LOTHIAN NHS BOARD

BOARD MEETING

DATE: WEDNESDAY 23 MARCH 2011

TIME: 9:30 A.M.

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

Members are reminded that they should declare any financial and non-financial interests they have in the items of business for consideration, identifying the relevant agenda item and the nature of their interest.

AGENDA

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<th>Agenda Item</th>
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<td>Welcome to Members of the Public and the Press</td>
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<td>Apologies for Absence</td>
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<tr>
<td>1. Minutes of the Previous Meeting of Lothian NHS Board held on 26 January 2011</td>
<td>CJW *</td>
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<tr>
<td>2. Matters Arising</td>
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<td>3. Committee Minutes for Adoption (Indicative Timing 9:40 - 10:00 a.m.)</td>
<td>PM</td>
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<tr>
<td>3.1. Area Clinical Forum - Minutes of the Meeting held on 3 February 2011</td>
<td>PM *</td>
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<td>3.2. Audit Committee - Minutes of the Meeting held on 8 February 2011</td>
<td>SGR *</td>
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<td>3.3. Finance &amp; Performance Review Committee - Minutes of the Meeting held on 12 January and 9 February 2011</td>
<td>GW *</td>
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<td>3.4. Healthcare Governance &amp; Risk Management Committee - Minutes of the Meeting held on 1 February 2011</td>
<td>PM *</td>
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<tr>
<td>3.5. Primary &amp; Community Partnership Committee - Minutes of the Meetings held on 19 January and 9 March 2011</td>
<td>RB *</td>
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<tr>
<td>3.6. Service Redesign Committee - Minutes of the Meeting held on 21 February 2011</td>
<td>JI *</td>
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* = paper attached
# = paper to follow
v = verbal report
3.7. Staff Governance Committee - Minutes of the Meeting held on 22 December 2010  
3.8. East Lothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 14 December 2010  
3.9. Edinburgh Community Health Partnership Sub-Committee Minutes of the Meeting held on 2 February 2011  
3.10. Midlothian Community Health Partnership Sub-Committee Minutes of the Meetings held on 25 November 2010 & 27 January 2011  
3.11. West Lothian Community Health and Care Partnership Board - Minutes of the Meeting held on 18 January 2011  

4. Chairman's Report  
5. Chief Executive's Report  
6. Quality Improvement (*Indicative Timing 10:10 - 10:30 a.m.*)  
6.1. Quality Improvement Report  
7. Policy (*Indicative Timing 10:30 - 11:00 a.m.*)  
8. Performance Management (*Indicative Timing 11:00 a.m. - 12:30 p.m.*)  
8.1. Financial Position to 31 January 2011  
8.2. Financial Plan 2011/2012  
8.3. Delivering Waiting Times  
8.4. Tackling Delayed Discharge  
8.5. Healthcare Associated Infection  

**LUNCH 12:30 p.m.**  
9. Other Items (*Indicative Timing 1:00 - 2:30 p.m.*)  
9.1. Future Delivery of Public Services  
9.2. NHS Lothian Response to the Formal Inquiry into Human Trafficking  
9.3. Self Directed Support (Scotland) Bill Consultation  
9.5. Appointment of Pharmacy Practices Committee Members  
9.6. General Pharmaceutical Services (Community Pharmacy) Revised Hours of Service Scheme  
9.7. Committees and Terms of Reference  
9.8. South East Scotland Research Ethics Committees Membership  

10. Liver Services - Presentation by Alistair MacGilchrist  
11. Communications Received  

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<th>Number</th>
<th>Description</th>
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<td>3.7</td>
<td>Staff Governance Committee</td>
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<td>3.8</td>
<td>East Lothian Community Health Partnership Sub-Committee</td>
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<td>3.9</td>
<td>Edinburgh Community Health Partnership Sub-Committee</td>
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<td>3.10</td>
<td>Midlothian Community Health Partnership Sub-Committee</td>
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<td>West Lothian Community Health and Care Partnership Board</td>
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<td>4</td>
<td>Chairman's Report</td>
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<td>5</td>
<td>Chief Executive's Report</td>
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<td>Quality Improvement</td>
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<td>Communications Received</td>
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12. Date, Time and Venue of Next Meeting: Wednesday 25 May 2011 at 9:30 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

13. Resolution to take items in closed session

Dates of Meetings in 2011:

<table>
<thead>
<tr>
<th>Board Meetings</th>
<th>Development Days</th>
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<tr>
<td>25 May 2011</td>
<td>27 April 2011 #</td>
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<td>22 June 2011*</td>
<td>22 June 2011 #</td>
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<tr>
<td>27 July 2011</td>
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<tr>
<td>28 September 2011</td>
<td>25/26 October 2011 #</td>
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<td>23 November 2011</td>
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* Special meeting to consider the Annual Accounts

# Trustees Meeting preceding Board Away Day
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<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Due Date</th>
<th>Action Taken</th>
<th>Outcome</th>
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<tr>
<td><strong>Mid Year Financial Review 2010/11 (26 January 2011)</strong></td>
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<td>• Activity section to re-appear in future iterations of the Board report.</td>
<td>SG</td>
<td>Ongoing</td>
<td>Agreed. Activity will be from the February 2011 Finance Report.</td>
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<td><strong>Delivering Waiting Times (26 January 2011)</strong></td>
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<td>• Provide Mr Anderson with details of costs around fractured neck of femur.</td>
<td>AMcM</td>
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<td>Actioned</td>
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<td>• Circulate the most recent position in respect of mental health waiting times and the immediate response available through the intensive care team, with a breakdown by category of response rates, if available.</td>
<td>AMcM</td>
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<td>Actioned</td>
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<td><strong>Tackling Delayed Discharge (26 January 2011)</strong></td>
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<td>• Provide details on how many guardianship orders are outstanding and how many are awaiting legal aid.</td>
<td>AMcM</td>
<td>March 2011</td>
<td>Brief prepared and emailed to Councillor Edie.</td>
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<td><strong>Royal Hospital for Sick Children and Department of Clinical Neurosciences Update (26 January 2011)</strong></td>
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<td>• Bring a more detailed update report to the March Private session meeting.</td>
<td>SG</td>
<td>March 2011</td>
<td>Update report to 23 March Private meeting.</td>
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Minutes of the Meeting of Lothian NHS Board held at 10.15am on Wednesday, 26 January 2011 in the Islay Room, Gillies Centre, 100 Strathearn Road, Edinburgh.

Executive Directors: Professor J J Barbour (Chief Executive); Mr A Boyter (Director of Human Resources and Organisational Development); Dr D Farquharson (Medical Director); Mr M Grieve (Representing Mrs J K Sansbury, Chief Operating Officer); Mrs S Goldsmith (Director of Finance); Mrs M Hornett (Nurse Director); Dr A K McCallum (Director of Public Health and Health Policy) and Professor A McMahon (Acting Director of Strategic Planning and Modernisation).

Non-Executive Directors: Dr C J Winstanley (Chair); Mrs S Allan; Councillor J Aitchison; Mr R Y Anderson; Councillor J Bell; Mr R Burley; Mrs T M Douglas; Mr E Egan (Vice-Chair); Councillor P Edie (From 10.55am); Professor J Iredale; Mr P Johnston; Professor P Murray; Mrs J McDowell; Mr B Peacock; Mr S G Renwick; Dr A Tierney; Mr G Walker; Mr I Whyte (from 12.06pm) and Dr R Williams.

In Attendance: Mrs S Lloyd (Shadowing Mr Egan, Vice-Chair); Mr E Morrison (Shadowing Professor Murray); Dr S Smith (For Item 121); Ms J A Stirton and Mr D Weir.

Apologies for absence were received from Councillor J Cochrane, Professor M Prowse and Mrs J K Sansbury.

Declaration of Financial and Non-Financial Interest

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

Chair’s Opening Comments

The Chair thanked Mr Anderson and the Edinburgh CHP (Community Health Partnership) for the informative presentation they had provided to the open public session which had been held immediately prior to the formal Board meeting.

The Board noted that Mr David Small the former General Manager of the Edinburgh CHP had taken up a new post as the General Manager for the East and Midlothian CHP and that Mr Robert Aitken had been appointed as the Acting CHP General Manager for Edinburgh.

The Chair welcomed Mrs S Lloyd, who was shadowing the Vice-Chair and Mr E Morrison, who was shadowing Professor Murray to the meeting. He also welcomed Dr David Farquharson to his first formal Board meeting as Interim Medical Director. The Chair further
welcomed Mr M Grieve, Director of Delivery, University Hospitals Division, who was representing Mrs J K Sansbury, Chief Operating Officer at this meeting.

The Chair advised that this would be Ms Stirton’s last Board meeting and commented that she had played a key role in the Board since he had taken up appointment. He advised that MSPs at a recent meeting had eulogised over Ms Stirton’s work and had expressed their sorrow that she was leaving the organisation. The Chair, on behalf of the Board, wished Ms Stirton well in her new role.

The Chair advised that a special meeting of the Trustees would be held immediately following the Board meeting.

The Chair welcomed the public and press to the meeting.

106. Minutes of the Previous Meeting of Lothian NHS Board held on 24 November 2010

106.1 The Minutes of the Lothian NHS Board meeting held on 24 November 2010 were approved as a correct record.

107. Matters Arising

107.1 Delayed Discharges Long Waits – Professor McMahon advised a report had been provided to the Finance and Performance Review Committee advising of progress in respect of resolving the longest waiting delayed discharge patients. He advised a further updated would be provided under the delayed discharge paper, which was scheduled to be considered later on the agenda.

108. Committee Minutes for Adoption

108.1 Area Clinical Forum – Minutes of the Meeting held on 25 November 2010 – the Board adopted the Minutes.

108.2 Audit Committee – Minutes of the Meeting held on 6 December 2010 – the Board adopted the Minutes.

108.3 Mutuality and Equality Governance Committee – Minutes of the Meetings held on 7 July and 13 October 2010 – the Board adopted the Minutes.

108.4 Finance and Performance Review Committee – Minutes of the Meeting held on 28 October 2010 – The Board adopted the Minutes. Mrs Douglas sought an update in respect of the cost of translation services. Mrs Hornett advised additional work was underway with robust debates taking place about what would be translated, as well as anticipated costs and possible future funding options. Mr Walker reported a further meeting of the Finance and Performance Review Committee (FPRC) had been held on 12 January 2011 to discuss the Royal Hospital for Sick Children (RHSC) and Department of Clinical Neurosciences (DCN) moving forward post the Scottish Government’s announcement on funding decisions.
108.5 Service Redesign Committee – Minutes of the Meeting held on 13 December 2010 – the Board adopted the Minutes.

108.6 East Lothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 28 October 2010 – the Board adopted the Minutes.

108.7 Edinburgh Community Health Partnership Sub-Committee – Minutes of the Meeting held on 14 October 2010 – the Board adopted the Minutes. Mr Anderson advised that the Sub-Committee should have met in December but this meeting had been cancelled due to weather conditions. He highlighted the significant contribution made by public partnership forum colleagues.

108.8 Midlothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 30 September – the Board adopted the Minutes. The Vice-Chair advised Mr G Power. General Manager of the East and Midlothian CHP had taken up a secondment to the Scottish Government Health Department and he wished to record his appreciation for his efforts within the CHP. The Vice-Chair advised the Midlothian Community Hospital was settling down with there being increases in bed occupancy, and he would wish to thank the Board for its investment in this facility.

108.9 West Lothian Community Health and Care Partnership Sub-Committee – Minutes of the Meeting held on 11 November 2010 – the Board adopted the Minutes.

108.10 The Chair reminded Board members that discussion of the Committee Minutes represented an important part of the Board’s governance process and represented an opportunity for the Board to hold Committee’s to account.

109. Chair's Report

109.1 The Chair updated the Board on a number of internal visits he had undertaken since the previous Board meeting. In respect of external visits, as part of liaison with the Army, he had met with the new Commander of the Scottish Brigade. The Chair advised that Dr Farquharson would lead work to put in place contracts with the military with a focus on specialist services at Veteran’s First Point, LEAP and in rehabilitation.

109.2 The Chair advised that on 9 December he had attended the Edinburgh Partnership Away Day, which comprised of representatives of the Council, Police, Fire, health and the voluntary sector. He was pleased to note that the City of Edinburgh Council was working in close collaboration with partners around efficiencies.

110. Chief Executive's Report

110.1 The Chief Executive advised that the thrust of his report was of consistent celebration of the commitment and achievements of staff, starting with extraordinary performance during the height of the worst weather in 40 years. He provided illustrative examples of performance of individuals and groups of staff whilst stressing this was only reflective of the broader commitment demonstrated. The
Chief Executive commented staff actions had been celebrated through the website, staff newspapers and on an individual basis and he felt it was important the Board recorded its appreciation for commitment above and beyond the call of duty. Ms Stirton undertook to ensure the Board’s appreciation was shared appropriately with staff.

110.2 The Chief Executive reported NHS Lothian staff had also been recognised by external organisations for their efforts and provided the Board with details, advising this was an important part of the process taking NHS Lothian towards its goal of being one of the world’s top 25 health providers.

110.3 The Chief Executive commented in respect of GP extended opening hours that the uptake position had improved from 32% in June 2008 to 70% in November 2010 and this reflected well on the commitment and enthusiasm of local GP colleagues.

110.4 Dr Williams reminded the Board that extended hours, in his view, had been introduced largely to benefit patients who commuted and were unable to attend during normal hours. He advised in some practices there had not been sufficient patient uptake, as evidenced by patient surveys, to make it viable in all instances.

110.5 Mr Anderson agreed it was important the Board recognised the efforts of staff during the inclement weather. He wished to personally thank Ms Stirton for her assistance to him as a Non-Executive Director and former Chair of the West Lothian CHP and current Chair of the Edinburgh CHP. In particular, he found the Board briefs to be useful. These sentiments were echoed by other Board members.

110.6 Mr Renwick advised whilst he shared the Chief Executive’s enthusiasm about transplantation services, it was important to recognise these service represented complex case loads which, by definition, were expensive at a time when NHS Lothian’s finances were constrained by National Resource Allocation Committee (NRAC) considerations. The Chief Executive commented the service was nationally commissioned by the National Services Division (NSD) of National Services Scotland (NSS) and data had been provided by colleagues to ensure activity needs were recognised in the arrangement with NSD.

111. Mid-Year Financial Review 2010/11

111.1 Mrs Goldsmith commented the mid-year review position was confirming that year-end break-even would be achieved. She commented, however, that challenges remained significant and it would be important moving into next year to off-set additional recurrent costs.

111.2 Mrs Goldsmith commented the mid-year review process differentiated between unavoidable costs like rates or authorised additional spend from those areas of spend requiring operational management action. In that regard, debate had been held at the Executive Management Team in respect of waiting times where it had been agreed that the University Hospitals Division would be asked to manage the year-end position with an additional £2m.
111.3 Mrs Goldsmith commented there remained an issue in respect of operational budget management and no provision had been made for additional costs in this regard and managers would require to work to deliver break-even. She advised the month 9 financial position was showing a plateau of spend, and stressed further focused work would be required moving up to the year-end. She advised in-month the financial consequences of the inclement weather was the only additional adverse movement and this was to be welcomed.

111.4 Mrs Goldsmith commented she had received assurances from colleagues that the full LRP (Local Reinvestment Plan) would be met. She reiterated the importance of NHS Lothian delivering on its financial commitments for 2010/11.

111.5 The Chair commented that at the Finance and Performance Review Committee, an analysis of income had been discussed and he questioned whether this should be included in future Board reports. Mrs Goldsmith advised the financial plan would include a detailed income section, which would routinely be reported on throughout the year. Mrs Goldsmith, in response to a question from Mr Renwick advised the activity section would re-appear in future iterations of the Board report.

111.6 The Vice-Chair commented in respect of the significant cost of nursing incremental drift that it was unreasonable to expect the University Hospitals Division to absorb such costs and advised drift was evident within other staff groups and should be made explicit in the paper. The Vice-Chair commented he did not think it was reasonable to expect people to manage non-funded pressures of this magnitude. He commented in future it would be important Scottish Government Health Department initiatives were only automatically progressed if they were fully funded.

111.7 The Vice-Chair advised there were significant numbers of staff willing to exit the organisation with innovative packages which had been supported by partnership colleagues. He stressed this was the only such approach within the UK. He stressed the importance of meeting the stretched target in respect of sickness absence and commented partnership colleagues, in liaison with the Director of Human Resources and Organisational Development had agreed to target the top two hundred cases of sickness absence.

111.8 Mrs Goldsmith, in response to comments about pay incremental drift, advised all groups were being looked at with some areas being reflected in the financial plan, although she stressed funding incremental drift represented an increased LRP target.

111.9 The Chief Executive commented in respect of waiting time funds that the Board was working with colleagues from the Scottish Government Health Department to understand the baseline of activity to make best use of the waiting time funding available. He advised one of the current 5x5x5 projects was predicting that £1m of savings might be achievable and this would be pursued with vigour.

111.10 Mrs Goldsmith in response to Mr Burley advised the Napier programme in the paper, being delivered in partnership with Harvard, featured as requiring funding because the detail of the initiative had not been finalised until the end of summer with the financial plan having been finalised in April. Mr Boyter advised a paper on the outcomes of the Harvard programme would be produced for the Finance and
Performance Review Committee and would include examples of where contributions could be made to LRP as part of the process.

Councillor Edie joined the meeting.

111.11 The Board noted the financial position and accepted Mrs Goldsmith’s advice that NHS Lothian would meet its financial requirements at the year-end.

112. Capital Update

112.1 Mrs Goldsmith advised this would be the last year of a wide range of capital investments. She commented any year-end slippage would be invested in statutory compliance, medical equipment, eHealth and traffic management, all of which would require to have been undertaken in any event.

112.2 The Chair commented, in previous years, gaps had been funded by property disposals and questioned whether this would be a realistic proposal moving forward. Mrs Goldsmith advised from 1 April 2011, capital receipts would be deducted from the capital resource limit by the Scottish Government Health Department to fund capital programmes. In her view, the main issue was to rationalise the Estate in order to reduce infrastructure costs. Mrs Goldsmith advised, therefore, that there would be reduced ability to find non-recurrent solutions, at least for the next three financial years.

112.3 Mrs Goldsmith in response to Mr Burley commented discussions were ongoing with the Scottish Government Health Department around the detail of the funding route for the Royal Hospital for Sick Children and Department of Clinical Neurosciences.

112.4 The Vice-Chair questioned whether Consort had been requested to make any contribution in respect of life cycle costs. He further questioned whether the Board should be concerned about “approved but not yet legally committed schemes” quoting the birthing suite as an example of such a scheme.

112.5 Mrs Goldsmith advised discussions had been held with Consort about the need for partners to make contributions during a period of financial austerity, albeit that these discussions were being held within the constraints of contractual obligations.

112.6 Mrs Goldsmith commented in respect of schemes “approved but not committed” that she had found Consort’s current governance process to be complex and had, therefore, given assurances that NHS Lothian would carry the risk in order that the projects could commence. She advised the birthing suite had been committed on such a basis. She stressed, however, there was a need to work out mechanisms to do business quicker with Consort in future and she and colleagues were pursuing this.

112.7 The Vice-Chair commented NHS Lothian’s concerns about the NRAC position had been articulated to the Scottish Government Health Department and this linked to the funding requirements in respect of nursing slippage, and the issue of waiting time funding needed to be addressed and required to be discussed at the Finance and Performance Review Committee. Mr Walker commented this had been one of
the reasons Mrs Goldsmith had reviewed strategic initiatives, some of which had been discussed with Mr Renwick. He advised between himself as Chair of the FPRC and Mrs Goldsmith as Director of Finance, they would feed back messages to those who needed to hear them.

112.8 The Board noted the recommendations contained within the circulated paper and, in particular, that NHS Lothian was forecasting to achieve the capital resource limit (CLR) of £86.5m and return, in line with the Scottish Government’s expectations for Boards, around £6m of “project” funds to the Scottish Government Health Department to recognise cash flows over 2010/11 and 2011/12.

113. Delivering Waiting Times

113.1 Professor McMahon updated the Board on positive progress around a range of waiting time targets commenting that the effect of winter had been significant with discussions being held with the Scottish Government Health Department in respect of capacity and the cost of cancelled procedures.

113.2 Professor McMahon advised that the position had been made more difficult by the influx of H1N1 on the back of the poor weather, which had resulted in downstream effects on accident and emergency and intensive treatment units. He advised, however, that patient flows were now improving.

113.3 Professor McMahon commented good performance continued in respect of cataracts, cancer and audiology. He advised the national review outcome on scoliosis was still awaited. Professor McMahon commented that pressures currently evident within endoscopy were under review with capacity, in particular, being an area of focus. He advised further discussions in respect of endoscopy performance were being held with the Scottish Government Health Department.

113.4 Professor McMahon drew the Board’s attention to the proposal that the current arrangements for performance monitoring be rationalised, with the Finance and Performance Review Committee undertaking the detailed governance required for aspects such as waiting times and delayed discharges within an over-arching performance management paper. He commented in order to ensure the Board itself remained sighted on these important issues, a summary of overall performance would also be made available at future Board meetings. The Board agreed this approach.

113.5 Mr Renwick commented it was important to note the reference in the paper to patients having procedures cancelled was not factually correct as they had only been deferred, sometimes at their own request. He noted that in England the 4-hour accident and emergency target was being withdrawn and questioned whether a similar position would happen in Scotland. Professor McMahon advised the Royal College of Nursing had supported the cessation of the target in Scotland, although it was important to remember this would be an issue for Ministers to decide upon and, in the meantime, NHS Lothian continued to progress towards the national target.
113.6 Mr Walker commented the 97.8% performance achievement in the access target for November was positive and he further noted the strong performance in cancer. He questioned, however, the reported shortfall in ovarian cancer. Mr Grieve advised this related to one patient, which would have a significant impact on overall performance as the numbers of patients receiving such treatment was small.

113.7 Mr Anderson questioned whether work was underway to capture the cost of the adverse weather in financial and human costs, particularly, in respect of fractured neck of femur costs. Professor McMahon advised work was underway around identifying additional winter costs and these were being highlighted to the Scottish Government Health Department. Professor McMahon undertook to provide Mr Anderson with details of costs around fractured neck of femur outwith the meeting.

113.8 Dr Tierney referred to discussion at the public meeting held immediately before the formal Board meeting and questioned, in respect of mental health waiting times and the immediate response available through the intensive home team, whether a breakdown by category of response rates could be provided. Professor McMahon undertook to circulate the most recent position outwith the meeting.

113.9 The Board received the update report on NHS Lothian’s positive performance in meeting waiting time targets.

114. Tackling Delayed Discharge

114.1 Professor McMahon commented that delayed discharges had also been an area that had been impacted upon by the inclement weather, mostly as a consequence of transportation difficulties. However, the January census had shown an improvement across all areas in the partnership, with the monthly target having been met and exceeded with only 63 patients delayed, excluding patients where circumstances deemed they were not yet eligible for discharge.

114.2 Professor McMahon referred to debate at the previous meeting about actions to reprovide services for the longest delayed discharge patients and advised this had been discussed at the Finance and Performance Review Committee. He commented in November eight out of the fifteen patients had moved to appropriate new arrangements with another patient due to move imminently. Professor McMahon advised another three patients were in the learning disabilities category and alternative housing arrangements with Midlothian Council were being discussed for those individuals. He commented in response to a question from Mrs McDowell that the timescale for the reprovisioning of these new facilities was expected to be October of this year. Councillor Aitchison advised that Midlothian Council was aware of the complex needs of this group of patients.

114.3 Professor McMahon advised to date the revised arrangements had resulted in a reduction in 451 bed days saved, accompanied by small financial savings. Professor McMahon stressed, however, that throughout the whole process the emphasis had been on recognising and catering for the specific individual needs of the patients concerned.
Professor McMahon advised, in his opinion, further focus was needed around the rate of people moving to care homes, as well as patients exercising their home of choice option under the Moving On policy as, in some instances, these issues were causing delays in moving people into more appropriate accommodation. Professor McMahon advised continuing care beds were also being looked at in terms of supporting patients on a whole system basis.

The Vice-Chair advised in his role as Chair of Midlothian CHP he could confirm that there was particular focus in the reprovision of services and advised the patients in question had complex needs and required appropriate advocacy arrangements to be put in place on their behalf. He stressed the accommodation for these patients needed to be provided by the responsible agency as it had not previously existed. He confirmed Professor McMahon and CHP and Midlothian Council colleagues were working in tandem to re-provide services by the October deadline. The Vice-Chair commented it was important the alternative arrangements were appropriate to the needs of the patients concerned in order to allow them to live fulfilled lives.

Mr Burley commented progress had been made in the area of complex cases over the previous year and had been discussed at the PCPC. He commented his view was that this was an area that required continuing attention until the issue was resolved. Mr Burley commented it would be important for this group of patients that inappropriate tensions were not introduced in real life situations.

Councillor Edie questioned how many guardianship orders were outstanding and how many were awaiting legal aid. Professor McMahon undertook to provide details outwith the meeting. He commented, however, that it took time to complete assessments and appoint guardians and progress was being made on an active basis resulting in evidence of reductions in delays and timescales. Councillor Edie felt closer partnership working would help, particularly if people appreciated the cost to the public purse.

Councillor Bell commented in respect of guardianship issues that this was an area affected by the weather as psychiatrists and mental health officers had been impeded by transportation issues, which had resulted in downstream implication for court dates for hearings. She advised that East Lothian Council colleagues continued to work hard in achievement of the delayed discharge action plan, which had been designed to reduce delayed discharges and sustain reductions. She advised the Head of Adult Social Care had met with Mr David Small, the General Manager for East and Midlothian CHP and had fruitful discussions. Councillor Bell advised she would also be meeting with Mr Small.

Councillor Bell referred back to the impact of the inclement weather and reported on positive work in Liberton Hospital around partnership engagement where real efforts had been made to move patients into more appropriate arrangements. She commented despite these efforts sometimes the task had been hampered by the physical inability to transport patients to their final destination because of snow and the need to consider the impact on patient and staff safety, which required to be risk assessed. Issues had also been experienced by staff who required to assess patients being unable to make journeys because of the weather.
114.11 Mr Johnston commented he would welcome more information on the £20m change fund and assumed there would be local flexibility to put proposals forward for funding. He questioned how Lothian’s share of the fund would be determined and how it would be disbursed locally. The Chair advised he sat on the Ministerial group and commented the local disbursement could be appropriately managed through Community Health Partnerships rather than more complex groups and, if properly signed off, there would be no difficulty with accommodating local variations. Professor McMahon advised the Scottish Government Health Department guidance and list of funding areas was not exhaustive and local issues could be accommodated so long as national criteria was met. However, some aspects of the criteria would be expected to be demonstrated consistently through all partnerships. He was actively following up these issues with CHP and CHCP colleagues.

114.12 The Chief Executive commented the point raised by Mr Johnston was important. He advised the Board was accountable for these funds through local partnership arrangements and, in that respect, clear arrangements would be needed attuned to local circumstances which in turn would need to relate to the fact that some people were waiting a long time for discharge from hospital.

114.13 The Board received the update report on delayed discharges.

115. Healthcare Associated Infection

115.1 Dr McCallum updated the Board on progress and actions to manage and reduce healthcare associated infection across NHS Lothian. She commented that as Director of Public Health and Health Policy she could assure the Board all possible steps were being taken.

115.2 Dr McCallum reported that progress on the clostrium difficile target of 577 was on trajectory to meet the year-end requirements. She commented, however, in respect of staphylococcus aureus bacteraemia (SAB) that Lothian would not, in her opinion, meet the target of no more than 254 staphylococcal bacteraemias being reported between April 2010 and March 2011. Between April and December there had been 244 bacteraemias reported. While rates were continuing to decline, there was no evidence to suggest that there would be fewer than 10 bacteraemias across hospital and community services between 1 January and 31 March 2011. She anticipated the out-turn position at the end of March being around 335, which she stressed still represented a 33% reduction from the baseline figure of 498. Dr McCallum advised within the year-end figure of 335 that this would include a figure of 6-7% for false positives which could not be removed from the data until confirmed. She would also expect a reduction in the number of patients coming to Lothian from other Health Boards.

115.3 Dr McCallum advised the target for SAB by March 2013 was 213. She commented this would represent a 57.2% reduction from the 2005/06 figure of 498. The target for clostrium difficile infection by March 2013 was 325. This would represent a 70.8% reduction from the 2006/07 figure of 1,114.
Dr McCallum advised in respect of the targets moving forward, past experience and continuing focus meant that she was confident about being able to achieve the Clostridium Difficile target. In respect of the Staphylococcal target, she was less confident. There were two reasons for this. First, that targets were based on experience in a lower risk population than Lothian. The experience in Lothian was not of outbreaks but of single cases in high risk individuals. Detailed investigation in the renal unit identified that many of their patients were people being infected more than once with organisms from their own skin. The renal unit were seeing benefits from the interventions already underway but would require support from other parts of the care pathway to make the significant additional changes in the way that care was provided that they had identified as essential and this would take time. Dr McCallum also noted that the pace of improvement varied between wards and that it was necessary to ensure that changes in practice were embedded across the system.

Dr McCallum advised the Board her report also included details on the numbers of patients who had suffered H1N1. She commented as well as inclement weather, staff had also been required to deal with flu and norovirus and she commended the efforts of staff who had worked hard to address these issues. She advised the number of staff infections had been encouragingly low and was down to good attention being paid when treating patients and also good hand hygiene practice.

Councillor Bell advised in respect of norovirus that there were clear links with the delayed discharge position and the knock-on effect of the availability of social work staff to undertake assessment work as staff would not be permitted to enter affected wards. She commented patients with norovirus could not be discharged into a care home for fear of spreading the infection. Dr McCallum commented these were fair points advising there were appreciable morbidity and mortality rates in some instances and, for that reason, particular care was taken in addressing norovirus to include the prompt closure of affected wards.

Mr Peacock commented he did not think any departments should be given advance notice of cleanliness inspections as, in his view, this defeated the purpose. He advised the Scottish Health Council would be undertaking any such inspections without announcement. The Chair concurred advising the working environment should always be in a state of readiness that would pass any unannounced inspection.

Dr McCallum in response to a question from Mrs Douglas about GP antimicrobial prescribing advised quarterly reports were produced in GP practices and demonstrated a low rate of antimicrobial prescribing with low seasonal variation. She commented the good practice evident in primary care was being disseminated more widely.

Councillor Aitchison commented notwithstanding Government targets, he would be interested to know how many staff had taken up the offer of immunisation as absenteeism levels looked encouraging. Dr McCallum commented uptake had been better than in previous years and was good compared to the rest of Scotland.

Professor Iredale commented he endorsed the proposals to intervene in areas susceptible to positive influence. He commented the system had been seen to deal
effectively with H1N1 in terms of absenteeism and there was a need to look at H1N1 differently and to relentlessly pursue the need to have a high proportion of staff immunised against flu.

115.11 Mr Boyter commented every year NHS Lothian encouraged people to receive the flu vaccination, but stressed this remained a personal choice.

115.12 Dr Tierney commented the narrative in the report suggesting improvements in hand hygiene was not mirrored in the graphs in the appendices. She commented the expectation should be that achievement levels should be as close to 100% compliance as possible. Dr McCallum commented she would ensure consistency in future reporting and commented 98% compliance levels had been achieved in December at both the Royal Infirmary of Edinburgh and the Western General Hospital.

115.13 Mr Johnston questioned, given there was a zero tolerance approach to hand hygiene, when the system would move from an educational approach to a more formal position with non-compliant areas. The Vice-Chair commented professional codes of conduct were in place for registered staff and would be applied as appropriate. For other groups of staff, NHS Lothian’s policies and procedures would be used to address non-compliance, if necessary.

Mr Whyte jointed the meeting at 12.06pm.

115.14 The Board approved the recommendations contained within the circulated paper.

116. Quality Improvement Report

116.1 Dr Farquharson advised the updated quality report reviewed measures introduced to date to ensure effectiveness of care. He advised progress was being made around cancer, smoking cessation and its benefits, screening and sexual health measures.

116.2 The Chair commented he was enthusiastic about this area of work which was progressing ahead of the national agenda. He advised Lothian contributing to the national work on quality indicators would be useful and would inform future work.

116.3 Mr Whyte noted the report demonstrated good local progress and reminded the Board in the past he had sought comparisons with UK-wide performance. He commented this would be important as NHS Lothian progressed towards its objective of becoming one of the world’s top 25 healthcare systems. Dr Farquharson reported Lothian’s mortality rates in breast cancer, for instance, benchmarked well and it was his intention to look deeper at other conditions.

116.4 The Chief Executive commented data available from HealthTracker was now sophisticated and Dr Farquharson would interrogate this to provide comparative data in future reports.

116.5 Councillor Edie advised he was mystified by the fact that the report was stating 9% of patients had a reaction to medicine. Dr Farquharson confirmed this was the case
advising this figure was within expected parameters and was sourced from a review of patient notes.

116.6 Dr Tierney advised variations across the population were interesting and questioned whether the communications team could publicise the benefits of smoking cessation services to existing smokers. It would, in particular, be important to promote the benefits of this to people in deprived groups. Ms Stirton advised publicity work had been undertaken in conjunction with the Director of the West Lothian Community Health and Care Partnership focusing on social marketing which had proven to be a motivating approach.

116.7 Mrs Allan questioned in respect of breast screening updates whether more people were attending than in the past and what steps were being taken to encourage those who did not attend. Dr McCallum reported a multi-disciplinary and multi-agency approach was adopted with profiling work being undertaken to target those least likely to come forward and those most at risk. Dr McCallum reminded the Board that since the age range had increased, more people were now eligible to use the service with the profile of women changing through the influencing factors of the Forrest Review pilot.

116.8 Mr Boyter in response to a question from Mr Renwick confirmed Datix was now working on a single system basis. Dr Farquharson advised the system was now becoming embedded and this would be reflected in data available for future iterations of the report. Mrs Hornett updated on work underway within nursing.

116.9 Mr Burley commented in respect of complaints it would be important to consider the data within the context of reducing numbers sometimes indicating that people did not feel empowered to give feedback on the services they had used. It had been his belief that the complaints aspect of the report was going to focus on lessons learned. Mrs Hornett advised she agreed with Mr Burley’s comments about the number of complaints and these were carefully tracked as were the number of compliments and enquiries by NHS Lothian. She advised papers were submitted to the Healthcare Governance and Risk Management Committee, which provided further richness of data behind the headline numbers. She advised a piece of work was about to conclude on how best to capture people’s views about access to the service and this would make it easier for people to make a complaint, as well as allowing access to a web-based facility. Mrs Hornett advised she was also considering how best to report on patient satisfaction levels on an annual basis.

116.10 Dr Williams commented the positive progress around long acting reversible contraception was down to the positive inputs from General Practitioners and nursing staff and progress moving forward continued to be positive with the only limiting factor being the availability of training. The Chair commented in respect of the proposed effectiveness measures timetable that he would like to see primary care services reflected in order to receive details about the quality of the consultation. Dr Williams advised the quality framework approach, as part of the GP contract, had been an innovative way of obtaining details around the performance aspects of care provided.

116.11 The Board received the quality improvement report.
117. Royal Hospital for Sick Children and Department of Clinical Neurosciences Update (RHSC and DCN)

117.1 Mrs Goldsmith advised at the time of the previous Board meeting, the non-profit distributing (NPD) funding route for the RHSC and DCN had only just been announced by Scottish Government. She commented the circulated report provided an overview of work to date in respect of the procurement strategy; maximising the design work to date and the project structure. She advised a full report on the proposed way forward and options would be brought to the Board in Private session in March.

117.2 The Vice-Chair questioned whether the fact that the Scottish Parliament budget had yet to be approved represented a potential risk to the March timescales. Mrs Goldsmith commented she was unable to say at this point and commented if the budget was voted down she did not know what the impact would be, as no public funding would be available unless some other projects were dropped.

117.3 Dr Tierney referred back to comments made in the Chair’s report about DCN accommodation and suggested at some point consideration would need to be given to interim arrangements for DCN if major delays were experienced. Mrs Goldsmith advised colleagues from Estates would need to look at the condition of the building and, if improvements were required, these would be made within existing constraints, although additional theatre space could not be provided.

117.4 The Chief Executive reminded the Board the Cabinet Secretary was keen that the joint project be delivered with minimum delay and confirmed this was also NHS Lothian’s position. He commented the report to the March Board meeting would consider financial consequences prior to being submitted to the Scottish Government Health Department. Mr Walker advised he would encourage this approach from a Finance and Performance Review Committee perspective.

117.5 Mrs Goldsmith advised the Parliamentary budget made provision for the revenue costs of the RHSC and DCN projects through the NDP route. She advised the process would ensure NHS Lothian was not financially disadvantaged by the NDP funding route and this would feature as a key component of the Business Case coming forward before the Board in due course.

117.6 The Board noted progress and agreed a more detailed update be brought to the March meeting in Private session.

118. Delivering Public Value – Supporting Difficult Decisions

118.1 Mrs Hornett advised the paper before the Board was the product of the highly successful Board Away Day held in October, and detailed the key elements of the discussion around delivering public value.
118.2 Mrs Hornett advised the work had been taken forward following a review of current work streams and statutory requirements. She commented although the review had demonstrated a lot of work was underway committed to public value that public articulation of this needed to be refined and was work in progress with a particular focus on financial issues with key public partnerships representatives and strategic planning staff.

118.3 Mr Burley commented whilst he was pleased to see the paper and its proposals, he would like the Board to identify the meaning of public value and to articulate it to staff to allow them to enhance their work in relevant areas. Mrs Hornett commented in particular that the Harvard/Napier scheme focused on public value and she felt this was an excellent way of spreading the message to staff. Mr Burley noted this approach and suggested there was a need for a range of different vehicles to be used for an organisation of the size and complexity of NHS Lothian.

118.4 The Board agreed the recommendations contained within the circulated papers.

119. Committee Memberships

119.1 The Board agreed the appointment of:-

- Mrs Shulah Allan as a member of the Healthcare Governance and Risk Management Committee
- Dr Richard Williams as a member of the Organ Donation Committee
- Dr Richard Williams as Chair of the Organ Donation Committee from 1 October 2011, once Dr Tierney’s extended appointment to the Board ceased.


120.1 The Board noted the above documents.

120.2 The Vice-Chair commented, with the Chief Executive’s advice, it would be important from a fiscal viewpoint to look at how many SEAT initiatives were demonstrating value for money, as he felt there was opportunities to reduce duplication. The Chief Executive commented NHS Lothian had no discretion on whether to engage in regional planning, stating this was determined through a Scottish Government Health Department circular, which bound and obligated Health Board participation. He advised, through his current chairmanship of SEAT, he was attempting to make the work of the group relevant and hoped, in particular, that work around shared services would be fruitful.

121. Presentation on Compassionate Care

121.1 The Chair welcomed Dr Stephen Smith, Consultant Nurse to the meeting.
121.2 Dr Smith provided the Board with an informative presentation updating on the leadership in compassionate care programme run jointly between NHS Lothian and Edinburgh Napier University. He advised the four key strands of the programme were around beacon wards, leadership programme, undergraduate programme and the newly qualified practitioners programme.

121.3 Mr Walker commented during visits to beacon wards, staff had been very enthusiastic, although it had been evident that not all medical students were receiving exposure to the programme or something similar in their training, and questioned how other staff groups could become involved. Dr Smith advised staff in beacon wards would transfer skills through multi-disciplinary working and joint work was underway to address the comments made by Mr Walker.

121.4 Mr Boyter commented this programme of work linked with the psychological contract he was developing with colleagues and would be specifically referenced. He advised a key issue would be how to disseminate messages across the totality of such a complex system. Dr Smith and Mrs Hornett advised the techniques had been used elsewhere in the UK, although it was often simple things that made the biggest impact.

121.5 The Chair thanked Dr Smith for his presentation.

122. Communications Received

122.1 The Board noted the list of communications received from the Scottish Government Health Department.
## Item 3.1

**Action Checklist from Meeting held on Thursday 03 February 2011**

<table>
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<tr>
<th>Item</th>
<th>Action to be taken</th>
<th>By whom</th>
<th>Completion date</th>
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<tr>
<td>3.1</td>
<td>Members training and development needs, arrangements for succession planning and development of future clinical leaders - It was agreed that Mr Lee and the Chair should work on a first draft template for the way forward following today’s discussion and that this would come to the May Forum meeting.</td>
<td>PM/DL</td>
<td>May 2011</td>
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<tr>
<td>6.1</td>
<td>Revalidation: A Statement of Intent - October 2010 - In terms of regulation the Forum noted that there were some professions which were unregulated such as perfusion technicians, cardiac pacemaker staff and physician’s assistants. The Board should have awareness of these professions as there was potential for risk to the Board. Dr Stirling agreed to produce a summary relating to the unregulated healthcare science professions.</td>
<td>DS</td>
<td>May 2011</td>
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<td>11.1</td>
<td>Information Governance – Dr McCallum asked that this information be disseminated to the professional advisory committees and it was also suggested that the advisory committees may benefit from hearing Dr McCallum’s induction training presentation for new consultants in relation to information governance.</td>
<td>ALL</td>
<td>May 2011</td>
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DRAFT

LOTHIAN NHS BOARD

AREA CLINICAL FORUM

Minutes of the Meeting held on Thursday 3 February 2011 commencing at 2:00pm in Meeting Room 8, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Present:
Prof. Pat Murray Chair, Lothian Area Pharmaceutical Committee (LAPC) (Chair)
Dr Lind MacDonald Vice-Chair, Lothian Area Medical Committee (LAMC)
Ms Alison Meiklejohn Chair, Lothian Allied Health Professions Committee (LAHPC)
Mr Graham Bell Representative Patient
Dr Stuart Blake Chair, Lothian Area Medical Committee (LAMC)
Dr Alison McCallum Director of Public Health and Health Policy, NHS Lothian
Dr David Stirling Chair, LAHSC
Mr Kevin Wallace Chair, Lothian Area Optical Committee (LAOC)

In Attendance:
Mr Chris Graham Committee Administrator, NHS Lothian
Ms Jo Bennett Clinical Governance Manager, NHS Lothian
Mr David Lee Associate Director, Workforce & Organisational Development

Apologies:
Mrs Sally Egan Chair, Lothian Area Nursing and Midwifery Advisory Committee
Ms Anne Waugh Vice Chair, Lothian Area Nursing and Midwifery Advisory Committee (LANMAC)
Mr Norman Fraser Chair, Lothian Psychology Committee
Mr Alan Mentiplay Chair, Fife Area Clinical Forum
Mr Allan Bridges Chair, Forth Valley Area Clinical Forum
Mr John Hammond Chair, Borders Area Clinical Forum

The Chair welcomed members to the meeting.

1. South East and Tayside (SEAT) workplan responsibility: Performance Standards and Minimising Variation

1.1 Dr McCallum reported on a piece of SEAT work for which she was responsible, looking at a regional way forward on key clinical issues; using benchmarking, high cost volume clinical activity, existing technologies and intervention and good practice that could be adopted across the SEAT region. It was hoped that this work would deliver by the 18 March 2011. There would be an event on 25 February 2011 to discuss ways forward; informed ideas and develop an action plan.

1.2 There was discussion on consistency across the region and different approaches to treatments. Dr McCallum stated that whilst things may be named differently they are essentially not that different. The Forum also discussed the underlying education and training of staff – standardising competencies, understanding and skills across SEAT. It was noted that there were a large number of tests being requested and carried out when there was no need; over requesting; tests of limited
value or no benefit being requested. The results of lots of tests carried out were not being looked at and sometimes staff asking for tests did not know why they requesting it. It would also be helpful if completion of clinical details be made mandatory on test request forms. Patient education and the pressure to resist patient requests were also mentioned, along with why NHS Lothian was still providing homeopathic clinics.

2. **NHS Lothian Quality Improvement Strategy 2011-2014 Update**

*The Chair welcomed Ms Bennett to the meeting.*

2.1 Ms Bennett gave the forum an update on the review of the NHS Lothian Quality Improvement Strategy which was launched in May 2010. The Forum noted that the key area was how to define success; how this could be conveyed to others; and how it could be measured for improvement. Ms Bennett stated that all the areas in the Quality Improvement Strategy could apply to any working environment. The goal would be to have people confident enough to improve and use skills in everything they do within the NHS.

2.2 The Forum noted that the document was out for consultation until 31 March 2011. The Chair stated that there needed to be clarity on the measures as they appeared to be aspirational.

2.3 There was discussion on the use of the McKinsey Health Tracker for benchmarking and whether this was appropriate as some areas whilst called the same may have real differences. The same could apply to comparisons from UK and across Europe.

2.4 Ms Bennett reported that Institute for Healthcare Improvement (IHI) testing had happened on a couple of sites. There was a need to also change management skills; however some IHI testing was not transferrable as it was acutely focused. Looking at patient experiences using rapid feedback was also discussed.

2.5 The Chair thanked Ms Bennett for her update and was pleased that there was still time to reflect on the areas that will be expected to be delivered against. The Quality Improvement Strategy was something that should be woven into everybody’s business and the challenge was welcomed.

*Ms Bennett left the meeting at 3.25pm*

3. **Area Clinical Forum Work Plan**

*The Chair welcomed Mr David Lee to the meeting.*

3.1 Members training and development needs, arrangements for succession planning and development of future clinical leaders

*Ms Meiklejohn left the meeting at 3.30pm*
3.1.1 Mr Lee gave a brief overview of how he saw the Forum in a strategic context. This looked at how stakeholders were engaged; dynamics; strategic intent; who/what was being held to account; how individuals were selected to the Forum and the willingness of individuals to be available and motivated to benefit the organisation.

3.1.2 There was discussion on personal development of Forum members and the kind of skills that would be wanted and/or needed from members. The Chair mentioned recent non-executive training which highlighted three key issues:

- Accelerate what is done effectively to achieve improvement
- Focus on key issues
- Build relationships / partnerships

3.1.3 The introduction of an induction programme for new members was discussed along with the need for protected time to allow members to fully participate in the Forum. It was noted that independent contractors set no sessions aside. It was recognised that the Forum has a clear constitution and that the current network of the forum and advisory committees worked well together. There was discussion on the Forum’s role as peer reviewers; what the Chief Executive expected from the Forum and how the Forum could be more proactively involved in strategy development and receive commissioned tasks from the Board.

*Mr Wallace left the meeting at 4pm*

3.1.4 It was agreed that Mr Lee and the Chair should work on a first draft template for the way forward following today’s discussion and that this would come to the May Forum meeting.

**PM/DL**

3.2 **Work Plan**

| B1   | Changed from Ongoing to Being Achieved |
| B2   | Changed from Ongoing to Being Achieved |
| B3   | Achieving; AKM presentation to next Forum meeting |
| B4   | AKM to brief HR Director; How can PACs assist and support |
| B5   | Moving forward and being achieved against set targets |
| B6   | Communications Plan to come to next Forum meeting |
| B7   | Ongoing, Dr Stirling has discussed with Medical Director |
| B8   | Ongoing |
| B9   | Ongoing |
| B10  | Ongoing |
| B11A | Noted, in place |
| B11B | Noted |
| B11C | In Progress, Next Meeting |
| B11D | In Progress |
| B11E | In Progress, Next meeting |
| B11F | In Progress |

3.3 **Section B9: Safer Management of Controlled Drugs Update** - The Forum noted the update which linked into B9 of the ACF Workplan. There was discussion on the concerns surrounding GPs access to controlled drugs and contract compliance in relation to this.
4. **Minutes of Previous Meeting ~ 25 November 2010** - The circulated minutes of the meeting were approved as an accurate account of that meeting.

5. **Matters Arising [Action Checklist]** - There were no outstanding actions on the checklist and there were no other matters arising that were not on the agenda.

6. **Items for Discussion**

   6.1 **Revalidation: A Statement of Intent - October 2010** - The Forum noted that there had been a delay until 2012 with revalidation due to different views between Scotland and England. In terms of regulation the Forum noted that there were some professions which were unregulated such as perfusion technicians, cardiac pacemaker staff and physician’s assistants. The Board should have awareness of these professions as there was potential for risk to the Board. Dr Stirling agreed to produce a summary relating to the unregulated healthcare science professions.

   6.2 **The Next 5 years Mental Health Strategy "A sense of belonging" Summary Document** - The Forum noted the Summary Document of the draft strategy. Ms Meiklejohn reported on the four ‘Commitment to Change’ areas:

   - Addressing inequalities
   - Embedding recovery
   - Building social capital and wellbeing
   - Improving services

   6.2.1 The Forum noted that consultation period on the draft strategy would be running until 4 March 2011. The Chair stated that this was a very interesting document but work was still needed on how this was all going to be measured as this had not been captured in the draft. Ms Meiklejohn stated that there needs to be a link to HEAT targets and waiting list times and that all professions would need to be aware.

   6.2.2 There was discussion on aspects of mental health illness that needed expanded within the document e.g. reducing vulnerability; mind and body – reducing physical illness; staff understanding; socioeconomic vulnerability and validated assessment tools. There was also discussion on the living better project which would be reporting at a conference in March and the 10% efficiency saving expected from Allied Health Professions.

7. **Chair’s Business**

   7.1 The Chair raised issues emanating from the Board minutes.

8. **Board Issues**

   8.1 **NHS Lothian Service Redesign Committee** - The Forum noted the minutes of the meeting held on 13 December 2010.
8.2 Lothian NHS Board Papers available at www.nhslothian.scot.nhs.uk

8.2.1 The Forum noted the minutes of the Board meeting held on 24 November 2010 and the electronically circulated papers from the 26 January meeting. Under paragraph 96.3 of the November Board Minutes, there was discussion on whistle blowing and the network of confidential contacts which it was felt needed to be ‘advertised’ more prominently.

9. Lothian Professional Advisory Committees Minutes

9.1 Members noted the circulated minutes from meetings of the Professional Advisory Committees held since the date of the previous LACF meeting:

- Lothian Area Healthcare Scientists Committee 27/10/10
- Lothian Area Nursing & Midwifery Committee 17/11/10
- Lothian Allied Health Professions Committee 18/01/11
- Lothian Area Medical Committee 15/12/10
- Lothian Area Pharmaceutical Committee 06/01/11

10. Items for Information

10.1 The Forum noted the following items for information:

- Area Clinical Forum Chairs Group Minutes: 31/08/10
- Forth Valley NHS Board Area Clinical Forum Minutes: 29/07/10
- Lanarkshire NHS Board Area Clinical Forum Minutes: 15/07/10

11. Any Other Competent Business

11.1 Information Governance – Dr McCallum informed the Forum of a current information governance issue relating to increasingly sophisticated medical equipment that could hold patient data. There would be regulations on this coming out next year. Dr McCallum stated that work on an asset register was ongoing and that the Science Centre was helping by developing post-hoc solutions and identity stripping technologies. Dr McCallum asked that this information be disseminated to the professional advisory committees and it was also suggested that the advisory committees may benefit from hearing Dr McCallum’s induction training presentation for new consultants in relation to information governance.

ALL

12. Date of next meeting: Thursday 19 May 2011, 8.30 – 11.30am, Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG (Deadline for receipt of papers is 5 May 2011)

13. 2011 Meeting Dates: 18 August; 17 November
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<th>Action Required</th>
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<tr>
<td>Family Health Services – Payment Verification Procedures (12 October 2009)</td>
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<td>• To write to the Government with respect to Lothian’s experience of the</td>
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<td>dental payment verification protocol, and to report back to the Committee</td>
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<td>on what action can be taken locally.</td>
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<td>The first payment has been made.</td>
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<td>The Director of Finance has asked the General Manager (PCCO) to prepare a</td>
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<td>report on the systematic failures that led to the overpayment, and this</td>
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<td>shall be brought to the next Audit Committee.</td>
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<td><strong>Matters Arising from the Audit Committee of 21 June 2010 (11 October 2010)</strong></td>
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<td>• Mrs Goldsmith to provide a report to the December Committee on the transfer of the staff lottery from the exchequer.</td>
<td>SG</td>
<td>6/12/10</td>
<td>The Lothian Health Appeals Society has engaged a legal firm to advise and support the process of transferring the lottery to a new independent organisation. In parallel, the Board has sought CLO advice on the terms of the relationship with the new unincorporated body.</td>
<td>In progress</td>
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<td><strong>Linkages with Other Board Committees (6 December 2010)</strong></td>
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<td><strong>Staff Governance Committee – Minutes of the Meeting held on 29 September 2010</strong></td>
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<td>• Ms Goldsmith to check whether the standard terms of the contract with Spire provide sufficient cover for NHS Lothian irrespective of who Spire employs to perform the work, e.g consultants working individually or consultants working as part of limited companies.</td>
<td>SG</td>
<td>8/2/11</td>
<td>There are clear provisions in the SLA with respect to the quality of individual staff that Spire must use, as well as its responsibilities for clinical governance. Management are currently confirming that there are robust controls to ensure indemnity insurance arrangements in place when limited liability partnerships (of consultants) are engaged in the provision of care.</td>
<td>In progress</td>
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<tr>
<td><strong>Operational Audit Sub-Committee (8 February 2011)</strong></td>
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<tr>
<td>• Mr Payne to provide a snapshot of the current status of outstanding audit recommendations.</td>
<td>AP</td>
<td>12/4/11</td>
<td>This is being prepared.</td>
<td>In progress</td>
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<td><strong>Linkages with Other Board Committees (8 February 2011)</strong></td>
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<td><strong>Update on Finance &amp; Performance Review Committee held on 12 January 2011</strong></td>
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<tr>
<td>• Mr Woods agreed to check with the Project Sponsor whether auditors from the Scottish Government who had indicated an earlier interest are still expected to review the Royal Hospital for Sick Children Re-provisioning project.</td>
<td>DW</td>
<td>12/4/11</td>
<td>Mr Woods has contacted the Sponsor and shall provide an update at the Committee.</td>
<td>In progress</td>
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<td>Action Required</td>
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<td>Due Date</td>
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<td><strong>External Audit</strong> (8 February 2011)</td>
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<td>Audit Scotland – Draft Annual Audit Plan 2010/11</td>
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<tr>
<td>• Mr Martin to clarify the background and approach to the review of staff over £100k.</td>
<td>BM</td>
<td>12/4/11</td>
<td>The background has been clarified, the Scottish Government has issued further guidance, and the audit approach has been discussed and agreed with Human Resources.</td>
<td>Complete</td>
</tr>
<tr>
<td>• Mrs Goldsmith to review the proposed external audit fee.</td>
<td>SG</td>
<td>12/4/11</td>
<td>The Director of Finance has reviewed this.</td>
<td>Complete</td>
</tr>
<tr>
<td>• Audit Scotland to bring back a revised draft audit plan, reflecting comments from the meeting and any further feedback provided by members.</td>
<td>HR</td>
<td>12/4/11</td>
<td>An updated plan has been received.</td>
<td>Complete</td>
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<tr>
<td><strong>Corporate Governance</strong> (8 February 2011)</td>
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<tr>
<td>Audit Scotland – The Role of Boards</td>
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<tr>
<td>• Mr Payne to liaise with Ms Tait to progress a joint approach to the issues in this report.</td>
<td>AP</td>
<td>12/4/11</td>
<td>The report was updated, and a final version provided to the Director of Finance and the Associate Director (Service Modernisation). It has been agreed that the report will be used in a future Board development day, where the LEAN review of governance shall be considered.</td>
<td>Complete</td>
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<td>Action Required</td>
<td>Lead</td>
<td>Due Date</td>
<td>Action Taken</td>
<td>Outcome</td>
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<tr>
<td>Any Other Competent Business (8 February 2011)</td>
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<tr>
<td>• Finance Department – Mrs Goldsmith agreed to follow up arrangements for Mr Peacock to attend a training session on the role of the Finance Department.</td>
<td>SG</td>
<td>12/4/11</td>
<td>This is being arranged.</td>
<td>In progress</td>
</tr>
<tr>
<td>• Vehicle Fleet Management – Mr Woods agreed to meet with Mr Peacock out with the meeting to discuss the recent audit report on Vehicle Fleet Management.</td>
<td>DW</td>
<td>12/4/11</td>
<td>The meeting was held on 21 February.</td>
<td>Complete</td>
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</table>
LOTHIAN NHS BOARD

AUDIT COMMITTEE

Minutes of the NHS Lothian Audit Committee Meeting held at 9.00am on Tuesday 8 February, 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

Present: Mr S Renwick (in the Chair); Mr E Egan; Mrs T Douglas; Mr B Peacock.

