Action and Timeframe for Notifying SG Health EPRR
Level 1: Can be responded to and managed locally within respective business as usual capabilities and business continuity/emergency plans of the affected Health Board	Yes	Yes If part of BC plans	n/a	n/a	No Reporting Required
Level 2: Requires the response of more than one Territorial Board within a Resilience Partnership area or a local impact on a National Board and where support and coordination is at local/regional level	Yes	Yes Dependent on Incident Type	n/a	n/a	Submit SitRep to SG Health EPRR within 3 hours
Level 3: Requires a response from multiple Territorial Boards across regions and/or where there is sector impact from a National Board	Yes	Yes	Aware/ Liaison	Dependent on incident type	Immediate by phone followed by SitRep within 2 hours
Level 4: An incident that impacts the health sector across Scotland and requires national level command and control provided by Chief Operating Officer NHSScotland and potentially national government	Yes	Yes	Yes	Yes Dependent on incident type and impact on other sectors	Immediate by phone, followed by SitRep within 2 hours

An incident is described in terms of the level of response required which may change as the incident evolves. Incident response levels describe at which level co-ordination takes place and are outlined below in Table 2. These levels must be used by all NHS Boards when referring to incidents.

Table 2

Level	Type of Response	Responders
1	**Impact felt in a single, limited location**. Can be responded to and managed locally within respective business as usual capabilities and business continuity/emergency plans of the affected Health Board.	Local Health Board Multi-Agency/Regional (if part of Business Continuity Plans
2	**Impact felt across a single Health Board.** Requires the response of more than one Territorial Board within a Resilience Partnership area; or Local impact on a National Board where support and coordination is required at local/regional level	Territorial/National Health Boards Multi-Agency/Regional
3	**Impact felt across more than one Health Board and / or regionally.** Requires a response from multiple Territorial Boards across regions and/or where there is sector impact from a National Board.	Territorial/National Health Boards Multi-Agency/Regional Awareness/Advisory Role NHS Chief Executive & Chief Operating
4	**Impact felt across several Health Boards and/or impacting national capacity and capability**. An incident that impacts the health sector across Scotland and requires national level command and control	Chief Executive, NHS Scotland Chief Operating Officer, NHS Scotland SGHSCD: Health EPRR Scottish Government/Ministers Ongoing Support Territorial/National Health Boards Multi-Agency/Regional

Level 1	3
Level 2	0
Level 3	0
Level 4	0

There was no level 2, 3 or 4 incidents reported during 2024.

Capacity Critical Incident 2 and 3 January 2024 (Level 1)

Following the Stand-up of the Control Room at RIE, a debrief was facilitated by the Resilience Team to reflect on experiences as part of the Incident Management Response to capacity pressures on Acute Sites. Colleagues shared experiences to establish learning and the future positive use of such learning. This was taken forward by RIE staff.

Storm Isha (Level 1)

An Amber Weather Warning issued on 21 January 2024 where strong winds were encountered throughout the night uprooting trees and causing medium levels of impact to infrastructures throughout the region. In addition, there was major disruption to the local transport network which had a knock-on effect on NHS Lothian. Significant impacts were caused to staff due to cancelled trains and with local routes being blocked by fallen trees. However, these issues were resolved as the morning progressed. The WGH and SJH hospital sites reported fallen trees but no impact on infrastructure.

Western General Hospital (WGH) Power Outage (Level 1)

The Resilience Team were made aware of a high voltage power outage incident that occurred on the WGH site affecting both the Outpatients Department Building (OPD) and Royal Victoria Building (RVB) on 25 June 2024. The Estates team began working to resolve the issue while establishing generator power solutions. A debrief was held on 5 July and paper sent to Acute Senior Management Group (ASMG) to take forward the necessary actions.

Princess Alexandra Eye Pavilion Closure (PAEP) (Level 1)

In September 2024 the Resilience Team were made aware of an issue by the Acute Team regarding a leak within the PAEP from sewage pipes that had been installed when the building was first constructed. This resulted in asbestos and other materials becoming a significant factor within the building, which was required to close, and services relocated across the NHS Lothian framework. This was to allow repair works to be carried out over the next 6 months with a view to the resumption of normal service by March 2025.

The Resilience Team initially provided advice where necessary, however Estates & Facilities in conjunction with various Acute departments developed temporary solutions and repair schedules.

4.4 Action Tracker

A tracker has been developed to track learning and recommendations from Incidents, Exercising, Debriefs and Control Room Exercises to improve our governance process. This will be standard practice to track learning following debriefs. The following actions are underway.

Date	Action	Description	Priority	Action Due Date	Lead	Status	Progress
14.08.23	National Power Outage	NHSL Framework development	High	Feb 2025	JC		Framework developed and awaiting estates information to populate
13.11.23	Acute Services Decontamination Capability	The purchase order for one DC20	High	Ongoing	MC GC		Funding approved Nov 23. Short Life Working Group Established to manage this

4.5 Safety Advisory Group support

The Resilience Team are members of various Safety Advisory Groups chaired by the local authority. This is an advisory role to ensure the health & safety of planned large-scale events, music festivals, processions etc are coordinated in partnership with the Emergency Services, local authorities, and event organisers. These meetings are pre-arranged, follow a standard agenda and is a continuous process throughout the calendar year.

2024 saw a rise in local events post pandemic and there were medium to large events that had to be planned for such as the re-introduction of summer galas / processions / parades and music festivals. The biggest events were the Taylor Swift Concerts at Murrayfield in June 2024, which saw a Scottish record concert attendance of over 70,000 per night, and the Gensis Scottish Open in East Lothian with crowds over the 4 days reaching 70,000-80,000. This put considerable pressure on the Resilience Team for attendance at SAGs in the run up to the event to ensure the correct medical provision was in place for the events starting. It is worth noting that while the events described above had large crowds there was minimal impact seen within the NHS Lothian Emergency & Minor Injury departments.

And with 2025 SAG's already underway for next year's events which could equal or surpass this year's events in relation to Oasis & Robbie Williams at Murrayfield it shows the importance of the Resilience team attending these meetings.

4.6 NHS Standards for Organisational Resilience

In May 2018, the Scottish Government updated its *NHSScotland: Standards for Organisational Resilience (2016)* document to reflect changes within the health and social care context, new Policy imperatives and identified "Best Practice". This document specified minimum standards and related measure/performance indicator criteria for resilience within NHS Boards across Scotland.

These standards are currently being updated by a short-life working group.

5. Summary

5.1 Areas of Good Practice

Prevent Awareness Sessions were delivered to a variety of NHS Lothian staff in conjunction with Police Scotland in June and December 2024.

A Women's Services Escalation Exercise held on 6 November 2024 to test system pressures and capacity creation with all levels of communication required to collate accurate and relevant information for appropriate decisions to be made in the escalation process within the service.

A Joint Exercise was undertaken in October 2024 with Police Scotland Close Protection Officers and Royalty/VIP team to test our documentation for the transfer of a patient from RIE ED to Critical Care following NHS Lothian Patients of Interest to Media or Security (PIMS).

5.2 Identified issues and potential solutions

Unfortunately, staff absence within the Resilience Team significantly impacted the workplan delivery during the year. In recognition of this, CMT agreed to fund a temporary Resilience Officer post to support the team. The successful candidate came into post on 13 January 2025.

During a review of the assurance process a new process has been agreed that will provide improved service resilience and greater assurance reporting to SRG during 2025.

5.3 Future areas of work

- Agreement of Resilience Framework expected at the 3 February 2025 meeting of the SRG.
- Transfer of assurance approach to service Business Continuity Plans throughout 2025.
- Development on NHS Lothian Major Incident Plan.
- NHS Lothian Acute Services continue to look at options for the decontamination of patients involved in CBRN and HAZMAT incidents. A short life working group has been re-established to oversee this.

6. Next Review Date

The next annual report will be submitted to the SRG Group in November 2025.

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Health Protection Team Annual Report 2023**
Responsible Executive:	**Dona Milne**
Report Author:	**Alex Cockburn and Peter Harrison**

1 Purpose

[Please check the boxes for all items that apply in each section]

This report is presented for:

Assurance	☐	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☒	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHS Scotland quality ambition(s):

Safe	☒	Effective	☐
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to update the committee on:

- Levels of notifiable diseases and organisms within Lothian between 01 January 2023 to 31 December 2023
- Significant health protection situations managed by the service between 01 January 2023 to 31 December 2023
- Ongoing quality improvement and regionalisation work

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

2.2 Background

This paper provides a high-level summary of the work of the Health Protection Team including notifications of diseases and organisms, significant outbreaks and situations managed by the Health Protection Team between 01 January 2023 and 31 December 2023

Scope of Services

Statutory Function to protect health of population from infectious diseases and environmental hazards.

2.3 Assessment

Structures and Processes for Management and Oversight of Safety

Part of wider Public Health department governance structure. Senior Leadership team reports on performance through Lothian Public Health Senior Management team (PHSMT) Workplan is part of PHSMT workplan.

Management and governance structures

Risk Register for Public health

Adverse Event Management via Datix

Performance metrics and workplan agreed by PHSMT

Management and governance processes

Appendix 2 is not applicable to health protection service due to nature of statutory role.

2.3.1 Service Quality and Safety Assessment

Safe Care

Current evidence about safety

N/A reactive service to infectious diseases and environmental hazards.

Service Improvement Work to Address Safety Issues
Quality Improvement Team

Effective Care
Performance metrics in place

Person Centred Care
Surveys and QI work undertaken to gain view of user experiences for the team.

2.3.2 Workforce

The Lothian team has now merged with 4 other boards to become an East Region health protection Service. New governance in place.

2.3.3 Financial

Not Applicable

2.3.4 Risk Assessment/Management

There are no risks to raise in relation to the report recommendation

2.3.5 Equality and Diversity, including health inequalities

This paper is for information only and no impact assessment was required.

2.3.6 Other impacts

Not applicable

2.3.7 Communication, involvement, engagement, and consultation

Not applicable

2.3.8 Route to the Meeting

This has been previously considered by the following groups as part of its development. The groups have either supported the content, or their feedback has informed the development of the content presented in this report.

- Health Protection Senior Leadership Team meeting, 04 December 2025
- Public Health and Health Policy Senior Management Team meeting, 27 January 2025

2.4 Recommendation

Awareness – For Members' information only.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Site/ Service/Group of Services Scope
- Appendix 2, Assurance Mapping Appendix Table

Appendix 1 – Scope of Service

HSCP Name	N/A Health Protection Team covers all of Lothian	
Population size and characteristics served by this HSCP	All of Lothian	
What does this service/group of services do?	<u>Delegated Services</u> • Public Health and Health Improvement	<u>Hosted Services</u>
How many patients does this service see, and how many appointments or interventions are carried out each year?	N/A statutory service. Health Protection is reactive service to all threats to population health such as infectious diseases and environmental incidents. Numbers vary year on year dependent on outbreaks/pandemics etc.	
What facilities does the HSCP use?	Corporate facilities for staff only.	
How many staff does this service have	Staffing information correct as at November 2023 (to match report)	
	11.9 WTE in team (but part of wider department of public health staffing)	

Appendix 2: Assurance Mapping Appendix Table – HSCP Services

	Frequency and location of routine reporting & review					
Evidence	**HCG**	**[insert meeting name]**	**[insert meeting name]**	**[insert meeting name]**	**CMT(s)**	**Comments**
Adverse Events						
Outcome measures						
Number of reported major harm and death adverse events excluding mental health and substance use	Annual					
Number of all mental health reported major harm and death adverse events	Annual					
Number of all substance use reported major harm and death adverse events	Annual					
Number of adverse events with an outcome 3 or 4 reported	Annual					See section 7, page 8 of the Adverse Event Review Template for definitions of review outcomes.
Categories Reported with Serious Harm (Mod/Major/Death)	Annual					
Stage 1& 2 complaints received	Annual					
Process measures						
Number of overdue adverse events reported with major harm and death	Annual					
Number of closed major harm and death adverse events excluding mental health and substance use	Annual					
% Complaints closed within 20 working days						
Outcomes from LACAS cycles						
Any other relevant HSCP specific process measures broadly related to adverse events or general service safety assurance, e.g. % staff who have completed mandatory training, ratio of						

staff in post to staffing establishment, NHS staff sickness rate.						
Morbidity Indicators						
Outcome measures						
Total number of patients over 15 with C.Difficile toxin positive stool sample (CDI) in community hospitals						
Total number of patients over 15 with C.Difficile toxin positive stool sample (CDI)/100k OBD in community hospitals						
Total number of SAB patient episodes in community hospitals						
Total number of SAB patient episodes/100k OBD in community hospitals						
Inpatient falls with harm per 1,000 OBD in community hospitals						
Number of Grade 2 or above pressure ulcers per 1,000 OBD in community hospitals						
Any other HSCP specific morbidity outcome measures						
Process measures						
Inpatient falls per 1,000 OBD in community hospitals						
Rate of readmissions to community hospitals						
Occupied bed rate						
Rate of delayed discharges over 50 days						

Any other HSCP specific morbidity process measures, e.g. waiting times, readmission rates to hospital at home.						
Internal reports, external reports, inspections, national audits						
Mental Welfare Commission inspection reports						
Care Inspectorate inspection reports						

Health Protection Team Annual Report 2023

Public Health and Health Policy

Summary

This report is for the calendar year 2023 and is the final annual report of NHS Lothian Health Protection Team. Going forward there will be an East Region Health Protection Service Annual Report which will display NHS Lothian data along with NHS Borders, NHS Fife and NHS Forth Valley.

Generally, the team have seen numbers of most infections returning to around pre-Covid-19 pandemic levels and this has presented workload challenges for the team who have continued to respond to cases and incidents whilst also establishing the new regional service. The number of incidents and outbreaks that have required active management by the Health Protection Team continues to remain high, with 593 situations managed during the calendar year of 2023.

Contents

SUMMARY 1
ABBREVIATIONS 2
PUBLIC HEALTH AND HEALTH POLICY 0
INTRODUCTION AND CONTEXT 1
EQUALITIES AND HUMAN RIGHTS 2
Who we support 2
NOTIFIABLE DISEASES 3
Gastrointestinal Illness 4
Hepatitis B 5
Acute Hepatitis B 5
Chronic Hepatitis B 6
Babies Born to Mothers with Hepatitis B 6
SITUATIONS 0
Care Home Outbreaks 0
School and Nursery Outbreaks 1
INCIDENTS AND ISSUES 0
Brucella. Canis Follow Up 0
Group A Streptococcal Outbreak in a Local Prison 0
Scabies Outbreak in Asylum Seekers 1
TRAINING AND EXERCISING 2
Port Health 2
Torness (EDF) Nuclear Power Station Exercises 2
Forth Ports Exercise – Exercise Black Arrow 2
Familiarisation Visits 3
HPT GOVERNANCE AND PERFORMANCE 3
REGIONALISATION 3

Abbreviations

CDI:	Communicable Disease Investigation
ECOSS:	Electronic Communication of Surveillance Scotland
ERHPT:	East Region Health Protection Team
GAS:	Group A Streptococcal
GI:	Gastro-intestinal
HPT:	Health Protection Team
iGAS:	Invasive Group A Streptococcal
IMT:	Incident Management Team
PAG:	Problem Assessment Group
PDSA:	Plan, Do, Study, Act
PHS:	Public Health Scotland
PHW:	Public Health Wales
SLT:	Senior Leadership Team
SMiRL:	Scottish Microbiology Reference Laboratories
STAC:	Scientific and Technical Advice Cell

Public Health and Health Policy

The Public Health and Health Policy directorate consists of over 150 people working in 4 main divisions. We work to improve and protect the health of the people of Lothian.

Our underpinning principles for our work:

- Work in Partnership locally to reduce health inequalities and improve population health.
- Ensure that prevention is prioritised with a focus on strengthening communities.
- Ensure public health practice is evidence informed with resources and activity deployed proportionate to population need.
- Recognise the climate emergency as a public health priority and embed the UN Sustainable Development Goals/Scottish Climate Plan in public health activity.
- Nurture and support well-trained and motivated staff.
- Embed equality and human rights into our work, including trauma informed practice, The Promise and the UNCRC.
- Set and maintain a culture of continuous evidence-based improvement.

The Health Protection Team (HPT) are part of the Health Protection division of the directorate of Public Health and Health Policy. The Health Protection division work to protect the health of the local population from communicable and infectious diseases and environmental hazards.

Introduction and context

This report provides an overview of the work of NHS Lothian's Health Protection Team (HPT) over the 2023 calendar year. The report outlines work undertaken in this year, focusing on a variety of areas such as notifiable illnesses, outbreaks and incidents.

Lothian NHS Board has important statutory responsibilities for the prevention and control of communicable diseases, the assessment of environmental health risks and the coordination of the NHS response to major incidents. Protecting the health of the population from infectious and environmental hazards is an integral part of public health. NHS Lothian has a duty to provide a robust and responsive health protection function; however, this is not undertaken in isolation, it requires a great deal of partnership working to deliver. This involves working with colleagues across the NHS, specifically infection prevention control specialists, local General Practitioners, and partner organisations such as Local Authority Environmental Health Officers and Scottish Water. Achieving an effective health protection function requires good communication, extensive local knowledge, professional expertise and application of common practices and procedures. In addition, there is a need for high quality communicable disease surveillance arrangements, well-tested and rehearsed plans and escalation arrangements.

NHS Lothian Public Health and HPT cover four local authority areas: City of Edinburgh, Midlothian, East Lothian and West Lothian. The population within the health board was estimated at 902,900 individuals in the Scotland's Census 2022. For this report all 2023 figures will include data covering the whole calendar year of 2023 (January to December).

From the 12th of December 2023 NHS Lothian's HPT joined with NHS Borders, NHS Fife and NHS Forth Valley Health Protection Teams to become the East Region Health Protection Service (ERHPS). This will be the last HPT annual report for Lothian only: going forward this will now be part of the regional service annual report. The new regional service annual report will cover activity, adverse events, staffing and other relevant areas across all four NHS Boards. The report will be shared with the East Region Directors of Public Health Liaison Group (DPHLG) for assurance and submitted to all four Boards' Clinical Governance Committees (or equivalent).

Equalities and Human Rights

Who we support

We support any individuals or groups within NHS Lothian who are affected by specific notifiable diseases or organisms, outbreaks or environmental hazards which put the health of the public at risk.

Removing discrimination, advancing equality of opportunity and fostering good relations

- We do this by working with other services and partners: by facilitating meetings to ensure asylum seekers are screened for specific infections such as tuberculosis and hepatitis B, and to ensure that immunisations are offered to protect these groups. Many of the asylum seekers within Lothian are living in settings such as hotels where the opportunity for spread of infections and outbreaks is high.
- We work to ensure that information is available in the preferred language of the individuals using our services.
- We ensue that the application process for compensation is simple and clearly defined for individuals where exclusion or restriction orders under the public health etc. (Scotland) Act 2008 could push them into poverty.

Future Plans 2024-25:

- This is now sitting with the East Region Health Protection Service workplan. The service will continue to work with Public Health Scotland in producing appropriate guidance for vulnerable groups.

Notifiable Diseases

The Public Health etc. (Scotland) Act 2008 lists notifiable diseases and organisms that the Health Protection Team (HPT) are informed of directly from laboratories and clinical teams. Confirmed cases are also pulled through from the laboratory results system (ECOSS) onto HPZone, the case and situation management platform used by HPTs across Scotland. Not all organisms or diseases require active follow-up from HPT; the majority remain unmanaged cases that are notified for surveillance purposes only.

In 2023, a total of 11573 cases were added to HPZone from all sources.

Cases of confirmed notifiable diseases or illnesses added to HPZone by the HPT in 2023 that required active follow-up are shown in Table 1.

Table 1: Numbers of confirmed Notifiable Diseases and Organisms added to HPZone for active follow up in 2023.

Infection	2016	2017	2018	2019	2020	2021	2022	2023
IGAS	39	41	57	33	29	8	38	97
Legionella	8	8	12	≤5	9	≤5	6	6
Meningococcal (Invasive)	23	23	11	10	≤5	0	≤5	11
Measles	20	≤5	0	7	0	0	0	≤5
Mumps	12	282	158	221	296	0	≤5	≤5
Pertussis	241	102	73	132	42	≤5	≤5	13
Campylobacter	859	849	928	945	771	868	741	816
Salmonella	129	132	127	104	48	54	113	125
Cryptosporidium	102	55	61	81	28	51	72	137
Giardia	52	80	51	81	30	24	46	81
E.coli O157 & STEC	28	34	26	44	22	17	95	34
Shigella	11	8	27	21	7	≤5	12	21
Typhoid/Paratyphoid	≤5	6	≤5	≤5	≤5	≤5	8	6
Hepatitis A	7	16	6	8	0	≤5	≤5	9
Hepatitis B (acute)	≤5	≤5	≤5	≤5	≤5	≤5	0	≤5
Hepatitis B (Chronic)	153	105	98	126	69	78	111	135
Hepatitis E	24	15	10	33	17	18	22	30
Listeria	≤5	≤5	0	0	≤5	≤5	≤5	≤5
PVL	97	82	69	92	46	29	45	82
Mpox	0	0	0	0	0	0	32	0

Where there have been five or less notifications of cases, these will be represented as ≤5 for confidentiality reasons. Where there have been no cases notified this will be reported as 0.

Gastrointestinal Illness

Notifications of gastro-intestinal (GI) illness constitute the bulk of organisms notified to HPT. Campylobacter was by far the most common with an incidence rate of 90.38 per 100,000 population, but this organism only requires passive monitoring by HPT, so it has not been included in the graphs below, which focus on the organisms that require more active management such as the completion of Communicable Disease Investigation (CDI) forms. Incidence rates for 2023 have been calculated based on the 2022 population figures.

Communicable disease investigation (CDI) forms were completed for Salmonella, Cryptosporidium and Giardia (Figure 1) to help identify sources, clusters and contacts. Advice was given to cases in order to prevent further spread of the infection.

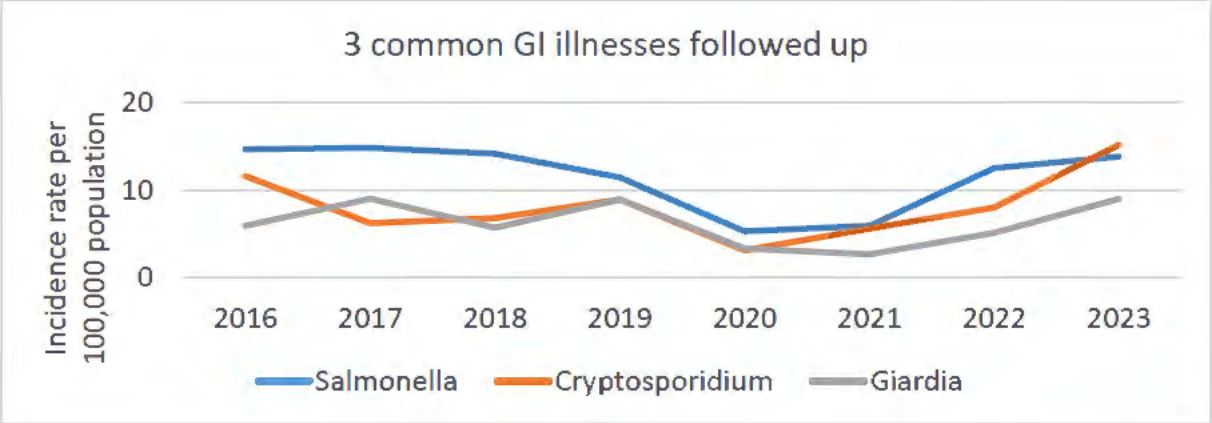


Figure 1: Trends in Lothian case rates per 100,000 population for Salmonella, Cryptosporidium and Giardia from 2016-2023 (inclusive)

The GI illnesses in Figure 2 also had CDI forms completed but sometimes required further public health interventions where higher risk groups were involved such as exclusion from specific settings (such as nurseries and hospitals) or restrictions on duties or activities (for example, those that work with vulnerable groups). Where these orders are implemented the cases or contacts generally require sampling criteria to be met before the exclusion or restriction can be lifted.

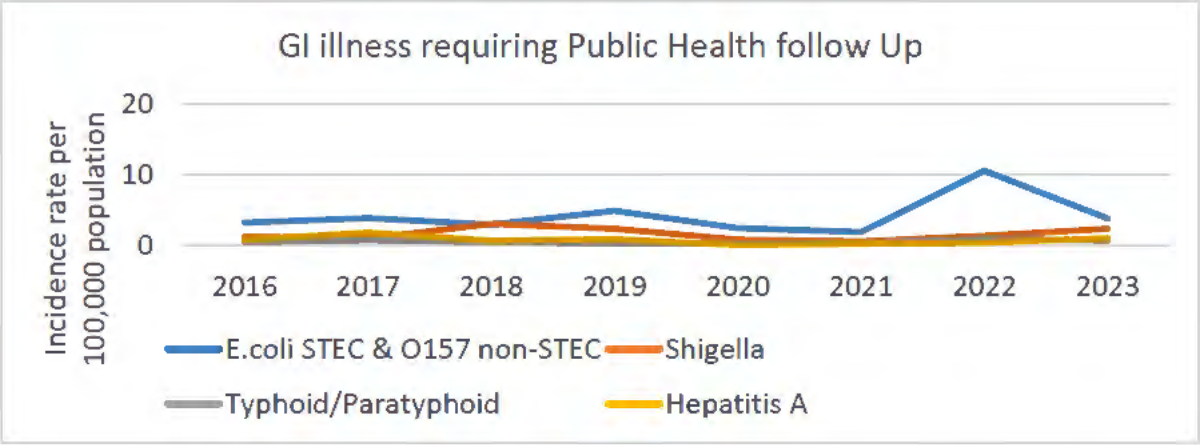


Figure 2: Trends in Lothian case rates per 100,000 population for E.coli O157 & STEC , Shigella, Typhoid/Paratyphoid and Hepatitis A from 2016-2023 (inclusive).

Hepatitis B

The Health Protection Team are notified of acute and chronic cases of Hepatitis B by the local virology lab. Cases are followed up to ensure that they are referred into appropriate services to give advice and trace contacts to ensure they are offered testing and vaccination.

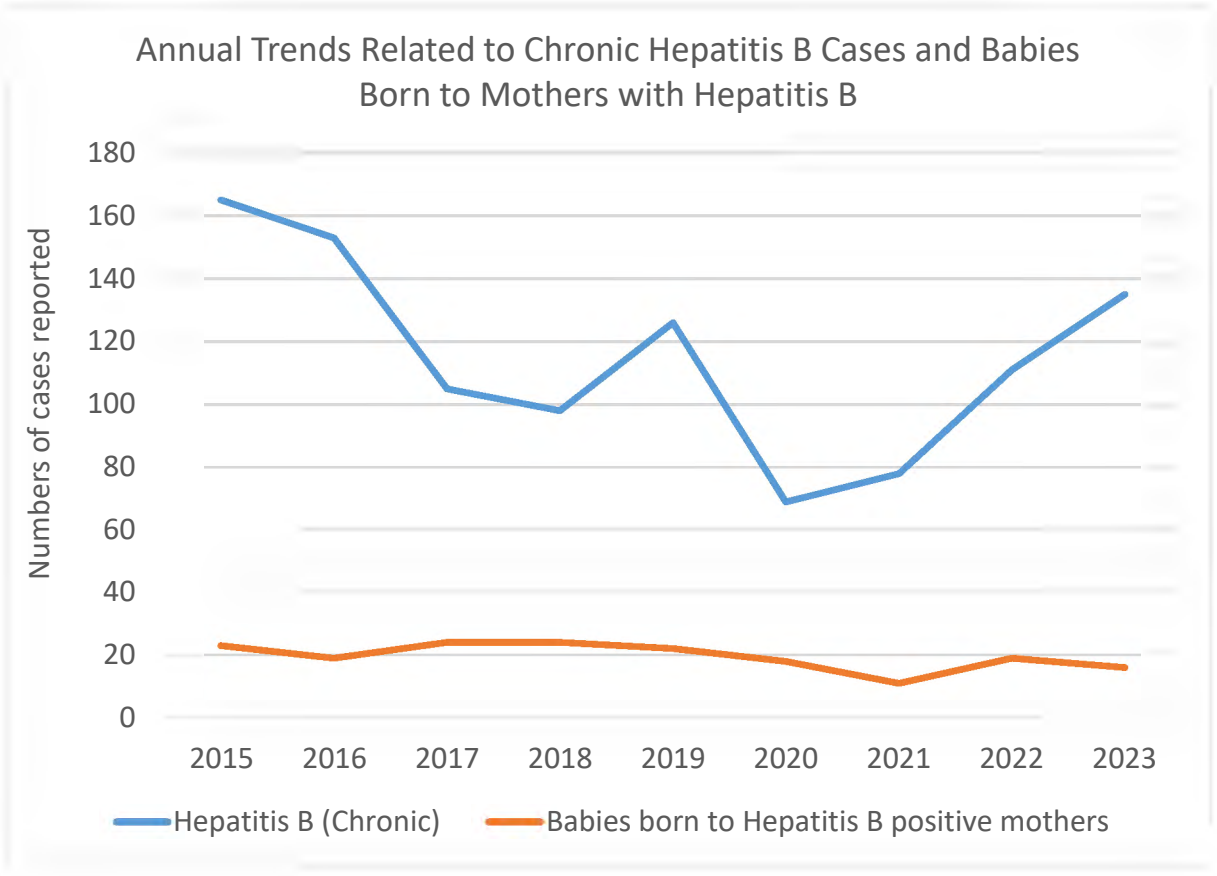


Figure 3: Chronic Hepatitis B and babies born to mothers with Hepatitis B, trends 2014-2023. Due to low numbers Acute Hepatitis cases have not been included in the graph.

Acute Hepatitis B

For years 2014 to 2023 (inclusive) the annual number of Acute Hepatitis B cases reported has consistently been five or less (2022 is the only year where no cases of acute hepatitis B were reported to HPT), for this reason the figures for acute hepatitis B have not been included in figure 3. The HPT follow up cases of acute hepatitis B immediately from notification to identify potential sources and trace contacts who may require prophylactic immunisation or immunoglobulins within a short window period from exposure.

Chronic Hepatitis B

Figure 3 shows newly identified chronic hepatitis B cases in Lothian by calendar year. There has been some variation in the numbers over the years. The highest numbers in 2015 (165) and 2016 (153) are likely due to the introduction of HPZone during 2014 as there were patients that were known to HPT already being added to the system along with newly identified cases. The lowest numbers in 2020 (69) and 2021 (78) are likely due to reduced testing during the Covid-19 pandemic. Since 2020, the numbers of newly identified cases of chronic hepatitis B in Lothian have been increasing to similar numbers seen pre-Covid and are currently just above the nine year average of 115 cases per year.

The vast majority of chronic hepatitis B cases in Lothian are identified in people who have moved here from countries where hepatitis B is more common or endemic.

Babies Born to Mothers with Hepatitis B

Babies born to mothers with Hepatitis B are followed up with additional Hepatitis B mono-dose vaccines at birth (immunoglobulin may also be given at birth if indicated), 1 month and 12 months. A blood test is offered at 14 months to check for infection and vaccine response.

Babies who move out with the NHS Lothian Board area are handed over to the new board of residence for follow up and are removed from the follow up numbers for NHS Lothian. Table 2 shows that the majority of children born to Hepatitis B positive mothers were followed up in 2022. It is too early to report on all of the 2023 figures.

Table 2: Information on the follow up of babies born to mothers with Hepatitis B 2019-2022

Year	2020	2021	2022	2023
Number of babies born	18	11	19	16
Number moved out with Board	[redacted]	[redacted]	[redacted]	0
Number left for follow up	16	9	17	16
4 week Hep B vaccine dose given	16	9	17	15
12 month Hep B vaccine dose given	14	7	16	N/A
Number with serology taken at 14 months	16	6 (2 booked)	15	N/A

Situations

The HPT follow up numerous situations throughout the year such as outbreaks of infection in community settings, infestations, environmental contamination or other issues that can affect public health. In 2023 the HPT actively followed up **593 situations**, these are coded onto HPZone under five categories: outbreaks, clusters, issues, exposures or threats (Figure 4).

