NHS LOTHIAN

BOARD MEETING

DATE: WEDNESDAY 28 SEPTEMBER 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

Welcome to Members of the Public and the Press

Apologies for Absence

1. Minutes of Previous Meeting of Lothian NHS Board held on 27 July 2011 CJW *
2. Matters Arising
3. Committee Minutes for Adoption (Indicative Timing 9:30 - 9:40 a.m.)
   3.1. Area Clinical Forum - Minutes of the Meeting held on 18 August 2011 PM *
   3.2. Audit Committee - Minutes of the Meeting held on 21 June 2011 SGR *
   3.3. Finance & Performance Review Committee - Minutes of the Meeting held on 17 August 2011 GW *
   3.4. Healthcare Governance & Risk Management Committee - Minutes of the Meeting held on 2 August 2011 PM *
   3.5. Service Redesign Committee - Minutes of the Meeting held on 27 June 2011 JI *
   3.6. East Lothian Community Health Partnership Sub-Committee - Minutes of the Meeting held on 29 June 2011 IW *

* = paper attached
# = paper to follow
v = verbal report
3.7. Edinburgh Community Health Partnership Sub-Committee Minutes of the Meeting held on 3 August 2011
3.8. Midlothian Community Health Partnership Sub-Committee Minutes of the Meeting held on 28 July 2011
3.9. West Lothian Community Health and Care Partnership Board Minutes of the Meeting held on 28 June 2011

4. Chairman’s Report

5. Chief Executive's Report

6. Governance (Indicative Timing 9:50 - 10:20 p.m.)

6.1. Quality Report
6.2. Report from the Organ Donation Committee 2010/11

7. Policy (Indicative Timing 10:20 a.m. - 10:50 a.m.)

7.1. Clinical Strategy

8. Performance Management (Indicative Timing 10:50 a.m. - 12:30 p.m.)

8.1. Financial Position to 31 July 2011
8.2. Delivering Waiting Times
8.3. Tackling Delayed Discharge
8.4. Healthcare Associated Infection Update

LUNCH 12:30 p.m.

9. Other Items (Indicative Timing 1:00 p.m. - 2:30 p.m.)

9.1. Webcasting and Communications with Key Partners and the Community
9.2. Committee Memberships and Terms of Reference
9.3. Better Together Adult Inpatient National Survey 2010
9.4. NHS Lothian Contribution to South East And Tayside Group Work

10. Managed Service in Partnership with Community Pharmacy Colleagues - Presentation - Elaine Rankine, Substance Misuse Pharmacist & Alan Glauch, Community Pharmacy Contractor

11. Communications Received

12. Date, Time and Venue of Next Meeting: Wednesday 23 November 2011 at 9:00 a.m. in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
**Dates of Meetings in 2011 & 2012:**

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* Special meeting to consider the Annual Accounts

# Trustees Meeting preceding Board Away Day
Minutes of the Meeting of Lothian NHS Board held at 9.30am on Wednesday, 27 July 2011 in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present:

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

Non-Executive Directors: Dr C J Winstanley (Chair); Councillor J Aitchison; Mrs S Allan; Mr R Y Anderson; Mr R Burley; Councillor P Edie; Mr E Egan (Vice-Chair); Professor J Iredale; Mr P Johnston; Professor P Murray; Mrs J McDowell; Mr B Peacock; Professor M Prowse; Dr A Tierney and Dr R Williams.

In Attendance: Ms V Alexander (For Item 58); Mrs S Egan (For Item 58); Ms J Harness (Shadowing the Vice-Chair); Mr S Hurding (Shadowing Professor Murray); Ms V Strong (For Item 58); Mr S Wilson and Mr D Weir.

Apologies for absence were received from Professor J J Barbour, Mrs S Goldsmith, Councillor J Cochrane, Mrs T M Douglas, Mr S G Renwick, Mr G Walker and Mr I Whyte.

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. Mrs Allan declared an interest under agenda item 7.1 ‘Sexual Health and HIV Strategic Programme: Financial Risk and Efficiency and Performance Metrics’ advising she was a Trustee of the Waverley Care Trust.

Welcome and Introduction

The Chair welcomed the public and press to the meeting.

The Chair advised the Board Mrs Sansbury would cover any items normally addressed by the Chief Executive as he was on annual leave. Mrs Potter would speak to any items normally addressed by Mrs Goldsmith, Director of Finance as she was also on annual leave.
The Board welcomed Mr Wilson, Director of Communications to his first Board meeting. The Chair also welcomed Ms Harnes and Mr Hurding advising they were shadowing the Vice-Chair and Professor Murray respectively.

32. **Minutes of the Previous Meeting of Lothian NHS Board held on 25 May 2011**

32.1 The Minutes were approved as a correct record.

33. **Minutes of the Special Meeting of Lothian NHS Board held on 22 June 2011**

33.1 The Minutes were approved as a correct record.

34. **Matters Arising**

34.1 **Arrangements for Board Meetings** – the Chair reminded the Board at its previous meeting it had been agreed Mrs Hornett would canvas further opinion from public engagement groups to determine what locations and times of day would be best to hold Board meetings in order to provide access to the broadest possible representation of the general public and future Board members.

34.1.1 Mrs Hornett advised following contact with other Health Boards five responses had been received. All responding Boards had reported low attendance despite a variety of approaches adopted in respect of venues and timing of meeting, with few regular attenders, usually Public Partnership Forum (PPF) members. Mrs Hornett commented the Boards with elected members had reported no increase in attendance since elected members had joined their Board. Increases in attendance had only been evident when a high profile issue had been discussed.

34.1.2 Mrs Hornett commented one Board was considering webcasting their meetings and this might be an area worth pursuing, as this would enhance the accessibility of meetings. She reported a short questionnaire had been sent to key PPF and hospital forum members with eleven responses received. There had been no consensus in the responses about the best time for meetings, although shorter meetings and advance notice of items emerged as key issues.

34.1.3 The Chair commented he was attracted to the possibility of webcasting meetings and this linked with stronger communications with key partners might prove to be the way forward. He reminded colleagues the Board attempted to make itself more accessible by visiting, in rotation, each of the local authority areas once a year.

34.1.4 The Vice-Chair commented any webcasting proposals should not come at significant cost. Professor Iredale stressed the need for webcasting to be undertaken on a pilot basis and, if not successful, it should be stopped. Mrs McDowell commented in advance of trialling webcasting, it would be important to foster awareness of the ability to attend meetings. The Chair suggested the approaches being considered were not mutually exclusive.
34.1.5 The Board agreed to receive papers at its next meeting from Mr Wilson detailing the costs of webcasting, as well as a proposed evaluation mechanism and looking at communications with key partners and the community to include key themes that might be discussed at future meetings.

34.2 NHS Lothian Contribution to SEAT Work – As requested at the previous Board meeting, Professor McMahon provided a report on the key workstreams within SEAT that NHS Lothian Executive Directors and the Employee Director were involved with and highlighted any implications where appropriate for the workings of NHS Lothian.

34.2.1 Mrs Sansbury reminded the Board SEAT was not an entity in its own right and governance arrangements remained the sovereign responsibility of the participating Boards, who were responsible for agreeing and approving the SEAT workplan. She advised SEAT was currently chaired by Professor Barbour.

34.2.2 The Vice-Chair commented he was not yet content with the robustness of SEAT partnership arrangements, as he felt the two Employee Directors were working at the periphery. In addition, there were some workstreams with no partnership engagement. The Vice-Chair stressed, in governance terms, it was important any work progressed by SEAT had the support of Lothian NHS Board. He felt current workstreams should be discussed at the Finance and Performance Review Committee to determine whether or not these represented value for money. Professor McMahon would progress.

34.2.3 Professor McMahon undertook to bring a SEAT update report to each Board meeting.

35. Committee Minutes for Adoption

35.1 Area Clinical Forum – Minutes of the Meeting held on 19 May 2011 – the Board adopted the Minutes.

35.2 Audit Committee – Minutes of the Meeting held on 12 April 2011 – the Board adopted the Minutes. The Vice-Chair reported consideration was being given to what other Committee Minutes should be considered by the Audit Committee to ensure a completeness of oversight.

35.3 Finance & Performance Review Committee – Minutes of the Meeting held on 8 June 2011 – the Board adopted the Minutes.

35.4 Healthcare Governance & Risk Management Committee – Minutes of the Meeting held on 7 June 2011 – the Board adopted the Minutes. Professor Murray, in response to a question from the Vice-Chair, undertook to ask the Committee to consider how best lessons learned from adverse incidents would be shared across the system.