In Attendance: Professor J J Barbour; Ms S Goldsmith (Director of Finance); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mrs H Russell (External Auditor – Audit Scotland); Mr D Woods (Chief Internal Auditor); Ms G Woolman (External Auditor - Audit Scotland); Mr A Payne (Corporate Governance & VFM Manager) and Miss L Baird (Committee Administrator).

Apologies for absence were received from Mr D Miller.

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

130. Minutes of the Previous Meeting

130.1 Minutes of the Previous Meeting held on 6 December 2010 – previously circulated minutes of the meeting of the NHS Lothian Audit Committee held on 6 December 2010 were approved as a correct record.

131. Matters Arising

131.1 Audit Scotland – Transport for Health & Social Care Project Brief - Mrs Woolman reported that a meeting between the Performance Audit Group and the Board Chairman to address Dr Wistanley’s concerns regarding the lack of clarity surrounding the Patient Transfer Services had been scheduled.

Mr Egan and Mr Martin entered the meeting

131.2 Matters Arising from the Meeting of 6 December 2010– the Committee noted the previously circulated paper detailing the matters arising from the Audit Committee meeting held on 6 December 2010, together with the action taken and the outcomes.

131.1.1 Mr Payne introduced the action note. With regards Spire, Mr Payne noted the clear provisions within the SLA with respect to the quality of individual staff Spire must use as well as its responsibilities for clinical Governance. Spire management have previously advised Board management in a clinical governance visit that they would confirm that appropriate indemnity insurance
arrangements are used when a consultant employs people to perform a role in the provision of care. The Committee requested that assurance be provided that the risk presented by limited companies providing the care, as opposed to individuals, is managed. There may be a risk if the limited company does not have indemnity insurance in place. There needs to be clarity as to when the Board would be liable, and when it is not.

131.1.2 Mr Woods advised the Committee that the current contract with Spire was due to end in March. However, the Committee noted that the principles being discussed are relevant for other third-party providers of healthcare.

131.1.3 Staff Lottery – Mrs Goldsmith advised that the management body for the lottery has now engaged legal advice. The Board is holding funds on its behalf, but shall transfer this to the new body once the legal structures are in place. Mr Woods highlighted that the new legal body may be an incorporated one, and not necessarily an unincorporated one as mentioned in the Action Note.

131.1.4 Payment Verification Procedures – Mrs Goldsmith updated the Committee on the progress of the outstanding orthodontist case noting that wording satisfactory to both parties had been agreed, and a conclusion would be achieved in the near future.

131.1.5 The Committee agreed to note the action taken in respect of the Matters Arising.

132. Operational Audit Sub-Committee

132.1 Minutes of the Operational Audit Sub-Committee held on 29 November 2010 – the Committee noted the previously circulated minutes of the meetings of the Operational Audit Sub-Committee held on 29 November 2010.

132.1.1 The Committee agreed to adopt the minutes of the Operational Audit Sub-Committee meeting held on 29 November 2010.

132.1.2 Update on Operational Audit Sub-Committee held on 31 January 2011 – the Chair gave a brief update on the meeting of 31 January 2011, noting discussions in respect of the draft internal audit plan.

Mr Peacock entered the meeting.

132.1.3 Following discussions surrounding the implementation of recommendations arising from audit reports, the Committee were assured of the level of scrutiny in place. A report providing a snapshot of the current position regarding outstanding action points would be presented at the next meeting.

133. Linkages with Other Board Committees

133.1 Finance & Performance Review Committee held on 28 October 2010 – the Committee noted the previously circulated minutes of the Finance and Performance Review Committee held on 28 October 2010.
133.2 Update on Finance & Performance Review Committee held on 12 January 2011 – the Chair updated the Committee on discussions surrounding the new Royal Hospital for Sick Children in relation to alternative funding mechanisms, clinical link with DCN and ongoing work to get a consensus with the Scottish Futures Trust.

133.2.1 Mr Woods agreed to check with the Project Sponsor whether auditors from the Scottish Government who had indicated an earlier interest are still expected to review the Royal Hospital for Sick Children Re-provisioning project.

134. Internal Audit Reports

134.1 Internal Audit Plan 2011-2012

134.1.1 Mr Woods updated the Committee on the development of the audit universe, prioritisation of audits and development of the audit plan. Also, members noted his recommendation to contract external expertise to conduct the proposed audit of the Royal Hospital for Sick Children Re-provisioning project.

134.1.2 Mr Woods advised that he is currently scoping a possible additional audit on the request of the Chief Executive. Members noted that any additional audits or changes to the audit plan would be subject to the approval of the Committee.

134.1.3 In response to the Chair’s query Mrs Woolman advised the Committee that Audit Scotland were satisfied with the processes in place for developing the audit plan, timeliness of the plan being presented to the Committee and ongoing dialogue between Audit Scotland and the Chief Internal Auditor.

134.1.4 The Committee agreed to approve the audit plan for 2011 to 2012.

135. External Audit

135.1 Audit Scotland – Draft Annual Audit Plan 2010/11 – Mrs Russell gave a detailed overview of the previously circulated Audit Scotland Draft Annual Audit Plan 2010/11.

135.2 Mr Egan expressed concerns that the proposed review of staff earning over £100k per annum was in breach of the Staff Governance Standard. Professor Barbour queried the provenance of the review when the original request instructed Boards to ensure that they were satisfied with arrangements in place. After further discussions Mr Martin agreed to urgently collate all correspondence to enable a review of the position liaising with Mrs Goldsmith, Mr Renwick, Professor Barbour and Mr Egan prior to providing a formal response to Audit Scotland.
Mrs Goldsmith agreed to liaise with Mr Egan surrounding the definition of consultants in relation to the use of consultancy services – follow up audit.

Professor Barbour left the meeting.

After some debate the Committee decided that further discussions in respect of the external audit fee was required.

Members agreed to provide comments on the plan to Mrs Russell by no later than Friday 11 February 2011. Mrs Russell would consider all comments before bringing the report back for approval at the next meeting.

136. Corporate Governance

Counter Fraud Services Quarterly Report – December 2010 – the Committee noted the previously circulated Counter Fraud Services Quarterly Report – December 2010 and the information there in.

Mr Woods introduced the report highlighting Operation Clove as the only case linked to NHS Lothian; Human Resources had been made aware of the case and the situation was being monitored.

Members were advised that the Director of Finance at the Scottish Government Health Department had written to Directors of Finance of NHS boards suggesting that Counter Fraud Services Bulletins be presented to Audit Committees. Mr Woods provided assurance that Bulletins are distributed and auctioned appropriately within NHS Lothian. The Committee agreed to receive copies of the next Bulletins issued and take a view thereafter on the need to keep receiving them.

The Committee discussed issues relating to the treatment of non-eligible overseas patients, the role of the UK Border Agency and GPs’ role as gatekeepers. The Chair reassured Members that a reasonable framework was in place, and noted that the topic has been discussed regularly at the Operational Audit Sub-Committee. Also, Mr Woods advised that the topic was to be specifically discussed at the next meeting of the Counter Fraud Action Group. The Committee will be updated as appropriate following discussions at the Counter Fraud Action Group. Also, at the year end, Mr Woods will be providing the Operational Audit Sub-Committee with annual fraud statistics including figures for non-eligible overseas visitors.

Audit Scotland: The Role of Boards – the previously circulated report to provide the Committee with a briefing on the Audit Scotland Report on the Role of Boards and an opportunity to inform the paper that will be presented to the Board was reviewed.

Mr Payne agreed to incorporate comments from Mr Egan and Mrs Douglas in relation to the Non-Executive induction process, the relationship between the
Chairman and Non-executive Directors and actions on page 13 into the analysis schedule.

136.2.2 After some discussion it was agreed that Mr Payne would liaise with Mrs Tait to take forward a joint approach prior to submission to the Board.  

136.2.3 The Committee noted the offer from Audit Scotland to assist in the development of the report.

136.3 Technical Bulletin Summary – Mr Martin outlined the report to brief the members on the latest releases from Audit Scotland - 2010/4 dated 15 December 2010.

136.3.1 The Committee noted the relevant highlights within the technical bulletin.

136.4 2009/10 Audits – NHS Audit Service Quality Survey – Mrs Woolman introduced the report that informed the Committee of the last audit of the interface between finance and external audit in the 5 year term of Audit Scotland’s employment.

136.4.1 The Committee agreed to note the report and the information therein.

137. Any Other Competent Business

137.1 Finance Department – Mrs Goldsmith agreed to follow up arrangements for Mr Peacock to attend a training session on the role of the Finance Department.  

137.2 Vehicle Fleet Management – Mr Woods agreed to meet with Mr Peacock out with the meeting to discuss the recent audit report on Vehicle Fleet Management.

138. Date of Next Meeting

138.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Tuesday, 12 April 2011 at 9.00am in Waverley Gate, Edinburgh.
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<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Due Date</th>
<th>Action Taken</th>
<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Management of Drug Spend (9 June &amp; 28 October 2010)</strong></td>
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<tr>
<td>• A further report on progress on LRP in pharmacy should be submitted to the</td>
<td>SG/PM</td>
<td>22/03/11</td>
<td>Further proposals for LRP currently being developed</td>
<td>Paper to April F&amp;PR</td>
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<td>next meeting.</td>
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<td><strong>Royal Hospital for Sick Children (9 June 2010)</strong></td>
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<td>• A cost comparison should be made against the cost of providing shelving for</td>
<td>JKS</td>
<td>07/03/11</td>
<td>Business outline case being prepared</td>
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<td>medical records against scanning the records and holding them electronically.</td>
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<td><strong>Terms of Reference (9 February 2011)</strong></td>
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<tr>
<td>• Take amended Terms of Reference to the March Board meeting</td>
<td>CJW</td>
<td>10/03/11</td>
<td>Paper on agenda for Board meeting</td>
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<tr>
<td><strong>Gullane GP Practice Reprovision - Initial Agreement (9 February 2011)</strong></td>
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<tr>
<td>• Take forward the Initial Agreement for the reprovision of Gullane Medical</td>
<td>DAS</td>
<td>March 2011</td>
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<td>Practice to Standard Business Case for submission to the financial governance</td>
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<td>process, subject to its approval by the CHP Sub-Committee on 24 February 2011</td>
<td>SG</td>
<td>April 2011</td>
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<td>• Prioritise the project in principle against the formula capital allocation</td>
<td>DAS</td>
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<td>in 2011/12, 2012/13, once the Standard Business case had been concluded</td>
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<td>• Discuss wider options with East Lothian Council if capital funding is not</td>
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<td>available.</td>
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<td><strong>Finance Report for Period April - December 2010 (9 February 2011)</strong></td>
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<tr>
<td>• Take the suggestion that budgets be reduced by 5% to the Executive Management Team</td>
<td>SG</td>
<td>30/03/11</td>
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<td>• Explore options for creating a fund to facilitate voluntary severance</td>
<td>SG</td>
<td>04/04/11</td>
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<tr>
<td>• Bring a paper explaining the relationships between increased costs and reduced activity to a future meeting of the Committee</td>
<td>SG/JKS</td>
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<td><strong>Performance Management Report (9 February 2011)</strong></td>
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<tr>
<td>• Use greyscale in the performance management report and appendices instead of colour</td>
<td>SG</td>
<td>04/04/11</td>
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<tr>
<td>• Include information on cost and activity in all Finance reports</td>
<td>SG</td>
<td>04/04/11</td>
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<td><strong>Workforce Reduction (9 February 2011)</strong></td>
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<td>• Submit written reports to all meetings of the Committee</td>
<td>AB</td>
<td>04/04/11</td>
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<td><strong>5x5x5 Presentations (9 February 2011)</strong></td>
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<tr>
<td>• Bring synopsis of 5x5x5 presentations to the Committee</td>
<td>AMcM</td>
<td>04/04/11</td>
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</table>
Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 9 February 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr G Walker (Chair); Mr R Y Anderson; Professor J J Barbour; Mr E Egan; Dr D Farquharson; Mrs S Goldsmith; Mr P Johnston; Professor M Prowse; Mr S G Renwick; Mrs J K Sansbury and Dr C J Winstanley.

In Attendance: Mr C Burden; Mr P Gabbitas; Dr P Gilfoyle; Mr I Graham; Mr A Jackson; Mrs L Khindria; Ms S Lloyd; Ms C Potter; Mr P Reith and Mr D A Small.

Apologies for absence were received from Councillor J Aitchison, Mr A Boyter, Mrs M Hornett, Professor J Iredale, Mrs J McDowell, Professor A McMahon, Dr A Tierney and Mr I Whyte.

Declaration of Financial and Non-Financial Interest

The Chair reminded members they should declare any financial and non-financial interest they had in the items of business for consideration, identifying the relevant agenda item and the nature of their interest. Professor Barbour indicated that he was registered as a patient with Gullane GP Practice. It was agreed that this was not a pecuniary interest and did not preclude him from participating in the debate.

78. Minutes of the Previous Meeting

78.1 The Minutes of the meeting of the Finance & Performance Review Committee held on 12 January 2011 were approved as a correct record.

79. Matters Arising

79.1 Royal Hospital for Sick Children and Department of Clinical Neurosciences Reprovision Project Update – the Committee received a report, tabled of necessity, from the Director of Finance and Chief Operating Officer providing an update on progress made in advance of the conclusion of the Business Case for the March Board meeting for the Royal Hospital for Sick Children and Department of Clinical Neurosciences reprovision project.
79.1.1 Mrs Goldsmith advised the Committee that there had been constant engagement with the Scottish Government on the reprovision project and an addendum was required to the Royal Hospital for Sick Children Outline Business Case demonstrating the non-financial benefits for the joint development and detailing the financial analysis. It was intended to use the current design team to develop the reference design, the level of which had yet to be determined. In addition, advisers had to be appointed to provide support to the Non-Profit Distributing Public Private Partnership Model (NPD) procurement process, including legal advice, financial advice and technical advice, subject to funding agreement from the Scottish Government Health Directorates.

79.1.2 The Committee noted that proposals had been presented by Consort and Barclays for a joint venture. It was felt that such a joint venture would require a wider definition of public value than simply the cost of the reprovision. It was noted that the lease swap with Consort had not yet taken place for the car park at Little France, but was being progressed with the aim of concluding the transaction on completion of the replacement Car Park F.

79.1.3 The Committee agreed to:

- note the requirement for an addendum to the Business Case, with the format now agreed with the Scottish Government Health Directorates;
- approve in principle the employment of a design team to support the existing NHS Lothian project team utilising the existing Health Facilities Scotland Framework to deliver a “reference design” and note the associated timescale, subject to funding agreement from the Scottish Government Health Directorates and the agreed scope with the Scottish Futures Trust;
- approve in principle the employment of technical advisory team, including legal and financial advisers to support the existing NHS Lothian project team and NPD procurement process, subject to funding agreement from the Scottish Government Health Directorates;
- note the proposed structure of the governance; and
- note the current position with Consort Healthcare in relation to the land transaction and their joint venture proposal, subject to clarification of the legal and vires issues.

SG/JKS

80. Terms of Reference

80.1 The Committee received a previously circulated report, together with revised terms of reference for the Committee.

80.2 The Committee noted that the circular issued by the Scottish Government Health Directorates DEL 32 (2010) on Future Handling of Capital Resources Across NHS Scotland had reduced the Board’s delegated limit for the approval of capital schemes from £10m to £5m. An amendment was therefore required to the Committee’s terms of reference to reflect the reduced delegated limit.
80.3 It was also noted that it had become increasingly difficult to fill all the Non-Executive Member vacancies on the Committee and it was proposed that this number be reduced from eight to seven.

80.4 A reference had also been included to ensure that appropriate links were in place with the Service Redesign Committee to ensure that financial aspects were appropriately considered in all service redesign.

80.5 Mr Egan noted that the terms of reference presently referred to the Board’s Vice-Chair being a member of the Committee when it should more appropriately be the Employee Director, who would not necessarily be the Vice-Chair and proposed that this be amended.

80.6 The Committee agreed to recommend to Lothian NHS Board that it adopt revised terms of reference for the Finance & Performance Review Committee, to include a paragraph “To ensure that appropriate links are in place with the Service Redesign Committee to ensure that financial aspects are appropriately considered in all service redesign.”; that the reference to the Board’s delegated limit be reduced from £10m to £5m; to amend the membership to include the Employee Director rather than the Vice-Chair and to reduce the number of Non-Executive Board members from eight to seven.

81. **Gullane GP Practice Reprovision – Initial Agreement**

81.1 The Committee received a previously circulated report and Initial Agreement for the reprovision of Gullane GP practice.

81.2 Mr Small explained that the present surgery, purpose-built in the 1950s, was now unsuitable and no longer fit-for-purpose. Although the project was third on the hubco priority list, the two projects ahead of it were dependent on housing developments which had not yet taken place in the current economic situation. The project was a joint venture with East Lothian Council and agreement was being sought to further development the Standard Business Case.

81.3 In response to a question from Mr Renwick, Mr Small confirmed that the project would be revenue neutral if NHS Lothian was in a position to make a capital grant payment to East Lothian Council, as the revenue required to service this was already in the budget for the current premises.

81.4 Mrs Goldsmith advised that the Board’s capital allocation was not yet known and it was noted that if the funding had to be obtained from hubco, East Lothian CHP would not have sufficient revenue to cover the costs.

81.5 The Committee agreed to approve the Initial Agreement for the reprovision of Gullane Medical Practice; that the Initial Agreement should be taken forward to Standard Business Case for submission to the financial governance process, subject to its approval by the CHP Sub-Committee on 24 February 2011; that the project should be prioritised in principle against the formula capital allocation in 2011/12, 2012/13, albeit that this could only be confirmed once the Standard Business case had been concluded and noted that the Initial
Agreement had been approved by the CHP Senior Management Team, NHS Lothian CHP’s Finance and Performance Group, the Lothian Capital Investment Group and NHS Lothian’s Executive Management Team. It was noted that if capital funding was not available wider options would have to be discussed with East Lothian Council.

82. **Edinburgh Cancer Centre, Western General Hospital: Replacement of Two Radiotherapy Linear Accelerators (LINACS) (Phase 8)**

82.1 The previously circulated report seeking approval for the Business Case for the phase 8 development of the radiotherapy facilities at Edinburgh Cancer Centre, was received.

82.2 Mrs Sansbury introduced the paper and advised the Committee that this was the latest phase of the modernisation of radiotherapy equipment, which was supported and funded by the Scottish Government Health Directorates to ensure that Scottish patients obtained access to state of the art treatments using more complex radiotherapy techniques.

82.3 It was noted that the current equipment had a recommended lifespan of ten years and one of NHS Lothian’s low energy LINACS was ten years old in December 2010 with another high energy unit becoming ten years old in March 2011. The procurement of replacement linear accelerators was a single prime contractor and it was expected that a national contract would be awarded on 1 March 2011. The Scottish Government Health Directorates had requested that all necessary Business Cases had been approved locally by 1 March 2011 and the national Business Case and equipment specification had been completed in October 2010.

82.4 Mrs Goldsmith indicated that a draft financial plan had been agreed with the other NHS Board in the South East and Tayside Group but that whilst capital costs for the equipment were provided by the Scottish Government Health Directorates, revenue costs would increase by a total of £293,000 driven by the increase in capital charges. The net increase would be shared between the South East and Tayside group health systems based on recognised shares and the NHS Lothian element would be factored into the financial plans for 2011/12 and 2012/13 and the other health systems had confirmed their contributions.

82.5 The Committee agreed to approve the Business Case for the replacement of two radiotherapy linear accelerators (phase) in order to support the national programme and approved the revenue, resulting from replacing two radiotherapy accelerators as recommended by the Scottish Radiotherapy Advisory Group and the South East Scotland Cancer Network being funded through the financial plan.

83. **Draft Financial Plan 2011/2012 Update**

83.1 Mrs Goldsmith advised the Committee that the draft financial plan was nearing completion and NHS Lothian would require to deliver savings of 5% over the
next financial year in order to fill the gap between likely income and proposed expenditure. It was noted that the growth in Lothian’s older population was three times greater than it was in the west of Scotland and if the NRAC recommendations had been implemented in full, NHS Lothian would have received the necessary resources to meet the demand created by this increase.

83.2 The Committee noted that whilst a single system approach was being taken to delivering savings, the actual work on delivery would have to be carried out locally. Local Reinvestment Plans would be at the head of the financial plan and work was underway to ensure that all the details were identified.

83.3 Mrs Goldsmith emphasised that the anticipated uplift to the Board’s financial allocation was so low that there would be little flexibility and lower levels of staff turnover, particularly in higher salaried bandings, made it more difficult to reduce staffing levels in the desired areas given current policy constraints.

83.4 Mr Egan commented that he did consider that a 5% savings target was achievable and proposed that budgets simply be reduced by 5% with managers being given the responsibility of delivering a service within the reduced budget.

83.5 Mr Johnston commented that the whole of the public sector was facing financial difficulties and service changes required to be delivered. He supported Mr Egan’s proposal that the 5% saving be applied at the outset of the financial year.

83.6 Professor Barbour commented he was confident that quality could be improved at the same time as cutting costs by 5% but that changes to the policy bottleneck would be necessary if these levels of saving were to be made.

83.7 The Committee agreed to note the position in respect of the draft financial plan and commend to the Executive Management Team the suggestion that budgets be reduced by 5% at the start of the financial year, accompanied by strict discipline in respect of budget holders not exceeding budgets.

84. Finance Report for the Period April-December 2010

84.1 A previously circulated report, giving an update on the financial position within NHS Lothian for the nine month period ended 31 December 2010, was received.

84.2 Mrs Goldsmith advised the Committee that whilst there had been a £5.75m overspend for the first nine months of the financial year, a break-even position at the end of the financial year was still predicted.

84.3 The Chair commented that reductions in the overall workforce to meet the workforce plan were still required and Mr Johnston suggested that further funding should be identified to facilitate voluntary redundancies.

84.4 Mr Renwick commented that it would be helpful to see a cross-reference of increased costs with reduced activity.
84.5 Mrs Sansbury reminded the Committee that much of the investment had been made in areas where activity was being transferred from inpatient care to day care as new models of care were developed and implemented. There was not, therefore, a simple correlation between activity levels and increased costs.

84.6 The Committee noted the financial position for the period ended 31 December 2010 and that the forecast year-end out-turn remained as break-even, although there were significant additional recurring costs in the system which had to be addressed by Local Reinvestment Plans in the following year.

84.7 It was agreed that the Director of Finance should explore options for creating a fund to facilitate voluntary severance and it was agreed that a paper explaining the relationships between increased costs and reduced activity should be brought to a future meeting of the Committee. SG/JKS

85. Capital Update

85.1 The Committee received a previously circulated report outlining the capital expenditure position for the period April-December 2010 and providing an overview on progress against individual major capital projects.

85.2 Mrs Sansbury emphasised that redesign of services often reduced activity as patient treatments transferred from inpatient to outpatient activity.

85.3 The Committee noted that NHS Lothian was forecasting the achievement of the capital resource limit of £86.5 following the return of around £36m of “project” funds to the Scottish Government Health Directorates and recognised the cash flows over 2010/11 and 2011/12. The Committee noted the expenditure of £47m to December 2010 on the agreed capital programme and the current position with each of the major projects.

86. Performance Management Report

86.1 A previously circulated report giving an update on performance against key target areas for the health improvement, efficiency, access and treatment objectives within the Local Delivery Plan for 2010/11.

86.2 Mr Egan commented on the poor performance in respect of the implementation of eKSF and expressed his concern at NHS Lothian’s ability to meet the Scottish Government Health Directorates’ targets.

86.3 The Committee agreed that as colour was no longer being used in the production of Board papers, in order to reduce costs, greyscale should be used in the performance management report and appendices instead of colour. SG

86.4 The Committee also agreed that cost and activity information should be included in financial reports and that a paper proposing ways of increasing the
degree of detail or precision contained in data should be submitted to a future meeting.

86.5 The Committee agreed to note the performance against the key target areas.

87. Workforce Report

87.1 Mrs Khindria apologised to the Committee that it had not been possible to provide a written report updating the position since the report was submitted to the 12 January 2011 Committee meeting.

87.2 Mrs Khindria indicated that good progress was being made with a reduction of 822 whole time equivalent posts with the reduction of a further 536 whole time equivalent posts in place at 31 March once the Local Reinvestment Plan had been delivered. Strict controls were in place and the major difficulty that was being encountered was that vacancies were not always following in areas where scope for reduction had been identified. Work was being undertaken to examine ways of redeploying staff in order to make best use of the workforce and it was anticipated that a further 800 whole time equivalent posts would be removed from the establishment in 2011/2012 through natural wastage.

87.3 The Committee noted that NHS Lothian was ahead of the agreed target with the Scottish Government.

87.4 Mrs Khindria also indicated that work was being undertaken examining new roles for staff and increasing productivity, as well as reducing sickness absence. The greatest challenges identified were the lower turnover rates in the current economic situation and funding for exit packages for staff seeking to take voluntary severance.

87.5 The Committee agreed to note the report.

88. Tackling Delayed Discharge and Delivering Waiting Times

88.1 Mr Jackson advised the Committee that, following the written report submitted to the Board meeting at the end of January, there had been a reduction in the number of delayed discharge patients in Edinburgh and Midlothian. The Edinburgh delays had mainly been caused by the lack of nursing home places and a new home would be opening shortly which would further help to address this problem.

88.2 It was noted that the February waiting time figures would show details of the waiting times over the extreme winter period.

88.3 Mr Renwick commented that there was a widespread public perception that waiting times were longer than they actually were and the Committee agreed that Communications should be asked to look into ways of overcoming this perception.
89. **Additional Meeting**

89.1 The Chair advised the Committee that a special meeting of the Finance & Performance Review Committee in March would be necessary in order to discuss the reprovision of services for the Royal Hospital for Sick Children and the Department of Clinical Neurosciences and advised that members would be advised when a suitable date was found. **PR**

90. **5x5x5 Projects**

90.1 Mr Egan suggested that the Committee be provided with an update on the 5x5x5 projects.

90.2 Professor Barbour proposed that, rather than providing lengthy presentations, which were more appropriately within the remit of the Service Redesign Committee, a synopsis of the projects and their progress should be brought to a future meeting of the Committee. **AMcM**

91. **Date of Next Meeting**

91.1 The Committee noted that the next scheduled meeting would be held on Wednesday, 13 April 2011 at 9.00am in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh. A special meeting of the Committee would be held in March at a date to be notified.
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<tr>
<td><strong>Emergency Access (October 2010)</strong></td>
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<td>• Dr Mckigen reported that this was due to various reasons including delays in decision making and discharge prescriptions not being ready. It was noted that the communication between acute and the CHCPs/CHPs could be improved. It was agreed an update report come back in six months, to the April 2011 meeting.</td>
<td>TM</td>
<td>April 2011</td>
<td>On April 2011 agenda</td>
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<tr>
<td><strong>NHSScotland National Catering and Nutritional Services Specification (October 2010)</strong></td>
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<td>• Mr Egan reported that there had been significant improvements but commented that the menu remained on a three week cycle and was not ideal for longer stay patients. Mrs Hornett reported that discussions were ongoing to consider an alternative menu cycle.</td>
<td>MH</td>
<td>April 2011</td>
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<td><strong>NHS Lothian Risk Register Report (October 2010)</strong></td>
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<td>• The Committee noted the risk register report. Dr Winstanley asked about the connection between internal audit and risk management and whether audit reports could be linked to the risk register. It was agreed that this should be taken forward and discussed at the Audit Committee.</td>
<td>PM</td>
<td>April 2011</td>
<td>Update to April 2011 meeting</td>
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<td><strong>Significant Event Analysis (October 2010)</strong></td>
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<td>• It was noted that the development of the Mental Health Observation policy in 2004 had significantly changed practice to ensure that there was a systematic, multi-professional, clinically effective and safe approach to the observation of the patient within an acute admission ward. The Committee agreed that this policy should be standardised across all hospitals.</td>
<td>PD</td>
<td>December 2011</td>
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<td><strong>Patient Transport System (PTS) (February 2011)</strong></td>
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<td>• Mr Grieve went through the recommendations set out in the report. He pointed out that some patients were refused patient transport by the Scottish Ambulance Service (SAS) as the</td>
<td>JKS</td>
<td>August 2011</td>
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patient did not meet the categorisation criteria. He added that SAS staff members booking transport did not always have the relevant expertise to assess all patients. The Committee noted the report and acknowledged that work was still to be done.

<table>
<thead>
<tr>
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<tr>
<td>Dr Farquharson gave a verbal update on a recent medical incident involving the administration of the anticoagulant heparin. He reported that a full review was being carried out and a further update would be given at the next meeting.</td>
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<tr>
<td>The Committee noted the report and suggested that the strategy be redrafted to include more references to the Catering Strategy and to incorporate the comments mentioned above.</td>
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<tr>
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<tr>
<td>The Committee would like to see an update paper with details on updated actions</td>
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<tr>
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LOTHIAN NHS BOARD

HEALTHCARE GOVERNANCE & RISK MANAGEMENT COMMITTEE

Minutes of the Meeting of the Healthcare Governance and Risk Management Committee held at 9.00am on Tuesday 1 February 2011 in Room 8, Waverley Gate, Edinburgh.

Present: Professor Murray (Chair); Professor A Tierney; Professor M Prowse; Dr R Williams Ms M Anderson; Mrs I Garden, Ms S Allan, Mrs M McFarlane and Mr W Rae.

In Attendance: Dr D Farquharson; Mr A Boyter; Dr A McCallum; Mrs P Dawson; Dr S Mackenzie (until 10am); Ms J Warner (Director of Patient Safety and Performance Assessment); Ms J Drysdale (item 6.5); Mr M Grieve (item 3.1); Professor A McMahon (item 4 & item 6.6) and Miss E Pendleton (Minutes).

Apologies for absence were received from Mr E Egan; Mr D Forbes; Dr C Winstanley; Mrs M Hornett; Ms J Sansbury; Dr J Hendry; Mr I Whyte; Ms L Falconer and Ms J Stirton

CHAIR’S REMARKS

The Chair welcomed members to the meeting and members introduced themselves. She reminded members that the December meeting had been cancelled due to the severe weather conditions. The Chair welcomed the new patient representatives – Irene Garden, Mary Scott McFarlane and William Rae to their first meeting of the Healthcare Governance and Risk Management Committee. The Chair also welcomed Ms Shulah Allan to her first meeting as a new Non-executive member of the Board. The Chair commented that there was unfortunately no representation from Partnership or the Community Health Partnerships at the meeting and after 10am no representatives from University Hospitals Division. The Chair referred to the Guidance for people and staff working together - that had been previously circulated to the Committee. The Committee noted the guidance set out in the report.

1. COMMITTEE CUMULATIVE ACTION NOTE

1.1 The Committee noted the Action Note and the information therein. The following actions were commented on:

- **Mandatory Training:** The Committee noted that a report on mandatory training had been prepared and would come to the April meeting.

- **Business Continuity Planning:** The Chair informed the Committee that Business Continuity and Emergency Planning were on the draft internal audit plan that would be presented to the Audit Committee on 8 February 2011 for approval.

- **NHS Lothian Risk Register Report (October 2010):** The Chair agreed to follow this up with Mr Renwick, Chair of the Audit Committee.
2. MINUTES OF THE PREVIOUS MEETING: 5 OCTOBER 2010

2.1 The minutes of the meeting of the previous meeting on 5 October 2010 were approved as a correct record.

3. MATTERS ARISING

3.1 Patient Transport System (PTS)

3.1.1 Mr Grieve attended the meeting to provide an update on the PTS. Mr Grieve went through the recommendations set out in the report. He pointed out that some patients were refused patient transport by the Scottish Ambulance Service (SAS) as the patient did not meet the categorisation criteria. He added that SAS staff members booking transport did not always have the relevant expertise to assess all patients. Ms Garden suggested using the information on patients’ bus passes as a way of assessing whether patients would need patient transport or not. The Committee agreed that this needed to be resolved. Dr Mackenzie also pointed out that it was important that patient transport was punctual when transferring patients to different hospitals as patient delays could result in longer stays and queues at the front door. Committee members suggested using community based drivers and a computerised system to book patient transport.

3.1.2 Dr Williams referred to point 2.4 of the report and noted that NHS Lothian outpatient booking letters no longer contained advice on securing transport though PTS. He added that this was not supported by all GPs and had resulted in an increase in enquires to GP surgeries about patient transport.

3.1.3 The Committee noted the report and acknowledged that work was still to be done. It was agreed that Mr Grieve would report back to the Committee in 6 months. The Chair thanks Mr Grieve for his paper and also informed him that this paper required a rapid impact assessment.

3.2 Significant Event Report

3.2.1 Dr Farquharson gave a verbal update on a recent medical incident involving the administration of the anticoagulant heparin. He reported that a full review was being carried out and a further update would be given at the next meeting.

4. INTERMEDIATE CARE

4.1 Professor McMahon presented the paper on the work being taken forward nationally and locally in the development of intermediate care. He went through the summary of issues and explained that intermediate care services helped people to improve their independence and aimed to provide a range of enabling, rehabilitative and treatment services in community and residential settings. This
could help prevent unnecessary admission to hospital, or help facilitate early discharge.

4.2 Professor McMahon commented that this was a framework for future plans and would provide a direction of travel for NHS Lothian. He highlighted that the report would go to the Joint Board of Governance on 28 February 2011 for approval. The Chair informed Professor McMahon that this paper required a rapid impact assessment.

5. QUALITY ASSURANCE

5.1 NHS Lothian Nutritional Care Strategy

5.1.1 Mrs Dawson presented the draft report on the updated Nutritional Care Strategy: Eating and Drinking to Keep Well and Feel Better. There followed some discussion on the draft strategy and members suggested that the strategy be linked and cross referenced to the NHS Lothian Catering Strategy. It was also suggested that more information was provided on opportunities for research and development. Professor Tierney pointed out that work of the Nutritional Care Strategy - Improving Patient Experience Group (NIPEG) should be highlighted in the report. The Committee noted that there had been vast improvements however there was still variability across sites and the focus should now be on reliability and consistency across NHS Lothian. There followed some questions on the patient menus and Professor Tierney explained that there were vegetarian, vegan and religious requirement options. The menu cards had contact numbers for the catering manager and patients were actively encouraged to call if they had any comments on the menu.

5.1.2 The Committee noted the report and suggested that the strategy be redrafted to include more references to the Catering Strategy and to incorporate the comments mentioned above. Committee members noted the helpful glossary included in the paper.

PD/MH

5.2 Nursing, Midwifery and Allied Health Professional Research Framework

5.2.1 Mrs Dawson spoke to the report on the Nursing, Midwifery and Allied Health Professional Research Framework. Members suggested that the Framework have a more direct alignment with the Board’s priorities and more specific measurable outcomes. There followed some discussion on possible income from research and it was suggested that income from research should be listed as one of the aims listed in point 3.3 of the report. The Committee noted the progress made with the implementation of the Lothian Clinical Academic Research Centre (CARC) and commented that the collaborative approach was a significant achievement and a major step forward.

5.2.2 Committee members added that a glossary would be useful to explain the acronyms used in the report. The Chair reported that this paper also required a rapid impact assessment.
5.3 Information Commissioners (ICO) Follow-up Audit Report

5.3.1 Dr McCallum spoke to the report on the Information Commissioners Follow-up Audit Report. She highlighted that NHS Lothian had agreed to participate in a follow up audit from the ICO. The original audit was undertaken following an investigation by the ICO enforcement division and was designed to enable the organisation to comply with data security recommendations relating to security breaches. The Committee went on to look at the recommendations and there were some questions regarding the actions that were partially incomplete or not implemented. Dr McCallum confirmed that the compliance action A6 – ‘Data protection risks should be managed through formal risk registers to ensure they are appropriately addressed’ was due to be taken forward and the corporate risk register to be revised in February 2011. It was also noted that risk C5 – ‘where fully automated tracking is not in place procedures should be considered for validating returned files/reconciliations conducted to provide early identification of missing files’ was not being implemented as Community TRAK would mitigate this. There were also concerns raised regarding recommendation C10 – ‘Confidential waste should be accorded an appropriate level of security and access restricted until disposal’. The Committee agreed they would like to see an update paper with details on updated actions.

6. RISK MANAGEMENT

6.1 Healthcare Associated Infection Update

6.1.1 The Committee received the routine HAI report. Dr McCallum explained that the Healthcare Associated Infection Reporting Template (HAIRT) from the Scottish Government Health Directorate was included in appendix 1. The Committee went through the summary and Dr McCallum highlighted that there had been a 28% reduction in Staphylococcus aureus Bactereraemia which meant that the 40% reduction target had not been met. However there had been a 79% reduction in MRSA and a 50% reduction in Clostridium Dificile. The Committee went on to discuss hand hygiene and noted that most staff groups were exceeding the national minimum target of 90% compliance. The recent compliance scores for medical staff were around 88% of 50 opportunities observed, lower than other staff groups. There followed some discussion on hand hygiene education and members suggested learning from colleagues in veterinary medicine. Members asked about hand hygiene education in primary care. Dr Williams confirmed that there were cleanliness champions in primary care and audits of hand hygiene took place.

6.2 Public Protection Services Update

6.2.1 Mrs Dawson went through the update on child protection, adult protection and Multi-Agency Public Protection Arrangements (MAPPA). She highlighted the number and summary details and actions on NHS Lothian from a number of reviews and reported that these were all being progressed. With regard to capacity building, Mrs Dawson highlighted achievements in regards of mandatory training and specific resource for adult protection. There would be an update on this to the next meeting. Mr Boyter referred to the Protection of Vulnerable Groups (Scotland)
Act and reported that, if implemented, this would replace the current disclosure arrangements for people who work with vulnerable groups. He reported that this could have financial implications for NHS Lothian as all staff that worked with vulnerable groups would be required to have a disclosure check. He added that staff that had recently been employed would have had a disclosure check as part of their recruitment process but added that this was not the case for longer serving staff.

6.2.2 The Committee went on to discuss education and training within adult protection. The Committee noted that 18,010 staff had completed adult protection training. Professor Prowse requested that this figure be included as a percentage. MH

6.2.3 In relation to MAPPA, the Committee noted the updates on two multi-agency significant care reviews.

6.3 NHS Lothian Incident Report

6.3.1 Dr Farquharson presented the report to the Committee to review the type and volume of incidents recorded on DATIX, the Risk management Information System (RMIS). He explained that NHS Lothian were continuing to see a rising trend in the number of incidents being reported – due to improvements in the incident reporting system and an increasing awareness of safety culture. He highlighted that the top 3 incidents reported were medicines, falls and aggression. It was noted that the Incident Management Policy was being revised and the Incident Management Operational Procedure would provide clear guidance to staff on all areas of policy implementation.

6.3.2 Mrs Dawson informed the Committee that there had been a National Scottish Patient Safety event in January featuring incident reporting and reported that this learning would inform the policy development.

6.4 NHS Lothian Risk Register Report

6.4.1 The Committee referred to the NHS Lothian Quarterly Risk Register for December 2010. Committee members requested that future Risk Register Reports were more concise. DF

6.5 Business Continuity Update

6.5.1 Ms Drysdale attended the meeting to update the Committee on the business continuity planning process. The Committee noted that recent work had focussed on the development and delivery of the multi-site walk through exercise ‘House of Cards’. Ms Drysdale reported that the NHS Lothian intranet had been used to provide information on the exercise and there had been 1225 hits on the site although there were only 215 players. The Committee noted that this was encouraging and demonstrated increased awareness of business continuity planning. It was also noted that the number of people trained on the e-learning module business continuity had more than doubled.
6.5.2 Ms Drysdale added that John Jack, Head of Facilities had reported that staff had gained confidence from taking part in the ‘House of Cards’ exercise to deal with the pressures during the severe weather.

6.5.3 It was noted that the full report and an action plan would be issued in the next few days. The Committee thanked Ms Drysdale for her update and commented that the exercise had been well demonstrated. Ms Drysdale also confirmed that the NHS Lothian Business Continuity Lead was now a permanent post. The Chair reported that this paper also required a rapid impact assessment.

6.6 Adults with Incapacity (Scotland) Act 2001 – Part 5

6.6.1 Professor McMahon attended the meeting to speak to the report on issues relating to current practices in NHS Lothian in relation to part 5 of the Adults with Incapacity (Scotland) Act. The Committee noted that there were some issues regarding accessibility to assessment of incapacity training. Professor McMahon reported that this was part of the action plan detailed in section 4 of the paper. The Committee members suggested training across sector and the possibility of learning from the implementation of the Mental Health Act. Mrs McFarlane referred to patients’ living wills and reported that it was important that these wills were adhered to.

6.6.2 The Committee noted the report and supported the actions proposed to address current practice and reduce the identified risks. The Chair also requested an update report in 2012.

6.7 Independent Audit of Forceps Deliveries in NHS Lothian

6.7.1 Dr Farquharson introduced the report with details on the findings from an independent review into forceps deliveries in NHS Lothian. He gave a brief background to the paper and reported that the audit was commissioned by the Nurse Director and the Medical Directors after the death of a term baby following a rotational forceps delivery. The Committee noted that there was no major cause for concern and the overall assisted delivery rate at the Royal Infirmary of Edinburgh was in line with published national averages. He also highlighted that the reviewers were impressed with the dedication and professionalism of the staff interviewed.

7. GOVERNANCE ISSUES

7.1 NHS Lothian’s Quality Improvement Strategy

7.1.1 The Committee considered the draft NHS Lothian Quality Improvement Strategy for 2011-2014. The strategy demonstrated how it contributed to NHS Lothian’s aim to be at the level if Scotland’s best and in the top 25 healthcare systems in the world in terms of outcome and value.

7.2 Immunisation of Infants against Respiratory Syncytial Virus: Response to the Letter from the Chief Medical Officer Advising its Introduction
7.2.1 Dr McCallum spoke to the report to advise the Committee of the current situation regarding immunisation of infants against Respiratory Syncitial Virus using Palivizumab. She explained that the advice of the lead clinicians and the neonatologists in Lothian was not to introduce the routine Palivizumab prophylaxis against Respiratory Syncital Virus infection in high risk infants. It was noted that this advice did not meet the requirements laid out in the Chief Medical Officer (CMO) letter dated 15 December 2010. She highlighted that there were concerns regarding the cost of introducing the Palivizumab prophylaxis programme without any additional resources. There followed some discussion on the legal implications. The Committee supported the advice of the clinicians but would like more clarification on the legal status of the letter from the CMO.

AKM

7.3 NHS Lothian Diabetic Retinopathy Screening Programme Annual Report: April 2009 to March 2010

7.3.1 The Committee noted the NHS Lothian Diabetic Retinopathy Screening Programme Annual Report: April 2009 to March 2010

8. PATIENT EXPERIENCE

8.1 Better Together National Adult Inpatient Survey Results

8.1.1 The Committee noted the performance of Lothian in patient services compared with the Scottish average in relation to the 1482 returned patient survey questions. The Committee reviewed the action plan attached at appendix 6.

8.2 Better Together National GP Survey Results

8.2.1 The Committee noted the overall performance of Lothian GP practices compared with the Scottish average in relation to the 31 individual patient survey questions. The Committee reviewed the progress in delivering the action plan to address the issues highlighted by the GP patient survey data.

8.3 Report in Response to SPSO Investigation into Patient Care at Liberton Hospital

8.3.1 Mrs Dawson spoke to the report. She explained that the report gave an update on the implementation of the required actions following the feedback from the SPSO in relation to a relative’s complaint. She also updated the Committee on the review visit which had taken place on 6 January 2011 and a positive letter from the complainant.

9. OTHER MINUTES: EXCEPTION REPORTING ONLY

9.1 The Committee noted the following sets of minutes:

Minutes of NHS Lothian Health and Safety Committee
Minutes of Child Protection Action Group
Minutes of the Lothian Infection Control Advisory Committee
10. EXCEPTION REPORTING ONLY

10.1 The Committee noted and approved the following items:

- Respiratory MCN Annual Report for 2009-10
- Coronary Heart Disease Managed Clinical Network Final Report 2004-2010
- Audit Scotland Report – Emergency Departments
- Working with Blood Bourne Viruses Strategic Policy
- Testing, Maintenance and Revalidation of Dental Decontamination Equipment
- Scottish Arthroplasty Project Annual Report 2010
- NHS Lothian Pharmacy Service Education, Research & Development (ERD) July 09 – Aug 10
- Clinical Governance and Risk Management: Vital Systems
- Interventional Procedures
- Implementation of the Public Health (Scotland) Act 2008
- NHS Lothian Complaints - Annual Review 2009-10
- NHS Lothian Diabetic Retinopathy Screening Programme

11. ANY OTHER COMPETENT BUSINESS

11.1 There was none.

12. DATE OF NEXT MEETING

12.1 Tuesday 5 April 2011 – from 9:00 in Room 8, Waverley Gate

Other Meetings for 2011

- 7 June 2011
- 2 August 2011
- 4 October 2011
- 6 December 2011
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<td><strong>Single Outcome Agreement/CH(C)Ps/Change Fund</strong></td>
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<td>Mr Anderson asked about the reporting arrangements</td>
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<td>for the Edinburgh Partnership Board. It was agreed</td>
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<td>that Mr Anderson would speak to the Chairman about</td>
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<td><strong>Public Involvement</strong></td>
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<td>Committee members went on to discuss the Committee</td>
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<td>meetings and public involvement. It was noted that</td>
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<td>arrangements had been put in place for the public to</td>
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<td>attend meetings but there had been a lack of public</td>
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<td>Douglas agreed to take this forward. Committee</td>
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<td>members added that it would be useful to have data</td>
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<td>on how many members of the public had attended each</td>
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<td><strong>Primary Medical Services – LRP</strong></td>
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<td>the Primary Care Forward Group and a paper had been</td>
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<td>It was agreed that this paper could be forwarded to</td>
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<td>Committee members. It was also agreed that the</td>
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<td>to represent University Hospitals Division. It was</td>
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<td>agreed that Professor McMahon would discuss this with</td>
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<td>Mrs Sansbury.</td>
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**Resource Transfer – Annual Uplift Arrangements**
Professor McMahon highlighted that it had been agreed that the uplift applied to resource transfers in 2011/12 financial year should be 0.5%. This was still to be signed off by COSLA. He suggested that this be discussed in more detail at a future meeting to consider governance arrangements.

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**GP Contracts**
Mr Miller reported that he had prepared a briefing on the changes to GP contracts that could be discussed in more detail at the next meeting.

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<th>DM</th>
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**CHCP Review**
Ms Hollis pointed out that the Audit Scotland report on the Review of CHPs would be released at the end of May. It was agreed that this would be picked up again at the July meeting. This would also mean that any policy direction post election should also be clearer.

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Minutes of the Meeting of the Lothian NHS Board Primary and Community Partnership Committee on Wednesday 19 January 2011 at 2pm in Room 7, Waverley Gate, Edinburgh.

Present: Mr R Burley (Chair); Mr R Y Anderson (from 2:50pm); Mr D Forbes; Ms T Douglas; Mr D Small; Mr B Peacock and Professor A McMahon

In Attendance: Mr D Miller; Mr M Grieve; Mr R Aitken (from 2:50pm); Dr N Williams; Ms L Hollis and Miss E Pendleton (Minutes)

Apologies for absence were received from: Mr N Williams; Mr I Whyte; Ms M Christie; Mr A Short; Mr E Egan; Ms J Stirton

Chair’s Remarks

The Chair welcomed members to the Committee.

Declarations of any Financial and Non-Financial Interests

There were no declarations from members.

1. Minutes from Previous Meeting

1.1 The Minutes from the meeting on the 10 November 2010 were approved as a correct record subject to the following amendments: Mr B Peacock was present and the first paragraph on the first page should read “Minutes of the Meeting of the Lothian NHS Board Primary and Community Partnership Committee”

2. Cumulative Action Note

2.1 Hosted Services Review - The Committee referred to the tissue therapy service and Professor McMahon reassured members that there would be no changes to the tissue therapy service in the near future.

2.2 Outcomes of 8 September PCPC Workshop - The Committee noted that this had been completed and a letter had been sent to all participants informing them of the outputs from the PCPC workshop and how they were being taken forward.

3. Matters Arising

3.1 Professor McMahon referred to the discussion on delayed discharge at the previous meeting and reported that the situation had improved and 8 out of 15
patients with the longest delays had now moved on. The Committee noted the positive outcome and noted that this had decreased the total length of stay for NHS Lothian. The Chair suggested that the Committee consider delayed discharge/complex codes in more detail and consider individual cases.

3.2 The Committee went on to discuss the increasing number of patients moving from acute care into care homes. It was agreed that Professor McMahon would bring a paper back to the next meeting for further discussion based on this issue.

4. Exception Reporting from Minutes: CHPs/CHCP/REAS/PCCO

4.1 West Lothian Community Health and Care Partnership Board: 19/10/2010

4.1.1 The Committee noted the minutes.

4.2 East Lothian Community Health Partnership: 28/10/2010

4.2.1 The Committee noted the minutes.

4.3 Mid Lothian Community Health Partnership: 30/09/2010

4.3.1 The Committee noted the minutes. There was some discussion on the homeopathy service and it was noted that a consultation would take place after May 2011.

4.4 NHS Lothian Primary Care Joint Management Group: 14/10/2010

4.4.1 The Committee noted the minutes. Mr Miller highlighted that patient surveys would take place every two years.

4.5 NHS Lothian Primary Care Finance and Performance Group: 24/11/2010

4.5.1 The Committee noted the minutes.

5. Delivering Quality in Primary Care

5.1 Professor McMahon spoke to the report to update the Committee on the progress with the development of the Lothian Primary Care Action Plan. The action plan made it clear who was responsible for each action and each action had information on current performance and key measurable deliverables and timeframes. Professor McMahon pointed out that the action plan had been discussed at the Primary Care Forward Group which included representatives from the Lothian Medical Committee (LMC). It was also noted that an event would be organised to engage all independent contractors – GPs, pharmacists, dentists and community optometrists.

5.2 Mr Anderson referred to Action 1 – for General Dental Services (GDS) and asked how this would be taken forward. Professor McMahon reported that there was work to be done to contribute to the national development of quality measures for dentistry but added that the Department of Health in England had published a document on Dentistry that may be useful in taking this forward.
5.2 The Committee went on to discuss the possibility of a more aspirational action plan with more actions linked to what would be needed in the future. Professor McMahon reported that moving forward it would be possible to consider long term aspirations but added that it was important to stabilise current processes. He also referred to the change fund and added that this would create more opportunities.

5.3 The Committee noted the report and agreed to receive an update on a two-monthly basis on the action plan and the work arising from it.

6. Single Outcome Agreement/CH(C)Ps/Change Fund

6.1 Professor McMahon presented the report on the single outcome agreement process and the change fund. The Committee noted the key measures of success:

- Reduction in unplanned acute bed-days in the over 75 population;
- Reduction in bed-days lost to delayed discharge;
- Remodelled care home use;
- Increase in proportion of older people living at home;
- Improved support for unpaid carers;
- Increased personalisation/SDS care; and
- Increases in housing related support.

6.2 It was noted that the first 4 targets listed above would be core targets across Lothian. There followed some discussion on the change fund allocation across CH(C)Ps. It was noted that the fund had been allocated to CH(C)Ps by the Scottish Government. It was agreed that Ms Hollis would report back to the next meeting with more information on the allocation.

LH

6.3 Mr Anderson asked about the reporting arrangements for the Edinburgh Partnership Board. It was agreed that Mr Anderson would speak to the Chairman about this.

BA

7. Proposed Membership of the West Lothian CHCP Sub-Committee

7.1 Mrs Douglas introduced the paper with details of proposed membership of the West Lothian CHCP Sub-Committee.

7.2 The Committee homologated the appointment of John Richardson and Sandra Mair as members of the West Lothian CHCP Sub-Committee.

8. Items for Information

8.1 There were no items for information

9. Any Other Competent Business

9.1 Community Health Partnerships: Delivering Better Outcomes and the Use of Joint Resources
9.1.1 Professor McMahon tabled the letter from Kathleen Bessos and the attached paper – Delivering Better Outcomes and the Joint Use of Resources. It was agreed that this should come back to the Committee for further discussion. The Chair pointed out that it would be useful if the paper could be added to the agenda for CH(C)P meetings before coming back the PCPC in order to make the discussion more informed.

9.2 Resource Transfer

9.2.1 Professor McMahon reported that any uplift for resource transfer would now be agreed nationally not locally. The Committee agreed that this should be discussed in more detail at the next meeting. Professor McMahon added that this would also be discussed at a meeting with all councils and CHP’s on 25 January 2011 and the UHD CHP meeting.