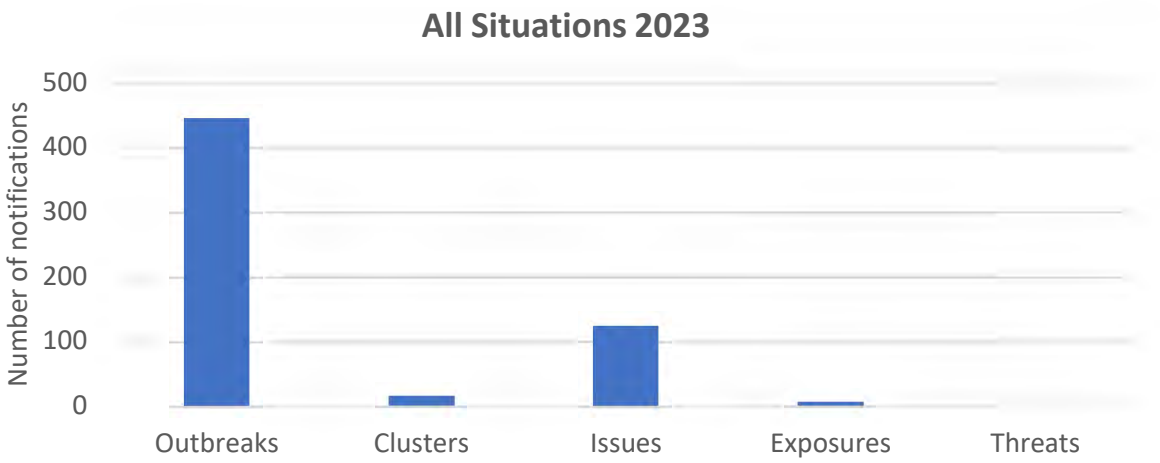


Figure 4: All Situations Notified to HPT in 2023 Requiring Active Follow up

Care Home Outbreaks

HPT provide outbreak management support and advice to care homes across Lothian.

During 2023, Covid-19 was by far the main cause of outbreaks in care homes which were notified to the HPT (Figure 7).

Norovirus outbreaks continued to remain below pre-pandemic reported numbers.

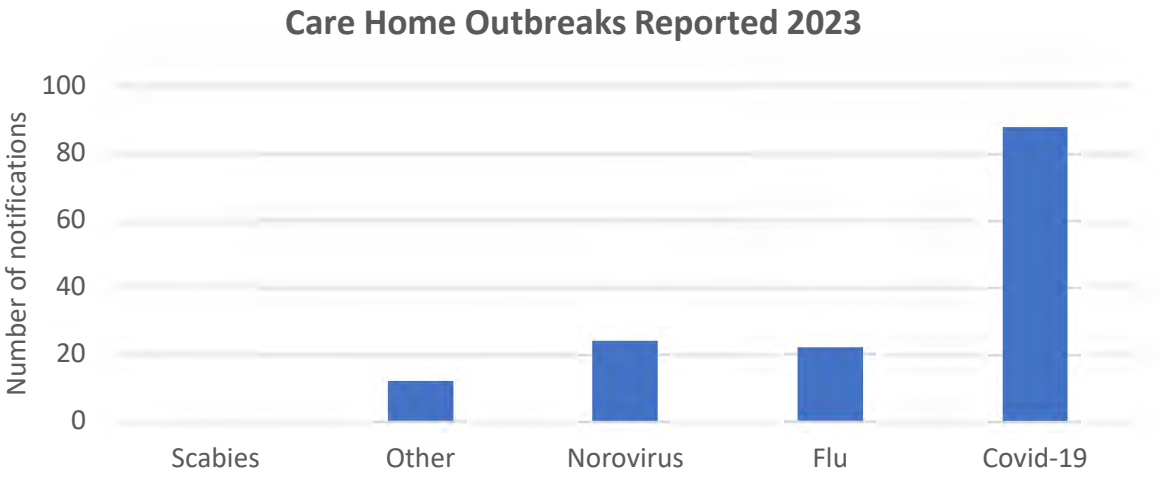


Figure 5: Care Home Outbreaks Notified to HPT in 2023

School and Nursery Outbreaks

In comparison to 2022, where there was a national increase in the number of scarlet fever and other non-invasive Group A Streptococcal (GAS) infections, notifications from schools and nurseries were reduced.

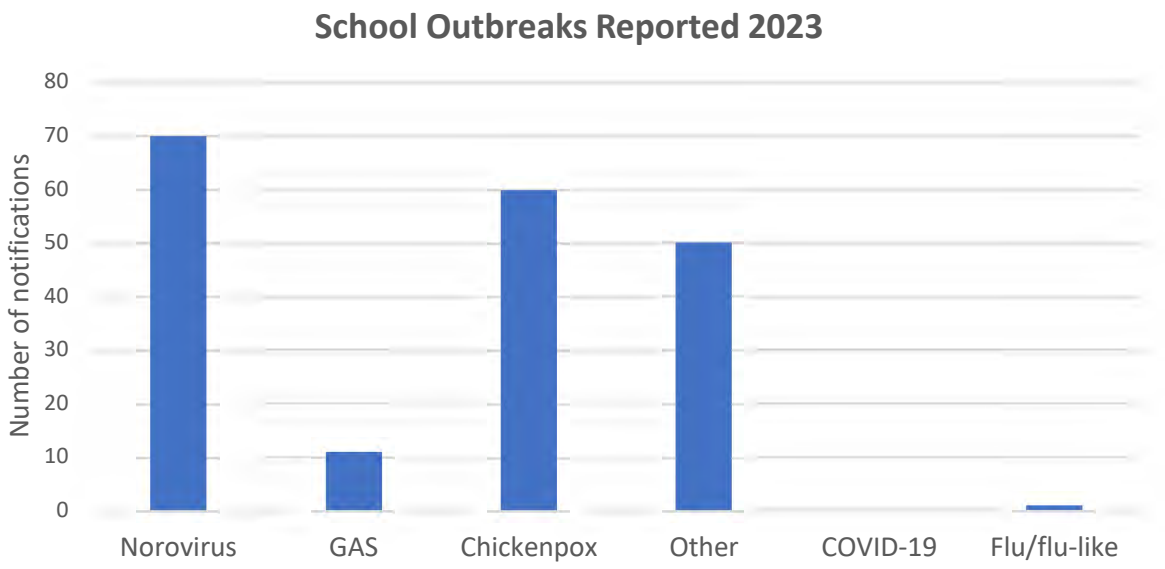


Figure 6: School Outbreaks Reported to HPT in 2023

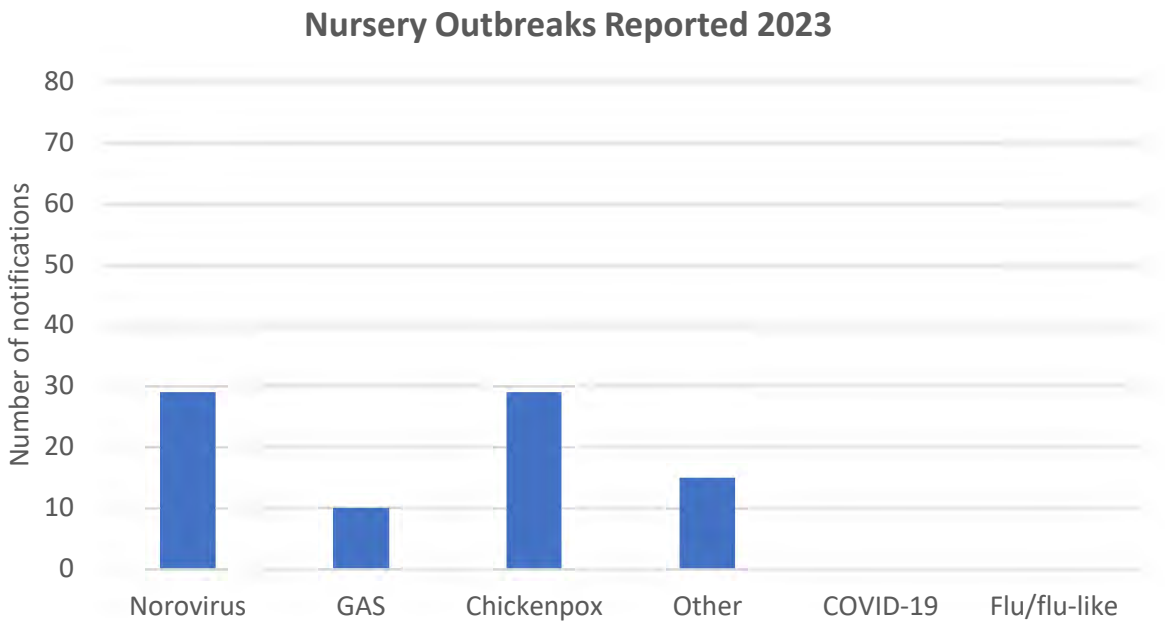


Figure 7: Nursery Outbreaks Reported to HPT 2023

Incidents and Issues

Public health incidents or issues occur when the health of the population may be at risk due to exposure to infectious diseases, hazardous substances, or adverse environmental conditions. In these situations, NHS Lothian will convene a multidisciplinary problem assessment group (PAG) or incident management team (IMT) to assess the risk and develop a response plan. Some examples of the incidents and issues lead by HPT in 2023 are:

Brucella Canis Follow Up

Public Health Wales (PHW) notified the HPT in March 2023 to advise that an individual within the Lothian area had bought a dog whose mother had been confirmed as having Brucella canis (B. canis), as part of follow up of a litter of pups.

B. canis is a type of bacterial species which causes an infection known as brucellosis. It can be transmitted from dogs to humans. There has been a recent increase in the number of dogs being diagnosed with B. canis since 2020 with most cases linked to dogs imported into the UK or links with imported dogs from Eastern Europe.

HPT undertook a risk assessment with the owner and the dog's vet to identify the potential risk and next steps. Ongoing support was provided to the owner and testing was undertaken for the identified dog. Throughout the incident information was shared with Public Health Scotland (PHS) and PHW. Testing demonstrated the dog was negative and all HPT actions were completed.

Group A Streptococcal Outbreak in a Local Prison

In April 2023 microbiology reported two cases of invasive Group A Streptococcal (iGAS) infection in a custodial setting with onset dates within 30 days of each other, they also noted an increase in non-invasive Group A Streptococcal (GAS) infections within a relatively short space of time. The typing identified the two iGAS cases as emm 76, a rare type which was previously linked to an outbreak of infections in people who use drugs back in 2014.

A Problem Assessment Group (PAG) was convened followed by a further three Incident Management Team (IMT) meetings with representation from the custodial setting including the healthcare team and the Scottish Microbiology Reference Lab (SMiRL) based in Glasgow. Ongoing surveillance of the situation was also undertaken for a period of time.

All iGAS samples are routinely typed but GAS infections from the prison were requested to be typed, including some historic samples which were stored. Snapshots of non-invasive GAS infections from the general population were also requested to be typed, this was to provide information on the strains circulating within the community as a whole.

Surveillance of this issue in 2023 identified:

- 26 episodes of GAS infection (25 individuals)
  - 22 isolates identified as emm 76
  - [redacted] identified as emm 1
  - [redacted] identified as emm 75
  - [redacted] to type
- 5[redacted] iGAS were identified
  - All in different units with no known direct contact
  - Subsequent[redacted] were all out with 30 days of each other

Over 50 isolates of iGAS and GAS samples from the general population were typed to see if emm 76 was circulating in the community, no emm76 was identified indicating this was an issue specific to the prison.

As no direct links were found between many of the cases, specific cleaning advice was issued for communal areas of the prison which were used by different units at different times. Prisoners were given information on signs and symptoms of infections, hand washing and cleaning of rooms/cells to help prevent onward transmission. As a result of the measures implemented and treatment of the confirmed cases, no further transmission was identified.

Scabies Outbreak in Asylum Seekers

In October 2023, the HPT were informed about a potential outbreak of scabies in a hotel housing asylum seekers.

A Problem Assessment Group was convened by health protection on the 11th October 2023 with representation from dermatology, public health pharmacy, the associated GP practice, district nursing team and representation from the hotel. Key issues discussed included: confirmation of diagnosis, challenges with treatment methods and potential language barriers. An incident was declared and a subsequent Incident Management Meeting was held over the following days.

Following confirmation of the diagnosis the IMT agreed that mass treatment of all hotel residents (approximately 120) should be undertaken in a co-ordinated fashion alongside correct management of laundry (clothing, bedding and towels). A script explaining the situation to the residents was agreed by the IMT and translated into the required languages to support the residents with both written and verbal advice. Mass treatment was carried out successfully and no further cases identified.

Training and Exercising

Part of NHS Lothian's statutory responsibilities for the prevention and control of communicable disease and the assessment of environmental health risks is to collaborate with colleagues and partner agencies in the production of emergency plans and to participate in exercising specific plans at regular intervals.

Port Health

Inter-agency emergency planning, and training and exercising activities at the airport were reduced to a minimum level following the impact of COVID-19 until recently. Two multi agency meetings were held in January 2023 and March 2023 with a plan to review the response call-out protocol and to train new staff in the response procedures through visits and exercises. Another key area of work included developing a scenario for a port health exercise to be undertaken late in 2024.

Torness (EDF) Nuclear Power Station Exercises

During 2023, HPT was represented at the EDF/East Lothian Council joint liaison meeting and exercise planning group, which focused primarily on planning the EDF Level 2 multiagency exercise (Exercise Puma) due to be undertaken in June 2024. The HPT focused on training activities for members of the health protection team including chairing a Scientific and Technical Advice Cell (STAC) and participating in the STAC support team. Two familiarisation visits to Torness Nuclear Power Station were completed by 19 staff members from the Public Health Directorate.

Forth Ports Exercise – Exercise Black Arrow

A consultant and two nurses attended a multi-agency desktop exercise hosted by East Lothian Council around an oil spill on the river Forth on the 2nd May 2023. The different exercise sites included the Marine Emergency Centre, Torness Strategic Co-ordination Centre and a hotel for media briefing. The HPT undertook a risk assessment on environmental contamination and provided advice on public health communication following a release of air pollutant from the incident site in the seas and spread of toxic material on the beach. At the exercise debrief communication between agencies on this kind of incident was noted to have improved markedly.

Familiarisation Visits

Over the year HPT members attended several familiarisation visits at key sites within NHS Lothian:

- Glencorse Water Treatment Works
- Torness Nuclear Power Station
- Dalmeny Tank Farm

These visits provide the team with an on the ground understanding of the site set up and layout; a chance to meet key members of the different teams and opportunities to ask questions and clarify elements of plans.

HPT Governance and Performance

The HPT Senior Leadership Team (SLT) met regularly to review the HPT work plan and discuss risk management including review of Datix/complaints; health and safety; and escalation of issues to the Public Health Senior Management Team. Performance metrics, introduced in 2022, focusing mainly on safety, effectiveness and patient/stakeholder experience were monitored throughout the year.

The SLT subgroups (Quality Improvement Team and Clinical Decision Making Group) continued to work on development areas across the whole of HPT.

Key elements included:

- PDSA approach to streamlining the E.coli clearance process
- Simplified systems process for follow up of PVL cases.
- Strengthening documentation on Health Protection case record system (HPZone), which subsequently informed the standard practice for the new East Region HPT.

Regionalisation

Work increased during 2023 to develop a new East Region Health Protection Service, combining four boards health protection teams: NHS Borders, NHS Fife, NHS Forth Valley and NHS Lothian. The main drivers for a regional service are to improve service resilience and sustainability; reduce unnecessary duplication; maximise the skills of the workforce and establish a modern service which would be attractive to work in.

The new East Region Health Protection Service daytime service officially commenced on the 12th December 2023, providing the health protection function for a total population of approximately 1.7milliom. The ERHPS aims to have a resilient, streamlined health protection service that delivers effective protection for the population from outbreaks of disease or

exposure to environmental hazards, along with robust surveillance and monitoring mechanisms. It also aims to provide expert guidance and support to partner organisations, other NHS colleagues and members of the public. In addition, the service aims to work collaboratively with other public health functions in each health board to promote population health. It is expected that the out of hours health protection responsibility will move to the regional service in 2025.

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28th January 2025**
Title:	**Tissue Viability Service Annual Report**
Responsible Executive:	**Pat Wynne- Nurse Director**
Report Author:	**Helen Ramsay- Lead Nurse**

1 Purpose

[Please check the boxes for all items that apply in each section]

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☐	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☒
Legal requirement	☐	Other [please describe]	☐

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☐
Children & Young People	☐	Finance (revenue or capital)	☐
Mental Health, Illness & Wellbeing	☐	Workforce (supply or wellbeing)	☐
Primary Care	☐	Digital	☐
Unscheduled Care	☐	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☒
Person-Centred	☒		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to provide the committee with an assessment of the quality and safety of care provided in the Tissue Viability Service (Adults), and work being undertaken to address risks and improve quality and safety from April 2023- March 2024.
The committee is recommended to accept moderate assurance that the Tissue Viability Service (Adults) have comprehensive systems in place to deliver safe, effective and person - centred care.

2.2 Background

This nurse-led service provides specialist advice for the management of patients with complex wounds, wound healing challenges and the prevention and management of pressure ulcers. The service provision document is provided in appendix 1. The Service does not provide cover for the Royal Hospital for Children and Young People, this is provided separately through Woman's and Childrens Services.
In early 2024 the service began to accept direct referrals from care homes with registered nurses, who could evidence use of safe email transmission. This has shown early signs of increasing referrals for the people living in care homes.
Further to this, referrals previously were received in the hospital sites via email, telephone or verbal requests. This has changed to the use of TRAK orders to request specialist input and the development of BOXI reports to demonstrate the service delivery.
Venous leg ulceration and grade 4 pressure ulcers remain the highest number of wounds referred to the service for specialist assessment pan Lothian. This is consistent with previous years reporting.
TVS responded to a total of 2901 patient referrals/contacts in 2023-24. 1596 of these were new referrals and 1305 were review visits/calls. This equates to an average of 242 patient contacts per month. This is lower than last year by 70 referrals however data from acute for March 2024 is not included due to BOXI.

2.3 Assessment

The TVS provides both a specialist nurse led advice service as well as providing education accessible to all within the NHS and other relevant areas including care homes.
The service provision demonstrates the Key Performance Indicators (KPI) for the service, which are used to ascertain service delivery and demand. KPIs for new referrals were achieved 77% for high-risk wounds and 77% for low-risk wounds.
Acute sites response KPI was achieved 88% for high-risk wounds and 90% for low-risk wounds. This does not include the data for the final month in the reporting year as this was not available from BOXI at time of writing.
Community areas response KPI was achieved 83% for high-risk wounds and 52% for low-risk wounds.
TVS staff participate in Commodity Advisory Panels (CAP) as part of national procurement work for dressings and associated therapies related to wound care. This includes a review of relevant literature and costings to inform choice and address financial efficiencies. This year saw a review of Negative Pressure Wound Therapy and work was undertaken with procurement to implement and aim to achieve savings for Lothian.

2.3.1 Quality/ Patient Care

The TVS continues to see high volumes of referrals from the RIE and Edinburgh community (Table 1), with district nursing and medicine of the elderly being the highest sources (table 2) This is consistent with previous years. Funding was sought to increase provision within the RIE from a business plan submitted in 2022 from acute. Unfortunately, this was not fulfilled, work has been undertaken within the team to release capacity from staff allocated to other areas to support the demand in RIE. Long term consideration will be given to recurring funding being released through staff retirement to support this demand without having a negative impact on other parts of the service. Work is to be undertaken to increase capacity within the service's E clinic which predominantly covers community sites and care homes. This will require a small element of investment to provide the camera equipment to support the process and is to be considered in the coming year.

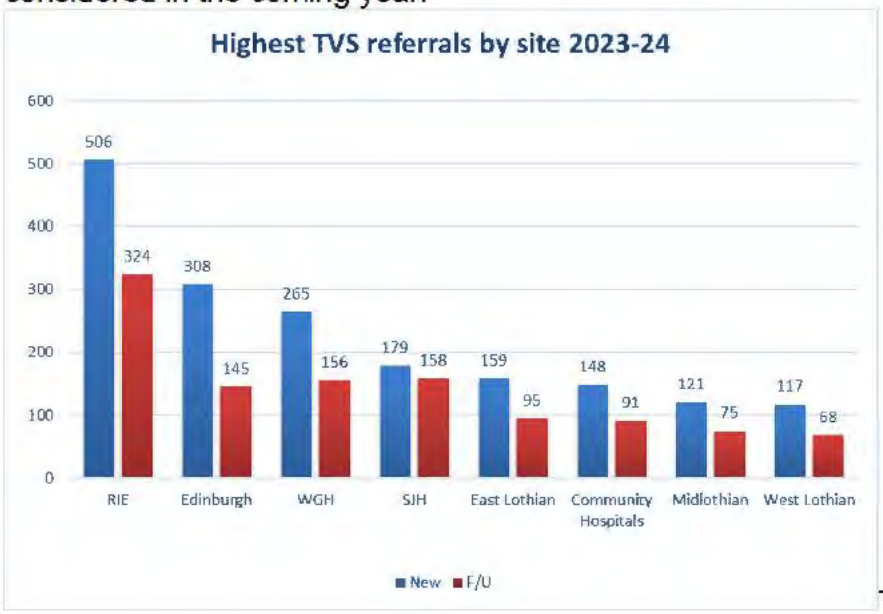


Table 1

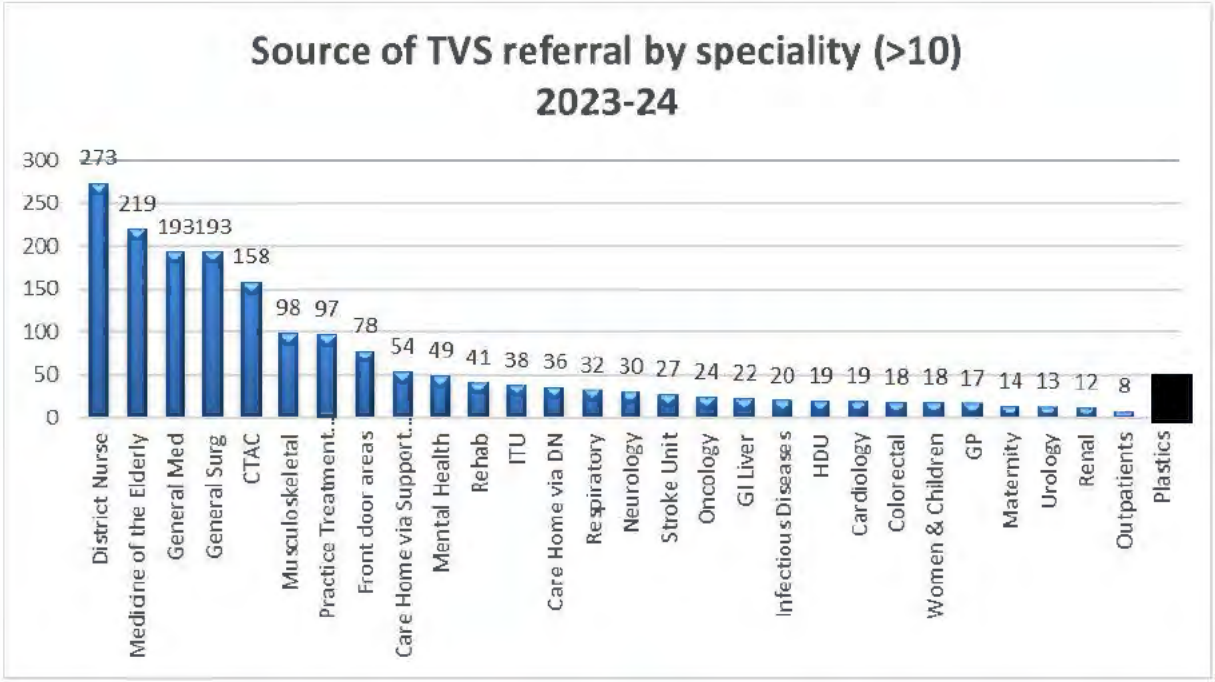


Table 2

In February 2024 the referral process was changed for Care homes who have registered nurses (RN) and access to a secure email network. Previously care homes required to go through a primary care provider for access to specialist support. This was highlighted as creating increasing

workload for District Nursing and was disrespectful of the role the RN played within the care home setting. Table 3 shows the data drawn from this change in process and is anticipated to continue to show an increase in referrals from care homes and the use of the direct referral route.

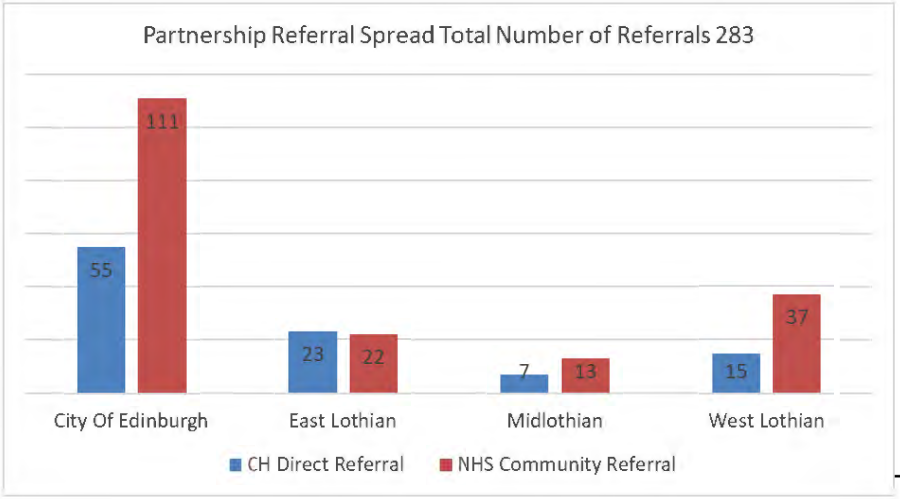
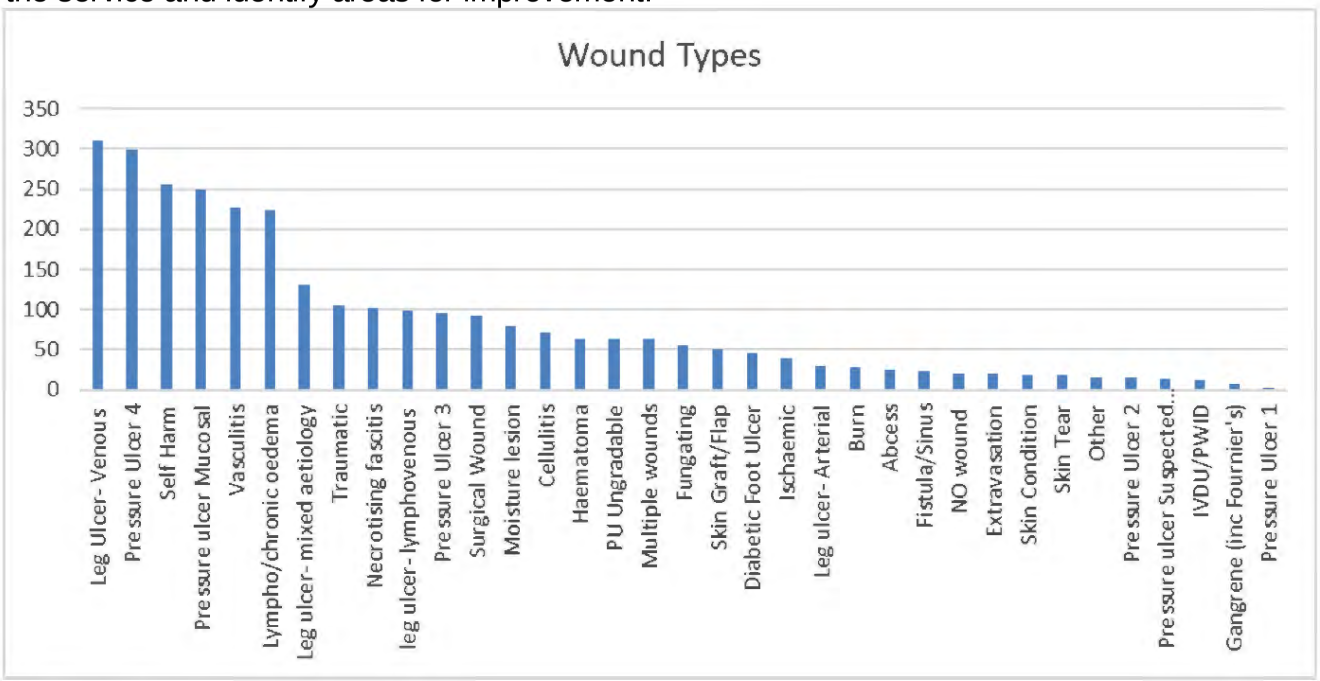


Table 3

The service collects data on the types of wounds referred (table 4) and this is has remained consistent with previous years. The data is now to be used to form the basis of the workplan for the service and identify areas for improvement.



Leg ulcers- These types of wounds are known to be some of the most difficult to heal and require early action to manage. By acting in a timely fashion evidence shows that improved healing rates can occur and recurrence can be reduced. Within Lothian we do not currently have a policy or guideline to support clinicians with early interventions therefore this is being developed in conjunction with the relevant stakeholders.

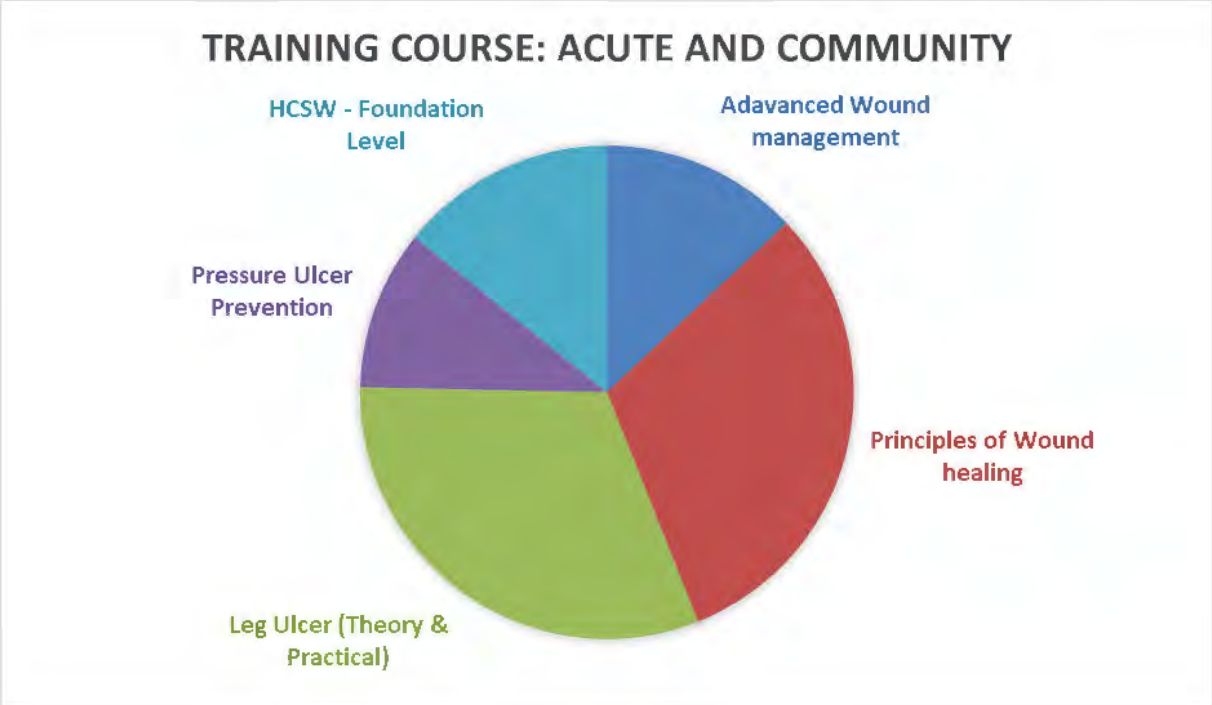
Pressure ulcers- Pressure Ulcers (PU) are one of the largest causes of harm to people accessing healthcare. Datix is used to record these events to provide data on the grade and location of the damage. In 2024 the service has offered support in reviewing all Major harm events recorded (Grade 4 PU) including developing action plans and learning sessions. In conjunction with the Quality Improvement Significant Adverse Event Team (QISAE) team all outstanding reviews are offered support to complete the timeline and identify learning to take forward. This has predominantly been with the district nursing service.