35.5 Mutuality & Equality Governance Committee – Minutes of the Meeting held on 31 May 2011 – the Board adopted the Minutes. The Chair asked Mrs McDowell in respect of the comments made in the Minutes about the cost of public attendance
at meetings to feed back that the Board was of the view, despite the cost, the practice of holding open meetings represented good practice and should continue.

35.6 Primary & Community Partnership Committee – Minutes of the Meeting held on 13 July 2011 – the Board adopted the Minutes. Mr Burley commented, dependent upon the outcome of discussions later on the agenda, this might represent the final meeting of the PCPC. He still intended to hold the workshop session on primary care.

35.6.1 Dr Williams sought an update on the current position in respect of nursing home provision in Lothian and any implications following on from recent media coverage around both local and national circumstances.

35.6.2 Professor McMahon commented the closure, at short notice, of the local nursing home had impacted on the delayed discharge position as a consequence of the need to manage transfers of patients following the closure of the home. He advised the transfer of patients had gone smoothly and both NHS and local authority colleagues should be commended for this.

35.6.3 Professor McMahon advised in addition to his local focus, he also served on a national contingency group set up by COSLA looking at the Southern Cross situation. He hoped a market solution would emerge within Lothian. He stressed, however, any reduction in the utilisation of care places by potential clients in these homes as a consequence of current concerns would adversely impact on the delayed discharge position.

35.6.4 The Board were advised by Professor McMahon through business continuity that work was progressing with local authorities to ensure the care of current residents would not be compromised following the closure of Southern Cross.

35.6.5 The Chair questioned whether there was any interest amongst local authorities to take any of the affected homes into Council ownership. Councillor Aitchison commented the only affected home in Midlothian currently operated a waiting list, although it was important to recognise the Council did not have the facilities to accommodate all residents from the home were it to close. He reminded the Board Loanhead Hospital was no longer available for decanting purposes.

35.6.6 Councillor Edie and Mr Johnston commented the primary objective within their Council areas was to retain the provision of care within care homes and contingency plans were in place should the position moving forward prove to be unsustainable. Councillor Edie commented he too hoped a market solution would emerge as, like Midlothian Council, he did not feel the City of Edinburgh Council had the resource to address any adverse consequences. He was of the view, in a worse case scenario situation, the Scottish Government Health Department should provide resourcing.

35.6.7 Dr Williams welcomed the assurances provided and questioned whether a ‘for profit’ model was the only solution being considered moving forward. Professor McMahon commented ongoing discussions were underway in respect of a range of options for future provision and this would also feature as part of the change fund discussions, which focussed on the provision of services to the elderly and not just
those in care. The Chair commented it would be important to consider how best to engage the third sector.

35.6.8 Mrs Allan questioned what additional advocacy and support services had been put in place for residents and families directly affected with the Southern Cross situation. Professor McMahon advised this issue had been discussed at COSLA the previous week and had included the need to provide information to families planning to place their loved ones in current Southern Cross facilities. He would pursue this further at the next national meeting, as it was important to avoid residents having to undergo multiple moves.

35.6.9 Professor McMahon undertook to keep the Board updated on any significant developments.

35.6.10 The Vice-Chair commented in respect of the Audit Scotland report on the review of CHPs that, to the best of his knowledge, neither CHP Chairs or Vice-Chairs had been asked to provide input before the report was written. he could not understand, given this position, how the report had reached the judgements it had.

35.7 Staff Governance Committee – Minutes of the Meeting held on 30 March 2011 – the Board adopted the Minutes. The Vice-Chair in his capacity as Employee Director, expressed disappointment at the language used in the Board brief in respect of attendance at work. He stressed it was not his or his Trades Union colleagues intention to ‘hunt down’ any member of staff and the issue had been about encouraging people back to work. He stressed the wording of the Board brief had caused considerable anxiety amongst staff and Trades Union colleagues. The Vice-Chair in his role as Employee Director, was working with Mr Boyter to correct the language used to reflect the desire to encourage people back to work. The Vice-Chair commented the eKSF target had now been met and the key issue moving forward was to ensure this was mainstreamed.

35.7.1 Mr Boyter commented in respect of attendance at work, it was important to formally recognise the sterling work undertaken by Trades Union colleagues in this difficult but critical area. He advised through partnership engagement, the NHS Lothian absence figures were at their lowest ever levels and this position had been sustained over a three month period. The Chair concurred advising in some areas of the media, NHS Lothian was being referenced as setting the standard others should follow.

35.8 East Lothian Community Health Partnership Sub-Committee – Minutes of the Meetings held on 21 April and 18 May 2011 – the Board adopted the Minutes. The Chair advised he would report progress on the East Lothian Council nomination to the Board as soon as further information became available.

35.8.1 Professor McMahon undertook to ensure the Board received an appropriate update on the East Lothian Child Protection HMie inspection.

35.9 Edinburgh Community Health Partnership Sub-Committee – Minutes of the Meeting held on 1 June 2011 – the Board adopted the Minutes.
35.10 Midlothian Community Health Partnership Sub-Committee – Minutes of the Meeting held on 26 May 2011 – the Board adopted the Minutes.

35.11 West Lothian Community Health and Care Partnership Sub-Committee – Minutes of the Meeting held on 9 June 2011 – the Board adopted the Minutes.

35.12 West Lothian Community Health and Care Partnership Board – Minutes of the Meeting held on 24 May 2011 – the Board adopted the Minutes.

36. Chairman’s Report

36.1 The Chair reported he had chaired a panel on 29 June 2011 to review the interim nature of the Medical Director’s appointment and, based on the Panel’s assessment, it was being recommended the Board confirmed Dr Farquharson in post. The Board approved the Panel’s recommendation and congratulated Dr Farquharson on his appointment.

36.2 The Chair advised the section on visiting the Craigmillar Greening project had been written in anticipation of the Board meeting and the visit had required to be rescheduled.

36.3 The Board received the Chair’s report.

37. Chief Executive’s Report

37.1 Mrs Sansbury presented the Chief Executive’s report covering local, regional and national initiatives, the contents of which were noted.

37.2 Mrs Hornett undertook to ensure in future all Board members received an invitation to the annual child protection conference.

38. Quality Improvement Report

38.1 Dr Farquharson commented the paper exceeded the size limit for a standard Board paper as it combined a number of other previous reports and was also in line with good practice that Boards focus a significant proportion of their time (20-25%) on quality issues. However, he was looking at a new format in which to present data which would shorten the report.

38.2 The Board received from Dr Farquharson update reports on hospital standardised mortality rates; adverse events; healthcare associated infection; complaints, concerns, contacts, inquiries and compliments.

38.3 Dr Farquharson advised the clinical effectiveness measures reported in the current paper were for child and maternal health. The Board received an update on the following areas, several of which were influenced by a range of factors outwith the NHS:-
1. pregnancy screening; uptake rates; sensitivity and false positive rates for Down’s syndrome screening;
2. percentage of babies born with low birth weight at term;
3. caesarean section and other intervention rates;
4. peri-natal and infant mortality rates;
5. percentage of babies exclusively breast fed at 6-8 months; and
6. percentage of children to complete all immunisations at 24 months of age.

38.4 The Chair welcomed the expansion of the suite of topics and commented a stage would be reached where the paper would become unwieldy. Dr Farquharson commented his intention was to produce a version of a dashboard indicator report for consideration by the Healthcare Governance and Risk Management Committee. He advised this would condense the data, as well as providing a brief overview of work.

38.5 Mrs Allan welcomed the report and in respect of complaints questioned what resources were in place to measure the satisfaction levels complainants had felt with the process and also how the outcome of complaints improved quality. Mrs Hornett advised in respect of the first point work was ongoing in this area with there now being an ability to track ethnicity data. She commented lessons learned were addressed in an annual report, although she would consider how to enhance this process outwith the formal cycle in order to expeditiously address areas of real concern and report that these had been addressed.

38.6 Professor Iredale commented whilst it was easy to compare Lothian performance with other Boards, he would welcome comparisons with other UK cities such as Liverpool and York. Dr Farquharson agreed this would be a useful exercise and would consider the current family of comparators.