10. Date of Next Meeting: Wednesday 9 March, 2:00 p.m. in Meeting Room 7 at Waverley Gate.

Other Dates for 2011:

   11 May 2011
   13 July 2011
   14 September 2011
   9 November 2011
LOTHIAN NHS BOARD

PRIMARY & COMMUNITY PARTNERSHIP COMMITTEE

Minutes of the Meeting of the Lothian NHS Board Primary and Community Partnership Committee on Wednesday 9 March 2011 at 2pm in Room 7, Waverley Gate, Edinburgh.

Present:  Mr R Burley (Chair); Mr R Y Anderson; Ms M Christie; Mr D Forbes; Ms T Douglas; Mr D Small; Mr R Aitken and Professor A McMahon

In Attendance: Mr D Miller; Dr N Williams; Ms L Hollis and Miss E Pendleton (Minutes)

Apologies for absence were received from: Mr I Whyte; Mr B Peacock and Mr E Egan

Chair’s Remarks

The Chair welcomed members to the Committee.

Declarations of any Financial and Non-Financial Interests

There were no declarations from members.

11. Minutes from Previous Meeting

11.1 The Minutes from the meeting on the 19 January 2011 were approved as a correct record subject to the following amendment: point 5.2 - the following sentence should read “The Committee noted the report and agreed to receive an update to every second meeting on the action plan and the work arising from it”

12. Cumulative Action Note

12.1 Single Outcome Agreement/CH(C)Ps/Change Fund- Ms Hollis informed the Committee that NHS Lothian’s proposed local transformation (change fund) plans had been submitted to the Scottish Government and NHS Lothian were now waiting on a response.

13. Matters Arising

14. Exception Reporting from Minutes: CHPs/CHCP/REAS/PCCO

14.1 Edinburgh Community Health Partnership: 02/02/2011

14.1.1 The Committee noted the minutes. Dr Williams asked about the plans for the GP in-reach pilot mentioned in item 63.2. Mr Aitken explained that the pilot had been extended until October/November 2011.

14.2 West Lothian Community Health and Care Partnership Sub Committee
14.2.1 The Committee noted the minutes. Mrs Douglas reported that the Sub-Committee meetings would now take place in the Fauldhouse Partnership Centre.

14.3 Mid Lothian Community Health Partnership: 25/11/2010

14.3.1 The Committee noted the minutes. Mr Small highlighted that the Homeopathy Service was undergoing further review and added that this was a Lothian wide issue.

14.3.2 Committee members went on to discuss the Committee meetings and public involvement. It was noted that arrangements had been put in place for the public to attend meetings but there had been a lack of public involvement at the Committee meetings. It was agreed that this should be considered in more detail at the Mutuality and Equality Governance Committee. Mrs Douglas agreed to take this forward. Committee members added that it would be useful to have data on how many members of the public had attended each meeting and information on the cost of hosting public meetings. Mr Aitken agreed to discuss this with the Drew McErlean, Committee Administrator.

14.4 NHS Lothian Primary Care Joint Management Group: 20/01/2011

14.4.1 The Committee noted the minutes. Mrs Christie highlighted that there were discussions ongoing to reschedule meetings and to increase member attendance.

15. Trend in Admissions of Elderly Patients to Care Homes

15.1 Professor McMahon spoke to the report to update the Committee on the trend in admissions of elderly patients to care homes. He pointed out that over the previous five years NHS Lothian had made significant progress to reduce delayed discharge. Professor McMahon pointed out that there were plans to review 32 patients who were delayed awaiting care home placement and to explore their pathway to identify possible improvements using an audit tool. The results of this audit would be presented to the Committee at the meeting in May. The Committee noted the figures in 3.2 and agreed that further work was needed to reduce the number of patients admitted to care homes directly from a hospital setting.

15.2 It was noted that consultants were not always aware of the options available for elderly patients. The Committee noted that discussions were ongoing to consider this in more detail and to make consultants aware of what was available for patients in the community. The Committee commented that more work could be done to evidence this and to demonstrate that patients could be supported in the community. The Committee noted that this was a very complex issue. There were also questions on consultant and nurse engagement with patient families. The Chair referred to the Discharge Analysis Tool and suggested adding a section on engagement with families.
15.3 The Committee noted the report and acknowledged that progress was being made but further work was still to be done to reduce the number of admissions to care homes directly from hospitals.

16. CHCP Review

16.1 Professor McMahon referred to the letter from Kathleen Bessos and the Delivering Better Outcomes and the Joint Use of Resources paper that had been tabled at the previous meeting. Ms Hollis pointed out that the Audit Scotland report on the Review of CHPs would be released at the end of May. It was agreed that this would be picked up again at the July meeting. This would also mean that any policy direction post election should also be clearer.

AMcM

17. Primary Medical Services – LRP

17.1 Professor McMahon outlined the information in the report, the letter to the Local Medical Committee (LMC) and the LRP programme for Primary Medical Services. It was noted that this had been discussed in detail at the Primary Care Forward Group. Professor McMahon highlighted that the plan should not have any direct impact on front line services within GP practices. The Committee asked whether there had been a reply back from the LMC. Professor McMahon reported that there had been concerns raised by the LMC regarding GP retainers and practice staffing.

17.2 Committee members referred to GP commissioning in England and wondered what impact this would have on Scotland. Mr Miller commented that this had been discussed at the Primary Care Forward Group and a paper had been prepared for the Operational Audit Sub-Committee. It was agreed that this paper could be forwarded to Committee members. It was also agreed that the minutes of the Primary Care Forward Group should be circulated to the Committee for information.

DM

18. NHS Lothian’s Joint Mental Health and Wellbeing strategy 2011-2016

18.1 Professor McMahon apologised that the NHS Lothian Joint Mental Health and Wellbeing strategy 2011-2016 had not been circulated to the Committee but informed members that this would be discussed at the NHS Lothian Board meeting on 23 March 2011. The Committee noted the report and the direction of travel. There followed some discussion on PCPC membership. Members suggested that Tim Montgomery, Director of Operations be invited to be a member of the Committee to represent University Hospitals Division. It was agreed that Professor McMahon would discuss this with Mrs Sansbury.

AMcM

19. Items for Information

19.1 Resource Transfer – Annual Uplift Arrangements
19.1.1 The Committee noted the paper on resource transfer – annual uplift arrangements. Professor McMahon highlighted that it had been agreed that the uplift applied to resource transfers in 2011/12 financial year should be 0.5%. This was still to be signed off by COSLA. He suggested that this be discussed in more detail at a future meeting to consider governance arrangements.

AMcM

20. Any Other Competent Business

20.1 Mr Miller reported that he had prepared a briefing on the changes to GP contracts that could be discussed in more detail at the next meeting.

DM

21. Date of Next Meeting: Wednesday 11 May 2:00 p.m. in Meeting Room 7 at Waverley Gate.

Other Dates for 2011:

13 July 2011
14 September 2011
9 November 2011
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<th>Due Date</th>
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<td>Workforce Model for Medicine of the Elderly (13 December 2010)</td>
<td>JKS</td>
<td>16/06/11</td>
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<td>• Provide an update on the position in six months time</td>
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<td>Releasing Time to Care (21 February 2011)</td>
<td>MH</td>
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<td>• Bring a report to the next meeting on both the costs and benefits arising from the use of the software and quantifying the amount of time spent by staff.</td>
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<td>Lothian Long-Term Conditions Collaborative: Progress Report (13 December 2010)</td>
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<td>• Provide further updates on progress</td>
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<td>Lanfine Unit – Review and Redesign of Service to People with Progressive Neurological Conditions (13 December 2010)</td>
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<td>16/06/11</td>
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<td>• Bring a further report to the June 2011 meeting describing the progress achieved, the outcomes of the review and the redesign proposals for the Lanfine Unit.</td>
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<td>Improving Care, Investing in Change (13 December 2010)</td>
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<td>06/04/11</td>
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<td>• Submit suggested areas for discussion</td>
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<tr>
<td>NHS Lothian Quality Improvement Strategy (21 February 2011)</td>
<td>JB</td>
<td>20/05/11</td>
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<td>• Provide Committee members with the final version of the draft strategy</td>
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<td>• Pass comments directly to Ms Bennett</td>
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<td>28/02/11</td>
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<td>Action Required</td>
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<td>Reshaping Care for Older People, Transformation Plans and the Change Fund (21 February 2011)</td>
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<td>• submit worked-up plan to the next meeting</td>
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<td>AMcM</td>
<td>06/04/11</td>
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<td>• submit further reports to the Committee</td>
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Minutes of the Meeting of the Service Redesign Committee held at 2.00pm on Monday, 21 February 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Professor J Iredale (Chair); Dr A Agrawal; Ms V Baker; Mr A Boyter; Ms C Craig; Mrs L D'Arcy; Councillor P Edie; Dr D Farquharson; Mr D Forbes; Mr P Gabbitas; Mrs S Goldsmith; Mrs M Hornett; Dr S Mackenzie; Professor A McMahon; Dr S Payne; Ms L Tait and Dr C J Winstanley.

In Attendance: Ms J Bennett (Clinical Governance Manager) (For Item 33); Ms L Irvine (For Item 34) and Mr P Reith (Secretariat Manager).

Apologies for absence were received from Ms J Anderson; Ms L Khindria; Dr B McKinstry and Dr A Tierney.

Declaration of Financial and Non-Financial Interest

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

The Chair welcomed members to the meeting and advised that he had discussed the role of the Committee with various members and officers and was prioritising areas of service redesign for consideration by the Committee. Members were invited to submit suggestions on areas in which they felt the Committee would benefit from being better informed, such as information technology.

32. Minutes of the Previous Meeting

32.1 The Minutes of the previous meeting of the Service Redesign Committee, held on 13 December 2010, were approved as a correct record.

33. Matters Arising

33.1 Releasing Time to Care – Mrs Hornett advised the Committee of the cost of the licence fee for the strands of Releasing Time to Care, and indicated that the overall fee for NHS Lothian was £37,000. Mrs Hornett advised that she would bring a report to the next meeting on both the costs and benefits arising from the use of the software and quantifying the amount of time spent by staff. The
Committee agreed to receive a report on both costs and benefits at the next meeting.

33.2 Improving Care, Investing in Change – a previously circulated report giving an update on progress with implementing the “Improving Care, Investing in Change” programme since December 2010 with particular focus on those projects which had not yet been completed, was received.

33.2.1 Professor McMahon introduced the paper and advised the Committee that six monthly reports would be produced in future in line with those being given to the NHS Lothian Board. Mr Forbes suggested that more information would be required on the proposed funding arrangements for the new Royal Hospital for Sick Children and the Department of Clinical Neurosciences through the Scottish Futures Trust, in order that the proposals could be considered by the staff side. Mrs Goldsmith advised that work was being undertaken on the Business Case, which was still a long way from being agreed. It was noted that the forthcoming Scottish Parliamentary elections might have an impact on the funding models available and it was agreed that Mrs Goldsmith be invited to give a presentation to the Committee explaining the differences in revenue and capital funding. Members were asked to submit suggested areas for discussion during the presentation.

33. NHS Lothian Quality Improvement Strategy

33.1 The Chair welcomed Ms Jo Bennett, Clinical Governance Manager to give an update on the Board’s Quality Improvement Strategy. Ms Bennett tabled a copy of the draft strategy which had already been considered by the Board and undertook to provide Committee members with the final version.

33.2 Councillor Edie asked about patient choice and Ms Bennett explained this was not one of the criteria for the NHS Scotland Healthcare Quality Strategy.

33.3 Dr Farquharson explained that patient choice was encompassed in the patient centred criterion. Ms Bennett explained that the report focused on the plans to deliver improvements and included monitoring of performance against all national improvement standards. There were a lack of comparators for certain key criteria. Ms Bennett undertook to forward to Committee members the timetable for reporting specific quality information to the Health Board.

33.4 The Committee noted that the consultation on the Lothian strategy ended on 31 March and members were invited to pass their comments directly to Ms Bennett.


34.1 The Chair welcomed Ms Irvine to the meeting. Ms Irvine explained that the notion of belonging or social identify was a central aspect of how people defined who
they were and that social identity was a fundamental aspect of what it was to be human.

34.2 It was noted that the physical, mental and societal consequences of emotional and social isolation placed a huge burden on public services. Policies and strategies that emphasised the social network, community empowerment and civic engagement could improve social capital and build a more inclusive society where fewer felt isolated or on the outside looking in.

34.3 The Committee noted that priority actions on promoting transformational change, collaborating in the current economic climate, increasing collaboration with the third sector, promoting greater participation and engagement, achieving Governments’ strategic objectives, addressing the mental health impact, resource and resource allocation, ensuring a fit for purpose workforce and promoting awareness, training and education emphasised the commitment to change.

34.4 A number of inequalities would be addressed and it was noted that redesign and developments within this area would require to be consistent with two major areas of policy focus: promoting and supporting recovery and further shifting the balance of care.

34.5 Dr Agrawal questioned whether an equality impact assessment had been undertaken and Ms Irvine indicated that this was the case. The Chair queried what action would be taken in respect of potentially increased number of patients as the recession continued.

34.6 Ms Irvine advised that ways would have to be found to work differently.

34.7 Councillor Edie questioned how the strategy benchmarked with other local authorities and emphasised the need to have mental health at the heart of community planning.

34.8 Professor McMahon commented the strategy placed a considerable emphasis on social inclusion.

34.9 The Chair thanked Ms Irvine for her presentation.

35. Lean in Lothian – Five Year Review and Proposals for the Future

35.1 Ms Tait gave a presentation to the Committee explaining the drivers behind the Lean in Lothian approach, together with its aims and the method of delivery.

35.2 The Committee noted that 328 staff had already completed one or more elements of Lean in Lothian training and over 700 staff had participated in rapid improvement events. As well as enabling significant productivity gains to be released, efficiency gains and savings greater than £1m per annum leading to £6m to date had been achieved.
Ms Tait indicated that going forward it was proposed to undertake projects including further work on older people’s pathways, long term conditions pathways such as respiratory failure and diabetes, rehabilitation pathways, administrative and clerical processes and one-off small projects which provided efficiency opportunities.

Dr Winstanley suggested that there was scope for applying Lean methodology to other areas and the Chair suggested looking at a number of key problems areas to see what was going wrong. The Committee agreed that the idea of a team to identify gaps in service efficiency was a sensible approach.

The Chair thanked Ms Tait for her presentation.

Reshaping Care for Older People, Transformation Plans and the Change Fund

Professor McMahon introduced the report and explained that it provided an update and overview of the proposals for agreeing the local transformation (change fund) plans across Lothian. He indicated that some of the time had been lost from the consultation process because of the approaching Scottish Parliamentary elections and a report would be going to the Executive Management Team on 2 March 2011. The worked-up plan would be submitted to the next meeting.

Councillor Edie commented that this would be a long-term project as there were various political solutions.

Dr Agrawal questioned how the success of self-directed support could be monitored. Dr Agrawal commented that circumstances could change and the process required to be constantly reviewed to ensure they were working properly.

Mr Gabbitas commented that there were also opportunities to make savings and investments in future care.

The Committee agreed to note the implications of the national guidance for the development of local transformation plans and that further reports would be submitted to the Committee.

Date of Next Meeting

It was noted that the next meeting of the Committee would be held on Monday, 18 April 2011 at 2.00pm in meeting room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
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<th>Action Required</th>
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<td><strong>eKSF Update (22/12/2010)</strong></td>
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<td>• Draw any such failings to the attention of the Remuneration Committee, in order that they could be taken into account in future years’ appraisals and to keep the Remuneration Committee advised of progress in achieving the specified targets</td>
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<td>• Discuss with the Director of Human Resources &amp; Organisational Development how managers could be guided into taking up training and achieving the target.</td>
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<td>• Take a paper to the Executive Management Team proposing that an instruction be issued to the Chief Operating Officer and CHP General Managers to bring forward their plans for achieving the HEAT target</td>
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<td><strong>Employment Placement Service (29/09/2010)</strong></td>
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<td>• Progress Report to be submitted to the Staff Governance Committee on 30 March 2011</td>
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<td><strong>Quarterly Workforce Report (29/09/10)</strong></td>
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<td>• Include a comparison with the local population and routinely submit to the Staff Governance Committee</td>
<td>AB</td>
<td>13/12/10</td>
<td>Standing item on agenda</td>
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<td><strong>Retirement Awards Update</strong></td>
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<td>• Discuss the urgent establishment of a staff benefit fund with the Director of Finance and to report back to the next meeting of the Staff Governance Committee</td>
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<td>• Provide a copy of the report for distribution to Committee members</td>
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<td>24/12/10</td>
<td>Copy provided and sent out.</td>
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<td>• Distribute report to Committee members</td>
<td>PR</td>
<td>24/12/10</td>
<td>Report distributed to Committee members</td>
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<tr>
<td><strong>Monitoring Performance or Behaviour of General Practitioners</strong> (22/12/10)</td>
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<td>• Publicise the Board’s policies more widely so that more people could receive the necessary support before patients were put at risk</td>
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<td><strong>Proposed Changes to Mandatory Training</strong> (22/12/10)</td>
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<td>• Provide an update in six months time</td>
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<td><strong>Workforce Report</strong></td>
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<td>• Check the figures out and explain the position to Mr Whyte outside the meeting</td>
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<td><strong>Staff Governance Self-Assessment Audit 2009/10 – NHS Lothian</strong> (22 December 2010)</td>
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<td>• Take a full report to the next meeting of the Committee</td>
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DRAFT

LOTHIAN NHS BOARD

STAFF GOVERNANCE COMMITTEE

Minutes of the Staff Governance Committee Meeting held at 9.30am on Wednesday, 22 December 2010 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr E Egan (Chair); Mr R Y Anderson; Mr A Boyter; Mr R Burley; Mrs T Douglas; Ms L Falconer; Mrs J McDowell; Professor C P Swainson; Mr I Whyte and Dr C J Winstanley.

In Attendance: Dr P Berry (For Item 85); Dr D Farquharson; Mr D Lee (For Item 87); Ms P Eccles; Mr J Jack (For Items 89); Dr C Kalman; Mrs R Kelly; Professor P Padfield; Mr P Reith and Ms J Stirton.

Apologies for absence were received from Councillor J Cochrane and Mrs M Hornett.

Declaration of Financial and Non-Financial Interest

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

83. Minutes of the Meeting of the Staff Governance Committee held on 29 September 2010

83.1 The previously circulated Minutes of the meeting of the Staff Governance Committee held on 29 September 2010 were approved as a correct record.

84. Matters Arising

84.1 e-KSF Progress Report – Mrs Kelly reported that the e-KSF target required to be achieved by the end of March 2011. The meeting noted that progress of full implementation was slow and that service capacity had been identified as a major issue to be taken forward.

84.1.1 The Chair expressed concerns that NHS Lothian was not showing the necessary commitment to implement eKSF. He emphasised that the side staff would not continue to support the use of the system if management did not fully implement it throughout NHS Lothian.
84.1.2 The Chair undertook to discuss with the Director of Human Resources & Organisational Development how managers could be guided into taking up training and achieving the target. It was noted that access to information technology appeared to be a barrier to some staff. EE/AB

84.1.4 The Director of Human Resources and Organisational Development undertook to take a paper to the Executive Management Team proposing that an instruction be issued to the Chief Operating Officer and CHP General Managers to bring forward their plans for achieving the HEAT target. AB

84.3 Retirement Awards Update – Ms Kelly advised the Committee that alternative schemes were being looked at to replace the previous vouchers. Approximately 260 staff had retired since 1 April 2010 and a proposal had been made for either an evening or lunch time meal to be provided to retiring staff.

84.3.1 The Committee noted that, whilst it had already been established that expenditure on retirement awards could not come from Endowments, it was also noted that some of the funding within the Endowment Funds had been specifically donated for the benefit of staff rather than patients and there was a longstanding and frequently reiterated request for Finance to establish a separate staff benefit fund to which patients and members of the public could make specific donation for the benefit of staff.

84.3.2 The Committee agreed that the Chair and the Director of Human Resources & Organisational Development should discuss the urgent establishment of a staff benefit fund with the Director of Finance and to report back to the next meeting of the Staff Governance Committee. AB


85.1 The Committee received a previously circulated report, together with the annual Consultant/SAS grades appraisal report for 2009.

85.2 The Chair welcomed Professor Padfield who explained that NHS Lothian had a robust system for Consultant and SAS grade appraisals in place and the quality of the appraisals themselves was improving. When revalidation started, it would be based on a cycle of appraisals undertaken to national standards. Mr Anderson sought clarification on the risks to NHS Lothian if the number of doctors failing to revalidate their medical qualifications was excessive and Dr Winstanley asked how the process could be expedited and how quality outcomes could be included.

85.3 Professor Padfield emphasised that it would take at least two years to achieve 100% completion.

85.4 The Chair welcomed Dr Berry to the meeting and the Committee received a verbal report on the monitoring of performance or behaviours of General Practitioners. Dr Berry undertook to provide a copy of the report for distribution to Committee members. PB
85.5 The Committee noted that NHS Lothian was responsible to National Education Scotland (NES) for the delivery of the service.

85.6 The Committee noted that the annual report had been reviewed by QIS in 2008 and had proved successful. The Committee agreed to note the report and that the report should be distributed to members.

86. Monitoring Performance or Behaviour of General Practitioners

86.1 A previously circulated report advising of the results of the monitoring investigations of doctors where concerns had been expressed about their behaviour or performance was received.

86.2 Professor Swainson spoke to the paper and it was noted that the number of doctors with problems in NHS Lothian was relatively low with figures about half those of the average for Scotland.

86.3 The Committee noted that updated appendices would be provided outwith the meeting.

86.4 Dr Kalman advised that the vast majority of staff making use of the Board’s policies on alcohol and substance addiction were doing so as a result of a specific incident rather than making use of the policies before the incident happened.

86.5 The Committee noted the need to publicise the Board’s policies more widely so that more people could receive the necessary support before patients were put at risk.

86.6 The Committee agreed to note the report on the monitoring performance or behaviour of Doctors and Dentists.

87. Proposed Changes to Mandatory Training

87.1 The Committee received a previously circulated report outlining a revised approach to the provision of organisational mandatory training in order to mitigate risk associated with service incapacity to release the staff and work towards achieving compliance.

87.2 The Chair welcomed Mr Lee to the meeting.

87.3 Mr Lee outlined the procedures in place to ensure as many people as possible received the mandatory training and work was being undertaken to ensure the records of all staff were logged on to Empower so that it would be relatively easy to identify areas where inadequate numbers of staff were undertaking mandatory training. Mr Lee commented that the intention was to ensure full compliance by linking training records with the HR system and this would be kept under continuous review.
87.4 The Director of Human Resources & Organisational Development thanked Mr Lee for his work and the Committee agreed to endorse the approach subject to ongoing evaluation with Mr Lee providing an update in six months time.  

87.5 The Director of Human Resources & Organisational Development also undertook to raise the issue of mandatory training with the Remuneration Committee in order that compliance could be enforced through the performance management and appraisal system.  

88. Health and Safety Annual Report 2009/10

88.1 The Committee received the previously circulated third NHS Lothian annual health and safety report for 2009/10.

88.2 The Chair commented on the importance of health and safety. Dr Kalman spoke to the report and emphasised that the period covered had been encompassed by the fatal accident at the Western General Hospital.

88.3 Mrs McDowell questioned the status of the actions and Dr Kalman explained that these were all in the process of being completed. He was able to reassure the Committee that, over the last two years, health and safety issues had taken on a much higher priority.

88.4 The Committee agreed the health and safety annual report for 2009/10.

89. Fatal Accident Involving an NHS Lothian Vehicle on the Western General Hospital Site on 21 April 2009

89.1 The Committee received a previously circulated report giving details of the regrettable accident at the Western General Hospital on 21 April 2009 in which a 77 year old woman died after an NHS Lothian vehicle reversed into her.

89.2 Mr Jack explained that the Health and Safety Executive had asked Lothian and Borders Police to lead the investigations and the police investigation was still underway.

89.3 The Chair expressed his continuing concern that the Central Legal Office refused to represent NHS Lothian staff facing police interview. He had raised this issue with the Scottish Government and other Health Boards and the Committee noted that the Senior Solicitor had consulted with the senior NHS Lothian staff being interviewed by the police.

89.4 The Committee noted that NHS Lothian could not know what statements had been given by staff to the police.

89.5 The Committee agreed to record its sadness that a member of the public had died as a result of the accident and commended the work undertaken following the accident to make the main sites in NHS Lothian safer.
89.6 The Committee agreed to note the circumstances of the unfortunate incident and the subsequent actions taken and that the police led investigation was still ongoing.

89.7 Dr Kalman advised that further reports would be submitted to the Staff Governance Committee.

Mr Jack and Mr Lee left the meeting.

90. Health and Safety Committee Minutes

90.1 The Committee received the previously circulated Minutes of the Health and Safety Committee meeting held on 21 October 2010.

90.2 Mr Anderson commented on the number of apologies for the meeting and suggested that the Committee needed to improve its efficiency.

90.3 Dr Kalman emphasised that many of the members present at the meeting were actually deputising for whoever had apologised.

90.4 The Committee also noted that problems were being experienced with the absence of tags on bags of clinical waste at St John’s Hospital and that, following a reversing accident at the Royal Infirmary of Edinburgh, Consort had been instructed to erect permanent barriers to prevent lorries reversing on a particular part of the site.

91. Workforce Report

91.1 The Committee noted the previously circulated quarterly workforce report for the period July-September 2010.

91.2 Mr Whyte commented that the report appeared to indicate that there were more staff working for NHS Lothian in 2010 than in 2009, which seemed at odds with budget constraints and Mrs Kelly undertook to check these figures out and explain the position to Mr Whyte outside the meeting.

92. Staff Governance Self-Assessment Audit 2009/10 – NHS Lothian

92.1 The Committee received a previously circulated letter from the Head of Staff Governance, Health Workforce Directorate at the Scottish Government, commenting on the self-assessment audit conducted in 2009/10. The information contained in the letter was based on the 2008 staff survey.

92.2 The Committee noted that the 2010 staff survey had now been completed and results were awaited. It was noted that there were no references in the letter to the Staff Governance Action Plan submitted to the Scottish Government previously.
92.3 It was anticipated that the results of the 2010 survey would be published in January 2011 allowing a full report to come to the next meeting of the Committee.

93. Communications

93.1 The Committee received a previously circulated communications update and members noted that Ms Stirton would be leaving NHS Lothian in February 2011 to take up a new post outwith the NHS.

94. Date of Next Meeting

94.1 It was noted that the next meeting of the Staff Governance Committee would be held on Wednesday, 30 March 2011.
Note of the 31st meeting of the East Lothian Community Health Partnership Sub-Committee (Public Session) held on Tuesday 14\textsuperscript{th} December 2010 at 2pm in the Quay Complex, Musselburgh.

Present:  
Iain Whyte (Chair) (IW)  
Gerry Power, General Manager (GP)  
Dr Jane Hopton, Assistant General Manager (JH)  
Councillor Jacqui Bell, East Lothian Council Representative (JB)  
Dr Ian Johnston, Medical Director (IJ)  
Dr Graham Alexander, General Practitioner Representative (GA)  
Laurelle Edmunds, PPF Representative (LE)  
Tony Segal, Carers of East Lothian (TS)  
Gill Colston (PPF Representative) (GC)  
Liz Cregan, Chief Nurse (LC)  
Thomas Miller, Partnership Representative (TM)  
Alan Ross, East Lothian Council (AR)  
Murray Leys, East Lothian Council (ML)  

In Attendance:  
Mike Porteous Associate Head of Finance (MP)  
Colin Lumsdaine (Minute item 39)  
Drew McErlean, Minutes (DM)  

Apologies:  
Morag Barrow, Allied Health Professional Manager (MB)  
Sylvia Mack, Employee Relations Manager (SM)  
Fiona Mitchell, Acute Sector (FM)  
Lindsay Howden, (Pharmacy Representative)  

36. Welcome and Apologies  
36.1 Apologies were noted as above.

37. Minutes of the Previous Meeting Held 28\textsuperscript{th} October 2010  
37.1 The minutes were agreed as being a true and accurate record of the meeting.

38. Matters Arising / Action Note  
38.1 The Action note was reviewed. Items 1 and 4 will be completed by the papers from the Carers Forum tabled at this meeting.

Item 2 in relation to the CT scanner at Roodlands will remain on the action plan as discussions are continuing with the Acute Sector.

Item 3 in relation to Doctor rotas at Roodlands will remain on the
38.2. (27.2) **Eye Testing**

It was noted that it may be appropriate to invite a Community Ophthalmologist to join the CHP Sub Committee.

39 **SHPS (Scottish Health Promotions Service) – Tobacco Prevention (Presentation)**

It was noted that the Scottish Household Survey indicated that whilst smoking rates for 13 – 15 year olds are on a decreasing trend there is an increasing trend for 16 – 24 year olds.

The presentation outlined the relevant policy and legislation. The approach being taken is a Smoking Prevention Action Plan which will reduce the attractiveness, availability and affordability of cigarettes.

A programme of work has been developed including focus on schools and youth agencies, 16 – 24 year olds, stop smoking services and Trading Standards.

The presentation outlined the exposure rates of children to second hand smoke, the impact this has on children taking up the habit themselves, and the health consequences.

The presentation highlighted the detailed work taking place in Phase 2 of the project across the NHS Lothian area. The potential reach is 14,700 children with a cost per child of £2.85.

The work being done by the Bridges Project in Musselburgh is an example of local involvement within East Lothian.

**Decisions**

Colin Lumsdaine was thanked for a very informative presentation and the CHP Sub Committee noted its support for the work being undertaken.

40. **General Manager’s Report**

40.1. The Sub Committee considered a report from the General Manager which had been circulated in advance of the meeting.

The November 2010 census showed that the national target of no patient delayed in a short term setting had again been met. The national target of zero patients waiting over 6 weeks had been breached in relation to 2 patients. The overall number of patients delayed was 13 which is a considerable improvement over the course of the year.
The report noted that the work on the Musselburgh Primary Care Centre has now commenced – the official completion date is targeted at March 2012.

The initial agreement for the Gullane Surgery project is progressing with a view to it being taken to the NHS Lothian Board in the early part of 2011.

The report noted that the General Manager would be leaving his post as of 17th December 2010 to take up a secondment with the Scottish Government. David Small, General Manager Edinburgh CHP will be assuming the role of General Manager for East Lothian and Midlothian CHPs.

Decisions

The report was noted.

On behalf of the CHP Sub Committee the Chair noted the Sub Committee’s appreciation of the efforts of the General Manager in the work he had carried out in the CHP and wished him well for his future role.

40.2 Staff Governance Report –

The Sub Committee considered a report which had been circulated in advance of the meeting.

The report noted that the turnover rate for staff in the period 1st September to 30th November 2010 was 1.26%. The annualised turnover rate is 5.08%.

The staff sickness rate for November 2010 was 5.28%, of which long term absence accounted for 3.25% and short term absence was 2.03%

The exceptional efforts made by staff in the recent extreme weather conditions was highlighted. The efforts of East Lothian Council staff in clearing access to sites were acknowledged.

The report also referred to the Scottish Health Award nominations and noted changes being made to Recruitment and Selection training and Equality and Diversity law.

Decisions

The report was noted. The Sub Committee commended the exceptional efforts made by staff to attend work and maintain patient services during the recent adverse weather conditions.
41. Clinical Director’s Report

The Sub-Committee considered a report from the Clinical Director which had been circulated in advance of the meeting.

The report noted that discussions are continuing to resolve the rota issues at Roodlands Hospital. The Clinical Director advised that significant progress has been made in recent days and he is hopeful that a solution can be implemented in the near future.

The report noted that Practices had continued to deliver services in very difficult weather conditions and the curtailment / cancellation of Lab Van Services. Centralised pick up points were implemented to help alleviate the situation.

Decisions

The report was noted.

42. Chief Nurse Report

The Sub-Committee considered a report by the Chief Nurse which had been circulated in advance of the meeting and noted the key issues.

42.1 Child Protection, Adult Protection and Public Protection

The report highlighted that as of October 2010 there were 90 children from 49 families in the Child Protection register. It was noted that the number of Child Protection case conferences has risen slightly.

Inter agency referral discussions (IRD) continue to rise on a year-on-year basis.

The report confirmed that the Child Protection HMIE inspection in East Lothian will commence on 31st January 2011 for a 2 week period. Initial self assessments have been completed by all agencies. 33 cases have been identified by HMIE for review. The process of the review was outlined.

The Chief Nurse noted that she is confident of a positive outcome to the inspection.

Decisions

The report was noted

A briefing paper on the HMIE inspection is to be circulated by the LC
Chief Nurse prior to the commencement of the inspection.

43. **AHP Manager’s Report**

There was no business raised under this item.

44. **Carers Forum**

44.1 The report considered a draft terms of reference for the Carers Working Group.


Tony Segal noted that the recent Scottish Budget had included provision for the Carers Information Strategy monies to be carried over for an additional year.

Tony Segal enquired what the process would be in Lothian for implementing the Carers Strategy for Scotland Action Plan and deciding which projects would continue to receive support and identifying those which would not be supported in the future.

The General Manager noted that NHS Lothian is arranging a meeting with Carers organisations to assess the impact and identify priorities. Tony Segal will liaise with the appropriate Programme Manager at NHS Lothian.

**Decisions**

The update was noted.

45. **Public Partnership Forum (PPF)**

45.1 The minutes of the PPF Meeting of 19th October were tabled.

In addition there had been several further meetings of various groups including a presentation on the proposed new Gullane GP Practice and Day Centre which had been very well attended.

Discussions in relation to parking issues at the Musselburgh Primary Care Centre are continuing.

Elections for the PPF Chair and the CHP Sub Committee Representative will be required in January 2011.

**Decisions**

The update was noted.
46. **Hosted Services – LUCS / Health Promotion**

A report was circulated to the meeting.

The LUCS performance report for November showed no significant changes to trends with 8,975 contacts in the month.

In relation to Finance it was noted that LUCS continues to achieve its LRP in full and on a recurring basis.

There is a projected overspend of £282k at the end of the financial year. This is a consequence of pressures from pay enhancements and support costs for the ADASTRA IT system.

It was highlighted that LUCS had performed well during the recent period of severe weather. All rotas have been filled for the Christmas and New Year period.

The report referenced that an audit of attendance at Sick Kids A & E and appropriateness for primary care had recently taken place and initial indications are that around 15% - 20% of attendances could be appropriately dealt with by primary medical care.

**Decisions**

The report was noted.

47. **Community Health Partnership Committee Appointments**

47.1. There was no business raised under this item.

48. **A.O.C.B.**

48.1. It was noted that this would be the last CHP Sub Committee meeting to be attended by Alan Ross, East Lothian Council and Laurelle Edmonds, PPF Representative. On behalf of the CHP Sub Committee the Chair acknowledged the valuable contributions both Alan and Laurelle had made to the work of the CHP Sub Committee and wished them well for the future.

49. **Date of next meeting**

It was agreed that the next meeting would take place on Thursday 24th February 2011 at 2.00pm. The Quay Complex Musselburgh
NHS LOTHIAN
EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB-COMMITTEE

Note of the twenty third meeting of the Edinburgh Community Health Partnership Sub-Committee held on Wednesday 2nd February 2011 at 1.00 p.m. in the Boardroom, Waverley Gate, Edinburgh

Present: Bob Anderson, (Chair)
         Peter Gabbitas, Director of Health and Social Care
         Robert Aitken, Acting General Manager Edinburgh CHP
         Dr Ian McKay, Clinical Director, Edinburgh CHP
         David Jack, Head of Strategic Support, City of Edinburgh Council
         Jim Kendall, South Edinburgh Public Partnership Forum
         David King, Head of Finance
         Jim Brown, North Edinburgh Public Partnership Forum
         William Hardie, North Edinburgh Public Partnership Forum
         Dr Ramon McDermott, General Practitioner
         Lynda Cowie, Chief Nurse
         Frances Fraser, North West Edinburgh LHP
         Stuart McLauchlan, Staff Partnership Representative
         Maureen Reid, South West Edinburgh LHP
         John Davidson, Dental Practitioner
         Cllr Paul Edie, Council Elected Representative
         Cllr Norman Work, Council Elected Representative
         Seb Fischer, Carers Representative
         Dr Margaret Douglas, Consultant in Public Health Medicine
         Fiona McCready, Pharmacy Representative
         Ella Simpson, VOCAL

In Attendance: Carole Kelly, Carer Services Development Manager. (Minute Item 62.1)
                Tricia Campbell, City of Edinburgh Council, (Minute Item 63.10)
                Drew McErlean, Acting Secretary

Apologies: Angela Lindsay, AHP Manager, Edinburgh CHP
           Bashir Wadee, Optometrist
           Heather Levy, South Edinburgh Public Partnership Forum
           Lyn McDonald, Director of Operations, Acute Sector

61. Welcome/Introduction/ Declarations of Interest/ Apologies

There were no declarations of interest made.

The apologies were noted as above.

It was noted that the meeting scheduled for 9th December had been cancelled as the venue had been un-accessible due to the adverse weather conditions.

Robert Aitken was welcomed to the first meeting of the CHP Sub Committee that he was attending in his capacity as Acting General Manager for the CHP.

The members of the public in attendance were welcomed.

61.1 Minutes of Previous Meeting held on 14th October 2010

( 56.4) – Finance Report It was noted that £74,000 had been the movement within the month for August 2010 on core services and £20,000 was the movement within the month for hosted services
The minutes were otherwise agreed as being a true and accurate record of the meeting.

61.2  **Matters Arising Not Covered on the Agenda**

All matters were covered on the agenda.

62.  **Presentations**

62.1  **Carer Information Strategy**

A presentation was made to the CHP Sub Committee by Carole Kelly, Carer Services Development Manager.

The presentation referenced the key policy drivers such as the ageing population and Carers as being the main care providers.

The key national and local strategic developments including the NHS Lothian Carer Information Strategy 2008 – 2011 were highlighted. Local developments include training for carers, the establishment of a carer network and young carers identification and support. Carole Kelly noted the work that will be done to adapt a national website for young carers to reflect local needs and issues.

Jim Kendall asked if any work was done with employers on the needs of carers. Carole Kelly noted that there is nothing specific at the moment but this will be considered in the future.

The work being done to develop a Bill of Rights for carers was referenced as this has been acknowledged by the Scottish Government as a national issue. Work is underway to identify specific areas where Carers are discriminated against.

**Decisions**

The presentation was noted.

62.2.  **Health Inequalities**

The Sub Committee received a joint presentation from Margaret Douglas and David Jack on the Health Inequalities Framework for Edinburgh.

The presentation outlined the definitions and causes of health inequalities.

It was noted that male life expectancy in Edinburgh can vary between 61 years and 86 years depending on area of residence – a very marked difference.

The presentation referenced the NHS Lothian Whole System approach to tackling Health Inequalities. These are

- Ensuring mainstream services are appropriate for all
- Targeted initiatives
- Partnership work to address determinants of inequality.

It was noted that the Edinburgh Health Inequalities Framework had been based on the Marmot review and had established 6 priority areas. The presentation highlighted the key policy objectives of the Edinburgh Health Inequalities Framework.
It was noted that the Edinburgh Partnership had an away day in December where it had been agreed that real service delivery change is needed to be able to achieve demonstrable results in tackling health inequalities.

The away day had identified the need to look specifically at the needs of young people who are post-school but pre-work as youth unemployment is a very serious issue in Edinburgh.

The away day had also identified social exclusion for older people in deprived areas as a key issue.

It was noted that the allocation of funding from Fairer Scotland will be considered by the City of Edinburgh Council on 10th February.

Jim Kendall asked who was being consulted and David Jack confirmed this had been progressed via Neighbourhood partnerships to date but he would welcome views on other groups that should be consulted.

David Jack asked if the CHP would be interested in signing up to a document that would define health inequalities and specify in detail the actions to be taken in Edinburgh to address these. Bob Anderson confirmed that the CHP would be interested in considering this.

In response to a question from Seb Fischer, David Jack noted that the isolation issues identified in relation to older people are also relevant to carers. Seb Fischer noted the importance of recognising that many carers are not in that role through choice and that the role of a carer can have a dramatic impact on family relationships.

Jim Kendall commented that many of the issues are national and it may be difficult to tease out local initiatives. David Jack noted that NHS Lothian and City of Edinburgh Council could play a key role in providing job placement opportunities for those who are not yet ‘work ready’.

Decisions

The presentation and report were noted.

63. **Items for Discussion / Information**

63.1. **Chairman’s Report**

The Chairman provided an update on the activities he had undertaken since the previous meeting in relation to the CHP.

These were noted as

- Joint Board of Governance Away Day on Health Inequalities at which the issue of alcohol abuse as a public health issue had been stressed.
- Edinburgh Homelessness Forum meetings
- A visit to Royal Edinburgh Hospital which included a focus group with staff.
- A visit by a Chinese delegation to the CHP on 5th November 2010.
- Scottish Health Awards Presentation.
• NHS Lothian Board Meeting on 26th November had been hosted by Edinburgh CHP and the presentations had been made by members of the CHP Management Team. These had received very positive feedback from members of the Board.

Decisions

The update was noted.

63.2. Clinical Director’s Report

The Sub-Committee considered a report which had been circulated in advance of the meeting.

The report provided an update on

• GP in-reach pilot – this finished in June 2010 and since then the service has continued and work has been done to develop an extended service with a GP presence in the Combined Assessment Area at A & E.
• Mental Health Services which covered the review of acute mental health services in progress and the key community service issues in relation to the Counselling Review, the 18 week referral to treatment target and Lothian Psychological Intervention network.
• Positive Mental Training – a training scheme that has been running in Edinburgh CHP for several years.
• Envopaks – the secure transport system referenced in previous reports is in the process of being introduced.

Decisions

The report was noted.

63.3. General Managers Report

The sub-committee considered a report which had been circulated in advance of the meeting.

The report provided an update on the Premises and Capital Plans noting progress on the Wester Hailes, Chalmers Sexual Health Centre, West End Medical Practice and in-patient facilities at Astley Ainslie Hospital projects.

The reported highlighted the positive outcome from the Investors in People Assessment that took place in December 2010.

The report noted the role played by the CHP in the delivery of the NHS Lothian Winter Plan.

The report noted the initial work being done on the Phased Implementation within Stroke and Orthopaedic pathways for the Older Peoples Model of Care.

The role of the CHP in maintaining services across Lothian during the severe weather of November / December 2010 was highlighted. No significant service interruptions occurred and learning points about the logistics of moving community staff and supplies had been recorded.
The Lab Van service was raised as an issue as this had been severely impacted during the first 2 – 3 days of the adverse weather. It was noted that the option of having the Lab Vans designated as emergency vehicles had been raised several times before and rejected as this would require a change in UK Government primary legislation. Peter Gabbitas noted that he was satisfied that this had been investigated as far as was possible and that raising the issue again would not result in a different outcome.

Decisions

The report was noted. Staff efforts in delivering services to patients during the adverse weather were commended.

63.4. Finance Report

The Sub Committee considered a report which had been circulated in advance of the meeting.

The report highlighted that the CHP was overspend by £622,000 for the nine months to 31st December 2010.

The mid year review projected an overspend on Prescribing of circa £1.5 million and this will be supported on a non recurrent basis by the projected underspend on the GMS budget.

A further pressure on the Prescribing budget has arisen through the loss of income from reduced prescription charges. This has been estimated at £104,000 for the year to date. Work is underway to find non recurrent support to manage this pressure.

The CHP is continuing to project a break-even out-turn position.

The 9 month target for LRP is £3,163,000. The LRP actioned is £2,940,000 leaving a gap of £223,000.

The CHP is forecasting that LRP will be fully achieved in 2010 – 2011.

The LRP target for 2011 – 2012 will be based on 5% of HCH, Prescribing and the element of the GMS budget not supported by the Scottish Government.

Budget setting for 2011 – 2012 is now underway. There are a significant number of issues and pressures to be managed. The need to plan carefully the level of activity that can be supported by the budget was emphasised.

Decisions

The report was noted.

The Chair noted that the Performance Management Sub Group would be scrutinising the financial plans in detail.

63.5. Better Together Reporting of the GP Patient Experience Survey.

The Sub Committee considered a report which had been circulated in advance of the meeting.
The report highlighted the overall performance of Lothian GP Practices compared with the Scottish average in relation to 31 individual patient survey questions. Lothian scored marginally below the Scottish average for many of the questions, but the differences were not significant.

Confidentiality of patient information in reception areas and patients understanding of medicines they are given are 2 areas in which Lothian needs to achieve improvement.

A general improvement plan has been developed and a specific programme of support has been put in place for the small number of GP Practices that scored poorly in the survey. It was noted that General Managers have the detailed results for GP Practices.

The report also detailed the progress made to date in delivering the action plan to address the issues highlighted in the survey.

Changes to the way in which the survey will be carried out in 2011 were noted, as an ‘opt in’ process by GPs will be used.

Decisions

The report was noted.

63.6. Delivering Quality in Primary Care

The Sub Committee considered a report which had been circulated in advance of the meeting.

The report noted that the Primary Care Modernisation strategy (PCMS) 2007 – 2012 and its associated work streams are coming to an end.

The report sets out the plan for taking forward the actions within NHS Lothian and an action plan detailing this had been circulated with the paper.

The report highlighted that Long Term Conditions was one of the key success areas driven forward by PCMS aided by the £4m of support from the CH (C)Ps.

The undernoted issues were highlighted.

- Section 17c Primary Care Audit of Outcomes
- Section 17c Initiatives – Contract Re-design and A & E attendances audit.
- Enhanced Services Review.

The paper outlined the actions being taken across Lothian.

Decisions

The paper was noted and it was agreed that Duncan Miller will provide an update to the CHP Sub Committee in several months on the specific actions relevant to the CHP.

DM
63.7. Edinburgh CHP Management Arrangements

The Sub Committee received a verbal update from the General Manager.

Work is progressing on the co-location of 5 existing locations to one base servicing a North and South Management arrangement.

The co-location of Nursing Management, Administration and Locality Development Managers and others to create efficiencies is also progressing.

Dr McKay is drawing up a proposal for consultation with GPs on a standardised approach across localities in North and South Edinburgh including practice participation in CHP discussions.

The Chief Nurse is progressing cluster nursing in the Community.

Decisions

The update was noted.

63.8. Edinburgh Commissioning Strategy for Care and Support Services 2011-2016 and The Commissioning Plan for Adult Services

The Sub Committee received a verbal update.

Peter Gabbitas noted that the draft strategy had been approved by the City of Edinburgh Council in December 2010 and the consultation period had been started. It was noted that the end date for the consultation process has now been extended by 2 weeks to 4 March 2011.

The strategy covers adults, children and homeless people.

Tricia Campbell outlined the overall vision of the service which emphasises the importance of independent living. Services procured must be of good quality and affordable.

The vision covers 9 principles and provides a framework for the commissioning process.

The ways in which people and organisations can participate in the consultation were outlined.

The work done with Checkpoint Groups in the process to date was referenced and Ella Simpson noted that these discussions had been very robust and positive.

It is expected that there will be a substantial number of responses received to the consultation process.

It was noted that North and South PPF were aware of the consultation process and are considering a submission.

Decisions

The update and deadline for the consultation was noted.

63.9 Scottish Health Survey 2011
The Chair referred the Sub Committee to the planned survey and the fact that some members of the public who are asked to take part may contact their GPs or CHPs seeking reassurance about the legitimacy of the survey.

63.10 Joint Review of Independent Advocacy Services in Edinburgh

The Sub Committee received a report and the meeting was adjourned to allow members present to review the paper before it was considered by the Sub Committee.

The report noted the conclusions and proposed outcomes from the joint review of Independent Advocacy services.

It was noted that the current arrangements for the funding of 7 organisations for advocacy services are a historical legacy that had not been the subject of review for some time. It had been identified that there were some overlaps and in-efficiencies and also gaps in some of these arrangements.

It had been recommended that ‘Option 4’ from the original report be supported which would result in the awarding of 3 contracts bit not necessarily to 3 different advocacy service providers.

The contracts will be for

- Individual and collective advocacy for people with mental health support needs and carers of people with a mental disorder.
- Individual and collective advocacy for people with learning disabilities.
- Individual and collective advocacy for older people and people with physical disabilities and collective advocacy for older people living in care homes.

The rationale and legal issues around the tendering process were outlined.

It had been recommended that procurement of the services should be taken forward by City of Edinburgh Council Health & Social Work department on behalf of both NHS Lothian and City of Edinburgh Council.

The future of Advocacy services will be considered by the City of Edinburgh Council at its meeting on 3rd February. Jim Brown asked whether it was felt that the proposal would be approved by the Council. Cllr Paul Edie stated his confidence that the Full Council would support the award of three contracts and the move to competitive tendering.

Decisions

The Sub Committee approved the model for the delivery of independent advocacy in Edinburgh – option 4 with 3 client groupings of independent advocacy services.

The Sub Committee noted the development of a Commissioning Plan for independent advocacy in Edinburgh.

The Sub Committee approved the proposal for City of Edinburgh Council to undertake the procurement on behalf of both organisations, following agreement of the tender document by the Performance Management Sub Group.
The Sub Committee approved the commencement of the procurement stage, on the basis of advertising and tendering the services.

The Sub Committee noted that the arrangements for commissioning independent advocacy services in Edinburgh would be considered by the City of Edinburgh Council on 3rd February 2011.

64. **Items for Decision Making**

64.1 **Pill Dispensers**

The Sub Committee considered a report which had been circulated in advance of the meeting.

The paper provided an update on the Management of Medicines in Home Based Services policy.

The report noted the emphasis on establishing a system of work which protects the safety and well being of service users and detailed the system being put in place to support patients at home to take their medicines safely. The system will support trained care workers to safely administer medicines to patients in their own homes.

The report noted the National Care Standards (Care at Home) relate to services that are delivered in a service users home.

City of Edinburgh Council care workers are undertaking a training programme that will allow them to administer medicines to an agreed protocol once training has been undertaken.

It was clarified that the word ‘administer’ has several more detailed definitions but there will be no forcing of medicines to be taken. This point will be clarified in an update to the paper.

Jim Kendall noted that this is a very positive development overall. It was noted that the definition of ‘care worker’ includes home helps.

Fiona McCready noted that all Pharmacies have signed up to provide patients with a home medications chart but that the proposals within this paper do not forma part of the core contract for Pharmacies.

**Decisions**

The Report was noted.

64.2 **Firhill Partnership Centre – Initial Agreement**

The Sub Committee considered a report which had been circulated in advance of the meeting.

The project aims to improve the delivery of community based health and social care services in South Central Edinburgh on a site adjacent to the exiting Firhill Medical Practice. This will support the co-location of several GP practices and other services.

The project has been included in the pipeline for the South East Scotland Territory Hubco programme.
Decisions

The paper was approved.

65. Items for Review

65.1. Action Note

The Sub-Committee considered the updated Action Note which had been circulated in advance of the meeting.

Decisions

The Action Note will be updated to reflect items that are now complete and new actions agreed for future meetings.

65.2 Minutes from other Groups

65.2.1. Edinburgh CHP Performance Management Sub-Group – 15th September, 13th October, 17th November and 15th December 2010 - Copies of the minutes were circulated to members and noted.

The Chair noted the excellent contributions made to the meetings of this Group by Jim Brown and Jim Kendall who represent the PPFs.

65.2.2. Edinburgh CHP Communications Group – 22nd September and 11th November 2010 - Copies of the minutes were circulated to members and noted.

65.2.3 Edinburgh CHP Health and Safety Committee – 14th September 2010 – A copy of the minutes was circulated to members and noted.

Peter Gabbitas noted that in future there would be a requirement to evidence that action had been taken to communicate to staff the implications of Health & Safety bulletins issued by the Scottish Government.

65.2.4 Edinburgh CHP Health Inequalities Standing Group – 12th August 2010 and 7th October 2010. – Copies of the minutes were circulated to members and noted.

65.2.5. Primary Healthcare Governance and Risk Management Group – 5th August and 4th November 2010. Copies of the minutes were circulated to members and noted.

65.2.6. Edinburgh CHP Quality Improvement Team- 27th August and 26th November 2010. Copies of the minutes was circulated to members and noted.

Dr McKay noted that the Digital Patient Stories referred to in the minutes of IM 26th November had been very powerful. It was agreed that these should be presented at a future meeting of the CHP Sub Committee.

Dr McKay noted that he felt further work was required to evidence whether or not GPs were carrying controlled drugs.

65.2.7. Edinburgh Alcohol and Drugs Partnership – 29th September 2010. A copy of the minutes was circulated to members and noted.
The launch of the Edinburgh Drugs and Alcohol strategy will take place in the week beginning 7th February 2011 by a Scottish Government Minister.

It was noted that the new waiting times for Initial Referral to Initial Assessment have been introduced and first results show that performance is close to target although the figures have yet to be validated. Peter Gabbitas stressed the importance of early assessment where the patient has acknowledged the desire to address their addiction issues. Evidence suggests that an early intervention in these cases significantly improves the potential of a positive outcome.

The issue of advertising of legal highs was discussed and a particular local example highlighted by the Chair will be referred to the appropriate department by Peter Gabbitas for further investigation. It was noted that legal highs are a significant issue in Edinburgh and that detox from these substances can be a greater challenge than from alcohol and heroin.

65.2.8. North Edinburgh PPF – 6th October 2010 - A copy of the minutes was circulated to members and noted.

65.2.9. South Edinburgh PPF – 7th October 2010 - A copy of the minutes was circulated to members and noted.

65.2.10. Edinburgh CHP Partnership Forum – 7th September and 16th November 2010 Copies of the minutes were circulated and noted.

65.3. LHP Reports

65.3.1. South Central Edinburgh LHP– There was no business raised under this item.

65.3.2 North West Edinburgh LHP– There was no business raised under this item.

65.3.3 North East Edinburgh LHP– There was no business raised under this item.

65.3.4 South East Edinburgh LHP– There was no business raised under this item.

65.3.5 South West Edinburgh LHP – There was no business raised under this item.

66. Questions from Members of the Public in Attendance

66.1. There were no questions raised. However Mr Norman Tinlin who was present commented that he felt there would be very little chance of the LAB Vans (Minute Item 63.3.) being given authorisation to use bus lanes as the appropriate authorities would not want to set a precedent.

67. Any Other Competent Business
67.1 It was agreed that minutes of the Carer Implementation Strategy Group should be tabled at the meetings of the Sub Committee in the future. Drew McErlean will arrange this via Angela Lindsay.

68. **Date and Time of Next Meeting**

68.1 It was noted that the next meeting of the Edinburgh CHP Sub-Committee would take place on Wednesday 6\(^{th}\) April 2011 at NHS Lothian, Waverley Gate, Edinburgh.