Between Jan and March 2024, the service provided 1 bespoke session to review all learning points from an SAE for one DN team lasting 2 hours. This allowed the team to discuss the case

fully and the opportunity to ask more detailed questions on what happened as part of the event. This has evaluated well and is to be replicated in the coming year.
For the past two years, there has been limited assurance on reducing pressure ulcers (PU), partly due to the absence of a dedicated improvement programme, as reflected in the data in presented within the Q and S report. In November 2024, the Nursing and Midwifery Care Assurance Oversight Board commissioned a Pan-Lothian, whole-system collaborative approach to reducing PUs. An oversight group has been established, co-chaired by a Chief Nurse and an Associate Nurse Director, with contributions from LACAS, EiC, TVS and the Quality Directorate. Quality Planning activities are currently underway across acute sites and Health and Social Care Partnerships (HSCPs), aligning with the SPSP Pressure Ulcer Change Package. The PU Collaborative will provide regular flash-reports to the Nursing and Midwifery Care Assurance Oversight Board.

Education

The TVS provides education on a core group of topics (Pressure ulcer prevention, Principles of wound healing, Advanced wound healing, Leg ulcer assessment and management, Tissue viability for HCSW foundation level). Predominantly taught virtually this suite of education is open to all NHS staff and some sessions are available to staff from care homes. In total 1311 people have attended.
Feedback is obtained regarding the training which currently evaluates well. Outcome data is currently not gathered but plans are in place to address this, which will be in line with other education streams within Lothian. This will include capturing the impact on staff and the care they provide 3, 6 and 9 months after attendance.



The service also provides specific education for care home staff focusing more on sessions which can be run face to face within the care home to maximise attendance.

2.3.2 Workforce

Role/Band	Remit	WTE
Lead Nurse B8	Pan Lothian service management	1.0
Tissue Viability Nurse Specialist B7	Acute sites- RIE, SJH, WGH	2.8
Tissue Viability Nurse Specialist B7	Community Areas	1.54
Tissue Viability Nurse Specialist B7	Care Homes	1.0
Tissue Viability Nurse B6	Community Areas	1.0
Tissue Viability Nurse B6	Care Homes	4.0
Admin Support B3	Pan Lothian service support	1.0

The service currently has a Lead nurse, this post had been held by the nurse consultant who left in July 2023, which provided a development opportunity from within the team to step into the Lead post. Recurring funding compromises both Tissue Viability Nurse Specialist, Tissue Viability Nurses, and Admin support, with further support from care home funding for several posts. The service saw staff move on and development opportunities arise over the course of the year. With one person acting up into a senior role and increasing hours for part time staff who wished to return to full time work.

The service currently has 1.0 WTE TVN on secondment funded via sustainability team to undertake work on obtaining wound management products via PECOS. This work has been undertaken within primary care to support a move from a prescribing based model of wound management product provision to a PECOS model. This is estimated to return significant savings and will be reported via sustainability and value reports. Having the specialist nurse input has ensure this is based around the formulary and is appropriate for care within all primary care settings. The project is estimated to end in March 2025 with the partnerships then taking ownership of this. Full financial savings were not available to evidence the impact at this point but will be to follow as part of the project report.

2.3.3 Financial

The TVS currently is funded for staffing and a small proportion of travel only and does not carry a budget for ongoing service costs. This is currently managed within budget due to vacancies. The service is currently carrying 1 vacancy due to retirement, maternity leave and awaiting recruitment to backfill the secondment post.

2.3.4 Risk Assessment/Management

2.3.5 Equality and Diversity, including health inequalities

Annual report for awareness and assurance.

2.3.6 Other impacts

2.3.7 Communication, involvement, engagement and consultation

Annual report only.

2.3.8 Route to the Meeting

Annual report for awareness and assurance

2.4 Recommendation

- **Awareness** – For Members' information only.
- **Assurance** – Moderate assurance is requested based upon the service data provided for patient care and education, and involvement with wider teams, service and groups to support the work around pressure ulcers.

3 List of appendices

The following appendices are included with this report:

- Appendix 1, Service Provision

Tissue Viability Service Provision

This nurse-led service provides specialist advice for the management of patients with: Complex wounds, Wound healing challenges and Pressure Ulcer prevention. *Diabetic Foot Ulcers should always be referred to Diabetic Podiatry Teams or Clinics*

A member of the Tissue Viability Service (TVS) should be available to provide advice Monday to Friday (excluding Bank Holidays). ***Please be aware the TVS is NOT a dressing service and therefore TV staff do not supply wound care products or compression bandages.***

PATIENT ASSESSMENT AND REFERRAL - *All forms and documents are available on the Tissue Viability Intranet Pages

- All wounds should be assessed and documented using the Trak or paper wound assessment chart before referral
- Please refer to East Region Formulary dressing selection guide for dressing choices
- Tissue Viability (TV) link nurses should be approached as an initial resource for advice if the plan of care fails to be effective, the wound is static or deteriorating.
- The TV nurse specialists should become involved when complications arise, complex cases present or wounds are failing to progress to healing. (See page 2 for types of wounds)
- **Please note when the Tissue Viability Nurse Specialist (TVNS) is assessing a patient/wound a Registered Nurse (RN) requires to be present to ensure continuity of patient care**

Adult Acute sites - Referral Process: A *Trak Order referral* should be completed: please refer to our intranet page for further information on how to complete: Inpatient Referrals Via Trak (scot.nhs.uk)

Adult Community sites (non eWound Clinic Services) – Referral Process: An *electronic referral form** must be used and emailed to: loth:tissueviability@nhs.scot

eWound Clinic (District Nursing Teams, Ferryfield House, Finlay House, Maple Villa and Tippethill, Care Homes with secure email addresses) – Referral Process: 1) Obtain signed consent form. 2) Photograph wound. 3) Complete eClinic referral form. 4) Upload all and email to: loth:eWoundclinic@nhs.scot (full details on TV Intranet page)

Children - Referral Process: A *Trak Order referral* should be completed: please refer to our intranet page for further information on how to complete: Inpatient Referrals Via Trak (scot.nhs.uk) – This process is for all children's services
For community staff please email referral form to: plasticdressingclinicrhsc@nhslothian.scot.nhs.uk

Neonatal Unit: Neonatal unit who still must complete a paper referral.

Non-NHS Areas i.e. care homes - Tissue Viability Information & Referrals – Care Homes (nhslothian.scot) is available for external agencies

TRIAGING REFERRALS

All referrals will be triaged and the TVN allocated to cover your area will respond. However, during times of absence this will be another member of the team.

Adult Acute and Community Non eWound Clinic:
A member of the TV team will contact you to discuss your referral in more detail. In order to help the triage process please have the following information at hand:

- History and cause of wound
- Current treatment regime including dressings or specialist therapies/equipment
- Previous treatments used
- Known sensitivities or allergies

eWound Clinic:
All referrals will be triaged and the TVNs will provide treatment recommendations via email or a home visit or NearMe Consultation will be arranged.

Updated by TVS August 2024 - Review Date November 2026

Triage Response Criteria (Mon - Fri excl. PH) - Acute Hospitals
HIGH RISK- the TVN for the area aims to make contact with the clinical team within 2 working days and for the patient to be seen within 3 working days when presenting with: • Complex surgical wounds/dehiscence • New Grade 3 & 4 pressure ulcers • Rapidly deteriorating wound e.g. escalating wound infection, exposure of underlying structures e.g. bone, tendon, bowel • To support assessment for specialist therapies, urgent advice/intervention, imminent hospital discharge/transfer **LOW RISK -** the TV team aim to make contact with the clinical team within 2 working days and for the patient to be seen within 5 working days • Long term wounds present in excess of 3 months duration with limited progress and/or further deterioration
Adult Community and Non eWound Clinic
HIGH RISK - the TV team aim to make contact with the clinical team within 2 working days and for the patient to be seen within 3 working days when presenting with: • New Grade 3 & 4 pressure ulcers • Rapidly deteriorating wound e.g. escalating wound infection, exposure of underlying structures e.g. bone, tendon, bowel • To support assessment for specialist therapies, urgent advice/intervention, imminent hospital discharge/transfer **LOW RISK -** the TV team aim to make contact with the clinical team within 2 working days and to see the patient within 5 working days or provide advice until an appointment can be arranged. • Long term wounds present in excess of 3 months duration with limited progress and/or further deterioration
eWound Clinic
HIGH RISK - the TV team aim to make contact within 2 clinic days and provide advice within 3 clinic days **LOW RISK -** the TV team aim to make contact within 3 clinic days and provide advice within 7 clinic days If a patient requires a visit following an eWound Clinic referral this will be arranged as per Community criteria above.

Tissue Viability Nurse Specialist – Cover Across Lothian - For contact details please refer to TVS Intranet contacts page
Locations covered
Lead Nurse – [redacted] – Mon - Fri
TV Service Admin – [redacted] – Mon-Fri
WGH - [redacted] - Mon, Tues, Thurs, Fri
RIE - [redacted] – Mon - Fri
RHSC - [redacted] – Mon - Fri
SJH, West Lothian HSCP – [redacted] – Wed, Thurs, Fri and Katharine Rolland Mon & Tues
Liberton, REH, AAH, Ellen's Glen and Community Services - eWound Clinic – All District Nurses, All CHST, Ferryfield House, Finlay House, Maple Villa and Tippethill, Practice Nurses, CTAC, Prisons, Community Hospitals and Care Homes – [redacted]

Updated by TVS August 2024 - Review Date November 2026

NHS Lothian Health & Safety Committee Minutes (Draft)

Wednesday 28th August 2024, 09:30
Microsoft Teams

Present:

Tracey Gillies (TG)(Chair)	Executive Medical Director	
John Sturgeon (JS)	Head of Programme & Development	
George McGrandles (GMc)	Head of Fire Safety	
Tobias Kunkel (TK)	RCN Lead H&S Rep	
Karen Ozden (KO)	Nurse Director, REAS	
Gordon Archibald (GA)	Partnership	
David Collins (DC)	Head of Health and Safety	
Graham Roberts (GR)	Business Manager	W&C
Julia Johnston (JJ)	Lead Occupational Health Advisor	
Linda Carruthers (LC)	Head of Oncology Physics	WGH
Roxanne King (RK)	Executive Business Manager	MLHSCP
Steve Elliott (SE)	Clinical Nurse Manager	ELHSCP
Helena Wilson (HW)	Operations Business Manager	WLHSCP
Fiona Ireland (FI)	Deputy Director, Corporate Nursing	
Heather Tait (HT)	Head of Service, EHSCP	EHSCP
Karen Fraser (KF)	Head of Risk, Quality & Assurance	E&F
Criag Newton (CN)	Management of Aggression Team Lead	
Gordon Mills (GM)	Deputy Associate Nurse Director	DATCC
Tracey McKigen (TMc)	Service Director REAS	REAS
Colin Munro (CXM)	Head of Manual Handling	
Aris Tyrothoulakis (AT)	Site Director, RIE	RIE
Anne Smith	General Manager, Head & Neck	SJH
Danny Gillan (DG)	Head of Soft FM	
Morag Campbell (MC)	Director of Estates & Facilities	
Carolyn Meldrum (CM)	Associate Nurse Director, OAS	OAS
Tommy Logan (TL)	Head of Operations Hard FM	
Edmund Witkowski (EW)	Clinical Service Manager, LUCS	Corporate
Lewis Rutherford (LR)(Notes)	Personal Assistant OHSS	

Apologies:

Allister Short	Service Director	W&C Chair
Yvonne Lawton	Head of Service Health & Social Care	WLHSCP Chair

1.	**Items for Approval**
1.1.	**Minutes from Previous Meeting and Action Log: Wednesday 1st May 2024** The previous minutes were approved. TG noted that actions will be picked up during the meeting and advised that her allocated action with KF and DG is still open, as they have not been able to meet. All other actions should be closed.
2.	**Matters Arising**
2.1.	**Zebra Printers (Fire) Datix No 529696** JS provided a brief summary of the SBAR on Zebra Printers, he informed that there are 1,890 printers attached to PCs with 100 in hospitals and 853 in GP practices/community. 1,367 which are Trak Network printers which are primarily in hospitals. The initial focus is on the RIE site and then will move on to the WGH and SJH. There have been 386 devices recalled and replaced in total 296 in hospitals and 72 in GP practices. JS noted that actions taken to date are: • A DATIX has been raised with involvement from Fire safety and H&S. • Information was sent via email to all practices and users providing step by step instructions on how to locate and report any problems. • There was engagement with the safety action notice process, and an alert went out on 30th July to all sites. • A report was completed for the Corporate H&S Local Committee GMc and JS advised that the devices should be switched off when not in use as they are still required for blood tube labels across NHSL and there should be no combustibles near these devices. TK informed that staff side has raised this at ward level and incorporated in workplace inspections. TG requested that JS to send SBAR to LR for circulation to all local chairs. **Action: SB/LR**
3.	**Items for Discussion**
3.1.	**Environmental Ligature SLWG** KO provided a background to the SLWG, which identified inconsistencies on environmental ligature management throughout the organisation. An implementation 'Task and Finish' group has been established and are working through the actions of the report presented at the last NHSL H&S Committee. The group have met once with representation from all sites, with a small group identified who will test the current documentation. KO advised that it is estimated that the group will complete all tasks within 18 months. TG stated that we need to demonstrate a significant level of progress and be more specific with the tasks. Linda Rumbles, Staff side representative to receive the dates for the Task & Finish group. TG requested the totality of the work that is planned, including the detail and time course for the business as usual to be in place, and requested another update to the committee

	in 6 months. **Action: KO**
3.2.	**Nitrous Oxide** DC provided a brief background and noted that Nitrous Oxide is used as an anaesthetic in Medical and Dental settings, is classed as hazardous substance and under the COSHH 2002 Regulations we need to conduct checks on exposure to the gas. Scavenging systems, as well as fixed and mobile destruction units, are the potential control measures that have been identified. Further data collection is required for SJH site before we can determine how the organisation will move forward. There are 15 dental sites that will be sampled the next few months by the Corporate H&S team. TK questioned point 2.4 regarding midwives wearing analytical equipment, the size of it and how long they would be required to wear it. DC informed that it is a direct instrument reader and is small in size so will not interfere with any of their duties. TG questioned the timeframe for all the assessments. DC confirmed that all assessments will be complete by end of December 2024. TG requested a plan of who is doing what to come to the February 2025 meeting. **Action: DC**
3.3.	**Key Risk Project Update/ Workplace Safety Inspection** JJ provided an update, stating that in Q1 the 'Keeping People Safe' templates were launched, partnered with bitesize sessions to support the refreshed assurance reporting system. This was in line with the launch of the Workplace Safety inspection App, which is a recording tool, to record all inspections with an action log, whereby managers and committees can view on Tableau. JJ advised that the digital solution process has been fluid, and we are still in the testing stages, the plan is to test with Corporate and potentially W&C in Q2.TK informed that the colour branding is very welcome and will be helpful when it comes to knowing which quarter you are reporting. TK noted that the Workplace Inspection App is a very useful tool and questioned if it can only be used on an NHS Lothian device. JJ confirmed that this is the case. RK thanked the H&S team for the work and support, the openness of the key risks has sparked good conversation at the meetings. HW advised that she had completed a trial on the workplace inspection app and found for West Lothian it would be easier to do on paper then input into the application. TG requested that JJ bring back a report in Feb 2025 and suggested that once we have had these risks for a year it would be useful to have a H&S colleague from another board to come and provide some feedback. **Action: JJ**
3.4.	**V&A Programme Board** FI informed that at the previous meeting it was agreed that a measurement framework would be brought to this meeting. There is work ongoing around the work-based trainers to enable the strategy to be delivered but some tweaks have been made around the roles and responsibilities, it is suggested that local H&S committees look at the active trainers within their areas to indicate whether we are in a position to deliver the required sessions.

	We have had some escalation from local risk registers to the programme board and have addressed some around REAS and Staff Bank, although it has been agreed that at future programme boards we will look at local risk registers to ensure that we are not missing anything. FI updated that three posts are currently out for recruitment, an Admin post and two additional trainers. 311 training needs assessments submitted and 126 risk assessments (Purple Pack). The view is that this is quite a low return, in order to provide meaningful data, we need to understand the denominator. FI will need the help from committee chairs to identify how many we should expect to allow us to report accurate numbers. SE advised that the work around the purple pack was good, and well received by the team but noted that the training needs analysis was not clear within it which could have had an impact on the return rate. HT noted that within EHSCP they raised with the programme board the lack of training availability for their mental health inpatient areas and noted that an SBAR was submitted to the programme board. and there is a plan to take forward over the next few months. LC highlighted that the dominator is a challenge on the WGH site as they have been reviewing all the reports to determine which ones they should be receiving from each area which highlights site versus service as there is some services based on the WGH site but come under a different area. TG requested that local chairs provide the number of reports there should be for their area to allow the denominator to be identified and run with that to allow us to see some data coming back and then make any required changes. Information to be sent to LR by Friday 13th September. **Action: All Committee Chairs/LR**
3.5.	**Policy Update** JJ advised that the Falls from Windows and Balconies Policy was planned to be submitted to the committee, however as Morag Campbell, Director of Estates & Facilities is the owner, she has asked that she has an opportunity to review the policy prior to it being submitted to the Policy Approval Group (PAG). There has been a review of the RPE Policy in line with the three-year review, and the Equality Impact Assessment has identified that there is a requirement for some changes in terms of to be clean shaven for fit testing or wearing a FFP3 mask. The original policy discriminated against protected characteristics, and the policy was too prescriptive in terms of Facial hair where it states that NHS Lothian applies a policy of full face clean-shaven. Face Fit Testing must be aborted if employee does not follow this instruction. Discussion was made at the PPE Strategic Group, and it was agreed that before the policy is submitted to the Policy Approval Group, a consultation with key stakeholders is required.
3.6.	**HSE Contact** No HSE contact.
3.7.	**Water Safety Assurance** KF advised that traction has been good since the last committee. KF reminded the committee that where there are water outlets of closed areas they

	require to be highlighted to Estates and Facilities colleagues.
3.8.	**Radiation Committee Minutes** Callum Idle will provide minutes going forward. LR to seek the minutes, circulate to the group and request the minutes for future meetings. **Action: LR**
3.9.	**Staff-side Activity Report** TK provided a general update on membership for the different SLWGs, and long-term groups being attended by the staff side, and ongoing workplace inspections. Gordon Archibald advised that he is supporting the SMART centre with workplace safety inspections.
3.10.	**Violence & Aggression (V&A) Service Update** CN informed the committee, that there were two organisational communications in relation to the Purple Pack. • Ten MS teams sessions over the 10 weeks of Q1 weekly, • Face to face and bespoke sessions. • Trainers went door to door. • The online survey was open 121 days. This was Phase 1 of the implementation process with a focus on REAS & Staff Bank.
3.11	**Manual Handling Service** CM informed that the team have a risk assessment approach to the corporate induction, they are moving forward with tracking and working with E&F to provide a LOLER workshop.
3.12.	**Fire Safety** TG acknowledged the clear paper and quality of information received. GMc highlighted 2.7 is a large project for RIE. The Fire Safety advisor attends, and this is having an impact on his day job, therefore an SBAR requesting additional resource, is in progress. There is an action plan, to try and reduce risks which was started in 2024, reducing extreme risks. There have been no fire incidents in Q1. A fire evacuation has been carried out at the RIE; this is before the lifecycle works. There has been good engagement from staff, with a structured evaluation. The full exercise report is still in draft. GMc is keen to raise awareness, therefore was advised to go through education colleagues across different disciplines.
3.13.	**Staff Adverse Events Statistics** JJ clarified in the report where it states, 'There is limited assurance of the quality of investigations of RIDDOR adverse events, where support is not in place from the Corporate Health and Safety Team'. This excludes E&F as they have their own SAER group. JJ informed that the Sharps & Contamination key risk project was carried out from June to early August 2024. Focussing on identifying lessons learned, implemented and improvements. A sample group from WGH was identified and based on interviews, discussions, review of incidents, benchmarking with other NHS Scotland Boards, we have identified lessons learned and an action plan for implementation. Contributors included the Corporate H&S team, Clinical Director, Medical Director, Colleagues from WGH, QIST team, and Procurement.
4.	**Assurance and Scrutiny (By Exception Only)**
4.1.	**Estates & Facilities** KF updated that this is the first time we have reported on the critical systems assurance levels. Fly tipping has been identified as an emerging risk, which it is thought to be down the local authorities changing how local recycling centres are accessed. KF asked that is

	anyone sees anything that they let E&F know. DG highlighted the annual security report, with a focus on: • Staffing numbers, • Equipment and • PPE. • Expectations placed on security by clinical colleagues. • Lock down. • Martyn's law • Training figures. • Security and threat learn pro module. TG advised that the committee chairs take the security report to local committees next time, for relevant stakeholders to join the security committee, to consider and promote the availability of the LearnPro module. **Action: Committee Chairs**
4.2.	**Royal Edinburgh & Associated Service (REAS)** TMcK highlighted risks related to fire safety, and risk of fires, stating that at times REAS have had no security, with provides an added pressure.
4.3.	**Woman and Children's Services** GR advised Moderate assurance for all areas. JJ checked that assurance levels for Childrens services in relation to Safer Bathing have been sourced, GR confirmed that this was received retrospective of the local meeting.
4.4.	**Outpatient and Associated Services (OAS)** CM The committee was clear that there was some learning in terms of the key risks. Key risk was fire safety at Lauriston Building and is feeling more comfortable regarding fire as have had input from the fire advisors.
4.5.	**Edinburgh Health and Social Care Partnership** HT Limited for V&A and MH due to missing reports in areas where there are high staff numbers. Moderate assurance for all other areas.
4.6.	**East Lothian Health and Social Care Partnership** SE The main issue is the split with NHS and Council and the procedures not running alongside each other. Moderate assurance across all areas. Security – we now have a few more unoccupied buildings now, if anything happens we need to deal with and wait for the police. TG suggested that it might be useful for all the HSCP chairs get together and discuss working alongside council colleagues. **Action: HSCP Committee Chairs**
4.7.	**Midlothian Health and Social Care Partnership** RK updated Moderate assurance for all areas. The chief nurse has completed a piece of work to improve our DATIX process. RK raised an issue related to GP alarms that were thought to go to the police, MC noted that she is not aware of them going to the police and thought that that it went to a security company and suggested that this be raised with Tommy Logan. **Action: RK/TL**
4.8.	**West Lothian Heath and Social Care Partnership** HW advised that there was a positive water sample at one of the health centres, with remedial work ongoing and further testing will take place following the work.
4.9.	**Royal Infirmary Hospital Site** AT advised he had nothing to report by exception, there has been a focus on V&A and

	Fire safety. There was a brief discussion regarding safer bathing, with a review and consideration of a different approach. In relation to stairwells there is still some discussion, with limitations regarding costs, looking at different alternatives, and they are trying to identify a solution. There is clear communication across the site with regular audits of stairwells and spot audits from a site perspective, we are planning to take forward as a priority, as a site. Limited assurance for V&A which they are working on, improving this assurance level.
4.10.	**Western General Hospital** LC advised that there has been a follow up regarding prevention from falls from windows & balconies, a couple of near misses although still compliant. LC specifically related to unforeseen force on the window restrictors and there has been discussion across the site. A comprehensive report highlighted a clear statement for the SCN to check if there is a restrictor to report immediately and an expected response for rectification immediately. There is some shared learning across NHSL and there are different restrictors and familiarity on how they are supposed to work and to accommodate in their PPM on site. Fire safety that the EFAPs had been completed although there is a lack of confidence, suggesting that copies are made available.
4.11.	**St. John's Hospital Site** No specific issues to highlight.
4.12.	**Corporate Services** EW advised that the assurance levels were impacted by training levels for V&A. EW acknowledged the input from the Fire team who met with members of the committee stating that is was much appreciated. There has been some work starting re the move from Waverley Gate to West Port.
4.13.	**Diagnostics, Anaesthetics, Theatres and Critical Care (DATCC)** GM highlighted that there had some increase in sharps injuries. We are prioritising our fit testing as winter approaches for critical care. TG requested that LR move DATCC further up the agenda for next meeting. **Action: LR**
4.14.	**Overall Assurance** Appendix 1
5.	**Date of Next Meeting** **Wednesday 6th November 2024, 0930am, Microsoft Teams**

Appendix 1: Overall Assurance Table

Table 2: Overview of results for local committee assurance levels for Q1: 2024/25

	Assurance Levels for all Local Committees			
Q1 Key Risks	**Significant**	**Moderate**	**Limited**	**None**
Management of Violence and Aggression	0	10	[redacted]	0
Manual Handling	0	10	[redacted]	0
Safer Bathing, Showering & Surface Temperatures	[redacted]	10	[redacted]	0
RIDDORS	[redacted]	11	[redacted]	0
Review of Staff Adverse Events	[redacted]	12	0	0
Total number of assurance levels	[redacted]	**53**	**8**	**0**

The following definitions are used to ensure consistency*:*

Significant (Fully (100%) compliant)
The Board can take reasonable assurance that the system of control achieves or will achieve the purpose that is designed to deliver. There may be an *insignificant* amount of residual risk or none.

Moderate (Mostly (75%) compliant)
The Board can take reasonable assurance that controls upon which the organisation relies to manage the risk(s) are in the main suitably designed and effectively applied. There remains a *moderate* amount of residual risk.

Limited (Some (50%) compliance)
The Board can take some assurance from the systems of control in place to manage the risk(s), but there remains a *significant* amount of residual risk which requires action to be taken.

None (Limited (25%) compliance)
The Board cannot take any assurance from the information that has been provided. There remains a *significant* amount of residual risk and *urgent* action to be taken.

Appendix 2: NHS Lothian Health and Safety Committee Action Log

Date	Item	Action	Owner	Timescale	Status
28.08.2024	2.1.	**Zebra Printers (Fire) Datix No 52969** JS to send SBAR to LR for circulation to all local chairs.	JS/LR	06.11.24	Closed
28.08.2024	3.1.	**Environmental Ligature SLWG** The totality of the work that is planned, including the detail and time course for the business as usual to be in place, and requested another update to the committee in 6 months.	KO	06.02.25	Open
28.08.2024	3.2.	**Nitrous Oxide** A plan of who is doing what to come to the February 2025 meeting.	DC	06.02.25	Open
28.08.2024	3.3.	**Key Risk Project Update/ Workplace Safety Inspection** JJ to provide a report in Feb 2025, and once we have had these risks for a year, to have a H&S colleague from another board to provide feedback.	JJ	06.02.25	Open
28.08.2024	3.4.	**V&A Programme Board** All committee chairs to provide the number of reports there should be for their area to allow the denominator to be identified and run with that to allow us to see some data coming back and then make any required changes. Information to be sent to LR by Friday 13th September.	Committee Chairs	13.09.24	Open
28.08.2024	4.1.	**Estates and Facilities** All committee chairs take the security report to local committees next time, for relevant stakeholders to join the security committee and to promote the availability of the LearnPro module.	Committee Chairs	06.11.24	Open
28.08.2024	4.6.	**Security** All HSCP chairs to meet and discuss working alongside council colleagues.	HSCP Chairs	06.11.24	Open

ACUTE CLINICAL MANAGEMENT GROUP (CMG)
Tuesday 8th October 2024, 08.30am
Microsoft Teams

PRESENT: (Total: 38)

Eddie Balfour (EB)	AHP Director
Elizabeth Bream (EB)	AMD, QI & Patient Safety
Dave Caesar (DC)	AMD, Medicine Services, RIE & OAS
Peter Campbell (PC)	AND RHCYP
Emma Childs (EC)	Nurse Consultant Oncology
Simon Edgar (SE)	Director of Medical Education
Mike Gillies (MG)	SMD, RIE
Lindsay Guthrie (LG)	Head of Infection Control
Kirsten Hood (KH)	Deputy Chief Nurse, Clinical Education and Training
Laura Inglis (LI)	Acting DAND RIE
Michelle Jack (MJ)	AND, RIE
Kallirroi Kefala (KK)	AMD, ATCC
Sarah Keir (SK)	Realistic Medicine Lead
Claire MacIntosh (CMacI)	AMD, WGH
Andrew Marchant (AM)	Medical Device Committee Lead
Gillian McAuley (GMcA) **Chair**	Nurse Director, Acute Services
Dave McKean (DMcK)	CD, ED
Jane McNulty (JMcN)	AND, Theatres & Anaesthetics, RIE
Carolyn Meldrum (CM)	AND OAS
Kelly Moffat (KM)	Lead Nurse Palliative Care
Hannah Monaghan (HM)	Head of Histopathology
Jeannette Morrison (JM)	Head of Patient Experience
Victoria Mulholland (MH)	Nurse Consultant, Acute Medicine
Donald Noble (DN)	CD, SJH
Claire Palmer (CP)	AND WGH
Mercedes Perez-Botella (MPB)	Director of Midwifery, Women's Services
Jim Powell (JP)	AMD, Surgery RIE
Colette Reid (CR)	AMD, Cancer Services
Agnes Ritchie (AR)	AND SJH
Katy Ruggeri (KR)	AND, Womens Services
Caroline Whitworth (CW)	Medical Director, Acute Services

IN ATTENDANCE:

Amanda Barugh (AB)	CD, MOE
Fergus Doubal (FD)	Consultant, MOE
Sarah Davie (SD)	Executive Assistant to Medical Director, Acute -Notes
Brenda Duncan (BD)	CNM, CC
Rebecca Miller (RM)	Head of Strategic Development
Callum Mutch (CM)	ST7 Medical Microbiology
Alasdair Ruthven (ARu)	Point of Care committee lead

APOLOGIES:

Patrick Addison (PA)	Site Medical Director SJH
Melinda Cuthbert (MC)	Associate Director of Pharmacy
Fiona Ewing (FE)	AMD, Radiology
Ingo Johannesen (IJ)	Director of Laboratory Services
Gregor McNeill (GMcN)	Deteriorating Patient Clinical Lead
Donald Inverarity (DI)	Consultant Microbiologist, Labs
Sara Robinson (SR)	Deputy Director Medical Education
Jenny Scott (JS)	Lead Pharmacist

Item	Business	ACTION
2.	**Welcome, Introductions and Apologies** GMcA welcomed everyone to the meeting and SD agreed to note apologies in the minutes (as above), any queries for Pharmacy should be directed to JS by email.	
2.1	**Previous Minutes** No comments or amendments were received so the minutes of the previous meeting were accepted as an accurate record of discussions.	
2.2	**Action Log** *Item 312/22* – Zenith arch access for centre procedure – update after 5 cases – 2 cases done so far (Aug). *Item 304/23* – Lateral Orbital Decompression – 10 cases now done – arranging date to return to CMG Oct/Nov or Dec. **November agenda.** *Item 305/23* – Laser Ablation Service – to return on completion of 3 cases – contact JK in **'25 for update**. *Item 302/24* – Mortality screen tool to be standardised and controlled version rolled out **– 01/25**. *Item 302/24* – Adult audiology action plan progress to come to **Oct '24** *Item 302/24* – Gluten sensitivity in wards – permanent/visible method for flagging patients who have food intolerance – SLWG with NHS Bradford/Sheffield commenced. *Item 402/24* – Hybrid Thoracoflo – to bring update after 2/3 cases. One case done so far (Aug). **December CMG** *Item 305/24* – Individual Deteriorating patient plans to come to **November CMG.** *Item 306/24* – Challenges around deaths after discharge to be discussed with Primary Care – CW advised that she has discussed with Jeremy Chowings (MD for Primary Care) who noted there is no uniform process/practice/policy to let Secondary Care know of a death. 08/10 - Jeremy Chowings is going to try and find out but CW does not think there is a unified starting point, there is nothing obviously electronically to highlight it. This should remain on action log meantime. *Item 307/24* – Audit of data following new staff group carrying out laser eye treatment to come back to CMG **07/25**. *Item 307/24* – Oxygen transfer document to be updated/SJH SAE data and information to link with transfer documentation – CP noted that following previous discussions the transfer document had been amended with regard to oxygen cylinder section and PPE requirements with escorts. The document (attached) was accepted as a live document. CP will ensure she links with MC regarding Medical Gases and will also ensure there are links to other transfer documentation.	

