

Mr Macdonald
Convener
Health and Sport Committee
T3.60
Scottish Parliament
Edinburgh
EH99 1SP

Date 27 February 2018
Your Ref
Our Ref JMC/EV/CC
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Dear Mr Macdonald

NHS Forth Valley attendance at Health and Sport Committee – January 16th 2018

Thank you for your letter further to our attendance at the Health and Sport Committee on 16th January 2018. I would like to thank you and Committee members for affording us the opportunity to attend. I will deal with the issues you raise in turn.

Annual Reviews

You have asked what the other ‘tricky issue’ was that had been referred to. I can confirm that this was in respect of CAMHS performance, a topic considered separately in this response letter.

Annual reviews provide a useful opportunity for Health Boards to publicly review their achievements and challenges over the year, whilst providing evidence to chart progress or actions being taken to ensure best value and ongoing improvement against Government set standards and/or targets.

Action points from Annual Reviews are usually informed by performance against these set standards and/or targets which can often relate to waiting times or finance. Action points form part of the Ministerial letter to the Chair of the Health Board and as such are actively followed up and scrutinised on a regular basis. In NHS Forth Valley all points raised over recent years form part of our Balanced Scorecard and are considered at many levels in the organisation to ensure remedial action is taken where necessary.

Staphylococcus Aureus Bacteraemia (SAB)

You have requested further information around our work to tackle the SAB target and in particular raise the issue of community acquired SABs.

As you know the SAB rate is one indicator amongst a “basket” of measures which we use to assess our Healthcare Acquired Infection (HAI) performance. Despite a consistently high performance against all other published HAI measures it has proved difficult to achieve or maintain a SAB “rate” below the published target.

We have investigated this locally in some detail as we have been determined to try and improve this indicator. During the meeting we described at some length the difference between the actual numbers of cases we observe in our hospital compared with the published rate calculated by Health Protection Scotland (HPS) and used to draw comparisons between Health Boards.

To calculate the rate of SABs, the total number of positive microbiological test results reported by our diagnostic laboratory is divided by the total number of Acute Occupied Bed Days (AOBD) in our local health service. NHS Forth Valley, despite achieving “pretty spectacular results” in reduction of actual hospital infections (we have delivered a 34% reduction in actual cases of SAB infection between 2014 and 2017, and over the past year have seen a reduction in average actual number of SABs from 2.7 per month to 1.8 per month) there is no change in the figures published nationally and reported to Scottish Ministers as during the reporting period reviewed our AOBDs also decreased with the closure of additional winter capacity.

HPS published summary data is further complicated by the inclusion of the community acquired SAB cases. When the rate was devised as an indicator of HAI the belief was that almost all diagnosed SAB cases were acquired in Healthcare settings. Local data shows that in Forth Valley there are now so few hospital cases that the majority of SAB cases are Community Acquired and have no relation to occupied bed days or to quality of patient care. We believe these cases should no longer be included in the published rate.

This use of AOBDs in calculating the rate also accounts for the incorrect observation that Forth Valley has higher SAB numbers than other “areas with high levels of drug users”. NHS Forth Valley has a very small number of Community SAB cases but again dividing community cases by Acute Occupied Bed Days produces a misleading picture. Dividing the number of community SAB cases by the actual size of the community reveals a very different picture where NHS Forth Valley has a lower SAB rate per head of population when compared with other Health Boards.

To date, NHS Forth Valley has followed an assertive policy of applying the “sepsis 6” bundle to all admissions with pyrexia to diagnose and treat sepsis. This has substantially increased the number of blood culture tests performed (in line with best practice) and

therefore the number of community SABs detected. Despite the challenges in data reporting described above NHS Forth Valley remains committed to driving down the levels of SAB cases. Our Hospital Infection Control team individually investigates each identified SAB case in search of further effective prevention measures. Levels of SABs within the hospital are very low with individual wards going many months between cases. In order to try and further understand the remaining cases we now also investigate every Device Associated Infection whatever the organism as we strive to identify further causes and control measures.