NHS LOTHIAN
EDINBURGH COMMUNITY HEALTH PARTNERSHIP SUB-COMMITTEE
2\(^{nd}\) February 2011

**ACTION NOTE**

<table>
<thead>
<tr>
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MIDLOTHIAN COMMUNITY HEALTH PARTNERSHIP

Note of the meeting of the Midlothian Community Health Partnership Sub-Committee (Public Session) held on Thursday, 25th November 2010 at 2pm in The Midlothian Council Offices, Dalkeith.

Present: Eddie Egan, Chairman  
Gerry Power, General Manager, Midlothian CHP  
Dr Jane Hopton, Asst General Manager, Midlothian CHP  
Councillor Jackie Aitchison, Midlothian Council Representative  
Liz Cregan, Chief Nurse, Midlothian CHP  
David King, Head of Finance  
Mandy MacKinnon, Health Promotions Manager  
Tom Welsh, Midlothian Council  
George Wilson, Voluntary Sector Representative  
Andrew Duffy, Pharmacy Representative  
Thomas Miller, Unison  
Morag Barrow, AHP Manager  
Sue Edmond, PPF Representative  
Dr Hamish Reid, Acting Clinical Director Midlothian CHP  
Sylvia Mack Employee Relations Manager

Apologies: Alex Philip, PPF Representative

In Attendance: Brian Brockie – Minute Item 41.2  
Gail Denholm, Susan Heggie and Rosie Townsley – Minute Item 41.1  
Drew McErlean – Minutes.

41. Apologies and Welcome

Apologies were noted as above.

The Chair welcomed the four members of public who were in attendance.

It was noted that the General Manager would be taking up a Secondment with the Scottish Government and would be leaving his post with the CHP on 17th December.

The Chair thanked the General Manager on behalf of the Sub Committee for his excellent contribution to the achievements of the CHP over the previous 5 years and wished him well for his period of secondment to the Scottish Government.
41.1. Presentation – Care Accolade Award – Multi Agency Team

The Sub Committee was given a presentation by members of the team which won the Care Accolade Award.

The presentation highlighted the scenario prior to the changes introduced with separate teams and bases.

The team highlighted the vision and aspiration – e.g. partnership, improving quality and early intervention.

The consultation process and the part played by service users was highlighted.

The key steps in the preparation for the changes were noted.

The key aspects of the changes introduced were highlighted as

- An enhanced community mental health service
- Greater service user inclusion.
- Enhanced partnership working
- The willingness of key stakeholders to take risks.

Feedback from the evaluation process was very positive – after 3 years admissions have reduced by 33%.

In June 2010 the CARE Accolade was won for the Planning and Redesign work. The General Manager noted how well deserved the honour was as the team had shown great commitment in designing and implementing the changes introduced.

41.2 Physically Active Community Education Activate (PACE) Presentation

The Sub Committee received a presentation on the Vision for Musculoskeletal Services on behalf of East and Midlothian Physiotherapy.

The presentation outlined why a re-design of physiotherapy services was needed, what progress had been made and sought the support of the CHP Sub Committee for the changes being progressed.

It was noted that a key finding in the review had been that there is significantly reduced need for 1 – 1 interventions with group sessions proving to be more helpful with patients sharing experiences.

The presentation referenced the case for change identifying the evidence base, cost effectiveness and the Lothian wide AHP review.
Change in the locus of delivery, expansion of current programme and guided signposting to lifelong commitment to physical activity were noted as key parts of the change.

Sue Edmond asked on behalf of Midlothian PPF if more localised services would be available in the future. Brian Brockie noted that geographic and demographic issues would be taken account of in determining where services would be provided.

The publication of patient feedback to the wider community is being planned and this will include PPF consultation.

The Chair asked if appropriate financial resource was in place to support the direction of travel for the service. The AHP Manager noted that resource has been allocated for a further year.

Decisions

The presentation was noted and the CHP noted support for the changes being made and the direction in which the service was being taken.

42. **Minutes of the Previous Meeting held 30th September 2010**

It was noted that the heading for Item 35.2 should be ‘Looked After Children and Young People.’

The minutes were otherwise agreed as being a true and accurate record of the meeting.

43. **Matters Arising / Action Plan**

43.1 The Action plan was reviewed and will be updated accordingly.

44. **General Manager’s Report**

44.1 The Sub-Committee considered a report which had been circulated in advance of the meeting.

**Delayed Discharges**

The report noted that the census undertaken in October 2010 recorded 9 Midlothian residents in total as delayed discharges. Both national targets were achieved. The report noted the additional investment in intermediate care beds and a strengthening of the Rapid Response Service in 2010 – 2011.

**Midlothian Community Hospital**

The report noted that staff and patients are settling in well to the new hospital.
Dalkeith Health Centre

The project remains on course for completion in July 2011.

Penicuik Health Centre

The refurbishment and extension work were reported as having started in November 2010 and completion should be achieved by April 2011.

Management Arrangements

David Small, currently General Manager of Edinburgh CHP will be taking up the post of General Manager of East Lothian and Midlothian CHPs with effect from 27th December 2010.

Decisions

The report was noted.

44.2. Staff Governance Report

The Sub-Committee considered a report which had been circulated in advance of the meeting.

The report highlighted that the turnover rate for staff in the period 1st August – 31st October 2010 was 2.38% The annualised rate of turnover is now 9.45%

The staff absence rate for October was 3.22% - with 1.24% being long term absence and 1.98% short term absence. The improving trend and the work undertaken to achieve this was noted.

The report provided updates on the Staff Survey, the NHS Lothian Business Continuity Exercise, seasonal flu vaccinations and the finalists for the Scottish Health Awards. The success of the Midlothian Health Visiting Team at the Scottish Health awards was noted.

Cllr Aitchison asked if statistics on the take up rate for staff flu vaccination were available. Sylvia Mack will report back on this.

Decisions

The report was noted.
45. **Clinical Director Report**

45.1 **Quality Improvement Team**

The Sub-Committee considered the minutes of the East and Midlothian Quality Improvement Team Meeting of 28th October 2010 which had been circulated in advance of the meeting. This was the first meeting of the joint team and this new approach was felt to be a positive move.

**Decisions**

The minutes were noted.

45.2 **Prescribing**

The Sub Committee considered a paper which had been circulated in advance of the meeting.

The current overspend position was noted. It was noted that Midlothian had the lowest overspend in Lothian and the lowest rate of volume growth.

**Decisions**

The report was noted.

45.3. **Medical Staffing**

It was noted that a consultation exercise around Medical Service Provision in General Adult Psychiatry had been completed. It was emphasised that staff impacted by the changes had been re-deployed and were not made redundant.

**Decisions**

The report was noted.

45.4. **GP Practice Reps Minutes**

The Sub Committee considered the minutes of a meeting of the Midlothian Practice Reps Group of 5th October.

The meeting had been attended by Sue Edmond from the PPF. At the meeting it had been agreed that Radiology Department at Royal Infirmary Edinburgh would provide a walk in service for Midlothian patients for plain film at the Midlothian Community Hospital.

**Decisions**

The report was noted.
46. **Chief Nurse Report**

### 46.1 Child Protection

The Sub Committee considered a report which had been circulated in advance of the meeting.

The report provided updates on –
- Best Practice Guidance on managing allegations
- The Midlothian Quality Assurance Sub Group.
- The Joint East Lothian and Midlothian Practice and Training Sub Group.
- Adult Protection – the scoping exercises to consider merging Adult Protection and Child Protection Learning and Development and Engagement Sub Committees were noted.
- Public Protection Unit.

**Decisions**

The report was noted.

### 46.2 Summary

The Sub- Committee considered a report which had been circulated in advance of the meeting.

The report provided updates on
- Midlothian Community Hospital
- Community Mental Health Team the work on Demand Capacity Access and Queues (DCAQ) was highlighted.
- It was noted that in relation to the Dementia Demonstrator Site, Midlothian Council will be appointing a Project Manager shortly and that the Scottish Government is very interested in this work.
- Releasing Time to Care – Newbattle cluster District Nursing Team will participate in the first cohort of Community Nursing staff in Lothian.
- Access to District Nursing Service – with effect from 1st October patients in receipt of palliative care will have direct access to the service via Lothian Unscheduled Care Services.
- Health Start – a replacement for the former ‘welfare food scheme’. It was noted Children’s vitamin drops will be available from Dalkeith and Bonnyrigg Health Centres. Sue Edmond asked if this meant that people from elsewhere in Midlothian would need to travel to Dalkeith or Bonnyrigg as that raised issues of service quality. Liz Cregan will address this and report back.

**Decisions**

The report was noted.
47. **AHP Manager Report**

The Sub Committee considered a report that had been circulated in advance of the meeting from the AHP Manager.

It was noted that the AHP Team had won an award from Association of Public Sector Excellence: Leisure and Sport.

The report highlighted that waiting times for Physiotherapy remain low.

The report also provided an update on
- The piloting of the National Musculoskeletal pathway for Scottish Government in Lothian.
- Technology development as a means of delivering AHP services referring to Tele Pulmonary Rehabilitation and work taking place in the Speech and language Therapy Team. It was noted that the AHP Manager will be making a presentation to the Royal Society of Medicine Telemedicine conference in London in December.
- Physiotherapy self referral which was reported as continuing successfully.
- Progress on the Lothian wide Podiatry and AHP strategy reviews.
- Midlothian Active choices which is continuing to support patients successfully. It was noted that support from Midlothian Council for this programme had been excellent. The General Manager noted that he felt this programme was a valuable example of how such initiatives can be successful.

**Decisions**

The report was noted.

48. **Hosted Services**

48.1 **Health Promotions Service Update**

The Sub-Committee considered a report which had been circulated in advance of the meeting.

The report highlighted the current position in the areas of –

- Service Re-design – work on the workforce re-design is awaiting the outcome of the Agenda for Change review process.
- Service Plan – the business plan is in place for 2010 – 2011.
- Financial Position – SLAs have been revised to reduce costs. It was noted there are additional pressures from the withdrawal of planned deferred monies. Contingency plans are being developed for the projects impacted.
• Accommodation issues affecting the HPS Library and Resource Centre. The Chair noted that this issue is about where the centre will be located in the future and is not about whether or not it will still exist.
• Alcohol Brief Interventions Programme
• Workplace Programme

The work being done to ensure value for money for all the voluntary sector projects in which NHS Lothian is investing was highlighted.

The Chair noted that a presentation had been made to the Board of NHS Lothian on 24th November and the positive impacts made from many of the Health Promotions initiatives.

Decisions

The report was noted.

It was agreed that the presentation to the Board on 24th November should also be made to a future meeting of the CHP Sub Committee.

49. **Carers Forum**

It was noted that Wendy Brooks has resigned as the Carers Representative on the CHP Sub Committee and there is no designated depute.

It was agreed that Vocal should be asked if they can provide a resource to cover Carers representation on the CHP Sub Committee.

Decisions

The update was noted.

50. **Community Health Partnership Committee Appointments**

There was no business raised under this item.

51. **Public Partnership Forum**

The Sub Committee considered the minutes from the Public Partnership Forum of 16th September 2010.

It was noted that in the short term Alex Philip will not be able to attend meetings of the CHP Sub Committee and Sue Edmond is arranging cover for this position.

It was noted that the PPF is willing to work with Health Promotions to manage the impacts of any reductions in funding.
Decisions

The minutes were noted.

On behalf of the Sub Committee the Chair asked that best wishes be passed on to Alex for a speedy return to duties.

52. **A.O.C.B.**

52.1. **Homeopathy Service Review**

The Sub Committee considered a report which had been circulated in advance of the meeting.

The report provided details of a review of the evidence base for continued provision of Homeopathic Services in NHS Lothian.

The report noted that in view of the lack of evidence of efficacy, and cost-effectiveness, Midlothian CHP should recommend that NHS Lothian ceases funding homeopathic services.

The report noted that consideration would need to be given to communication and transition of patients currently in receipt of homeopathic treatment especially those on long-term treatment.

The General Manager noted that the paper had been discussed with Midlothian PPF and it had been agreed that the recommendations in the report should be referred to the Scottish Health Council for wider consultation before any recommendations can be made to Health Boards. It will be a matter for the Scottish Health Council to advise on the scope and timescale of the consultation process.

It was noted that funding for the service will continue until that process of consultation is complete and decisions are reached about any changes to the service.

**Decisions**

It was agreed to refer the report recommendations to the Scottish Health Council so that a wider consultation process can be initiated.

52.2. **Future Dates of Midlothian Community Health Partnership Sub Committee Meetings**

A schedule of meeting dates for the Sub-Committee for the period March 2011 – January 2012 was tabled. The schedule highlighted the deadline dates for submitting papers.

**Decisions**

The schedule of meeting dates was agreed.
53. **Date and Time of Next Meeting**

Thursday 27th January 2011 14.00 – 15.30 – Council Chambers, Buccleuch Street, Dalkeith
MINUTE of MEETING of the WEST LOTHIAN COMMUNITY HEALTH AND CARE PARTNERSHIP BOARD of WEST LOTHIAN COUNCIL held within STRATHBROCK PARTNERSHIP CENTRE, on TUESDAY, 18 JANUARY 2011.

Present – Theresa Douglas (Chair), Ellen Glass (Vice-Chair), Robin Burley, Janet Campbell, John Cochrane, Jane Houston and John McGinty

Apologies – Mike Boyle

In Attendance – Alan Bell (Senior Manager - Communities and Information, West Lothian Council), Marion Christie (Head of Health Services), Lynne Hollis (Associate Director of Finance, NHS Lothian), Dr James McCallum (Clinical Director, NHS Lothian), Pamela Main (Senior Manager - Older People, West Lothian Council), John Richardson (PPFHC), and Jennifer Scott (Head of Council Services (Interim))

Apologies – Jim Forrest (CHCP Director), Gill Cottrell (Chief Nurse, NHS Lothian)

1. OPENING REMARKS BY CHAIR

The Chair welcomed to the meeting Dr James McCallum, the newly appointed Clinical Director.

2. DECLARATIONS OF INTEREST

John Cochrane declared a non-financial interest in relation to agenda item 8 as a council-appointed Director of West Lothian leisure Limited, but in light of the nature of the item of business he advised that he would remain and participate.

3. MINUTES

(a) The Board approved the minute of its meeting held on 19 October 2010 as a correct record.

Matters arising:-

(i) Page 513 – in relation to decisions 3(a) and (b) in item 5 of the minute (Pharmacy Strategy 2009/2012), the Chair agreed to consult with the CHCP Director about a date for completion and the inclusion of these items in the Running Action Note.

(ii) Pages 513-514 – in relation to item 6 of the minute (ONS Project), agreed that the CHCP Director should consider and advise on the possible provision of regular follow-up reports to the Board to monitor the continuous savings achieved by the project, and noted that the head of health services would contact Ellen Glass to provide more detailed information requested by her in relation to that Project.

(ii) Page 515 – in relation to item 9 of the minute (Staff Governance) agreed that the provision of information to Board members about the Harvard Leadership Programme should be added to the Running Action Note with a date for completion.

(b) The Board noted the Minute of the meeting of the Sub-Committee held on 30 September 2010.
The Board noted the minute of the meeting of the NHS Lothian Primary and Community Partnership Board held on 10 November 2010. It was noted that the Chair and Robin Burley would provide further clarification of item 362.1 of the minute (Matters Arising – CHAMS) at the next meeting of that Board due to take place on the following day, and that in relation to item 365.1 of the minute (Delayed Discharge – Complex Codes), the Chair would advise the Vice-Chair in relation to the proposed visits by clinicians to care homes and hospitals.

The Board noted the Minute of the meeting of the NHS Lothian Primary Care Joint Management Group held on 9 September 2010.

The Board noted the Minute of the meeting of the NHS Lothian Primary Care Joint Management Group held on 14 October 2010.

4. RUNNING ACTION NOTE

The Board considered an updated Running Action Note (which had been circulated) for the current financial year to date showing matters arising from meetings of the Board and the progress towards their completion.

Decisions

1. To agree that item 5 (Overspend in Mental Health) was not complete and that a further report would be on the agenda for the Board meeting in March 2011.

2. In relation to Appendix 1 (Mental Health Quality Improvement Team), to note that the Mental Health Scottish Patient Safety Programme would be considered by the Sub-Committee in due course.

3. To otherwise note and agree the content of the Running Action Note for the financial year to date.

4. To agree that the Running Action Note, amended to reflect the changes approved and matters arising, would be placed on the agenda for the next meeting of the Board in March 2011.

5. PRESENTATION – EQUALITY AND DIVERSITY

The Board heard a presentation by James Glover (Head of Equality and Diversity, NHS Lothian) and Kenny Selbie (Equality Officer, West Lothian Council) in relation to the joint and common approach to equality and diversity issues in the CHCP, in particular the Equality Impact Assessment procedures used and their relevance to the reports brought to the Board for noting and for decision. The Board was advised that the report template adopted required that equality issues be identified and explained, or else if none were identified then that had to be explained as well.

Decisions

(1) To note the information provided and to thank James Glover and Kenny Selbie for their presentation.
(2) To agree that Board members should take care to scrutinise reports in relation to equalities to ensure the issues are addressed where appropriate and the necessary assessments are carried out.

6. CHAIR’S REPORT

The Board considered a report by the Chair (which had been circulated) advising of the CHCP activity she had carried out since the last meeting of the Board, under the following headings:-

- “Sure Start” Annual Conference.
- St. John’s Hospital Stakeholders Group.
- Visits (West Lothian Council’s Services for Looked-After Children and Mental Health Team).

Decision

To note the contents of the report.

7. WEST LOTHIAN FIRST STEPS TO HEALTH AND WELL-BEING PROJECT

The Board considered a report by the Clinical Director (which had been circulated) explaining the progress of the First Steps project run in partnership with West Lothian leisure Limited and the Pitstop at Addiewell, and seeking continued support for the project from the Board.

The report set out the key elements of the project and the activities covered and the monitoring by the Project Steering Group, and concluded that continued funding of the project would make an important contribution to tackling mental and physical health issues across West Lothian and improve the health and well-being of the local community.

Decisions

1. To note the report.
2. To agree that continued support of the project could not be given until a full business case was developed and made available for consideration.
3. To agree to continue financial support for the project for the first two months of the next financial year.
4. To note that officers would bring a further report to the meeting of the Board in March with a full business case for the continuation of the project.

8. REDMILL NURSING HOME, EAST WHITBURN – REPORT ON IMPROVEMENTS SINCE NOVEMBER 2010

The Board considered a report by the Acting Head of Council Services (which had been circulated) outlining the progress made by Redmill Nursing Home in complying with an Improvement Notice served by the Care Commission.
The report set out the background to the inspection of the Home, the reasons for the Improvement Notice and the steps required to ensure compliance. It went on to summarise the partnership liaison arrangements which had been put in place to address the problems, the subsequent actions taken by the Home, the follow-up inspections by the Care Commission and the conclusion that substantial improvements had taken place with a commitment to complete those improvements as demanded by the Commission.

Decision

1. To note the report.

2. To endorse the measures undertaken by Health and Social Care staff.

9. HEALTH & CARE GOVERNANCE IN THE CHCP

(a) CLINICAL GOVERNANCE

The Board considered a report by the Clinical Director (which had been circulated) informing the Board of the “Delivering Quality in Primary Health Care National Action Plan” for the implementation of the Healthcare Quality Strategy for NHS Scotland.

The report set out the priorities for Primary Care over the next five years, the National Actions required and summarised the role of the CHCP in planning and delivering primary and community healthcare services and implementing the Action Plan for the West Lothian area.

Decisions

1. To note the report.

2. To agree to support the CHCP Senior Management Team in progressing work with GP practices and other independent contractors in delivering the Action Plan.

(b) CARE GOVERNANCE – WEST LOTHIAN COUNCIL CHIEF SOCIAL WORK OFFICER ANNUAL REPORT – APRIL 2009 TO MARCH 2010

The Board considered a report by the Acting Head of Council Services (which had been circulated) explaining the statutory role of the council’s Chief Social Work Officer and the requirement made by Scottish Government Guidance that there be an annual report about the work of the Chief Social Work Officer. The first such annual report, for April 2009 to March 2010, was attached to the report in Appendix 1.

Decisions

1. To note the report.

2. To welcome the report as an informative summary of the work of the Chief Social Work Officer.

3. To note that feedback from Board members on the format and content of the report was requested.
(c) STAFF GOVERNANCE

The Board considered a joint report by the Acting Head of Council Services and the Head of Health services (which had been circulated) updating the Board in relation to staff issues in the CHCP.

The report advised of the achievement of the Investors in People standard by CHCP health staff, the progress of the NHS staff survey, the adoption of new and updated clinical policies, the appointment of a new Medical Director, the success of council CHCP staff in the council’s Celebrating Success awards, and the work in providing flu clinics in West Lothian.

Decision

To note the report.

10. PERFORMANCE MANAGEMENT IN THE CHCP

(a) PERFORMANCE MANAGEMENT REPORT

The Board considered a joint report by the Acting Head of Council Services and the Head of Health services (which had been circulated) advising the Board of operational performance in key areas of CHCP activity.

The report explained the CHCP’s approach to performance management and the incorporation of national community care outcomes within routine business processes. It went on to explain that data from the services’ separate systems had been used to build performance indicators in the council’s Covalent system, and a report from that system was contained in Appendix 1. Appendix 2 to the report contained information on drug, alcohol and smoking cessation services, and in Appendix 3 was an Absence Management Report for the six-month period from May 2010 to November 2010.

Decisions

1. To note the report.

2. To note that officers would provide confirmation as to whether the TRAC adaptor was or was not operational.

(b) TACKLING DELAYED DISCHARGE

The Board considered a joint report by the Acting Head of Council Services and the Head of Health services (which had been circulated) updating the Board in relation to the delayed discharge census and the work being done to support their discharge from hospital.

The report provided the result of the December census and explained the issues arising in relation to a small number of patients still experiencing extended stays in hospital, especially in connection with welfare guardianship orders, and the reasons for a small number of delays on October and November 2010.

The report went on to explain strategic developments and central government funding available to tackle these issues and set out the key measures of success in those developments.
Decisions

1. To note the results of the December 2010 census.

2. To note the current progress in reducing the number of patients whose discharge from hospital was delayed.

3. To note that despite progress there were still patients with complex support needs who had extended periods of delay within a hospital setting, and the reasons given for that.

(c) 2010/11 REVENUE BUDGET-MONITORING REPORT AS AT 30 NOVEMBER 2010

The Board considered a joint report by the Acting Head of Council Services and the Head of Health services (which had been circulated) providing a report on financial performance in the CHCP for the period to 30 November 2011.

The budgets overall were forecast to break even for 2010/2011, with an anticipated underspend in the council budget of £300,000 due largely to one-off savings from staff vacancies and the Norvell Lodge Sheltered Housing Unit and the Forrest Walk Physical Disability Unit.

The main risks involved in respect of the budget forecasts were identified along with the steps being taken by managers to monitor budget performance and address these areas of risk.

Decision

To note the report.

(d) RESOURCE TRANSFER MONITORING REPORT TO 31 October 2011

The Board considered a report by the CHCP Director (which had been circulated) providing details of phased expenditure in the period to 31 October 2010.

The report explained that the target figure of zero delayed discharge had been maintained in both Learning Disabilities and Mental Health, but that due to exceptional demand along with a temporary reduction in capacity at one care home there were 8 people delayed during October. It was anticipated that this situation would improve and that the figures for November would return to a zero delay.

Decision

To note the report.

11. DIRECTOR’S REPORT

The Board considered a report by the CHCP Director (which had been circulated) setting out areas of work in which the Partnership had been involved since the last Board meeting in the following areas:-
• Development of a residential, respite and day support resource for people with physical disabilities in Uphall.

• Webinar through Health Tracker.

• West Life.

• Tough Choices update.

Decisions

1. To note the report.

2. To note that officers would advise Board members if all those due to move into the new resource at Uphall were already resident in West Lothian.

12. WEST LOTHIAN INTERFACE UPDATE

The Board considered a report by the Head of Health Services (which had been circulated) advising of the progress of the Interface Group which had been established to improve communications and facilitate dialogue relating to the provision of seamless clinical pathways to improve outcomes and patient experience.

The report set out the background to the establishment of the Group, its membership and its agenda. It advised that meetings had been well-attended across all areas and had enabled a shared understanding of issues and highlighted areas for improvement in communication flows, access to diagnostics and referral pathways all of which would contribute to improved patient care and experience and streamlining of processes.

Decision

To note the report.

13. CARE HOMES – ACTIVITY AND PERFORMANCE

The Board considered a report by the Acting Head of Council Services (which had been circulated) updating Board members on activity and performance in relation to Care Homes in West Lothian for the period from September to November 2010.

The report explained the number of care homes operating in West Lothian, the inspection regime applied by the Care Commission, the capacity of homes in West Lothian and demand for places, and provided information about waiting lists for places.

Appendix 1 to the report contained information on Quality grades and Total bed Capacity, and in Appendix 2 was data in relation to Empty Beds and Waiting Lists.

Decisions

1. To note the report.

2. To note that the Chair and CHCP Director would discuss the appropriate forum for future governance of the subject matter of the report.
14. **REPORT ON CARE COMMISSION INSPECTION - ACTION PLAN FOR CRAIGMAIR – MAY 2010**

The Board considered a report by the Acting Head of Council Services (which had been circulated) advising the Board of actions taken in response to the Care Commission's inspection report for Craigmair in May 2010.

The report explained the inspection regime applied by the Care Commission, its inspections of Craigmair since 2004 and the findings of its report in May 2010. It advised of the Action Plan developed in response, and which was contained in Appendix 1, and concluded that most of the required actions had been implemented or were on target for completion as required.

**Decisions**

1. To note the report.
2. To note that the Chair and CHCP Director would discuss the appropriate forum for future governance of the subject matter of the report.

15. **WEST LOTHIAN COUNCIL DOMICILIARY CARE SERVICES – STRATEGIC DIRECTION**

The Board considered a report by the Acting Head of Council Services (which had been circulated) advising the Board of the proposed strategic direction for the council's in-house domiciliary care service.

The report set out the strategic objective outlined in the Older People’s Service Statement for 2009-2012, the background and strategic context, the past success of the council's re-enablement model, proposals for a new service model, a crisis response service, an extended re-enablement service, and the council’s approved plans for implementation.

The Chair commented that although this report had been shown in the agenda as "For Information", nevertheless it deserved full scrutiny and discussion.

**Decision**

To continue the report to the next meeting of the Board to allow the CHCP Director to be present and offer his advice, and to allow the partners to further consider the content of the report for discussion and deliberation.

16. **SINGLE SHARED ASSESSMENT AND USE OF C-ME**

The Board considered a joint report by the Acting Head of Council Services and the Head of Health services (which had been circulated) updating the Board on the usage of the Single Shared Assessment and C-Me, in accordance with a request made by Board members previously for more detailed information. In relation to the age groups eligible for assessment, the numbers assessed and the numbers being missed form the assessment process.

Detailed information was provided in Appendix 1 in relation to the number of assessments carried out in the preceding 12 months broken down by age groups, but advised that there were no mechanisms in place for identifying those who may be potentially subject to such assessments.
The Board was invited to consider whether similar information should be provided in future routine reports.

Decisions

1. To note the report.

2. To agree that the information in the report should not be included in future reports

17. INSPECTION BY THE SOCIAL WORK INSPECTION AGENCY 2010

The Board considered a report by the Acting Head of Council Services (which had been circulated) informing the Board of progress made during the initial Scrutiny phase of the current inspection by the Social Work inspection Agency (SWIA). SWIA’s Guidance was contained in the appendix to the report.

The report set out the inspection process used by SWIA, in particular the initial Scrutiny Level Assessment and its aims and the ways in which the findings of the scrutiny activity would be reported. The steps taken by the council to prepare for the inspection were explained along with the current state of progress of the initial stage of the inspection.

Decision

To note the report.

18. HMIE REPORT ON SERVICES TO PROTECT CHILDREN AND YOUNG PEOPLE IN WEST LOTHIAN

The Board considered a report by the Acting Head of Council Services (which had been circulated) informing the Board of the outcome of the HMie inspection of services to protect children and young people in West Lothian.

The report explained that the HMie report had been published on 7 October 2010 following the inspection carried out in June 2010. It went on to detail the evaluations of the four key quality indicators for West Lothian, the other two areas evaluated during the inspection, the strengths identified and the areas identified for improvement and agreed with HMie.

The report concluded by advising that the evaluation was a very positive one and reflected the hard work of all staff involved, and that as a result of the high standards established there would be no further visits by HMie.

Decision

To note the report.
CHAIRMAN’S REPORT

1. Internal

1.1 Short Stay Elective Surgical Centre, St John’s Hospital - On 1 March I hosted the official opening by the Cabinet Secretary for Health and Wellbeing of the new Short Stay Elective Surgical Centre at St John’s Hospital.

1.2 Visits - Visits in this period included the Western General Hospital on 2 February and Midlothian CHP on 8 March.

1.3 MSP Briefing - Our quarterly briefing of MSPs took place on 25 February, and a repeat briefing for those unable to attend the earlier date was held on 10 March.

1.4 LEAP Graduation - I presented the certificate at the LEAP graduation ceremony on 3 March.

2. External

2.1 Mercy Corps - On 10 January I attended a reception organised by NGO Mercy Corps to mark the anniversary of the Haiti earthquake. NHS Lothian is a member of Edinburgh Council’s Disaster Relief Committee, which channels funds raised from the public to Mercy Corps.

2.2 Non-Executive Event - With several NHSL Non-Executive Board colleagues I attended the annual meeting of Scottish Public Sector Non-Executive Board members on 13 January. Areas of mutual interest were discussed.

2.3 NHS Borders Chair - On 17 Jan I had a farewell visit from the outgoing Chair of NHS Borders, Mary Wilson.

2.4 East Lothian Council - On 21 Feb I attended a very positive meeting with East Lothian Council to review joint progress on the Older People’s Strategy.

2.5 Consort/ NHSL Joint Board - The NHS Lothian/Consort joint Board met on 22 Feb to review areas of interest.

2.6 Carers of East Lothian - On 10 March I was a guest the opening of the new Musselburgh headquarters of the Carers of East Lothian (CEL). The opening was
performed by HRH the Princess Royal. I subsequently attended a meeting at which NHS management outlined the funding arrangements for CEL.

2.7 **Army Liaison** - On 17 March I met the Edinburgh Garrison commander, Col Simon Vandeleur.

2.8 **Alzheimer’s Society’s Society** - On 21 March I attended a seminar on ‘Personalisation’ at which the Alzheimer’s Society of Scotland set out their views on ‘personalised’ care budgets.

Charles Winstanley
Chairman
9 March 2011
CHIEF EXECUTIVE’S REPORT

1. Local Initiatives

1.1 Visit to Edinburgh CHP in the Company of Peter Gabbitas, Director of Health and Social Care – I visited Edinburgh CHP on February 11. The visit focused on innovation in continuing care and I was delighted to see the developments at the Firrhill campus, including work on Edinburgh Community Stroke services. I was also delighted to have a preview of the new care home facility opened at Inch View, which offers excellent modern accommodation. I also visited the site of the new development at Chalmers Hospital and had a tour of the site with Dr Gordon Scott, the clinical lead in sexual health services. The visit focused on excellent examples of health and social care staff providing integrated and personalised services.

1.2 Edinburgh BioQuarter Partners Forum – I attended a meeting of the BioQuarter Partners Forum on February 1. The meeting was chaired by John Swinney, the Cabinet Secretary for Finance and Sustainable Growth and re-affirmed continuing positive progress in the development of the BioQuarter. We heard from Mike Capaldi, Director of the Edinburgh BioQuarter on progress on commercialisation and the development of the Bio-incubator building, which is being promoted as a joint venture involving the BioQuarter partners, offering over 70,000 sq ft of laboratory and office accommodation.

1.3 Awards – Board members will wish to note that NHS Lothian has been shortlisted in the Second Annual Oracle UK Customer Awards under the heading of Best Green Project – Reducing Carbon Footprint. The award ceremony takes place in London on March 23 and we will be represented by Martin Egan, Director of eHealth.

We continue to enjoy success in Communication awards and at the Institute of Internal Communication Scotland Awards, held in Edinburgh on March 4, 2011, our Communications Team won awards in the following categories - Best Employee Newspaper for Connections; Best Campaign for our work on “Sign up to Save a Life”. The same campaign won an award for the best use of online communication, plus Victoria Mundell of our Team won the award for Young Communicator of the Year. Members will wish to acknowledge the success of all those involved.

2. Regional Initiatives

2.1 South East and Tayside Regional Planning Group (SEAT) – I chaired the SEAT meeting on January 21. At the meeting, the Group heard an update on the work to establish the Managed Clinical Network for Neonatal Services, a report from the
national Managed Service Network for Children and Young People with Cancer and an update on the Telestroke pilot, which is being run in South East Scotland to ensure out-of-hours stroke thrombolysis. The meeting also gave NHS Lothian an opportunity to update other Boards on the position in respect of the development of our Sick Children’s Hospital and the Department of Clinical Neurosciences.

2.2 Regional Cancer Advisory Group (RCAG) – On the same date, I chaired a meeting of the South of Scotland Regional Cancer Advisory Group. Matters discussed included an update on eHealth developments for the SCAN Network, including the roll-out of a clinical portal across South of Scotland, which enables clinical staff in different locations to view patient data from a variety of sources. The Group also heard of the work in introducing telepresence technology across the network, which will allow clinical teams to be linked for multi-disciplinary meetings with a future extension of use to include remote patient consultation.

The Group also heard a progress report from the SCAN Clinical Lead, Dr John Davies on the regional non-surgical oncology review, which had been established in response to the growing recognition that oncology services face a number of significant challenges across the South East of Scotland cancer network. The review confirmed the agreement of funding to sustain the service, as well as an ambitious programme of service redesign to support the delivery of outreach services. The review has also featured a seminar held in the Edinburgh Cancer Centre with external advice from a London-based Medical Oncologist setting out their experience of innovation in the provision of acute oncology. Further work over the coming months will include capacity and demand analysis, service redesign and improvement and interface with other services across the region.

3. National Initiatives

3.1 Patient Safety – I attended a national conference organised by Scottish Government on patient safety held in Glasgow on January 28. Dr David Farquharson was also able to attend part of the conference and important follow-up work being undertaken by David and his team will be in respect of effective and early communication relating to untoward incidents affecting patients, continuing work to ensure clear and unambiguous accountability in respect of compliance and how our information systems will generate real time information, which will inform the patient safety agenda.

3.2 Scottish Partnership Forum – I attended a meeting of the Scottish Partnership Forum on February 8. The agenda for the meeting including discussions on the national research project on partnership working, which confirmed a very positive position across Scotland, a progress report on a pilot project in Highland involving lead commissioning and an update from Scottish Government colleagues on the efficiency and productivity programme.

James Barbour
Chief Executive
9 March 2011
QUALITY IMPROVEMENT REPORT

1 Purpose of the Report

1.1 This report presents the updated Quality Report for March 2011 including the measures introduced to date.

2 Recommendations

The Board is asked to:

2.1 Review the quality measures presented.

2.2 Review and comment on this Quality Improvement Report.

3 Introduction

3.1 The Quality Dashboard was introduced to the Healthcare Governance & Risk Management Committee in February 2010 and to the Board in March 2010 as the Quality Matrix. The title has been changed to Quality Improvement Report to reflect the terminology set out in the Quality Strategy (2010) launched on 10th May 2010.

3.1.1 The quality improvement report includes a suite of measures which, at a system level, will allow monitoring of the quality of care provided by NHS Lothian.

3.1.2 This paper presents the updated quality improvement report for March 2011. Table 1 shows each of the individual measures reported quarterly, their data source, and what questions they answer about the care we deliver and summary of results.
Table 1: Core quality measures, summary of which questions each measure answers and summary results for March 2011

<table>
<thead>
<tr>
<th>Measure</th>
<th>How good is our care?</th>
<th>Is our care getting better?</th>
<th>How do we compare?</th>
<th>Data Source</th>
<th>Summary Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR*</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>ISD</td>
<td>• HSMR remains stable at less than one with no observed reductions.</td>
</tr>
<tr>
<td>Adverse Events</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>IHI Global Trigger Tool Review</td>
<td>• Baseline starting to stabilise, from which an improvement target can be set.</td>
</tr>
<tr>
<td>Hospital Acquired Infection(HAI)</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>Infection Control Team</td>
<td>• S.aureus Bacteraemia – Not meeting HEAT target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• C.difficile Infection – Met and exceeded HEAT target</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• Hand Hygiene – Met HEAT target and local stretch target met.</td>
</tr>
<tr>
<td>Incidents</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>Datix System</td>
<td>• The reporting of incidents and associated harm remains stable.</td>
</tr>
<tr>
<td>Complaints</td>
<td>✓</td>
<td>✓</td>
<td>x</td>
<td>Datix System</td>
<td>• There continues to be a significant reduction in formal complaints.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>• National 3-day response and local 20-day response targets continue not to be met.</td>
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</tbody>
</table>

*HSMR: Hospital Standardised Mortality Ratio

A tick indicates that the measure does answer the question asked, a cross indicates that it does not.

3.2 Links to the Quality Strategy

3.2.1 The NHSScotland Healthcare Quality Strategy launched in May 2010 included a three level Quality Measurement Framework (QMF). Level 1 is national reporting towards the quality ambitions, level 2 contains HEAT targets and level 3 is for other local or national measures required for quality improvement. The ‘core’ measures Healthcare Associated Infection (HAI), adverse events and Hospital Standardised Mortality Rate (HSMR) presented in the NHS Lothian Quality Improvement Report are already aligned with the Quality Strategy level 1 measures.

3.3 Quality of Care Measures

Hospital Standardised Mortality Rate (HSMR)

Hospital Standardised Mortality Ratio (HSMR) is calculated by Information Services Division and used by the Scottish Patient Safety Programme (SPSP). There is an SPSP target reduction in HSMR of 15% by December 2012 against a baseline of October 2006 to September 2007. The baseline HSMR figures and the quarters up to September 2010 and corresponding 15% reduction are set out in Table 2 below.
HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs have therefore been used as system level ‘warnings’ for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

The 15% target reduction in HSMR is ambitious; it equates to 15% of current deaths being avoidable. Health Boards who have seen a reduction in HSMR have had a baseline that exceeded NHS Lothian’s and was in some cases more than 1. The Scottish HSMR for July to September 2010 was 0.90. HSMR remains stable at less than one with no observed reductions.

Table 2

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<tr>
<td>RIE</td>
<td>0.88</td>
<td>0.93</td>
<td>0.84</td>
<td>0.81</td>
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<td>WGH</td>
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<td>0.72</td>
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<td>SJH</td>
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<td>0.72</td>
<td>0.85</td>
<td>0.81</td>
<td>0.81</td>
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</table>

3.3.1 Figures 1a-c show the number of observed and expected deaths at Royal Infirmary Edinburgh (RIE), St. John’s and Western General Hospital (WGH). These are all less than 1, indicating that the number of observed deaths is fewer than the expected number.

Figure 1a
Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh
Number of observed and expected deaths; October 2006 – Sept 2010
3.4 Adverse Events

Adverse events are currently measured at the three main acute sites by retrospective case note review using the ‘Global Trigger Tool’. This measure is being reviewed at national level as the feasibility of achieving the expected baseline set by SPSP of 80/90 adverse events per 1000 patient days has been challenging for all boards. This review is being progressed by National Quality Strategy Clinical lead. The baseline is now stabilising at a rate of 52 adverse events per 1,000 patient days, as illustrated by Figure 2.
3.5 **Healthcare Associated Infections**

3.5.1 *S. aureus* Bacteraemia (SAB)

NHS Lothian’s HEAT target for SAB reduction is 40% by March 2011. In the quarter to January 2011, NHS Lothian continues to not meet this HEAT target. There has, however, been a decrease in the SAB rate in January, as illustrated by Figure 3a.

*Figure 3a* – Progress against HEAT Target for *S. aureus* Bacteraemia (SAB)
3.5.1.1 A national rapid 90-day SAB improvement programme is taking place in five Health Board areas where the SAB target is not being met. These are NHS Lothian, Grampian, Tayside, Forth Valley and Ayrshire & Arran. The programme is extremely intensive, and is externally supported by Health Protection Scotland and the National Patient Safety Team. An NHS Lothian 90-day SAB action plan has been drawn up supported by Infection Control and SPSP team, which aims to achieve the SABs target by 14th May 2011. The action plan includes the following:-

- Improved data gathering and analysis and the use of local data to target and drive local SAB improvement.
- Implementation of robust and reliable enhanced surveillance.
- Clinical skills development to best in class in target areas, such as Accident & Emergency, admissions units and renal services. This includes reliable use of safe techniques for priority groups in order to:
  - Reduce device related SABs
  - Reduce contaminated blood cultures
  - Improve hand hygiene
- Improved communication with all from Board to point of care
- Patient and carer involvement

3.5.2 *C. difficile* Infection (CDI)

In June 2010 the Scottish Government Health Department (SGHD) issued a new HEAT Target for CDI to all NHS Boards, increasing the target from a 30% to a 50% reduction by March 2011.

NHS Lothian has put in place an extensive CDI programme which is fully integrated with the Patient Safety Programme. This has resulted in an improved sustained performance that has outstripped the HEAT target requirements. This is illustrated in Figure 3b.

*Figure 3b* – Progress against HEAT Target for *C. difficile* Infection (CDI)
3.5.3 **Hand Hygiene**

There has been a significant and sustained improvement in compliance since October 2007. NHS Lothian continues to exceed the national target of 90% compliance and is currently achieving 95% as of January 2011. NHS Lothian has now also achieved its local stretch target of 95% compliance, and improvement plans are in place to sustain this improvement.

3.6 **Reported Incidents**

Incidents are reported using the DATIX system recording incidents that affect patients and staff. The category and degree of harm associated with each incident is also recorded. There are improvements to be made in the degree of standardisation in this process and actions to improve standardisation are being led by the Risk Management Team in conjunction with clinical management teams.

Figures 4a, 4b and 4c show that incident reporting has stabilised throughout 2010 across NHS Lothian. The top three reported types of incidents for this quarter were falls (28%), violence and aggression (19%) and medication incidents (8%); these continue to be consistent themes. To address these themes, the following interventions are taking place:-

- The testing of an evidence-based inpatient falls bundle using SPSP methodology. The aim of the programme is to reduce the incidents and associated harm from inpatient falls.

- A significant number of incidents concerning violence and aggression (31%) are generated by the Royal Edinburgh & Associated Services (REAS). REAS has set up an Incident Action Plan group focussing on 4 types of incidents and looking at a number of interventions to reduce violence, aggression and associated harm.
- The SPSP programme continues to reduce medication errors through the implementation of medicine reconciliation and work on high-risk medications.

- Following on from a significant medication administration error, the Nurse Director has led a number of major changes to the procedures for competency assessments of intravenous drugs administration to ensure 100% achievement of calculations and accountability components.

- NHS Lothian will also participate in a national pilot to assess numeracy and this will inform future education and individual practitioner support systems.

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Figure 4a - Number of incidents reported per month in NHS Lothian (Jan 2009-Dec 2010)

![NHS Lothian Incidents Reporting Trends](image)

Figure 4b - Number of incidents reported per month in Community and Primary Care including Hosted Services (Jan 2009-Dec 2010)
Community & Primary Care Incident Reporting Trends

Figure 4c - Number of incidents per month in UHD including Royal Edinburgh & Associated Services (REAS) in NHS Lothian (Jan 2009-Dec 2010)

UHD (including REAS) Incident Reporting Trends

3.6.1 Figures 4d, 4e and 4f show that incidents reporting with moderate or major harm and death have stabilised throughout 2010. Incidents associated with major harm
are reported to executive and operational leads and monitored for progress on a weekly basis.

Figure 4d - Number of incidents associated with moderate or major harm or death reported per month in NHS Lothian (Jan 2009-Dec 2010)

Figure 4e - Number of incidents associated with moderate or major harm or death reported per month in Community and Primary Care including Hosted Services in NHS Lothian (Jan 2009-Dec 2010)
3.7 Complaints

3.7.1 NHS Lothian received a total of 169 complaints during the period October-December 2010. This represents a decrease of 25% on the previous quarter.
3.7.2 NHS Lothian has achieved an average 20-day response time of 70% in respect of the local target of 85%. This represents a decrease in the previous quarter, as illustrated in figure 5b. The Scottish average is 76% in 2009/10 (ISD).

3.7.3 NHS Lothian’s performance in quarter 3 is 93% compliant with the national target to respond to all formal complaints within 3 working days. The Scottish average for 2009/10 is 97%.
3.7.4 Reviewing the formal complaints for NHS Lothian for this period the top three themes are listed below:-

- Clinical treatment 37%
- Staff attitude and behaviour 21%
- Waiting Times 6%

This remains unchanged from previous quarters with the exception of waiting times which have replaced communications oral and/or written. It is unclear why this has become focus for concerns and will be monitored in the coming quarter.

3.7.5 Example of lessons learned from complaints

After a catalogue of incidents concerning an elderly patient with cognitive impairment and miscommunication with the family, a meeting between staff and family members was suggested. The family accepted the offer to meet and are working with the Chief Nurse to develop an action plan to improve a range of issues. There were, however, a number of generic findings that emerged from the investigation of this case which will inform improvements in the current complaints system, which include the need for:

- Clarity about logging complaints
- Clarity around staff owning complaint and responsible for closure
- Improvements in post fall management which have been taken forward by the Patient Safety Team and Falls Co-ordinators
- Improvement in identified senior staff on all sites to listen and respond when relatives wish to complain
- Improved staff confidence when dealing with angry and upset people
- Improved information on respite provision for staff and families
3.7.6 During quarter 3 the Scottish Public Services Ombudsman (SPSO) has published one report with respect to NHS Lothian. The report identified a number of care home issues for an elderly Alzheimer’s disease patient from the provision of adequate stimulus to the need for improved communication between staff and family. Actions have been taken to address issues raised in the published report which include enhanced communication between staff and relatives (SPSO 200904074).

3.7 Effectiveness Measures

3.7.1 The clinical effectiveness measure for this report is for Coronary Heart Disease. Renal and Respiratory effectiveness measures will be reported in the next Board report in May 2011.

3.7.2 Coronary Heart Disease (CHD)

For Coronary Heart Disease (CHD), the effectiveness measures are as follows:

1. Achievement of blood pressure targets for patients with CHD in the community;
2. Achievement of cholesterol targets for patients with CHD in the community;
3. Survival for 30 days after emergency admission for acute myocardial infarction;
4. Time to emergency coronary revascularisation in the Royal Infirmary of Edinburgh with comparison to data from other contributors to the National Cardiac Benchmarking Collaborative;
5. Overall CHD mortality rates in Lothian;
6. Premature CHD mortality rates among the whole population and the most deprived 15% of the population rates in Lothian.

The first two measures reflect evidence-based approaches to the secondary prevention of CHD in primary care. The measures related to hospital care are limited at this time; however Lothian now participates in several national (UK) audits and in future years it is anticipated that results from these can be presented in this report.

Effectiveness measures included in other parts of the Board’s effectiveness measures timetable are also of relevance to CHD; for example smoking cessation (included in cancer measures) and diabetes management (included later in 2011).

1 and 2: Achievement of blood pressure and cholesterol targets among patients with CHD in the community

Lothian’s position is similar to that of Scotland as a whole for control of high blood pressure and high cholesterol in patients with CHD (Figures 6a and 6b). For both factors, whilst the coverage for checks is high, there is still room for improvement in the successful treatment of patients.
Figure 6a - Percentage of patients in Lothian and in Scotland registered with general practices using new General Medical Services contracts who have had a BP check within the last 9 months and percentage whose BP is below the recommended limit for 2006/7-2009/10. Source: ISD Scotland [http://www.isdscotland.org/isd/3305.html](http://www.isdscotland.org/isd/3305.html)

Figure 6b - Percentage of patients in Lothian and in Scotland registered with general practices using new General Medical Services contracts who have had a cholesterol check within the last 15 months and percentage whose cholesterol is below the recommended limit for 2006/7-2009/10. Source: ISD Scotland [http://www.isdscotland.org/isd/3305.html](http://www.isdscotland.org/isd/3305.html)

3. Survival for 30 days after emergency admission for acute myocardial infarction

The percentage of patients surviving for 30 days after emergency admission with a main diagnosis of acute myocardial infarction in Lothian is similar to that in Scotland as a whole when the data are adjusted for age, sex and deprivation (Figure 6c).
4. Time to emergency coronary revascularisation

The times to coronary revascularisation following a myocardial infarction at the Royal Infirmary of Edinburgh are favourable compared with other centres currently participating in a national (UK) collaborative. Whilst this does not include all centres in the UK, it does include other large tertiary referral centres.

Table 4 - ‘Call to balloon’ and ‘door to balloon’ times in minutes for the Royal Infirmary of Edinburgh (RIE) and for all centres participating in the National Cardiac Benchmarking Collaborative (2008/9 and 2009/10).

<table>
<thead>
<tr>
<th></th>
<th>2008/9</th>
<th>2009/10</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>RIE</td>
<td>All centres</td>
</tr>
<tr>
<td>Call to balloon times (mins): Median for RIE and median and (range) for all centres</td>
<td>n/a</td>
<td>114 (52-180)</td>
</tr>
<tr>
<td>Door to balloon times (mins): Median for RIE and median and (range) for all centres</td>
<td>54</td>
<td>59 (30-111)</td>
</tr>
</tbody>
</table>

5. Overall CHD mortality rates

Figure 6d shows that CHD mortality has decreased in Lothian over the last eleven years, as is the case for the Scottish population overall.
6. Premature CHD mortality rates and rates by deprivation

Figure 6e shows that the trend of reducing mortality is also seen for premature (defined as under 75 years of age) CHD mortality for the whole population and that the target to reduce the mortality rate by 60% between 1995 and 2010 looks achievable. However for the most deprived parts of the population trends in premature mortality from CHD are less favourable in Lothian (Figure 6f).

Detailed analyses of the data to 2006 took place to investigate the differing pattern in Lothian from Scotland as a whole and investigation of the most recent years’ data is on-going. The small numbers of deaths in this population sub-group must be noted here; it is possible that a larger number of deaths among particularly young people in one year may have contributed to this finding or that there has been a chance increase in numbers. Aside from further work to understand the data, programmes of work such as Keep Well are addressing the high risk of CHD mortality in deprived populations.
Figure 6e - European Age Standardised Mortality Rates per 100,000 population for Lothian for those under 75 (1995-2010) with trend against target (60% reduction in mortality by 2010)

Figure 6f - European age and sex standardised mortality rates for Lothian and for Scotland for people under 75 in the 15% most deprived quintiles of the population (1996-2009)
4  Impact on Health Inequalities

4.1 This paper is a report on progress against the NHS Lothian Quality Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010), Scottish Patient Safety Programme (assessed in May 2009) and the Complaints Modernisation Strategy (May 2010). The Strategy will have a positive impact on equality in terms of both patients and staff.

5  Resource Implications

5.1 There are no resource implications associated with this report.

Dr David Farquharson / Jo Bennett / Dr Elizabeth Bream
Medical Director / Clinical Governance Manager / Public Health Consultant
15 March 2011
LOTHIAN NHS BOARD

Board Meeting
23 March 2011

Director of Public Health & Health Policy/Acting Director of Strategic Planning

LOTHIAN SEXUAL HEALTH AND HIV STRATEGY 2011-2016

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to endorse the Lothian Sexual Health and HIV Strategy for 2011-2016 (Appendix 1).

2 Recommendations

The Board is invited to:


2.2 Acknowledge the extensive consultation that was undertaken over three months and that the final strategy reflects the main themes to emerge from consultation.

3 Summary of the Issues

3.1 A draft sexual health and HIV strategy was approved for public consultation at the NHS Lothian Board in September 2010. The subsequent consultation ran for three months and consisted of an online survey and focus groups with key stakeholders, including sex workers, people living with HIV, young people and service providers, including statutory and third sector organisations. Groups and individuals were invited to complete an online questionnaire to record their views. There were over 130 responses to the public consultation. Appendix Two summarises the consultation process and main themes to emerge.

3.2 The strongest theme to emerge from written comments and focus groups was broad support for the direction of travel proposed in the draft strategy. There was strong support (87% of responses using the online survey) to directing resources towards helping people who are at greater risk of poor sexual health. There was some concern that this could reduce access to comprehensive sexual health services for the general population and to provision of general sex and relationship education available to young people. The Sexual Health and HIV Strategic Programme Board will ensure services are in place to meet the needs of the general population and also provide targeted services for people at higher risk of poor sexual health and HIV.
3.3 The following table summarises the views of the 119 groups, services and individuals who completed the online questionnaire:

<table>
<thead>
<tr>
<th>Percentage of online responses</th>
<th>View</th>
</tr>
</thead>
<tbody>
<tr>
<td>87.4%</td>
<td>Supported proposal to direct resources (staff and services) more towards helping people who are at greater risk of poor sexual health</td>
</tr>
<tr>
<td>95.8%</td>
<td>Supported the proposal to develop services in local areas for those at higher risk of poor sexual health</td>
</tr>
<tr>
<td>89%</td>
<td>Supported the proposal to target HIV testing and prevention at higher risk groups</td>
</tr>
<tr>
<td>100%</td>
<td>Agreed that it is important to improve people’s ability to talk about sex in relationships, to help reduce the likelihood of having an unplanned pregnancy or getting a sexually transmitted infection and to help people have more rewarding sexual relationships</td>
</tr>
<tr>
<td>93.2%</td>
<td>Supported access to free condoms and contraception in local communities</td>
</tr>
<tr>
<td>93.2%</td>
<td>Agreed with the approach of asking about the use of alcohol / substance misuse in sexual health consultations</td>
</tr>
<tr>
<td>72.6%</td>
<td>Agreed with the approach of ‘earlier access to medical abortion, following counselling’</td>
</tr>
</tbody>
</table>

3.4 The attached strategy has taken into account the themes that emerged from the public consultation. The implementation plan has been developed by members of the Sexual Health and HIV Strategic Programme Board.

3.5 The final strategy was approved by the Sexual Health and HIV Strategic Programme Board on Friday 4th March.

3.6 It is important that the Sexual Health and HIV Strategic Programme Board can measure and demonstrate progress towards achieving the four long-term impacts described in the strategy. To measure progress a dashboard of indicators is being developed by Strategic Planning using indicators that are based on routinely-collected data. This dashboard will be presented for approval at the Sexual Health and HIV Strategic Programme Board in June 2011. New data will become available as NaSH (National Sexual Health System) is fully utilised by the Lothian Sexual and Reproductive Health Service. Some of the indicators will require further work to develop a sustainable approach to capturing data.