	2410 Transfer Document.docx *Item 307/24* – Mapping of M&M services and enhancement of system – October agenda. *Item 308/24* – **Covid and planned admissions discussion.** MG to write down guidance regarding patients being positive for Covid before elective and urgent surgery. Bring back in **October 24**. MG – ask Mike?????? *Item 309/24* - CP will bring back the patient story to the December meeting. This patient story is regarding an SPSO feedback and will potentially have implications for all areas. Bring back in **December 24**. *Item 310/24* - An admin request to be put in for admin support to help expedite the SAEs and assist clinicians with interview bookings and note taking. JMcN thinks this is a good point and will link in with the team around this as she thinks this is something they can support. 8.10 – JMcN noted that she needs to raise this with Jill Gilles. LB advised that she has had a discussion about it which will come back to November CMG.	
3.	**Assurance and Governance**	8.50-10.20
3.1	**Stroke Audit update** Item 3.1 Scottish Stroke Care Audit (SS FD advised that the attached report had been discussed in detail at the RIE site PSEAG meeting. It is the Scottish Stroke Care Audit findings looking in to increased mortality rates for 90 days post stroke, at the RIE. A review of patients who had died was carried out to see if there were any problems with care delivery but, although some issues were identified, there were no systematic problems that required addressing. Consideration was then given into what reasons there might be for increased death rates, data collection, case mix adjustments and how we compared with the rest of the country. The main difference is that we have a lower rate of ischemic stroke in the area in comparison, noticeably lower. On investigation it appears that some patients with ischemic stroke and minor stroke are looked after in the outpatient setting rather than being admitted, and don't get included in audit data etc. This is potentially one reason for the increased mortality in Stroke. The review team also looked into LoS within Stroke and short stays have reduced, with the area performing better than the rest of Scotland. CW thanked FD and the team for carrying out this piece of work, asking if they were surprised by findings? FD noted that the findings were reassuring. A review of modelling is ongoing and a change in practice to try and avoid admissions is a key message taken from the audit. We need to better understand the benefits of data. Item 3.1 Deaths outwith ASU case revi	

	AB noted that a review of inpatient mortality in wards was carried out and it appeared that some excess of death was happening out with the Stroke Unit. A sample of 12 of these deaths were investigated further to see if there were any issues of note with their care, using the NHSL structured mortality tool. 3 pairs of reviewers (inc. stroke experts) noted that care of the 12 patients was appropriate and did not impact on outcome for most patients. There was some good practice noted in relation to communication with the families and also with end of life care. Most care and delivery service problems identified related to prolonged time in the ED, and lack of involvement of the Stroke team in [redacted] cases. In [redacted] cases there was a lack of clarity around why the patient was not in the Acute Stroke Unit. [redacted] were classified as an outcome 3; this means that a difference in care might have affected the outcome for the patients. Some areas for improvement noted were poor documentation and lack of specialist Stroke review but there was no clear evidence of avoidable mortality. None of the cases met the Stroke Care Standards so recommendations following the review are to focus on meeting the standards moving forward, feeding findings in to existing work streams in relation to flow across the site, to help maximise the patients that are admitted to the Stroke Unit. The team has already implemented a revised approach to our M&M review and governance process to align all reviews to the audit outcomes.	
3.2	**<u>Point of Care Committee update</u>** ARu noted that he has been Lead of the Point of Care Committee since April and that this was his first update for CMG. The new committee is now established and has met a couple of times (1/4ly meetings). Succession planning work is ongoing with focus on the transition of glucose meters as current devices have been discontinued. ARu advised that there may be reduced support with some POC testing and troubleshooting abilities as staffing levels are currently down at 60% of normal; 2 WTEs have left resulting in reduced capacity in the department. A decision has been taken to pause new and early development POC testing projects given these staffing, issues to allow for priority to existing services. This pause may impact on the running of some services, such as Diabetic clinic, and possibly patient flow at the front doors with respect to respiratory POC testing. Nadine Wilkinson has requested assurance that funding will be available to replace these 2 WTEs. GMcA noted CMG is not able to approve funding and that wherever the funding sat (i.e. DATCC) would be able to check the status of budgets for her. CW added her support to escalation of recruitment/posts if there will be an impact to Services. JMcN noted that these have been flagged by DATCC.	**6 mth return**
3.3	**<u>Lothian RDS proposal</u>** SE noted that there have been a number of presentations previously to CMG about the Right Decision Service and the demand from clinical teams to get guidelines on this platform. A robust process and oversight is required around the governance of such guidelines, including references to medication management and treatment options. An Oversight group has been recommended to ensure that there is collaboration between various workstreams, and conversations are ongoing around who should be included in this group, what it should look like and where this group should report in to. SE agreed that the paper will be finalised and brought back to the November meeting for further discussion. CW agreed that further conversations are required to help with clarification around what would go to the RDS Oversight Board and anxiety around links with RefHelp which is a very established portal for guidelines. CW asked if	

	RDS would be more for guidelines around treatment and interventions rather than around referrals. SE noted that RDS system can be whatever we would like it to be and that the challenges are more for clinical teams who are already writing guidelines and storing them in various places, and pulling all of these together with robust oversight and governance. An updated paper will come to the November meeting for further discussion.	**Callum Mutch/SE Nov**
3.4	**Thrombectomy Delivery**  241008 Future Thrombectomy Servic RM gave an overview of the current service position, which runs 7 days a week, 8am-8pm. See attached slides. Non recurring funding has been reduced and there is now a shortfall of £700k; rates of pay have been reduced, out of hours enhancements have been removed and no. of posts reduced also. These reductions will not cover the financial shortfall. RM talked through cases per month etc and the various options moving forward and the group discussed proposals. There was lengthy discussion around the possibilities suggested and questions raised around getting a steer from the Scottish Government; RM advised that they have not said what to stop so NHSL needs to allocate the funds and make the decisions. It was agreed that we have an excellent service and that we need to make all efforts to ensure the service is available to those who request it. It is hard to decide upon and compare services but we need cost effect treatment, we need to try and weave it in via Realistic Medicine, build in LOS data, expansions and savings all whilst having a degree of scrutiny over it and other areas. CW noted that strategically we need to reduce spend and that the Executive team have said we should be looking within a Service rather than across them and that it is incumbent on all to make savings and change the way we think. This was agreed but also noted that some services are simply not cost effective but require support by finding the funding for them from elsewhere. CR advised that she would value a different approach to looking at treatment options, adding that Cancer Services does not use Realistic Medicine. She wondered if an overarching group looking at everything would work, possibly taking some of the very emotional decisions away from Services? GMcA noted that a discussion at SMG may be a useful way to pre-empt the SMT conversation? There is strong support for this Service but support is required around the difficult decision making, at an Acute level. We need to try and influence the system collectively and ensure there is robust discussion around it. MG suggested to reduce numbers would mean that Clinicians will carry the risk, have difficult conversations and that there would be moral injury to those making the decisions. It was agreed that there is little work that can be stripped out as all believe that what they are doing is worthwhile. JP questioned what is 'value' and to 'whom', adding that there is nothing with no value so perhaps we should focus on 'low to medium' value? GMcA agreed that there was strong support to maximise this and that cost/LOS translation is required which may in turn support the making of difficult decisions. RM has, since the meeting, advised that the cost estimates have been revised and that refined costs are reflected in the paper which is going to Acute SMT Thursday 31st October.	
3.5	**LACAS report** GMcA noted that the adult inpatient LACAS report had been distributed with papers and was for noting only. It is submitted to HGC as part of the annual	

	CMG report. It includes nursing care assurance for the 58 acute wards. There were improvements across 11 standards since the last report, with 'leading and managing the team' being the lowest scoring area; this has however improved on last year. Improvements have been seen in falls, PVC insertion, maintenance bundles and associated management and documentation for bundles. There has been a piece of focused work carried out on pressure ulcers with a deep dive into this on RIE site. A patient experience survey has been carried out as part of the HCG annual report too. The OAS LACAS report covers 9 outpatient areas and it is noted that there is some IPC and Person Centeredness work required.	
3.6	**<u>Mapping of M&M services and what could be enhanced</u>** LB noted that discussions are ongoing regarding M&M meetings and guidance to inform M&M's is currently being trialled in a few areas; this is a fairly straightforward 1-page document (comments received have been incorporated). A sample ToR for M&Ms has been requested also. Tracey Gillies has signed these off and to date there has been a generally positive response to them. The group agreed to sign these off also.	
3.7	**<u>Pathways – RIE ED Urology</u>** MG advised that Urology have been developing a pathway and that they waiting for their final approval of it. Voula has now given this and MG will circulate it to the group for information. The pathway is similar to that existing for colorectal with prostatitis going directly to WGH with a phone call and other cases to be assessed in ED with transfer to WGH. Urology have had sight of the proposed RIE ED pathway, have commented and approved it. With this in mind CMG approved the pathway. Should there be any further comments these should be directed to MG. This should be disseminated via CD/AMDs.	
3.8	**<u>Internal Service Assurance Report - Infection Prevention Control</u>** LG noted that there has been no update on LDP targets other than 10% reduction on SAB and CDI. There were 28 SABs with 9 of these being hospital acquired; a few of these were device related.. The trend is going the wrong way so work is ongoing locally to improve this. 53 ECBs in August of which 15 were hospital acquired. There were no local exceptions and NHSL have the lowest rate for ECB so we are not carrying out any focused work currently. Community CDI has gone up but there are no clear themes. Obstetrics SSI post pandemic currently sitting at 3.7 so thematic analysis is ongoing; 16% were elective surgeries. MRSA reporting is seeing improvements being made with good engagement. CPE clinical compliance has improved also going from 44 to 60%. There are no open IMTs currently and no new SAEs. Staffing within the IPC/ICN is currently noted as very high risk; Rona Broom who retired recently, has still not been replaced due to a lack of funding. Carol Calder retires in March which will add to recruitment difficulties. These workforce issues add to the significant challenges and workload demands. The team does, however, have a new surveillance practitioner. Work continues to support the Eye Pavilion decant. Emerging infections include M-Pox; this is a low to medium risk in the UK. There have been 3 +ve HCIDs in Acute Services, 1 LASSA and 1 MERS at	

	the RIE and WGH; a lack of isolation has been reported along with poor face fit testing and use of appropriate PPE. The Scottish Hospital inquiry continues which includes water systems and safety. Gap analysis for this is going through the Water Group and some recommendations made, which we likely can not achieve. GMcA noted that she is happy to link with LG offline to discuss workforce challenges and to see if nursing can help with IPC staffing issues. GMcA further noted that there had been some work with BD around the training being offered to us. There is a cost implication for us if they do this training as we would need to use their Chloraprep which is a more expensive. LG advised that we had agreed many years ago to use the Clinell skin wipes but that we now have multiple education and inconsistent education programmes nationally and internally. LG is happy to pause the BD training meantime and take conversations about training within NHSL offline as BD will only do the training if we use their products. DMcK raised concerns around inadequate isolation facilities at the front doors, adding that if staff are not given an M-Pox vaccination and are exposed to it then they would then need to isolate for 1 month, adding considerable pressure on the rest of the team. DMcK also noted that Chloraprep takes longer to dry to be effective consistently and that over a period of 1 year it cost £100k in ED alone. CMack noted that RIDU is moving to the Royal Victoria later this month. There are ventilation issues, and they are trying to avoid patients traveling via the front doors. There are cost implications associated with upgrading the ventilation system within the new ward to make it fully compliant but once done most RIDU patients will be admitted there. They are trying to encourage direct admissions avoiding front door (this is the pathway), hopefully avoiding any concerns. CW questioned vaccination (M-Pox) for staff given that if there is a contact that there is a month's isolation – CMack advised that staff vaccinations are being considered and that she wasn't sure about limitations for front doors. LG advised face fit testing, RPE and contact management.	
3.9	**<u>Site & Business Unit assurance exception reports</u>** **Due to the length of the agenda Sites/Services were asked to give high level exception reporting only.**	
3.9.1	**<u>Women's Monthly report</u>** KR noted that preparations are in progress for the HIS inspection which is expected soon, likely next year. Work is ongoing with the Maternity and Neonatal Programme Board and work is continuing on revisions to the Escalation Policy. Lifecycle work is scheduled to begin in February so decant preparation is being worked up. Recruitment – all vacancies filled. There was a maternal death a few weeks ago and support has been put in place for the staff involved in the case; shared learnings from this will be ongoing also.	
3.9.2	**<u>OAS Monthly report</u>** The Flow Centre lead post interview is scheduled for next week and the ENP co-location has finished. It has been decided to support the clinical model/sustainable clinical model. With the substantive staff at the Flow Centre it is not sustainable in its current form. Adult Audiology – the main thing to note is the TRAK integration – there is no date for this as yet. Paediatric Audiology has happened. They are working through the PAEP decant currently with some outpatient	

	services requiring a move short term. The PAEP is huge collectively so whole system work is required. The Audiology update is included within the HCG report.	
3.9.3	**<u>WGH Monthly Report</u>** CP noted that the site CMG meeting has been re-evaluated, asking attendees what matters to the site to help aid meaningful conversations and enable a reset. The QI team is supporting this piece of work by looking at reporting to help identify new ways of working with a focus on patients, realistic medicine and care planning. There have been some valuable conversations. The first 'new' CMG meeting takes place later in October. CP to bring any shared learning from the site CMG 'reset' to the February meeting, giving a few months to embed new ways of working. SPSO returns have been interesting with shared learning around a complex case, complex family issues, NOK and Power of Attorney. The SPSO supported our position but the case has given food for thought for future cases. JM noted that there are different laws around NOK etc when a patient is deceased and what is noted within TRAK is no longer relevant. The process is changed from consent to treat to consent to sharing etc. Fiona Ireland is revisiting the current policy and has convened a SLWG looking into this, the new proposed process is very different to our normal, current practice. So, in short, when a patient is deceased we will need to make a call to the estate, executor etc. Different evidence will be required – an overview of this should be brought back to the next meeting and consideration given to sharing this information more widely due to changes in practice. An HCID debrief has taken place following a recent incident (not a PAG) looking at local actions and learnings; the Flow Centre will need to be involved in future conversations and communication out to GP's will be key moving forward. Early identification of these patients is essential and this work links well with work ongoing into self-presenters to WGH, risk based decisions around safe isolation and placement.	**CP Feb '25** **CP Nov?**
3.9.4	**<u>RIE Monthly Report</u>** MJ noted that a recent Renal SAE, related to a deteriorating patient/NEWS scoring in the Outpatient dialysis setting, had highlighted some shared learning for the site; collaboration with education colleagues will hopefully help focus on documentation. Work is ongoing to see what this will look like but is likely around familiarity of patients who attend regularly, and recognising when that patient is unwell or changes in them are noted. The site Safety huddle is being revamped and restructured, using more of a NEWS Oversight Board process, supporting some of the discussions around patients, again, recognising deteriorating patients etc. The hope is that colleagues go back to their wards looking in a more focused way at their patients, ensuring that plans are in place for them. The QI team is supporting this work. An HCID walk-round was completed through the Front door pathway and outcomes will feedback into the HCID group. MJ added that she would be interested to hear feedback around the WGH CMG reformatting as she and JP have previously discussed something similar. Now that MG is in post this may be a good time to consider changes for the RIE CMG meeting too.	
3.9.5	**<u>DATCC Monthly Report</u>** 9 open SAEs current; 1 closed relating the clinical sharps where there has been a rise in incidents being reported. Walkrounds continue – a Storeroom	

	monitor post has been recruited to and improvements in stock levels and tidiness have already been seen. LIMS has gone live in NHS Fife and is scheduled to go live in Lothian in November. There are no complaints requiring escalation. A Risk Register review is to be carried out as some of the recorded risks have been on the register since 2018. The reprovision of PAEP, to allow for major building repairs etc. is consuming a lot of time for teams as expected.	
3.9.6	**SJH Monthly Report** AR noted that struggles to find reviewers to lead SAE investigations continues and that work is ongoing with support from the QI team. The temporary closure of PAEP for essential and urgent building works, as with DATCC, is causing considerable work for teams and AR thanked everyone for their ongoing help with this. AR noted that they are keeping services together wherever possible. Work is ongoing with support from the Deteriorating Patient Overview Board and AR added that they are seeing less deteriorating patients and associated DATIXs. She thinks this is likely down to using a slicker, smoother process. There isn't a sustainable rota for the Wallace Burns unit until January so they are using the PAEP unit until then. AR advised that the other governance issue for the site is the AV handling unit in IVT?? They are trying to re-establish and utilise Ward 20 and this is hoped to be in place by mid November.	
3.9.7	**Childrens Monthly Report** PEWS continues to be going well; there were some issues with access initially but these have resolved. PC thanked colleagues for their support during the PEWS implementation. PC noted a winter bed deficit of 10 beds. 21 applications recently for the final 10 outstanding posts. Medical Students have been used as Scribes at weekends covering ward rounds – this has been going well. 11 complaints currently which are being worked through – no unexpected themes.	
3.10	**SAEs over 6 months** GMcA asked if any Services required support to help expedite and longstanding SAEs. No support requested.	
3.11	**Deteriorating Patient Plans** This paperwork was for information only and GMcA added that there has been a focus on NEWS at the RIE recently.	
3.12	**Healthcare Governance annual CMG report** GMcA noted that the Acute CMG annual report for HCG is scheduled for submission to the October meeting. This will cover the 3 Adult site and OAS. DATCC and Cancer Services will be submitted in November. Children's and Maternity go earlier in the year. This paper is for noting and GMcA added that she, CW and Catherine Kelly were working through it trying to finish it in time. The first section includes scoping documentation and data, assurance mapping is complex and challenging noting oversight and governance down to Service level. Quality and safety go through KPI's, highlighting any deviations. LACAS outcomes, Perfusion, Audiology and Realistic Medicine are all included. Appendix 1 is not included within papers but they are aware it is still to be	

	added in once agreed upon. Discussion ensued around language used but it was agreed that moderate assurance is given, noting deviations where required.	
4.	**Patient Safety and Experience** **Focus Session on Element of Safety or Experience**	10.20-11.00
4.1	**Patient Story – DATCC** Item 4.1 Patient Story RIE Critical Care 1161 [redacted] (BD, CNM) noted that this month's story relates [redacted] The focus of the story is communication as the patient could [redacted] response to questions for quite some time. The ward comprises of 42 beds over 4 pods and BD noted that there was no reliable way to inform how long each patient had been in the ward, so following a SLWG any patients over 21 days were highlighted to a weekly MDT where formalised plans were put in place around learning for each patient and what, why, where and when. As there are upwards of 250 nurses and 40+ consultants in the area patients were given names of senior nurses for patient communication. The patient underwent s[redacted] The patient was given goals, which in general were different to ours, the whiteboard was updated daily (the patient could see this too) and the newly rolled our ICCA system was updated for all to read. A rehab flow chart was made available for all to access and this was updated weekly. During recovery the patient was able to give a lot of valuable feedback which was very helpful and added to learnings shared at MDT meetings. Much of the learning shared has been integrated into daily routines. GMcA thanked BD for sharing this story and noted that there are some students coming to visit the RIE from Germany on 21st October. It is hoped to take the students to some clinical areas and she asked if it would be possible to include CC in this visit? JMcN agreed that they would do what they could to ensure this could take place.	
4.2	**SPSO** JM noted that monthly activity has reduced slightly. Stage 1 complaints are sitting at 51% and Stage 2 at 53%. A Cardiology report (RIE) was published by SPSO, which was not taken forward, there were recommendations made and points of note, which should be taken onboard. There were 19 cases not taken forward in total, 8 for Acute Services. JM thanked teams for their hard work, adding that working together can improve outcomes and that consistency is key.	
5.	Improvements	
5.1	Not Discussed.	
	New Risks and Escalations and AOCB	
6.	**New risks** – There were no new risks of note. **AOCB -** No other business to be discussed.	

	Actions of note: GMcA/CW to take this to SMG for wider choices discussion – this is not yet a risk. DATIX Endoscopy access/PAEP. Endoscopy is already flagged due to the disproportionate impact on Service due to decisions being made affecting service. Similar issues noted within Ophthalmology also. AR is aware of the risk due to redesign and reprovision of Services but there are no red flags at this stage; there is an element of risk due to mixing services (burns and in-patient PAEP). Access to information – change in process for deceased patients – JM to advise once process finalised. PVC maintenance bundles – this work can be pulled into LACAS work.	
7.	**Date of Next Meeting: Tuesday 12th November 2024, 8.30am, MS Teams**	

ACUTE CLINICAL MANAGEMENT GROUP (CMG)
Tuesday 12th November 2024, 08.30am
Microsoft Teams

PRESENT: (Total: 36)

Patrick Addison (PA)	Site Medical Director SJH
Melinda Cuthbert (MC)	Associate Director of Pharmacy
Eddie Balfour (EB)	AHP Director
Elizabeth Bream (EB)	AMD, QI & Patient Safety
Dave Caesar (DC)	AMD, Medicine Services, RIE & OAS
Emma Childs (EC)	Nurse Consultant Oncology
Simon Edgar (SE)	Director of Medical Education
Mike Gillies (MG)	SMD, RIE
Lindsay Guthrie (LG)	Head of Infection Control
Laura Inglis (LI)	Acting DAND RIE
Kallirroi Kefala (KK)	AMD, ATCC
Sarah Keir (SK)	Realistic Medicine Lead
Corrine Love (CL)	AMD, W&C's
Claire MacIntosh (CMacI)	AMD, WGH
Gillian McAuley (GMcA) **Chair**	Nurse Director, Acute Services
Dave McKean (DMcK)	CD, ED
Carolyn Meldrum (CM)	AND OAS
Donald Inverarity (DI)	Consultant Microbiologist, Labs
Hannah Monaghan (HM)	Head of Histopathology
Jeannette Morrison (JM)	Head of Patient Experience
Donald Noble (DN)	CD, SJH
Claire Palmer (CP)	AND WGH
Jim Powell (JP)	AMD, Surgery RIE
Colette Reid (CR)	AMD, Cancer Services
Laura Reilly (LR)	DAND, RHCYP
Agnes Ritchie (AR)	AND SJH
Sara Robinson (SR)	Deputy Director Medical Education
Katy Ruggeri (KR)	AND, Womens Services
Jennifer Watters (JW)	Deputy Associate Nurse Director
Caroline Whitworth (CW)	Medical Director, Acute Services

IN ATTENDANCE:

Sarah Davie (SD)	Executive Assistant to Medical Director, Acute -Notes
Stephen Hartley (SH)	Lead Resuscitation Officer
Keith Kelly (KKe)	Consultant Anaesthetist
Paul Leonard (PL)	Consultant Paediatrics ED, Clinical Lead
Robert Peden (RP)	Consultant Ophthalmologist and Oculoplastic Surgeon
Deepa Rangar (DR)	Consultant, MOE

APOLOGIES:

Peter Campbell (PC)	AND, RHCYP
Lesley Cunningham (LC)	RCN Representative
Fiona Ewing (FE)	AMD, Radiology
Kelly Moffat (KM)	Lead Nurse Palliative Care

Item	Business	ACTION
2.	**Welcome, Introductions and Apologies** GMcA welcomed everyone to the meeting and SD agreed to note apologies in minutes, as above.	
2.1	**Previous Minutes** No comments or amendments were received so the minutes of the previous meeting were accepted as an accurate record of discussions.	
2.2	**Action Log** *Item 312/22* – Zenith arch access for centre procedure – update after 5 cases – 2 cases done so far (Aug). *Item 304/23* – Lateral Orbital Decompression – 10 cases now done – arranging date to return to CMG Oct/Nov or Dec. **Complete/Remove** *Item 305/23* – Laser Ablation Service – to return on completion of 3 cases – contact JK in **'25 for update**. *Item 302/24* – Mortality screen tool to be standardised and controlled version rolled out **– 01/25**. *Item 302/24* – Gluten sensitivity in wards – permanent/visible method for flagging patients who have food intolerance – SLWG with NHS Bradford/Sheffield commenced/ongoing. *Item 402/24* – Hybrid Thoracoflo – to bring update after 2/3 cases. One case done so far (Aug). **December CMG** *Item 305/24* – Individual Deteriorating patient plans to come to **November CMG.** *Item 306/24* – Challenges around deaths after discharge to be discussed with Primary Care – CW advised that she has discussed with Jeremy Chowings (MD for Primary Care) who noted there is no uniform process/practice/policy to let Secondary Care know of a death. 08/10 - Jeremy Chowings is going to try and find out but CW does not think there is a unified starting point, there is nothing obviously electronically to highlight it. This should remain on action log meantime. *Item 307/24* – Audit of data following new staff group carrying out laser eye treatment to come back to CMG **07/25**. *Item 308/24* – **Covid and planned admissions discussion.** MG to write down guidance regarding patients being positive for Covid before elective and urgent surgery. Bring back in **October 24**. MG – ask Mike?????? *Item 309/24* - CP will bring back the patient story to the December meeting. This patient story is regarding an SPSO feedback and will potentially have implications for all areas. Bring back in **February '25**. *Item 310/24* - An admin request to be put in for admin support to help expedite the SAEs and assist clinicians with interview bookings and note taking. JMcN thinks this is a good point and will link in with the team around this as she thinks this is something they can support. 8.10 – JMcN noted that	

	she needs to raise this with Jill Gillies. LB advised that she has had a discussion about it which will come back to November CMG. Email correspondence since the November meeting notes that the SBAR was predominantly aimed at the RIE who require admin. support for SAEs. It further noted that it would be good, if possible, to build this into the SAE review process for all sites and service areas.	
3.	**Assurance and Governance**	8.50-10.20
3.1	**Resuscitation Committee update** KKe gave a very detailed overview of key activities since May, staff training (high nonattendance of 12% for some sessions), medical emergency calls (rising year on year over the last 4 years) and Resus figures (thanks to Wendy Ford and team for their work pulling these together). RIE 2222 calls have risen to 700, 268 for SJH and 350 WGH – escalation policies ensure that we intervene quicker than we used to. Discussion ensued around the increase in medical emergency being better than CA calls and if there were any links with NEWS and escalation of deteriorating patients? Were there concerns that they are now accessing senior decision makers by going down this route? LB noted that work is ongoing with deteriorating patients. CP advised that there is also work ongoing into this at WGH. 4 recommendations were made for consideration by CMG. 1.) Defibrillators for satellite nonclinical areas in NHSL properties – *there is no additional funding for this so there is compromise/worry regarding public access. If there is a source of funding to cover this then the team will hour it. Caveats would be keeping Resus informed and also Medical Physics. Do not order non approved defibrillators – 2222 is the fall-back process. The team would be happy to visit areas to advise and can add to risk registers.* 2.) Rationalisation of cardiac arrest teat at RIE – *high level management discussions are ongoing, analysing the medical group to bring numbers down.* 3.) Updating of NHSL Resus policy – *new guidelines are awaited (from Resus Council), hopefully by '25.* 4.) Movement of PAEP services to SJH – *moving Princess Alexandra Eye Pavilion to SJH is challenging. When moving services we must ensure that equipment moves back when the time comes. This is a redesign of Services so keep this in mind.* GMcA thanked KKe and SH for their comprehensive report, as always. KKe noted that most of the work is completed thanks to the RO's.	
3.2	**TEP Leaflet** DR shared a presentation [redacted] and noted that this is an update on work carried out within MOE and Stroke Medicine, to help improve care for deteriorating patients. This QI leaflet has been created and can be scaled up if suitable. The team first looked at Treatment Escalation Plans (TEP) in the post Covid times, focusing on MOE wards for 4 months, then upscaling to the whole Directorate. The various components of TEPs completed (Resus TEPs are very reliable) were analysed and goals of care identified. Not everything was felt to be of value but the work culminated in various improvements. The TEP leaflet was then tested in the ward, over the 3 wards, and finally after many iterations and feedback over the Directorate for a 6 week period. It is simply written, patients seem to like it and it is easy to understand. They will continue to use within MOE and further data should be available to share soon. The group agreed that this was a great piece of work which involved patient	

	feedback and that conversations are not starting with 'DNA CPR'; 80% completion of TEPs is very good. AR added that she would be very keen to share this presentation with SJH and would also be keen to be a further test area for the TEP leaflet. JM noted that the Policy Hub may be able to support finalising the leaflet too. CR asked that Colleagues don't concentrate work on 'end of life' conversations and noted that meaningful TEP conversations should start much sooner; preparatory work is key in the wards and this leaflet is a great prompt for this. GMcA suggested that there may be a 'package' of documentation, not just the TEP leaflet – could something like this be put together and shared? SK reminded the group that training is key and also of the book about difficult conversations written by Dr Robin Taylor. She added that AI conversations can also be tailored to many situations; if preparing a training package could we get licences to use AI? DC added that difficult conversations must be recognised, it is a basic skill, a core competency and should not be an additional need. CR agreed that some do not feel able to ask patients what they want, particularly given the increasing numbers of frail patient conversations needed; we must be able to have these conversations. MG agreed that leaflets can be useful in combination, and reinforce conversations – we just need to ensure we use them the right way. GMcA thanked everyone for adding to this discussion, which was beyond that of the TEP leaflet. It has highlighted gaps in the system, 'what matters to you' conversations and the multi-professional, collaborative work ongoing in many areas. It was agreed that a small group should get together to consider a package of leaflets and documentation which could in turn support and add to difficult conversations. DR was delighted to hear the support for this work and agreed to help lead on this work piece. Those colleagues interested in joining this group should let GMcA know and she would pass details over to DR to get things moving forward. CR, CMack, JW, AR, amongst others noted their interest during the meeting.	
3.3	**SBAR: Iron deficiency anaemia – investigation pathway** Deferred to December	
3.4	**Lateral Orbital Decompression update**  CMG lateral decompressions auc RP gave a brief background to the above procedure and an overview of cases carried out to date. Proptosis can, if left untreated lead to pain, double vision, disfigurement and occasionally loss of vision. The procedure is used to treat moderate protrusion and can be combined with medial decompression for worse cases. A break down of audit data recorded during the initial cases completed was given, with supporting photographic images of before and after surgery. All patients have been pleased with results following the procedure. The group agreed that the visuals shared were a great way to show the before and after for patients, and that this procedure is clearly a successful addition to the procedural portfolio for the team, as well as having a good outcome for patients.	
3.5	**Clinical Systems Board update** PL gave a detailed update on work being carried out by the Clinical Systems Board. Work progressing currently is listed in the previously distributed paper. There has been a pause put on requests to the Trak system, apart from canned text, by Intersystems (who provide Trak) as much their resource is	

	investigating how to safely migrate to a new User Interface (UI). Our current UI is quite dated so moving to a new one will have its benefits though this will impact on local development. Intersystems underestimated the work required and this is now impacting on progress. Work already started, such as planned discharge date/Border Comms will continue as it had already been started. There have been some episodes of unplanned downtime, each being treated as a 'digital' major incident and being investigated. Lessons have been learned and business continuity improved. Contingency laptops require kits and cards etc and guarantees can't be given that there won't be more downtime.	
3.6	**HGC Acute Services DATCC paper** GMcA noted that the Cancer paper for submission to HGC is still undergoing changes. The DATCC paper is due for submission today – this is going through final tweaks and checks. Both papers should be docked at CMG in December for information JM advised that there was no digital patient story yet so GMcA advised that CP or JMcN could speak to the stories previously brought to CMG in September/October? CP apologised that she may not be able to attend HGC to speak to a patient story as the date had not been shared previously and that she would be chairing another site meeting at the time, the DATCC story can be used meantime. JM noted that an invitation for this meeting should have been shared previously by the Secretariat and that the workplan had been updated – she will ensure that the programme for HGC '25, and when attendance is required by sites/services, be shared in plenty of time to enable availability. LB added that feedback received to date regarding site papers was positive. GMcA to discuss further with JMcN and CP.	
3.7	**RDS and RefHelp** Item 3.7 Right Decision Service in Lo SE noted that an RDS Oversight Group has now been set up. When the RDS proposal (digital home for clinical guidelines) was first brought to CMG last year there was no governance structure in place – this has now been worked up and agreed. When guidelines have been developed they should be submitted to the RDS Oversight group, who will ratify as required – see flowchart at end of the below paper. There is a lot of support available to ensure that 'good' guidelines are produced. A policy around clinical guidelines is still required but the Medical Director (TEG) and Pharmacy (Jane Browning) have agreed to proposals to date. REAS guidelines will follow a separate route. Item 3.7 Right Decision System - CM Eddie Doyle will chair the monthly group and membership of the group will be revisited to ensure the right people are part of discussions - GMcA agreed to put forward a nursing representative. There was discussion around how to encourage future guidelines submission to the RDS platform and if guidelines already on QPulse (?) should be moved over? SE noted that they should not be moved, the plan is NOT to deconstruct existing systems. There was assurance that no submissions will be taken unless they follow this new route via the RDS Oversight Group and that a retro review of guidelines on the system would be carried out if they haven't followed the route too.	**GMcA**

	GMcA noted that the group is supportive of RDS as a way forward and that a further update should come back to CMG next year.	**SE '25?**
3.8	**SNAP Audit** The above report was distributed to the group in advance of the meeting and there were no comments of note registered.	
3.9	**Internal Service Assurance Report - Infection Prevention Control** LG noted that the report previously distributed includes data to end September '24. There were no significant exceptions to report. Meetings have taken place with Critical Care investigating line related SABs as there have been 7 this year (3 currently). Outcome of conversations will be brought to the December meeting. LG advised that some work is being done on the tableau dashboards previously used and that some historical data will no longer be available. This will include blood cultures – there are no plans to bring this back online. Investigation of a nasal cluster is ongoing. There was brief discussion around ultra sound gels – LG noted that guidance around these are found on the IPC webpages. DI noted that water management continues to be assessed by the Water Safety Group with co-ordination of recommendations.	