38.7 Dr Farquharson at the suggestion of Professor Prowse undertook to produce a report for consideration at the appropriate Board Committee showing the impact and year-on-year improvement in respect of the outcomes of interventions around falls and medication errors. Dr Tierney suggested moving forward there was a need to focus on patient safety and other critical areas where sustaining improved performance would have most impact on patients. Dr Farquharson advised he would address this as part of the action in respect of the suggestion made by Professor Prowse.

38.8 Mrs Hornett commented a major exercise was underway in respect of the falls strategy which would demonstrate improvements moving forward. She advised there might be an issue about how falls were recorded and this was being investigated. Mrs Hornett stressed not all falls led to major harm, although they would be distressing to the patient involved. She advised work was also underway in respect of medicine errors in order to identify where the system needed to improve in future.
38.9 The Vice-Chair commented a key issue was about how to change attitude and behaviours and noted Mrs Sansbury was looking at practice south of the border. He suggested the way falls and other incidents were reported could have an impact and referenced the approach used by the construction industry, which had resulted in fewer accidents through a change in culture. He suggested there was a need to concentrate on and communicate big ticket issues in a way that made the message feel real to staff working in the areas affected.

38.10 Professor Murray advised whilst some of the figures might look significant, it was important to remember in the past few years staff had been encouraged to report all incidents irrespective of how trivial they might appear. In this respect, it was now easier to monitor trends through the Board’s Committee structure. She suggested moving forward the focus should be on outcomes and lessons learned.

38.11 The Board received the quality improvement report and noted the positive performance of NHS Lothian in this important area.

39. Delivering Better Care – Nursing and Midwifery Care Governance in NHS Lothian

39.1 Mrs Hornett commented the purpose of her report was to set out a framework for assuring and improving nursing and midwifery care in NHS Lothian, particularly in light of high profile coverage of poor, neglectful and abusive care reported across the UK. She reminded the Board the Cabinet Secretary had announced an inspectorate would be introduced to examine care of older people in acute care settings.

39.2 Mrs Hornett commented her paper set out NHS Lothian’s work in the context of personalised care where people were co-producers within a wider platform of safe, effective and person-centred quality ambitions, and provided examples of how these were delivered through the ‘Leading Better Care Programme’; ‘Compassionate Care Programme’ and the ‘Releasing Time to Care Initiative’. She advised progress would be monitored through the Executive Management Team where the importance of good quality essential patient care across Lothian was a key focus.

39.3 The Vice-Chair welcomed the paper, although he questioned how its aspirations sat within the context of expenditure constraints. In the risk metrics, he noted there was no reference to staffing levels. The Vice-Chair commented he was aware of incidences where nursing staff had raised issues about staffing levels on Datix and had not received a response from line management and questioned how this linked with the performance reported in the paper before the Board.

39.4 Mrs Hornett in response to the Vice-Chair advised staffing reductions would not be allowed to compromise patient safety. She advised a national workload measurement tool was available to assist in the way establishment levels were set, although this did not take account of patient activity or independence levels. She advised it was important staff had a mechanism for raising concerns and the issues around Datix raised by the Lothian Partnership Forum were being addressed with clinical nurse managers and others. She reminded the Board that the Datix system
was not and had never been intended to be, a replacement for direct discussion between staff and their managers, in respect of any service concerns.

39.5 Dr Tierney commented that this was a very important issue for the Board to consider, given recent concerns across the UK about standards of nursing care. She noted it was perplexing, given the increased level of graduate entrance into nursing that culturally there seemed to be difficulties in areas of providing basic care to patients. She felt there was a need to move from communication to more focused conversation to ensure nurses took more responsibility to address issues affecting public confidence.

39.6 Mrs Hornett in response to a comment by Dr Tierney advised the issue of whistle blowing policies and reporting of variations in performance was important. She commented an IT solution was being developed to present data in the way described by Dr Tierney. In addition, Mrs Hornett reported that Mrs Sansbury was keen to pursue a ward accreditation scheme, which would allow areas requiring support to be more easily identified and so receive further assistance, as well as recognising and rewarding areas of good practice.

39.7 Mrs Hornett advised progress on this important area would be reported routinely through the Healthcare Governance and Risk Management Committee, as well as the Executive Management Team.

39.8 The Board endorsed the governance and assurance framework which was being delivered working within professional and line management settings.

40. Sexual Health and HIV Strategic Programme: Financial Risk and Efficiency and Performance Metrics

40.1 Mrs Allan declared and interest in this agenda item as she was a Trustee of the Waverley Care Trust.

40.2 Professor McMahon reminded the Board at its meeting in March 2011, the 2011-2016 Lothian Sexual Health Strategy had been approved following a robust public consultation. At its March meeting the Board had requested a paper updating on the financial risk to the programme and on the progress to deliver metrics to measure performance against the outcomes specified in the strategy.

40.3 Professor McMahon advised the metrics at appendix 1 of the paper reported Lothian was in a good position against national indicators. He commented, however, there were some areas where data could not be extracted and other areas which were missing from both Lothian and national datasets. Professor McMahon commented he was confident progress would continue in this important area and that robust monitoring arrangements had been put in place.

40.4 The Chair commented the availability of comparative data at national and international level would be important in setting future targets. He advised it would also be important to ensure data in respect of improvements was sufficiently robust prior to it being brought to the Board for discussion.
40.5 The Vice-Chair reminded the Board the reason for the report back to the current meeting was to confirm a reduction in financial risk, although this had not been quantified in the paper. He commented details around the financial reports associated with LRP, NRAC and workforce targets were all clear and known and it was important to recognise a point would be reached when the Board needed to decide whether to progress some issues if full funding was not available.

40.6 Professor McMahon advised the risk equated to £3.1m and verbal, but not written, assurance had been received from the Scottish Government Health Department that funding would be made available. He commented, in the meantime, the approach was to manage service provision within budget. Professor McMahon reported consideration was being given to other initiatives which would reduce the financial requirement downstream.

40.7 Professor Iredale commented given future decisions would be based on data, it would be important data capturing was as robust as possible. He noted there had been exciting interventions introduced through this agenda and it would be important to capture these as this would be the justification for future funding.

40.8 Professor McMahon, at the request of the Vice-Chair, undertook to email Board members if there was any reduction in allocation in this key area.

41. Financial Position to 31 May 2011

41.1 Mrs Potter provided the Board with an overview of the financial position of NHS Lothian for the first two months of financial year 2011/2012. She advised the month 3 data was not yet finalised and would be signed off by the Director of Finance on her return from leave, prior to Executive Management Team review.

41.2 Mrs Potter advised NHS Lothian was reporting an overspend of £1.888m at the end of month 2, although the report still assumed a break-even position at the year end. The overspend reflected under delivery of £1.323m against the local reinvestment plan (LRP) target and £0.565m of overspend on other budgets.

41.3 Mrs Potter commented in respect of efficiency and productivity £4.653m of savings had been achieved against a target of £5.977m. She stressed continued management focus on delivery of the efficiency target was ongoing and was central to the achievement of financial balance at the year-end. Mrs Potter reported the out-turn of the quarter 1 financial review would be considered at the Executive Management Team in August and the Finance and Performance Review Committee in September.

41.4 The Chair questioned whether action plans were in place to address the overspend in prescribing, given this budget like all others required to break even. Mrs Sansbury advised CHPs were actively addressing this issue, although it was important to remember whilst NHS Lothian was an exemplar in terms of efficient prescribing, the system was also experiencing an ever increasing ageing population who, by definition, required more medication. Mrs Sansbury reported medicines wastage was also being investigated by Professor Murray.
Professor Murray advised CHPs, Finance and Pharmacy colleagues were working collegiately to deliver LRP and good progress was being made. She commented activity remained a challenge and was being looked at within the context of demographics, repeat prescribing and waste.

Dr Williams sought confirmation the budget was set at the correct level and reminded the Board Lothian had the most cost effective primary care prescribing record in Scotland. It is well known that the biggest drivers in respect of prescribing costs were the number, age and gender of the population which would inevitably lead to increased levels of prescribing in primary care.

The Vice-Chair expressed disappointment the paper only reported on the financial position to 31 May 2011 as he was aware the early month 3 financial figures were being discussed and reflected no improvement over the month 2 position. He was of the opinion the availability of up-to-date financial information was an essential part of enabling him to discharge his role as a Non-Executive Director on a board of governance.

The Chair commented it was his understanding the month 3 figures had not yet been through the normal validation process including the Executive Management Team and it would be important to recognise this position was no different from previous reports and did not represent information being withheld from the Board. The Vice-Chair commented, notwithstanding these points, the June figures were, in his opinion, available and he was concerned that the Board should receive the most up-to-date information available.