3.7 NHS Lothian is working with Scottish Government to develop a range of nationally-collected indicators that will inform progress towards achieving the Lothian strategy and the Scottish Government 2011-2015 Sexual Health and Blood-Borne Virus Framework.
3.8 The following table summarises the indicators that will be used to monitor improvements to achieve the four long term impacts. Baseline data will be available for NHS Lothian from September 2011.

<table>
<thead>
<tr>
<th>Long-Term Impact</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| Reduce Harm from sexual ill health and HIV | - Waiting times for access to the Lothian Sexual and Reproductive Health Service  
- Waiting times for access to a sexual problems service  
- Percentage of young people reporting using condoms during last sexual encounter  
- Percentage of men who have sex with men tested for STIs in previous 12 months  
- Percentage of men who have sex with men tested for HIV in previous 12 months  
- % of men who have sex with men who have had contact with HIV prevention activity in previous 12 months.  
- The level of acute STIs diagnosed within Lothian  
- Number of people diagnosed with HIV by risk group  
- Level of successful STI contract-tracing  
- Services targeted to populations at higher risk of HIV or poor sexual health |
| People with HIV live long and healthy lives | - Percentage of young people receiving education to reduce stigma of HIV in S4 and S5  
- We will work to develop a metric which can be used by providers of HIV support services to measure wellbeing. A potentially applicable tool is already used by Waverley Care.  
- We will work with third sector providers to develop a metric to measure the stigma people living with HIV have experienced in the previous 12 months |
| Reduce unintended pregnancies            | - Number of women accessing very long methods of contraception (vLARC)  
- Percentage of women who have a termination within 9 completed weeks of gestation  
- Percentage of abortions that are non-surgical  
- Percentage of women who have an abortion who had a previous abortion  
- Number of abortions per 1000 live births  
- Number of abortions per 1000 women aged 15-44  
- Number of abortions per 1000 women aged 15-44 in SIMD Quintiles 1 (most deprived) |
| People make confident and competent decisions about sex | - Percentage of young people who receive sex and relationship education in schools  
- Number of young people accessing Healthy Respect and c:card.  
- We are working to identify how we might develop metrics including using the Lothian Health and Lifestyle survey |
4 Impact on Health Inequalities

4.1 A Rapid Impact Assessment was undertaken as part of the process to develop the strategy. One of the outcomes of the assessment was to target consultation visits towards groups who may be adversely affected by the strategy (e.g. gypsy travellers, disabled people, lesbian, gay and bisexual people, sex industry workers and people with low income). This informed the development of the action plan with specific actions to improve access for population groups (e.g. reducing barriers that gypsy travellers experience to access contraception).

5 Resource Implications

5.1 The mainstream HIV and sexual health services in NHS Lothian are augmented by Scottish Government funding for Blood Borne Virus Prevention (£2.5M per annum) and Sexual Health Strategy Funding (£606K). These budgets are used to fund a range of services including those provided by 3rd sector agencies like Gay Men’s Health, Waverley Care and LGBT Youth Scotland (a community-based lesbian, gay, bisexual and transgender organisation). They also fund a range of NHS services including Healthy Respect, c:card and some services provided by the Lothian Sexual and Reproductive Health Service and the Harm Reduction Team.

The following actions will be undertaken by the Sexual Health and HIV Strategy Board to ensure that funding is prioritised and used effectively to have the strongest chance to achieve this strategy’s high level impacts:

Align funding to achieve outcomes: All Sexual Health and HIV resources in Lothian will be assessed and, where required, be realigned to deliver on the strategy outcomes. This will be led by service and agency managers working with the strategy board to refocus resources (an example of work already underway is the review of NHS sexual health peripheral clinics).

Prioritise services that make the biggest impact: All allocations from the Blood Bourne Virus Prevention Fund and Sexual Health Strategy monies from Scottish Government will be reviewed to identify whether the outcomes achieved from the allocations represent best-value or whether an alternative, more cost-effective model can be developed to achieve the same outcomes.

Work closely with other organisations to make strategic decisions: Strong partnership working will remain a core principle of the strategic programme. The prevailing multi-agency working ethos will be maintained and the strategy board will seek to strengthen partnership working. This will be particularly important if the financial envelope reduces and the strategic programme needs to reduce spend.

Ensure value for money: Revised Performance Management Arrangements have been put in place to ensure that all spend on statutory and 3rd sector services is achieving the required outcomes.
List of Appendices

Appendix 1: 2011-2016 Sexual Health and HIV Strategy
Appendix 2: Consultation Methodology:
1 INTRODUCTION

This strategy describes the vision to improve sexual health across Lothian and reduce the ill-health caused by HIV. The strategy and implementation plan have been developed through consultation with a wide range of people representing different population groups.

The four high-level impacts this strategy will achieve over the next five years are:

1. There is reduced harm from sexual ill health and HIV
2. People with HIV live long and healthy lives
3. There are fewer unintended pregnancies
4. People make confident and competent decisions about sex

2 HOW THIS STRATEGY HAS BEEN DEVELOPED

Lothian has a robust multiagency Sexual Health and HIV Strategic Programme Board (appendix 1) which has strategic representation from Health, Local Authority and third sector agencies. The Strategic Programme Board is responsible for the development and implementation of the Lothian 2011-2016 Sexual Health and HIV Strategy.

The strategy will continue with the direction established by the 2005-2010 Lothian Sexual Health Strategy and Respect and Responsibility, the Scottish Government sexual health strategy, but has taken into account the evolving Scottish policy context and added prevention and treatment of HIV. This strategy is aligned with the direction established within the Scottish Government HIV Action Plan and the forthcoming Sexual Health and Blood-Borne Virus Framework. The aims of the Lothian Sexual Health and HIV Strategy link with aims of the Scottish Government Quality Strategy by:

• Firstly, to ensure that at all times those most at risk of poor sexual health outcomes and/or BBV are at the heart of our service planning.
• Secondly, to provide the users of these services with effective treatments, interventions and support when they need them, whilst at all times working in partnership with stakeholders to ensure that services provided are evidence based and appropriate.
• Thirdly, to enable people to maintain high levels of health, good relationships and wellbeing; to live well through self management, improved health literacy and by supporting anticipatory and preventative responses through an asset based approach to sexual health and BBV.
Sexual Health and HIV cuts across a number of other national and local strategies. This strategy has taken cognisance of a number of these and in particular has a relevance to the following documents:

- Alcohol and Drug Partnership Strategies
- National HIV Action Plan, 2010
- Scottish Government Sexual Health and Blood-Borne Virus Framework, 2011
- National Teenage Pregnancy Guidance, 2009
- Scottish Government, Looked After Children and Young People: We Can and Must Do Better, 2007

The Lothian strategy will cover specialist and general sexual health services, sexual health and HIV prevention and treatment, quality measures and health promotion. Partnership working at all levels is necessary to achieve outcomes and maximise the use of resources.

A broad outline of the draft strategy was developed by members of the Sexual Health and HIV Strategy Board through a process of engagement with over 100 stakeholders. The initial draft aims of the strategy were considered at a large stakeholder event on April 27th 2010. This event was attended by people representing service users, third sector and statutory agencies. The output from this event contributed to formulating the outcomes the strategy aims to achieve.

A logic-model approach (see diagram below) was adopted by the strategy board to identify the outcomes needed to achieve improvements within the Lothian population. This approach enabled the board to identify how outcomes achieved in the short and medium-term will lead to achieving the long term improvements in sexual health and HIV.

A three-month public consultation on the draft strategy was launched in November 2010 with the support of the NHS Lothian Board. There were over 130 responses from
individuals, groups, services and organisations. A summary of the outcome of the consultation, including the submitted comments and the Strategic Programme Board’s response, is available separately.

The strongest theme to emerge from written comments and focus groups was broad support for the direction of travel proposed in the draft strategy. There was strong support (87% of responses using the online survey) to directing resources towards helping people who are at greater risk of poor sexual health although there was concern that this might reduce access to comprehensive sexual health services for the general population and to provision of general sex and relationship education available to young people. The Strategic Programme Board will ensure that services are in place to continue to meet the needs of the general population as well as provide targeted services for people at higher risk of poor sexual health and HIV.

3 DESCRIBING THE CHALLENGE:

Not everyone in Lothian is at risk of poor sexual health, HIV and unintended pregnancy. There are people who are more at risk and we need to direct our resources (people and services) towards helping those individuals in these higher risk groups.

Who is at higher risk of HIV and poor sexual health?

The evidence shows that the population groups at higher risk of HIV are Men who have sex with men (MSM), people from areas of higher prevalence, particularly sub-Saharan countries, and to a much lesser extent people who share needles to inject drugs.

People who are at a higher risk of sexually transmitted infections are young people and men who have sex with men. There are also specific areas of Lothian where there is higher prevalence of Sexually Transmitted Infections in the population. To reduce the presence of Sexually Transmitted Infections and HIV in these communities we need to increase regular condom use and continue to raise awareness of how to reduce risk and prevent transmission of these infections.

We also need to reduce onward transmission of sexually transmitted infections and HIV by reducing the level of undiagnosed and untreated sexually transmitted infections and HIV. We can achieve this through increasing access to testing, re-testing of those previously positive and reducing unprotected sex in these groups.
Who is at higher risk of an unintended pregnancy?

One proxy for unintended pregnancy is information on abortions from ISD Scotland and we can use this to understand which women are more at risk of an unintended pregnancy:

- Women who have had a previous abortion (30.3% of abortions in Lothian 2009 were for women who have had a previous abortion)
- Some women living in areas of deprivation (19.2 abortions per 1000 live births in the most deprived areas compared to 9.1 in the least deprived)
- Young women where there is a high level of repeat pregnancies during adolescence

To reduce unintended pregnancies women need to be better supported to make informed, positive decisions about when to become pregnant. We want to focus resources to increase the uptake of LARC (Long Acting Reversible Contraception) and increase the general use of contraception in higher risk groups. We also need to improve communication between men and women about sex so that they are more confident to talk about and negotiate safer sex and the use of contraceptives. In the medium term we need to see an increase in the use of effective contraception and a reduction in the number of abortions, repeat abortions (accounting for 30% of Lothian abortions), and a reduction in repeat pregnancies during adolescence.

Supporting People living with HIV

Long-term survival with HIV has greatly increased with the development of new treatments. People living with HIV can now expect to live long and healthy lives, hindered as little as possible by their HIV status. To achieve this, all Lothian residents with HIV require access to high quality, effective treatment and care as soon after infection as possible because early diagnosis and access to treatment improves the long-term clinical outcomes.

HIV affects many people who already experience stigma and discrimination (e.g. gay and bisexual men, immigrants and drug users). It remains a condition that carries a stigma. To ensure the impact of HIV is minimised on individual’s lives, this stigma will need to be further addressed so that services are offered and taken up promptly and quality of life is not diminished.
Improving communication about sex and pregnancy

People find themselves in all sorts of situations that, with the gift of hindsight, they might regret or wish they were not in. Often it can be decisions that were barely consciously made, with judgement clouded by alcohol, drugs or emotions or a combination of all three. The evidence shows that if we improve communication between people about sex, this in turn will lead to a reduction in the stigma associated with sex and will reduce levels of regret and coercion because people will make more informed choices.

4 THE VISION

The vision for sexual health and HIV across Lothian is to achieve the following high level impacts:

1. There is reduced harm from sexual ill health and HIV

2. People with HIV live long and healthy lives

3. There are fewer unintended pregnancies

4. People make confident and competent decisions about sex

To make these impacts it is important that partnership working is maximised to use all sexual health and HIV resources across Lothian are used effectively. We need to focus services, interventions, people and finance on achieving specific evidence-based outcomes. We define outcomes as ‘specific changes in attitudes, behaviours, knowledge, skills, status, or level of functioning’.

The outcomes identified to make these high level impacts are described in the next section and form the core of this strategy.
## IMPACTS AND OUTCOMES

### LONG TERM IMPACT 1: There is reduced harm from sexual ill health and HIV

The strategic outcomes required to make this impact:

<table>
<thead>
<tr>
<th>Short-term outcomes (achieved in two years)</th>
<th>Medium-term outcomes (achieved in three years)</th>
<th>Long-term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increased awareness of risk of STIs and HIV within groups at higher risk of infection</td>
<td>Increased awareness of STIs and HIV and how to reduce risk and prevent transmission</td>
<td>Decrease prevalence of STIs and HIV in communities with highest prevalence</td>
</tr>
<tr>
<td>Increased awareness of the importance of using condoms to prevent onward HIV and STI transmission</td>
<td>Increased uptake in condom use</td>
<td>Reduce onward transmission of STIs and HIV</td>
</tr>
<tr>
<td>Increased access to STI and HIV testing in higher risk groups</td>
<td>Reduce level of undiagnosed and untreated STIs and HIV</td>
<td>Improve sexual wellbeing for people with sexual problems</td>
</tr>
<tr>
<td>Increased awareness of health professionals about who and how to test for HIV</td>
<td>Early treatment provided to those with sexual problems</td>
<td>Reduce the need for surgical terminations</td>
</tr>
<tr>
<td>Increased level of retesting (STIs and HIV) for people in high risk groups who have previously tested negative.</td>
<td>Increased uptake in early medical abortion for those women who choose this option</td>
<td></td>
</tr>
<tr>
<td>Reduction in unprotected sex where there is frequent partner change in population groups with a high prevalence of STIs and HIV</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased access to sexual problems service</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Better information, awareness and access to non-surgical abortion services for those women who choose this option</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LONG TERM IMPACT 2: People with HIV live long and healthy lives

The strategic outcomes required to make this impact:

<table>
<thead>
<tr>
<th>Short-term outcomes (achieved in two years)</th>
<th>Medium-term outcomes (achieved in three years)</th>
<th>Long-term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase early access to testing (which leads to earlier access to high quality, effective treatment and care for people with HIV)</td>
<td>People experience less discrimination when accessing services</td>
<td>People with HIV enjoy lives that are not minimised by ill health due to HIV</td>
</tr>
<tr>
<td>Increased awareness by service providers on how to avoid discriminating against people living with HIV and their partners</td>
<td>People living with HIV enjoy improved emotional and mental wellbeing</td>
<td></td>
</tr>
<tr>
<td>People living with HIV have an increased knowledge base on living well with HIV</td>
<td>People living with HIV have greater confidence in managing the different aspects of their condition</td>
<td></td>
</tr>
<tr>
<td>People living with HIV feel well integrated into society and experience less social isolation</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LONG TERM IMPACT 3: **There are fewer unintended pregnancies**

The strategic outcomes required to make this impact:

<table>
<thead>
<tr>
<th>Short-term outcomes (achieved in two years)</th>
<th>Medium-term outcomes (achieved in three years)</th>
<th>Long-term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Increase in uptake of LARC in population</td>
<td>less abortions</td>
<td>Reduction in unintended pregnancies</td>
</tr>
<tr>
<td>Increase in uptake of LARC post-pregnancy</td>
<td>less unintended pregnancies</td>
<td></td>
</tr>
<tr>
<td>Increased uptake of LARC following abortion</td>
<td>less repeat abortions</td>
<td></td>
</tr>
<tr>
<td>Increase general uptake of contraception in higher risk groups</td>
<td>Reduced prevalence of repeat pregnancies during adolescence</td>
<td></td>
</tr>
<tr>
<td>Improved knowledge for young people both at school and in non-school settings.</td>
<td>Young people are more confident to talk about and negotiate sex and contraceptive use</td>
<td></td>
</tr>
<tr>
<td>Improved communication between young people about sex and sexual choices</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
LONG TERM IMPACT 4: People make confident and competent decisions about sex

The strategic outcomes required to make this impact:

<table>
<thead>
<tr>
<th>Short-term outcomes (achieved in two years)</th>
<th>Medium-term outcomes (achieved in three years)</th>
<th>Long-term outcomes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved communication between people about sex and sexual choices</td>
<td>People are more confident to talk about sex</td>
<td>Reduction in stigma about sexual ill-health</td>
</tr>
<tr>
<td>Improved awareness of the link between alcohol and drug use and level of regret associated with sexual activity</td>
<td></td>
<td>Reduced level of regret or coercion</td>
</tr>
</tbody>
</table>
5. IMPLEMENTING THE STRATEGY

The current range of sexual health and HIV services across Lothian provide a firm base from which to implement the new strategy. This section summarises the current range of services and interventions already in place across Lothian within the Five Tiers of Sexual Health Services:

Five Tiers of Sexual Health and HIV services

Summary of the service provider and interventions in service tiers.

- **Tier 5**
  - Lothian Sexual and reproductive Health Service and peripheral clinics
  - Regional Infectious Diseases Unit (RIDU)
  - HIV Paediatric service
  - Abortion service

- **Tier 4**
  - Enhanced primary care
  - Harm Reduction Team – clinics for sex workers

- **Tier 3**
  - ROAM outreach
  - Chill Out Zone (West Lothian)
  - MYPAS (mid Lothian)
  - Primary Care
  - BBV specialist social work services
  - Caledonia Youth

- **Tier 2**
  - c:card and c:card plus
  - Healthy Respect
  - LGBT Youth
  - Waverley Care
  - Sex and Relationship education and support in schools and community settings
  - Pharmacies (emergency contraception, chlamydia testing)

- **Tier 1**
  - Gay Men’s Health
  - LGBT Centre

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Tier 5 Services: Consultant Led Specialist Service

The consultant-led Sexual Health Service is provided by the Lothian Sexual and Reproductive Health Service (formed from the merger of Family Planning and Genito-Urinary Medicine). This service will operate from the Chalmers Sexual Health Centre from May 2011 with a network of clinics operating across Lothian. This service is available to the whole Lothian population through a combination of drop-in clinics and booked appointments. Specific clinics are targeted towards priority populations including young people and MSM.

The consultant-led HIV treatment service is delivered by the Regional Infectious Diseases Unit (RIDU) at the Western General Hospital and the Lothian Sexual and Reproductive Health Service. There is also a HIV treatment clinic provided in Livingston. A HIV paediatric service is provided within the Royal Hospital for Sick Children.

The Abortion service is provided at the Royal Infirmary of Edinburgh and St Johns Hospital in West Lothian. It provides a full range of pre-abortion counselling, medical and surgical procedures and post-abortion counselling and contraception.

Tier 4 Enhanced Baseline Sexual Health and HIV Services

Tier 4 services provide a targeted approach for sexual health and HIV and are delivered by the Lothian Sexual and Reproductive Health Service, RIDU, Substance Misuse Directorate, Caledonia Youth (a specialist third sector organisation) and by some General Practices that provide an enhanced service (includes IUDs and implants).

Services provided in tier 4 include STI testing and treatment including treatment for HIV, STI partner-notification, management of complex contraception problems, provision of IUDs, hormonal implants, sexual assault service, assessment and management of psychosexual issues.

The Substance Misuse Directorate provides a service in saunas which provides sexual health advice and testing for Blood-Borne Viruses and a sexual health clinic for drug users. There is also an outreach clinic for sex-workers.

Tier 3 Baseline Sexual Health and HIV Services

Tier 3 services are provided by General Practice and by specialist statutory and third sector agencies. Service provision includes STI testing including HIV, treatment for some STIs, provision of contraception (except IUDs and implants), sexual history, primary care gynaecological / obstetric management, and risk taking assessment and referral to tier 4 and tier 5 services. The importance of general practice should not be underestimated because most contacts between services and people about sexual health happen within primary care.

Vaccination for human papilloma virus (HPV) is undertaken by tier 3 services

The specialist third sector agencies providing tier 3 services are Caledonia Youth, which offers a drop-in provision in central Edinburgh for 13-25 year-olds, Chill Out Zone, which provides a drop-in service in West Lothian for 12-20 year-olds, and MYPAS, based in Dalkeith offering a similar service for 12-25 year olds.
The NHS Lothian ROAM service provides an outreach service for MSM that is available online, in cruising areas and in saunas.

**Tier 2: Individualised Information with limited intervention**

Services in tier 2 are delivered by third sector and statutory services (including pharmacies) and provide education and access to emergency contraception, free condoms, and pregnancy testing. Most services in tier 3 also provide tier 2 services. An important activity in tier 2 is to raise awareness about risk taking and to describe how to reduce harm. A wide range of providers deliver a tier 2 service. Specific providers include the following but there are a wider range of providers delivering tier 2 services across Lothian:

**Healthy Respect:** provides a network of 25 drop-in services for young people aged 13-18 in partnership with other statutory and third sector organisations (including school nurses) which provide advice, support and information on all health issues including sexual health and relationships.

**c:card:** a free condom service provided across Lothian from 70 sites with 34,000 annual visits.

**Gay Men’s Health:** a third sector organisation that works with gay and bisexual men to improve health and wellbeing of all men who have sex with men. This includes men living with or affected by HIV. They also provide an outreach service into bars.

**LGBT Youth:** Provide a drop in service for young people ages 13 -25 offering advice, support, information and signposting to specialist services. They provide an outreach service and education for young people.

**Waverley Care:** Provides support for people living with HIV.

Relationships, Sexual Health and Parenthood Education is delivered to all young people across Lothian in line with Curriculum for Excellence. Getting it right for every child (GIRFEC) also provides a clear framework against which the needs of all children are assessed and services delivered.

A shared partnership approach between local authorities, NHS Lothian and third sector seeks to establish and maintain a multi-faceted approach that links Information, Education and Services. All local authorities engage in partnership working to enhance relationships education.

All educational providers are required to develop approaches which meet the needs of the young people they are working with. These approaches are designed to reflect the cultural, social and faith based needs of young people.

Tailored responses are required to address the additional needs of more vulnerable young people and those who are harder to reach, including those who are (but not limited to):

- Experiencing deprivation
- Looked after and accommodated
- Gypsies and travellers
- Physically and/or learning disabled
- Experiencing social, emotional, and behaviour difficulties and/or mental ill-health
- Lesbian, gay or bisexual
- Transgender
- Young Offenders
- From some minority ethnic backgrounds
TIER 1 Self-Help/Self-Management

Non-specialised, non clinical information provided by generic third sector and statutory staff. Training is provided by a range of providers to youth workers.

Non-specialised, non-clinical information is available through a range of sources including:
- Health Promotion materials
- Websites
- Other health, social care and schools and community based staff working with priority groups (e.g. social workers teachers, youth workers)
6. **Action Plan**

This section describes the action plan the Strategic Programme Board will follow over the next five years to deliver the strategy outcomes. This action plan assumes that the current comprehensive range of sexual health and HIV services and interventions summarised in the previous section continue to be available within Lothian. Where a review of existing service provision is required this has been identified as a specific action the Strategic Programme Board will take forward.

The actions listed all contribute to achieving the four long-term impacts described in the strategy. Further actions are likely to be identified as work develops to implement the action plan. The Sexual Health and HIV Strategic Programme Board will be responsibility for taking forward the actions and will review progress annually. A paper will be presented to the NHS Board annually to describe progress. Responsibility for specific actions will be delegated to members of the Strategic Programme or to the relevant sub-group. Overall responsibility for the delivery of the actions is with the Chair of the Sexual Health and HIV Strategic Programme Board.

<table>
<thead>
<tr>
<th>ID</th>
<th>Summary of Action</th>
<th>Delivery Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>We will ensure that the Lothian Sexual and Reproductive Health Service is supported by an effective and efficient NaSH system (sexual health patient management system)</td>
<td>April 11</td>
</tr>
<tr>
<td>2</td>
<td>Allocations from the Sexual Health Strategy and BBV Prevention budgets from Scottish Government will be aligned to achieving the strategy outcomes.</td>
<td>March 11</td>
</tr>
<tr>
<td>3</td>
<td>We will review specialist young people’s sexual health services (in tiers 4 and 5) in Lothian and develop a model for service provision which is targeted at highest need and is accessible to young people across Lothian.</td>
<td>December 11</td>
</tr>
<tr>
<td>4</td>
<td>We will stop promoting chlamydia testing amongst the over 20s.</td>
<td>April 12</td>
</tr>
<tr>
<td>5</td>
<td>We will extend access and promote LARC for women who have a termination of pregnancy.</td>
<td>April 12</td>
</tr>
<tr>
<td>6</td>
<td>We will support primary care in promoting and providing LARC and continue to advocate local and national incentives for LARC.</td>
<td>April 12</td>
</tr>
<tr>
<td>7</td>
<td>We will increase awareness of service providers on how to avoid discriminating against people living with HIV and their partners</td>
<td>April 12</td>
</tr>
<tr>
<td>8</td>
<td>We will develop fully integrated tier 4 sexual health services in Howden, Sighthill, Wester Hailes, Whitburn, Bathgate, Craigmillar, Craigroyston, Tranent, Dalkeith and Leith.</td>
<td>April 12</td>
</tr>
<tr>
<td>No.</td>
<td>Objective</td>
<td>Date</td>
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<td>---------------------------------------------------------------------------</td>
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<tr>
<td>9</td>
<td>We will ensure the delivery of a range of services to those involved in the indoor and outdoor sex industry.</td>
<td>April 12</td>
</tr>
<tr>
<td>10</td>
<td>We will merge the current sexual problems services to form an integrated service in the new Chalmers Sexual Health Centre to achieve a sustainable model for an accessible sexual problems service.</td>
<td>April 12</td>
</tr>
<tr>
<td>11</td>
<td>The Lothian Sexual Health and Reproductive Health Service will work with services that work with gypsy travellers to improve access to sexual health services.</td>
<td>April 12</td>
</tr>
<tr>
<td>12</td>
<td>We will improve the HIV partner contract tracing service to reduce the number of people with undiagnosed HIV.</td>
<td>April 12</td>
</tr>
<tr>
<td>13</td>
<td>We will review and update the local clinical guidelines for HIV prescribing to ensure that best-value is a factor of clinical decision making.</td>
<td>April 12</td>
</tr>
<tr>
<td>14</td>
<td>We will take STI testing out to MSM and people from sub Saharan Africa by expanding our near-patient testing programmes.</td>
<td>April 12</td>
</tr>
<tr>
<td>15</td>
<td>We will improve the HIV prevention education given to people receiving HIV treatment.</td>
<td>April 12</td>
</tr>
<tr>
<td>16</td>
<td>NHS Lothian will work with the City of Edinburgh Council and third sector agencies to coordinate resources within two areas in Edinburgh with poor sexual health to pilot an enhanced community development model to improve local sexual health outcomes.</td>
<td>December 12</td>
</tr>
<tr>
<td>17</td>
<td>We will review the sexual health service needs for communities peripheral to Edinburgh to ensure an appropriate level of service provision is available in East, Mid and West Lothian.</td>
<td>December 12</td>
</tr>
<tr>
<td>18</td>
<td>We will ensure that women who want a termination of pregnancy experience minimal delays and receive a high quality service and that women are offered and receive a range of contraceptives post termination in line with the QIS standard</td>
<td>December 12</td>
</tr>
<tr>
<td>19</td>
<td>We will take specific actions to reduce the number of women having multiple terminations of pregnancy.</td>
<td>December 12</td>
</tr>
<tr>
<td>20</td>
<td>We will work in partnership with Local Authorities, third sector and health to Implement the Scottish National Teenage Pregnancy Guidance (2009).</td>
<td>December 12</td>
</tr>
<tr>
<td>21</td>
<td>We will focus chlamydia testing through Primary Care, c:card, Healthy Respect and schools to target populations with high chlamydia rates and towards people under 20 years of age</td>
<td>December 12</td>
</tr>
<tr>
<td>No.</td>
<td>Action Plan</td>
<td></td>
</tr>
<tr>
<td>-----</td>
<td>-------------</td>
<td></td>
</tr>
<tr>
<td>22</td>
<td>We will strengthen partnership working between specialist third sector agencies and NHS services to increase access for people at high risk of poor sexual health or HIV.</td>
<td>April 13</td>
</tr>
<tr>
<td>23</td>
<td>We will work with Local Authorities and schools to enhance Sex and Relationship Education for S4 pupils to raise awareness and reduce stigma about HIV.</td>
<td>April 13</td>
</tr>
<tr>
<td>24</td>
<td>We will identify and move clinical activity that can take place within a lower tier to reduce demand on the consultant-led tier five service.</td>
<td>April 13</td>
</tr>
<tr>
<td>25</td>
<td>We will develop a training approach to ensure that appropriate clinical and non-clinical professionals and workers are trained to use Motivational Interviewing techniques and brief interventions to reduce risk-taking behaviour.</td>
<td>April 13</td>
</tr>
<tr>
<td>26</td>
<td>We will work with GPs, primary care and leaders from sub-Saharan African community groups to reduce the barriers African men and women experience when accessing sexual health/HIV services.</td>
<td>April 13</td>
</tr>
<tr>
<td>27</td>
<td>We will work with the relevant clinical services to develop care pathways to support the rising number of people with HIV who have malignancy, renal, liver or cardiac disease.</td>
<td>April 13</td>
</tr>
<tr>
<td>28</td>
<td>We will explore the educational and training needs of the HIV related workforce, priorities will be identified and educational solutions developed and implemented. (HIV ACTION PLAN NUMBER 11).</td>
<td>April 13</td>
</tr>
<tr>
<td>29</td>
<td>We will improve access to HIV treatment and care for prisoners in Addiewell and Edinburgh prisons.</td>
<td>April 13</td>
</tr>
<tr>
<td>30</td>
<td>We will ensure that HIV treatment services are provided in an equitable and integrated approach across Lothian.</td>
<td>April 13</td>
</tr>
<tr>
<td>31</td>
<td>Ensure HIV services meet QIS standards for prevention, testing, treatment and support.</td>
<td>April 13</td>
</tr>
<tr>
<td>32</td>
<td>The MSM group will develop effective interventions and services which will reduce the number of MSM who have not been tested for STIs. Currently, 40% of men questioned in the MSC bar survey have never attended a GUM clinic.</td>
<td>April 13</td>
</tr>
<tr>
<td>33</td>
<td>The MSM group will develop consistent information and community development approaches with an emphasis on joint-working.</td>
<td>April 13</td>
</tr>
</tbody>
</table>
and consistent messaging by organisations to ensure that men who have sex with men are receiving clear messages to make informed decisions about risk-taking and know how to access an appropriate service.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>34</td>
<td>We will use a common community development approach across the range of providers working with MSM to reduce complacency about HIV of men who have sex with men.</td>
</tr>
<tr>
<td>35</td>
<td>We will work strategically with Local Authorities and Alcohol and Drug Partnerships &amp; third sector organisations to identify and implement community development approaches to tackle risk-taking behaviour (smoking, sex, substance misuse).</td>
</tr>
<tr>
<td>36</td>
<td>We will develop health and social care services to meet the changing needs of people living with HIV</td>
</tr>
</tbody>
</table>
7. PERFORMANCE AND OUTCOME METRICS

It is crucial that the Sexual Health and HIV Strategic Programme Board is able to measure and demonstrate progress towards achieving this strategy’s four long term impacts. A dashboard of strategy indicators has been developed. These indicators are based on routinely collected data. New data will become available as NaSH (National Sexual Health System) is fully utilised by the Lothian Sexual and Reproductive Health Service. Some of the indicators will require further work to develop a sustainable approach to capturing data.

Performance will also be monitored against implementation of the action plan and achievement of the Quality Improvement Standards for HIV and for Sexual Health. NHS Lothian will be visited by QIS in May 2011 to review performance against the Sexual Health Standards. A date has not been set for the visit to review attainment in Lothian of QIS HIV standards.

NHS Lothian is working with Scottish Government to develop a range of nationally-collected indicators that will inform progress towards achieving the Lothian strategy and the Scottish Government 2011-2015 Sexual Health and Blood-Borne Virus Framework.

The following table summarises the indicators that will be used to monitor improvements to achieve the four long term impacts.

<table>
<thead>
<tr>
<th>Long-Term Impact</th>
<th>Indicators</th>
</tr>
</thead>
</table>
| Reduce Harm from sexual ill health and HIV | - Waiting times for access to the Lothian Sexual and Reproductive Health Service  
- Waiting times for access to a sexual problems service  
- Percentage of young people reporting using condoms during last sexual encounter  
- Percentage of men who have sex with men tested for STIs in previous 12 months  
- Percentage of men who have sex with men tested for HIV in previous 12 months  
- % of men who have sex with men who have had contact with HIV prevention activity in previous 12 months.  
- The level of acute STIs diagnosed within Lothian  
- Number of people diagnosed with HIV by risk group  
- Level of successful STI contract-tracing  
- Services targeted to populations at higher risk of HIV or poor sexual health |
| People with HIV live long and healthy lives | - Percentage of young people receiving education to reduce stigma of HIV in S4 and S5  
- We will work to develop a metric which can be used by providers of HIV support services to measure wellbeing. A potentially applicable tool is already used by Waverley Care.  
- We will work with third sector providers to develop a metric to measure the stigma people living with HIV have experienced in the previous 12 months |
| Reduce unintended pregnancies | - Number of women accessing very long methods of contraception (vLARC)  
- Percentage of women who have a termination within 9 completed weeks of gestation  
- Percentage of abortions that are non-surgical  
- Percentage of women who have an abortion who had a previous abortion  
- Number of abortions per 1000 live births  
- Number of abortions per 1000 women aged 15-44  
- Number of abortions per 1000 women aged 15-44 in SIMD Quintiles 1 (most deprived) |
| People make confident and competent decisions about sex | - Percentage of young people who receive sex and relationship education in schools  
- Number of young people accessing Healthy Respect and c:card.  
- We are working to identify how we might develop metrics including using the Lothian Health and Lifestyle survey |
8. **FINANCIAL SPEND AND GOVERNANCE**

NHS Lothian contributes over £13 million per annum for HIV and sexual health services and prescribing through a combination of core and Scottish Government ring-fenced funding. This includes the core funding for GUM and Family Planning and for services including c:card, MYPAS and Caledonia Youth. In addition NHS Lothian has committed to developing the Chalmers Hospital building to locate the new Lothian Sexual and Reproductive Health Service.

Further funding from Local Authorities and charitable grants to third sector organisations have a significant impact on the outcomes required to achieve this strategy and it will be important for organisations with funding in this programme to work in partnership to ensure effective use of resources.

There are significant incentives to invest in effective prevention of HIV and sexual ill health. There are approximately 1100 people in Lothian currently receiving treatment for HIV and it is predicted this will increase by 10% per annum. The approximate cost of the drug treatment alone is between £7,000 and £10,000 every year per patient. The number of new HIV diagnoses in Lothian in 2007 and 2008 averaged 119 patients. This equates to an additional pharmacy cost to NHS Lothian of between £833,000 and £1.1 million for drug treatment. Approximately 50% of new HIV transmissions are thought to have occurred inside the UK.

The Teenage Pregnancy Independent Advisory Group (TPIAG) (2010) estimated that every £1 invested in contraception saves the NHS £11 plus additional welfare costs. This group also identified that, UK-wide, teenage pregnancy costs £63 million to the NHS alone. This does not take into account non-NHS costs in terms of housing needs, use of social support services.

The current economic position in the public sector means there is significant uncertainty in funding over the lifetime of this strategy. The mainstream HIV and sexual health services in NHS Lothian are augmented by Scottish Government funding for Blood Borne Virus Prevention (£2.5M per annum) and Sexual Health Strategy Funding (£606K). These budgets are used to fund a range of services including those provided by third sector agencies like Gay Men’s Health, Waverley Care and LGBT Youth Scotland. They also fund a range of NHS services like Healthy Respect, c:card and some services provided by the Lothian Sexual and Reproductive Health Service and the Harm Reduction Team. It has not been confirmed if either funding streams will continue beyond March 2011, although it is anticipated they will continue in some form.

The Sexual Health and HIV Strategy Board is committed to improving the quality of services and reducing the negative health impacts of HIV and sexual ill health by achieving the outcomes specified in the draft strategy. This will need to be progressed within an uncertain financial envelope.

The process to deliver the strategy will take cognisance of the financial climate and use resources effectively to improve Lothian’s ability to achieve the strategy’s outcomes. The following actions will be undertaken by the Sexual Health and HIV Strategy Board to ensure that funding is prioritised and used effectively to have the strongest chance to achieve this strategy’s high level impacts.
Align funding to achieve outcomes: All Sexual Health and HIV resources in Lothian will be assessed and, where required, be realigned to deliver on the strategy outcomes. This will be led by service and agency managers working with the Chair of the Strategic Programme Board to refocus resource (an example of work already underway is the review of NHS sexual health peripheral clinics).

Prioritise services that make the biggest impact: All allocations from the BBV Prevention Fund and Sexual Health Strategy monies from Scottish Government will be reviewed to identify whether the outcomes achieved from the allocations represent best-value or whether an alternative more cost-effective model can be developed to achieve the same outcomes.

Work closely with other organisations to make strategic decisions: Strong partnership working will remain a core principle of the strategic programme. The prevailing ethos of multi-agency working will be maintained and the strategy board will seek to strengthen partnership working. This will be particularly important if the financial envelope reduces and the strategic programme needs to reduce spend.

Ensure value for money: Revised Performance Management Arrangements have been put in place to ensure that all spend on statutory and 3rd sector services is achieving the required outcomes.
### Appendix 1: Membership of the Sexual Health and HIV Strategic Programme Board

The Sexual Health and HIV Strategic Programme Board has strategic representation from NHS, Council and third sector providers. The following table summarises the remit and membership of the Board.

<table>
<thead>
<tr>
<th>Group</th>
<th>Sexual Health and HIV Strategic Programme Board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Description:</strong></td>
<td>The Strategic Programme Board (SPB) is the strategic decision-making body for the sexual health and HIV programmes. Membership includes chairs of sub groups, strategic representation from Lothian services, Councils, and Lothian-wide third sector agencies.</td>
</tr>
</tbody>
</table>
| **Responsibility** | - Developing the long term strategy for Sexual Health and HIV in Lothian  
- Implementing the actions required to achieve the strategy outcomes  
- Ensuring the implementation of Scottish Government strategy and policy relating to sexual health and HIV  
- Ensuring the implementation of QIS standards  
- Developing strategic response to new challenges or developments within the sexual health and HIV programmes. |
| **Chair** | NHS Lothian Strategic Programme Manager for Sexual Health and HIV (Jamie Megaw) |
| **Service/Organisation** | **Named representative** |
| NHS Services/Departments |  |
| Lothian Sexual and Reproductive Health Service (LSRHS) | Gordon Scott, Clinical Lead for Sexual Health |
| Lothian Sexual and Reproductive Health Service (LSRHS) | Alison Craig, Nurse Consultant |
| RIDU | David Wilks, Consultant |
| Health Promotion | Mandy McKinnon, Manager of Health Promotion |
| Public Health | Dona Milne, Public Health Lead for Sexual Health |
| Primary Care | Ewen Stewart, General Practitioner |
| Strategic Planning | Christine Wallace, Strategic Lead for Young People and Sexual Health |
| Partnership Representation | Jenny McKinnon, Partnership Rep |
| Edinburgh CHP (hosts LSRHS) | Sheena Muir, Assistant General Manager |
| Harm Reduction Service | Jim Shanley, Manager of Harm Reduction Service |
| **Membership** |  |
| third sector partner organisations |  |
| Gay Men’s Health | Bruce Fraser, Chief Executive |
| Waverley Care | David Johnson, Director of Waverley Care and Chair of Edinburgh LSHG |
| Caledonia Youth | Hawys Kilday, Chief Executive |
| LGBT Youth | Hugh Torrance, Director of Programmes |
| Local Authorities and Local Sexual Health Groups |  |
| Chair of Edinburgh Local Sexual Health Group (LSHG) | David Johnson, Director of Waverley Care and Chair of Edinburgh LSHG |
| West Lothian Council | Angela Jenkins, Public Health Nurse and Chair of West Lothian LSHG |
| Chair of West Lothian LSHG |  |
| City of Edinburgh Council | Lynne Porteous, Early Intervention Strategic Manager  
Paul Hambleton, Corporate Social Strategy Manager |
| East Lothian Council | No representative at present |
| Midlothian Council | Annette Lang, Health Improvement and Chair of Midlothian LSHG |
| Chair of Midlothian LSHG | Midlothian LSHG |
| Chair of East Lothian LSHG | Kirsty Kurcik, (acting Chair) |
Glossary

ABI  Alcohol Brief Intervention (a short intervention usually provided by a healthcare professional which can lead to people reducing their level of alcohol consumption)

Asset Based Approach to sexual health and BBV

Such an approach enables individuals to take control of their own health and wellbeing while also promoting self esteem and the coping abilities of individuals and communities.

Initiatives to support good sexual health and relationships, to reduce the incidence of BBVs and to empower people living with BBVs to strive for better health and wellbeing can create positive attitudes, enabling individuals to develop the resources that they require in order to be resilient in the face of challenging circumstances.

BASH/  British Association for Sexual Health and HIV
BHIVA  British HIV Association
COZ  Chill out Zone (Children First, West Lothian)
HIV  Human immunodeficiency virus
ISD Scotland  Information and Statistics Division (an NHS Scotland department providing national health data)
IUD  Intrauterine Device (coil), a small, T-shaped contraceptive device inserted in the uterus to prevent pregnancy
LARC  Longer Acting Reversible Contraception
LGBT  Lesbian, gay, bisexual, and transgender
MRC  Medical Research Council
MSM  Men who have sex with men
MYPAS  Midlothian Young Persons Advisory Service
NaSH  National Sexual Health Systems
QIS  NHS Quality Improvement Scotland (an organisation responsible for reviewing evidence and developing clinical standards)
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>SALSUS</td>
<td>Scottish Schools Adolescent Lifestyle and Substance Use Survey</td>
</tr>
<tr>
<td>SHSSB</td>
<td>Sexual Health and HIV Strategy Board</td>
</tr>
<tr>
<td>SRE</td>
<td>Sex and Relationship Education</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
</tbody>
</table>
CONSULTATION METHODOLOGY: SEXUAL HEALTH AND HIV STRATEGY 2011-2016

Background

The draft strategy was presented to the Lothian NHS Board in September 2010, at which the intention to consult on the draft strategy with users, carers, NHS staff, voluntary organisations and communities was stated. The aim of the consultation was to ensure that they had the opportunity to be involved in the further consideration and development of the NHS Lothian draft Sexual Health and HIV Strategy.

The draft strategy built on the previous evidence and views obtained in the engagement stage of the development of the draft strategy (a separate report is available). This included an event with over 100 people, including NHS staff, voluntary organisations and users of services. The plan for the consultation was discussed with the Scottish Health Council.

Materials to Support the Consultation

Materials prepared to support the consultation process included:

- The full draft strategy and a summary document. The latter contained questions about the draft strategy. The summary version also contained contact details (phone, postal address, website and email) where people could obtain more information and the next steps following consultation.
- Information placed online, including the full version of the strategy and the summary document. A link to the page was placed on the NHS Lothian homepage of the website. If people wanted hard copies of any of the documents, these were posted out on request. The online information also contained a link to an online survey, which asked the same questions as those contained in the summary document.
- Posters providing information on the consultation, how to get more information and the deadline for consultation responses. These were posted in all relevant clinics and sent by email for further distribution options.
- Information was highlighted at key points during the consultation on the NHS Lothian Facebook and Twitter pages, where people could also give feedback.

Consultation Process

There was consultation with the service users, carers, voluntary organisations and communities:

- Information on the draft strategy and how to access it on the NHS Lothian website was distributed to groups with a particular interest and remit for supporting people in this area of work. In addition it was also sent to voluntary organisations (those supporting the interests of minority ethnic communities, older people, young people, disability, carers groups). Further education colleges and education departments including schools were emailed the draft
strategy and online survey links. The covering email included information about the development of the draft strategy and invited people to contact NHS Lothian if they wanted hard copies of the summary of the strategy or more information.

- **Edinburgh Equalities Network** was contacted through their email newsletter (groups and communities of interest across the “equalities domains” of age, caring role, disability, ethnicity, faith/belief, gender/gender identity, and/or sexual orientation).

- **Grapevine Disability Information Service** newsletter. (Grapevine provides free, confidential information to disabled people, their families and any other organisation or individual looking for disability-related information in Edinburgh, East Lothian and Midlothian).

- The **Public Partnership Fora** (PPFs) and the hospital patient networks were informed that the draft strategy was out for consultation and invited to ask for a meeting.

- **Healthlink** - NHS Lothian’s public newspaper - included in the winter 2010 edition an article about the draft strategy and how members of the public could respond to the consultation.

- **Connections** - NHS Lothian’s staff newspaper- also included an article about the draft strategy and how members of the public could respond to the consultation.

- Posters showing a link to the consultation papers and online survey were distributed widely in sexual health services and through partnership networks.

- 200 paper copies of the draft consultation paper were printed and distributed at visits and made available at sexual health services with a Freepost address for responses.

The consultation plan recognised that it is good practice to reach out to groups who may not wish, or be able, to respond to the consultation in writing, but whose views are important as they reflect the diversity of the population in Lothian. A range of harder to reach groups were identified, contacted and invited to meet with a member of staff. The following groups responded to this offer:

- **SHAKTI Women’s Aid** (supporting black / minority ethnic women, children and young people experiencing and/or fleeing domestic abuse): 14 female project workers gave the views of some of the young people and women they work with

- **Young people** at a youth agency in two areas of deprivation: approximately 14 girls and boys

- **Looked after young people** in a residential setting: 3 resident young people and 2 workers

- **Sex industry workers** (visits to four saunas): 14 women were involved in the discussions

- **African women’s group**: African project worker and 5 African women attended discussion (both infected and affected by HIV)

- **People with learning disabilities** (People First is a national self-advocacy organisation): visit to 4 members (3 male and one female, one from East Lothian, 2 from Midlothian and one from the City) and 2 workers

- **Gypsy travellers** (Keep Well is a project funded to work with this group with a remit for coronary heart disease): visit to 2 project workers who have a professional relationship with travellers
Consultation with Health and Social Care Professionals

Information was distributed widely to health and social care professionals via email. The email contained links to the consultation summary paper, full paper and the online survey was distributed widely across health and social care professionals including: Primary Care, Sexual Health Services (staff and posters for service users) in both hospitals and communities, NHS Board, Strategic Planning (including managers with responsibilities for Mental Health and Wellbeing, Learning Disabilities, Older People and Community Planning), Public Health and local multi-agency Sexual Health Planning Groups.

Presentations and discussions were facilitated at the Sexual Health & HIV Strategy Board and its sub groups (Clinical Services, African group, and Men who have Sex with Men (MSM) group.

The paper was also presented to the Health Council and will go to the Partnership Forum for approval.

Written responses

Individual responses were received from the following:

- Clinical Psychologist
- Family Planning Association
- Waverley Care
- Scottish Catholic Education Service
- LGBT Centre (third sector organisation for lesbian, gay, bisexual and transgender people)
- Caledonia Youth
- ROAM (NHS outreach service for Men who have Sex with Men)
- c:card (Lothian’s free condom service)
- HPV Service (Human Papilloma Virus)
- East Lothian Sexual Health Promotion Group

The consultation ended on 31 January 2011 but we are committed to continuing the process of engagement during the implementation of the strategy.
Analysis of the Responses

A total of 119 responses were received from the online survey which included 96 individual responses and 23 from organisations. 95% of respondents reported as living in Lothian.

Overall the Draft Sexual Health & HIV Strategy was well received with overall agreement on the direction and 4 main aims. It should be noted that under the longer term, Aim 2 should read as: ‘People with HIV enjoy lives that are not minimised by ill health due to HIV’.

Responses to consultation questions

<table>
<thead>
<tr>
<th>Percentage of online responses</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>87.4%</td>
<td>Supported proposal to direct resources (staff and services) more towards helping people who are at greater risk of poor sexual health</td>
</tr>
<tr>
<td>95.8%</td>
<td>Supported the proposal to develop services in local areas for those at higher risk of poor sexual health</td>
</tr>
<tr>
<td>89%</td>
<td>Supported the proposal to target HIV testing and prevention at higher risk groups</td>
</tr>
<tr>
<td>100%</td>
<td>Agreed that it is important to improve people’s ability to talk about sex in relationships, to help reduce the likelihood of having an unplanned pregnancy or getting a sexually transmitted infection and to help people have more rewarding sexual relationships</td>
</tr>
<tr>
<td>93.2%</td>
<td>Supported access to free condoms and contraception in local communities</td>
</tr>
<tr>
<td>93.2%</td>
<td>Agreed with the approach of asking about the use of alcohol / substance misuse in sexual health consultations</td>
</tr>
<tr>
<td>72.6%</td>
<td>Agreed with the approach of ‘earlier access to medical abortion, following counselling’</td>
</tr>
</tbody>
</table>

Consultation Question: We propose to direct our resources (staff and services) more towards helping people who are at greater risk of poor sexual health (including having an unplanned pregnancy or a sexually transmitted infection). Do you agree with this approach?

Online Survey

87.4% of online survey responses either agreed or strongly agreed to the proposal to direct resources (staff and services) more towards helping people who are at greater risk of poor sexual health. Only 3.3% either disagreed or strongly disagreed, with 9.2% unsure. The main themes of the written responses reflect the concern that universal provision of accessible services should still be available and inclusion of ongoing educational work and preventative interventions. Several people commented that there were gaps and problems in current service provision including GUM services and lack of services for Transsexuals.
Responses from engagement and consultation visits
Most people agreed that targeting of resources was the right approach but there was also support to ensure good universal access for all.

While not specifically targeted, universal services should provide appropriate services for people with learning difficulties and for people who are lesbian or transsexual.

All services need to be of a high quality and accessible to patients.

Consultation Question: The Chalmers Sexual Health Centre opens in Edinburgh city centre in spring 2011. We also think it’s important to have services in local areas for those at higher risk of poor sexual health to make access.

Online Survey
95.8% of respondents either agreed or strongly agreed with the proposal to develop services in local areas for those at higher risk of poor sexual health alongside the development of the Chalmers Sexual Health Centre, with only 1 person disagreeing and 3.4% unsure. The main themes of the written responses reflect the differing views of people, with some highlighting the benefits of accessing a central sexual health service and others highlighting the benefits of accessing a local service (including Primary Care). Others argued the negative aspects of accessing central and local services.

Responses from engagement and consultation visits
Most people welcomed a central integrated service, while others very clearly felt more comfortable in accessing a local service and particularly for young people who may not travel easily, or some Black and Minority Ethnic (BME) women who found it difficult to access a ‘sexual health service’ and would choose a GP often from a similar ethnic background. Gypsy travellers were more likely to attend a local service and need good links into services from those professionals who work with them.

Consultation Question: We plan to target HIV testing and HIV prevention at higher risk groups (some men who have sex with men, some people living in Lothian from sub-Saharan Africa, some intravenous drug users, and some young people). Do you agree with this approach?

Online Survey
89% either agreed or strongly agreed with the proposal to target HIV testing and prevention at higher risk groups, with 5% disagreeing and 5.9% unsure. The main themes of the written responses suggest that many people feel that we also need to focus on raising awareness for ‘the general public’ including use of generic social marketing campaigns. Several strong concerns were highlighted that the targeted approach, while evidence-based, stigmatised particular groups further, including men who have sex with men and those from sub-Saharan Africa.
Responses from engagement and consultation visits

Most people agreed that targeting of resources was the right approach but there was debate about this particularly in relation to HIV testing for ‘all Africans’. Some African women expressed anger that this was discrimination. Support for public awareness and tackling stigma was reflected in visits particularly to BME women.

Consultation Question: Please mark how important each of the following are to improve talking about sex in relationships.

- High quality, sexual health & relationships education for young people
- Programmes to support parents/carers to talk to young people about sexual health & relationships
- Access to information including leaflets and websites
- Tackling stigma for those who are lesbian, gay, bisexual or transgender

Online Survey

100% of respondents agreed that it is important to improve people’s ability to talk about sex in relationships, to help reduce the likelihood of having an unplanned pregnancy or getting a sexually transmitted infection and to help people have more rewarding sexual relationships.

On further exploration in this subject we asked respondents to mark how important 4 given areas were. 82.2% agreed the importance of ‘high quality sexual health & relationships for young people’. The second highest (50.8%) was the importance of ‘tackling stigma for those who are lesbian, gay, bisexual or transgender’. 45.3% gave top priority to ‘access to information including leaflets and websites’. Finally, but again at a high rate of 44.1%, ‘programmes to support parents/carers to talk to young people about sexual health & relationships’.

Several people commented that all areas were important to address. Other comments included the need to provide information in different languages and to make it accessible to those with poor literacy skills. Leaflets and websites should also include tackling stigma. Comprehensive training for teachers was also raised by several respondents.

Responses from engagement and consultation visits

People with Learning Disabilities felt it was important that they were included in all sexual health and relationships education (SRE) and receive ongoing good information but in a format that was easily understandable. They felt it important that they were treated and given equal rights in relationships. Challenges in terms of gender based violence for some BME women and for some sex industry workers. Difficulty in communication in some cultures where there may be gender issues, e.g. in some gypsy travellers. A few young people expressed the view that talking about sex was too embarrassing and easier just to ‘do it’. Some felt they had good information and found websites useful, while others felt their SRE at school was poor.

Important to link to and build on Scottish Government’s Let’s Talk About Sex national campaign.
Consultation Question: We think we can support people to reduce unintended pregnancies by offering the following:

- Increasing access to free condoms and contraception in local communities
- Increasing access to long lasting methods of contraception, e.g. implants and coils
- Increasing access to services for those under 16 years in local communities
- Earlier access to medical abortion services (after counselling)
- Asking about use of alcohol/substance misuse in sexual health services and offering support

Online Survey
We asked respondents their views on a range of approaches to reducing unintended pregnancies. The majority were supportive of all approaches recognising the need to have access to free condoms and contraception in local communities (93.2%) including access to long acting methods of contraception (91.5%).

92.3% agreed that increasing access to under 16s in local communities was important. 93.2% agree with the approach of asking about the use of alcohol/substance misuse in sexual health consultations and offering support. 72.6% agree with the approach of ‘earlier access to medical abortion, following counselling’.

The main themes of the comments included discussion about earlier access to abortions, some feeling that this could encourage a ‘rushed decision’ while others felt that the speed was important. There was debate about the need to look behind why people had abortions. This included addressing behaviour change, as well as looking at self-esteem issues in young people, their aspirations and their ability to negotiate sexual relationships.

We then asked respondents to prioritise these, with the top three being ‘increasing access to free condoms and contraception in local communities’ (46.3%), ‘increasing access to under 16s in local communities’ (34.9%) and ‘increasing access to long acting methods of contraception’ (29.6%). 16% rated ‘earlier access to medical abortion, following counselling’ as top priority but with the majority rating this as the lowest of the four areas (41.5%). 20% rated ‘asking the use of alcohol/substance misuse in sexual health consultations and offering support’ as top priority and 20.9% as lowest priority. Comments included strongly supporting this as ‘many people have unprotected sex after either drug taking or drinking too much’ while another person argued that ‘if you ask about drug/alcohol abuse, it can be seen as irrelevant and could potentially discourage people from seeking help in separate matters’.