3.10	**Site & Business Unit assurance exception reports** **Due to the length of the agenda Sites/Services were asked to give high level exception reporting only.**	
3.10.1	**SJH Monthly Report** Falls have risen to [redacted] SAB over 12 months down to [redacted]. 7 SAEs currently, [redacted] possible DoC – meeting to discuss these tomorrow. A break down of SAEs over the last year can be seen within the report. The move of Ophthalmology from the Eye Pavilion continues with a lot of work going on behind the scenes. There have been 19 contacts reported and improvements are being seen in response to these. Themes include communication, access to admission, delays, staff attitude and behaviours. A reduction in compliments received is disappointing but Care Opinion feedback continues to be positive overall. NQNs have started but there are still gaps of 10-11%, notably in Wards 9, 25 and in Endoscopy. AR noted that Violence and Aggression training continues for staff across the site; she added that there are some days and nights when there is no Security on site and that a Business Case is being put forward to support this 24/7 due to the number of staff assaults reported. There is an increased number of patients in distress and with mental health problems on the site nowadays.	
3.10.2	**OAS Monthly report** A very detailed and comprehensive report was distributed in advance of the meeting and a high-level overview was given. This included the following; there are 7 open SAEs currently, [redacted] level 1, the rest are local level. Complaints have risen with themes including waiting times, communications and staff attitude. Most areas completing LACAS cycles have achieved Gold standard. QI work continues, Challenges continue with the clinical model within the Flow Centre. A group has been set up to oversee improvements across the Phototherapy Service – GMcA asked that a spotlight on learnings be brought back to either the February or March meeting.	
3.10.3	**Women's Monthly report** 22 open SAEs currently, 12 of these with Maternity Services. 21 complaints of which many are gynae waiting times, elective surgery or outpatient appointments. Both good and bad feedback is reported from Care Opinion. There are 4 large QI pieces of work ongoing which include 1.) Quality of Care, Midwifery/HIS, 2.) Leadership to support a culture of safety, 3.) Midwifery professional leadership and 4.) Maternity and Neonatal Services Programme Board. Lifecycle work is due to start with a decant to 203, likely Easter time. Extra Caesarean section lists have been introduced taking the number from 4 to 8; this should help ease waiting lists. RSV vaccine rollout for maternity patients is impacting on service pressures and will be added to next year with the rollout of Strep vaccines. PLGF testing (placenta growth factor) started on 4th November to aid identification of pre-term pre-eclampsia.	
3.10.4	**WGH Monthly Report** Work continues on the 18 open SAEs; these have reduced. Falls have reduces also as have falls with harm. CP noted that a [redacted] A number of actions and recommendations have been put in place to prevent	

	this happening again. The site is on high alert for CPEs with work ongoing around safe placement and risk assessment for patients at risk. Pan resistant CPE is a concern for all immune-compromised patients. IPC are sharing learning and implications around this, with a focus on hand hygiene etc. Ward 74 has closed with 6 patients being repatriated across the site. RIDU will move into this area once improvement work is complete. Existing staff from the ward were asked for choices of where they would prefer to be moved to and all efforts made to ensure they got one of their top choices. Complaints have gone down but some of these are complicated, with media interest in 1 case. A statement for this case was released prior to the completion of the investigation so the response doesn't align well with the press release. DI advised that there has been [redacted] I added that there are cost implications for treating such patients using [redacted]. There was brief discussion around keeping a supply of such medications in the system and it was agreed to take discussions offline and out with this meeting.	
3.10.5	**DATCC Monthly Report** There was no one present from DATCC to speak to this report. KK was not aware of anything to highlight for ATCC.	
3.10.6	**Childrens Monthly Report** LR noted that they have had [redacted] is being replaced. 45 SAEs open of which 15 were expected deaths; [redacted] There are [redacted] lead nurse investigations ongoing currently. Fridges continue to be found with undated and untimed items in them and unlocked drug cupboards have been identified too. Medical staffing have been found sleeping in these areas also – CDs have been asked to raise this with their teams. There is an ongoing IMT in Critical Care. QI LACAS cycle1 is ongoing within OP. Complaints data can be found within the report. The 'Play Service' continues to receive lots of positive feedback. Errors have reduced in the B-Braun Infusion Pumps – Medical Physics are rolling these out further to Lochranza. Due to lower acuity one 15 bedded ward is split 10 medical beds/5 surgical. It is hoped to reopen the remaining beds following the next round of recruitment.	
3.10.7	**RIE Monthly Report** JW advised that there had been no site CMG in October, so the Site Monthly report was quite light in content. A reduction in falls has been noted [redacted] this month). Action plans from closed SAEs can be found within the report. Compliance with the Uniform Policy has dropped off with a number of staff found with shellac nails and issues with use of PPE reported, in particular around a recent patient with ? measles. Complaints have gone up to 51 with compliance currently sitting at 74% - these are mainly waiting list/times etc. All vacancies currently filled with positions being sought for end of 3rd year students for 11.5 hrs. Work continues across site with 107 being complete. 106 is moving to 203 shortly. Overcrowding at the Front Door continues. GMcA asked that an update on Front Door activity be brought to the December meeting.	**JW/12/24**

3.10	**SAEs over 6 months** GMcA asked if any Services required support to help expedite and longstanding SAEs. No support requested.	
4.	**Patient Safety and Experience** **Focus Session on Element of Safety or Experience**	10.20-11.00
4.1	**New Interventional Procedure – Thumb Joint Replacement** Operation technique_ST_110-32 NHS Lothian_Touch CMC business case_Fiexternal_LPTouch-11(Patient information PA gave an overview of the attached proposal, for patients with thumb based osteo arthritis. This procedure has been carried out elsewhere in Scotland/England for around 10 years. Previously treatment would have been conservative/physiotherapy or surgery to perform trapeziectomy – this can cause shortening of the thumb and have a long recovery period, amongst other issues. Funding for a small number of cases per year has been agreed. There are [redacted] cases on the waiting list currently and PA noted that he anticipated roughly 6-8 cases per year. Qualifying patients would generally be young, active patients who could expect a rapid return to work with a stronger joint and less pain than previously. Support was given for the team to carry out this procedure with an update to come back to Acute CMG after completion of 6 cases.	**PA - 6 cases**
4.2	**Introduction of MVA in Gynaecology** Manual Vacuum Aspiration NHS Lothia KR shared a presentation (above). This manual vacuum aspiration (MVA) procedure is carried out at SJH as an OP during a 45 minute appointment and aims to improve management of miscarriage and abortion care. General anaesthetic is not used and the procedure is suitable for patients under 12 weeks; initially for those women suffering a loss. There will be one appointment available per week, with disposal of products at Mortonhall. There is no specific training or skillset required to carry out the procedure. Following presentation and discussion it was agreed to support use of the MVA procedure, and that it would not be required to come back for a follow up in future.	
4.3	**Patient Story – SJH** This story relates to a patient [redacted] There have been various complaints received around this case, with many emails, letters [redacted]	

	AR agreed that perhaps we have not responded to aspects of the complaints in a timely manner regarding observations and treatment escalation plan (TEP). A meeting took place [redacted] There was no TEP in place and poor records kept. Learnings shared include the [redacted] Lengthy discussion ensued around us having 'one shot to get it right', could we have got a 2nd opinion and involved others; fresh eyes and ears can help. Bringing someone in who is not emotionally involved with conversations can help.	
4.4	**SPSO** JM noted that adverse event investigations do take a long time to complete, adding that it is helpful to keep in touch with those involved, even if to say there is nothing to add yet but that work is ongoing. She reminded the group that good documentation is essential to support conversations. Generally we do quite well with cases not being taken forward by the SPSO. There has been a slight dip in compliance with stage 2 complaints. An increase has been reported in enquiries to the Chief Executive, with lots of high profile correspondence coming through; JM is now meeting with the Chief Exec. about these on a weekly basis. Amendments to the current process for contacts from MSPs etc are being considered and are work in progress. Caroline Hiscox is much more involved with these than our previous Chief Exec. MC commented that there are currently issues with accessing various medicines, notably some for ADHD (a few requests have been received recently), where the situation is impacting on patients directly, but that there is nothing we can do to circumnavigate the situation. JM agreed that there some difficult messages out there but that we need to remain clear about them; the Scottish Government sometimes stops us doing anything in some cases. It was agreed that there is concern that those who shout the loudest, to short circuit the waiting list for surgery, by making demands to the Board get preferential treatment; we need reassurance that this will not be the case and that patients remain fairly in line.	
5.	Improvements	
5.1	Not Discussed.	
	New Risks and Escalations and AOCB	
6.	**New risks** – There were no new risks of note. **AOCB -** No other business to be discussed. Actions of note: QI work being undertaken/lead by Deepa Rangar should come back to the	

	April meeting. Escalations for SMG; PA feels there are many things 'crumbling' which leads to failing our patients - these include pathology skin biopsy results which are running 4-5 months late, radiology is taking 6-12 months to report on testing, derma-pathology result delays etc, etc. He believes that other Boards are using waiting list initiative clinics and use of Locums to try and keep pace with lenghthening waiting lists? CW advised that this has been raised at various forums already and that it will be raised at Executive PSEAG on Thursday. She added that it is not easy to extrapolate adverse events reviews raised as 'harm due to waiting for procedures', on DATIX. HM advised that they raise a DATIX for such cases when identified and that these can be forwarded to CW if it would help. DC added that we will not be able to capture patients who also come to harm who we haven't yet seen as they are on a waiting list for initial assessment. We are also not capturing harm due to enabling services and estates.	
7.	**Date of Next Meeting: Tuesday 10th December 2024, 8.30am, MS Teams**	

Policy Approval Group

Tuesday 10 September 2024, 10.00am–12.00pm
Via Microsoft Teams

Meeting notes

Action

Present:
Ailsa McMillan, Nursing, Queen Margaret University (AM)
Edward Doyle, Ass. Divisional Medical Director, Women & Children's Services (co-vice chair)
Fiona Ireland, Deputy Director of Nursing, (co-vice chair) (FI)
Heather Cameron, Allied Health Professions (HC)
Julia Johnston, Health and Safety (JJ)
Karen Fraser, Estates and Facilities (KF)
Sheila Hedley, Partnership (SH)
Tobias Kunkel, Partnership (TK)

In attendance:
Amy Drummond, Policy Hub (AD) (notes)
Emma Cochrane, Policy Hub (EC)
Jeannette Morrison, Patient Experience (JM)
Jane Oldham, Haematology (JO)
Nicola Tait, Infant Feeding (NT)
Rhian Thompson, Policy Hub (RT)

Apologies:
Carolyn Wyllie, Public Protection (CW)
Jenny Scott, Pharmacy (JS)
Kirsten Hood, Nursing and Midwifery (KH)
Laura Inglis, Nursing, Quality Improvement and Standards (LI)
Sarah Rhynas, Nursing, Edinburgh University (SR)
Tracey McGillivray, Infant Feeding (TMcG)
Tracey McKinley, Information Governance (TMcK)

1.0 Welcome and apologies

ED welcomed those present to the meeting. Apologies were received as above.

2.0 Previous minutes and matters arising

EC advised that additions were made to the previous minutes for the meeting on the 11 June in section 4.2 regarding accountability and delegation, to reflect the changes made to the Assistant Practitioner Scope of Practice Policy.

The Taxi Policy which was approved after the previous meeting now requires further changes following a review from HMRC.

3.0 Policies for approval

3.1 Referral of NHS Lothian Nurses and Midwives to the NMC Policy **FI**

FI advised that the policy, specific to nursing and midwifery, outlines the criteria for NHS Lothian to refer staff to the regulator, replicating what is already available in other areas.

The group discussed the involvement of HR in this policy. ED advised that HR have a policy on revalidation and maintaining registration and that this new policy should also be taken to the HR policy group.

TK suggested that the role of HR should be added to section 5.1 under roles and responsibilities.

HC, AM and FI agree that referrals to the regulator should be classed as a professional issue rather than a HR issue and note that HR may refer to Occupational Health. The group agree there should be reference to HR even if it is not a HR process.

JJ highlighted that the associated documents will be related to HR policies.

The group discussed where the policy should be made available and agreed it would be useful to have on Policy Online rather than the HR site, if the HR team are in agreement.

The group agreed to arrange a discussion with HR about the above. FI to take policy to HR policy meeting on 29 October and discuss at next PAG meeting on 10 December 2024. **FI**

AM asked for more clarity around 'stronger practice' on page 7. FI to clarify in policy. **FI**

The group discussed the 'ill health' referral process in section 4.4. AM advised the guidance for referral is clear, and is based on whether an individual's ability to practice is affected by illness, not a specific diagnosis. FI agreed.

HC asked that Alison MacDonald's title is updated to Executive Nurse Director in the document. **FI/EC**

3.2 Authorisation of Blood Components by non-medical Authorisers Policy **JO**

JO advised that the policy is based on Once for Scotland template and UK framework to guide nurses and midwives. There was previous governance around this but was it was minimal. In 2022 the revised framework opened up to non-medical professionals which is reflected in this policy. This is the first NHS Lothian policy of its kind and outlines Lothian-wide register managed by the NHS Lothian Transfusion Committee (LTC).

ED advised that the 'executive lead' needs to be confirmed before the policy is approved.

ED highlighted a lack of clarity around the term 'lead clinician' in the policy. JO to define clinical director level and nursing level in line with organisation structure and appointed roles. **JO**

The group discussed data protection of the register. JO informed the group that Margot McCulloch previously advised it should be a protected document. JJ advised JO to contact the Information Governance team as they can advise. HC also suggested JO contact the radiology or pharmacy service to discuss PGDs. **JO**

The group discussed the addition of eESS for reporting. JO raised concerns that management staff already have a large amount of documents to complete. JJ suggested that permission for eESS can be given to administrative staff and suggested JO include reporting into eESS as part of the responsibilities. Also to add into documentation what is required for compliance checks. **JO**

The group discussed the decision to not carry out an Impact Assessment. JO confirmed the Scottish National Blood Transfusion Service (SNBTS) national group previously did an IA and did not identify any impact on specific groups. EC and JO have reviewed this IA for use in Lothian and decided it was not necessary to complete a new one.

HC and EC advised that the guidance from the PAG states that an IA must be 'considered' for every NHS Lothian policy, not that an IA should be completed for every policy. The group agree an IA is not required for this policy and a link to the national IA can be added to the policy.

The group agree to review the policy again at the next meeting on 10 December 2024, once above changes have been made. **JO**

3.3 Infant Feeding Policy **NT**

This is an update of a pre-existing policy which now includes Once for Scotland and WHO guidance. The policy clarifies the impact this will have on individual staff. More 'inclusive' language around breastfeeding and new mothers and parents has been introduced to the policy. The policy also highlights the 'cash first' response for patients experiencing hardship and food insecurity to reflect exisiting practices.

ED highlighted a minor spelling error in the implementation and communication plan. NT to correct spelling of 'Tracey'.

The group agree the IA for this policy was very clear and comprehensive.

The PAG confirmed that the policy met the 6 tests for approval:

- There is a clear need for the policy and it does not represent a duplication of any existing policy.
- The proposed policy has been prepared in line with the requirements of this procedure and the agreed NHS Lothian policy template has been used.
- Those who will be responsible for implementing the material, or will otherwise be affected by it, have been involved and consulted as part of the development or review process.
- A Policy Implementation and Communication Plan has been completed for the policy, which is credible and robust
- An Equality, Fairer Scotland and Children's Rights Impact Assessment Report, **or** a Record of decision not to carry out an Impact Assessment (PAG) has been completed and received
- The policy being submitted for approval takes account of the Board's Sustainable Development Framework and Action Plan

On the basis of above revisions, the policy was approved.

4.0 AOCB **ED**

None

Date of next meeting: Tuesday 10 December 2024, 10.00 – 12.00, via Microsoft Teams

NHS Lothian

Meeting:	**Healthcare Governance Committee**
Meeting date:	**28 January 2025**
Title:	**Corporate Risk Register**
Responsible Executive:	**Tracey Gillies, Medical Director**
Report Author:	**Jill Gillies, Associate Director of Quality**

1 Purpose

This report is presented for:

Assurance	☒	Decision	☐
Discussion	☒	Awareness	☒

This report relates to:

Annual Delivery Plan	☐	Local policy	☐
Emerging issue	☐	NHS / IJB Strategy or Direction	☐
Government policy or directive	☐	Performance / service delivery	☐
Legal requirement	☐	Other – corporate risk	☒

This report relates to the following LSDF Strategic Pillars and/or Parameters:

Improving Population Health	☐	Scheduled Care	☒
Children & Young People	☒	Finance (revenue or capital)	☒
Mental Health, Illness & Wellbeing	☒	Workforce (supply or wellbeing)	☒
Primary Care	☒	Digital	☒
Unscheduled Care	☒	Environmental Sustainability	☐

This aligns to the following NHSScotland quality ambition(s):

Safe	☒	Effective	☐
Person-Centred	☐		

Any member wishing additional information should contact the Responsible Executive (named above) in advance of the meeting.

2 Report summary

2.1 Situation

The purpose of this report is to review NHS Lothian's Corporate Risk Register (CRR) and associated processes to ensure it remains fit for purpose.

Committee members are asked to:

2.1.1 Review the September/October 2024 updates provided by the executive leads concerning risk mitigation, as set out in the assurance table in appendix 1.

2.1.2 Note that the internal audit report of the corporate risk register process has been received and presented to the Audit and Risk Committee at the November meeting. (see appendix 2)

2.2 Background

2.2.1 Role of the Corporate Management Team (CMT)

It was agreed at the February 2021 CMT that the CRR would be managed through the CMT and subject to review every two months, with the risk manager in attendance to ensure proactive management, including timely feedback from assurance committees and alignment of assurance levels and risk grading. A process has been established to meet executive leads prior to each CMT to inform the CMT risk paper.

The CMT then make recommendations to the Board with respect to new and/or amended risks, with a clear articulation of the risk that cannot be managed at an operational level, explicit plans to mitigate the risk along with associated measures to assess the impact of these plans. This collective oversight strengthens the NHS Lothian risk management system including our assurance system.

2.2.2 Escalation of Risks – Divisional Very High/High Risks

Understanding the very high and high risks at divisional and corporate level is a key component of Lothian's risk management system and an area identified for improvement in the Risk Management Internal Audit 2021. The current very high and high risks at Acute, REAS, HSCP level as well as corporate single system risks registers such as Public Health, Nursing and Pharmacy were reviewed by the CMT in December 2024.

There is a requirement that all very high and high divisional and corporate risks have plans in place to mitigate the risk which are monitored proactively. If the risk cannot be managed by a director, it will be escalated to CMT for discussion.

2.2.3 All risks on the CRR relate to the delivery of NHS Lothian objectives as agreed by the Board in April 2024.

2.2.4 Any new or materially worsening risks will be presented to the Strategic Planning and Performance Committee (SPPC) prior to submission to the Board.

2.2.5 The risk management process is set out in the Risk Management Policy as approved by the Board in April 2023.

2.3 Assessment

2.3.1 The internal audit report has now been received and presented to the November Audit and Risk committee. (see appendix 2). Moderate assurance was assigned overall with 4 of the 6 risks rated as significant assurance. Agreed management actions are now being progressed.

2.3.5 Summary of risk profile

An overview of changes to the CRR over the last 2 calendar years is provided in Table 1 below.

Table 1

Risk Title	CMT Meetings 2022-2024												
	Nov-22	Jan-23	Feb-23	Apr-23	Jul-23	Aug-23	Oct-23	Dec-23	Feb-24	Apr-24	Jun-24	Sep-24	Nov-24
3600 - Finance	25	25	25	25	25	25	25	25	25	25	25	25	25
5186 - 4 Hours Emergency Access Target	20	20	25	25	25	25	25	25	25	25	25	25	25
3726 - Hospital Bed Occupancy	20	20	25	25	25	25	25	25	25	25	25	25	25
5185 - Access to Treatment	20	20	25	25	25	25	25	25	25	25	25	25	25
5510 - REH Bed Occupancy		25	25	25	25	25	25	25	25	25	25	25	25
5784 - Low Secure Accommodation				Split of risk 5687, approved by Board April 2024					20	15	15	15	15
5785 - High Secure Female Accommodation				Split of risk 5687, approved by Board April 2024					12	12	12	12	12
5388 - HSDU Capacity	20	20	20	20	20	20	20	20	20	20	20	20	20
3828 - Nursing Workforce	20	20	20	20	20	20	20	20	20	12	12	12	12
5737 - Royal Infirmary of Edinburgh Fire Safety				New risk approved by Board Dece			20	20	25	25	25	25	25
1076 - Healthcare Acquired Infection	16	16	16	16	16	16	16	16	16	16	16	16	16
5189 - RIE Facilities	15	15	15	15	15	15	15	15	15	15	15	15	15
3455 - Violence & Aggression	15	15	15	15	15	15	15	15	15	15	15	15	15
3328 - Roadways/Traffic Management	12	12	12	12	12	12	12	12	12	12	12	12	12
5020 - Water Safety and Quality	12	12	12	12	12	12	12	12	12	12	12	12	12
5322 - Cyber Security	12	12	12	12	12	12	12	12	12	12	12	12	12

2.3.6 Quality/ Patient Care

The CRR includes risks to quality and patient care and risk mitigation plans will positively impact on quality of care.

2.3.7 Workforce

The resource implications are directly related to the actions required to mitigate against each risk. The mitigation of risks relating to staff health and safety will positively impact on health and well-being.

2.3.8 Financial

The resource implications are directly related to the actions required to mitigate each risk. This is managed through relevant governance and operational management structures which are set out against each risk.

2.3.9 Risk Assessment/Management

In line with the CRR process, risks are identified and/or escalated for assessment and consideration by the CMT who will in turn make recommendations to the Board. Risk mitigation plans are in place for all risks on the CRR and are monitored through reporting to relevant governance committees for assurance.

2.3.10 Equality and Diversity, including health inequalities.

This paper does not consider developing, planning, designing services and/or policies and strategies therefore the statutory duties do not apply.

2.3.11 Communication, involvement, engagement, and consultation
This paper does not consider developing, planning, designing services and/or policies and strategies therefore the statutory duties do not apply.

2.3.12 Route to the Meeting
In line with agreed process, discussions are held with executive leads to provide updates on risks which are then considered by the CMT who make recommendations to the Board. Following Board review, the updated CRR is shared with Audit and Risk and Healthcare Governance Committees to provide context for discussions at their meetings.

2.4 Recommendation

Discussion – Committee members are asked to:

- Review the September/October 2024 updates provided by the executive leads concerning risk mitigation, as set out in the assurance table in Appendix 1.
- Note that the internal audit report of the corporate risk register process has been carried out and the report has been received. (see appendix 2)

3. List of appendices

The following appendices are included with this report:

- Appendix 1: Risk assurance table
- Appendix 2: Risk management internal audit report

Risk Assurance Table – Executive/Director Updates

Datix ID	Risk Title & Description	Committee Assurance Review Date	
3600	**Finance** There is a significant risk that the Board is unable to respond to core existing service requirements as well as those arising from the population growth in all age groups across NHS Lothian, whilst maintaining its aging estate. This is because of a combination of the greatly restricted level of capital and revenue resource available for 2024/25, together with the uncertainty around future resources. This will result in an inability to plan for and deliver not only core services, on a financially prioritised and risk/ needs assessed basis, but also the additional capacity and infrastructure required. Resource limitation also impacts recovery from this situation and the ability to plan in the medium to long term, against a trajectory of increasing demand and ageing capital assets. Executive Lead: Craig Marriott Corporate objective: Revenue	**Finance & Resources Committee** **March 2024** ▪ Limited assurance accepted. ***Next to be presented March 2025***	
		Outcome of Executive Lead Discussions **July/August 2023** • Concluded quarter 1 forecast and anticipate a further deterioration of £10m with the outcome expected of £32m deficit. • Discussions taking place with Financial Improvement Group (FIG), Financial oversight board (FOB), CMT to identify handbrake turns to improve financial position. • Ongoing discussions with Scot gov on the tension between financial and service performance. • DoFs are working with Scot Gov to review other national mitigation actions. • Information still awaited re pay awards and implications for further funding pressures. **September/October 2024** • **Pay awards have now been confirmed although recurrent funding has still to be identified at a national level.** • **The limited capital flexibility is now having an impact on fragile services. The Eye Pavilion and RIDU have both got significant and urgent capital investment requirements. This will also have a detrimental impact on the revenue position.** • **We are now progressing with the financial plan for 2025/26 - it is clear that the size of the recurrent gap will increase due to the limited recurrent uplift and pressure on services. In mitigation, we are running a series of sessions to review potential choices to improve our fiscal sustainability. These will potentially impact on the service performance.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		Very High 25	Very High 25
5186	**4 Hours Emergency Access Target** There is a risk that NHS Lothian will fail to deliver safe and timely unscheduled care to patients presenting to EDs due to the volume and complexity of patients, challenges in managing flow through the department, especially when maintaining red Covid streams, and availability of beds, leading to a delay in first assessment, diagnosis and subsequent treatment for patients and therefore increased likelihood of patient harm and poor experience of care. New risk created from previous risks 3203 & 4688. Approved by June 2021 Board. Executive Lead: Jim Crombie Corporate objective: Unscheduled care	**<u>Healthcare Governance Committee</u>** – person-centred, safe, and effective care. **July 2024** • Limited assurance accepted. ***Next to be presented January 2025*** **<u>Strategic Planning and Performance Committee</u>** – Performance **November 2023** • Limited assurance: ***Next to be presented November 2024***	
		<u>Outcome of Executive Lead Discussions</u> **July/August 2024** ▪ There have been notable improvements in admitted flow when comparing 2023/24 winter to the previous year. This is evidenced when comparing sites nationally and ranking them in terms of admitted flow performance. The target for non-admitted 4-hour performance in 2024/25 is 85%; latest performance is circa 76% for NHS Lothian. ▪ The Emergency Access Standard (EAS) project board continues to oversee implementation of the recommendations made in the external review report commissioned. 25 of the 29 recommendations made by the RIE external review report have now been implemented; the remaining are in progress. Progress has been reported at HCG in July 2024. ▪ There has been an improved performance for long waits within the emergency departments, however these remain high (including nationally). ▪ The average 4-hour performance for NHS Lothian (all patients) is 66.1% in June 2024. Over the last circa 6 weeks the 4-hr performance at the RIE has been around 55%.	

Datix ID	Risk Title & Description	Committee Assurance Review Date
		▪ Recent feedback from Centre for Sustainable Delivery (CfSD) on NHS Lothian's USC LSDF plans has been encouraging – it was acknowledged that the plan includes almost all of the recommendations made by the national team. **September/October 2024** • **The average 4-hr performance for NHS Lothian in August was 61% against the national average of 65.8%. This was below the trajectory of 65.7%.** • **As part of the RIE improvement work, a Breach Process Review has been drafted to complement the NHS Lothian 4- hour Emergency Care Standard & Breach Reporting Standard Operating Procedure.** • **There is a risk that changes to the bed base in Edinburgh City will have an impact on RIE capacity, increasing delays and adding further pressure to acute flow.** • **Work is ongoing with Edinburgh HSCP to develop proposals to mitigate impact including the expansion of the RIE ED frailty model, introduction of the model WGH and securing additional community capacity.** • **There is a risk that RIE services will not be able to offset winter pressures through service led initiatives because there will not be a winter funding provision nationally unlike previous years, leading to high levels of overcrowding in ED and poor patient flow.**
	Risk Grading:	**CMT September 2024**: Very High 25 — **CMT November 2024**: Very High 25
3726	**Hospital Bed Occupancy** There is a risk that patients do not receive safe and effective care due to high level of bed occupancy, leading to increased risk of harm, poor patients and staff experience and impacting on flow resulting in crowding in front door areas and long waits for admission, cancellation of elective procedures and NHS Lothian's capacity to achieve national standards.	**Healthcare Governance Committee** – person-centred, safe, and effective care. **July 2024** • Limited assurance accepted. ***Next to be presented November 2024*** **Strategic Planning and Performance Committee** – Performance **May 2023**

Datix ID	Risk Title & Description	Committee Assurance Review Date
	Executive Lead: Jim Crombie Corporate objective: Unscheduled care	• Limited assurance accepted. ***Next to be presented January 2025***

		<u>Outcome of Executive Lead Discussions</u>
		
		July/August 2024
		▪ Bed occupancy rates continue to exceed 85% in all sites in April 2024.
		▪ Average number of delayed discharges across all NHS Lothian sites in June 2024 was 306. A new 'target rate' of delays has been assigned to each Health and Social Care Partnership (HSCP) to work towards by October 2024. This is being closely monitored and supported in a whole system approach.
		▪ Recent feedback from (Centre for Sustainable Delivery (CfSD) on NHS Lothian 's unscheduled care LSDF plans has been encouraging – it was acknowledged that the plan includes almost all of the recommendations made by the national team.
		▪ The three adult acute sites are commencing Length of Stay improvement programmes with the aim of reducing downstream bed occupancy levels to improve flow.
		▪ Work undertaken as part of Early Supported Discharge services has had an initial significant impact on hospital bed occupancy at the RIE.
		▪ Edinburgh City HSCP has consistently decreased occupied bed day (OBD) occurrences within RIE throughout 2023/24 through implementation of the Home First and Discharge Without Delay programmes. The new RIE ED frailty team has notably contributed to this positive outcome.
		▪ Daily bed occupancy reports are now shared with HSCP partners detailing each HSCP usage of their "commissioned bed base".
		