Mr Burley concurred with the Vice-Chair and commented the Board should have been in receipt of the month 3 figures, and suggested a Lean exercise should be undertaken to review the process of financial reporting to the Board in order to ensure the provision of timely data.

Mrs Sansbury commented the month 3 financial data was still provisional and had not been considered by the Executive Management Team. She re-assured the Board the system was working to put in place robust recovery plans. She advised the majority of slippage was around LRP schemes and colleagues were working through these to ensure financial requirements were met.

Mrs Potter reported a new financial system had been implemented which would allow a faster financial close at the month-end which, in turn, would facilitate quicker reporting to the Executive Management Team and thereafter the Board.

The Board, at the suggestion of Mr Anderson, agreed the Finance and Performance Review Committee meeting, previously scheduled for August and subsequently cancelled, should be re-instated to receive an update on the month 3 financial position. Mrs Potter would progress.

The Board noted the financial performance of NHS Lothian to 31 May 2011 and agreed that Mrs Potter would re-convene the Finance and Performance Review Committee during August to consider the month 3 financial position.
42. Delivering Waiting Times

42.1 Professor McMahon provided the Board with an outline of NHS Lothian’s largely positive performance on waiting times. Performance on 31 and 62 day cancer standards was positive and above Scotland-wide averages. He commented the issues raised at the previous Board meeting were being looked at in respect of patient pathways, in particular for lung cancer.

42.2 Professor McMahon advised performance was behind schedule on ENT, ophthalmology and plastic surgery with opportunities for providing additional capacity being looked at. He commented previous difficulties with diagnostics had been resolved with the 6 week standard being delivered in agreement with the Scottish Government Health Department.

42.3 Professor McMahon reported the A&E 4 hour wait had been marginally below the standard over the last period and this was an area of challenge for all Boards across Scotland. Mrs Sansbury commented performance at the Royal Infirmary of Edinburgh was always the most challenging largely because of the volume of activity. She advised the use of the A&E observation ward was being looked at to see if this would provide any benefit. In addition, she commented steps were being taken to discharge patients earlier in the day to free up bed capacity in order to move patients through the system quicker.

42.4 The Chair questioned whether there was any evidence of patients self-presenting to A&E. Professor McMahon advised this issue had been discussed at the Primary Care Forward Group with areas of collaborative work between primary and secondary care having been identified and appropriate actions agreed. The Board noted from Professor McMahon that a GP nurse pilot at the Royal Hospital for Sick Children had been positive, although some parents had responded by continuing to take their children to A&E despite acknowledging the alternative provision.

42.5 The Chair commented a further update report should be presented to the reconvened Finance and Performance Review Committee in August in respect of the A&E 4 hour wait and this report would focus on the variability across the system. Professor McMahon would progress.

43. Tackling Delayed Discharge

43.1 Professor McMahon reported at the census point in June, NHS Lothian was reporting increased numbers of patients delayed with 100 delayed overall and 18 patients delayed over 6 weeks. In the case of Edinburgh, colleagues had identified the main reason for this increase as being the closure of Elsie Inglis care home which necessitated the transfer of over sixty patients to other care homes and the opening of an additional hospital ward. Whilst this process had been extremely well managed by City Council and NHS staff, it placed additional pressure on care home availability within the City.

43.2 The Chair commented on the importance of ensuring the risk section of Board papers were adequately completed in future.
43.3 Mr Burley noted there had been slippage in performance around patients with complex issues. Professor McMahon commented some of these patients required to be repatriated to their local Health Boards and he had written to those Boards affected. He advised as a result one patient had been repatriated resulting in a significant reduction in the overall length of stay statistics. Professor McMahon acknowledged the need to improve the speed of assessment and repatriation for this group of patients.

43.4 The Vice-Chair thanked Councillor Aitchison and Midlothian Council for their work in increasing funding to ensure no patients were waiting more than 6 weeks.

43.5 The Board noted the results of the May and June 2011 census in relation to local targets and the national 6 week standard.

44. Healthcare Associated Infection Update

44.1 Dr McCallum updated the Board on progress and actions to manage and reduce healthcare associated infection across NHS Lothian.

44.2 Dr McCallum advised there had been 14 episodes of staphylococcus aureus bacteraemia (SAB) reported in June 2011 (4 MRSA, 10 MSSA) compared to 16 episodes in May 2011 (3 MRSA, 13 MSSA). She advised currently NHS Lothian was on trajectory to achieve the Health Efficiency Access Treatment (HEAT) target of 0.26 cases or fewer per 1,000 acute occupied bed days by March 2013. She commented this translated to no more than 265 cases of SAB in 2011-12 and no more than 213 in 2012-13.

44.3 Dr McCallum advised in respect of clostridium difficile infection there had been 23 episodes of infection in patients aged 65 or over in June 2011 compared to 24 in May 2011. She advised currently NHS Lothian was on trajectory to achieve the HEAT target of 0.39 cases or fewer by 1,000 acute bed days by March 2013. She advised this translated to no more than 342 cases of colistrium difficile infection in patients age 65 or over in 2011-12 and no more than 326 in 2012-13.

44.4 Dr McCallum advised in respect of hand hygiene that the bi-monthly national hand hygiene audit report published in May 2011 indicated NHS Lothian was presently achieving a hand hygiene compliance rate of 95%. She reported nursing staff groups, allied health professionals and ancillary staff continued to exceed the national minimum target of 90% compliance. She commented hand hygiene education and training continued with a focus on improving compliance amongst medical staff groups and target areas.

44.5 The Board noted the Healthcare Environment Inspectorate report of the Royal Hospital for Sick Children inspection carried out on 15 and 16 June 2011 was now available and generally positive. She advised an action plan was in place to deal with any recommendations.

44.6 The Chair questioned whether there was any method of tracking the hand hygiene status of patients. Dr McCallum advised this was done on an intermittent basis and...
she would consider how best to bring forward the outcomes of high-level results of such exercises to the Board.

44.7 The Vice-Chair commented in respect of rogue items being sent to the Laundry, whilst he acknowledged the work being done by senior colleagues he stressed 44 rogue items in 2 months was still unacceptable and raised governance issues for patients. Mrs Sansbury commented she shared the Vice-Chair’s views advising this was area of focus within her management team.

44.8 Professor Iredale advised NHS Lothian had been successful in managing HEI and commented this was a war of attrition and it was inevitable at some point incidents would occur. It was important, in his opinion therefore, the system remained vigilant.

44.9 The Board noted the progress and actions to manage and reduce healthcare infection across NHS Lothian.

45. NHS Lothian's Corporate Objectives 2010/11 and 2011/12

45.1 Professor McMahon advised the circulated paper outlined NHS Lothian’s performance against corporate objectives set for 2010/11 and also detailed refinements to the objectives for 2011/12 following their approval at the Board meeting in May.

45.2 The Board noted the position against NHS Lothian corporate objectives for 2010/11 and agreed the finalised list of corporate objectives for the present year.

46. Lean in Lothian Programme of Process Improvement Annual Report

46.1 Mrs Hornett advised the Lean programme, which had been commissioned by the Board on September 2006, was now 5 years old. Mrs Hornett reminded the Board the original commission to GE Healthcare was both to develop skills and to deliver time improvement projects and these had continued to be the objectives of the programme now determined and delivered by in-house staff. The Board noted partnership support and engagement had been key to the success of the Lean process.

46.2 Mrs Hornett drew the Board’s attention to the workplan for 2012 which linked with the clinical strategy. She advised a project looking at the Laundry pathway had been included to reflect recent concerns, including those discussed earlier in the meeting.

46.3 Mrs McDowell commented in terms of encouraging public engagement, it would be important to produce documents in plain English and which were jargon free. Mrs Hornett advised the circulated report was for internal consumption and a short summary would be produced for wider distribution addressing the issues raised by Mrs McDowell.
46.4 The Vice-Chair advised there was a need to keep sharing learning and this should be embedded in the way NHS Lothian undertook routine business. He commented partnership colleagues had committed significant resource to making the Lean process successful. He questioned how sustainable it would be to apply LRP to the Lean team, given the success of the outcomes. Mrs Hornett advised this issue had been discussed at the Executive Management Team and work was underway to consider enhancing the current team to focus on delivering some of the large system-wide LRP projects.

46.5 The Chair advised future reports should show the cost of administering the Lean process mapped against actual savings achieved. He commented the section on the risk register needed to be more complete than at present, as the Board needed to be able to recognise the priority of initiatives in a period of reducing resources.