Responses from engagement and consultation visits
Strong support for local services providing contraception and condoms. Some looked after and accommodated young people felt they didn’t have enough knowledge about contraception, sexually transmitted infection and how to access services including condoms.
**Evaluation and Future Work**

An evaluation of the consultation process will be completed in late March 2011. This will be taken to the NHS Lothian Involving People Group, which in turn reports to the Mutuality and Equality Governance Committee. This will be followed by subsequent dissemination to lead staff within Strategic Planning to share good practice.

All those who participated in the strategy consultation will receive information on the outcome of the consultation and how implementation of the strategy will be taken forward. A short newsletter will be collated outlining comments received, what we are taking forward in the strategy and its implementation. The newsletter will also contain an explanation of what is not being taken forward specifically and why.
1. **Purpose of the Report**

1.1. The purpose of this report is to update the Board on the financial position of NHS Lothian for the ten month period ended January 2011.

2. **Recommendation**

2.1. The Board is asked to note the report and the ongoing actions to secure a break-even revenue position for financial year 2010/11.

3. **Summary Financial Position to 31 January 2011**

3.1. NHS Lothian is reporting an over spend of £5.86m for the ten months of financial year 2010/11, an adverse movement in the month of £0.1m. The position at the end of January reflects current under-delivery of the efficiency target of £3.43m and £2.43m of overspends on other budgets and remains on track with the mid year review forecast of overall break-even.

Table 1 – Financial Position to 31 January 2011

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Outstanding Efficiency Savings</th>
<th>Net of Efficiency Savings</th>
<th>Movement in Month</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
<td>£’000</td>
</tr>
<tr>
<td>University Hospital Division</td>
<td>(3,033)</td>
<td>(1,588)</td>
<td>(1,445)</td>
<td>251</td>
</tr>
<tr>
<td>CH(C)Ps/REAS</td>
<td>(1,196)</td>
<td>(350)</td>
<td>(846)</td>
<td>(314)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(36)</td>
<td>-</td>
<td>(36)</td>
<td>(125)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>(1,596)</td>
<td>(1,491)</td>
<td>(105)</td>
<td>88</td>
</tr>
<tr>
<td>Q1 review flexibility</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td><strong>Under/ (Over)spend</strong></td>
<td>(5,861)</td>
<td>(3,429)</td>
<td>(2,432)</td>
<td>(100)</td>
</tr>
</tbody>
</table>

3.2. A verbal update will be provided on the month 11 position.

4. **Operational Budget Performance Movements in month**

4.1. Delivery of the LRP targets for the year remains a significant challenge amid continuing operational financial pressures.
4.2. Appendix 1 sets out the financial performance by management area and the Divisional issues on the year to date results are detailed in sections 5-8 below.

5. University Hospitals Divisions

5.1. The Divisional underspend of £0.250m during the month reflected an improvement in a number of areas including children’s services, theatres, clinical support and head & neck services

5.2. Whilst overall progress has been made towards the Mid Year Review forecast, the underlying overspends on medical staffing and clinical supplies are still evident.

5.3. The LRP position was favourable, with an overachievement of £0.07m in the month. A total of £11.5m of the annual target of £19m has been delivered as at 31 January.

6. CHPs/CHCP/REAS

6.1. At the end of January, the CHPs / CHCP and REAS reported a net overspend of £1.2m. This is a worsened position from previous months; mainly due to the overspend on prescribing.

6.2. There was a significant increase in prescribing volume in Lothian during December as disclosed in Chemist Declared Volume information. Further analysis of this position will be completed, once actual validated volume data is available. The volume pressure has been identified at £0.500m for the 10 months and has been added to the existing exposure on prescription charge income compensation of £0.2m for the same period. Whilst GMS support to offset these costs remains as previously anticipated, this is not sufficient to cover the additional prescribing pressures identified during the month.

6.3. There has been a £0.13m improvement in month relating to LRP. The Division anticipates meeting its full current year target of £11.5m.

7. Corporate Budgets

7.1. Corporate Budgets delivered a £0.1m under spend in January, resulting in a net overspend of £1.6m for the period to date.

7.2. The year to date position is largely represented by unmet LRP of £1.49m; principally in Facilities management (£1.1m) and HR (£0.33m). There are other operational overspends in HR (£0.41m) and Facilities Management (£0.46m), compensated by under spends in Planning (£0.29m) and Pharmacy (£0.41m).

7.3. The Corporate Departments have achieved £4.84m (61%) of the savings target to date. Full year delivery of recurring LRP remains an issue, particularly within Facilities and HR.
8. **Strategic Budgets**

8.1. Strategic budgets were largely breakeven against budget at the end of January. This position continues to reflect the offsetting of pressures from SLAs and UNPACs against non-recurring benefits from the capped CNORIS premium for 2010/11 and through rigorous management of allocations.

9. **LRP**

9.1. The summarised position at 31 January is as follows:

**Table 2- LRP By Division**

<table>
<thead>
<tr>
<th>Division</th>
<th>Cash Releasing Target for Year £’000</th>
<th>YTD Target £’000</th>
<th>YTD Actual £’000</th>
<th>Slippage £’000</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHD</td>
<td>18,977</td>
<td>13,081</td>
<td>11,493</td>
<td>(1,588)</td>
</tr>
<tr>
<td>CH(C)Ps/PCCO/REAS</td>
<td>11,538</td>
<td>9,313</td>
<td>8,963</td>
<td>(350)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>8,260</td>
<td>6,329</td>
<td>4,839</td>
<td>(1,490)</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>38,775</strong></td>
<td><strong>28,723</strong></td>
<td><strong>25,295</strong></td>
<td><strong>(3,428)</strong></td>
</tr>
</tbody>
</table>

9.1.1 There was an £3.428m overall slippage against the phased target overall in month. 65% of the revised annual target has been delivered over 10 months, with £13.5m remaining to be delivered. It is anticipated that the saving target will be delivered in full by 31 March 2011, but c. £3.8m may only be achieved on a non recurring basis, thus impacting on targets for the next financial year. Delivery of the in year savings is underpinned by approx 381 wte reductions in workforce.

10. **Year End Forecast**

10.1. The Mid Year Review, which confirmed the overall breakeven forecast projection against RRL, highlighted a number of specific actions required in order to secure delivery of the balanced financial position and which had to be prioritised across all areas, namely:

- LRP and delivery of budgets
- Tight controls on vacancy management
- Continued restrictions on discretionary spend, including all agency and locum costs, travel, hospitality, taxi usage.

11. **Capital Position**

11.1. Expenditure of £52.3m has been incurred to the end of January against the programme for the year. There is a forecast underspend of £2.4m for the year. This primarily relates to the changes at the RIE and agreement has now been reached with SGHD that this underspend can be carried forward into 2011/12. Appendix 2 provides further detail on individual schemes.
12. Payment Performance

12.1. Performance in November and December 2010 has been maintained during January 2011, with average credit taken remaining at 28 day, 84% of invoices by volume being settled within 30 days and over 50% within 10 days.

13. Conclusion

13.1. As we approach the final weeks of the current financial year, we are maintaining the forecast year end revenue position at a breakeven. It is essential that tight financial control is maintained, and the message of financial austerity is reinforced across the organisation. This has been further emphasised through the Financial Plan and Budget Setting exercises for 2011/12.

Susan Goldsmith
Director of Finance
17 March 2011

List of Appendices

Appendix 1: Expenditure Position
Appendix 2: Capital Investment Programme 2010/11
## Summary Financial Position as at January 2011

### APPENDIX 1

<table>
<thead>
<tr>
<th></th>
<th>Annual Budget 2010-11</th>
<th>YTD Budget</th>
<th>YTD Actuals</th>
<th>Variance</th>
</tr>
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<td></td>
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<td>£k</td>
<td>£k</td>
<td>£k</td>
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<td><strong>UNIVERSITY HOSPITAL DIVISION</strong></td>
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<tr>
<td>Medical</td>
<td>163,547</td>
<td>136,174</td>
<td>137,991</td>
<td>(1,817)</td>
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<tr>
<td>Surgical</td>
<td>139,001</td>
<td>116,556</td>
<td>119,452</td>
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<tr>
<td>Women &amp; Children &amp; Neuroscience</td>
<td>92,305</td>
<td>75,203</td>
<td>75,227</td>
<td>(24)</td>
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<tr>
<td>Cancer, Clinical Support, Head &amp; Neck</td>
<td>125,315</td>
<td>104,470</td>
<td>105,103</td>
<td>(632)</td>
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<tr>
<td>Corporate</td>
<td>15,340</td>
<td>8,784</td>
<td>6,448</td>
<td>2,336</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>535,508</strong></td>
<td><strong>441,187</strong></td>
<td><strong>444,220</strong></td>
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<td><strong>CHCP/CHPs/REAS/PCCO</strong></td>
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<td>East Lothian CHP</td>
<td>62,591</td>
<td>53,793</td>
<td>54,046</td>
<td>(252)</td>
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<td>Edinburgh CHP</td>
<td>238,182</td>
<td>198,765</td>
<td>199,485</td>
<td>(719)</td>
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<tr>
<td>Midlothian CHP</td>
<td>63,760</td>
<td>54,960</td>
<td>55,034</td>
<td>(74)</td>
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<tr>
<td>West Lothian CHP</td>
<td>95,228</td>
<td>77,789</td>
<td>77,836</td>
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<tr>
<td>PCCO</td>
<td>8,734</td>
<td>(1,132)</td>
<td>(1,000)</td>
<td>(131)</td>
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<td>REAS</td>
<td>42,371</td>
<td>34,915</td>
<td>34,887</td>
<td>28</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>510,866</strong></td>
<td><strong>419,090</strong></td>
<td><strong>420,286</strong></td>
<td><strong>(1,196)</strong></td>
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<td><strong>STRATEGIC BUDGETS</strong></td>
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<td>70,921</td>
<td>39,307</td>
<td>39,344</td>
<td>(36)</td>
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<td><strong>CORPORATE BUDGETS</strong></td>
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<td></td>
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<td>Chief Executive's Department</td>
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<td>436</td>
<td>(2)</td>
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<tr>
<td>Medical Director</td>
<td>919</td>
<td>665</td>
<td>610</td>
<td>55</td>
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<td>Consort</td>
<td>41,631</td>
<td>34,629</td>
<td>34,692</td>
<td>(63)</td>
</tr>
<tr>
<td>Communications</td>
<td>624</td>
<td>519</td>
<td>532</td>
<td>(13)</td>
</tr>
<tr>
<td>Ehealth</td>
<td>21,521</td>
<td>17,079</td>
<td>17,161</td>
<td>(82)</td>
</tr>
<tr>
<td>Facilities Management</td>
<td>80,108</td>
<td>66,213</td>
<td>67,860</td>
<td>(1,647)</td>
</tr>
<tr>
<td>Finance</td>
<td>9,390</td>
<td>7,823</td>
<td>7,799</td>
<td>24</td>
</tr>
<tr>
<td>Human Resources &amp; OH&amp;S</td>
<td>11,534</td>
<td>9,474</td>
<td>10,218</td>
<td>(744)</td>
</tr>
<tr>
<td>Nursing</td>
<td>4,304</td>
<td>2,990</td>
<td>2,918</td>
<td>72</td>
</tr>
<tr>
<td>Pharmacy **</td>
<td>12,472</td>
<td>10,258</td>
<td>9,942</td>
<td>316</td>
</tr>
<tr>
<td>Planning</td>
<td>3,260</td>
<td>2,762</td>
<td>2,437</td>
<td>325</td>
</tr>
<tr>
<td>Public Health</td>
<td>3,905</td>
<td>3,128</td>
<td>2,994</td>
<td>133</td>
</tr>
<tr>
<td>Other</td>
<td>(72)</td>
<td>(753)</td>
<td>(784)</td>
<td>31</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>190,119</strong></td>
<td><strong>155,220</strong></td>
<td><strong>156,816</strong></td>
<td><strong>(1,596)</strong></td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,307,414</strong></td>
<td><strong>1,054,804</strong></td>
<td><strong>1,060,666</strong></td>
<td><strong>(5,862)</strong></td>
</tr>
</tbody>
</table>
## Appendix 2

NHS Lothian Capital Investment Programme 2010/11

### Agreed Programme following Quarter 1 Review vs 10/11 Expenditure as at December £m

<table>
<thead>
<tr>
<th>Schemes over delegated limit</th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Committed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Royal Victoria Hospital</td>
<td>10.427</td>
<td>7.342</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children</td>
<td>8.098</td>
<td>5.397</td>
</tr>
<tr>
<td>RHSC Enabling Works</td>
<td>6.090</td>
<td>2.470</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>3.125</td>
<td>1.200</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre (land purchase)</td>
<td>1.531</td>
<td>1.531</td>
</tr>
<tr>
<td>Midlothian Community Hospital</td>
<td>1.427</td>
<td>0.835</td>
</tr>
<tr>
<td>St John's Elective Surgical Centre</td>
<td>4.654</td>
<td>3.927</td>
</tr>
<tr>
<td>Chalmers Hospital</td>
<td>5.963</td>
<td>4.124</td>
</tr>
<tr>
<td><strong>Total - SCHEMES OVER DELEGATED LIMIT</strong></td>
<td><strong>41.315</strong></td>
<td><strong>26.825</strong></td>
</tr>
<tr>
<td><strong>Approved, not committed</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>0.485</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Total - SCHEMES OVER DELEGATED LIMIT</strong></td>
<td><strong>41.800</strong></td>
<td><strong>26.825</strong></td>
</tr>
</tbody>
</table>

### Schemes under delegated limit

#### Rolling Programmes

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Compliance</td>
<td>6.954</td>
<td>2.729</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>8.587</td>
<td>2.351</td>
</tr>
<tr>
<td>Imaging Strategy</td>
<td>1.000</td>
<td>0.000</td>
</tr>
<tr>
<td>E-Health Strategic Priorities</td>
<td>3.600</td>
<td>2.095</td>
</tr>
<tr>
<td>RIE Lifecycle Costs</td>
<td>3.827</td>
<td>2.870</td>
</tr>
<tr>
<td>RIE Additional Lifecycle Costs</td>
<td>0.510</td>
<td>0.383</td>
</tr>
<tr>
<td>National PACS Refresh 2007-17</td>
<td>0.128</td>
<td>0.001</td>
</tr>
<tr>
<td>Specific Allocations</td>
<td>0.152</td>
<td>0.139</td>
</tr>
<tr>
<td><strong>Total - Rolling Programmes</strong></td>
<td><strong>24.757</strong></td>
<td><strong>10.569</strong></td>
</tr>
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</table>

#### Committed

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical Accommodation Release Strategy (CARS)</td>
<td>2.960</td>
<td>2.821</td>
</tr>
<tr>
<td>Traffic management</td>
<td>2.600</td>
<td>1.092</td>
</tr>
<tr>
<td>Dalkeith Medical Centre</td>
<td>2.463</td>
<td>0.872</td>
</tr>
<tr>
<td>Unscheduled Care Collaborative ARAU</td>
<td>0.090</td>
<td>0.080</td>
</tr>
<tr>
<td>Expansion of renal capacity RIE</td>
<td>0.278</td>
<td>0.000</td>
</tr>
<tr>
<td>Muirhouse Modular Accommodation</td>
<td>0.023</td>
<td>0.005</td>
</tr>
<tr>
<td>Chemotherapy e-Prescribing &amp; Administration System (CePAS)</td>
<td>0.190</td>
<td>0.056</td>
</tr>
<tr>
<td>Laboratory Equipment</td>
<td>0.524</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>Total - Committed</strong></td>
<td><strong>9.129</strong></td>
<td><strong>4.925</strong></td>
</tr>
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</table>

#### Approved, not committed
<table>
<thead>
<tr>
<th>Project Description</th>
<th>Agreed Programme following Quarter 1 Review</th>
<th>10/11 Expenditure as at December</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£m</td>
<td>£m</td>
</tr>
<tr>
<td>2nd Breast Theatre Unit Wgh</td>
<td>1.423</td>
<td>0.399</td>
</tr>
<tr>
<td>West End Medical Practice</td>
<td>0.200</td>
<td>0.013</td>
</tr>
<tr>
<td>Observation ward RIE</td>
<td>1.148</td>
<td>0.000</td>
</tr>
<tr>
<td>Birthing suite (SJH)</td>
<td>0.045</td>
<td>0.004</td>
</tr>
<tr>
<td>Birthing suite (RIE)</td>
<td>2.557</td>
<td>(0.205)</td>
</tr>
<tr>
<td>Management of Finance Leases</td>
<td>0.250</td>
<td>0.059</td>
</tr>
<tr>
<td></td>
<td><strong>5.622</strong></td>
<td><strong>0.269</strong></td>
</tr>
<tr>
<td>Unapproved</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Energy Efficiency</td>
<td>0.900</td>
<td>0.000</td>
</tr>
<tr>
<td>Speech Recognition</td>
<td>0.750</td>
<td>0.743</td>
</tr>
<tr>
<td></td>
<td><strong>1.650</strong></td>
<td><strong>0.743</strong></td>
</tr>
<tr>
<td>Total - SCHEMES UNDER DELEGATED LIMIT</td>
<td><strong>41.159</strong></td>
<td><strong>16.506</strong></td>
</tr>
<tr>
<td>National schemes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centrally Funded Schemes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiotherapy - Phase 6</td>
<td>3.180</td>
<td>3.020</td>
</tr>
<tr>
<td>Radiotherapy - Phase 7</td>
<td>0.016</td>
<td>0.001</td>
</tr>
<tr>
<td>Brachytherapy</td>
<td>0.038</td>
<td>0.000</td>
</tr>
<tr>
<td>GDP dental premises</td>
<td>2.088</td>
<td>0.574</td>
</tr>
<tr>
<td>Pharmacy Modernisation</td>
<td>0.070</td>
<td>0.036</td>
</tr>
<tr>
<td></td>
<td><strong>5.391</strong></td>
<td><strong>3.630</strong></td>
</tr>
<tr>
<td>Total - NATIONAL SCHEMES</td>
<td><strong>5.391</strong></td>
<td><strong>3.630</strong></td>
</tr>
<tr>
<td>Grand Total</td>
<td><strong>88.350</strong></td>
<td><strong>46.962</strong></td>
</tr>
</tbody>
</table>
1. Purpose of the Report

1.1. This report sets out the draft NHS Lothian Financial Plan for 2011/12. Detailed supporting schedules are attached at Appendix 1: Financial Plan Summary and Appendix 2: Local Reinvestment Programme Schemes agreed to date.

2. Recommendation

2.1. The Board members are invited to note:

- NHS Lothian is required to deliver financial balance and the plan identifies the level of efficiency required to achieve this target;
- The underlying planning assumptions; these are currently being tested against the all-Scotland position;
- The specific risks identified;
- Further scrutiny of LRP plans will be undertaken at the Finance & Performance Review Committee in April;
- Scenario planning for 2012/13 and beyond will be developed, for consideration by the Finance & Performance Review Committee in April;
- A further update of the Financial Plan will be provided to the NHS Board in May, to seek formal approval of the planned income and expenditure for 2011/12, and the supporting savings programmes required to deliver financial balance.

2.2. The Board members are invited to agree:

- The Financial Plan is presented as work in progress to the Scottish Government Health Directorates, as part of the Local Delivery Plan later this month;

3. Summary of the Issues

3.1. As previously highlighted to the Executive Management Team and the Finance & Performance Review Committee, development of the Financial Plan for 2011/12 has taken cognisance of planning assumptions in relation to pay, prices and drugs uplifts, and the likely annual savings targets required to deliver ongoing financial balance. There has been a key focus on ensuring a clear understanding and assessment of our current recurring cost base including all known or anticipated costs within the system. These commitments, including any regarded as unavoidable, are compared against our forecast income, to determine the extent to which we must reduce costs, thereby generating funds for reinvestment, in order to deliver financial balance.
3.2. The draft Financial Plan was most recently considered by both the Finance & Performance Review Committee and Executive Management Team, during the week commencing 14 March.

3.3. Table 1 provides a high level summary of the position for 2011/12. This compares the total additional sources of funding with costs presently being incurred for which there is currently no recurring budget, and those new costs which are deemed unavoidable and / or relate to service requirements (eg SMC drugs). In addition, a summary of savings plans across specific workstreams is provided; delivery of these schemes in full will allow a balanced plan to be presented for the year. Further detail is attached as Appendix 1.

3.4 There has been significant progress made in identifying LRP schemes, but at the time of writing work is ongoing to develop further proposals to increase LRP delivery, and to reduce cost. In addition, opportunities for potential bridging funding, including the NRAC uplift are being identified.

Table 1 – Financial Plan 2011/12

<table>
<thead>
<tr>
<th></th>
<th>Recurring</th>
<th>Non recurring</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uplift</td>
<td>10,771</td>
<td>0</td>
<td>10,771</td>
</tr>
<tr>
<td>NRAC</td>
<td>13,850</td>
<td>0</td>
<td>13,850</td>
</tr>
<tr>
<td>Other sources</td>
<td>1,200</td>
<td>1,200</td>
<td>2,400</td>
</tr>
<tr>
<td><strong>Total income</strong></td>
<td>25,821</td>
<td>1,200</td>
<td>27,021</td>
</tr>
<tr>
<td><strong>Expenditure</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pay, price and drug uplifts</td>
<td>27,816</td>
<td>0</td>
<td>27,816</td>
</tr>
<tr>
<td>Unavoidable Cost Increases</td>
<td>16,510</td>
<td>0</td>
<td>16,510</td>
</tr>
<tr>
<td>LRP brought forward</td>
<td>2,702</td>
<td>0</td>
<td>2,702</td>
</tr>
<tr>
<td>NRAC investment funding</td>
<td>7,576</td>
<td>0</td>
<td>7,576</td>
</tr>
<tr>
<td>Other investments</td>
<td>20,081</td>
<td>1,635</td>
<td>21,715</td>
</tr>
<tr>
<td><strong>Total expenditure</strong></td>
<td>74,685</td>
<td>1,635</td>
<td>76,320</td>
</tr>
<tr>
<td><strong>Net position before LRP</strong></td>
<td>(48,864)</td>
<td>(435)</td>
<td>(49,299)</td>
</tr>
<tr>
<td><strong>Savings</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical Productivity</td>
<td>4,676</td>
<td>200</td>
<td>4,876</td>
</tr>
<tr>
<td>Workforce</td>
<td>18,324</td>
<td>1,835</td>
<td>20,158</td>
</tr>
<tr>
<td>Drugs and Prescribing</td>
<td>4,159</td>
<td>0</td>
<td>4,159</td>
</tr>
<tr>
<td>Procurement</td>
<td>3,801</td>
<td>13</td>
<td>3,814</td>
</tr>
<tr>
<td>Support Services</td>
<td>1,435</td>
<td>85</td>
<td>1,520</td>
</tr>
<tr>
<td>Estates and Facilities</td>
<td>3,033</td>
<td>0</td>
<td>3,033</td>
</tr>
<tr>
<td><strong>Savings identified to date</strong></td>
<td>35,428</td>
<td>2,132</td>
<td>37,560</td>
</tr>
<tr>
<td><strong>Further management action required</strong></td>
<td>(13,436)</td>
<td>1,698</td>
<td>(11,739)</td>
</tr>
</tbody>
</table>
3.5 The draft financial plan considers the financial year 2011/12 only. Further work will be undertaken for the update of the Financial Plan to the Finance & Performance Review Committee in April, to consider potential scenario planning for 2012/13 onwards. Underpinning this work will be an assumption of 1% per annum uplift on the baseline funding position, plus £10m per annum towards NRAC parity, per recent correspondence from the Scottish Government Health Directorates.

4. Income

4.1. The Scottish Government confirmed NHS Board allocations for 2011/12 on 11 February. This highlighted a total increase of £280m or 2.7% over the available Health spend in 2010/11. Funding for Territorial Boards is to increase by £232m, or 3.2%, which is a combination of uplift and transfer of funding previously categorised as “earmarked recurring”:

- £81m to meet the element of expected additional costs for pay, supplies, increase in VAT, and changes to the National Insurance thresholds;
- £70m to establish pooled funding arrangements with Local Authority partners to redesign health and social care services;
- £57m to allow delivery of the full impact of prescription charges
- £24m has been allocated to NHS Boards which remain below NRAC parity.

4.2. NHS Lothian has received an above average settlement; with an increase of £42.9m or 4.2%. This is summarised below:

Table 2 – Baseline Allocation 2011/12

<table>
<thead>
<tr>
<th></th>
<th>£m</th>
<th>£m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recurring baseline 2010/11</td>
<td>1,011.531</td>
<td></td>
</tr>
<tr>
<td>Uplift</td>
<td>10.771</td>
<td></td>
</tr>
<tr>
<td>Change Fund</td>
<td>9.747</td>
<td></td>
</tr>
<tr>
<td>Prescription Charges</td>
<td>8.525</td>
<td></td>
</tr>
<tr>
<td>NRAC</td>
<td>13.850</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td><strong>42.893</strong></td>
</tr>
<tr>
<td>Initial allocation 2011/12</td>
<td></td>
<td>1,054.424</td>
</tr>
</tbody>
</table>

4.3. The Financial Plan presented at Appendix 1 reflects the baseline uplift of £10.771m, plus the £13.850m additional NRAC funding. Whilst the baseline uplift is slightly lower than our earlier assumption of £11.2m; the increase in NRAC funding is considerably more than the previously expected £5.8m. The additional funding of £7.6m has been ‘ring fenced’ within the Financial Plan, with funds targeted at services most vulnerable to population pressures, invest to save initiatives, including voluntary severance and bridging funding for service redesign. In addition, SGHD colleagues have indicated, albeit informally, that the increased NRAC funding is also a contribution to the development costs for the Royal Hospital for Sick Children and Department of Clinical Neurosciences reprovision projects. Work is already well progressed to finalise the likely revenue costs for these projects over the next twelve months, and further updates will be brought back to
EMT and the Finance & Performance Review Committee in parallel with the development of the Business Case. In relation to invest to save and bridging funding for service redesign, specific proposals will be developed via the LRP and Planning Groups during the first quarter of the new financial year, with the allocation of funding to be agreed in parallel with the Quarter 1 financial review.

4.4. Table 3 on the following page shows the total anticipated income that NHS Lothian will receive in 2011/12. An integrated income strategy is being developed which will ensure robust and transparent income recovery systems and processes are in place. This will support the routine reporting of income during 2011/12, including separately reporting activity for Non Lothian residents and allowing the development of mechanisms to revise a number of specific clinical departmental budgets to ensure they remain as accurate and up to date as possible.

<table>
<thead>
<tr>
<th>Table 3 - NHS Lothian Total Income 2011/12</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>£b</strong></td>
</tr>
<tr>
<td>Initial SGHD allocation</td>
</tr>
<tr>
<td>Further in year allocations anticipated</td>
</tr>
<tr>
<td>Junior doctors and national services</td>
</tr>
<tr>
<td>Scottish Board SLAs</td>
</tr>
<tr>
<td>Other income</td>
</tr>
<tr>
<td><strong>Gross Income</strong></td>
</tr>
</tbody>
</table>

5. Expenditure

5.1. Uplifts - Pay / Prices / Drugs: £27.8m

5.1.1. Current planning assumptions reflect the draft Scottish Government Budget, with a minimum uplift of £250 for staff earning less that £21k, and a pay freeze for all other staff. This does not, however, remove the need for additional costs of the ongoing impact of the seniority payments applicable under the Consultants contract, and increments for Agenda for Change.

5.1.2. Supplies have been uplifted at a rate of 1.9% per year, with the Consort payment closer to 2.5%, recognising the terms of the contract. In addition provision has also been made for the VAT increase. This is expected to add £4.1m to the cost of supplies for the current year.

5.1.3. Drugs and prescribing increases are based on a review of the SMC Forward Look, and the impact of activity relating to previous SMC decisions, demographic change both in Acute prescribing and Primary Care, and the ongoing impact of the GMS contract, and the Keep Well programme.

5.2. Previously approved strategies: £1.1m

5.2.1. The Financial Plan takes account of previously agreed investments arising from approved strategies. References to new or emerging strategies have been removed.

5.3. Revenue consequences of capital investment programme: £4.6m
5.3.1. Recognising the impact of the capital investment programme, the revenue implications for 2010/11 reflect the costs agreed in individual business cases for a range of projects including Midlothian Community Hospital, Chalmers Hospital and the Radiotherapy Replacement Programme which are already approved and underway.

5.3.2. Work remains ongoing to confirm the likely costs required to support the Royal Hospital for Sick Children and Department of Clinical Neurosciences reprovision projects, under the Non Profit Distributing Model. The development costs over the next twelve months are likely to be significant, with considerable support required from a range of advisors: technical, legal and financial; due to the complex nature of the project and the impact of the existing PFI contract at the Little France site. At this time, a high level estimate has been included in the Financial Plan. This also includes the ‘in house’ support, which under the previous funding arrangements, would have been a charge to the capital budget.

5.4. National and regional priorities: £2.4m

5.4.1. Adjustments to reflect new nationally designated services have been incorporated into the plan along with other known national and regional schemes including Cancer and Children’s Services. The expected additional eHealth cost for the Prison Service is also included. In addition, provision has also been made to reflect activity and cost increases associated with patient flows to other Boards, although these are being challenged.

5.5. Research and development: £1.0m

5.5.1. The funding allocated in the Financial Plan is the second tranche of a previously approved £2.1m investment over three years, to support R&D activity across NHS Lothian.

5.6. Local investments: £1.6m

5.6.1. A small number of other local investments are proposed within the Financial Plan for 2011/12. These include funding to support the Weight Management services, Traffic Management priorities, the Electronic Employee Support System, and the Lymphoedema Service.

5.7. Cost increases deemed unavoidable: £16.5m

5.7.1. Clinical supplies – As highlighted in the Financial Plan for 2010/11, which was presented and approved by the NHS Board in May 2010, there are budgetary issues within clinical supplies which were not funded in 2010/11 or in previous financial years. These were highlighted as a key risk in delivering financial balance, and relate to changes in activity and clinical practice. In agreeing the paper, the Board required that any resulting overspends be managed by budget holders in 2010/11. A detailed analysis has been carried out which demonstrates that not all these costs will not be reduced unless clinical practice is changed. At present there is no evidence that this will happen, and thus they are “recognised” in the Financial Plan as requiring an LRP solution. It remains a concern that the changes in clinical practice...
which caused the overspend were accepted by Lothian managers unless an accompanying agreement on how they could be funded.

5.7.2. Rates – the issue regarding the rates revaluation across Scotland has been highlighted to SGHD. There is scope for us to challenge the level set by the Local Authorities, which has been appealed. However, recognising the risk and the relative materiality of the costs, we have assumed a worst case scenario at present.

5.7.3. CNORIS – the costs associated with the Clinical Negligence and Other Risks insurance premium are rising year on year. This reflects an increase in the value of payments being made across Scotland. Additional funding was allocated in the 2010/11 financial plan, and although this was sufficient to cover the in year costs, this was only as a result of SGHD capping all Boards’ contributions at 2009/10 rates; the actual costs were considerably higher.

5.7.4. Waiting times – since 2007/08, costs attributed to ‘Waiting Times’ have been funded either on a non-recurring basis following the Mid Year Review each year, or through specific additional funding from SGHD. These costs are now seen by managers as “embedded” with their overall cost base, in terms of capacity management. This is despite a lack of accompanying specificity on the activity which these allocations were being used to fund. In order to provide a clear base budget position across the services affected, these costs have been so far included as a funding requirement in the Financial Plan. However, the ongoing 5X5X5 process will give an opportunity for management to review these costs, and to seek potential options to deliver recurrent savings.

5.7.5. Nursing staffing budget review – while Nursing budgets have been reviewed over recent years, there has been a lack of commitment in budget setting across the organisation. A further “single system” review has been led by the Director of Nursing, which has identified a number of drivers for the level of overspend. These include the drop in turnover of staff and the subsequent impact on incremental drift, as well as the impact of AfC enhancements. The recognition of these costs as an investment funding requirement in the Financial Plan on a recurring basis will be dependent on the outcome of the Nursing Review and delivery of the sickness absence targets set at 3.5%.

6. Efficiency and Local Reinvestment Programme (LRP)

6.1. The Scottish Government has increased the national efficiency target from 2% to 3% for 2011/12. There is clear direction that these savings are to be retained by NHS Boards with explicit focus on meeting expected additional service cost pressures.

6.2. The level of savings required locally, to balance the Financial Plan as it is currently predicted, is in the region of £49m or 5%. Through the LRP Group, all budget holders were set a 5% cost reduction target. The detail of these schemes is provided in Appendix 2. Where delivery is expected to be phased over a number of years, budget holders have been asked to identify non recurring schemes to offset
these timing issues. Table 4 below sets out a comparison of the savings plans identified, against the target applied to each area:

### Table 4 – Savings Plans

<table>
<thead>
<tr>
<th>LRP target</th>
<th>LRP identified</th>
<th>Balance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Brought forward</td>
<td>Total LRP target</td>
</tr>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>UHD, Facilities &amp; REAS</td>
<td>1,093</td>
<td>28,813</td>
</tr>
<tr>
<td>CH(C)Ps &amp; PCCO</td>
<td>1,560</td>
<td>15,043</td>
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<tr>
<td>Corporate departments</td>
<td>81</td>
<td>3,020</td>
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<tr>
<td>Strategic</td>
<td>0</td>
<td>1,771</td>
</tr>
<tr>
<td>Totals</td>
<td><strong>2,734</strong></td>
<td><strong>48,647</strong></td>
</tr>
</tbody>
</table>

6.3 Work is currently underway to risk assess proposals submitted and to determine the level that will be delivered in year.

6.4 As highlighted in section 4, some of the additional NRAC uplift may be used to provide non recurring bridging funding to support the redesign of services and / or further changes in staffing structures, in order to deliver agreed savings proposals.

7. Activity

7.1. Given the previous lack of linkage between Waiting Times funding and activity at local level, activity targets are being developed for acute activity only. In the main, these reflect the average activity delivered by specialty and patient type over the past 2 years. These will be required a part of the sign-off on the budget setting process.

7.2. As a performance indicator this is very high level and does not reflect changes in clinical behaviour or practice. Work will continue through the year to develop a link between activity and costs at an HRG level for acute and also to develop appropriate activity measures for primary care services.

8. Risks

8.1. Whilst every effort has been made to ensure all likely additional costs and national, regional and local priorities for investment have been incorporated into the five year plan at this time, there remain a number of inherent uncertainties and associated risks.

8.2. The financial planning process is an ongoing and iterative cycle. It is not possible to fully eradicate all financial risks facing individual service areas, nor the wider organisation. These risks do, however, need to be managed and this is a key responsibility of all budget holders, managers and Executive Directors.
• Delivery of a recurring savings to the value required;

• Availability of SGHD funding for previously separately funded programmes and initiatives;

• Revenue impact of the capital investment programme including transitional or double running costs not yet identified, and development costs required to support all projects;

• New or changed policy initiatives emerging during the financial year;

• Ability of the organisation to manage the impact of allocations received in 2010/11 which are required in 2011/12;

• Differentiate in realising the full benefits of efficiency progress within current policy parameters.

Susan Goldsmith
Director of Finance
15 March 2011

List of Appendices

Appendix 1: Draft Financial Plan 2011/12
Appendix 2: NHS Lothian LRP 2011/12
### Appendix 1: Draft Financial Plan 2011/12

<table>
<thead>
<tr>
<th></th>
<th>R</th>
<th>NR</th>
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<td>(435)</td>
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## Appendix 2: NHS Lothian LRP 2011/12

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<td>0</td>
<td>1,771</td>
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<td><strong>48,647</strong></td>
<td><strong>51,381</strong></td>
<td><strong>35,428</strong></td>
<td><strong>13,821</strong></td>
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DELIVERING WAITING TIMES

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to outline NHS Lothian’s performance on Waiting Times in the most recent period available.

2 Recommendations

The Board is invited to:

2.1 Receive this report in a new format following proposals accepted at the last Board meeting;

2.2 Acknowledge the actions taken to ensure that Access Targets are met in the coming period.

3 Performance Reporting on Waiting Times

As agreed at the last Board Meeting, the detailed consideration of Waiting Times and Delayed Discharge will occur at the Finance and Performance Review Sub Committee of the Board. It was proposed that the Board itself received a summary on performance in these areas. This is the first such report relating to Waiting Times.

4 Summary of the Issues

NHS Lothian’s performance during December 2010 was affected by adverse weather.

This contributed to difficulties in achieving outpatient and inpatients standards, as well as A&E and Hip Fracture performance.

Provisional information shows that subsequent performance in these areas has improved since the turn of the year.
Work is also ongoing to improve the Waiting Times experienced by patients waiting for diagnostic endoscopies.

5 Performance by Individual Measure

In the latest period, the following measures were successfully met or bettered.

- 62 days from referral to treatment for those with suspicion of cancer
- Treatment within 31 days of diagnosis of cancer
- Progress towards 18 Weeks RTT
- Cataracts waiting times standard
- Cardiac waiting times standard

Areas where performance was not ideal during the period are outlined below:-

5.1 New Outpatient Standard and Inpatient Standard

As the recent ISD publication shows performance across Scotland was affected by the severe weather in November and December.

It was recognised by SGHD that these conditions did restrict the ability for elective standards to be met and that the rebooking of patients affected would impact on performance in early 2011.

Reported outpatient figures are also impacted by long waits for endoscopy patients, which are covered in the diagnostic section below.

5.2 Wait for Diagnostic Tests

As has been highlighted previously, waiting times for diagnostic scopes have increased for routine patients.

Work is in progress to ensure that a maximum waiting time of 12 weeks is attained by the end of March with a further reduction to 4 weeks no later than June 2011.

Steps taken have stemmed this growth and additional capacity, both internal and external, has been put in place to reduce patients waiting longer than necessary with the aim of bringing performance within standard in the summer.

5.3 A&E Waits

As reported previously, A&E position improved during January, reaching 95.9% and provisional information shows that this improvement further continued in February to 97.5%.
5.4 **Hip Surgery Waits**

As highlighted previously, hip fracture waits were affected by the severe weather in December, which resulted in markedly higher levels of trauma. Provisional management information shows that compliance with the standard returned in February to 100%.

5.5 **Mental Health, Substance Misuse and Learning Disabilities**

Performance has been sustained at 98% and detail for individual services and teams level has been circulated to Board members.

5.6 **Audiology**

Audiology services across Scotland are currently working to deliver a 12 week stage of treatment timeframe. In Lothian this is largely already the case in paediatrics while in adults the service is working to ensure that this is met by the spring.

6 **Impact on Health Inequalities**

As has been indicated on other occasions, reduction of waiting times addresses inequities between different social groups, as those who are more affluent are more able to take advantage of opportunities to circumvent long NHS waits, such as opting for private treatment or being more able to accept short notice appointments.

As a performance report, it has been confirmed there is no need for an equality and diversity impact assessment to be undertaken as a matter of course.

Andrew Jackson  
Associate Director, Strategic Planning  
11 March 2011
TACKLING DELAYED DISCHARGE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on the performance of NHS Lothian and Local Authority partners in tackling delayed discharge.

2 Recommendations

The Board is invited to:

2.1 Receive this report in a new format following proposals accepted at the last Board meeting.

2.2 Note the performance at January and February 2011 census in relation to the local targets and the national 6 week standard.

3 Performance reporting on delayed discharge

3.1 As agreed at the last Board meeting, the detailed consideration of Delayed Discharge and Waiting Times will occur at the Performance & Finance Review sub committee of the Board. It was proposed that the Board itself received a summary on performance in these areas. This is the first such report relating to Delayed Discharge.

3.2 Scottish Government set the national delayed discharge standard stating that partnerships are to have no patients delayed for more than six weeks from their date ready for discharge.

4 Summary of the Issues

4.1 The table gives a summary of headline figures from the recent census:

<table>
<thead>
<tr>
<th></th>
<th>Total ISD Delays (incl. x-codes)</th>
<th>Total Delays (excl. x-codes) NHSL target - 66</th>
<th>Complex Codes</th>
<th>6 Weeks+ (National standard - 0)</th>
<th>Short Stay (Target - 0)</th>
<th>Average length of stay</th>
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</thead>
<tbody>
<tr>
<td>January</td>
<td>114</td>
<td>63</td>
<td>51</td>
<td>15</td>
<td>5</td>
<td>32</td>
</tr>
<tr>
<td>February</td>
<td>117</td>
<td>78</td>
<td>39</td>
<td>5</td>
<td>&lt;5</td>
<td>21</td>
</tr>
</tbody>
</table>
4.2 At census point in February, NHS Lothian is reporting slightly increased numbers of patients delayed from January however this is set against a backdrop of a 30% increase in referrals to social work. There has been a significant reduction in the length of stay of patients, demonstrating more effective patient flow through the health and social care system.

4.3 There has also been a significant reduction in the number of patients delayed over 6 weeks, reducing to 5 in February and a further reduction in the number of patients who are coded as complex (x-codes).

4.4 The table below sets out the performance across the Partnership areas for February, with January data in brackets. To avoid possible patient identifiable information, numbers under 5 have been suppressed however detailed figures can be provided to NHS Lothian Board members on request.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>57 (45)</td>
<td>15 (15)</td>
<td>5 (&lt;5)</td>
<td>&lt;5 (&lt;5)</td>
</tr>
<tr>
<td>Over 6 weeks</td>
<td>&lt;5 (13)</td>
<td>&lt;5 (&lt;5)</td>
<td>0 (0)</td>
<td>0 (0)</td>
</tr>
<tr>
<td>Short Stay</td>
<td>&lt;5 (&lt;5)</td>
<td>0 (&lt;5)</td>
<td>0 (&lt;5)</td>
<td>0 (0)</td>
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</table>

4.5 In Edinburgh the local target of 48 was not achieved with the partnership reporting 57 delays overall. However, the number of delays over 6 weeks has decreased to less than 5 in February. Care home choice and length of time awaiting placement remains the largest challenge, both in terms of overall capacity and people exercising their right of choice.

4.6 East Lothian is reporting the same number of patients delayed as January with 15 and less than 5 patients delayed over 6 weeks. The commencement of the reablement service in February in East Lothian will begin to have a positive impact on the number of patients delayed locally.

4.7 In Midlothian, the development of community based services continues to show dividends with 5 patients delayed overall and no patients delayed over 6 weeks.

4.8 In West Lothian, there were less than 5 patients delayed overall but no patients were delayed for more than 6 weeks.

4.9 Patients whose discharge is delayed because they require complex solutions to meet their needs are coded according to ISD guidelines as ‘X-codes’ and are not counted against the national standards. The table below sets out the delays across Partnership areas at February census, with January data in brackets.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
<th>Non-Lothian</th>
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</thead>
<tbody>
<tr>
<td>Complex codes</td>
<td>20 (30)</td>
<td>&lt;5 (&lt;5)</td>
<td>5 (6)</td>
<td>6 (9)</td>
<td>&lt;5 (&lt;5)</td>
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</table>

4.10 There has been a decrease in the number of patients who are coded as complex to 39, down from 51 in January. However the average length of stay has increased to 232 days up from 187 in January. The main reason for the increase are patients going through the Guardianship process in West Lothian and work continues with West Lothian Council in addressing this situation.
5 Strategic Developments

5.1 Board members will recall previous discussions on identifying appropriate care solutions for patients who have been experiencing significant delays. Of the 15 patients reported at the November Board meeting, discharge solutions have been found for 9 of the patients.

5.2 In terms of the remaining patients, Midlothian Council are in the process of procuring a facility for the three longest delays, which should be available by October 2011. Of the other 3 patients, 2 are Guardianship cases, which we are working with the relevant Council to progress. The other patient is from outwith Lothian, with progress being made by the relevant health board in providing a local care solution to meet the needs of the patient.

6 National Situation

6.1 Lothian continues to compare well with other NHS Board areas. The latest National data (February) shows Lothian as the 3rd best mainland Health Board. The national average for the number of delays per 100,000 population is 16.6, with Lothian well below that at 9.4. The following table shows each of the 14 NHS area Boards with the number of delays both broken down as a ratio per 100,000 population and the actual number.

<table>
<thead>
<tr>
<th>NHS Board area of treatment</th>
<th>Number of delays per 100,000 population</th>
<th>Number of &gt;5Week delays per 100,000 population</th>
<th>Population</th>
<th>Total</th>
<th>Number outwith the six week discharge planning period</th>
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</tbody>
</table>

7 Impact on Health Inequalities

7.1 As a performance report, it has been confirmed there is no need for an equality and diversity impact assessment to be undertaken as a matter of course.

Allister Short
Strategic Programme Manager
15 March 2011
HEALTHCARE ASSOCIATED INFECTION

1 Purpose of the Report
1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian. The Director of Public Health and Health Policy can assure the Board that everything possible is being done.

2 Recommendations
2.1 The Board is recommended to support the following activities, under the overall direction of the Director of Public Health and Health Policy in delivering the agenda to reduce and manage Healthcare Associated Infection:
   • Maintain enhanced weekly surveillance of Meticillin Resistant Staphylococcus aureus and Meticillin Sensitive Staphylococcus aureus Bacteraemia to target resources for a sustained reduction; continue the roll-out of the Meticillin Resistant Staphylococcus aureus screening programme.
   • Continuing communications to staff, patients and the public about the importance of hand hygiene, increasing the focus on visual communication as advised by the Healthcare Environment Inspectorate.
   • Increased compliance with best practice, as recommended by the Antimicrobial Management Team.
   • Recognise the need for ongoing work to prepare hospitals for announced Healthcare Environment Inspectorate visits and maintain standards in anticipation of unannounced visits.
   • Continued provision of detailed reports to the public, as required by the Scottish Government and outlined in Appendix 1.

3 Summary of the Issues
3.1 Staphylococcus aureus Bacteraemia
There were 23 episodes of Staphylococcus aureus bacteraemia (4 Meticillin Resistant Staphylococcus aureus, 19 Meticillin Sensitive Staphylococcus aureus) recorded in February 2011, compared to 25 episodes (4 Meticillin Resistant Staphylococcus aureus, 21 Meticillin Sensitive Staphylococcus aureus) in January 2011. NHS Lothian’s Health Efficiency Access Treatment target is a 15% reduction based on the 2009/10 figure of 299, making the new target to achieve by March 2011 254 episodes. As of February 2011 there...
have been 298 episodes of Staphylococcus aureus bacteraemia recorded. While it is disappointing we have not achieved the Health Efficiency Access Treatment target of 254 or less in the year 2010/11, the trend shows that Staphylococcus aureus bacteraemia have decreased over the last five year period. We believe the 90 day improvement plan will deliver significant progress by the end of May.

3.1.1 Action plan for Staphylococcus aureus Bacteraemia reduction
A Nurse Consultant from Health Protection Scotland has been spending one day a week at NHS Lothian, working with Infection Control, Clinical Effectiveness and Clinical Teams. She has concentrated on Staphylococcus aureus Bacteraemias data overall, investigating:

Reducing false positive blood cultures:
- Standard Operating Procedure for obtaining blood culture has been written in conjunction with initial users and shared with the Scottish Patient Safety Programme.
- Blood Culture data reviewed and reported through the Healthcare Associated Infection Monthly Report.
- ‘Best in class’ are being asked about process blood culture sampling techniques and asked to assist in rolling out best practice.
- Liberton Hospital is arranging an education roll-out with the assistance of the Infection Control Nurses.
- The Hospital at Night Team has been included in the roll-out.

Improving root cause analysis of Staphylococcus aureus Bacteraemia:
- Health Protection Scotland’s form is being used by clinicians; there is minimal increase in data collected.
- Rapid Staphylococcus aureus Bacteraemia investigations are completed by Infection Control Nurses in all Staphylococcus aureus Bacteraemias in Lothian within 48 hours of diagnosis, with a view to rapid intervention, feedback and improved data.
- The new lead Infection Control Doctor is heading an improvement programme for Root Cause Analysis of Staphylococcus aureus Bacteraemias. As part of improvement programme a Foundation Year 2 medical trainee is undertaking a project involving Root Cause Analysis of Staphylococcus aureus Bacteraemias. The aim is to improve the form for completion, improving data collection and staff understanding of the action required.

Minimising device related Staphylococcus aureus Bacteraemia:
- Continued support for Clinical Effectiveness Scottish Patient Safety Programme bundles implementation and compliance across NHS Lothian.
- Invasive device audits in all areas with >3 Staphylococcus aureus Bacteraemias per annum, continuing weekly in those scoring <80% on initial audit.
- Renal bundles are commencing as a priority.
- Feedback to clinical area device-related Root Cause Analysis figures, linking them to bundle compliance rates and Staphylococcus aureus Bacteraemias.
As well as the above, there is a Chief Nursing Officer directive led by Quality Improvement Scotland Healthcare Associated Infection and Scottish Patient Safety Programme teams to undertake a 90 day rapid improvement cycle programme, to build on the *Staphylococcus aureus* Bacteraemias improvement work already underway for the five Boards who have not achieved their *Staphylococcus aureus* Bacteraemias target. The 90 day rapid improvement cycle is from 15/2/11-15/5/11. Within NHS Lothian the plan for the 90 day improvement cycle is to focus on the front door areas, starting with the Emergency Department in the Royal Infirmary Edinburgh, with a plan to spread to the other admission areas once the process is reliable. The Hospital at Night Team has also signed up to this project and they will have an impact on all areas within the Board. The improvement will focus on three interventions: peripheral Vascular Catheter insertion; implementing best practice for taking blood cultures and reducing the number of cultures taken and number of contaminated samples; improving compliance with hand hygiene using both opportunity and technique.

### 3.2 *Clostridium difficile* Infection

There were 15 episodes of *Clostridium difficile* Infection in patients aged 65 or over in February 2011, compared to 22 episodes in January 2011. As of February 2011, NHS Lothian has recorded 323 episodes of *Clostridium difficile* Infection in patients aged 65 or over. NHS Lothian’s initial Health Efficiency Access Treatment target for *Clostridium difficile* Infection was a minimum 30% reduction by March 2011, with a subsequent reduction to 50% with the new target of 557 episodes to be achieved by March 2011. The annual incidence rate in Scotland is 0.71 cases of *Clostridium difficile* Infection per 1000 total Occupied Bed Days. NHS Lothian’s annual incidence is reported by Health Protection Scotland as just above the national average at 0.74 cases per 1000 total Occupied Bed Days.

### 3.3 Hand Hygiene

NHS Lothian is presently achieving a hand hygiene compliance of 94%, with most staff groups continuing to exceed the national minimum target of 90%. Provision of hand hygiene education and training continues throughout all staff groups and targeted areas for improvement.

### 3.4 Meticillin Resistant *Staphylococcus aureus* National Screening Programme

Since January 2010, NHS Lothian has successfully completed the roll-out of the national screening program to all wards and departments that admit within its remit. The remit covers all elective admissions within Lothian and emergency admissions to the four key areas: Dermatology, Renal, Vascular and Medicine of the Elderly. To date, NHS Lothian has screened over 17,800 patients via the national screening project, in addition to the patients that are screened via established screening practice in departments such as Orthopaedics, Vascular, Renal Burns and Respiratory. The current compliance rate is 95%, with a Meticillin Resistant *Staphylococcus aureus* prevalence of 3.6%.
3.4.1 As of 23/2/11, new minimum standards for Meticillin Resistant *Staphylococcus aureus* screening have been announced by the Scottish Government Health Department. Minimum screening practice across NHS Scotland should take the form of a three question Clinical Risk Assessment that is applied to patients on admission or pre-admission. Those patients who answer positively to any of the three questions will proceed to nasal and perineal swab based screening. This two-stage approach should identify around 10% of patients for nasal/perineal swab-based screening and pre-emptive management. In addition, all patients in five high impact specialties (renal, cardiothoracic, vascular, intensive care and orthopaedics) will be screened as a matter of course using nasal and perineal swabs, given the limitations that exist in identifying all potential Meticillin Resistant *Staphylococcus aureus* positive cases through Clinical Risk Assessment alone where Meticillin Resistant *Staphylococcus aureus* infection would have a high impact on patients’ mortality. All NHS Boards will be asked to ensure local delivery against the operating protocol by end March 2012. Transitional funding will be provided for 2011-2012.

3.5 **Cleaning**
An updated cleaning matrix is in the process of being rolled-out throughout NHS Lothian. During the winter period there has been a higher demand on the service, with an increase in the number of terminal cleans due to the high number of cases of Norovirus. Domestic Services continue to give priority to ensure that beds are available at the earliest opportunity.

3.6 **Antimicrobial Management:**
3.6.1 **Primary Care**
Lothian is a low user of antibiotics compared to other Boards and is improving usage of recommended antibiotics. A prescribing indicator was introduced in 2008/09 to support the *Clostridium difficile* Infection Health Efficiency Access Treatment target. NHS Lothian achieved a 4% seasonal variation in quinolone prescribing in primary care (09/10), meeting the national prescribing indicator target (<5%). The next update of this target will be July 2011.

3.6.2 **Secondary Care**
Empiric Prescribing Indicators - these indicators comprise: compliance with the University Hospitals Division Antibiotic Prescribing Guidelines; documentation of indication in patient case notes; documentation of antibiotic duration in at least 95% of patient therapy audited and are measured in the front door areas of the three major acute sites in Lothian. The indicators demonstrate improving compliance with antimicrobial prescribing policy and recording of indications in patient notes; however, documentation of antimicrobial duration/review date still requires improvement.

3.6.3 **Prescribing Indicators for surgical prophylaxis**
Compliance with surgical prophylaxis prescribing policy and duration of antibiotic prophylaxis less than 24 hours is currently at the target level of 95% for procedures audited in cardiac colorectal vascular, obstetric and orthopaedic surgery.
3.6.4 University Hospitals Division antibiotic usage analysis

Antibiotic prescribing patterns and *Clostridium difficile* Infections: NHS Lothian currently monitors the use of drugs (cephalosporins, co-amoxiclav, quinolones, clindamycin and piperacillin-tazobactam) identified by the Scottish Antimicrobial Prescribing Group as those where use should be restricted due to a high causative association with *Clostridium difficile* Infection. Use of these antibiotics has decreased during the last quarter along with a decrease in rate of *Clostridium difficile* Infection. Antibiotic expenditure: there has been a decrease in total antibiotic expenditure, along with a decrease in expenditure on intravenous antibiotics and antibiotics associated with a high risk of causing *Clostridium difficile* Infection.