		September/October 2024
		• **Bed occupancy rates continue to exceed 85% in all sites.**
		• **The three adult acute sites continue Length of Stay (LoS) improvement programmes with the aim of reducing downstream bed occupancy levels and improving system flow.**
		  • **RIE**
		  o **Weekly discharges have remained steady with mean LoS across the site starting to recover compared with earlier in 2024. A decrease in Total Occupied Bed Days (TOBD) has been observed across the site by circa 400 days in one month.**
		  • **WGH**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		○ **Discharge without Delay (DwD) funding is only secured on a non-recurring basis for 2024/2025, which has resulted in reductions to both Home First and Social work resources from March 2024 due to the funding model being non-recurring limiting recruitment opportunities.** • **SJH** ○ **Data still suggests that Planned Date of Discharge (PDD) implemented on wards is having a positive impact on the average LoS.** ○ **The average LoS on wards with PDD implemented remains at an average of 5.9 days, reflecting a sustained improvement compared to pre-PDD levels.** ○ **Occupied Bed Days for delayed discharges remains challenging across Lothian - 321 bed days were lost to delays in Jan to July 2024 against the 221 recorded for the same period in 2023. There is ongoing work from West Lothian HSCP in particular to address the increase in delays.**	
	Risk Grading:	**CMT September 2024** Very High 25	**CMT November 2024** Very High 25
5185	**Access to Treatment** There is a significant risk that NHS Lothian will fail to achieve waiting time standards and that waits further increase for inpatient, day case procedures, Out-patients, diagnostic and cancer patients which has been compounded by COVID 19 cancellations with demand exceeding capacity. This will lead to delay in diagnosis and potential progression of disease and hence poorer experience and outcomes for patients. New risk created from previous risks 3211 & 4191. Approved by June 2021 Board.	**Healthcare Governance Committee** – person-centred, safe, and effective care. **May 2024** • Limited assurance accepted. ***Next to be presented November 2024*** **Strategic Planning and Performance Committee** – Performance **May 2024** • Limited assurance accepted. ***Next to be presented November 2024***	

Datix ID	Risk Title & Description	Committee Assurance Review Date
	Executive Lead: Jim Crombie Corporate objective: Scheduled care	**<u>Outcome of Executive Lead Discussions</u>** **July/August 2024** • Reporting of performance against waiting time standards is included in the Public Board Performance paper at every meeting for information. • Performance will be impacted by financial constraints, both capital and revenue, with impact and mitigations included in the Annual Delivery Plan 2024/25 (ADP). This plan was approved by the Scottish Government in Q1 2024 and details specific service and specialty level trajectories for this financial year. • NHS Lothian received £7.5m (NRAC share of overall £50m nationally). GJNH 2024/25 capacity allocations have been confirmed; 2,589 Ophthalmology See & treat. 1832 Treat only across Orthopaedics, Plastics, GS, Colorectal. • A further £30m has been identified nationally to support activity delivered in Quarters 1 and 2 2024/25 - NHS Lothian have been allocated £1.6m. A further £70m is anticipated for Quarters 3 and 4, with timing and process for allocation to be confirmed. • NHS Lothian received confirmation of £1.6m to support cancer waiting times as per last year. • £2m of Detect Cancer Earlier (DCE) non-recurring revenue funding is available nationally to support local implementation of the National lung cancer and head and neck cancer optimal diagnostic pathways in 2024/25. NHS Lothian bids are in development for submission in July 2024. **September/October 2024** • **Reporting of performance against waiting time standards is included in the Public Board Performance paper at every meeting for further information.** • **Performance will be impacted by financial constraints, both capital and revenue, with impact and mitigations included in the Annual Delivery Plan 2024/25 (ADP). This plan was approved by the Scottish Government in Quarter 1 of 2024.** • **Scheduled Care Trajectories were resubmitted to Scottish Government in August 2024 to reflect the additional activity predicted due to funding received (see July/August update). Scottish Government have indicated that they plan to write to NHS Lothian acknowledging the resubmitted trajectories in the next few weeks.** • **£2m of Detect Cancer Earlier (DCE) non-recurring revenue funding is available nationally to support local implementation of the National lung cancer and head and neck cancer optimal diagnostic pathways in 2024/25. Following submission of NHS Lothian bids on 26 July 2024, Scottish Government have asked for a prioritisation of requests due to the volume received**

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		and insufficient funding available. NHS Lothian confirmed prioritisation of original requests on 2 August 2024 and await confirmation of funding available/ bids to be supported. Further information will be provided to the Board via the Performance Paper presented to the Board meetings.	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		Very High 25	Very High 25
5388	**HSDU Capacity** There is a risk that HSDU is unable to meet current or future capacity demands for theatre equipment due to physical space limitations of the current department and lack of staff with appropriate competence to maintain and repair key equipment leading to closure of operating theatres and subsequent cancellation of patient operations impacting on quality of patient experience. New risk approved by Board June 2022. Executive Lead: Jim Crombie Corporate objective: Capital	**<u>Finance and Resources Committee</u>** **August 2024** • Limited assurance accepted. ***Update provided to every meeting alternating paper and verbal – next paper December 2024*** **<u>Outcome of Executive Lead Discussions</u>** **July/August 2024** • Re-provision project remains on hold and will do for the foreseeable future. • The Chief Executive and Director of Finance have raised the matter of HSDU funding and resilience with Scottish Government contacts at the NHS Lothian Spring Engagement session in July 2024. • The Estates & Facilities Associate Director of Operations continues to be involved in the national conversations and position surrounding CDU resilience, to ensure that NHS Lothian is a priority given significant fragility of the current unit. • A paper is in development outlining the most recent asset review of critical infrastructure due for completion by end August 2024 and presentation to the Estates & Facilities SMT and HSDU Risk Mitigation Group. • The paper will articulate those assets now beyond lifecycle and will detail proposed 5-year investment requirements in order to ensure the HSDU has stable critical infrastructure. It is believed that most of these systems are under the responsibility of the PFI provider and, as such, impact to BLM priorities will be minimal.	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		September/October 2024 • **Re-provision project remains on hold.** • **Paper regarding the critical infrastructure has not reached completion. It is anticipated the paper will be completed by end September 2024.** • **Additional issues with steam pipework and supply are noted since the last update, however these have not caused major disruption to productivity.** • **The unit continues to support NHS Grampian with approximately 50 trays being processed per week.** • **Risk mitigation plan has been updated as part of the most recent formal corporate risk paper and was accepted by Finance & Resource Committee.**	
	Risk Grading:	**CMT September 2024** Very High 20	**CMT November 2024** Very High 20
3828	**Nursing Workforce** There is a risk that safe nurse staffing levels are not maintained as a consequence of additional activity, patient acuity and/or inability to recruit to specific posts. The subsequent high use of supplementary staffing to counteract shortfalls potentially leading to compromise of safe patient care impacting on length of stay and patient experience. Executive Lead: Alison MacDonald Corporate objective: Workforce	**<u>Staff Governance Committee</u>** **October 2024** • **Moderate assurance accepted.** **<u>Outcome of Executive Lead Discussions</u>** **July/August 2024** • Still on track with circa 700 new starts in coming months • Current vacancy gap is 5.9%, compared to 9.3% in the same period 2023. • The target is 5% and we are on track to reduce further to around 3% Oct/Nov • New starts in the 1st quarter April – June 2024: 318; leavers 321, again an improvement on previous years • Additional non-registered staff continue to be recruited through trainee band 3 scheme. **September/October 2024** • **Still on track with expected new starts in coming months.**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
		• **Vacancy gap in August was 6.71% which is expected as new starts come in towards the end of August.** • **Establishment gap of less than 5% is anticipated by the end of 2024.** • **There are recognised pockets of shortfall e.g. neonates, Melville unit, St Johns.** • **Continuing to host open days and engagement sessions with potential recruits.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		High 12	High 12
5020	**Water Safety and Quality** There is a risk that Legionella may be present in water supplies to healthcare premises due to reduced or no usage of water in some areas during Covid pandemic, seasonal increase in water temperature and incomplete implementation of existing plans to improve systems of control around water safety and provide assurance through documented evidence. This may lead to harm to patients, staff and the general public, potential prosecution under H&S law. In addition, the ability to remobilise services following Covid-19 will be affected where we are not able to demonstrate safety of water systems. New risk approved by Board 12 August 2020. Executive Lead: Jim Crombie Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian	**<u>Staff Governance Committee</u>** **July 2024** • Limited assurance accepted. ***Next to be presented December 2024***	
		<u>Outcome of Executive Lead Discussions</u> **July/August 2024** • It has been agreed to review and update the original risk description, which was predominantly focused on the recovery from the COVID pandemic and third-party premises. • Re-drafted risk will be agreed by the NHS Lothian Water Safety Group, Estates & Facilities SMT prior to presentation to CMT to recommend to the Board during 2024/25 • 'Adequacy of Controls' agreed by SGC to be 'Satisfactory' (previously weak) **September/October 2024** • **Paper currently being drafted following proposed changes agreed by the Water Safety Group. This paper will review the risk description and mitigation plan to ensure alignment with the current risk profile.** • **A paper instructing Consort to comply with Scottish Health Technical Memorandum (SHTM 04) is to be taken to the Water Safety Group for consideration.**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		High 12	High 12
5189	**RIE Facilities** There is a risk that facilities in the RIE are not fit for purpose because of a failure to carry out required Life cycle Works and maintenance of the estate including: • Infrastructure (lifts, electrical systems, heating, ventilation, water, medical gases) • Water quality and management of water systems (flushing, temperature control, periodic testing) • Window safety and maintenance • Fire Safety Leading to interruption to services, potential harm to patients and staff and significant remedial costs. New risk approved by Board June 2021. Executive Lead: Jim Crombie Corporate objective: RIE	**Finance & Resources Committee** **October 2024** • **Limited assurance accepted.** **Outcome of Executive Lead Discussions** **July/August 2024** • A wider review of this risk is underway with the potential of an updated risk description required in order to accurately reflect the current position and key areas of focus following significant scoping and investigation carried out thus far. • Regarding the infrastructure factors impacting this risk, there are elements that require escalation and further works agreed. This is being addressed through the appropriate governance channels. For example, discussions are progressing with the PFI regarding a heads of terms agreement which would explicitly define NHSL's role in the decisions taken relating to infrastructure spend. A resulting Service Level Agreement is anticipated in 2024/25. **September/October 2024** • **A wider review of this risk is yet to be established. This, however, is required to ensure this risk is fully updated and in line with the current risk profile.** • **A formal update paper will be required for the F&R Committee meeting of October 2024.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		High 15	High 15
3455	**Violence & Aggression**	**Staff Governance Committee**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	The nature of services provided by NHS Lothian means there is a potential risk of violent and/or aggressive behaviour across all the organisation but in particular mental health, learning disability services and emergency departments resulting in harm to person and poor patient and staff experience, with potential prosecutions, and fines for health and safety breaches. Executive Lead: Alison MacDonald Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian	**October 2024** • **Moderate assurance accepted.** **<u>Outcome of Executive Lead Discussions</u>** **July/August** • Q1 risk assessments carried out in line with requirements of the revised purple pack risk assessment and being reviewed by the V&A programme board. • Training needs analysis has been carried out across whole organisation. • Training strategy is being implemented including 'training the trainers'. • 10 specific trainers are in place to ensure all bank staff are appropriately trained. • Pooled budget is now in place for lone working devices to circulate unused (spare) equipment to increase flexibility and cost effectiveness. • Measurement evaluation framework is under development and aim to present to August H&S committee. • Q1 risk assessments carried out in line with requirements of the revised purple pack risk assessment and being reviewed by the V&A programme board. • Training needs analysis has been carried out across whole organisation. • Training strategy is being implemented including 'training the trainers'. • 10 specific trainers are in place to ensure all bank staff are appropriately trained. **September/October** • **Staff bank and REAS have successfully recruited and trained trainers and are making a significant impact with around 360 bank staff trained and in REAS around 280.** • **Challenges remain in recruiting trainers in acute services and amongst medical staff, with the bulk being covered by nursing staff.** • **A measurement evaluation framework has been developed and agreed by the H&S committee.** • **Further work is underway to improve accuracy of purple pack completion, incorporating training needs analysis. Digital support is being explored to assist with this.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		High 15	High 15

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td colspan="4"></td></tr>
<tr><td rowspan="3">3328</td><td rowspan="3">Roadways/Traffic Management

There is a risk that the road traffic infrastructure on the 4 acute sites (RIE, St John’s, WGH, REH) is inadequate, due to the volume of traffic as a result of increased demand for parking plus construction projects causing interruption to traffic flow. This impacts on access to services, increasing levels of staff abuse and the potential physical harm to staff, patients, and the public.

Executive Lead: Jim Crombie

Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian</td><td colspan="2"><u>Staff Governance Committee</u>

July 2024
• Limited assurance accepted.

Next to be presented December 2024</td></tr>
<tr><td colspan="2"><u>Outcome of Executive Lead Discussions</u>

July/August 2024
• A review has been commissioned with the Corporate Health & Safety Team to consider the current assessment of risk, in relation to a system wide context of risk grading at Board level. An update on this is expected in September 2024 for Staff Governance Committee in autumn 2024.

September/October 2024
• The afore noted review, carried out by Corporate Health & Safety (H&S) colleagues, has now concluded, and was discussed at CMT. This review contains a series of recommendations which will alter the detail of this Corporate Risk.
• A paper will be drafted by Estates & Facilities for the Staff Governance Committee in October 2024 and CMT which will incorporate the recommendations from the H&S Team review.</td></tr>
<tr><td>Risk Grading:</td><td>CMT September 2024
High 12</td><td>CMT November 2024
High 12</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>1076</td><td>Healthcare Associated Infection

There is a risk of patients developing a preventable infection while receiving healthcare as a result of:</td><td colspan="2"><u>Healthcare Governance Committee</u>

May 2024
• Moderate assurance accepted.</td></tr>
</table>

<table>
<tr><th>Datix ID</th><th>Risk Title & Description</th><th colspan="2">Committee Assurance Review Date</th></tr>
<tr><td></td><td>• sub-optimal clinical practice
• exposure to healthcare environmental hazards
• patient to patient or staff to patient transmission
due to inadequate or inconsistent implementation and monitoring of HAI prevention and control measures, leading to potential harm and poor experience for both staff and patients

Executive Lead: Alison MacDonald

Corporate objective: Underpins the quality and safety of delivery of services throughout NHS Lothian</td><td colspan="2">Next to be presented January 2025

<u>Outcome of Executive Lead Discussions</u>

July/August 2024
• SG have not yet advised targets for 2024/25. Although there has been no formal instruction to do so, we continue to monitor rates and report by exception if out with current control limits.
• ECB, SAB and CDI targets were not met for 2023/24, however, overall performance was better than or similar to other boards of comparable size and complexity.
• Risk description updated for consideration by CMT.
• Work continues to develop and strengthen the risk mitigation plan with a focus on embedding governance and assurance lines across the organisation.
• Internal audit on HAI governance and assurance is about to commence and will support this effort.

September/October 2024
• Revised risk description agreed by the Board at October meeting.
• Internal audit on HAI governance and assurance is commence October.</td></tr>
<tr><td></td><td>Risk Grading:</td><td>CMT September 2024
High 16</td><td>CMT November 2024
High 16</td></tr>
<tr><td colspan="4"></td></tr>
<tr><td>5322</td><td>Cyber Security

There is a risk of cyber-attacks on clinical and business critical systems within NHS Lothian and interdependent third-party digital systems because of an increase in new threats including malware and ransomware which bypass most traditional defence systems, resulting in</td><td colspan="2"><u>Finance and Performance Review Committee</u>

• Paper now planned to go to F&R May 2022 and for Board discussion May 2022.
• Paper presented to F&R 31 May 2022 and risk mitigation plans accepted. No specific level of assurance proposed or agreed.

<u>Audit and Risk Committee</u></td></tr>
</table>

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	critical systems being unavailable, causing significant disruption to patient care, privacy and wider services. New risk approved by Board February 2022. Executive Lead: Tracey Gillies Corporate objective: Digital	**June 2024** • Moderate assurance accepted. **Board** **October 2024** • **Private Board accepted moderate assurance.** **Outcome of Executive Lead Discussions** **July/August 2024** • NISR audit compliance confirmed as 97% which is a significant achievement. • Noting that NISR audit compliance is in relation to our policy and procedures and does not negate the need for continuous diligence, security monitoring and improvement, in conjunction with potential disaster recovery planning. • The risk remains high due to current circumstance and type of breaches other organisations are experiencing (mainly initiated by phishing etc) which require continuous raising awareness amongst staff. • It is recognised that there is a requirement to use nationally provided and externally hosted systems, therefore reliance on their cyber security arrangements e.g. in relation to the global impact of the recent "CrowdStrike" patching issue, no internal NHSL systems were affected, only our externally hosted BT call centres, and eRostering. **September/October 2024** • **Existing risk mitigation plan continues to be implemented.** • **A desktop cyber security exercise will be planned during the next quarter.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		High 12	High 12
5510	**Royal Edinburgh Bed Occupancy**	**Healthcare Governance Committee**	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	There is a risk that patients do not receive safe and effective care due to high levels of bed occupancy, leading to increased risk of harm, poor patient and staff experience and impacting on flow, leading to overcrowding, patients having to be boarded overnight in other specialities, being placed out of area, or sleeping in areas within wards not designed for this purpose. New risk approved by Board December 2022. Executive Lead: Caroline Hiscox Corporate objective: Mental health, illness, and wellbeing	**January 2024** • Limited assurance accepted. ***Next to be presented January 2025***	
		<u>Outcome of Executive Lead Discussions</u> **July/August 2024** • Capacity remains a significant concern across REH with no reduction in overall occupancy. • Full pathway review has started with Dementia pathway and multi- stakeholder engagement. This will expand across all pathways over coming months. Outputs from bed modelling work will be used throughout. **September/October 2024** • **Acute bed capacity has been even more constrained with ongoing pressure on inpatient beds.** • **Work continues with Edinburgh HSCP to look at alternatives to admission as our admissions per 100,000 of the population are very slightly higher than the National average 215 vs 200.** • **Current mitigations remain the same.**	
	Risk Grading:	**CMT September 2024** Very High 25	**CMT November 2024** Very High 25
5737	**Royal Infirmary of Edinburgh Fire Safety** Two components: 1. There is a risk that the technical standards of the building provided by the PFI are not adequate and do not meet current fire safety standards.	**<u>Staff Governance Committee</u>** **July 2024** • Limited assurance accepted. ***Next to be presented December 2024***	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	2. There is a consequential risk that NHS Lothian has inadequate fire safety arrangements in place at the Royal Infirmary of Edinburgh (RIE) following the recent identification of risks and issues. This may lead to enforcement action by the Scottish Fire & Rescue Service, disruption to services/facilities where remedial work is identified and finally serious reputational damage. In the unlikely event of a fire, this may lead to an extreme risk of harm to patients, staff, and the general public, along with the potential for prosecution under the Fire (Scotland) Act 2005 and Fire Safety (Scotland) Regulations 2006. New risk approved by Board December 2023. Executive Lead: Caroline Hiscox Corporate objective: RIE	**<u>Outcome of Executive Lead Discussions</u>** **July/August 2024** • All actions which are the responsibility of NHS Lothian continue to be progressed and updated and are detailed in the risk mitigation paper which will be consider by the Staff Governance Committee on 31 July 2024 for assurance. • Confirmation now received from SFRS that they have formally withdrawn the Enforcement Notice issued in relation to the former NHS Lothian Chief Executive, due to retirement. The remaining enforcement notices issued to NHS Lothian remain in place. • The Facilities Management company contracted by the PFI Provider have since had their Enforcement Notice formally withdrawn by SFRS. • A Fire Strategy Development and Implementation Group (FSDIG) has been initiated. The core remit of this group is to develop and implement a holistic strategy for addressing fire improvement works within the available remaining Lifecycle budget. • Collaborative approach to actioning the SFRS enforcement notice requirements continues. SFRS now invited to attend the Monthly Project Board. • The SFRS enforcement notice SLWG continues to meet on a fortnightly basis to report on progress. A weekly update tracker is circulated to Hospital Management, which details progress against all actions identified in the enforcement notice. **September/October 2024** • **All actions under the responsibility of NHS Lothian were updated in Corporate Risk Reporting Paper issued to the Staff Governance Committee in July 2024** • **No further significant update on points raised in August 2024, however it must be noted that progress continues on the risk mitigation actions associated with this risk.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		Very High 25	Very High 25

Datix ID	Risk Title & Description	Committee Assurance Review Date	
[redacted]			
5784	**Inappropriate and Inadequate Low Secure Accommodation in the Estate** There is a risk that patients who require low secure accommodation will be inappropriately placed because there is a lack of low secure accommodation for any patient in Lothian. This could potentially lead to harm to patients themselves, other patients, and staff as well as the potential for legal challenge against the level of security which is a risk to the organisation. *New risk approved by CMT March 2024. Executive Lead: Caroline Hiscox Corporate objective: Mental health, illness and wellbeing	**Healthcare Governance Committee** **July 2024** • Moderate assurance accepted. ***Next to be presented January 2025***	
		Outcome of Executive Lead Discussions **July/August 2024** • Lack of capital funding from Scottish Government continues. • Remains on prioritisation list for NHS Lothian capital prioritisation, however, SG are responsible for the capital funding required to complete the business case development. • Block booking contract in place with Ayr Clinic and Surehaven for three years from 1st July 2024. **September/October 2024** • **We continue with the contracts for out of area placements and are reviewing some of those patients to see if they are now able to be safely managed on REH campus.** • **Mitigations remain same with block booking contract in place with Ayr Clinic and Surehaven for three years from 1st July 2024.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		High 15	High 15
[redacted]			
5785	**Absence of Female High Secure Accommodation in the Estate** There is a risk that female patients who require high secure accommodation will be inappropriately placed because there is a lack of female high secure accommodation in Scotland. This could potentially lead	**Healthcare Governance Committee** **July 2024** • Limited assurance accepted. ***Next to be presented January 2025***	

Datix ID	Risk Title & Description	Committee Assurance Review Date	
	to harm to patients themselves, other patients, and staff as well as the potential for legal challenge against the level of security which is a risk to the organisation. *New risk approved by CMT March 2024. Executive Lead: Caroline Hiscox Corporate objective: Mental health, illness and wellbeing	**<u>Outcome of Executive Lead Discussions</u>** **July/August 2024** • This is a National programme with State Hospital Chief Executive leading. • Note that the responsibility for delivery of female high secure care sits with Scottish Government and the mitigations in place for both untried and convicted woman are the responsibility of NHS Lothian. • Current arrangements to provide beds if required with Rampton (England) continue. **September/October 2024** • **We continue to wait on feedback from State Hospital and SG on plans to create a high secure on the state hospital campus and the current mitigations remain the same.**	
	Risk Grading:	**CMT September 2024**	**CMT November 2024**
		High 12	High 12

Risks removed and rationale.

Risk ID	Opened	Risk Title	Recommendation	Rationale
4813	**23/07/19**	**Royal Hospital for Children & Young People/Dept of Clinical Neurosciences**	Board approved closing the risk as per 7 April 2021 Board Corporate Register Paper	Services will be fully operational by the end of March 2021.
4694	**04/04/19**	**Waste Management**	Board approved closing the risk as per 7 April 2021 Board Corporate Register Paper	This risk was accepted onto the CRR due to unforeseen external provider availability which resulted in additional financial risk and H&S issues. The financial risk has been addressed, a new contractor is in place and any residual service risk is being managed at an operational level with clear management oversight.

Risk ID	Opened	Risk Title	Recommendation	Rationale
3527	26/07/13	**Medical Workforce**	Board approved closing the risk as per 7 April 2021 Board Corporate Register Paper	Aspect of the Medical Workforce within our control are being managed at an operational level and captured on operational risk registers.
4693	04/04/2019	**Brexit/EU exit**	Board approved closing the risk as per 1 Decembe 2021 Board Corporate Register Paper	The potential risks have not materialised and will be kept under review nationally and locally.
3454	13/02/2013	**Learning from Complaints**	Board approved closing the risk as per 6 April 2022 Board Corporate Register Paper	The January 2022 Healthcare Governance accepted Moderate assurance with respect to management of complaints and the improvement plan that has recently been put in place along with the moderate risk grading. Given the level of grading and assurance, the CMT will be recommending to the Board that this risk be removed from the corporate risk register and be placed on the corporate nursing register for regular review.
5034	29/06/2020	**Care Homes**	Board approved closing the risk as per 9 February 2022 Board Corporate Register Paper	The January 2022 Healthcare Governance accepted Moderate assurance with respect to management of complaints and the improvement plan that has recently been put in place along with the moderate risk grading. Given the level of grading and assurance, the CMT will be recommending to the Board that this risk be removed from the corporate risk register and be placed on the corporate nursing register for regular review. A paper in May 2022 will come to HGC setting out the proposed reporting schedule for complaints management as part of the wider Patient Experience Strategy reporting.
3189	16/02/2012	**Facilities Fit for Purpose**	Board approved closing the risk as per 3 August 2022 Board Corporate Register Paper	Formal risk mitigation plan now in place and accepted by F&R committee and CMT.

Risk ID	Opened	Risk Title	Recommendation	Rationale
				F&R accepted moderate assurance at the 31 May 2022 meeting. Ongoing monitoring of risk mitigation plans will be through facilities operational management structures. The June 2022 CMT agreed reduction of grading to medium (9) likelihood – possible, impact moderate.
5187	**23/06/2021**	**Access to Psychological Therapies**	Board approved closing the risk as per 23 August 2023 Board Corporate Register Paper	The grading of the risk was reduced to medium (8) and removal from the CRR agreed due to continued improvement of performance leading to de-escalation by Scottish Government from level 3 to level 2. There is an agreed performance trajectory based on confirmed funding by SG plus a clear escalation process based on performance which is monitored through the Performance Oversight Board. The risk will remain on the REAS risk register for continued management and monitoring.
5188	**23/06/2021**	**Access to CAMHS**	Board approved closing the risk as per 23 August 2023 Board Corporate Register Paper	The grading of the risk was reduced to medium (8) and removal from the CRR agreed due to continued improvement of performance leading to de-escalation by Scottish Government from level 3 to level 2. There is an agreed performance trajectory based on confirmed funding by SG plus a clear escalation process based on performance which is monitored through the Performance Oversight Board. The risk will remain on the REAS risk register for continued management and monitoring.
5360	**06/04/2022**	**Public Health (Covid-19)**	Board approved closing the risk as per 23 August 2023 Board Corporate Register Paper	It was agreed to stand down the COVID risk in line with national, UK and global direction. In May 2023, the WHO declared an end to COVID-19 as a global health emergency. The WHO noted that the pandemic had been on a downward trend over the last 12 months,

Risk ID	Opened	Risk Title	Recommendation	Rationale
				with immunity increasing due to the highly effective vaccines. Death rates had decreased and the pressure on once overwhelmed health systems, had eased. The National Incident Management Team was stood down on 27th April 2023, in line with the other nations and the UK wide response. Reporting of COVID data was incorporated into business-as-usual reporting and moved to monthly publications.
5687	**21/08/2023**	**Inappropriate and Inadequate Accommodation in the Secure Estate**	Board approved closing the risk as per 24 April 2024 Board Corporate Register Paper	As different risks and mitigations were in place for high and low secure provision it was agreed that the risk should be closed and split into two risks: 1. New Risk - Inappropriate and Inadequate Low Secure Accommodation in the Estate 2. New Risk – Absence of Female High Secure Accommodation in the Estate
3829	**15/10/2015**	**Sustainability of Model of General Practice**	**Board approved closing the risk as per 10 Octobe 2024 Board Corporate Register Paper**	**It was agreed to regrade the risk from high (12) to medium (9), based on a reduction of the impact from major to moderate. Furthermore, it was agreed that the risk is de-escalated to the Primary care services risk register and noted that it would continue to be included in HSCP risk registers. Although some challenges remain, particularly around funding to fully deliver Primary care improvement plans and increased costs for practices for facilities management services, these are being managed. Workforce supply is improving, and patients can access Primary care services.**

Grant Thornton

NHS Lothian

Internal Audit 2024/25

Risk Management

October 2024

FINAL REPORT

Emily Mayne
Head of Internal Audit
T 0121 232 5309
E emily.j.mayne@uk.gt.com

Hannah McKellar
Manager, Public Sector Audit
T 0131 659 8568
E hannah.l.mckellar@uk.gt.com

Linda Chadburn
Independent Consultant
T 0161 953 6915
E linda.g.chadburn@uk.gt.com

Contents

Section	Page
Executive summary	03
Headline messages	05
Summary of findings	07
Detailed findings & action plan	08
Appendices	
Appendix 1: Staff involved & documents reviewed	16
Appendix 2: Our assurance levels	17
Appendix 3: Our recommendation ratings	18

Report Distribution

Executive Lead:

- Tracey Gillies, Medical Director

For action:

- Jill Gillies, Associate Director of Quality

For Information:

- Caroline Hiscox - Chief Executive
- Craig Marriott – Director of Finance
- Audit and Risk Committee

Executive summary

Background

Corporate risks are uncertainties or potential events that could negatively impact the achievement of an organisation's objectives at a strategic level. These risks can arise from various sources and affect different aspects of the organisation's operations. Corporate risks can range from operational and compliance risks to financial and technological risks.

NHS Lothian has a Risk Management Policy which highlights that the Corporate Management Team is responsible for directing the application of the policy through operational management structures, while the Audit and Risk Committee is responsible for assurance on the overall system of risk management and overseeing all risks on the corporate risk register. Each corporate risk is assigned to a named Executive Lead who is responsible for overseeing the management and mitigation of that risk. Each risk is assigned to a relevant committee or committees of the Board for assurance, in line with the committee's' terms of reference.

The purpose of the internal audit is to provide assurance on the internal controls relating to the management and mitigation of corporate risks. This will be achieved by selecting a sample of three corporate risks, each reported through different oversight committees. The audit will assess the design and application of controls for assessing, mitigating, and monitoring these risks to ensure that any impact on NHS Lothian's objectives is minimised.

Objectives

The objective of this review is to provide an independent assessment of the design and operational effectiveness of NHS Lothian's corporate risk management arrangements. Our review focussed on the following potential risk areas:

- Inadequate policies and documentation may lead to ineffective risk management practices and regulatory non-compliance.
- Poor risk assessment processes could result in the failure to identify significant risks or improper resource allocation.
- Insufficient documentation of gaps and mitigations can lead to incomplete risk management efforts, preventing the Board from obtaining a comprehensive understanding of the risk landscape.
- Ineffective mitigation controls may lead to insufficient risk reduction, exposing the organisation to unacceptable levels of risk.
- Ineffective risk management may result if risk handlers and owners do not collaborate and work together effectively.
- Inadequate monitoring and reporting processes at committee level can result in a lack of appropriate risk management oversight.

Executive summary

Limitations in scope

Please note that our conclusion is limited by scope. It is limited to the risks outlined above. Other risks exist in this process which our review and therefore, our conclusion has not considered. Where sample testing has been undertaken, our findings and conclusions are limited to the items selected for testing.

This report does not constitute an assurance engagement as set out under ISAE 3000.

Acknowledgement

We would like to take this opportunity to thank your staff for their co-operation during this internal audit.

Headline messages

Conclusion

Moderate Assurance

We have reviewed the processes and controls around Risk Management with a focus on the Corporate Risk Register and have concluded that the processes have provided a **MODERATE LEVEL OF ASSURANCE**. This was confirmed through testing in specific areas of the organisation and through discussions with various individuals across the organisation.

We have provided 'Moderate Assurance' based on our findings, indicating that the controls upon which the organisation relies are suitably designed and, in most cases, effectively applied. However, a moderate amount of residual risk remains. We have reported by exception against the areas where we consider that Management and the Audit and Risk Committee should focus their attention.

Our internal audit of NHS Lothian's risk management processes identified that NHS Lothian made revisions to the Risk Management Policy and its associated Risk Management Operational Procedure in April 2023. However, there are opportunities to further enhance the governance arrangements in place to ensure the roles and responsibilities of sub-Committees and risk handlers are clearly defined and communicated.

Additionally, there are opportunities to strengthen the Assurance Report and Risk Mitigation Plan template to ensure consistent reporting, expanding the risk descriptions to ensure these are fully defined and setting out how each risk aligns to the relevant underlying corporate strategic objectives.

In a previous internal audit during the 2023/24 financial year, it was noted that there was opportunities to enhance the Datix reports as these are inadequate for managing risks effectively and reports do not include all the expected information, and this is still valid. We recognise that discussions are ongoing around Datix and if this will be replaced moving forward.

Three key weaknesses were identified, resulting in medium risk recommendations. This noted that the Datix reports, Assurance reports and Risk Migration plan templates are inadequate for managing risks effectively as the reports do not include all key information and could be strengthened. Additionally, there was no evidence that the completion of actions to date has resulted in any change to the risk level or score. There is a risk to the Board that despite spending time and resources on actions to date, the Board face continued exposure and unresolved vulnerabilities to the risk area. We note that further actions are ongoing which should reduce the risk level or score.

We will review progress made as part of our recommendation tracking during 2024/25.

Headline messages

Conclusion

We have raised eight recommendations including two improvement point. The grading of the recommendations are based on risk and summarised in the table below.

Risks	Assurance rating	Number of recommendations			
		High	Medium	Low	Imp
1. Inadequate policies and documentation may lead to ineffective risk management practices and regulatory non-compliance.	Moderate Assurance	-	2	1	1
2. Poor risk assessment processes could result in the failure to identify significant risks or improper resource allocation.	Significant Assurance	-	-	1	-
3. Insufficient documentation of gaps and mitigations can lead to incomplete risk management efforts, preventing the Board from obtaining a comprehensive understanding of the risk landscape.	Significant Assurance	-	-	-	-
4. Ineffective mitigation controls may lead to insufficient risk reduction, exposing the organisation to unacceptable levels of risk.	Moderate Assurance	-	1	-	-
5. Ineffective risk management may result if risk handlers and owners do not collaborate and work together effectively.	Significant Assurance	-	-	1	-
6. Inadequate monitoring and reporting processes at committee level can result in a lack of appropriate risk management oversight.	Significant Assurance	-	-	1	-

Summary of findings

Examples of where recommended practices are being applied

- The Risk Management Policy and Risk Management Operational procedure are in date and are accessible via the internet. The two documents sit alongside each other giving easy access and providing the relevant information to employees.
- The risk assessment process is described well within the Risk Management Operational Procedure. The procedure includes a well described process to defining a risk and includes a good range of examples. This means that risk handlers and owners can ensure a risk is fully understood at the onset of the risk assessment process, leading to a more meaningful identification of gaps and controls to mitigate a risk.
- Assurance Reports produced for the Governance Committees evidence that a detailed update of the progress made in relation to the actions associated to each 'key factor' is reported.