Local initiatives which we are currently delivering include the use of insertion and maintenance bundles for **peripheral venous cannula** (PVC). PVC present a risk for SAB during insertion and as long as they remain in place and Angela Wallace described in her evidence how it is now unusual to see patients in our wards with a PVC in place. Insertion and maintenance bundles for urinary catheters (again we are striving to reduce risk by reducing the use of catheters and the time they remain in place) and also insertion and maintenance bundles for long lines such as central venous catheters. In the community we are continuing to work with our local Alcohol and Drug Partnership to deliver safe injecting information and promotion of clean needle exchange. All of the above measures will continue to drive down the actual number of SAB cases in Forth Valley.

Child and Adolescent Mental Health Services (CAMHS)

Performance

You highlight that the Committee would welcome further detail on how the effect of “a 10 or 12% difference in staffing levels” could result in the dramatic reduction in service delivery and why it will take until June to rectify.”

We remain disappointed that having achieved and sustained the 90% CAMHS LDP Standard for 9 consecutive months our compliance dropped from 95% in June 2017 to 75% in July 2017 and 57% in August 2017. Performance has remained consistent around 50-60% since August to date.

This deterioration is due to a number of factors. In March 2017 the Service received 232 referrals - the highest number ever within a single month, the average referral rate at that time being 156 per month. To meet the Referral Treatment Time (RTT) standard these young people required to be seen in July 2017 which coincided with a number of vacancies, and an increase in long term sickness absence. The service has experienced further increased activity demands.

Staffing Capacity Priorities

At the time, with reduced staffing, decisions were made regarding staffing priorities. It was felt important, from a clinical care perspective, that the treatment pathway for young people already in the Service was maintained. Therefore existing staff, as well as any new staff capacity, was prioritised to continue treatment pathways. It was felt that creating long internal waits and delaying treatment by prioritising new patients, over existing patients was not appropriate and may also lead to longer episodes of treatment for the young person, which in turn would increase the waiting list even further.

T3/T4 Provision

Forth Valley CAMHS has also experienced an increase in the presentation of children and young people with severe psychiatric disorders requiring intensive T3/T4 provision. In July 2017 the CAMHS service was supporting 5 young people in hospital with a further 5 young people receiving intensive supports. Both of these care groups require different interventions and treatment. Those young people being treated in the community required the redirection of staffing capacity to provide intensive provision to avoid admission. In the absence of a T4 or intensive service, Forth Valley CAMHS required to redirect and prioritise multi disciplinary provision to meet the needs of this group. Following a service review and redesign the Service intends to implement an Intensive CAMH service from April 2018. This direction further supports the care pathways of children most at risk, and brings us in line with other CAMHS teams in Scotland.

Recruitment

Recruitment has been challenging and with significant additional NHS Board funds it has created a very competitive recruiting environment as NHS Boards compete to appoint to new and vacant posts.

In early July 2017, the NHS Board produced a Workforce Retention & Planning Proposal in response to performance data anticipating a decline in performance against the LDP Standard from July onwards. This proposal was aimed at retaining existing experienced staff but also to support supervision structure and mentoring etc. As part of that plan the NHS Board approved making 5 fixed term child psychology posts substantive. These posts were previously funded year on year by NES and one of the Local Authorities.

In October 2017 the NHS Board identified funding for 4 further substantive new posts (2 child nursing and 2 child psychology), to increase resilience within the CAMHS workforce. The service is recruiting to these posts and with the new staff coming into post and staff returning from long term sick leave and maternity leave by June, it is anticipated that there

will be a gradual increase in performance against the LDP standard and the service anticipates achieving the 90% RTT during 2018.

In addition, it is my intention to hold a mental health event in the Spring involving users of our service, Local Authority and Integration Joint Board members and wider Community Planning Partners including the Third sector to jointly review our service and the community assets at our disposal to co-create how we enhance our prevention and early intervention investment as well as timely access to services that take account of people's physical as well as mental wellbeing.