3.7 Healthcare Environment Inspectorate

An unannounced Healthcare Environment Inspectorate inspection was carried out at the Western General Hospital on 24/1/11; the report and action plan were published on the NHS Quality Improvement Scotland website on 7/3/11. The following areas were inspected by the Healthcare Environment Inspectorate:

- Acute receiving admissions unit
- Minor injuries unit
- Ward 1 (renal)
- Ward 6 (Breast Surgery)
- Ward 11 (Rheumatology/Dermatology)
- Ward 42/43 (Infectious Diseases)
- Ward 53 (Gastrointestinal)
- Ward 58 (Surgical High Dependency Unit)

There were nine requirements and three recommendations noted in the report, the same as the announced inspection in August 2010. A paper addressing these will come to EMT.

3.8 Norovirus

A point prevalence report is submitted weekly to Health Protection Scotland and published on their website. Within NHS Lothian the first outbreak of Norovirus for 2010-2011 was recorded in the community in September 2010. To date, there have been 94 incidents of gastro-enteritis investigated in NHS Lothian. Of these, Norovirus has been confirmed in 67 (71%) of the incidents by the Virology laboratory. In the remaining 27 (29%) the cause was not identified. This was due to Norovirus not being detected, no samples being received from affected patients or samples having not yet been tested by the laboratory.

3.9 H1N1 Surveillance

Within NHS Lothian the first case of H1N1 for 2010/11 was recorded in October 2010. For the period of 1/10/10-3/3/11, a total of 2,495 patient samples were tested for H1N1. 476 patients (19%) were confirmed positive by Polymerase Chain Reaction at the Virology laboratory. H1N1 numbers peaked in the last week of December 2010, where 179 patient samples were confirmed positive. Between 13/12/2010 and 03/03/2011, 52 patients (11 of whom were non-Lothian residents) were diagnosed with H1N1 whilst in
Lothian Intensive Care or High Dependency Units (30 in Royal Infirmary Edinburgh, 9 in Royal Hospital for Sick Children, 6 in St John’s Hospital, 7 at Western General Hospital). There have been 9 deaths associated with H1N1 (2 in St John’s Hospital and 7 in Royal Infirmary Edinburgh).

4 Impact on Health Inequalities
4.1 Infection with the organisms used as markers for Healthcare Associated Infection is more common in patients with co-morbidities, diabetes and alcohol problems. As these are socio-economically patterned, reducing the burden of Healthcare Associated Infection will reduce the excess burden of avoidable disease in patients from these groups.

5 Resource Implications
5.1 The excess cost of each episode of Staphylococcus aureus Bacteraemia and Clostridium difficile Infection is variable but estimated to be between £4,000 and £15,000. This is contributed to by increased length of stay and additional treatment required.

Fiona Cameron
Head of Service, Infection Control
16 March 2011

List of Appendices
Appendix 1: Healthcare Associated Infection Reporting Template
Healthcare Associated Infection Reporting Template (HAIRT)

Section 1 – Board Wide Issues

This section of the HAIRT covers Board wide infection prevention and control activity and actions. For reports on individual hospitals, please refer to the ‘Healthcare Associated Infection Report Cards’ in Section 2.

A report card summarising Board wide statistics can be found at the end of section 1

Key Healthcare Associated Infection Headlines for March 2011 Report

During February 2011 there were 23 episodes of SAB recorded in NHS Lothian (4 MRSA, 19 MSSA).

There were 15 episodes of CDI in patients aged 65 or over in February 2011.

Staphylococcus aureus (including MRSA)

*Staphylococcus aureus* is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. The most common form of this is Meticillin Sensitive *S. aureus* (MSSA), but the more well known is Meticillin Resistant *S. aureus* (MRSA), which is a specific type of the organism which is resistant to certain antibiotics and is therefore more difficult to treat. More information on these organisms can be obtained from:

S. aureus [www.nhs24.com/content/default.asp?page=s5_4&articleID=346](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=346)

MRSA [www.nhs24.com/content/default.asp?page=s5_4&articleID=252](http://www.nhs24.com/content/default.asp?page=s5_4&articleID=252)

NHS Boards carry out surveillance of *S. aureus* isolated from a Patient's blood sample. These infections are referred to as a *S. aureus* Bacteraemia (SAB). These are a serious form of infection and there is a national target to reduce them. The number of patients with SAB caused by MSSA and MRSA for the Board can be found at the end of Section 1 and for each hospital in Section 2. Information on the national surveillance programme for SAB can be obtained from:


There were 23 episodes of SAB (4 MRSA, 19 MSSA) recorded in February 2011 compared to 25 episodes (4 MRSA, 21 MSSA) in January 2011.

NHS Lothian’s HEAT target is a 15% reduction base on a new target to achieve by March 2011 254 episodes.

As of February 2011 there have been 298 episodes of *Staphylococcus aureus* bacteraemia recorded. Whilst it is disappointing we have not achieved the HEAT Target the trend shows that SAB have decreased over the last 5-year period.
Action plan for *Staphylococcus aureus* Bacteraemia reduction

A Nurse Consultant from Health Protection Scotland has been spending one day per week at NHS Lothian working with Infection Control, Clinical Effectiveness and Clinical Teams. She has concentrated on *Staphylococcus aureus* Bacteraemias data overall, investigating:

Reducing false positive blood cultures:
- Standard Operating Procedure for obtaining blood culture has been written in conjunction with initial users and shared with the Scottish Patient Safety Programme.
- Blood Culture data reviewed and reported through Healthcare Associated Infection Monthly Report.
- ‘Best in class’ are being asked about process blood culture sampling techniques and asked to assist in rolling out best practice
- Liberton Hospital is arranging an education roll-out with the assistance of the Infection Control Nurses.
- The Hospital at Night Team has been included in the roll out.

Improve root cause analysis of *Staphylococcus aureus* Bacteraemia:
- Health Protection Scotland’s form is being used by clinicians; there is minimal increase in data collected.
- Rapid *Staphylococcus aureus* Bacteraemia investigations are completed by Infection Control Nurses in all *Staphylococcus aureus* Bacteraemias in Lothian within 48 hours of diagnosis, with a view to rapid intervention, feedback and improved data.
- The new lead Infection Control Doctor is heading an improvement programme for Root Cause Analysis of *Staphylococcus aureus* Bacteraemias. As part of improvement programme an FY2 medic is undertaking a project involving Root Cause Analysis of SAB. The aim is to improve the form for completion thus improving the data collection and staff understanding of the action required.

Minimised device related *Staphylococcus aureus* Bacteraemia:
- Continued support for Clinical Effectiveness Scottish Patient Safety Programme bundles implementation and compliance across NHS Lothian.
- Invasive device audits in all areas with >3 *Staphylococcus aureus* Bacteraemias per annum, continuing weekly in those scoring <80% on initial audit.
- Renal bundles are commencing as a priority.
- Feedback to clinical area device-related Root Cause Analysis figures, linking them to bundle compliance rates and *Staphylococcus aureus* Bacteraemias.

As well as the above there is a Chief Nursing Officer directive led by QIS HAI and SPSP teams to undertake a 90 day rapid improvement cycle programme to build on the *Staphylococcus aureus* Bacteraemias improvement work already underway for the five boards who have not achieved their SAB target. The 90 day rapid improvement cycle is from 15 February -15 May 2011.

Within NHS Lothian the plan for the 90 day improvement cycle is to focus on the front door aras starting with A&E in the RIE with a plan to spread readily to the other admission areas once the process is reliable. The Hospital at Night Team has also signed up to this project and they will have an impact on all areas within the Board.

The improvement will focus on three interventions:
- PVC insertion
- Implementing best practice for taking blood cultures and reducing the number of cultures taken and number of contaminated samples.
- Improving compliance with hand hygiene using both opportunity and technique.
Clostridium difficile

*Clostridium difficile* is an organism which is responsible for a large number of healthcare associated infections, although it can also cause infections in people who have not had any recent contact with the healthcare system. More information can be obtained from:

[www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx](http://www.nhs.uk/conditions/Clostridium-difficile/Pages/Introduction.aspx)

NHS Boards carry out surveillance of *C. difficile* Infection (CDI), and there is a national target to reduce these. The number of patients with CDI for the Board can be found at the end of section 1 and for each hospital in section 2. Information on the national surveillance programme for CDI can be obtained from:


Lothian initial HEAT target for CDI was a minimum 30% reduction by March 2011 with a subsequent reduction to 50% with the new target of 557 episodes to be achieved by March 2011.

There were 15 episodes of CDI in patients aged 65 or over in February 2011, compared to 22 episodes in January 2011 in patients aged 65 or over. As of February 2011 NHS Lothian has recorded 323 episodes of CDI in patients aged 65 or over.

The annual incidence rate in Scotland is 0.71 cases of CDI per 1000 total Occupied Bed Days (OCBDs). NHS Lothian annual incidence is reported by HPS as just above the national average at 0.74.

Hand Hygiene

Good hand hygiene by staff, patients and visitors is a key way to prevent the spread of infections. More information on the importance of good hand hygiene can be obtained from:

[www.washyourhandsofthem.com/](http://www.washyourhandsofthem.com/)

NHS Boards monitor hand hygiene and ensure a zero tolerance approach to non compliance. The hand hygiene compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national hand hygiene monitoring can be obtained from:

[www.hps.scot.nhs.uk/haiic/ic/nationalhandhygienecampaign.aspx](http://www.hps.scot.nhs.uk/haiic/ic/nationalhandhygienecampaign.aspx)

NHS Lothian is presently achieving a hand hygiene compliance of 94%, with most staff groups continuing to exceed the national minimum target of 90%.

Provision of hand hygiene education and training continues throughout all staff groups and targeted areas for improvement.
Cleaning and the Healthcare Environment

Keeping the healthcare environment clean is essential to prevent the spread of infections. NHS Boards monitor the cleanliness of hospitals and there is a national target to maintain compliance with standards above 90%. The cleaning compliance score for the Board can be found at the end of section 1 and for each hospital in section 2. Information on national cleanliness compliance monitoring can be obtained from:

www.hfs.scot.nhs.uk/online-services/publications/hai/

Healthcare environment standards are also independently inspected by the Healthcare Environment Inspectorate. More details can be obtained from:

www.nhshealthquality.org/nhsqis/6710.140.1366.html

An unannounced HEI Inspection was carried out at the Western General Hospital on 24 January 2011. The report and action plan was published on the HEI website on 7 March 2011.

The following areas were inspected by the HEI
- Acute receiving admissions unit
- Minor injuries unit
- Ward 1 (renal)
- Ward 6 (Breast Surgery)
- Ward 11 (Rheumatology/Dermatology)
- Ward 42/43 (Infectious Diseases)
- Ward 53 (Gastrointestinal)
- Ward 58 (Surgical High Dependency Unit (HDU))

There were nine requirements and three recommendations noted in the report which is the same number as the announced inspection in August 2010.

Outbreaks

Norovirus

A point prevalence report is submitted weekly to Health Protection Scotland and published on their website. Within NHS Lothian the first case of Norovirus outbreak for season 2010-2011 was recorded in the community during September 2010.

To date there have been 94 incidents of gastro-enteritis investigated in NHS Lothian. Of these, Norovirus has been confirmed in 67 (71%) of the incidents by the Virology laboratory. In the remaining 27 (29%) the cause was not identified. This was due to Norovirus not being detected or no samples received from affected patients or samples not yet tested by the laboratory.

H1N1 Surveillance

Within NHS Lothian the first case of Influenza A H1N1 for season 2010/11 was recorded in October 2010. For the period of 1st of October 2010 to 3rd of March 2011, a total of 2,495 patient samples were tested for Influenza A H1N1 and 476 patients (19%) were confirmed positive by Polymerase Chain Reaction (PCR) at the Virology Laboratory, Royal Infirmary of Edinburgh. Influenza A H1N1 numbers peaked in the last week of December 2010, where 179 patient samples were confirmed positive. Between 13/12/2010 and 03/03/2011, 52 patients (11 of whom non-Lothian residents) were diagnosed with influenza A H1N1 whilst in Lothian hospital ITU or HDU units (30 in RIE, 9 in RHSC, 6 in SJH, and 7 at WGH). There have been 9 deaths associated with H1N1, 2 in SJH and 7 in RIE.

Table 1: NHS Lothian Flu cases – updated to week 01 (2011)
Year 2010-2011

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<th>Influenza B</th>
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<td>24</td>
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<td>20-Feb</td>
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<td>27-Feb</td>
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**Figure 1:** H1N1 activity within NHS Lothian

**NHS Lothian Flu cases from 1 Oct 2010 to 3 March 2011**

Source: ECOSS system and RIE Virology database

**Other HAI Activity**

**Education**

The e-learning package for the Mandatory Update Programme is being reviewed at present in conjunction with LearnPro and the Infection Control team continue with specific face to face training courses as required or on request.
Antimicrobial Management Team (AMT)

Primary Care

Lothian is a low user of antibiotics compared to other Boards and is improving usage of recommended antibiotics.

A prescribing indicator was introduced in 2008/09 to support the CDI HEAT target. NHS Lothian achieved a 4% seasonal variation in quinolone prescribing in primary care (09/10), meeting the national prescribing indicator target (<5%). The next update of this target will be July 2011.

Secondary Care

Empiric Prescribing Indicators:

These indicators comprise a) compliance with the UHD Antibiotic Prescribing Guidelines, b) documentation of indication in patient case notes and c) documentation of antibiotic duration in at least 95% of patient therapy audited and are measured in the front door areas of the three major acute sites in Lothian.

The indicators demonstrate improving compliance with antimicrobial prescribing policy and recording of indications in patient notes however documentation of antimicrobial duration/review date still requires improving.

Prescribing Indicators for surgical prophylaxis:

Compliance with surgical prophylaxis prescribing policy and duration of antibiotic prophylaxis less than 24 hours is currently at the target level of 95% for procedures audited in cardiac colorectal vascular, obstetric and orthopaedic surgery.

UHD antibiotic usage analysis:

i. Antibiotic Prescribing patterns & Clostridium difficile infections

Lothian currently monitors use of drugs (cephalosporins, co-amoxiclav, quinolones, clindamycin & piperacillin-tazobactam) identified by the Scottish Antimicrobial Prescribing Group (SAPG) as those where use should be restricted due to a high causative association with CDI.

Use of these antibiotics has decreased during the last quarter along with a decrease in rate of CDI.

ii. Antibiotic expenditure

There has been a decrease in total antibiotic expenditure along with a decrease in expenditure on intravenous antibiotics and antibiotics associated with a high risk of causing CDI.

MRSA National Screening Programme

Since January 2010 NHS Lothian has successfully completed the roll-out of the national screening program to all wards and departments that admit within its remit. The remit covers all elective admissions within Lothian and emergency admissions to the four key areas: Dermatology, Renal, Vascular and Medicine of the Elderly.

Screening activity: to date, NHS Lothian has screened over 17800 patients via the national screening project, in addition to the patients that are screened via established screening practice in departments such as Orthopaedics, Vascular, Renal Burns and Respiratory. The current compliance rate is 95%, with a MRSA prevalence rate of 3.6%.

As of the 23rd of February, new minimum standards for MRSA screening have been announced by the SGHD.

Minimum screening practice across NHS Scotland should take the form of a three question Clinical Risk Assessment that is applied to patients on admission or pre-admission.
Those patients who answer positively to any of the three questions will proceed to nasal and perineal swab based screening. This two-stage approach should identify around 10% of patients for nasal/perineal swab-based screening and pre-emptive management.

In addition to this all patients in five high impact specialties (renal, cardiothoracic, vascular, intensive care and orthopaedics) be screened as a matter of course using nasal and perineal swabs, given the limitations that exist in identifying all potential MRSA positive cases through CRA alone where MRSA infection would have a high impact on patients mortality.

All NHS Boards will be asked to ensure local delivery against the operating protocol by end March 2012. Transitional funding will be provided for 2011-2012.
NHS Lothian

CDI Nineteen episodes (15 in ≥65 Y) recorded in February 2011.

SAB Twenty-three episodes (4 MRSA & 19 MSSA) recorded in February 2011.

CDI HEAT Target NHS Lothians target is 557 episodes in patients ≥65 years by March 2011. This represents a 50% reduction from 2007-2008 figures. As of February 2011 NHS Lothians has recorded a total of 323 episodes.

SAB HEAT Target NHS Lothians target is 254 episodes by March 2011. This represents a 49% reduction from 2005-2006 figures. As of February 2011 NHS Lothian has recorded a total of 298 episodes.
Quarterly rolling year *Clostridium difficile* Infection Cases in patients aged 65 and over per 1000 total occupied bed days for HEAT Target

<table>
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<th>Target</th>
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*Data for period A10-M11 is incomplete*

Quarterly Rolling Year *Staphylococcus aureus* Bacteraemia Cases for HEAT Target Measurement

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<td>A10 - M11</td>
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*Data for period A10-M11 is incomplete*
Healthcare Associated Infection Reporting Template (HAIRT)

Section 2 – Healthcare Associated Infection Report Cards

The following section is a series of ‘Report Cards’ for the Royal Infirmary of Edinburgh, Western General Hospital, St Johns Hospital, Liberton Hospital, Royal Hospital for Sick Children and the Royal Victoria Hospital. In addition, information is provided for the Community Hospitals in NHS Lothian.

The ‘Report Cards’ report on the number of cases of Clostridium difficile Infection (CDI) and Staphylococcus aureus Bacteraemia (SAB) together with the cleaning compliance.

The information in the report cards is provisional local data, and may differ from the national surveillance reports carried out by Health Protection Scotland and Health Facilities Scotland. The national reports are official statistics which undergo rigorous validation, which means final national figures may differ from those reported here. However, these reports aim to provide more detailed and up to date information on HAI activities at local level than is possible to provide through the national statistics.

Understanding the Report Cards – Infection Case Numbers

CDI and SAB cases are presented for each hospital, broken down by month. Cases of SAB are further broken down into Meticillin Sensitive S. aureus (MSSA) and Meticillin Resistant S. aureus (MRSA). Data are presented as both a graph and a table giving case numbers. More information on these organisms can be found on the NHS24 website:

C. difficile  www.nhs24.com/content/default.asp?page=s5_4&articleID=2139&sectionID=1
S. aureus  www.nhs24.com/content/default.asp?page=s5_4&articleID=346
MRSA  www.nhs24.com/content/default.asp?page=s5_4&articleID=252&sectionID=1

For each acute hospital, the cases per month are those which have been reported as positive from a laboratory report on samples taken more than 48 hours after admission. For the purposes of these reports, positive samples taken from patients within 48 hours of admission will be considered to be confirmation that the infection was contracted prior to hospital admission and will be shown in the “out of hospital” report card.

Understanding the Report Cards – Hand Hygiene Compliance

NHS Lothian does not have data Hand Hygiene Compliance data for individual hospitals. Please see the NHS Lothian summary in Section 1 – Board Wide Issues.

Understanding the Report Cards – Cleaning Compliance

Hospitals strive to keep the care environment as clean as possible. This is monitored through cleaning compliance audits. More information on how hospitals carry out these audits can be found on the Health Facilities Scotland website www.hfs.scot.nhs.uk/online-services/publications/hai/. The first page of each hospital Report Card gives the hospitals cleaning compliance percentage in both graph and table form.

Understanding the Report Cards – ‘Out of Hospital Infections’

CDI and SAB cases are all associated with being treated in hospitals. However, this is not the only place a patient may contract an infection. This total will also include infection from community sources such as GP surgeries, hospices and care homes.

The final ‘Report Card’ report in this section covers ‘Out of Hospital Infections’ and reports on SAB and CDI cases reported to a Health Board which are not attributable to a hospital. Given the complex variety of sources for these infections it is not possible to break this data down in any more detail.
CDI During February 2011 there were four episodes recorded, a decrease of twelve compared to January.

SAB There were two episodes (>48 h after admission) recorded during February (0 MRSA & 2 MSSA), which is a decrease of eight compared to January 2011.
CDI: During February 2011 there were four episodes recorded, a decrease of two compared to January.

SAB: There were five episodes (>48 h after admission) recorded during February 2011 (0 MRSA & 5 MSSA), which is an increase of four compared to January.
CDI During February 2011 there was one episode recorded, a decrease of one compared to January.

SAB There were no episodes (>48h after admission) recorded in February 2011 (0 MRSA & 0 MSSA), same as January.

Clostridium difficile Infection

MSSA Bacteraemia

MRSA Bacteraemia

Hand Hygiene Compliance

Cleaning Compliance
Liberton Hospital

**CDI** During February 2011 there were two episodes recorded, an increase of one compared to January.

**SAB** There were two episodes (>48 h after admission) recorded in February 2011 (1 MRSA & 1 MSSA), same as January.

**Clostridium difficile** Infection

![Graph showing Clostridium difficile Infection](image)

**MSSA Bacteraemia**

![Graph showing MSSA Bacteraemia](image)

<table>
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<th>A-10</th>
<th>M-10</th>
<th>J-10</th>
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**MRSA Bacteraemia**

![Graph showing MRSA Bacteraemia](image)

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**Hand Hygiene Compliance**

![Graph showing Hand Hygiene Compliance](image)

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**Cleaning Compliance**

![Graph showing Cleaning Compliance](image)

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<td>95%</td>
<td>97%</td>
<td>na</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Royal Hospital for Sick Children

CDI During February 2011 there were no episodes recorded.

SAB There were no episode (>48 h after admission) recorded in February 2011 (0 MRSA & 0 MSSA), same as January.
CDI During February 2011 there were no episodes recorded, a decrease of two compared to January.

SAB There were no episode (>48 h after admission) recorded in February 2011 (0 MRSA & 0 MSSA), a decrease of two compared to January.
CDI During February 2011 there were three episodes recorded, this is an increase of three compared to January.

SAB There were no episodes recorded in February 2011 (0 MRSA & 0 MSSA), same as January.
Out of Hospital Infections

CDI During February 2011 there were five episodes recorded, a decrease of one compared to January.

SAB There were fourteen episodes (>48 h after admission) recorded in February 2011 (3 MRSA & 11 MSSA), this is an increase of four compared to January.
3.2 EMT colleagues and the NHS Lothian Board are being asked to agree the content of this submission which has focused predominantly on positive aspects of the improvement work done in Lothian.
5 Resource Implications

5.1 There are no specific resource implications as a direct result of this submission. One of the key themes throughout the proposed submission is the importance of maximising resources and ensuring added value.

Alex McMahon
Acting Director of Strategic Planning
10 March 2011

List of Appendices:

Appendix 1: NHS Lothian proposed submission
Appendix 2: Commission on the future delivery of public services – call for evidence
Dear Professor Christie

FUTURE DELIVERY OF PUBLIC SERVICES

Thank you for asking NHS Lothian to provide a written submission to the review which you are chairing on behalf of the Scottish Government.

The response below has taken on board the views of senior colleagues within NHS Lothian and builds on the work that is already well established within our organisation.

In developing this response we have paid particular attention to the improvement / good practice opportunities that the review has sought information on. At the same time we have offered comments in respect of the wider issues that this review offers.

We note the particular questions that the Commission wishes to focus on as part of the review and would wish public bodies such as NHS Lothian to reflect on in responding. Within our response, we highlight each of these issues:

- our experiences of the operation of public services;
- examples of projects, services, innovations or improvement work, including evaluations or assessments, which may be relevant to the work of the Commission;
- our views on the obstacles to and opportunities for improvement; and
- our views on the options for the future.

I hope this information is helpful and we look forward to seeing your final report.

Yours sincerely

PROFESSOR JAMES BARBOUR OBE
Chief Executive
Experiences of the operation of public services

In respect of this particular question it might help the Commission to understand the full scope of the work that NHS Lothian undertakes for the population that it covers and the challenges that it has to meet, together with the changes that have been delivered.

About NHS Lothian:
- We provide healthcare for around 850,000 people and it is predicted that the growth in this population will increase by at least 10% over the next 10 to 20 years. The rate of growth is thought to be amongst the highest in the country.
- We are Lothian’s biggest employer with around 28,000 staff and are major contributors to the local economy. We employ some 10,500 nurses, almost 1,900 hospital doctors and just over 2,000 allied health professionals (such as physiotherapists) amongst other groups of staff.
- We provide care in 20 hospitals and over 300 Health/Medical Centres.
- In any one year, there are more than 4.4 million patient contacts across all of NHS Lothian, with more than 90% of them in primary and community settings.
- The Royal Infirmary of Edinburgh is Scotland’s busiest accident and emergency department, seeing approximately 9,000 people a month.
- In 2008/09 there were 77,500 emergency inpatients, 60,000 day cases and 31,500 elective inpatients across NHS Lothian.
- NHS Lothian has an annual budget of circa £1.4 billion, almost half of which is spent on staff costs.
- There are around 600 WTE GPs working in 126 GP practices across Lothian.
- We provide some services to the south east of Scotland, e.g. cancer services, plastic surgery, specialist cardiology services and mental health services.
- We provide some specialist health care for patients from all over Scotland, e.g. liver transplantation and paediatric scoliosis.
- We are still committed to a significant capital investment programme but like other public bodies are now working through the options based on a much reduced capital allocation from the Scottish Government.

We are ambitious for NHS Lothian and the people who we provide healthcare to. Part of our vision for the future is to be one of the world’s leading healthcare organisations and we are already making a very good start as is evidenced in our performance throughout 2010/11, outlined later in the document. Our work in being amongst the world’s leading healthcare providers is also progressing and we are using this to help us to benchmark
and look to others for ways we can learn from the improvements that they have made in areas such as coronary heart disease, cancer treatment, stroke and other aspects of managing physical health care. In relation to cardiology we have just commenced a programme of work with international partners from Australia, Hong Kong and Singapore. We would hope that we can not only learn from but also benchmark well against other leading healthcare providers across the globe and implement any positive changes locally.

We have to look forward to make sure our services remain fit for purpose and meet the needs of the future population. We recognise that we must do this in consultation with members of the public and, importantly, with our staff and our trade unions through our strong Partnership Forum. These groups are vital to making change happen. Indeed we recently started a process of engagement with patients and the public under the ‘public value’ banner and we report some of the positive outputs from that event later in our response.

Our staff are one of our key attributes and we need to support them in order that we can strive to be one of the world’s best and best in class in Scotland. We look to do this through education and training alongside needs identified through Personal Development Plan’s and objectives. We have also invested significantly in change methodologies and in leadership programmes; these are highlighted later in the response.

We use our annual ‘Planning for the Future’ event each April (May this year) to reflect on our achievements over the previous year and outline our vision for the future. This event, attended by our top managers and clinical leaders helps to cascade the leadership vision throughout the organisation to each and every member of staff, allowing everyone equal opportunity to find out more about the importance of their role within the wider NHS Lothian context.

NHS Lothian is already making good progress in the areas of waiting times for treatment for inpatients and day cases but also for areas such as cancer treatment, something that we know is very important to the public. As well as the Scottish Government HEAT targets, we continue to set ourselves ambitious local targets in areas such as mental health, learning disability, Child and Adolescent Mental Health Services, and drug treatment services. Indeed in relation to mental health targets, NHS Lothian is at the forefront in Scotland. Moving forward we would wish to ensure that people get the right care at the right time but there will be challenges, both financial and capacity. We, along with other Boards will be looking to develop a discussion on these, post the outcome of the General Election on 5 May.
We continue to look for opportunities to drive the ‘shifting the balance of care’ agenda forward and in particular how we work with primary care and local authorities. The recent development of the top slicing of the health budget to develop a transformation fund for older people is welcome, but like any reduction in budgets we need to, as guardians of the public budget, ensure that we and our community planning partners can evidence that we are adding value. There is a strong focus here on ensuring that we can reduce the rate at which elderly people are admitted to hospital or that the number of admissions is reduced. Equally we want to see the continued reduction in the number of people delayed in hospital. NHS Lothian has made significant progress over the last five years to reduce the number of people delayed in hospital. This, at a time when other partnerships are struggling to keep this momentum, should be recognised. There will be challenges but the creation of the Change Fund will enable us to develop a community infrastructure that will support early discharge and where possible the avoidance of a hospital admission. We will work towards these ambitions whilst at the same time recognise that as the demographic shifts take place we will deal with more people who have dementia and also challenging behaviour. One of our ambitions is that we develop a community infrastructure that can support a sense of community and tackle social isolation, a key determinant of having physical and mental well-being.

Partnership working as we move forward will also embrace other areas of our work, such as the shift in the place of death for people. This is a key quality indicator and we are working with health, local authority and hospice providers to ensure that we change the place of death, where appropriate, away from acute hospitals to a domiciliary or hospice setting. Partnership working is also evident through our work on the development of our new sexual health and HIV strategy and also the progress towards the transfer of prison healthcare back to NHS Boards by 1 November 2011. The latter will bring challenges but also opportunities but will mean that the way that public money is used across a number of different agencies i.e. prison service, community justice and local authorities as well as health will have to be maximised. Reduction in substance misusing and its association with criminal activity could pay dividends across different aspects of society but there is a need to flag that the costs of the transfer to Boards will likely bring a financial challenge which was not anticipated. This and other such policy decisions must be borne in mind as we progress with the wider social reform agenda.

In turn this means that never has there been a greater need to have close scrutiny on how we spend public money and ensure value for money. There will be even more challenging times ahead and we have already begun making hard decisions about funding with input and support from all. Work around the Integrated Resource Framework will assist us in how we make decisions about what services need to be redesigned in order to achieve
value for money and ensure better outcomes and improved patient experience. This is work that will involve the whole system as well as our council partners but the broad principles (which are very similar to Total Place) could be used to look at wider approaches to the delivery of public services.

Working in partnership with staff is a strong theme in Lothian, as we value our workforce and are keen to utilise the talent that we have. Ensuring that we gain maximum productivity through a fit, healthy and well supported workforce is important. Through actions at a government level many senior managers have had to take a pay freeze, those on low income have had some support but at a basic level. We in NHS Lothian have now started the process of reviewing the way in which we incentivise and pay for other staff groups. In particular we are looking at work with primary care practitioners as well as hospital based consultants. We do so with an eye to ensure that people’s livelihoods are not taken from them but at the same time we want to maximise productivity and reduce duplication. This at a time when it is reported that productivity is down but costs are up. We are working to ensure that we marry up activity, productivity and costs

NHS Lothian has a corporate responsibility to take every reasonable step to ensure the safety and well-being of our staff. We do this through our commitment as an exemplar employer and our human resources and organisational development strategy, but also by complying with health and safety legislation. We are committed to achieving Investor in People status, which we aim to achieve for the whole organisation by the end of March this year.

As an organisation we are committed to ensuring that we grow and retain the best talent that there is. 2009/10 saw the launch of the 5x5x5 concept in NHS Lothian. This involves five teams of five people covering five different themes. Each team challenges us in relation to our performance in key areas by looking at best national and international evidence and comparators and putting forward a business case for change. We are now in the second year of this development and already there have been benefits from the work of the first cohort, e.g. through the implementation of recommendations for how to look after people who have had strokes, or older people who have had the need for orthopaedic work done, as well as the whole agenda around patient safety and quality of care. Work in the 2010/11 programmes are focusing on how we maximize the use of our theatres, better referral management from GPs to secondary care, patient experience, looking after vulnerable people in acute care and tackling health inequalities.

Ensuring that we deliver quality care is paramount and we believe in NHS Lothian that we can not only evidence this but we can also show that we are a cost effective organisation.
Recent evidence shows that we benchmark well across the UK, and within a Scottish context we can show that we deliver more for the money that we are allocated.

Primary care is a key area for development as this is where most people will come into and have contact with the NHS.

**Key points:**
- GPs across Lothian continue to deliver an excellent service to patients
- Patients value the ability to see their doctors outside core hours (extended hours)
- GPs continue to perform well against the Quality and Outcomes Framework of the new GP contract
- The new GP contract continues to improve care for patients
- At the same time no area is exempt from the need to deliver efficiencies and we have begun a positive dialogue with primary care contractors about possible areas for redesign; invest to save and financial efficiency.

GP Access - Since 2004, Lothian has demonstrated 100% (practice self-reported) compliance with 48-hour access to an appropriate healthcare professional.

Patient Satisfaction - Patient feedback in relation to their satisfaction with GP services for Lothian practices has consistently demonstrated a high level of satisfaction for most practices. In 2009/10 a new national GP survey was implemented as part of the Better Together Patient Experience Programme. In addition to the access questions patients were asked to rate practice performance against a wide range of measures including, for example, interaction with receptionists, confidentiality issues, whether the doctor or nurse listens and involves patients in their care, medicines management, etc.

GP Extended Hours - 65% of GP practices in Lothian are currently participating in an enhanced service to extend opening times outwith core contractual hours, i.e. 07.00-08.00 and 18.00-20.00 Monday - Friday, and Saturday mornings. This is to provide additional capacity for patients requesting pre-booked appointments. Evaluation data indicates the service is highly valued by patients.

Anticipatory Care - A number of services associated with anticipatory care have been introduced, including 117 care homes (c. 5,000 beds) linked to an indentified lead GP practice. Ongoing evaluation data indicates a significant reduction in emergency admissions from care homes and a questionnaire sent to care home managers confirmed a high level of satisfaction with the new arrangements. The Keep Well project has been delivering anticipatory care through 14 practices in Edinburgh since 2006 and has recently
been extended to West Lothian CHCP. We are committed to ensuring that learning from this initiative is embedded across the whole of NHS Lothian. It will support the development of inequalities targeted anticipatory care in all practices from 2011. Scottish Government has indicated that the Keep Well programme will be further extended from 2011/12.

- Examples of projects, services, innovations or improvement work, including evaluations or assessments, which may be relevant to the work of the Commission

- How best can our public services achieve positive outcomes for and with the people of Scotland?

NHS Lothian has for many years now invested in and used the LEAN change methodology to support improvements locally. We have trained almost 300 staff on the use of this methodology and this in turn has meant that we have developed a workforce that understands change methodology but also means that we have limited, indeed almost eradicated the need for external change managers needing to be employed to support our work. To date, we estimate the LEAN programme has saved in the region of £6m, which has in turn been redirected into other areas of care.

The LEAN work has been applied in many areas from acute care, primary care, working with children and older people and has over recent years also involved partnerships such as local authority teams participating in change programmes. Currently there is a strong emphasis on pathway work, focusing on older people in areas such as geriatric orthopaedic care, stroke, and general medicine of the elderly and dementia and delirium. These work programmes are already showing how we can reduce variation across our system and within wards and teams. We are seeing the reduction in the length of stay that patients need to have and at the same time staff are now much more aware of the needs for patients, particularly the care of people with dementia or delirium who might be admitted to hospital and the diagnosis is not known. By identifying symptoms, patients and indeed their families can be supported but at the same time it means that staff can actually respond much more effectively to the needs of patients and use the appropriate interventions in doing so.

In the orthopaedic work we have started to see a reduction of 20 days in the average length of stay. This has allowed us to start the process of closing a ward and considering the closure of another but putting the infrastructure into the community to support people
to go straight home, rather than having multiple moves within hospital settings. This is efficient, productive and also meets good standards of care and enhanced patient experience.

We have already made reference to the work that we are taking forward through the 5x5x5 initiative. As well as this we are also in the first year of our work in developing a leadership programme with Harvard and Napier Universities. This will not only lead to a Masters level qualification for the staff that participate in it but it will also ensure that every dissertation that is produced will have direct payback to the organisation as each focuses on an aspect of their day to day work which, through this programme, will allow them to develop their thinking on how best to deliver a change or introduce an innovation which will deliver tangible benefits and financial efficiencies.

Staff development is paramount but at the same time we recognise, as has been stated already, that there is an absolute need for robust dialogue with the people of Scotland and particularly Lothian. In many ways this is the only way that we will have absolute confidence that the outcomes that we strive to deliver have been informed by input through public/patient participation. To that extent we work very closely with the Scottish Health Council but also through our local patient public forums. Recently we undertook an exercise re ‘public values’. That was very enlightening. It showed that not only were the public positive about being engaged about service redesign, they were also positive about efficiencies and savings that will require to be made as the public finances get ever tighter. Areas for consideration re potential effectiveness & efficiency included:

- Recycling – all aspects but including unused drugs
- Transport – working with Scottish Ambulance Service but also with other public sector providers such as local authorities
- Reducing variation in practice
- Single Clinical Assessment
- Focus on rehabilitation to prevent readmission
- Increasing accessibility of Board papers
- Inclusion of socio-economic impact in Impact evaluations
- New Ways of Working in a radical way
- With Royal Hospital for Sick Children Family Council (with invites to this group) to focus on paediatric issues
- Patients Council at the Royal Edinburgh Hospital and the development of new services for those with mental illness
There is however a challenge that needs to be reflected here, which is although we welcome the engagement with the public we also appreciate that certain groups will bring ‘their’ agenda to the table. Ultimately it will be for Boards to find a robust mechanism for ensuring what is funded and what services can be delivered and where but this must be done through the use of evidence and information. Within Lothian we have a process for agreeing how ‘new’ services or new developments will be supported, through the NHS in Lothian Planning Group. Alongside this, we are developing a ‘Clinical Strategy’ which will help inform the public and the staff in Lothian about what we think the priorities are that we need to invest in over the next five years and beyond. This will be work that we will take forward over the next three to four months, and which will allow time for the outcome of the election and the building in of any new policies or financial considerations to take place.

- **How best can wider organisational arrangements (including functions, structures, and processes) support and enable the delivery of effective services?**

Overall from the perspective of NHS we need to focus on:

1. Being clear about value added of all our activities, with a greater focus on clear understanding of what we need to achieve at all levels:
   - **Board** policy and strategy outcomes, alongside financial probity, patient safety and quality of care
   - **Managers** understanding the demand/need for services and understanding the resources they have to deliver.
   - **Front-line staff** understanding the tasks they are expected to achieve and the processes they should use to do so reliably and efficiently.

2. Linked to this, greater management focus on the processes of service delivery, using improvement science and data for performance management and improvement. We need to understand variance and where this needs to be reduced. An example of this is the use of pathways – standard pathways which allow all to receive high quality evidence based care, with monitoring of cases to identify those who are not progressing as expected on pathway, so that more specialised individual plans can be initiated when required.

3. Value added to patients/public of all new ideas, initiatives, policies to be critically assessed before implementation, and consideration given to what resource will be required to implement, monitor effectiveness, and importantly what impact this will
have for the tasks already being undertaken by front line staff. There is currently a steady and incremental addition of systems, processes and tasks which, though small in themselves, steadily complicate and re-focus the roles of staff, with potential to lead to duplication of effort, errors, inefficiency and devaluation of the service to the public.

Focus on doing less better, getting the basics right, and reducing/eliminating bureaucracy – we should always challenge ‘why?’ and ‘what value is being added?’ when asked to do something extra by “the system”.

At the same time staff at all levels across the NHS have to accept a level of responsibility for not just delivering within agreed budgets but also for ensuring that the quality of care that we deliver can be the very best that they can deliver and they should tackle and address poor practice and not just assume that others will, it’s the responsibility of all to eradicate poor clinical and managerial practice.

- **What shared values and ethos should underpin Scotland’s public services and how best can they be embedded in the delivery of public services in the future?**

  **Shared Values and Ethos:**
  - Focus on patient/public and their needs – addressing equality and diversity strands and ensuring that services work to reduce health inequalities
  - Mutual respect and responsibilities/rights
  - That staff are employed to do the job to the best of their ability – come to work – contribute positive ideas for improvement and at the same time sickness absence is tackled effectively
  - Continuous improvement – striving for perfection – this should be part of everyone’s day job
  - Back to traditional values of public service but ensuring value for money and quality of care

- **Views on the obstacles to and opportunities for improvement**

  **Opportunities for the future:**
  - Clear lines of accountability. Every manager in the public sector needs to be clear about their area of influence and also the budgets that they manage. They should be supported in delivering change but at the same time there is a need for accountability to be reinforced.
- Delegated authority to lowest possible level but with an understanding of what the organisation’s aspirations are, alongside those of the government.
- Harness skills, knowledge, and enthusiasm of staff by involving/empowering and here we would again emphasise the work that we are doing through 5x5x5 and the Harvard Napier Leadership Programme.
- Managers and clinicians as leaders and champions of improvement and change.
- Engaging with the public on decision making – validate professional/managerial/organisational perspective.
- Better integration of activity for planning joint services
- Tackle social isolation
- Provide the best possible start in life and provide support at transition points in people’s life stages.
- Better integration and ways of working with community planning partners, particularly local authorities and the 3rd sector and also with volunteers and carers.

• Views on the options for the future

Obstacles:
- Too many new initiatives. We need a period of stability in relation to the number of ‘targets’ and new initiatives which are centrally driven but have no long term funding or support. We need to focus on the work that needs to be done and through using processes such as LEAN and the 5x5x5, Napier Harvard programme and patient public engagement look for redesign or invest to save opportunities, which if locally developed are more likely to be owned locally.
- NHS Boards need to have autonomy. Unlike other public bodies the level of accountability that we have as well as the performance reporting does, on many occasions, stand in the way of progress. This is linked to the comments on new initiatives, timescales for consulting and influencing the way that policy is developed.
- Too much data collection, not enough use of information. This is a culture that has to be turned around and does relate to the point above. We need to understand baselines better as well as maximizing our capacity, workforce and money. We need to know where we want to get to over a period of time and we have to be clear about how we will measure success, based on agreed definitions and sources. Again the work locally in Lothian around the development of the IRF and the work on pathways are good examples of how we can do that within health but also with other public sector partners.
- Too much fire-fighting not enough forward planning. This culture should change with a focus on shifting the balance of care; better use of baselines and data to measure progress against but also a better understanding of what care and treatment should be
delivered where, by whom and when. This is an agenda which is being progressed in many areas but particularly around older people, people with mental illness, learning disabilities, early years and areas such as looked after and accommodated children.

- At the same time there is the need for planning at a national government level to be reviewed in light of the financial constraints but also the pressure on delivering the current policy agenda within an ever decreasing budget. As a minimum we would want to see the process for agreeing any new policy reviewed as well as the timescales. On occasion policy is decided with minimal opportunity for full debate. This needs to be reviewed moving forward.

- Not an obstacle at present but there clearly is a need to look at the structure and focus of public bodies that exist within a country with a population as small as Scotland. Geography and local communities are important but there must be the scope to reduce the number of bodies and in turn create greater efficiencies for the use of public money and also in driving better efficiency and productivity. We would emphasise the need to look at value added and improved efficiency as well as driving safety and quality of care, which has been on the whole the approach that we have tried to take in providing the evidence within this response to the Commission. We believe that within Lothian we are leading the rest of Scotland in respect of progressing partnership working through the establishment of our single system working, which means that we have better integration and management within health. As well as this the work that we have done with West Lothian, where we have created a CHCP and appointed a Joint Director. Alongside this we have also appointed a Joint Director for Health and Social Care with Edinburgh Council. Work is currently progressing with East and Midlothian Councils and we are encouraged by the work that both councils are doing to move towards one joint social care directorate. If this were to be achieved we would be interested in bringing this together with one CHP and create a CHCP. We believe that these are not only efficient ways of working but also show progressive partnership working with other public sector bodies.

- Co-production is a key theme and it is one that can be used for the way in which we work with partnerships, not just patients or the third sector. We should look to maximise the contribution that others can bring to the health and wellbeing of the people of Scotland. Another good example is the use of volunteers within the NHS. We know that they make a significant contribution in the areas where they are active but we need to look to how we would strategically see areas where historically it has been harder to engage volunteers and see where we can address this.

- We need to utilise expertise and groups to maximise our planning potential and delivery of better outcomes. For example, the national planning forum includes the Directors of Planning from all the NHS Boards, with input from the Scottish Government and other agencies such as the Health Technology Board. Recently this
Forum commissioned a review of an intervention for patients suffering from a heart condition and who might need a new procedure called a Trans Aortic Value Implant (TAVI). This is not available in Scotland and the evidence as it stands shows that the outcomes are not significant and the costs would not indicate value for money. The important point here is that this was a national review which was then endorsed by the Planning Forum and provided to Chief Executives to support. This is not about denying patients new procedures, indeed the emphasis is on, if and when better outcomes are available and financial value has improved, we will recommend we undertake this. Equally the review of national managed clinical networks is another opportunity for us to collectively look at entities that we set up in the last ten years and objectively review whether we need such systems. If we do, fine but if not, and we feel that the work is now embedded in the systems or is no longer required we can disinvest and re-invest in other areas where we can maximise the funding.

- Tackling culture change in the use of public services. We need to get people to stop using Accident and Emergency as a minor injuries department or as an alternative to their GP. This will take time but a change in policy direction and also an agreement on ‘what A&E is’ would be advantageous.

Summary:

- We welcome the review.
- We think that there is a need to reduce the number of organisations within all aspects of the public sector but are not clear at this time what those reductions should be as more work would require to be done but we would be willing participants in such discussions.
- Regardless of the outcome of the point above we feel well placed in NHS Lothian to cope with change due to the work that we have done though our regional and local planning but also in our improvement work.
- Applying LEAN and other improvement methodologies to the delivery of care is important and can help maximise benefits.
- We welcome wider partnership approaches and would flag the work on older people and the change fund as well as the use of the IRF and the forthcoming work on prison healthcare as good examples of such work moving forward.
- We need to challenge every assumption about each pound that is spent and we need to look for and maximise productivity.
- Patients, the public and staff must be central to everything that we do so engagement is a key to success.
COMMISSION ON THE
FUTURE DELIVERY OF PUBLIC SERVICES
CALL FOR EVIDENCE

Introduction

1. This is an invitation to submit evidence to the Commission on the Future Delivery of Public Services. The Commission has been established by the Scottish Government to develop recommendations for the future delivery of public services.

2. The Commission is chaired by Dr Campbell Christie CBE; its membership and a broad timescale for its work are attached at Annex A. The remit of the Commission is attached at Annex B. The work of the Commission will be taken forward independently of Government. It has been asked to report by June 2011.

3. The Commission sees its work as being to produce a ‘road map’ for the future reform of public service delivery in Scotland. It hopes that its recommendations will inform work to reform public service delivery in Scotland over the coming 5 to 10 years. The ultimate goal is to achieve the vision for public service delivery set out in the Commission’s remit. To support this, the Commission wants to ensure that its recommendations are founded on evidence, and on the experiences and understanding of users and providers of public services in Scotland.

4. The Commission recognises the contribution made by the Independent Budget Review (IBR). Its work will be informed by submissions to that process, and by the call made in the IBR report for a long-term strategic framework for reform of public services (see Chapter 7, “Shaping the Future”).

Questions for the submission of evidence

5. In fulfilling its remit, the Commission wishes to address three broad questions:
   • how best can our public services achieve positive outcomes for and with the people of Scotland?
   • how best can wider organisational arrangements (including functions, structures and processes) support and enable the delivery of effective services?
   • what shared values and ethos should underpin Scotland public services, and how best can they be embedded in the delivery of public services in the future?

6. The Commission invites respondents to consider these questions, and to tell them about:
   • their experiences of the operation of public services;
   • examples of projects, services, innovations or improvement work, including evaluations or assessments, which may be relevant to the work of the Commission;
   • their views on the obstacles to and opportunities for improvement;
   • their views on the options for the future.
7. To give an indication of the scope of its work, the Commission has identified an initial set of issues it considers likely to arise; this is attached at Annex C. Respondents may wish to consider this list of issues in preparing their response, but should not be constrained by it.

Submitting evidence

8. To allow the Commission to explore the evidence submitted and focus its work on key themes, responses are invited by 31 January 2011. If it is not possible to meet this date, the Commission will be prepared to receive evidence until the end of March.

9. Respondents are asked to complete the response sheet at Annex D and submit it alongside their response to this Call for Evidence.

10. Where respondents have already addressed relevant matters in their responses to the Independent Budget Review, they may wish to refer to those responses, and add any further comments they consider relevant to this Commission’s work and to the questions set out above.

11. In addition to this general Call for Evidence, the Commission will be seeking evidence directly from a range of individuals and organisations it considers to have a specific contribution to make to the Commission's work, including those currently engaged in significant work to reform public services.

12. As indicated in the timescale attached (see Annex A), the Commission intends to hold a number of discussion events in February and March of next year, to enable a more in-depth investigation of the issues raised in the evidence submissions. Further information on these events will be provided in due course on the Commission’s website.

13. Thank you for your interest in the work of the Commission.
The membership of the Commission is as follows:

- **Dr Campbell Christie CBE**, Former General Secretary of the STUC, President of Scottish Council for Development and Industry since December 2009 (Chair)
- **Dr Alison Elliot OBE**, Convener, SCVO, and former Moderator of the General Assembly of the Church of Scotland
- **Dr Roger Gibbins**, Chief Executive of NHS Highland from April 2000 until 31 December 2010. Former local authority Director of Social Services
- **Alex Linkston CBE**, Recently retired Chief Executive, West Lothian Council. Pioneer of EFQM-based performance improvement, community planning and single outcome agreements
- **Kaliani Lyle**, Scotland Commissioner of the Equality and Human Rights Commission, former Chief Executive of Citizens Advice Scotland and former Chief Executive of the Scottish Refugee Council
- **Jim McColl OBE**, Chairman and Chief Executive Clyde Blowers, Chairman of Glasgow Works and member of the Scottish Government's Council of Economic Advisers
- **Professor James Mitchell**, School of Government and Public Policy, University of Strathclyde, and published widely on multi-level government, devolution and public policy
- **Eddie Reilly**, former Scottish Secretary of the Public and Commercial Services Union and former member of the General Council of the STUC
- **Dr Ruth Wishart**, Journalist and broadcaster and Member of the Board of Creative Scotland

The broad timescale for the Commission’s work is as follows:

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<thead>
<tr>
<th>Event</th>
<th>Date</th>
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<tbody>
<tr>
<td>Announcement of remit and membership</td>
<td>19 November 2010</td>
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<tr>
<td>First meeting</td>
<td>30 November 2010</td>
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<tr>
<td>Second meeting</td>
<td>13 December 2010</td>
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<tr>
<td>Issue of Call for Evidence</td>
<td>14 December 2010</td>
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<tr>
<td>Date by which responses are requested</td>
<td>31 January 2011</td>
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<tr>
<td>Discussion events</td>
<td>February-March 2011</td>
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<tr>
<td>Development of recommendations</td>
<td>April-June 2011</td>
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<td>Publication of report</td>
<td>By end of June 2011</td>
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The **remit** given to the Commission by the Scottish Government is as follows:

Facing the most serious budget reductions for at least a generation, there is an urgent need to ensure the sustainability of Scotland's public services. At the same time we must continue to improve outcomes for the people of Scotland: by driving up the quality of services (so the average meet the standards of the best); and by redesigning services around the needs of citizens, tackling the underlying causes of those needs as well as the symptoms.

We are ambitious for Scotland's public services and wish to take them from good to excellent in every facet and in every place. We have a vision of Scotland's public services that:

- are innovative, seamless and responsive, designed around users' needs, continuously improving;
- are democratically accountable to the people of Scotland at both national and local levels;
- are delivered in partnership, involving local communities, their democratic representatives, and the third sector;
- tackle causes as well as symptoms;
- support a fair and equal society;
- protect the most vulnerable in our society;
- are person-centred, reliable and consistent;
- are easy to navigate and access;
- are appropriate to local circumstances, without inexplicable variation;
- are designed and delivered close to the customer wherever possible, always high quality;
- respond effectively to increasing demographic pressures;
- include accessible digital services, that are easy to use and meet current best practice in the digital economy; and
- have governance structures that are accountable, transparent, cost-effective, streamlined and efficient.

The Commission is therefore asked to identify the opportunities and obstacles that will help or hinder progress towards this vision and make recommendations for change that will deliver us to our destination. In particular the Commission is asked to:

- address the role of public services in improving outcomes, what impact they make, and whether this can be done more effectively;
- examine structures, functions and roles, to improve the quality of public service delivery and reduce demand through, for example, early intervention; and
- consider the role of a public service ethos, along with cultural change, engaging public sector workers, users and stakeholders.

The Commission should take a long term view and not be constrained by the current pattern of public service delivery, but should recognise the importance of local communities and the geography and ethos of Scotland as well as the significant direct and indirect contribution the delivery of public services make to Scotland's economy.

It should have clear regard to joint work already underway to take forward the increasing integration of health and social care and to develop sustainable police, fire and rescue services for the future. Updates on work in both areas are expected to be available to the Commission in good time for it to take into account in its recommendations.

The Commission is invited to report with recommendations by the end of June 2011.
ANNEX C: INDICATIVE LIST OF ISSUES

To give an indication of the scope of their work, the Commission has identified an initial list of issues it considers likely to arise – see below. Respondents may wish to consider this list of issues in preparing their response, but should not be constrained by it.

Achieving positive outcomes
- the extent to which public services are successful in achieving outcomes for and with individuals and communities;
- the extent to which public services are efficient and financially sustainable;
- the extent to which individuals and communities are supported, empowered and involved in the design of services;
- the extent to which services help prevent future problems;
- the extent to which services are able to support individuals and families with multiple and complex needs;
- the extent to which innovations in public services have proved successful, and the extent to which that success may be replicated;
- the effectiveness of varying models for the delivery of public services;

Supporting delivery
- the longer-term challenges facing the delivery of public services, and their implications for the sustainability of public services;
- the effectiveness of processes by which services are designed, commissioned and managed, including the effectiveness of partnership processes and user involvement;
- the effectiveness of innovative approaches to partnership or other joint working in delivering public services;
- the balance between service provision and individual and community capacity and action;
- the extent to which sectoral and geographical boundaries affect organisations’ ability to deliver effective services;
- the extent to which financial arrangements can help or hinder the achievement of outcomes;
- the effectiveness of the processes through which services and commissioning organisations account to users, the public and their political representatives;
- the interaction between local and national accountability;
- the availability of information about the performance of public services;
- the relationship between public, third sector and private sector delivery;
- the appropriateness of the range of delivery vehicles used;
- the relationship between services in devolved areas and those in reserved areas;
- the role of inspection and scrutiny;
- the capacity of the system to innovate;
- the extent to which efforts to improve or reform public services have been successful;

Values and ethos
- the appropriate role of public services in promoting equality and fairness;
- the extent to which services are effective in supporting the most vulnerable;
- the extent to which services support and empower individuals;
- the nature and value of a ‘public service ethos’.  

5.
COMMISSION ON THE FUTURE DELIVERY OF PUBLIC SERVICES
CALL FOR EVIDENCE: RESPONSE SHEET

Please use this response sheet when submitting evidence to the Commission. It will help us both to organise the many responses received, and to reflect your wishes for how the material is used. It can be completed and returned either electronically or posted back in hard copy.

Please send this coversheet and your submission to the following address:

Commission on the Future Delivery of Public Services, Thistle House, First Floor, 91 Haymarket Terrace, Edinburgh, EH12 5HE.