Areas requiring improvement

- Datix reports do not include all the information expected to be in the report to enable effective risk management. This means that the key people involved in the management of a risk cannot see the full picture and vital information relating to the risk (note, this was raised as a recommendation in the 2023/24 audit).
- The Risk Assurance Report template does not capture the information we would expect to be included in the report. This leads to Governance Committees not being provided with information which may help them make informed decisions.
- Risk Mitigation Plans are used inconsistently and do not detail the controls, gaps in controls and the adequacy of the individual controls already in place. This leads to Committees not being aware of important information.
- A Corporate Risk Register generally contains strategic risks which compromise the delivery of the organisations objectives and any operational risks which cannot be managed at a lower level or have an impact across the system, and this is reflected in the Risk Management Operational Procedure. Unfortunately, there was no evidence that the risks we reviewed were mapped to the relevant corporate objectives.
- Although actions have been completed for each of the three risks we reviewed, no action has had an impact on the level of the risk to date and no risk level or score has reduced. This may be due to key actions not completed and focus should be given to those actions.
- Risk handlers are not sure of their status, and this should be clarified to ensure the right people are involved in the management of risks.
- The Governance Committees terms of reference are not consistent and do not include any reporting into the Committees.

Detailed findings & action plan

1.	Moderate Assurance	Inadequate policies and documentation may lead to ineffective risk management practices and regulatory non-compliance.

Finding and implication	Audit recommendation	Management response, including actions
Committees' responsibilities are not reflected in policy. A review of the Risk Management Policy confirmed it is in date and accessible via NHS Lothians internet pages. The policy defines the responsibilities of the Audit and Risk Committee, the Healthcare Gavernance Committee and the Staff Governance Committee. No other Committees are referred to in the policy and this should be revised to reflect the responsibilities of other Committees which have oversight of individual risks, for example the Finance and Resource Committee. If roles and responsibilities are not detailed, there is the potential for confusion, inefficiency, and a lack of accountability, which can hinder effective decision-making and oversight within the organisation.	**Recommendation 1. Policy** To ensure there are robust governance arrangements and consistent responsibilities of all Committees which may hold oversight of corporate risks, the policy should be revised to include the responsibilities of ALL Committees with responsibility. This may be a generic statement of responsibly for Committees rather than specifying the names of individual Committees.	**Actions:** Specific references to Healthcare Governance and Staff Governance Committees will be removed. **Responsible Officer:** Associate Director of Quality. **Executive Lead:** Medical Director. **Due Date:** 31 October 2024.
Datix reports are inadequate for managing a risk effectively. Review of an extract from Datix provided by the Corporate Risk Management Team highlighted that not all expected information to enable effective risk management is made available to key persons. Issues identified included the following: • The individual likelihood and consequence ratings for a risk are recorded narratively and a numerical score is not provided as seen in other organisations, for example Extreme = 5, Almost Certain = 5, therefore risk score = 25. • We noted there was no target rating for two of the three risks indicating the risk tolerance following mitigating actions being taken. We were informed that this would be discussed with relevant risk owners at the bi-monthly meeting, due late July /early August 2024. • Gaps within the controls of a risk are not detailed within Datix. • The decision to either treat, tolerate, transfer or terminate is not captured within Datix and we were informed all risks are expected to be treated. We note that this decision is described as part of the process within the Risk Management Operational Procedure. • The corporate objectives to which a risk relates is currently being updated by the Corporate Risk Management Team and will be confirmed with the relevant risk owners. Further discussion highlighted that Datix is only used as a 'dock' of information for Corporate Risks rather than to manage the risks. There are plans to replace Datix in the future and that system may be used in a different capacity at that point.	**Recommendation 2. Datix** To ensure an effective and consistent approach to managing corporate risks, the Risk Management System should capture all relevant information relating to a risk, including the numerical make-up of the risk score, the target rating/score, the gaps in the controls, as well as the current decision to either treat, tolerate, transfer or terminate the risk ar the activity associated to the risk. These factors should be considered during the procurement af a Risk Management System in the near future.	**Actions:** Findings acknowledge that reports from Datix are not used to update risks and alternative documentation is used, with the final updates, as ratified by the Board being recorded in Datix. Current documentation including the risk assurance table is currently being reviewed to incarporate all relevant information. Datix fields also being reviewed to enable relevant information to be captured and enhanced report to be provided. **Responsible Officer:** Associate Director of Quality. **Executive Lead:** Medical Director. **Due Date:** 31 December 2024.

Detailed findings & action plan

1.	Moderate Assurance	Inadequate policies and documentation may lead to ineffective risk management practices and regulatory non-compliance.

Finding and implication (ctd.)	Audit recommendation	Management response, including actions
<u>The Assurance Report and Risk Mitigation Plan template could be strengthened.</u> A template document is available which includes an Assurance Report and a Risk Mitigation Plan. Review of the Assurance Report highlights a gap in the information we would expect to be included, and these can be mapped to those gaps we have highlighted within Datix described earlier within this report. Review of the Risk Mitigation Plans of the three risks in our sample highlighted a general inconsistency in the reporting style and format. Discussion with risk handlers confirmed they feel the template works well overall, and the template can be adjusted as required to meet their reporting needs. In addition, our review of the templates also identified the following issues: • Assurance Reports and Risk Mitigation Plans do not detail the controls and gaps in controls in place to manage a risk and interviews with risk handlers highlighted uncertainty to how a Governance Committee is made aware of these. • Assurance Reports do not state the adequacy of individual controls to the Governance Committees. However, the summary section of the reports state the 'overall' adequacy of controls. • Interview with the Corporate Risk Management Team informed us that gaps are expected to be detailed in the 'key factors' of the risk mitigation plan but our review highlights the 'key factors' are generally the individual areas of focus or workstreams relating to a risk rather than a gap in the controls. • We were unable to determine whether completed actions have become a control within the Assurance reports. • We noted inconsistencies that there were overlaps within the HSDU Assurance report, with progress on actions reported in more than one section. Furthermore, review of Governance Committee meeting minutes indicated that the Healthcare Governance Committee like the format of the 'Access to Treatment Assurance Report' and would like all risks presented to the Committee to be in this format. The Committee suggested it would be helpful to define the highest risk areas and associated measurements for improvement. The Staff Governance Committee highlighted the significant work undertaken and progress achieved against the six workstreams of the Violence and Aggression risk.	**Recommendation 3. Assurance Report & Risk Mitigation Plan template** To promote consistent reporting and ensure the Governance Committees are provided with the full picture of the position of a risk, we recommend that discussions are held regarding a redesign of the template Assurance Report and Risk Mitigation Plan, including the following: • A breakdown of the score (Likelihood/Consequence) • Target score • Risk response (tolerate, treat, transfer or terminate) • Relevant corporate objective to which the risk relates • Gaps in controls and actions • Controls, including the movement of an action to a control. This may be in the form of a dashboard or revisions to the current template.	**Actions:** Current Risk Mitigation template will be reviewed to include recommended information. **Responsible Officer:** Associate Director of Quality. **Executive Lead:** Medical Director **Due Date:** 31 December 2024.

Detailed findings & action plan

1.	Moderate Assurance	Inadequate policies and documentation may lead to ineffective risk management practices and regulatory non-compliance.

Finding and implication (ctd.)	Audit recommendation	Management response, including actions
<u>Other Risk Management tools are used in isolation.</u> It was noted that some risk handlers use the SCART tool, a critical analysis framework which provides an extra layer of assurance. We note that the tool is not mandated, and the Corporate Risk Management Team is not aware of it. An assessment of the SCART tool may determine whether this framework would further enhance the risk management process and ensure a consistent approach across the organisation.	**Improvement Point 4. SCART Tool** To ensure the risk management process makes use of all available resources, we recommend that the Corporate Risk Management Team undertake an assessment of the SCART tool to determine whether this critical analysis framework would further enhance the risk management process.	No action required but may be of interest to management.

Detailed findings & action plan

2.	Significant Assurance	Poor risk assessment processes could result in the failure to identify significant risks or improper resource allocation.

Finding and implication	Audit recommendation	Management response, including actions
<u>Risk descriptions are not written in accordance with policy.</u> The risk assessment process is outlined within the Risk Management Operational Procedure. Generally, an effective assessment and management of a risk commences with a clearly defined risk description, describing, what event could happen, why the event could occur and what would be the consequence, and this is advocated in the procedure with described guidance on how to define a risk with examples. A review of the risk descriptions of the three risks in our sample, highlighted that not all risks state why the event could occur. Understanding 'why' an event can occur will assist in the identification of the best actions to take to minimise risk, and the importance of considering 'why' is well defined in the Operational Procedure. Additionally, for each risk, it is not clear which corporate objective the risk relates to, and we were unable to confirm alignment of risks to the corporate objectives from interviews with the Corporate Risk Management Team or the Risk Handlers. We would expect that identification of the corporate objective to which a risk relates is identified during the risk assessment phase when a risk is being added to the Corporate Risk Register. We recommend that the risk owners and handlers consider whether risk descriptions are sufficient with the support of the Corporate Risk Management Team at the next planned meeting and ensure each risk is clearly aligned to corporate strategic objectives.	**Recommendation 5. Risk Descriptions** To ensure the continuous assessment and monitoring of corporate risks is effective, we recommend that risk descriptions are reviewed by the risk handlers and owners at least annually, with the support of the corporate Risk Management Team at the scheduled bi-monthly meetings. We recommend that identification of the relevant strategic objectives to which the risk impacts upon is identified during risk assessment and reviewed during these meetings. This should be easily identifiable in all reporting.	**Actions:** All risk descriptions will be reviewed at the next bi-monthly meetings. Associated strategic objective now included risk assurance table and in Datix. **Responsible Officer:** Associate Director of Quality (in conjunction with risk owners). **Executive Lead:** Medical Director. **Due Date:** 31 December 2024.

Detailed findings & action plan

4.	Moderate Assurance	Ineffective mitigation controls may lead to insufficient risk reduction, exposing the organisation to unacceptable levels of risk.

Finding and implication	Audit recommendation	Management response, including actions
<u>There was no evidence that the completion of actions to date have led to a change in the risk level or score.</u> Review of Assurance Reports, Risk Mitigation Plans and interviews with risk handlers highlighted that although actions have been completed for the three risks reviewed, no action has impacted the level of the risk or reduced its score. We acknowledge there are key actions relating to each of the risks which have yet to be completed, and it is considered that the completion of those key actions will reduce the risk score. We therefore recommend that the key actions impacting the risk level are easily identifiable within the Risk Mitigation Plans to encourage discussion with the Governance Committees, and that resources and monitoring of those actions become the focus of the Committees. There is a risk to the Board that despite spending significant time and resources on actions which do not impact on the scoring of the risk level/score, continued exposure and unresolved vulnerabilities still exist.	**Recommendation 6. Key actions** To encourage the direction of resources to mitigate and minimise risks, we recommend: • Risk Mitigation Plans provide focus to the key actions required to reduce risk levels, • Discussion of these key actions should be encouraged at Committee and Board level, including the identification of resources to deliver the most suitable actions. • Future monitoring of those actions should become the focus of reporting to Committees and the Board. • Work should be undertaken to explicitly link key actions of the Risk Management Plan to the actions required to deliver strategic objectives.	**Actions:** Current Risk Mitigation template will be reviewed to ensure identification of key actions to facilitate focussed discussion at Governance Committees. **Responsible Officer:** Associate Director of Quality (in conjunction with risk owners and Committee Chairs). **Executive Lead:** Medical Director **Due Date:** 31 December 2024.

Detailed findings & action plan

5.	Significant Assurance	Ineffective risk management may result if risk handlers and owners do not collaborate and work together effectively.

Finding and implication	Audit recommendation	Management response, including actions
<u>The risk handlers roles and responsibilities should be clearly defined and documented.</u> It was noted that the Corporate Risk Management Team meet with a risk owner on a two-monthly basis, a function developed in response to the recommendations of a previous internal audit. We observed the bi-monthly meeting held between a risk owner and the Corporate Risk Management Team. There was evidence of a detailed report being prepared in advance of the meeting and the risk owner and Corporate Risk Management Team working together with the risk handlers to collate information to report progress against the mitigation actions. The risk owner had a good knowledge base of the risks under their management to ensure discussions focused on progress. Review of the meeting schedule highlighted that risk handlers are not invited to all meetings. The roles and responsibilities of a risk handler is not documented or defined, which can result in a lack of clarity within the organisation and result in difficulties in working together effectively as individuals aren't clear on their role.	**Recommendation 7. Risk handler role** To ensure risks on the Corporate Risk Register can be managed effectively, the risk handler's roles and responsibilities should be clearly documented and defined, including the appropriateness of attending all bi-monthly meetings with the risk owner and Corporate Risk Management Team.	**Actions:** Risk handler's roles and responsibilities will be added to documented CRR process. *To note: Risk management procedure says: 'The risk handler typically undertakes the detailed work on the particular risk, and reports to the risk owner on that work.'* *Also risk handlers do attend bi-monthly meetings for other Exec leads but process slightly different for deputy CE meeting as updates and discussion with handlers takes place prior to the meeting.* **Responsible Officer:** Associate Director of Quality. **Executive Lead:** Medical Director. **Due Date:** 31 December 2024.

Detailed findings & action plan

6.	Significant Assurance	Inadequate monitoring and reporting processes at committee level can result in a lack of appropriate risk management oversight.

Finding and implication	Audit recommendation	Management response, including actions
<u>Risk management responsibilities and reporting requirements are not consistently reflected in the Governance Committees terms of reference.</u> A review of the terms of reference for the Committees with oversight of each of the risks in our sample confirmed that each Committee holds responsibility for monitoring and reviewing strategic risks and informing updates to risk assurance and mitigation plans. Our review identified numerous issues: • The terms of reference for the Healthcare Governance Committee do not make direct reference to the management of risks within the 'remit' for the Committee or as a 'core function'. • The terms of reference for the Corporate Management Team, which has oversight of all risks on the Corporate Risk Register, were recently updated (July 2024) and do not reflect this oversight as a 'purpose' of the group. • In addition, none of the terms of reference state the reporting requirements into the Committee. A review of the Workplans of the Committees highlighted inconsistencies in the scheduling of the Risk Assurance Reports. • The Healthcare Governance Committee workplan indicates that the Corporate Risk Register is a standing agenda item for all meetings and the Access to Treatment Risk Mitigation Plan is scheduled for discussion annually. • The Staff Governance Committee workplan states updates are to be provided to the Committee at each meeting, and this includes the Violence & Aggression risk. • The Finance & Resources Committee does not have a formal workplan in place, although we acknowledge update reports are requested by the Committee at least annually, and this includes the HSDU Capacity risk. Interviews with risk handlers confirmed that there are other forums with responsibilities for the individual elements (key factors) of the risk, for example the Outpatient Delivery Group oversees the actions relating to the Access to Treatment ' Outpatients' element of the Risk Mitigation Plan, and the Cancer diagnostic delivery board oversees the actions relating to the Cancer 31 and 62 days and the Diagnostics elements of the Risk Mitigation Plan. We did not review documentation from these forums as it outside the scope of this review.	**Recommendation 8.** **Governance Committees responsibilities** To ensure the Committees risk management responsibilities are made clear, concise and consistent across the Committees, we recommend the following elements are considered: • The terms of reference for the Healthcare Governance Committee is revised at the next scheduled review to make direct reference to the management of risks within the remit of the Committee or as a core function. • All Committees terms of reference detail the reporting arrangement *into* the Committee rather than only *from* the Committee. • The new terms of reference for the CMT are revised to ensure the group's oversight of all corporate risks is reflected as a 'purpose' of the group. • The expectations for a risk handler and owner to produce a report to a Governance Committee is consistent for all Committees and reflected in an approved annual workplan.	**Actions:** All Committees Terms of Reference will be revised to include relevant points at next scheduled reviews. Scheduling of reports will be agreed alongside revision of current risk mitigation templates. **Responsible Officer:** Board Secretory. **Executive Lead:** Medical Director. **Due Date:** February 2025

Appendices

Appendix 1:
Staff involved and documents reviewed

Staff involved

- Tracey Gillies, Medical Director
- Jill Gillies, Associate Director of Quality
- Sue Gibbs, Quality & Safety Assurance Lead
- Alison MacDonald, Executive Nurse Director
- Michelle Carr, Chief Officer, Acute Services
- Fiona Ireland, Nurse Director (Corporate Nursing)
- Morag Campbell, Director of Estates & Facilities
- Robert Aitken, Associate Director of operations, Estates & Facilities
- David Collins, Head of H&S Services
- Alexander Crawford, Business Manager, Estates & Facilities
- Karen Fraser, Head of Risk, Quality & Assurance, Facilities
- Wendy Reid, Head of Performance & Business Unit, Executive Office
- John McHale, Executive Office
- Catherine Kelly, Business Manager, Acute Services

Documents reviewed

- Risk Management Policy, April 2023
- Risk Management Operational Procedure, April 2023
- Extract of Corporate Risk Register (CRR) fram DATIX (Sample of three risks)
- Healthcare Governance Committee documentation
- Strategy, Planning & Performance Committee documentation
- Finance & Resources Committee documentation
- Staff Governance Committee documentation
- Corporate Management Teom documentation
- Process for managing the CRR
- Risk reporting paper template
- Schedule for CRR meetings with risk owners

Appendix 2:
Our assurance levels

The table below shows the levels of assurance we provide and guidelines for how these are arrived at. We always exercise professional judgement in determining assignment assurance levels, reflective of the circumstances of each individual assignment.

Rating	Description
Significant Assurance	The Board can take reasonable assurance that the system(s) of control achieves or will achieve the control objective. There may be an insignificant amount of residual risk or none at all. There is little evidence of system failure and the system appears to be robust and sustainable. The controls adequately mitigate the risk, or weaknesses are only minor (for instance a low number of findings which are all rated as 'low' or no findings)
Moderate Assurance	The Board can take reasonable assurance that controls upon which the organisation relies to achieve the control objective are in the main suitably designed and effectively applied. There remains a moderate amount of residual risk. In most respects the "purpose" is being achieved. There are some areas where further action is required, and the residual risk is greater than "insignificant". The controls are largely effective and, in most respects, achieve their purpose with a limited number of findings which require management action (for instance a mix of 'medium' findings and 'low' findings)
Limited Assurance	The Board can take some assurance from the systems of control in place to achieve the control objective, but there remains a significant amount of residual risk which requires action to be taken. This may be used when: • There are known material weaknesses in key control areas. • It is known that there will have to be changes that are relevant to the control objective (e.g. due to a change in the law) and the impact has not been assessed and planned for. The controls are deficient in some respects and require management action (for instance one 'high' finding and a number of other lower rated findings)
No assurance	The Board cannot take any assurance from the audit findings. There remains a significant amount of residual risk. The controls are not adequately designed and / or operating effectively and immediate management action is required as there remains a significant amount of residual risk (for instance several HIGH rated recommendations)

Appendix 3:
Our recommendation ratings

The table below describes how we grode our audit recommendations based on risks:

Rating	Description	Possible features
High	Findings that are fundamental to the management of risk in the business area, representing a weakness in the design or application of activities or control that requires the immediate attention of management	• Key activity or control not designed or operating effectively • Potential for fraud identified • Non-compliance with key procedures/standards • Non-compliance with regulation
Medium	Findings that are important to the management of risk in the business orea, representing a moderate weakness in the design or application of activities or control that requires the immediate attention of management	• Important activity or control not designed or operating effectively • Impact is contained within the department and compensating controls would detect errors • Possibility for fraud exists • Control foilures identified but not in key controls • Non-compliance with procedures/standards (but not resulting in key control failure)
Low	Findings that identify non-campliance with established procedures, or which identify changes that could improve the efficiency and/or effectiveness of the activity or control but which are not vital to the management of risk in the business area.	• Minor control design or operational weakness • Minor non-compliance with procedures/standards
Improvement	Items requiring no action but which may be of interest to management or which represent best practice advice	• Information for management • Control operating but not necessarily in accordance with best practice

grantthornton.co.uk

NHS LOTHIAN

CORPORATE MANAGEMENT TEAM

Minutes of the Corporate Management Team Meeting held at 8.30am on Tuesday 22 April 2025 in Meeting Room 10 West Port and on MS Teams.

Present: Caroline Hiscox (Chair), Jim Crombie, Tracey Gillies, Alison Macdonald, Dona Milne, Craig Marriott (from 8:40am), Morag Barrow, Colin Briggs, Michelle Carr (from 9:05am), Morag Campbell, Judith Mackay, TracyAnne Miller, Christine Laverty, Jenny Long, Tracey McKigen (from 8:45am), Tom Power, Fiona Wilson, Scott Garden and Heather Cameron.

In Attendance: Yvonne Lawton (for Alison White), Amanda Langsley (Items 15 & 16), Darren Thompson and [redacted] (Minute).

Apologies for absence were received from Alison White.

INTRODUCTION

The Chief Executive welcomed colleagues to the meeting.

1. Minutes of Previous Meeting – 8 April 2025

1.1 The minutes of the previous meeting held on 8 April 2025 were approved as a correct record.

2. Matters Arising & Action Note

2.1 The circulated Action Note and the position as outlined was noted.

DISCUSSION ITEMS

3. Chief Executive Update

3.1 The Chief Executive provided an update on meetings and other items of interest since the last CMT:

National Chief Executives Meeting - There had been discussion on links with NHS Lanarkshire around cancer performance and learning opportunities, NHS Academy training around diagnostics and endoscopy, the dental services review and levels of risk and inadequacy of service, business systems funding and draft operational business case, the development of a workplan to underpin collaboration, the timescales and concerns around the reduced working week implementation plans and the appointment of the Chief Executive as MSG chair.

NHS Executive Group Meeting - Key items discussed included the Health Board Collaboration and Leadership paper that had been shared with all Boards, the Operational Improvement Plan, removals from waiting lists, community glaucoma reporting, NSS finance and productivity and efficiency remained a significant focus. The Chief Executive would circulate further papers for information along with the framework for reform updated slide-deck.

CH

There had also been discussion on the Oncology Task and Finish Group which would now have a new focus and would be chaired by Dr Scott Davidson, Medical Director NHSGGC. The new focus would be a reset for how engagement would look nationally. There was an informal agreement for the same approach to be taken around Vascular but that Task and Finish Group remained ongoing at the moment.

CMT discussed the robustness of the membership of the oncology group and noted that the group's focus was oncology, not cancer services which was an important distinction to make. Scott Garden confirmed that he was sitting on the oncology group and part of the reframing was to ensure planning and general management representation on the group. The group was still forming and was scheduled to meet on 25 April.

4. Proposals for CMT Performance Reporting

4.1 CMT agreed to defer the performance item and have updates on the following instead:

Mental Health Performance

CMT noted that the REH/RIE ED situation remained challenging and discussed a recent situation where nine REH patients were waiting in RIE ED with the longest wait at eight days, which was clearly unacceptable. This patient had not been seen by a medic for six of these eight days and a Datix would be logged for this.

There has been ongoing work with staff and the establishment of a group to focus on this challenge. Six beds had been opened last week, as an extension to the REH rehabilitation unit which had reduced the pressure of the immediate issues and there had been meetings every day over the past weekend to get patients assessed. There was consensus that RIE ED was not where mental health patients should be sent.

CMT noted discussions with consultant colleagues and the appointment of a locum consultant who was starting today to help as part of easing pressure. There had also been a shift where the on-call consultant had attended RIE ED to assess patients there and had discharged two patients who did not need to go to REH. There would also be a discharge co-ordinator temporary post appointed to once partnership sign off was confirmed, which would assist with improved ownership of discharge.

CMT noted the effort and work that had been undertaken by REH and RIE ED teams, and the continued cooperation to address the challenge. The leadership input from Chief Officers was also appreciated. The need for a change to the discharge profile was recognised.

There was further discussion on the need to have more mature bed reporting and data constantly available around fundamentals such as escalation and flow and the requirement for an immediate action plan was acknowledged and would be taken forward through a weekly group meeting, chaired by the Chief Executive, which would start next week. The action plan would be reported back to CMT on an ongoing basis.

CB/AW/Chief Officers

Unscheduled Care Performance

CMT noted the month-on-month improvement around 4hr EAS, which was further detailed in the item 18.2 paper. The recent dive in performance, drop in daily discharge numbers and reduction in delayed discharges, was noted. There was discussion on the acute occupancy rate and a number of areas identified to improve the efficacy of the discharge process. There was also discussion on the daily target of 150 discharges, delivering this target consistently, the discharge profile, the directing of people to community capacity with partnership staff based in RIE, the effectiveness of PDD and the use of data to drive focus.

The Chief Executive added that performance would be focused on by CMT in a different way moving forward and would also bring in planned care.

5. Corporate Accommodation

5.1 CMT received an update on the current position with corporate accommodation. It was noted that Tom Power would be taking over the SRO function for this work and would have a handover meeting with Colin Briggs later today and would also catchup with TracyAnne Miller around staff support, communications and timings.

5.2 CMT noted that the Scottish Ministers decision around the NES position had been made in accordance with the new Property Controls – Guidance for Public Bodies (Government, 2025) published by the Scottish Government in February 2025.

5.3 Craig Marriott confirmed that moving forward there would be three specific workstreams:

- Understanding of time frames, how long this work takes and the NHSL West Port lease extension request with a note to go to the Director General.
- Refreshing of the Corporate Accommodation Business Case and options.
- Capital spend considerations.

5.4 CMT also discussed future staff briefings with further staff engagement sessions possible in early May following clarification around the extension request.

5.5 CMT endorsed the revised project parameters as set out, the broad approach to, and requirement for the development of a contingency plan for a potential West Port exit at the end of July 2025 and the revisiting of the previous business case.

6. Capital Prioritisation Panel Update

6.1 CMT were updated on the outcome of the recent capital prioritisation panel and proposed actions. There was discussion on the proposed shift in focus across the scored projects, the narrowing of space between category B and category A projects, the importance of getting the message across to Scottish Government that although there is support for projects such as PAEP to go ahead, this is actually the 5th ranked priority for NHSL in the immediate needs category. It is important but there are other high priorities such as HSDU and NTC.

6.2 CMT supported the named projects proposed to support initial reviews. CMT noted the outcomes of the Capital Prioritisation Panel held on 2nd April 2025, recognising the unchanged position in scoring, the required direction to review previous solutions and the identified projects for initial review, the identified infrastructure risks requiring contingency planning and the financial position for capital continuing to constrain capacity.

7. RAAC – Ward 1 Western General Hospital

7.1 CMT received an update on progress to address the presence of RAAC within the roof of Ward 1 at the WGH.

7.2 CMT noted that there was full engagement between Morag Campbell and the WGH Site Director. CMT recognised that this was a complex challenge and there was discussion on the required works, funding, decant, Aseptic suite modular unit plans and lead in time, structural complexities with the Clock Tower Building, the complete removal of RAAC against the do minimum option, appropriate clinical engagement, business continuity planning,

7.3 CMT agreed that further detail was required to address the concerns around timings, costings, sequencing and the feasibility of propositions. The Chief Executive requested that a site walkaround be arranged for herself and Morag Campbell.

MCam

7.4 CMT noted the ongoing work of the group chaired by the WGH Site Director, the ongoing engineering work on the Clock Tower structural supports which would report back to CMT, and endorsed the recommendations in the paper:

- A programme of surveys to monitor Ward 1 RAAC is initiated *(noted already in place)*
- Ward 1 decant planning and clinical engagement is commenced *(group chaired by WGH site director)*
- Engagement with Tier 1 contractor and Design Team to assess 'do minimum' options for Ward 1 RAAC *(will be part of options appraisal work)*
- Feasibility and investigation into the phasing of roofing works for Ward 15 *(will be undertaken by capital team as is capital project)*

8. Western General Hospital – CJD Surveillance Unit Building

8.1 CMT received the paper looking to progress on plans to acquire the CJD Surveillance Unit, on the grounds of the Western General Hospital, which is currently leased to, and operated by, the University of Edinburgh. CMT noted that the building was due to be vacated by the end of April 2025, with the University of Edinburgh requiring formal notice of NHS Lothian intentions to acquire.

8.2 CMT discussed the proposal as outlined noting the intention to use the space for RIDU and Blood Lab services.

8.3 CMT noted that an external specialist had been instructed to carry out a series of surveys of the building, in its current condition. It was recognised that upon receipt of the surveys a series of remedial works would be formulated, based on risk criticality, and presented through relevant governance. It was acknowledged that the facility is an aging modular style build and, as such, it was expected that a level of remediation would be required.

8.4 CMT agreed that without the outcome of these surveys, there was not enough information to support the paper's recommendation and the output of the surveys would be docked with CMT before a final decision was taken.

MCam

9. Astley Ainsley Steering Group Update

9.1 CMT noted the paper providing an update following the meeting of the Astley Ainslie Strategic Steering Group on 25 March. The paper set out anticipated tasks and timelines within four key activity stages that would determine the opportunities within the overall Masterplan. As previously noted in the update paper provided to CMT in November 2024, this would incur costs. The details of costings associated with the Site Disposal Strategy were noted in the paper.

10. NHS Lothian Month 12 2024/25 Financial Position

10.1 CMT noted that the final allocation from Scottish Government was awaited on 1 May before the accounts could be closed off and welcomed the news that a breakeven position would be delivered.

11. Adult Neurodevelopmental Services Baseline Audit and Lothian Service Response

11.1 CMT received the paper which set out NHS Lothian's consolidated response from the four HSCPs to the Scottish Government's national baseline survey on Adult Neurodevelopmental (ND) Services, due for submission by 30 April 2025. The paper also summarised current provision, referral pathways, staffing, and capacity across and highlighted key areas of variation and concern, particularly regarding access and waiting times.

11.2 CMT discussed the Lothian waiting list, number of assessments undertaken in the past six months, lack of dedicated funding and staffing across the four HSCPs, the variation in service models and support across Lothian, the referral threshold, the risks and needs and the opportunities for early intervention and support.

11.3 CMT noted the establishment of the Lothian ND Sub-Group in October 2024 which was working to determine demand with input from analytical services, NAIT and QMU. It was recognised that the sub-group had been set up to establish a baseline and to progress the work further, would require a refreshed/expanded membership, meeting more frequently than once a month.

11.4 CMT supported the pan-Lothian model and the work across the HSCPs on the submission. There was further discussion on appropriate thresholds for psychiatric assessment and best use of this scarce workforce resource.

11.5 CMT also discussed planned engagement with the GP Sub-Committee, the impact on waiting lists, the impact on children's ND pathways and the adult/children age cut off, constraints caused by lack of availability of suitable expertise, children's partnership engagement, support needed in the children's space, the approaches being taken by other Boards across Scotland, support for our own staff that may have a diagnosis, quality of diagnosis made outside of the NHS and taking a waiting list validation approach applying the proper validation principles.

11.6 CMT noted the findings from the baseline audit on adult ND services which could be submitted. It was agreed that there would be further collation of how to develop this work and this would be brought to the CMT Strategic Thinking Session on 30 May. This would be led by Colin Briggs with input from Chief Officers.

CB/Chief Officers

12. Innovation and Transformation Update

12.1 Item deferred to CMT on 6 May 2025.

13. Corporate Objectives

13.1 CMT noted that the Corporate Objectives had been discussed at the Board meeting last week and the Chief Executive and Colin Briggs would discuss adding the Board Assurance Framework as its own Corporate Objective, with input from the Board Secretary, as well as clarifying the children's objective before these are taken back through SPPC.

CH/CB/DT

14. Agenda for Change Reform - Reduced Working Week (RWW)

14.1 CMT discussed the planning work and the template as agreed with partnership in October last year. The magnitude of the challenges around reducing the workforce to 36hrs per week, was well recognised and the intention was to have all services' completed templates by the end of June so that an overall picture of the situation could be established. This was in line with the approach being taken by other Boards. The templates would be considered by the RWW Programme Board and then come back to CMT.