46.6 Mr Burley commented significant success had been demonstrated over the previous 5 years and it was important to celebrate its dissemination across the system. He had first seen the benefits of the Lean process in the construction industry.

47. NHS Lothian Representation on the St John’s Hospital Stakeholder Group

47.1 The Board agreed to the appointment of Mrs Theresa Douglas as Chair of the St John’s Hospital Stakeholder Group for the remaining period when NHS Lothian would hold the Chair. The Board also agreed the appointment of Professor John Iredale as a member of the St John’s Hospital Stakeholder Group. The Vice-Chair thanked the Chair for his contribution to the Stakeholder Group, which had resulted in benefit to the citizens of West Lothian and beyond. Mr Johnston added his own appreciation.

48. Committee Structure

48.1 The Chair advised the purpose of his report was to recommend the disbandment of the Primary & Community Partnership Committee (PCPC) and reminded the Committee of the reasons for its initial establishment.

48.2 The Chair commented the Finance & Performance Review Committee was now taking an increased interest in monitoring primary care performance as single system working was refined and developed. He further advised as the number of CHPs had reduced and their role within an NHS Lothian single system had developed, he felt there was no longer a need for a layer between the CHPs and the Board. He reminded colleagues CH(C)P Minutes were now received by the Board itself and Chairs had a platform to raise relevant issues directly with the Board.

48.3 Mr Burley, as current Chair of the PCPC advised he felt the recommendation was the correct one as consideration of issues around primary care and community should be considered as part of the continuum of overall business. He commented, however, other Committees would need to consider how to reflect discussion
around primary care and the community on their agendas, as well as ensuring these service areas were represented on Committee memberships.

48.4 Mr Burley further commented he felt matters around primary care and community needed to be cited at Director-level, particularly in respect of ongoing governance. Mrs Sansbury advised primary care and community matters were routinely discussed at the Executive Management Team with Mrs Goldsmith, Professor McMahon and CHP General Manager playing key roles in the management of this important area.

48.5 Professor Iredale advised if the Service Redesign Committee was taking on a new role to include stronger links with CHPs, there would be a need for a robust system to be put in place to ensure the issues previously considered by the PCPC were being addressed. In that regard, there might be a requirement to revisit representation on the Service Redesign Committee. The Chair commented when seeking CHP representatives the automatic assumption should not always be to appoint the Chairs of the CHP.

48.6 Mr Anderson advised both the Christie Commission and the recent Audit Scotland report on CHPs sought and focussed on the need for greater integration and he felt the current proposals went a significant way to achieving this desire. He agreed with the need for appropriate representation on the Board’s Committee structure in order to ensure primary and community care was adequately represented. He felt as CHP Chairs there was a need to become closer to the work of the Primary Care Joint Management Group and the Primary Care Forward Group as he felt these areas of work were not yet fully integrated.

48.7 Mr Burley suggested the proposal to disband the PCPC was a good opportunity to revisit the agenda to create issues that would help to develop pathways moving into a new era.

48.8 The Board agreed to disband the PCPC following its pathway workshop session. It was further agreed Mr Burley would, for a short period, become a member of both the Finance & Performance Review Committee and the Service Redesign Committee to ensure appropriate Non-Executive representation on primary and community issues.

49. Schedule of Board and Committee Meetings for 2012

49.1 The Board agreed the schedule of Board and Committee meetings for 2012, subject to Mrs Goldsmith confirming the suitability of the date for the Audit and Finance and Performance Review Committees on her return from leave. The Vice-Chair expressed disappointment that Mrs Goldsmith had been unable to confirm the dates for approval at the current meeting.

50. South East Scotland Research Ethics Committees Annual Reports

50.1 The Board accepted the annual reports of the three South East Scotland Research Ethics Committees for 2010-2011.
50.2 Mr Boyter would confirm for future iterations of the annual reports whether the Board required to receive such detailed reports or whether a more focussed approach would suffice.


51.1 Professor McMahon commented his previous paper had covered the majority of issues contained within the summary report. He advised the Cabinet Secretary had agreed new arrangements for annual reviews. Professor McMahon commented the NHS Lothian review meeting would be held on 27 October 2011 and would not, on this occasion, be attended by the Cabinet Secretary, who would only now attend on alternate years. The Chair asked Board members to secure this date in their diaries.

51.2 The Vice-Chair commented it was interesting given the implications for them that SEAT Boards had only noted progress on the Royal Hospital for Sick Children/Department of Clinical Neurosciences business case. Professor McMahon stressed neighbouring Boards were committed to the project and had been kept fully up-to-date about the details through Chief Executives, Directors of Finance and Planning and other communications.

51.3 The Board noted the SEAT summary report.

52. Report of the Director of Public Health 2009-11

52.1 Dr McCallum commented this publication, her fifth Director of Public Health Report, was entitled ‘Our Health, Our Future’. She advised in the report she explored the impact of the global burden of disease – globally, nationally and locally and why our health was now important to the public’s health in future. She advised the report also explored these issues through the themes of ‘improving access, engagement and health outcomes; current interventions to reduce the burden of disease in the future; and a comparison of health systems’.

52.2 Dr McCallum advised communications regarding the publication would be arranged to ensure as many people as possible knew about the key issues affecting the health of the Lothian population. She advised the CD ROM and website versions would again be designed to be user friendly and would contain both the report and detailed health data for Lothian.

52.3 The Board welcomed the Director of Public Health annual report commenting on the importance of recognising the future contribution of the third sector, ongoing engagement with local authorities on healthy built environments as well as health implications of planning applications. Dr Tierney suggested there would be merit in focussing on alcohol and smoking as areas where significant health benefits would be achieved and to subject these areas of work to the same rigorous performance management arrangements as other parts of the agenda. Mr Anderson concurred advising he felt there would be benefit in focussing on common risk factors.
52.4 Dr McCallum commented there would be a need to learn lessons from previous recessions in minimising the potential impact of the recession in the health of people in lower socio-economic groups.

52.5 Professor McMahon advised his team and Public Health colleagues were considering how best to influence the clinical strategy and he would anticipate Dr Tierney and Mr Anderson’s comments being addressed through that process.

52.6 The Board received the report of the Director of Public Health for 2009/11.

53. **Family Nurse Partnership – Presentation**

53.1 Mrs Hornett welcomed Mrs Egan, Ms Alexander and Ms Strong to the meeting advising they had been instrumental in driving forward the pilot work on the Family Nurse Partnership (FNP).

53.2 Mrs Hornett advised the FNP followed up on the work of a national test site project progressed with the Scottish Government Health Department with full funding. She commented the ethos had been about improving health and contributing to reducing inequalities.

53.3 Councillor Edie questioned how it would be possible to undertake a full evaluation of the benefits of the FNP when comparable data was not available. Ms Alexander advised the focus of evaluation was about the implementation of the pilot and not its efficiency, although a randomised control trial undertaken by Cardiff University might provide baseline statistics and would show similar comparisons to the original work carried out by Professor Olds, who had created the process.

53.4 Mrs Egan reported Dundee was joining the scheme and the Scottish Government Health Department was rolling out the programme. She advised with some small datasets it was difficult to produce relevant data. Mrs Egan commented the intervention with mothers was what had made the difference allowing young people to continue with their education as demonstrated to the Board by video case studies as part of the PowerPoint presentation.

53.5 The Board heard that the programme had been available to all pregnant teenagers and had crossed the social divide without excluding anyone. Mrs Hornett advised the future roll-out of the programme would be bound by the strict conditions of the license which did not allow for local interpretation, although feedback could be made through Dr Olds to influence future practice. She advised further work would be required in respect of impacts on the existing workforce.

53.6 Dr Tierney commented it would have been useful if the presentation had highlighted how the FNP was different from services already provided through health visiting and what the extra benefits of the FNP were that could not be delivered through existing nursing services. Ms Strong confirmed there was an ongoing research component embedded within the existing work.
53.7 The Chair thanked colleagues for their informative presentation commenting the FNP was a fabulous programme. He commented it would be interesting to see the progress of the group of children involved over time.

54. Communications Received

54.1 The Board received the list of communications from the Scottish Government Health Department.

54.2 The Vice-Chair sought confirmation, given headlines elsewhere, that an auditable process was in place confirming NHS Lothian’s compliance with standards of care for dementia in Scotland (CEL (2011) 020). Professor McMahon confirmed an active programme of work was underway in this respect to address the raft of guidelines and standards issued by the Scottish Government Health Department. He reported the outcome of this work would be submitted to the Executive Management Team in September with an update provided to the Board thereafter.