Or to the following e-mail address:

FDOPSCoission@scotland.gsi.gov.uk

Information required:

Name of organisation or person responding:
_________________________________________________

Contact name (if responding on behalf of an organisation):
_________________________________________________

Address and telephone number:
_________________________________________________
_________________________________________________
_________________________________________________

Disclosure

Evidence and views submitted to the Commission are subject to disclosure under the Freedom of Information Act. If any of the evidence or views submitted are deemed confidential, please clearly mark these sections of the evidence and explain your reasoning; this will be considered in relation to exemptions in the Act. Please note that information marked confidential will not necessarily be exempt from release under the Freedom of Information Act.

Have you submitted any confidential evidence? (Y/N) ____

Are you content for this submission to be published on our website? (Y/N) ____

Would you be content to be approached by the Commission for further discussion on your submission? (Y/N) ____

Thank you for your submission.
LOTHIAN NHS BOARD

Board Meeting
23 March 2011

Acting Director of Strategic Planning

SELF DIRECTED SUPPORT (SCOTLAND) BILL CONSULTATION

1 Purpose of the Report

1.1 The purpose of this report is to seek approval from the Board to submit the attached response on behalf of NHS Lothian to the Scottish Government consultation on Stage 2 of the Self Directed Support (Scotland) Bill.

2 Recommendations

The Board is invited to:

2.1 Approve our response to the Self Directed Support (Scotland) Bill Consultation, attached at Appendix 1

3 Background

3.1 As reported to both the Executive Management Team and the Board of NHS Lothian respectively in May 2010 Self Directed Support enables individuals to purchase and manage for themselves some or all of the care they have been assessed as needing. This is one way of increasing the flexibility, choice, and control people have over the care they receive, enabling them to live more independently in their own home and community and compliments the work of NHS Lothian in regard to Better Together, involving the patient in service design, development and delivery and offers a tool to further improve the patient experience.

3.2 The vast majority of people assessed as being eligible for social care service, have the opportunity to use self directed support as a means of organising their own support. Restrictions regarding the individuals who are eligible for Self Directed Support are detailed in the Self Directed Support (Scotland) Bill Consultation. NHS Lothian is in the process of testing out the application of this tool in test sites within the areas of Complex Care and Long-term Conditions specifically Acquired Brain Injury, Multiple Sclerosis and those with a diagnosis of first Stroke.

3.3 The current Government is moving this agenda towards legislation which will greatly increase the understanding and uptake of Self Directed Support across
health and / or social care routes. The Scottish Government are now seeking views on the draft legislation, which is now at the second stage of the Parliamentary process.

3.4 NHS Lothian responded to the initial Self-directed Support Bill consultation in June 2010

This stage of the consultation process was preceded by the publication by the Scottish Government of *Self-Directed Support: a National Strategy for Scotland* in November 2010, a 10 year strategy for Self-directed Support in Scotland which sets out the policy direction and desired cultural shift around the delivery of support that views people as equal citizens with rights and responsibilities. NHS Lothian is represented on the national implementation group, which on the national implementation group which was established in January 2011 was established in January 2011, by the Self Directed Support pilot Project Manager.

3.5 The Scottish Government’s ambition with the development of Self Directed Support can be linked to the further development of CHPs. Consideration of the principles and mechanisms of self directed support may be of use to NHS Boards and CHPs in considering how they build on the Scottish Government's paper "Delivering Better Outcomes and Use of Joint Resources" published in November 2010

Furthermore Self Directed Support offers a tool which will assist the delivery of primary and community based health and social care to deliver preventative support and services for individuals, in a manner which encompasses the principles of Better Together and improves the patient experience.

4 Scottish Government Self Directed Support (Scotland) Bill consultation.

4.1 Attached at Annex 1 is a copy of the draft NHS Lothian response to the above consultation.

The key messages from the draft response that we wish to bring to the attention of the Board are:

- NHS Lothian welcomes the development and expansion of self directed support as a means of ensuring that people who are assessed as requiring support are supported to be as in control of their lives and services as they wish to be.
- Whilst the principles of AWIA are embedded within the Draft Bill, as it currently stands the protective measures of the 2000 Act are not included and therefore do not have to be enacted to support the provision of SDS. The proposed response from NHS Lothian is one of concern with this provision, and a recommendation that the protective measures provided by the AIWA are embraced in full by the Self Directed Support Bill.
5 Impact on Health Inequalities

5.1 An Equality Impact Assessment forms part of the Scottish Government’s Self Direct Support Bill consultation. In addition to this a Rapid Impact Assessment of NHS Lothian’s Self Directed Support Pilot has been undertaken, chaired by the Head of Equality and Diversity. This overwhelmingly concluded that the application of self directed support within test sites of NHS Lothian would have a positive impact on access to and quality of service, improved equality for all groups of people, a positive impact on a person’s social environment and would also be complimentary in supporting the organisation’s duty in addressing issues of Adult Support and Protection.

There were no negative impacts identified in relation to the implementation of self directed support as a means of delivering health care across the test site areas.

6 Resource Implications

6.1 There are no resource implications to responding to this consultation

Allie Cherry
Project Manager – Self Directed Support
15 March 2011

Alex McMahon
Acting Director of Strategic Planning

List of Appendices

Appendix 1: NHS Lothian’s proposed response to Scottish Government Self Directed Support (Scotland) Bill consultation.
NHS Lothian’s proposed response to Scottish Government Self Directed Support (Scotland) Bill consultation

QUESTION 1(a)

What are your views on the objectives that we have set for the Bill?

NHS Lothian Board welcomes the objectives of the draft Bill

- To provide a positive, empowering legal framework (for the assessment and provision) of care and support
- To reformulate the “balance” in the legislation between the citizen and the state, i.e. raising the profile of the rights and responsibilities of the citizen.
- To be clear to people, practitioners, and providers about the legislative framework, entitlements and any restrictions.

QUESTION 1(b)

Do you think that the draft Bill meets the objectives that we have set?

If not, why not and how might the Bill be changed in order to meet them?

Whilst the Bill aims to raise the profile within adult social care of the rights and responsibilities of the citizen, it should continue to build on the existing framework providing an adequate level of protection to those most vulnerable in society i.e. those individuals who would be encompassed by Section 10 1(b), i.e. people with a mental disorder or people who have difficulty communicating because of their physical disabilities.

NHS Lothian Board recommends that the support and protection of vulnerable people is given the utmost priority in all systems developed to deliver SDS.

QUESTION 2(a)

What are your views on the general principles included in the draft Bill?

“General principles

(1) A local authority must have regard to the principles in subsections (2) to (4) in carrying out its functions under this Act or Part 2 of the 1968 Act.
(2) A person should have as much involvement in the assessment of the person’s needs and the provision of services or support for the person as is reasonably practicable.

(3) A person should be provided with any assistance that is reasonably required to enable the person to make an informed choice when choosing an option for self-directed support.

(4) A local authority should co-operate with a person in dealing with any matter relating to the services or support provided to the person.”

At stages throughout the Bill the underpinning principles of the AWIA Scotland Act 2000 are explicitly referenced, for example Section 11, appropriate person, also 6a - when determining the past or present wishes of a service user, there is an obvious reference to the AWIA Principles 1, 3 and 4.

NHS Lothian Board suggests that the 5 principles of the AWIA Scotland Act are added to Section 1 so there is no doubt of the intention of application and the use of SDS as a means of delivering service.

**QUESTION 3(a)**

What are your views on our “framework” provisions? [Bill reference: sections 2, 3, 6, 9, 13, 14 and 15]

**Section 2**

“**Options for self-directed support**

(1) The options for self-directed support are—

Option 1 the selection by the supported person within the supported person’s individual budget of the support and the making of arrangements for the provision of it by the local authority.

Option 2 the making of a direct payment by the local authority to the supported person for the provision of the support.

Option 3 the making of arrangements by the local authority for the provision of the support for the supported person.

Option 4 the selection by the supported person of Option 1, 2 or 3 for each type of the support.

(2) In this section—

“individual budget”, in relation to a person, means such amount as the local authority is to make available for the provision of the services or
support to the person, “supported person” and “the support” are to be construed in accordance with section 6, 7 or 8 (as the case may be).”

NHS Lothian Board welcomes the 4 options, particularly option 4 which, if enacted, clearly enables a supported person to have a combined package in the manner that best suits their circumstances. However the language used to describe each of the 4 options is cumbersome, NHS Lothian Board recommends a re-writing of the 4 options, and that the Scottish Government develops information which details in the full range of the 4 options.

Section 3

“Promotion of options for self-directed support

A local authority must take all reasonable steps to promote the availability of the options for self-directed support.”

NHS Lothian Board supports Section 3.

Section 6

“Provision of services: adults

(1) This section applies where a local authority decides under section 12A of the 1968 Act that the needs of an adult (the “supported person”) call for the provision of community care services (“the support”).

(2) The authority must give the supported person the opportunity to choose one of the options for self-directed support unless the authority considers that the supported person is ineligible to receive direct payments.

(3) If the authority considers that the supported person is ineligible to receive direct payments the authority must—
(a) notify the supported person of—
(i) the reason why the authority considers that to be the case, and
(ii) the fact that the supported person has a right to require the authority to review that reason under section 13, and
(b) give the supported person the opportunity to choose one of the options for self-directed support other than—
(i) Option 2, and
(ii) so far as relating to that option, Option 4.

NHS Lothian Board supports Section 6 (1), (2), (3).

However, in Section 6 (4) - If the supported person does not make a choice in pursuance of subsection (2) or (3) (b) the supported person is deemed to have chosen Option 3.” through lack of any other decision.
NHS Lothian Board recommends this section is revised to explicitly require consideration of whether or not the person has the capacity to make the decision, prior to section 6(4) being invoked.

NHS Lothian Board recommends that if the supported person opts not to make the decision, and where Option 3 is the default, that the Bill put a duty on the local authority to inform the supported person of that, and the date at which point this support option will be reviewed.

The experience of receiving support in a particular way may motivate an individual to more proactively exercise a choice about the manner in which they wish to organise their support in future, and they should be enabled to make that choice in a framework that is appropriate to both parties.

Section 9 (3)

“The authority must give the explanation and information required by subsection (2) in writing or (so far as is reasonably practicable) in such other form as is appropriate to the needs of the person to whom they are given.”

NHS Lothian Board recommends this section is strengthened to make it a duty that information regarding an individual's service is provided in a means suitable to that individual to ensure they are fully involved and informed at all stages.

Section 13

“Eligibility for direct payment: review

(1) This section applies where a person receives notice under section 6(3)(a), 7(3)(a) or 8(3)(a).

(2) In specified circumstances, the local authority must on the request of the person review the reason stated in the notice.

(3) In subsection (2), “specified” means specified by the Scottish Ministers in regulations.”

NHS Lothian Board recommends the Bill is strengthened to ensure that local authorities respond within an agreed timescale to any request to review a decision ruling a person ineligible for the option of a direct payment.

Section 14

“14 Further choice of option for self-directed support

(1) Subsection (2) applies where—
(a) under section 6, 7 or 8 a local authority gives a person an opportunity to choose an option for self-directed support,
(b) the person chooses an option, and
(c) there is a material change in the person’s circumstances after the choice is made.

(2) The authority must offer the person another opportunity to choose an option under the section concerned.

(3) The authority and the person may agree that subsection (2) also applies in other circumstances.”

NHS Lothian Board recommends that where the person has defaulted to Option 3, that there should be an agreed point of review where the person has the opportunity to request a change to their SDS option.

As the Bill is currently written, the individual can be deemed ineligible by local authority opinion because they (the local authority) deem the individual to require assistance, without any evidence via formal assessment.

The Bill does not offer any mechanism, or suggest the need for any mechanism for the individual to appeal that decision. We recommend that the NHS Lothian Board response seeks a revision of Section 10 "Assistance to Service Users" to provide for the opportunity of due process to appeal any such decision, and, if the appeal is upheld, the individual should have the opportunity to choose from the four options of SDS.

Section 15

“15 Local authority functions

(1) This section applies where under section 6, 7 or 8 a local authority gives a person an opportunity to choose an option for self-directed support.

(2) The local authority must give effect to the self-directed support option chosen by the person.

(3) Compliance with the requirement imposed by subsection (2) fulfils any duty imposed on the authority by the relevant enactment to provide to the person the services or support to which the option relates.

(4) Compliance with the requirement imposed by subsection (2) does not affect—
(a) any other function of the local authority in relation to the provision to the person of the services or support, to which the option relates,
(b) the exercise by the local authority of the power in section 12(1) of the 1968 Act to make available assistance in cash to or in respect of the person in relation to the services or support to which the option relates.

(5) In this section, “relevant enactment” means Part 2 of the 1968 Act or, as the case may be, section 22 of the Children (Scotland) Act 1995.”
This document supports section 15, "Local Authority Functions" as currently described in the draft Bill.

QUESTION 3(b)

Do you think that the rights, duties, powers and choices set out in the Bill are the right ones, specifically the four options, the duty on local authorities to provide those four options and the duty to provide the adult's preferred option?

We would wish to reinforce the comments made at Section 1 (a) the NHS Lothian Board welcomes the four options and the proposed duty placed on local authorities that the adult's preferred option is provided.

QUESTION 3(c)

Is there anything that you would change or do you think that something is missing from this legislative framework?

The NHS Lothian Board response to the draft Bill notes that application of SDS options would be greatly enhanced through formal reference to the role of advocacy at all relevant places. In addition the Bill would be strengthened through the provision of guidelines for timescales of various functions e.g. expected time frame from identified choice of SDS option to the arrangements being in place.

QUESTION 4(a)

What are your views on section 16 within the draft Bill? In particular, do you think that there should be further legislative provisions relating to self-directed support, individual care packages and joint working between social care, health and beyond? If so, what should be added and why?

“Section 16 Carrying out of certain delegated functions

(1) This section applies where a function of a local authority under this Act or Part 2 of the 1968 Act is delegated under section 15 of the Community Care and Health (Scotland) Act 2002 (asp 5) to an NHS body.

(2) The local authority must take reasonable steps to ensure that, in carrying out the function, the NHS body has regard to section 1.

(3) In this section, “NHS body” has the meaning given by section 22(1) of the Community Care and Health (Scotland) Act 2002.”
NHS Lothian Board notes that section 16, as written in the Bill, does not reflect the ambition stated in the guiding notes i.e. joint working to deliver SDS packages. It is not clear that this comes under delegated functions. The example of delegated assessment given in the text of the consultation document would, in practice, place a duty on all NHS staff members engaged in assessment and discharge planning to inform the individual of their rights and opportunities within SDS, and the implications of all 4 options.

If enacted, a significant training and education programme would be required to provide staff with the necessary knowledge skills and tools with which to support individual patients/ service users to make informed choices.

It is recommended that the NHS Lothian Board response highlights the resource implications of this section for training and education of NHS staff, plus the provision of materials to facilitate informed decisions by patients with additional needs.

**QUESTION 5(a)**

What are your views on the provisions relating to self-directed support for children and young people? [Bill reference: section 8]

"Provision of services: children and members of child’s family"

(1) This section applies where a local authority decides to provide services under section 22 of the Children (Scotland) Act 1995 (c.36) ("the support") to a child or a member of a child’s family.

(2) The authority must give the supported person the opportunity to choose one of the options for self-directed support unless the authority considers that the supported person is ineligible to receive direct payments.

(3) If the authority considers that the supported person is ineligible to receive direct payments the authority must—
   (a) notify the supported person of—
      (i) the reason why the authority considers that to be the case, and
      (ii) the fact that the supported person has a right to require the authority to review that reason under section 13, and
   (b) give the supported person the opportunity to choose one of the options for self-directed support other than—
      (i) Option 2, and
      (ii) so far as relating to that option, Option 4.

(4) If the supported person does not make a choice in pursuance of subsection (2) or (3)(b) the supported person is deemed to have chosen Option 3.

(5) In this section—
   “supported person” means—
(a) where the support is to be provided (wholly or partly) for the child or a member of the child’s family who is also a child—
(i) if the child is under 16 years of age, the person having parental responsibilities for the child,
(ii) otherwise, the child,
(b) where the support is to be provided (wholly or partly) for a member of the child’s family who is not a child, that person.”

It is recommended that the NHS Lothian Board supports the proposal to expand the existing provision of direct payments, to the full range of SDS options for children and young people.

QUESTION 5(b)

Do you agree that all forms of self-directed support should be available to children, young people and their families, and that they should have the same options as adults directing their own care and support?

Section 8 in the draft Bill, which this question refers to, provides for the option of support being delivered to a member of the child’s family, as opposed to directly to the child, where the outcome would be beneficial to the child's health and wellbeing. This suggests that the actual person receiving the support is an adult if support is to be provided for a member of the child's family, but the person being supported is not a child. NHS Lothian Board recommends that this comes within the remit of Section 7, i.e. provision for adult carers.

QUESTION 5(c)

Do you think that sixteen and seventeen year olds should be empowered to direct their own support?

NHS Lothian Board supports this development

QUESTION 5(d)

What are your views on how the various other provisions within the Bill apply to children and young people? For example, are there any specific circumstances where you feel that a particular provision should not apply to children and young people’s support?

NHS Lothian Board notes that in terms of this question and of Section 5 generally, there is a challenge with classifying children as being children up to the age of 18, where the AWIA takes effect at 16. Therefore, if a child at 16, was deemed to not have capacity, they would be transferring to adult legislation at that point, and undergoing transition to adult social care.
QUESTION 6(a)

What are your views on providing a power to local authorities to facilitate an “appropriate person” arrangement where guardianship or power of attorney is not in place and where such applications under AWI procedure would be disproportionate? [Bill reference: sections 10 to 12]

“10 Assistance for service-users

(1) This section applies where—
(a) a local authority decides under section 12A of the 1968 Act that the needs of an adult (the “service-user”) call for the provision of services, and
(b) it appears to the authority that the service-user would benefit from assistance from another person in relation to making decisions about relevant matters because of—
(i) mental disorder, or
(ii) difficulties in communicating due to physical disability.

(2) The authority may appoint a person (an “appropriate person”) to assist the service-user in making decisions about relevant matters.

(3) The authority may appoint a person under subsection (2) only if—
(a) the person agrees to the appointment, and
(b) the person meets such requirements as may be specified by the Scottish Ministers in regulations.

(5) Before appointing a person under subsection (2) the authority must—
(a) take all reasonable steps to enable the service-user to make a choice under section 6(2) or (3) (b),
(b) take into account so far as is reasonably practicable the matters mentioned in subsection (6).

(6) Those matters are—
(a) the present and past wishes and feelings of the service-user so far as they can be ascertained by any means of communication whether human or by mechanical aid (whether of an interpretative nature or otherwise) appropriate to the service-user,
(b) so far as made known to the authority, the views of—
(i) any relative of the service-user of whom the authority is aware,
(ii) any carer of the service-user,
(iii) any other person appearing to the local authority to have an interest in the welfare of the service-user or in the appointment of a person under subsection (2).

“11 Appropriate person: general considerations

(1) Subsection (2) applies where an appropriate person is appointed under section 10(2) for a service-user.
(2) The principles set out in subsections (2) to (4) of section 1 of the 2000 Act apply in relation to any assistance that the appropriate person proposes to give to the service-user as they apply in relation to any intervention in the affairs of an adult under or in pursuance of that Act.

“12 Termination of appointment of appropriate person

(1) Subsection (2) applies where a local authority appoints an appropriate person under section 10(2) for a service-user.

(2) The authority may terminate the appointment if—
(a) the service-user requests it, or
(b) the authority considers that—
(i) the appropriate person is not complying with section 11, or
(ii) the appropriate person is not acting in the best interests of the service-user.”

NHS Lothian Board notes concern regarding classifying the power to direct someone's social care support (which can be significant in terms of volume and monetary value) as being NOT a significant intervention.

NHS Lothian Board notes that the text states that AWIA remains the sole route for significant interventions, but as the Bill currently reads, a Self Directed Support choice is not subject to AWIA, and it deems AWIA processes to be disproportionate. If this statement is retained in the Bill it belittles the experience of the person receiving support, the fundamental importance of this support and the impact this can have on an individual's life, safety health and wellbeing.

NHS Lothian Board recommends that Section 10b of the Bill should be re-written to ensure that the Scottish Government places a duty on the local authorities that any assessment of incapacity, which under AWIA is situation specific, and therefore could apply only to a decision regarding an individual’s choice of Self Directed Support options, must be based on a formal assessment of capacity under Section 47 of the 2000 AWIA Act.

NHS Lothian Board notes that by not putting this in place that this in effect takes power away from an individual without any recourse or right of appeal and furthermore under Section 14 and the right of review, the Bill gives the right of review to the local authority or the appropriate person, but not to the individual, therefore they are denying the person the right to;

- inform the method of delivery
- a Direct Payment
- challenge that decision
- request a review of the support arrangements

NHS Lothian Board notes that this is a restriction of liberty as defined by the MWC and EHR Act. At minimum it is discriminatory and, we would suggest, an oversight that this has not been identified by the EQIA which accompanies the consultation.
QUESTION 6(b)

What are your views on the “trigger point” to allow such powers to be used?

NHS Lothian Board should recommend a formal assessment of capacity if / when the local authority is considering whether the person is eligible for a Direct Payment, or as the text of the consultation document details when an "adult needs assistance in directing some or all of the elements of their own support due to a mental disorder or disability that prevents the person from being able to make the necessary decision".

If the Bill remains as is currently written, we would suggest there is a contradiction with the guidance provided for the purpose and implementation of the AWIA Act which states that; "The Act changes the system for safeguarding the welfare, and managing the finances and property, of adults (aged 16 or over) who lack the capacity to take some or all decisions for themselves because of mental disorder or inability to communicate by any means. It allows other people to make decisions on behalf of these adults, subject to safeguards.”

In addition the Scottish Government's guidance and web site on the AWIA Act states that; "It protects adults (people aged 16 or over) who lack capacity to take some or all decisions for themselves because of a mental disorder or an inability to communicate."

QUESTION 6(c)

If enacted, the provisions in this Bill would join the current Section 13ZA of the 1968 Act. Section 13ZA provides quite wide ranging powers to local authorities. Do you think that section 13ZA should be amended in any way in light of this Bill?

The NHS Lothian Board response reinforces the need for any interventions with adults who lack capacity should formally be taken forward within the framework of AWIA.

QUESTION 7(a)

What are your views on the provisions within the draft Bill relating to carers? [Bill reference: sections 5 and 7]

“5 Support for carers

(1) This section applies where a local authority carries out an assessment under section
12AA of the 1968 Act of the ability of a person (the “carer”) to provide or continue to provide a substantial amount of care on a regular basis for another person (the “person cared for”).

(2) The authority must—
(a) consider the assessment, and
(b) decide whether the carer has needs in relation to the care which the carer provides or intends to provide to the person cared for.

(3) If the authority decides that the carer has those needs, the authority must—
(a) consider whether the needs could be satisfied (wholly or partly) by the provision to the carer of any support, and
(b) if so, consider the matters mentioned in subsection (4).

(5) Subsection (2) does not apply in relation to a carer who provides care—
(a) by virtue of a contract of employment or other contract, or
(b) as a volunteer for a voluntary organisation (as defined in section 94(1) of the 1968 Act).

NHS Lothian Board suggests the Bill would benefit from a point of clarification. Currently section 5 suggests the timescales for the consideration of SDS options as a means of receiving support should be discussed with carers at the point of the Carers assessment, it is not clear that the Bill restricts the option to this point alone.

QUESTION 8(a)

What are your views on the provisions within the draft Bill relating to Direct Payments? [Bill reference: sections 17 – 22]

17 Direct payments

(1) A direct payment is a payment by a local authority to a person for the purpose of enabling the person to arrange for the provision of services or support by any person (including the authority).

(2) The amount of a direct payment is the amount that the local authority considers is a reasonable estimate of the cost of securing the provision of the services or support to which the payment relates during the period to which the payment relates.

(3) A direct payment may be paid in instalments.

18 Assessment of ability to contribute
(1) A local authority must carry out an assessment of a person’s ability to contribute to the cost of securing the services or support to which a direct payment relates.

(2) The assessment must be carried out—
(a) before the direct payment is made, or
(b) as soon as practicable after the payment is made (or, where it is being paid in instalments, after the first instalment is paid).

NHS Lothian Board notes that the Bill does not currently address the tension between financial charging for client contribution if the Direct Payment is arranged through a local authority and the inability for financial charges for contributions to be applied if the Direct Payment is arranged through the NHS under delegated duties. This would result in inequity for those individuals if not addressed.

QUESTION 9(a)

We propose to remove the current restriction which prevents people subject to a Compulsory Treatment Order receiving their care and support as a Direct Payment. Do you believe that any of the restrictions on various other categories of people should also be removed? If so, which ones and why?

NHS Lothian Board does not support the proposal to remove the current restriction which prevents people subject to a Compulsory Treatment Order receiving their care and support as a Direct Payment.

The application of compulsion is only applied to persons subject to Mental Health Tribunal’s and such measures are only invoked where, without such measures the assessed risk is that the person would not be compliant.

QUESTION 9(b)

Some have asked for the regulations that limit the employment of close relatives via a Direct Payment to be reformed. What are your views?

INHS Lothian Board notes that while the Bill would not allow the appropriate person to employ themselves, it would enable them to employ a member of their family, who may not be appropriate to the requirements of the supported person. It is therefore proposed that reforming of these regulations should be given robust consideration.

QUESTION 9(c)
What are your views on making Direct Payments available for residential accommodation?

NHS Lothian Board agrees that Direct Payments should be made available for residential accommodation.

QUESTION 9(d)

If this were to be permitted under the law, do you consider that in practice there will be any adverse issues in relation to: i) The National Care Home Contract for those 65 and over – particularly in relation to the potential for top up fees being imposed; or ii) Ordinary Residence. If so, how might these issues be addressed?

NHS Lothian Board notes that as Direct Payments are "in lieu of service" that the National Care Home Contract would need to recognise that, although in receipt of a Direct Payment the individual remains a publicly funded client.

In addition, NHS Lothian Board notes that with Ordinary Residence, the assessed need, if assessed prior to a move to another area, must be paid for by the original local authority that undertook the assessment although a time limit may be imposed on this arrangement.

QUESTION 9(e)

Should we consider an alternative to the stark choice of imposing or removing a particular time limit on residential care? Instead should we consider new, reformed regulations that provide greater scope for local practice and circumstances? For instance, to define particular circumstances where Direct Payments can be used in residential settings as opposed to the current situation where regulations define only where they cannot be used?

NHS Lothian Board recommends that this would not be applicable if residential care is made an option for Direct Payment.

QUESTION 10(a)

What are your views on bringing forward some additional amendments to elements of the Social Work (Scotland) Act 1968 in order to modernise the law in line with the theme of self-direction and person-centred support?

NHS Lothian Board recommends that the Scottish Government should amend the Social Work (Scotland) Act 1968 in order to modernise the law in line with the theme of self-direction and person-centred support.
QUESTION 10(b)

In particular, what are your views on the additional changes put forward in the discussion document: the proposals to reform the “trigger point” for assessment, to secure adults’ rights to request an assessment and to raise the role and profile of the individual in the assessment process?

NHS Lothian Board recommends that the individual should have the right to request an assessment and should have their role and profile in the assessment process raised.

QUESTION 10(c)

If you think that there are major items that are missing from the draft Bill, what are your proposals for additions to the Bill and why do you think they will make a difference?

NHS Lothian Board notes that the Bill does not address whether an individual or family member is able to top-up a Direct Payment.

QUESTION 11(a)

We have published a draft Business Regulatory Impact Assessment (BRIA). What are your views about the potential costs, benefits and impacts provided within the BRIA?

NHS Lothian Board notes that this Bill does not address the point made consistently by all political parties: that the current model of provision of social care and support is not sustainable. Neither the draft Bill, nor the Business Regulatory Impact Assessment addresses levels of provision or limits on levels of provision, although it should be acknowledged that the Bill does change the role of the individual in terms of directing the provision.

In the section addressing the Sectors and Groups affected, the BRIA fails to address the ambitions of the implications of SDS regarding delegated duties on the NHS, as detailed in page 18 of the consultation document. NHS Lothian Board notes in the section addressing the Legal Aid impact test that if the Scottish Government changes the Bill regarding the points of use of AWIA, there will be a potential cost for GPs undertaking assessments of capacity, in addition to potential costs in relation to people seeking intervention orders.

QUESTION 12(a)

We have published a draft Equality Impact Assessment. What are your views on the draft EIA?
NHS Lothian Board notes that the section of the draft EIA detailing the people affected by the Bill does not mention children.

The NHS Lothian Board response recommends that the impact of the Bill on gender should be revisited. Making support to carers an option under the Bill will have the potential to assist a significant number of those individuals, predominantly women, in a caring role.

**Step 4 - negative impact** - NHS Lothian Board notes that the Bill currently provides the ability to take away someone’s power without any formal assessment or challengeable process and is therefore discriminatory against people with disability and/or people with mental disorder.

**Page 10 - Race** - NHS Lothian Board notes that the EIA provides a breakdown of people from communities of interest in receipt of Direct Payment but does not compare this to the known percentage of people from communities of interest who currently receive social care. Without this comparison it will be unclear if there has been any positive change delivered as a result of SDS.

**Page 11 - Religion and Belief** - NHS Lothian Board notes that the EIA makes no reference to gypsy travellers/refugees or asylum seekers. It is unclear how the Scottish Government intends to ensure that this section of the Scottish population has equity of access to service using SDS.
1. Managed Clinical Network for Neonatal Services
SEAT noted that the Clinical Lead and the Network Manager are now in post for the regional Managed Clinical Network for Neonatal Services. As part of their induction process, they will meet with key personnel in the 4 participating Boards including Medical Directors, Nurse Directors and Chief Executives. A Chair is being considered for the MCN Steering Group.

2. Workstreams from SEAT Away Day
SEAT noted the updates on the 5 agreed workstreams from the October Away Day, acknowledging that further work was required to ensure full and appropriate partnership engagement. SEAT confirmed that detailed plans were expected from each of the workstream leads at the next meeting on the 18th March 2011. The following progress was noted:
   - **Rebalancing Care** – initial discussions have taken place and draft principles have been agreed with a focus on orthopaedics as a worked example.
   - **Performance Standards and Minimising Variation** – A report will be prepared by the end of February identifying procedures which are carried out with limited clinical value; looking at variations in lengths of stay, and admissions and re-admissions.
   - **Tele-Technology** – Using radiology as an exemplar, work has commenced in this area. SEAT proposed that out of hours radiology rotas should be looked at as part of the work.
   - **Complex Care Packages** – A review is underway of all care packages funded by the NHS with a view to identifying savings which could be used to provide care on a more local/regional basis.
   - **Corporate/Shared Services** – Work has commenced in the first instance in the areas of Finance and Human Resources with benchmarking information being analysed. This process will help inform the approach with other corporate services. Special Health Boards were asked to indicate whether they wished to be involved in this work.

3. Children’s Services
**National Delivery Plan for Specialist Children’s Services**
SEAT received a detailed update on the benefits which had been achieved through investment in Specialist Children’s Services, noting that sustainability of services had been the key priority in developing the SEAT regional plans. Scottish Government had advised that funding will be recurring if Boards can demonstrate that the investments have provided benefit to patients and additionality through the agreed quarterly performance reporting mechanism.
SEAT noted the importance of incorporating timely and robust information into the performance reports. A further report is to be prepared for a future meeting based on the Performance Reports and which details activity numbers.

**National Managed Service Network for Children and Young People with Cancer**
SEAT received a verbal update on progress with implementation of the National Managed Service Network (MSN) for Children and Young People with Cancer, noting that the appointment of a chair for the Steering Group was being finalised.

**4. Eating Disorders In-patient Unit**
SEAT noted that there had been a delay in progressing with the regional in-patient unit which has been due in part to unforeseen estates issues on the St John’s Hospital site in NHS Lothian. The delay presents issues for Boards in managing the associated capital which had been earmarked for 2010/2011, but will now be required in 2011/12. The Director of Finance, NHS Lothian advised that a solution is being sought to manage the capital position. Further discussion will take place at the next Directors of Finance meeting. SEAT agreed that the HR Directors should advise on the approach to recruitment.

**5. Radiotherapy Replacement Programme**
SEAT received a report on the national replacement programme for radiotherapy equipment. The report detailed the replacement of CT scanners and Linear Accelerators within the Edinburgh Cancer Centre during 2011/12 and 2012/12, the capital costs for which will be provided by the Scottish Government. It was noted that there are revenue implications for SEAT Boards which will be confirmed once the tendering process is concluded at the beginning of March.

**6. Workforce Planning**
SEAT was informed that the Scottish Government had confirmed the training numbers have been reduced by 49 for 2011/12, noting that the biggest impact will be in Emergency Medicine. SEAT requested that the Regional Workforce Director and the Post Graduate Dean confirm the position with regards to monies released. SEAT requested that further work is undertaken on the Executive/Senior Manager part of the workforce, with a view to understanding the distribution of this cohort across Scotland and within Boards.

SEAT noted that Professor Paul Padfield, Chair of the Regional Medical Workforce Group had retired and approved Dr Gordon Birnie as the new Chair.

**7. Update on Reprovision of Royal Hospital for Sick Children, Edinburgh**
SEAT were updated on the way forward for the reprovision following the budget announcement in November 2010.
8. Telestroke Pilot in SEAT
SEAT noted that the first meeting of the Telestroke Project Board had taken place and that an agreed Project Initiation Document would be brought to the next SEAT meeting. SEAT agreed that there should be appropriate metrics included in the 6 month evaluation which demonstrated improved outcomes, financial benefits and effective use of personnel. SEAT confirmed that any publicity around the launch of the project should be channelled through Board’s Communications Teams.

9. Abdominal Aortic Aneurysm Screening Programme
SEAT received confirmation that the Scottish Government had reconfirmed their commitment to introduce the Abdominal Aortic Aneurysm (AAA) Screening Programme in early 2011. A draft plan is being developed for Board Chief Executives, detailing the roll-out of the programme.

10. Guidance for Reshaping Care for Older People
SEAT agreed that it would be helpful for Boards to share their individual plans and metrics and that this should remain a regular agenda item.

11. Call for Evidence on the Future of Public Services
SEAT noted the recent call for evidence and would consider whether or not a response should be made on behalf of SEAT.

12. Individual Board Updates
NHS Education for Scotland
Work is underway on the General Medical Council survey data. NHS Education for Scotland are taking part in the shared services discussions between Special Health Boards.
Scottish Ambulance Service
Work is now complete on planned care services and this will be shared with planners. Unplanned care and retrieval services will now be focussed on.
NHS Forth Valley
A pilot scheme is underway in North West Stirling, looking at shifting and sharing skills across multi agencies.
NHS Borders
A new Board Chair is currently being sought. June Smyth has been appointed as Interim Director of Workforce Planning.
NHS Fife
Recent discussions between NHS Fife Chair and Fife Council had resulted in clearing some of the delayed discharges.
NHS Lothian
Work is to commence on agreeing policies which should allow employees to work in different Boards in the event of severe weather.

J Mc Clean
Regional Healthcare Planner
3rd Feb 2011
APPOINTMENT OF PHARMACY PRACTICES COMMITTEE MEMBERS

1 Purpose of the Report

1.1 The purpose of this report is to seek the appointment of 3 new non-contractor pharmacists and 5 lay members to the Pharmacy Practices Committee.

2 Recommendations

The Board is invited to:

2.1 Ratify the appointment of 3 additional NHS Lothian non contractor pharmacists.

2.2 Recommend the appropriate steps are taken to identify through the NHS Lothian process for meeting the national standard for community engagement 5 additional NHS Lothian lay members to the Pharmacy Practices Committee.

2.3 Agree that from now on Pharmacy Practices Committee members should be appointed for a term of four years, with a review by the Chair after a period of one year, and the option to extend for a second term of a further four years.

3 Summary of the Issues

3.1 The function of the Pharmacy Practices Committee is to consider new applications by community pharmacists for the inclusion of their names in the pharmaceutical list, in accordance with the National Health Service (Pharmaceutical Services) (Scotland) Regulations 2009, which is a consolidation of the 1995 Regulations.

3.2 On 1 October 1999, the responsibility for this function was devolved to Primary Care NHS Trusts. However, with the dissolution of NHS Trusts on 31 March 2004 the responsibility for such matters returned to the Board.

3.3 It had been anticipated that with the implementation of the new Community Pharmacy contract that a national system would be introduced, however this has not happened and it falls to the Board to discharge this statutory responsibility via the Pharmacy Practices Committee.

3.4 When considering any particular new application a Pharmacy Practices Committee should consist at its maximum of seven members:
(a) a Chairman who must be a non-executive member of the Board but must not be, nor previously have been, a doctor, dentist, pharmacist or ophthalmic optician, nor the employee of a person who is a doctor, dentist, pharmacist or ophthalmic optician;

(b) 3 lay members who must not be an officer of the Board nor must be, nor previously have been, a doctor, dentist, pharmacist or ophthalmic optician, nor the employee of a person who is a doctor, dentist, pharmacist or ophthalmic optician;

(c) 1 non-contractor pharmacist; and

(d) 2 pharmacists, whose names are included in the pharmaceutical list.

3.5 Currently, the pool of available members from which a Committee can be created include:

(a) Chair: Cllr Jack Aitchison

(b) Deputy Chair: Mr Peter Johnston

(c) non-contractor pharmacist: Mr Peter Jones
   Ms Julie Blyth

(d) contractor pharmacists: Mr Mike Embrey
   Ms Kaye Devlin
   Ms Fiona McCready;
   Mr Robbie McGregor

(e) lay members: Ms Patricia Eason
   Mr Ian Melville
   Ms Margaret Tait
   Ms Carole Stevenson

3.6 Given that an application can be received at any time, it can be difficult to establish a full Committee at any given time because of availability and conflict of interest issues.

3.7 The Pharmacy Practices Committee meets on average between six and ten times per year. Again this can be unpredictable given the nature of the application process.

3.8 Colleagues in Single System Pharmacy have identified 3 non-contractor pharmacists who have indicated their willingness to serve on the committee. They are Katie Johnson (Primary Care Pharmacist, Sighthill Health Centre), Maureen Reid (Primary Care Pharmacist, Sighthill Health Centre) and Christine Glover (Consultant Pharmacist, Integrated Health Care). All 3 named have previously been officially nominated by the Royal Pharmaceutical Society of Great Britain as is required in the terms of the Regulations.
3.9 The term of appointment for all is a four year period. However, a review of each appointment, in consultation with the Chair of the Pharmacy Practices Committee, will take place at the end of the first year of each appointment. Should it be considered appropriate that any appointment be extend beyond four years this can only be granted with the consent of both the Board and the individual concerned.

3.10 On agreement by the Board to the appointment of addition lay members the appropriate steps will be taken to recruit appropriate applicants. Applications to the Pharmacy Practices Committee may be sought from Public Partnership Forums and through the Edinburgh Equality Network to ensure that applications can be considered from all sectors of the local population. This will be progressed with the Head of Patient Focus and Public Involvement. The terms of office of existing lay members will also be reviewed and a report brought to a future Board meeting.

4 Impact on Health Inequalities

4.1 Equality and Diversity Impact Assessments will be carried out as required in relation to the service following advice from the leads for equality and diversity issues in NHS Lothian. When considering applications the Pharmacy Practices Committee will take into account the needs of the diverse population in NHS Lothian. An impact assessment is not required on this paper as there will be no change to the service as a result of this proposal.

5 Resource Implications

5.1 Non-contractor pharmacists who are self employed can claim loss of earnings for any time they are away from their business at the rate of £190 for the first 3.5 hours. Thereafter a maximum rate of £54.30 per hour applies. Additionally travel expenses can be claimed. Lay members may only claim for travel expenses. These are paid from the committee fees budget.

Duncan Miller
General Manager – Primary Care Contracts
1 March 2011
GENERAL PHARMACEUTICAL SERVICES (COMMUNITY PHARMACY)
REVISED HOURS OF SERVICE SCHEME

1 Purpose of the Report

1.1 The purpose of this report is to seek approval of the Revised Hours of Service Scheme for securing that one or more places of business on the Pharmaceutical List in each locality shall be open at all reasonable times, and specifying the arrangements for the dispensing of medicines required urgently at other times.

2 Recommendations

The Board is invited to:

2.1 Approve the Revised Hours of Service Scheme. Revisions address only administrative issues such as the deletion of references to “Lothian Primary Care NHS Trust” and updating to “Lothian Health Board”. A copy of the Revised Scheme is attached as Appendix 1.

3 Summary of the Issues

The contractual arrangements for general pharmaceutical services are covered by the National Health Service (Pharmaceutical Services)(Scotland) Regulations 2009. In particular regulation 11(1) and (2) state that:

“11(1) The Board, after consultation with the Area Pharmaceutical Committee, shall prepare a scheme for securing that one or more places of business on the pharmaceutical list in the area of the Board shall at all reasonable times be open. The scheme shall specify the days and hours during which such places shall be open, and the arrangements for the dispensing of medication required urgently at other times.”

“11(2) The provisions of the schemes prepared under paragraph (1) shall be subject to the approval of the Scottish Ministers.”

The hours of service scheme was last reviewed by the Board in 2000 and therefore has been updated to reflect the most recent regulations and to clarify the definition of public holidays as far as these affect community pharmacy.
The revised scheme was discussed with the Lothian Area Pharmaceutical Committee. By letter dated 14th July 2010 the Professional Secretary for the Lothian Area Pharmaceutical Committee confirmed that the revised scheme had been considered at a recent meeting and the proposals contained within the paper have the full support of the LAPC.

If the Board are content with the revised scheme it will require to be submitted to Scottish Ministers for approval.

4 Impact on Health Inequalities

A rapid impact assessment has not been undertaken given this is an administrative change to the existing hours of the service scheme. Issues such as accessibility in local geographic areas has already been considered and as there will be no significant change in the service an impact assessment is not required.

5 Resource Implications

There are no resource implications for the Board apart from the additional costs to support the opening of pharmaceutical premises on Christmas Day and New Year’s Day. This is funded annually from winter planning monies.

Duncan Miller  
General Manager – Primary Care Contracts

Lynda Campbell  
Contracting Support Officer (Pharmacy)  
3 February 2011
COMMITTEES AND TERMS OF REFERENCE

1 Purpose of the Report
1.1 The purpose of this report is to invite the Board to agree:

- the appointment of Paul Edie as a member of the Finance & Performance Review Committee
- to agree changes to the terms of reference to the Finance & Performance Review Committee

2 Recommendations

The Board is invited to agree:

2.1 the appointment of Paul Edie as a member of the Finance & Performance Review Committee to succeed Alison Tierney with effect from 1 October 2011;

2.2 changes to the terms of reference to the Finance & Performance Review Committee reducing the number of non-Executive Board members from 8 to 7, replacing the Vice-Chair with the Employee Director, reducing the delegated limit for the approval of capital schemes from £10m to £5m and including a reference to putting appropriate links in place with the Service Redesign Committee to ensure that financial aspects are appropriately considered in all service redesign.

3 Background (Terms of Reference)

3.1 The Terms of Reference for the Finance & Performance Review Committee presently specify 8 non-Executive Board members in addition to the Board Chair, Vice Chair and the University Board member (all of whom are of course non-Executive Board members in their own right). This gives a total of 11 non-Executive Board members. The non-Executive Board membership of the Committee was originally increased to this level because some difficulty had been experienced in achieving a quorum but this has not been a problem in the past few years, in part because meetings now start at 9:00 a.m. rather than 2:00 p.m. It is therefore proposed to amend the quorum requirements to 10 (to include the Chair,
Employee Director and University Board member plus 7 other non-Executive Board members)

3.2 The Finance & Performance Review Committee received a paper at its meeting on 28 October 2010 entitled CEL 32 (2010) Future Handling of Capital Resources Across NHS Scotland.

3.3 Amongst other things, the proposals in that paper reduced Lothian NHS Board’s delegated limit for the approval of capital schemes from £10m to £5m. With respect to the Board’s governance processes, the Committee’s Terms of Reference now require to be amended making this change.

3.4 A reference has also been included to ensure that appropriate links are in place with the Service Redesign Committee to ensure that financial aspects are appropriately considered in all service redesign.

5. Impact on Health Inequalities

5.1 This report is a matter of procedural business rather than policy and has no direct impact on health inequalities.

Peter Reith
Secretariat Manager
11 March 2011

List of Appendices

Appendix 1 - Finance & Performance Review Committee Terms of Reference
Appendix 2 - A chart showing the remits and membership of the Board Committees
FINANCE & PERFORMANCE REVIEW COMMITTEE

Remit:

- To scrutinise the Board’s finances, both Revenue and Capital, and ensure that corrective actions are taken whenever needed.

- To scrutinise the Board’s operational performance (our service to the Lothian community), and as with finance to ensure improvements are made when needed.

- To ensure a better reporting link between our financial inputs and our service delivery: i.e., what is the Board delivering to the community for the budget that it receives?

- Related to that, to continually review the value for money and efficiency that the Board is achieving in service delivery, and how it compares with other similar organisations across the UK.

- To ensure that appropriate links are in place with the Service Redesign Committee to ensure that financial aspects are appropriately considered in all service redesign.

- On the Board’s behalf, to approve business cases of a value between £500,000 and the Board’s delegated limit (£5m).

  The exception to this is any business cases that involve land transactions, as the detailed business cases must be referred to the Board. (per paragraph 7.2 of the Standing Orders)

  NB: The Strategic Capital Planning Group has delegated authority to approve business cases (within the approved capital programme) up to the value of £500,000. Operational capital committees have the authority to approve cases up to £250,000.

  For business cases that must be referred to the Scottish Government for approval (i.e. those higher than the Board’s delegated limit), the Committee will review the business case prior to submitting the business case with the assurance that the required financial resources are available to the Board. The approval of business cases and confirmation of Board support, prior to submission of the business case to the Government, is reserved to the Board.

- To improve the quality of information and proposals that come to the full Board, and thus enable more strategic and better informed discussions at full Board level.

12 January 2011
Membership:

The membership of the Committee shall consist of:-

- Non-Executive Member Chair
- Chair, NHS Lothian
- Employee Director, NHS Lothian
- University Board Member
- Seven Non-Executive Board Members one of whom should be a Local Authority member and one of whom should be a CHP/CHCP Chair
- Chief Executive, NHS Lothian
- Director of Finance, NHS Lothian
- Director of Human Resources & Organisational Development, NHS Lothian
- Acting Director of Strategic Planning
- Chief Operating Officer
- Medical Director, NHS Lothian

All Board members shall have the right of attendance and have access to papers.

Frequency of Meetings:

Meetings of the Committee shall be held at such intervals as the Committee may determine in order to conduct its business. In any event, meetings shall normally be held six times a year.

Quorum:

No business shall be transacted at a meeting of the Committee unless at least 5 members are present of whom a majority are non-Executive members. Any Non-Executive Board member may deputise for another non-Executive member of the Committee at any meetings.

Reporting Arrangements:

The Committee will report to the Board by means of submission of minutes to the next available Board meeting.
SOUTH EAST SCOTLAND RESEARCH ETHICS COMMITTEES MEMBERSHIP

1. Purpose of the Report

1.1. The purpose of the report is to seek the approval of the Board for revised memberships of the three South East Scotland Research Ethics Committees.

2. Recommendations

2.1. The Board is asked to agree the revised South East Scotland Research Ethics Committees memberships detailed in Appendix 1.

3. Introduction

3.1. Whilst the appointment of the Chairs and other members of Research Ethics Committees (RECs) is the responsibility of NHS Boards in Scotland these Committees are part of a National Research Ethics Service and the procedures for the recruitment and selection of members of Research Ethics Committees are laid down in detailed guidance issued by the National Research Ethics Service. The Board last agreed the present membership of the South East Scotland Research Ethics Committees at its meeting on 26 May 2010.

3.2. The Governance Arrangements for Research Ethics Committees (GAfREC) state that in Scotland the maximum term that any one person can serve on a single Research Ethics Committee is two consecutive terms, or eight years. Members may serve further terms of office on a different REC if they so wish. A number of members of the three South East Scotland Research Ethics Committees have now reached this limit and have either transferred to another REC in line with GAfREC or have stepped down from the Research Ethics Service.

3.3. As a consequence, the membership of all three of the South East Scotland Research Ethics Committees has been revised, including the addition of 13 new members:

Dr Vincent Bombail, Dr Tan Chee-Wee, Dr Jan Gill, Ms Alanah Kirby, Mr Alec Richard, Ms Kirsty Roberts, Dr Derek Santos, Ms Judy Scopes, Ms Sara
Smith, Ms Jill Stavert, Ms Lindsay Sutton, Ms Louisa Wilson, Ms Helen Wright.

All new members were recruited in accordance with the National Research Ethics Service guidelines, interviewed, offered induction training and, if appointed by the Board, will be added to the membership of South East Scotland Research Ethics Service. All three RECs continue to comply with the necessary requirements for REC composition as outlined in GAfREC.

3.4. The recruitment process for Chairs and other members formed part of the review of the South East Scotland Research Ethics Committees during a Quality Control exercise conducted in December by the National Research Ethics Service. All three Committees were found to be compliant with the national guidelines.

4. Impact on Health Inequalities

4.1 There are no health inequalities implications arising from this report or recommendations.

Dr Alex Bailey
Scientific Officer
10 March 2011

List of Appendices

Appendix 1: Membership Lists for the three South-East Scotland Research Ethics Committees.
South East Scotland Research Ethics Committee 1
Dr Janet Andrews (Chair)
Ms Fiona Barry
Dr Elizabeth Hare
Mrs Alexandra Harvey
Dr George Howat
Mrs Patricia Perry
Dr Calum MacKellar
Mr Lindsay Murray
Mr Andy Neustein
Ms Kirsty Roberts
Ms Judy Scopes
Ms Sara Smith
Ms Jill Stavert
Dr Gordon Steele
Mr W O D Walker

South East Scotland Research Ethics Committee 2
Mr Thomas Russell (Chair)
Dr Balkishan Agrawal
Dr Vincent Bombail
Mrs O M A Chiswick
Mr Willie Farquhar
Dr Carolyn Greig
Ms Alanah Kirby
Mr Yann Maidment
Mr Alexander McAfee
Dr Nigel Ostrowski
Dr Lynne Phillip
Professor Lindsay Sawyer
Dr Lillian Schweizer
Ms Lindsay Sutton
Dr Hester Ward

South East Scotland Research Ethics Committee 3
Dr Christine West (Chair)
Dr Tan Chee-Wee
Dr Jan Gill
Reverend Denise Herbert
Mr Hugh Olson
Ms Jo Mair
Ms Karen Mathews
Mr Alec Richard
Dr Derek Santos
Dr Kevin Smith
Mr Warwick Taylor
Mrs Anne Tod
Ms Louisa Wilson
Ms Helen Wright
Mr Vipin Zamvar
# COMMUNICATIONS RECEIVED

## 1 Purpose of the Report

1.1 The purpose of this report is to ask the Board to note the list of communications below received from the Scottish Executive:

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<thead>
<tr>
<th>No.</th>
<th>Reference</th>
<th>Description</th>
<th>Date</th>
<th>Reference</th>
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<tr>
<td>1</td>
<td>SGHD(CMO)(2011)001</td>
<td>Seasonal influenza: Antiviral prescribing and vaccination of NHS Staff.</td>
<td>07/01/11</td>
<td>DPHHP, MD, COO, GMPCC</td>
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<td>2</td>
<td>PCS(AFC)(2011)002</td>
<td>Extension of protected on-call arrangements under agenda for change beyond 31 March 2011</td>
<td>19/01/11</td>
<td>DHR &amp; OD, GMPCC</td>
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<td>Palliative and end of life care in Scotland</td>
<td>28/01/11</td>
<td>DSP</td>
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<td>PCP(P)(2011)002</td>
<td>Additional pharmaceutical services: Public Health service poster campaigns</td>
<td>03/02/11</td>
<td>GMPCC</td>
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<td>5</td>
<td>PCA(M)(2011)003</td>
<td>The national health service (general medical services contracts) (Scotland) amendment regulations 2010</td>
<td>02/02/11</td>
<td>DOF, GMPCC</td>
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<td>CEL(2011)005</td>
<td>Criminal Procedure (Scotland) Act 1995 new community payback orders.</td>
<td>07/02/11</td>
<td>REAS</td>
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<td>PCA(M)(2011)004</td>
<td>List of drugs subject to prescribing</td>
<td>08/02/11</td>
<td>MD, GMPCC</td>
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<td>Additional Public Holiday – Royal Wedding 2011</td>
<td>15/02/11</td>
<td>DHR &amp; OD</td>
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<td>CEL(2011)006</td>
<td>Strengthening carer involvement in community health partnerships (CHPs).</td>
<td>23/2/11</td>
<td>ND DHSC, DWHCP, GMEMCHP, GMECHP, GMWLCCH, CP</td>
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<td>NHSScotland Property Transactions Handbook 2011</td>
<td>28/02/11</td>
<td>DOF</td>
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<td>PCA(P)(2011)003</td>
<td>Additional Pharmaceutical Services Chronic Medication Service – implementation payments for contractors opening from 1 January 2011</td>
<td>28/02/11</td>
<td>GMPCC</td>
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<td>13</td>
<td>PCA(D)(2011)002</td>
<td>General Dental Services. Getting NHS Dental treatment in Scotland</td>
<td>01/03/11</td>
<td>GMPCC</td>
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<td>14</td>
<td>SGHD(CMO)(2011)002</td>
<td>Provision of Health Promotion advice and information by GP Practices</td>
<td>07/03/11</td>
<td>DHSC, DWLCHCP, GMELCHP, GMECHP, GMWLCHCP, GMPCC</td>
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<td>15</td>
<td>NHSSS(2011)001</td>
<td>Pension Tax Relief, Automatic Enrolment, Switch from RPI to CPI</td>
<td>07/03/11</td>
<td>GMPPC, DOF, DHR &amp; OD,</td>
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Douglas Weir  
Corporate Services Manager  
11 March 2011

AFC  Agenda for Change  
CEL  Chief Executive Letter (the designation for general circulars)  
CMO  Chief Medical Officer  
SAN  Safety Action Notice (a standard priority notice where action can be planned rather than immediate)  
HAZ  Hazard Notice (a high priority notice where immediate action is required)  
MDA  Medical Devices Agency  
PCA  Primary Care Administration (circulars relating to Primary Care staff i.e. P - Pharmacy, D - Dentistry)  
PCS  Pay & Conditions of Service (circulars relating to the pay and conditions of service of staff)  
SHS  Scottish Health Service  
SPPA  Scottish Public Pensions Agency  
SSI  Scottish Statutory Instrument