14.2 CMT noted that the implementation plan would go to Lothian Partnership Forum on 28 April for agreement and there remained a lot of workforce challenges and intricacies to work through. It was likely that there would be a nursing workforce paper coming to CMT in May, scoping out workforce implications.

14.3 CMT discussed the available funding for the RWW work and noted the reduction in the amount and the uncertainty around how long the Band 5 to 6 work would continue for. It was recognised that at the moment the situation remains unclear and it was important to process the templates, tie in with health and social care staffing legislation and support colleagues with completion of the templates. There was also potential tie in with the Board's Innovation and Transformation work and CMT noted that any feedback would go to the national group that had been set up, for which Tom Power was co-chair.

14.4 CMT noted the proposed planning approach for the implementation of the further reduction in the working week and took assurance that actions were being taken in line with the circular issued by the Scottish Government. CMT approved the proposed plan for the collection of the relevant data from service areas for further consideration.

15. Quarterly Mandatory & Appraisal Compliance Report

15.1 CMT noted the update on the status of mandatory training and appraisal compliance for NHS Lothian during Q4 – January to March 2025.

15.2 There was discussion on the current performance data and the following was recognised:

Appraisal Compliance - Overall, appraisal compliance had shown improvement across most directorates, with increases of up to 3% since the last quarter.
Facilities Core Mandatory Training - Compliance across the Facilities Directorate had dropped significantly, and there was ongoing work with Morag Campbell and facilities team to support the drive towards improved compliance.

Quarter 1 Report - The next report would reflect the changes in the move to TURAS from LearnPro, acknowledging that compliance data would need to be built up as this could not be transferred or synchronised between the systems.

15.3 There was also discussion on issues around TURAS access for care home staff. Amanda Langsley would pick this up with Fiona Wilson outside the meeting.

16. Menopause and Menstruation Policy – Lightweight Uniforms

16.1 CMT noted the update on the previous proposal to undertake a small pilot in West Lothian, to test the impact, benefits and consequences of supplying lightweight uniforms in line with the national Menopause and Menstruation Policy. It was noted that this pilot had been delayed following concerns raised at the Short Life Working Group.

16.2 CMT recognised the current NHSL position, including cost concerns and noted that the uniforms were available by request under NHS Scotland's Menopause and Menstrual Health Policy and that given that these uniforms were being routinely provided already by other Health Boards (NHS GGC and NHS Fife), the continued need for a pilot was questioned. It was noted that there had been no promotion of uniform availability with NHSL staff.

16.3 CMT agreed that the Chief Executive, Tom Power and TracyAnne Miller would meet to discuss the learning from and positions of other Boards and whether there was any continued benefit in undertaking a pilot as opposed just implementing the nationally agreed policy. Any procurement issues would be raised with Craig Marriott.

CH/TP/TAM

17. CMT Strategic Thinking Workshop 25th April 2025

17.1 CMT noted arrangements for the next workshop to be held on Friday 25 April, 9am-1pm, 1st Floor West Port, Room 3&4. The plan was to spend half the allocated session time on Prevention and half on Unscheduled Care.

ITEMS FOR APPROVAL OR NOTING (CONSENT AGENDA)

18. Items proposed for Approval or Noting without further discussion

18.1 **System Wide Bed Capacity Update –** CMT noted the number of beds reported across REAS, Acute and the four HSCPs and noted that a further update would be brought to CMT in May 2025. The REAS position would be updated to reflect earlier discussions around mental health and Alison MacDonald would pick this up with Alison White ahead of the next submission of this paper.

AMac/AW

18.2 **Unscheduled Care Improvement Programme -** CMT noted progress against the programme plan is as expected, the achievement of the March 2025 headline 4 Hr Emergency Access Standard (EAS) performance trajectory to date and the actions being taken to sustain and further improve this and the improved flow and patient safety measures which indicate the impact of the programme plan is beginning to evidence system improvements.

18.3 **Log of Scottish Government Letters -** The log of Scottish Government Letters was noted.

19. Any Other Competent Business

19.1 None.

20. Date of Next Meeting

Tuesday 6 May 2025, 8.30am.

NHS LOTHIAN

CORPORATE MANAGEMENT TEAM

Minutes of the Corporate Management Team Meeting held at 8.30am on Tuesday 06 May 2025 in Meeting Room 10 West Port and on MS Teams.

Present: Caroline Hiscox (Chair), Jim Crombie, Alison Macdonald, Craig Marriott (from 8:40am - until 11am), Colin Briggs, Michelle Carr, Morag Campbell (until 11am), Judith Mackay, TracyAnne Miller, Christine Laverty, Jenny Long, Tom Power, Alison White (from 8:40am), Fiona Wilson (until 11am), Scott Garden and Heather Cameron.

In Attendance: Grace Cowan (for Morag Barrow); Ashley Goodfellow (for Dona Milne); Eddie Doyle (for Tracey Gillies, until 10:30am); John Sturgeon (for Martin Egan); Mike Massaro-Mallinson, EHSCP Service Director, Operations (Items 5&6); Billie Flynn, Deputy Chief Nurse, EHSCP (Items 5&6); Andy Hall, Service Director – Strategic Planning Edinburgh HSCP (Items 5&6); Mike Reid, General Manager, REAS (Item 7); Mairi Simpson, Head of Workforce Development, Public Health (Item 8); Claire Ross, Chief AHP, Midlothian HSCP (Item 8); Fiona Ireland, Nurse Director, Corporate Nursing (Item 12); Ruth Kelly, Deputy Director of People & Culture (Items 12, 13 & 15); Laura Hutchinson, Equality, Diversity, Inclusion and Human Rights Lead (Item 15); Darren Thompson and [redacted] (Minute).

Apologies for absence were received from Tracey Gillies, Dona Milne, Tracey McKigen and Morag Barrow.

INTRODUCTION

The Chief Executive welcomed colleagues to the meeting.

1. Minutes of Previous Meeting – 22 April 2025

1.1 The minutes of the previous meeting held on 22 April 2025 were approved as a correct record.

2. Matters Arising & Action Note

The circulated Action Note was noted and updates were made to the actions marked as 'subject to delay.'

2.1 **RAAC – Ward 1 Western General Hospital - Engineering Work Output -** CMT noted that the Chief Executive walkaround had been undertaken on 25/04/25. A more detailed survey had been instructed on 30/04/25 and was now being undertaken. There was much more work to be done, there was discussion on alternative solutions for the Ward 1 decant, articulation of the risks, viability of the clocktower option and reprioritisation of funding arrangements. CMT recognised the timeline for completion of the Ward 1 work was 1 year and agreed that the risk associated with this work should now be formally captured. Craig Marriott and Morag Campbell would develop the articulation of the risk further and the funding associated, outside the meeting once the further survey report was completed and bring a further update back to CMT when appropriate.

CM/MCam

2.2 **CJD Building Survey Report -** CMT noted that the formal report from the contractor was still awaited but informal feedback provisionally suggested that the building may be suitable for NHS Lothian to use for next 5 years. Confirmation around electrical load and physical weight of equipment to be transferred in, was still expected but the risk for both these areas was seen as low. A formal recommendation would come back to CMT once the formal report was received.

MCam

DISCUSSION ITEMS

3. Chief Executive Update

3.1 CMT noted the future National Meeting Dates:

- 6th May: Board Chief Executive's Extraordinary Meeting re: Business Services OBC
- 13th/14th May: Board Chief Executives
- 29th May: NHS National Executive Leads Group

4. Proposals for CMT Performance Reporting

4.1 CMT discussed the Performance Snapshot and future reporting proposal, covering Unscheduled Care, Scheduled Care and Mental Health. It was noted that discussions with Scottish Government on available funding remained ongoing and therefore the revised trajectories were not yet available and the submitted Annual Delivery Plan trajectories remained extant.

4.2 There was discussion on recent interest from Non-Executive Director colleagues about the governance, management and validation of waiting lists and it was noted that there would be a focused discussion on waiting list management at the upcoming SPPC meeting, to provide Non-Executive Directors with assurance.

4.3 CMT agreed that a full Performance presentation, including updated trajectories, would be brought back by the Deputy Chief Executive on 3rd June 2025 and that in the meantime the extant Performance Framework would be recirculated to members for reference.

CGT

5. Liberton Hospital Reprovision

5.1 CMT examined and considered the implications of the planned moves off the Liberton site (in train with community capacity increasing to manage reductions in HBCCC and intermediate care beds).

5.2 There was discussion on loss of bed base, purchasing of private hospice beds and suitability of employers, staff governance, workforce organisation change, need for impact assessments, car parking, additional costs, weighting of options, benefits of having a joined up approach between clinicians and management, clinical leadership buy-in, mitigation of identified risks, hospice at home provision, and pharmacy input into the working group looking at hospice provision.

5.3 CMT noted the hard deadline to move off the site by December 2025. CMT agreed in principle to support the proposal to progress with moves of Intensive Older People's Service (IOPS) to Ellen's Glen, with a number of caveats , which would be addressed offline with the paper being updated. CMT acknowledged that the proposals would be going to Edinburgh Partnership Forum on 8 May 2025 and then the Edinburgh IJB meeting on 13 May 2025.

5.4 The updated proposal paper would come back to CMT to close the loop on areas that had been mitigated and would also describe programme management arrangements. CMT noted that this area remained escalated through PSOB.

6. Reform of Serious Mental Illness Pathway

6.1 CMT discussed the pathway paper, noting that a direction would follow to NHS Lothian regarding the closure of the REH 15 bed rehabilitation ward, once the proposal had been through the Edinburgh IJB meeting on 13th May.

6.2 The proposal had been supported by the Mental Health and Learning Disability Programme Board on 29th April 2025 and would be further discussed at the Edinburgh Partnership Forum on 8th May.

6.3 There was discussion on the specific cohort of individuals this pathway related to, the three-horizon approach being taken, concerns about losing beds from the REH site and optics around this, staffside awareness and staffing impacts, the need to work as an integrated system, and the availability of appropriate mental health evidence and data to support the proposed ambition.

6.4 CMT recognised that the proposal did support NHS Lothian's strategic direction and that the purchase of the Wheatley Care 19 highly supported accommodation beds was too good an opportunity to miss out on. However also recognised the risk in making decisions without the supporting data, but at the moment there seemed to be no alternative.

7. Actions to Achieve CAMHS LDP Standard

7.1 CMT discussed the actions identified to achieve the Child and Adolescent Mental Health Services (CAMHS) Waiting Times Local Delivery Plan (LDP) standard. CMT noted that a revised waiting list trajectory indicated that current capacity levels will not meet the December 2025 standard and that to meet the LDP standard by December 2025 on current assumptions, would require 127 additional new patient slots per month from March 2025, a 100% capacity increase.

7.2 The assumptions included:

- Current mean rate of additions to Tier 3
- Current CAMHS staff complement
- Proportion of total CAMHS staff deployed in Tier 3 services
- Current proportion of staff time dedicated to patient facing activity
- 'Length of stay' or new:follow up ratio
- That the clock is stopped at a treatment appointment which is weeks or months after an assessment

7.3 There was further discussion on workforce numbers, Choice appointment, clock-stopping and treatment starting. CMT recognised that for an early treatment start to be compliant with the standard the clinician must agree that the criteria in Child and Adolescent Mental Health Services Waiting Times Local Delivery Plan (LDP) standard definitions and scenarios are met. Standard Operating Procedures (SOPs) had been sought from Boards across Scotland. So far two had been received, one appears to offer a way to increase the number of compliant clock stops at Choice but not to stop routinely at Choice.

7.4 Workshops would be held throughout May to work with clinicians to identify ways in which meaningful treatment for young people can be brought forward which it is hoped would satisfy the LDP standard.

7.5 CMT requested that the Child Health Commissioner be involved and engaged with the Workshops and it was not clear why Families and Children would not be involved in the process until after completion of the clinician workshops. This would be picked up outside the meeting.

7.6 Once an SOP had been developed, after agreement at REAS SMT, it would be submitted to the Access and Compliance Assurance Committee as the appropriate governance route for sign off.

7.7 CMT noted the ongoing work alongside Scottish Government to improve performance against the LDP standard. Noted the actions identified to: reduce additions; deploy more staff in Tier 3 services or Tier 3 activity, increase face to face contact with CYP, review new:follow up ratio. Supported the intention to review local practice around treatment starts and the intention to develop new procedures and agreed the governance route for a revised SOP to increase treatment starts at Choice appointments, as outlined above at paragraph 7.6.

8. Healthy Weight and Type-2 Diabetes Prevention: Oversight Group

8.1 CMT agreed the proposal for senior oversight group with a focus on a system-wide, collaborative, and effective approach to healthy weight and obesity prevention throughout NHS Lothian. CMT requested that NHS Lothian own data be used for the framework development, as the Public Health Scotland data was already provided by NHS Lothian.

9. NHS Lothian Month 12 2024/25 Financial Position

9.1 CMT noted the achievement of financial balance by NHS Lothian, reporting a small underspend of £771k for 2024/25. CMT to also note the delivery of £60m of efficiency savings for 2024/25 and that all IJBs have achieve a balanced Health Position.

10. Structures & Processes Supporting Financial Governance & Performance

10.1 CMT endorsed the proposed changes to the Finance Oversight Board Terms of Reference, which aim to bring increased alignment between financial performance oversight and the wider system of performance in NHS Lothian and acknowledge the shifting role of FIG and the requirement for a dynamic approach to role of the group as Transformation and Strategic delivery plans are developed.

10.2 CMT also endorsed the ‘interim’ role of FIG in relation to oversight of schemes that have a service or system impact and the requirement for, and working draft of, an SOP for the decision making relating to schemes that have a service impact and/or are considered novel and contentious, as a mechanism for ensuring the organisation complies with relevant duties and responsibilities.

10.3 Tom Power and Craig Marriott would discuss the staff governance element with the SOP outside the meeting.

11. Resilience Planning Process Update

11.1 CMT approved the revised Framework and confirmed the final approval of the framework sits with the Board. CMT accepted that the NHS Lothian Framework provides assurance that the organisation is fulfilling its duties under the CCA and associated Regulations.

12. Nursing and Midwifery Vacancies

12.1 CMT agreed the way forward with 2025 recruitment of Newly Qualified Registered Nurses, and supported the recommendations in the paper, namely:

- that Business Units should approve and submit a RAF for all current and prospective Registered Nurse gaps.
- that the Generic Recruitment Team proceed to recruit to these positions making unconditional offers of employment to
  a) Specific Vacancies as currently available
  b) A Site / Partnership - with subsequent placement of these candidates to be co-ordinated as actual vacancies arise and RAFs are submitted through normal processes
  c) Over recruitment to support the estimated requirement to provide cover for the impact of the reduced working week as set out in table 3. These staff would be the recruits seeking the latest start dates (December to February).
  d) Consideration to the likely staffing requirements arising from HealthCheck work, particularly in mental health units.
- that Business Units consider any workforce requirements aligned to additional funding streams and to submit RAFs as early as possible to ensure supply.

12.2 CMT added that any emerging risks or changes should be reported to CMT as appropriate.

13. International Nurse Recruitment – Renewal of Visas and Certificates of Sponsorship

13.1 CMT approved the proposal as outlined in the paper, with the renewal of the Visas being the responsibility of the individual International Nurse, and the Certificates of Sponsorship being funded by NHS Lothian and cross charged out to the relevant service budget. The requirement for staff impacted to be given as much advance notice as possible of the requirement payment was acknowledged and work was underway to address this.

14. Innovation and Transformation Update

14.1 CMT noted the update and agreed that there would be further discussion on the 3 key priority areas identified in the paper, at the next meeting. CMT also noted that there would be a workshop held on 7th May, to look at submitted ideas and Innovation and Transformation was also on the SPPC agenda for discussion on 21st May.

15. Provision of Single Sex Services and Facilities

15.1 CMT noted the current position in relation to the Supreme Court judgment, the Equality and Human Rights Commission's (EHRC) interim update on the practical implications of the UK Supreme Court and the assessment set out in the paper and agreed the response as outlined in the paper, until such time as the EHRC updated Code of Practice was available.

15.2 CMT noted there would also be supportive communications issued along with communications for managers and that further information sessions for CMT and the Board were being considered.

16. Scheduled Care Plan 2025/26

16.1 CMT noted the update on the funding requested from Scottish Government to support delivery of Scheduled Care targets in 25/26 and the anticipated waiting times position in March 26 if fully funded. The support from Finance was also noted and it was hoped that correspondence from Scottish Government would be received later this week which would allow the trajectories to be reinstated into the Annual Delivery Plan.

ITEMS FOR APPROVAL OR NOTING (CONSENT AGENDA)

17. Items proposed for Approval or Noting without further discussion

17.1 **SPPC Draft Agenda 21/05/2025 –** CMT noted the proposed SPPC agenda as agreed with the Chief Executive and Board Chair.

17.2 **Princess Alexandra Eye Pavilion Update –** no update provided due to time constraints.

17.3 **Clinical Systems Programme Board - 6 monthly Minutes –** CMT noted the Clinical Systems Programme board aggregated minutes.

17.4 **Log of Scottish Government Letters -** The log of Scottish Government Letters was noted.

18. Any Other Competent Business

18.1 None.

19. Date of Next Meeting

Tuesday 20 May 2025, 8.30am.

NHS LOTHIAN

HEALTHCARE GOVENANCE COMMITTEE

CUMULATIVE ACTION NOTE

No.	Action	Point	Lead	Due date	Update
1.	It would be agreed when the next update on the Edinburgh Health and Social Care Partnership Bed Occupancy / Delayed Discharge risk mitigation plan would be brought to the Committee.	28/05/24 5.3.2	Tracey Gillies / Andrew Cogan	23/07/24	Completed. Discussed at the meeting on 19 November 2024.
2.	The outcome of the Cass report and any actions for NHS Lothian would be highlighted in the Board Committee Chairs' updates at the Board meeting following update from the Scottish Government. A further update on progress with the pathway for 17/18 year olds would be brought to the Committee.	28/05/24 10.1 19/11/24	Andrew Cogan / Tracey Gillies Tracey Gillies	23/07/24 28/01/25	An update report was discussed at the meeting on 19 November 2024. On agenda for the meeting on 28 January 2025.
3.	An update to be brought to the next meeting on the response to the national Infected Blood Inquiry recommendations, including blood tracking.	23/07/24 20.1.2	Tracey Gillies	19/11/24	A verbal update was given at the meeting on 19 November 2024. A full update on recommendations would be brought to the March or May 2025 meeting.
4.	A further update on the Edinburgh Health and Social Care Partnership Bed Occupancy Risk Mitigation Plan to be brought to the Committee.	19/11/24	Pat Togher	18/03/25	
5.	A further update on improvement work in Maternity Services would be brought to the Committee.	19/11/24	Michelle Carr	18/03/25	

HEALTHCARE GOVERNANCE COMMITTEE

Minutes of the meeting of the Healthcare Governance Committee held at 13.00 on Tuesday 28 January 2025 by video conference.

Present: Mr A. Cogan, Non-Executive Board Member (chair); Mr E. Balfour, Non-Executive Board Member; Mr A. Fleming, Non-Executive Board Member; Professor A. Khan, Non Executive Board Member; Mr P. Knight, Non-Executive Board Member.

In attendance: Ms E. Anderson, Associate Quality Improvement Advisor; Dr L. Bream, Associate Medical Director for Quality and Safety; Ms H. Cameron, Director of Allied Health Professionals; Ms J. Carmichael, Talent Management Programme (observing); Ms M. Carr, Chief Officer, Acute Services; Ms K. Clubb, Talent Management Programme (observing); Ms S. Davidson, Talent Management Programme (observing); Mr S. Garden, Director of Pharmacy; Ms J. Gillies, Associate Director of Quality; Ms T. Gillies, Medical Director; Ms S. Gossner, Chief Nurse, East Lothian Health and Social Care Partnership; Ms L. Graham, Talent Management Programme (observing); Ms L. Jess, Talent Management Programme (observing); Mr T. Logan, Talent Management Programme (observing); Ms L. Lynch, Talent Management Programme (observing); Ms G. McAuley, Associate Nurse Director, Acute Services; Ms E. McClure, Talent Management Programme (observing); Ms A. MacDonald, Executive Nurse Director; Ms T. McKigen, Service Director, Royal Edinburgh Hospital and Associated Services (item 63); Ms G. MacNaught, Talent Management Programme (observing); Ms J. McNulty, Associate Nurse Director; Ms D. Milne, Director of Public Health; Ms J. Morrison, Head of Patient Experience; Ms W. Parkinson, Talent Management Programme (observing); Ms M. Perez Botella, Director of Midwifery (item 64.2); [redacted] Committee Administrator (minutes); Ms K. Russell, Talent Management Programme (observing); Ms O. Prowse, Talent Management Programme (observing); Mr A. Short, Service Director, Women's and Children's Services (item 64.2); Ms T. Stewart, Talent Management Programme (observing); Ms F. Stratton, Chief Nurse, Midlothian Health and Social Care Partnership; Mr D. Thompson, Board Secretary; Dr C. Whitworth, Medical Director, Acute Services; Ms L. Yule, Chief Nurse, West Lothian Health and Social Care Partnership.

Apologies: Ms M. Carr, Chief Officer, Acute Services; Ms J. Clark, Partnership Representative; Professor C. Hiscox, Chief Executive; Mr M. Massaro-Mallinson, Service Director, Edinburgh Health and Social Care Partnership.

Chair's Welcome and Introductions

Mr Cogan 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.

60. Patient Story

60.1 A video was shown where a long term patient in the Craiglea Ward at the Royal Edinburgh Hospital talked about the activities and facilities available on the ward and the calm atmosphere and good staff support. Ms McKigen advised that refurbishment was needed in these areas where some patients would be resident

for the rest of their lives. There were some shared rooms and more shower facilities were needed. The Endowment fund had been used for some of these facilities in the past.

61. Committee Business

61.1 Minutes from Previous Meeting (19 November 2024)

61.1.1 The minutes from the meeting held on 19 November 2024 were approved as a correct record.

61.1.2 The cumulative action note would be updated following discussion at the meeting and would be circulated with the papers for the next meeting.

61.2 Revised Healthcare Governance Committee Terms of Reference

61.2.1 Ms J. Gillies presented the previously circulated paper. Members accepted the recommended change.

61.2.2 It was noted that it was standard that no business could be transacted if a meeting was not quorate.

61.2.3 The terms of reference required there to be an external member on the Committee. Several models to facilitate this had been previously tried, but there was not one currently in place. It was recognised that members of the public found it difficult to participate in discussions without background knowledge of the organisation and its services, and to add value to the Committee they must be able to contribute more than what was relevant to their own experiences as a patient. The most recent approach had been to have a small group of representatives who were supported to discuss specific papers and feed back at the meeting, but this had also had only variable success for both the representatives and the Committee. There had been feedback through the Communications Team and Patient Involvement Manager that a governance committee was not the best place to have meaningful patient and public input. It was agreed that this should be discussed further at the Healthcare Governance Committee workshop on 18 March 2025.

62. Emerging Issues

62.1 Ombudsman Report

62.1.1 Ms MacDonald advised that the Board had received an Ombudsman report following the death in October 2021 of a patient who had chronic illness and regular interventions both in hospital and in the community. A full report and action plan would be brought to the Committee following investigation. **AMcD**

63. Mental Health Assurance Report, including inpatient services, psychological therapies risk, specialist services

63.1 Ms McKigen presented the previously circulated paper. Mr Garden advised that in addition to what was included in the paper, work had been done over the past 18 months on improving governance of controlled drugs in prison including audits.

Actions from a safety and security review in 2023 were led by pharmacists including leadership walkrounds and improvements had been seen.

63.2 Ms McKigen advised that services run by the Royal Edinburgh Hospital and Associated Services directorate included delegated, non delegated and hosted services. All inpatient beds were delegated and provided on behalf of the Integration Joint Boards. These services were run by a Programme Board which included both Integration Joint Board and Royal Edinburgh Hospital representatives. The Child and Adolescent Mental Health Service was not delegated. Integration Joint Boards had oversight role over the Mental Health pathways.

63.3 High bed occupancy was driven by increasing numbers of admissions, issues with patient flow due to lack of sufficient services in the community, and a high acuity rate. Lothian had the second lowest bed base for the population and population increase meant an increase in admissions. Higher acuity and longer stays were being observed, but this was within the national average.

63.4 There was significant underspend in community health services. Work was now being undertaken modelling for community services and the cut off for going in and out of hospital. The Intensive Home Treatment Team could strengthen community provision and this team was being reviewed. Ms T. Gillies noted that that third sector mental health intervention could help with improving lifestyles to improve conditions, but enduring mental health conditions required medical and specialist support.

63.5 Ms McKigen advised that if a concern about safe staffing was raised, staff would be moved around to ensure all areas were safe. More long term work included improving care planning.

63.6 Ms McKigen advised that senior management teams were aware of problems in the Melville Unit prior to the Mental Welfare Commission report. This could perhaps have been shared more widely within the governance structure. The Mental Welfare Commission were content with the plans to spilt the Melville unit into two service areas in response to their recommendations. Ms T. Gillies also advised that the Corporate Management Team had discussed how the decision had initially been made to co-locate the Child and Adolescent Mental Health inpatient unit in the Children's Hospital and had found that this had been based on informal discussions but was not robust. An opportunity had been missed when the new Children's Hospital had opened to build up a unit that was better fit for purpose.

63.7 Moderate assurance was proposed in the paper, but members agreed to accept limited assurance overall because of the continuing risks in the Melville Unit and bed occupancy. There needed to be more steps shown with partners to reduce the bed occupancy rate. The improvement in the Melville Unit was recognised, but more work was needed on modelling and pathways. Ms McKigen advised that new systems and processes were in place which should lead to improvement in the near future. Ms McKigen was asked to present a further report within the next 3 months.

TMcK

63.8 Out of Area Placements Monitoring Team Annual Update

63.8.1 Ms McKigen presented the previously circulated paper. Significant assurance was proposed in the paper but although members noted that there was significant assurance on NHS Lothian's processes, moderate assurance was accepted on the basis that there could not be significant assurance of services run by external providers.

63.9 REAS Risk Assurance Reporting

63.9.1 Ms T. McKigen presented the previously circulated paper. The Scottish Government were now seeking a national solution for female high secure accommodation. Members accepted the recommendations laid out in the paper of limited for Royal Edinburgh Hospital bed occupancy, limited for female high secure accommodation, and moderate for low secure accommodation.

64. Safe Care

64.1 Gender Identity Services

64.1.1 Ms T. Gillies gave a verbal update. All clinical pathways in Children's Services for gender dysphoria had been reviewed and were in line with pathways in NHS England. There was also work to align these with other NHS Scotland Boards. This would be discussed at the Corporate Management Team meeting the following month.

64.1.2 Service delivery for under 18s at the Chalmer's Sexual Health Centre was stable. There had been good engagement with stakeholder groups on the clinical pathways. There were discussions in progress with the National Services Division regarding onward referral pathways for gender surgery.

64.1.3 It was believed that Chalmer's was the only clinic in the UK offering treatment to 17 year olds in the adult service; in other areas 17 year olds were treated in a children's service. Review of pathways showed that clinical governance was in place.

64.1.4 A further update would be provided at the next meeting. **TG**

64.2 Maternity Services update

64.2.1 Mr Short presented the previously circulated paper. It was noted that among other pieces of work LACAS was being set up in maternity as a way of ensuring that problems can be picked up sooner. All services, systems and processes available for clinical services were being used by maternity services, including training.

64.2.2 A review of the funded establishment workforce had been undertaken across all services as some establishment positions were no longer up to date due to changes in service. Maternity had been one of the areas where there was concern that what was now required by the service did not match the funded posts available. A proposal had been reviewed and agreed by the Corporate Management Team which would increase establishment and put the service in a better position.

64.2.3 Part of the safe staffing work being led by the Nurse Director for Acute Services included review of the lines of escalation where staff have concerns. Nurse directors meet daily, and no staffing concerns had been raised from Maternity, but it was noted that staff would become accustomed to the resources available and a proper review was needed to identify whether more was needed.

64.2.4 Ms Perez-Botella advised that staff are engaged and involved with the improvement work being done.

64.2.5 It was agreed that process issues for escalation of concerns for all services would be considered at the Healthcare Governance Committee workshop on 18 March 2025. A further update on Maternity services would be part of the Women's Services Annual Assurance Report in May 2025. **AS**

64.3 Patient Safety and Quality Annual Report

64.3.1 Ms Gillies presented the previously circulated paper. Ms J. Gillies advised that there was also information available on primary care improvement work, which would be included in the report next time.

64.3.2 It was requested that actions agreed at Non Executive Walk Rounds could be followed up and reported back as part of the Walk Round cycle.

64.3.3 Members accepted the recommendations laid out in the paper and accepted moderate assurance.

64.4 Hospital Standardised Mortality Rate Review final report

64.4.1 Ms T. Gillies presented the previously circulated paper and members accepted the report and noted that Standardised Mortality Rate across NHS Lothian was now below 1.00

65. Exception Reporting Only

Members noted the following previously circulated reports for information:

65.1 Tobacco Control Annual Report;
65.2 Tissue Governance Annual Report;
65.3 Scottish Trauma Audit Group Annual Report;
65.4 Resilience Annual Report;
65.5 Health Protection Team Annual Report;
65.6 Tissue Viability Annual Report.

66. Minutes of Management Meetings and Sub Committees

Members noted the previously circulated minutes from the following meetings:

66.1 Health and Safety Committee, 28 August 2024;
66.2 Clinical Management Group, 8 October 2024, 12 November 2024;
66.3 Policy Approval Group, 10 September 2024.

67. Corporate Risk Register

67.1 Ms T. Gillies presented the previously circulated paper. It was noted that the concerns raised in Maternity Services were not on the risk register but that a plan was underway and additional staffing had been agreed. A review of whether this should be on the risk register could be done following the update from the service in May 2025.

68. Reflections on the meeting

68.1 It was agreed that the chair would highlight in the Chair's updates section of the Board agenda that there had been comprehensive discussion of the Maternity services concerns and improvement plan, and would highlight the good assurance work done on the Hospital Standardised Mortality Rate review.

69. Date of Next Meeting

69.1 The next meeting of the Healthcare Governance Committee would take place at **1.00pm** on **Tuesday 18 March 2025** in **Meeting Room 10, First Floor, 102 West Port**, Edinburgh, EH3 9DN.

70. Further Meeting Dates

70.1 Meetings would take place on the following dates:
- 20 May 2025
- 22 July 2025
- 23 September 2025
- 21 October 2025
- 18 November 2025
- 27 January 2026
- 17 March 2026.

Signed by Chair
18 March 2025

NHS LOTHIAN

HEALTHCARE GOVENANCE COMMITTEE

CUMULATIVE ACTION NOTE

No.	Action	Point	Lead	Due date	Update
1.	A further update on progress with the pathway for 17/18 year olds would be brought to the Committee.	19/11/24	Tracey Gillies	28/01/25	A verbal update was provided at the meeting on 28 January 2025. Update on the agenda for meeting on 18 March 2025.
2.	An update to be brought to the next meeting on the response to the national Infected Blood Inquiry recommendations, including blood tracking.	23/07/24 20.1.2	Tracey Gillies	19/11/24	A verbal update was given at the meeting on 19 November 2024. A full update on recommendations would be brought to the March or May 2025 meeting. On agenda for the meeting on 18 March 2025.
3.	A further update on the Edinburgh Health and Social Care Partnership Bed Occupancy Risk Mitigation Plan to be brought to the Committee.	19/11/24	Christine Laverty	18/03/25	On agenda for meeting on 18 March 2025.
4.	A further update on improvement work in Maternity Services would be brought to the Committee.	19/11/24	Michelle Carr	18/03/25	Completed. An update was discussed at the meeting on 28 January 2025.
5.	Mental Health Services to update on areas of limited assurance before the annual service report in January 2026.	28/11/25	Tracey McKigen	22/05/25	
6.	Full ombudsman report and action plan on [redacted] would be brought to the Committee following investigation.	28/01/25 62.1.1	Alison MacDonald	22/05/25	
7.	A further Mental Health report on REAS bed occupancy risk and improvements in the Melville Unit would be brought to the meeting in May 2025.	28/01/25 63.7	Tracey McKigen	22/05/25	

Next Meeting: 18 March 2025