55. Any Other Competent Business

55.1 Rescheduled Finance and Performance Review Committee Meeting – Mrs Potter would arrange for the August meeting of the Finance and Performance Review Committee to be re-instated to consider the month 3 financial position.

56. Date and Time of Next Meeting

56.1 Wednesday, 28 September 2011 at 9.30am in the Boardroom, Waverley Gate, 2-4 Waterloo Place, Edinburgh.
NHS LOTHIAN  
LOTHIAN AREA CLINICAL FORUM  
Action Checklist from Meeting held on Thursday 18 August 2011

<table>
<thead>
<tr>
<th>Item</th>
<th>Action to be taken</th>
<th>By whom</th>
<th>Completion date</th>
</tr>
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<tbody>
<tr>
<td>3.</td>
<td><strong>Clinical Strategy – “How we treat people”</strong></td>
<td>CG</td>
<td>23/08/11</td>
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<td></td>
<td>Mr Jackson asked members to let him know of any changes that they were aware of</td>
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<td>that would be happening and whether they come under the heading of ‘reaffirmed’,</td>
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<td>‘soon’, or ‘longer term’ change. The Scottish Government guidance on what</td>
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<td></td>
<td>constitutes change would be circulated to members for information.</td>
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<td></td>
<td>Dr Moffoot asked Mr Jackson if he would come along to the Lothian Psychology</td>
<td>CG</td>
<td>18/08/11</td>
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<tr>
<td></td>
<td>Committee to give the presentation. The Co-ordinator agreed to facilitate this.</td>
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<tr>
<td>5.1</td>
<td><strong>ACF Workplan</strong> – It was agreed that Sally Egan would take over as ACF</td>
<td>CG</td>
<td>18/08/11</td>
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<td></td>
<td>representative on the Service Redesign Committee. The Committee Administrator</td>
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<td>would make the necessary arrangements.</td>
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<td>6.</td>
<td><strong>Quality</strong> Draft Healthcare Quality Standard – To be circulated to all PACs</td>
<td>ALL/CG</td>
<td>18/0</td>
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</table>
Minutes of the Meeting held on Thursday 18 August 2011 commencing at 8:30am in Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG

Present:
Professor Pat Murray Chair, Lothian Area Pharmaceutical Committee (Chair)
Ms Alison Meiklejohn Chair, Lothian Allied Health Professions Committee
Mr Graham Bell Representative Patient
Dr Alison McCallum Director of Public Health and Health Policy, NHS Lothian (until 10am)
Mrs Sally Egan Chair, Lothian Area Nursing and Midwifery Advisory Committee
Dr Anthony Moffoot Vice Chair, Lothian Area Medical Committee
Ms Anne Waugh Vice Chair, Lothian Area Nursing Midwifery Advisory Committee
Ms Liz Roebuck Vice Chair, Lothian Area Dental Committee (until 10am)

In Attendance:
Mr Chris Graham Committee Administrator, NHS Lothian
Ms Marina Copping NHS Lothian, Clinical Information Manager, Women & Children's Services (Item 1)
Dr Anne Hendry National Clinical Lead for Quality, Scottish Government (Item 2)
Mr Andrew Jackson Assistant Director of Healthcare planning, NHS Lothian (Item 3)

Apologies:
Mr Robert Naysmith Chair, Lothian Area Dental Committee
Dr Stuart Blake Chair, Lothian Area Medical Committee
Mr Kevin Wallace Chair, Lothian Area Optical Committee
Mr Norman Fraser Chair, Lothian Psychology Committee
Dr Simon Mackenzie Associate Medical Director, Acute Sector

1. **A Child's Journey through TRAK Health** *(presentation circulated electronically)*

1.1 The Chair welcomed Ms Marina Copping to the meeting. Ms Copping gave a presentation looking at the child’s journey through TRAK Health. The presentation covered the strategic aims; development of a child health record and looked at different screens in relation to antenatal booking; discharge; health visitor caseload and booking. The Forum noted that there was a clear and focussed strategic clinical eHealth vision of one Lothian record; this was ahead of all other Scottish Boards. The partnership between eHealth and clinical champions in defining, driving and delivering the products and change required was also noted.

1.2 There was discussion on the development of family linkages within the system; involvement of nurse partnership; the challenges associated with the Child and Adolescent Mental Health Service (CAHMS); links with community pharmacy and the progress being made with information sharing through the data sharing partnership.
1.3 The Chair thanked Ms Copping and she left the meeting.

2. Quality Strategy

2.1 The Chair welcomed Dr Anne Hendry to the meeting. Dr Hendry gave the Forum a verbal update on developments with the Quality Strategy since its launch last year. The Forum noted that the quality infrastructure was now established and there was now a move away from healthcare delivery to the wider issues, e.g. best start to life. Dr Hendry mentioned developments with the early years change fund and initiatives for the adult population such as keep well; smoking cessation and alcohol brief interventions.

2.2 Establishing a sustainable quality system was discussed as was workforce and leadership development. There was also discussion on why existing integrated systems could not be adapted for NHS Lothian’s needs e.g. the Montreal system used since 1995. It was important to note that all integrated systems were bespoke as they linked information through different things e.g. social insurance. Dr Hendry reported that the eHealth Strategy was currently with ministers and was due out in September.

2.3 There was also discussion on the Knowledge Management Strategy and the importance of IT in relation to supporting self management i.e. telehealth and telecare, which are part of NHS Lothian’s eHealth Strategy, broader learning and feedback is also critical to dissemination of good information.

2.4 In relation to engagement, Dr Hendry informed the Forum about the links project in primary care where some practices were working closely with voluntary sector organisations and the community. There was also a programme being developed with the Boys Brigade in Scotland, covering 20,000 households across Scotland. This is a programme that they will deliver and share through youth links.

2.5 The Chair thanked Dr Hendry and she left the meeting.

3. Clinical Strategy – “How we treat people”

3.1 The Chair welcomed Mr Andy Jackson to the meeting. Mr Jackson presented “How we treat people”, outlining the Board’s Strategic approach framework for 2011 – 2021. The presentation looked at core business functions of the organisation; financial, demography and medical workforce drivers; themes such as need based services; implications for existing strategies, developing strategies and service change.

3.2 The Forum noted that a progress report would be taken to the Board in September and Mr Jackson asked members to let him know of any changes that they were aware of that would be happening and whether they come under the heading of ‘reaffirmed’, ‘soon’, or ‘longer term’ change. The Scottish Government guidance on what constitutes change would be circulated to members for information.
3.3  Mr Bell gave feedback on the patient involvement event which Mr Jackson had presented the strategy at the previous day. It was the intention to have these events periodically in the development process. Dr Moffoot asked Mr Jackson if he would come along to the Lothian Psychology Committee to give the presentation. The Co-ordinator agreed to facilitate this.  

3.4  The Chair thanked Mr Jackson and he left the meeting.  

4.  Minutes of Previous Meeting ~ 19 May 2011 - The circulated minutes of the meeting were approved as an accurate account of that meeting.  

5.  Matters Arising [Action Checklist]  

*The Forum noted that all actions on the checklist had been complete.*  

5.1  ACF Workplan – There was discussion about ACF communications; workforce review board and ACF representatives on existing committees such as clinical board; service redesign and planning committee. It was agreed that Sally Egan would take over as ACF representative on the Service Redesign Committee. The Committee Administrator would make the necessary arrangements.  

5.  Quality  

The Committee noted the following received items which had been covered in discussion with Dr Hendry:  

- Update on Quality Strategy Implementation – Quality Outcomes & Indicators  
- Draft Healthcare Quality Standard – To be circulated to all PACs with comments back to the Committee Administrator.  
- Effective Delivery Group Action Note - 8 June 2011  
- Health Promoting Health Service: Revised Programme of Activities for NHS Boards  
- Quality Alliance Board Minutes - 9 May 2011  

6.  Chair’s Business  

7.1  Professional Advisory Committee Annual Reports  

7.1.1  The Following Professional Advisory Committee Annual Reports for 2010 were received and noted by the Forum:  

- Lothian Area Pharmaceutical Committee  
- Lothian Area Medical Committee  
- Lothian Area Healthcare Scientists Committee  
- Lothian Area Nursing & Midwifery Committee  
- Lothian Allied Health Professions Committee
7.2 **Area Clinical Forum Chairs’ Group Update** - The Chair invited Alison Meiklejohn to deputise for her at the next meeting in September.