I have also agreed separately with the Minister for Mental Health to produce a comprehensive plan that articulates how we will deliver fully integrated mental health service with partners that takes account of local, regional and national resources to manage acuity and respond to need in line with standards set.

Delayed Discharges

In respect of delayed discharges, you have requested clarity on the roughly 50:50 split I referred to and I can confirm this was in relation to the figures I reviewed from the 11th January when there were 33 standards delays and 26 guardianship and code 9 delays. In terms of target delivery, both local Partnerships remain focused on delivery of the targets with a range of measures in place which were described to the Committee. I made particular reference to Forth Valley's track record of integration and in a meeting which I called recently involving Local Authority Chief Executives and our Chief Officers the commitment to working together to further support integration was strongly evident. This level of joint working will continue to support improvement in performance in this key area.

Cost confirmation requested is as follows:

- Acute Care (FVRH) the cost is £350 for Ageing and Health and £481 for General Medical.
- Community Hospitals costs range from £230 to £297 depending on the clinical specialty.

In terms of the care home Moratorium discussed, I can confirm the facility referred to was subject to a Large Scale Investigation led by Stirling Council last year. It is a 60 bedded care home based in the Stirling Council area caring for older adults and people with dementia. Stirling Council, at the time of the investigation, had 52 older adults placed within the home.

Regular updates on the care home both in terms of the protection of vulnerable adults and the considerable pressure the Moratorium had on the number of care home places in the Stirling Council area and therefore across the Health and Social Care Partnership were provided to the Integration Joint Board in their oversight role.

The outcome of the investigation focused on recommendations surrounding management, culture, staffing and training amongst other areas of practice concerns. Families have been engaged in the process meeting all agencies involved with a clear action plan for the home which is being monitored regularly. It is noted that this is the third large scale inquiry of this home in five years. Lessons therefore need to be learnt from previous investigations and agreed actions.

Stirling Council as part of the Clackmannanshire and Stirling Health and Social Care Partnership facilitates quarterly forums for care homes where best practice, shared learning and developments can be discussed together. In addition, Stirling Council agreed as part of this investigation to host a workshop to review internal monitoring and review processes with care homes for older adults, with focus on working to prevent large scale investigations.

Integration changes

As someone who has worked in a variety of integration roles prior to and whilst a Chief Executive in Orkney (internal and external audit reports publicly available highlighted a proactive attitude towards integration, I also held the post of Director of Orkney Health & Care with Orkney Islands Council whilst being Chief Executive of NHS Orkney) I can assure the Committee that both my Chief Officers will be full members of my management team and supported by me and empowered to fulfil their roles.

Since taking up post I have in working with each of the Local Authorities and Integration Authorities confirmed my commitment to delegate further operational management responsibility by April 2018 to each of the Health & Social Care Partnerships. This responsibility builds on the budgets already devolved since 2016 in line with the legislation and the operational management responsibility for both community mental health and learning disability services to the health and social care partnerships in February 2017.

In order to implement my commitment I invited Local Authority Chief Executives and our Chief Officers to a meeting on the 16 February to present my intentions to further delegate operational management arrangements to Partnerships in the new financial year, however it was felt that April was too soon and a September 2018 date was agreed. In the

meantime much work is going on to inform this delegation including aligning up to 600 WTE staff to our agreed locality model across both Partnerships. Phase 2 (lead partnerships/hosting arrangements) will run in parallel with implementation at a later date in 2018. Like our Local Authority partners we are also in the process of agreeing budgets which include the agreed set aside services and corresponding set aside budgets as detailed in the Integration Schemes for both partnerships and updated throughout the year and reported to both Integration Joint Boards on a monthly basis.

Health Inequalities

As detailed in your letter, one of the core priorities the Committee have set relates to health inequalities and you are requesting detail about the progress we are making to reduce this as set out in our 2016-2021 strategy.

NHS Forth Valley is focussing on mitigating the effects of social inequalities and their effects on health. Whilst there are some individual actions which the NHS can deliver in isolation such as targeted smoking cessation advice, targeted immunisation programmes, screening programmes and alcohol brief interventions the main opportunities to alleviate social inequalities and their health consequences lie in partnership work with our Community Planning Partners and Alcohol and Drug Partnerships for example.