7.3 **Patient Rights (Scotland) Act 2011 Consultation on Secondary Legislation** - The Act would be circulated to all PACs with comments on the consultation back to Alison Meiklejohn by the end of September.

8. **Board Issues**

8.1 **Lothian NHS Board**  
Papers available at [www.nhslothian.scot.nhs.uk](http://www.nhslothian.scot.nhs.uk)

8.1.1 The Forum noted the minutes of the Board meeting held on 25 May 2011 and the agenda and electronically circulated papers from the 27 July meeting.

8.2 **NHS Lothian Service Redesign Committee**

8.2.1 The Forum noted the minutes of the meeting held on 27 June 2011.

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:

- Medical Committee 15/06/11
- Pharmaceutical Committee 04/08/11; 02/06/11
- Healthcare Scientists Committee 25/05/11
- Nursing & Midwifery Committee 20/07/11
- Allied Health Professions 14/06/11
- Dental Committee 23/06/11

*There was discussion on all the Professional Advisory Committees contributing towards an article to go into the Connections Newspaper to raise the profile of the role of the Committees and awareness of the Advisory Structure. Input was sought by the end of September. This would also contribute towards item 11(e) in the ACF Workplan.*

10. **Items for Information**

There were none.

11. **Any Other Competent Business**

12. **Date of next meeting**: Thursday 17 November 2011, 8.30 – 11.30am, Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh EH1 3EG *(Deadline for receipt of papers is 3 November 2011)*

13. **Future Meeting Dates 2012**

- 2 February 2012
- 17 May 2012
- 16 August 2012
- 22 November 2012
### Family Health Services – Payment Verification Procedures (12 October 2009)

- To write to the Government with respect to Lothian’s experience of the dental payment verification protocol, and to report back to the Committee on what action can be taken locally.
  
  **SG**

  **Due Date:** 7/12/09

  **Action Taken:** A report is on the Committee agenda for meeting of 11 October.

  **Outcome:** In progress

### Matters Arising from the Audit Committee of 21 June 2010 (11 October 2010)

- Mrs Goldsmith to provide a report to the December Committee on the transfer of the staff lottery from the exchequer.

  **SG**

  **Due Date:** 6/12/10

  **Action Taken:** The Committee of the Health for Lothian Appeal Society is reviewing 2 options for a new independent organisation (incorporated body), along with considering admin needs for ongoing operation. Also, CLO has provided guidance on naming restrictions for the new organisation. This work is expected to be completed by the end of the financial year.

  **Outcome:** In progress
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<tr>
<th>Action Required</th>
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<th>Action Taken</th>
<th>Outcome</th>
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<tbody>
<tr>
<td><strong>Any Other Competent Business</strong> (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>
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<td><strong>Internal Audit Reports</strong> (12 April 2011)</td>
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<td><strong>Internal Audit Progress Report (March 2011)</strong></td>
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<td>• The Controlled Drugs Governance Team to give a presentation to a future meeting of the Operational Audit Sub-Committee.</td>
<td>PM</td>
<td>30/5/11</td>
<td>The presentation was given on 26 September 2011.</td>
<td>Complete</td>
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<td><strong>Corporate Governance</strong> (12 April 2011)</td>
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<td><strong>Technical Brief Overview – Audit Scotland 2011/1</strong></td>
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<td>• Management to consider whether the reported fraud on fictitious pension payments could happen in NHS Lothian, and to report back to the Counter Fraud Action Group.</td>
<td>AP</td>
<td>24/5/11</td>
<td>This has been referred to the relevant managers. The outcome of the review will be presented to CFAG in December.</td>
<td>In progress</td>
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<td>Action Required</td>
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<td><strong>Operational Audit Sub-Committee (21 June 2011)</strong></td>
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<td>• Management to investigate the risk of NHS Lothian staff performing duties relating to maternity medical services, that are already covered by the Primary Medical Services Contract.</td>
<td>DM</td>
<td>27/9/11</td>
<td>Sally Egan is chairing a short life working group to review this. Maternity Medical Services is part of the Global Sum payment – issue is GP involvement now in booking and ongoing maternity care: discussions on going with Community Midwife Management to identify basis for GP Input. A further update will be given at a future meeting.</td>
<td>In progress</td>
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<td><strong>Linkages with Other Board Committees (21 June 2011)</strong></td>
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<td><strong>Finance &amp; Performance Review Committee – Minutes of 13 April 2011</strong></td>
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<td>• Mr Renwick to receive a copy of the letter to Scottish Futures Trust.</td>
<td>JJB</td>
<td>27/9/11</td>
<td>The letter was sent on 2/8/11.</td>
<td>Complete</td>
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<tr>
<td>• Mr Renwick to discuss RHSC/ DCN project issues with the chairs of Staff Governance Committee and Finance &amp; Performance Review Committee.</td>
<td>SGR</td>
<td>27/9/11</td>
<td>A report is on the agenda. (still to be received).</td>
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<td>Action Required</td>
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<td><strong>Healthcare Governance &amp; Risk Management Committee – Minutes of 5 April 2011</strong></td>
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<td>• Mr Renwick to discuss future arrangements for risk management with the Chairman and the Chair of the Healthcare Governance &amp; Risk Management Committee.</td>
<td>SGR</td>
<td>27/9/11</td>
<td>A meeting is being arranged.</td>
<td>In progress</td>
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<tr>
<td><strong>Internal Audit &amp; Counter-Fraud Reports (21 June 2011)</strong></td>
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<td><strong>Compliance with Policies &amp; Procedures (March 2011)</strong></td>
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<tr>
<td>• The Staff Governance Committee should receive the report and the action plan.</td>
<td>AB</td>
<td>29/6/11</td>
<td>Both the Staff Governance Committee and the Healthcare Governance &amp; Risk Management Committee have received the action plan.</td>
<td>Complete</td>
</tr>
<tr>
<td>• The Quarterly Workforce Report should contain a paragraph on the progress of mandatory training.</td>
<td>AB</td>
<td>27/9/11</td>
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<tr>
<td><strong>Counter Fraud Services Quarterly Report – March 2011</strong></td>
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<tr>
<td>• Mr Miller to prepare an accountability map for independent contractor payments. This should describe the claims process, who is responsible for ensuring payments are appropriate, and who is responsible for implementing improved systems of control where this is required. The Operational Audit Sub-Committee should receive this map.</td>
<td>DM</td>
<td>13/9/11</td>
<td>This has been presented to the Operational Audit Sub-Committee of 26 September 2011.</td>
<td>Complete</td>
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<tr>
<td><strong>Counter Fraud Services – Patient Exemption Checking – Annual Reporting Package 2010/11</strong></td>
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<tr>
<td>• Building on the accountability map, further work should be undertaken to reduce the risk of fraud and error within patient exemption for charges.</td>
<td>SG</td>
<td>27/9/11</td>
<td>CGVFM Manager is actively working with Counter Fraud Services on this subject.</td>
<td>In progress</td>
</tr>
<tr>
<td>Action Required</td>
<td>Lead</td>
<td>Due Date</td>
<td>Action Taken</td>
<td>Outcome</td>
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<tr>
<td><strong>Internal Audit &amp; Counter-Fraud Reports</strong> (21 June 2011)</td>
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<tr>
<td>Fraud Intelligence Alerts</td>
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<tr>
<td>• Mr Woods to send a copy of the bulletins to the Foundation Director.</td>
<td>DW</td>
<td>27/9/11</td>
<td>The bulletins were sent to the Director on 21 June.</td>
<td>Complete</td>
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<tr>
<td><strong>General Corporate Governance</strong> (21 June 2011)</td>
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<tr>
<td>Quality Outcomes Framework and Contract Review Update</td>
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<td>• Mr Miller’s paper to the Operational Audit Sub-Committee on the accountability map should include the issue of GP access within 48 hours in the risk analysis, as well as the issue of financial leverages.</td>
<td>DM</td>
<td>13/9/11</td>
<td>Further work is required in this area and the findings will be presented at a future meeting.</td>
<td>In progress</td>
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<td>2010/11 Healthcare Governance Committee Annual Report to Lothian NHS Board</td>
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<td>• Mr Renwick to discuss with the Chair of Healthcare Governance &amp; Risk Management Committee whether significant incidents are being notified to members of that Committee.</td>
<td>SGR</td>
<td>27/9/11</td>
<td>A meeting is being arranged.</td>
<td>In progress</td>
</tr>
<tr>
<td>• Mr Payne to review the format of the annual Committee reports for the 2011/12 assurance process.</td>
<td>AP</td>
<td>1/12/11</td>
<td>This will be presented to the December Audit Committee.</td>
<td>Not yet due</td>
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<td>2010/11 Annual Report from the Information Governance Assurance Group</td>
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<td>• Clarification to be given as to whether there is partnership representation on the Information Governance Assurance Group, and how this Group relates to the Healthcare Governance &amp; Risk Management Committee.</td>
<td>AP</td>
<td>27/9/11</td>
<td>The Director of Public Health &amp; Health Policy has confirmed that there is a partnership representative on the Group. Furthermore information governance is within the remit of HGRM, and the Group reports to the HGRM.</td>
<td>Complete</td>
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<tr>
<td>Action Required</td>
<td>Lead</td>
<td>Due Date</td>
<td>Action Taken</td>
<td>Outcome</td>
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<td><strong>General Corporate Governance (21 June 2011)</strong></td>
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<tr>
<td>SFR 18.0 – Summary of Losses and Payments for the Year Ended 31 March 2011</td>
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<td>• A revised paper, addressing the identified errors, would be circulated to the members along with the minutes of the meeting.</td>
<td>SG</td>
<td>31/8/11</td>
<td>A revised paper is on the agenda.</td>
<td>Complete</td>
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<tr>
<td>• The Director of Finance will provide the Committee with an update of the progress made in collecting income from overseas patients.</td>
<td>SG</td>
<td>27/9/11</td>
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<tr>
<td><strong>Formal Consideration of Resources Available to the Committee</strong></td>
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<td>• In recognition of the future changes in Board membership, succession plans should be developed to ensure that the Committee has the necessary skill set within its membership.</td>
<td>SGR/ AP</td>
<td>27/9/11</td>
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<tr>
<td><strong>Annual Accounts (21 June 2011)</strong></td>
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<tr>
<td><strong>Statement on Internal Control</strong></td>
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<tr>
<td>• Subject to minor correction, the Committee recommended that the Statement of Internal Control be signed.</td>
<td>BM</td>
<td>30/6/11</td>
<td>This was addressed in the process of finalising the accounts.</td>
<td>Complete</td>
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<tr>
<td><strong>Representation Letter</strong></td>
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<tr>
<td>• Subject to minor amendments, the Committee recommended that the letter be signed.</td>
<td>SG</td>
<td>30/6/11</td>
<td>This was addressed in the process of finalising the accounts.</td>
<td>Complete</td>
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Minutes of the NHS Lothian Audit Committee Meeting held at 9.00am on Monday, 21 June 2011 in Meeting Room 5, Waverley Gate, 2-4 Waterloo Place, Edinburgh, EH1 3EG.