“A Thriving Forth Valley” 2017-2021, our NHS Health Improvement Strategy was approved by the Health Board in 2017. This Strategy uses evidence from systematic reviews of the return on investment from public health interventions together with current policy and local consultation to establish five clear local priorities to tackle inequalities and enable our communities to live healthier lives. The Strategy has a particular focus on breaking inter generational cycles of deprivation and poverty through five strategic themes, children and early years, mental health and wellbeing, worthwhile work, the effects of substance misuse on individuals and families and population wide health improvement programmes.

The Health Board to date has also worked closely with our three Local Authority partners in the development of Local Outcomes Improvement Plans (LOIP) and whilst each LOIP has a distinct local influence the overall approach is consistent with the themes in “A Thriving Forth Valley”. Each LOIP has a detailed Action Plan and a set of agreed progress measures which are regularly reviewed by the leadership team of the respective Partnership. Local measures of particular interest amongst this wide basket of measures are childhood poverty, positive destinations after school and average income. It is my

intention to play a key role in community planning across all three Local Authorities to ensure we continue to improve the lives of the people of Forth Valley.

Wider Scottish Government Programmes delivered within Forth Valley are monitored through a range of performance measurement arrangements linked to the National Performance Framework as set out in Appendix 4 and 5 of A Thriving Forth Valley. Substance misuse activity and recovery orientated systems of care are monitored through the Alcohol and Drug Partnership whilst Alcohol Brief Interventions and Smoking Cessation are reported through the relevant NHS HEAT target. Immunisation Performance is monitored through nationally reported data as is the delivery of national screening programmes and both these activities include measures of deprivation and inequality.

The [Scottish Public Health Observatory \(ScotPHO\)](#) collaboration is led by ISD Scotland and NHS Health Scotland, and includes the Glasgow Centre for Population Health, National Records of Scotland and Health Protection Scotland. The Observatory publishes locality profiles and other relevant data which we also use to evaluate progress on wider health inequalities.

The Director of Public Health published an independent Annual Report on the Health of the Population of Forth Valley 2013-2015 and it is anticipated that the next Report, covering the period 2016-2018, will be published later this year.

Waiting Times

You are requesting further information in respect of the 12 week outpatient waiting time and the referral to treatment time standards. You rightly point out there are a number of specialties currently not meeting the standards and I along with my Team are working to develop our Annual Operational Plan for 2018/2019 which will outline our trajectories and actions to support improvement across a number of specialties notably orthopaedics. This Plan will be subject to robust scrutiny to ensure we deliver ongoing improvement.

In regard to performance to December 2017 NHS Forth Valley treated 85.1% of patients within 18 weeks of referral. In respect of the 12 week standard 79.3% of NHS Forth Valley patients were waiting within the standard. I appreciate that we are not meeting the standards yet but can assure Committee members that we are looking at ways to enhance our performance internally and with our regional colleagues in a number of specialties. In addition, we have seen a 12% increase in trauma related attendance and admissions during the past year which has had a resultant impact on capacity to manage the elective

orthopaedic programme. Despite this however, in December 2017, orthopaedics services had better performance for the admitted pathway than the peer specialty national average.

Prison Complaints

You requested clarity on why there is a differential in timescale for response to prison complaints versus non prison complaints. I can confirm that prison complaints are generally straight forward, often relating to an issue of drug administration or a change to a prescription on transfer. Alternatively they can be about waiting times for a particular service which again is a straight forward response. Due to the non complex nature of complaints they are now mostly dealt with under Stage 1 of the new Complaints Handling Procedure at local level within the prison. If requiring Stage 2 intervention, prisoners have the option to address issues to the Patient Relations Department.

I trust this information provides sufficient detail however please let me know if there is anything further required.

Yours sincerely

A handwritten signature in blue ink that reads 'Cathie Cowan' with a long horizontal flourish extending to the right.

Cathie Cowan
Chief Executive