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

In Attendance: Ms J Bennett (Clinical Governance Manager); Professor J J Barbour (Chief Executive); Mrs S Goldsmith (Director of Finance); Mr R Martin (Head of Corporate Reporting and Corporate Governance); Mr D Miller (General Manager, Primary Care Contracts); Ms H Russell (External Auditor - Audit Scotland); Mr D Woods (Chief Internal Auditor); Dr C J Winstanley (Chairman); Ms G Woolman (External Auditor - Audit Scotland); Mr A Payne (Corporate Governance & Value-for-Money Manager) and Miss L Baird (Committee Administrator).

Apologies for absence were received from Ms Carmichael.

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. The Chair declared that his employer had an interest in shared services contracts discussed at the Finance and Performance Review Committee.

10. Minutes of the Previous Meeting

10.1 Minutes of the Previous Meeting held on 12 April 2011—previously circulated minutes of the meeting of the NHS Lothian Audit Committee held on 12 April 2011 were approved as a correct record, however Mr Peacock’s submitted apologies should also be recorded.

10.2 Ms Woolman advised the Committee that the exercise on staff earning over £100,000 was complete. The final letter of assurance had been issued with the letter to the Cabinet Secretary.

11. Matters Arising

11.1 Matters Arising from the Meeting of 12 April 2011— the Committee noted the previously circulated paper detailing the matters arising from the Audit Committee meeting held on 12 April 2011, together with the action taken and the outcomes.
11.1.1 Mr Payne gave a brief overview of the action note noting the paper on the application of ESA 95 to the Royal Infirmary of Edinburgh contract that went to the Finance and Performance Review Committee on 8 June 2011.

11.1.2 Mrs Goldsmith advised the Committee that work to transfer the staff lottery would be completed within the financial year. Legal advice had been sought regarding the use of NHS Lothian’s name. It has already been confirmed that the “Lothian Health Board” and the “Edinburgh and Lothian’s Health Foundation” could not be used.

11.1.3 Members were advised that NHS Lothian had received the final payment in relation to the Orthodontist case. Mrs Goldsmith had met with PSD and legal advisors to progress the review. The outcome of this review will be reported to the September Operational Audit Sub-Committee, and thereafter the Scottish Government’s Health & Wellbeing Audit Committee.

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

12. Operational Audit Sub-Committee

12.1 Minutes of the Operational Audit Sub-Committee held on 28 March 2011 – the Committee noted the previously circulated minutes of the meeting of the Operational Audit Sub-Committee held on 28 March 2011.

12.1.1 Referring to the internal audit report on Community Nursing & Health Visiting, Mr Egan raised concerns that General Practitioners were being paid for duties performed by NHS Lothian staff. Members were advised that this had been discussed at the Primary Care Forward Group and a letter had been sent to the Lothian Medical Committee.

12.1.2 The Committee agreed to adopt the minutes of the Operational Audit Sub-Committee meeting held on 28 March 2011.

12.2 Update on the Operational Audit Sub-Committee held on 30 May 2011 – the Chair gave a brief overview of discussions in respect of the Death in Hospitals internal audit report which was received at the meeting.

12.2.1 In reply to a question from Mr Egan regarding Maternity Medical Services Mr Miller advised the Committee that these duties were part of the Primary Medical Services Contract which was negotiated on a four country contract basis and the global sum payments funded this service. Members noted that a Short-life Working Group had been tasked locally to review this service and make recommendations for consideration locally and nationally.

12.2.2 Mr Miller agreed to explore what would happen if NHS Lothian staff did not carry out these duties e.g. would these default to the General Practitioners. DM

Ms Bennett entered the meeting.
13. **Linkages with Other Board Committees**

13.1 **Finance & Performance Review Committee - Minutes of the Meetings held on 13 April 2011** - the previously circulated minutes of the Finance & Performance Review Committee meeting held on the 13 April 2011 were received.

13.1.1 The Committee discussed the revised funding mechanism and additional assurance required by the Scottish Futures Trust. The discussion highlighted concerns over whether the Committee has sight of the whole risks associated with the Royal Hospital for Sick Children / Department of Clinical Neurosciences project.

13.1.2 Professor Barbour advised the Committee that he had written to Mr White, Chief Executive Scottish futures Trust, sighting his concerns in respect of the requirements placed on NHS Lothian by the Scottish Futures Trust. He agreed to request that his Executive Assistant forward a copy of the letter to the Chair for his information.

Mr Woods advised the Committee that there are days in the 2011/12 internal audit plan to perform a review of the project. However, the scope and timing of the review are yet to be determined following changes in the structure of the project and close involvement already from Audit Committee members.

The Chair agreed to take forward project issues with Mr Egan and Mr Walker, Chair of the Finance and Performance Review Committee out with the meeting.

13.1.3 The Committee noted the Finance and Performance Review Committee minutes of 13 April 2011 and the information therein.

13.2 **Healthcare Governance & Risk Management Committee - Minutes of the Meeting held 5 April 2011** - the previously circulated Minutes of the Healthcare Governance & Risk Management Committee meeting held on the 5 April 2011 were received.

13.2.1 The Chair highlighted ongoing discussions in respect of the Risk Register at the Healthcare Governance and Risk Management Committee. Mr Egan raised concerns that he had observed gaps in the communication of risk to that Committee. The Chair advised the Committee of discussions surrounding moving risk to the remit of the Audit Committee. He agreed to discuss the move with Dr Winstanley and Professor Murray out with the meeting. The Audit Committee confirmed that it would like to have regular sight of the risk register.

13.2.2 Professor Barbour advised the Committee that Dr Farquharson would take forward devising a standard wording to clarify that adding risks to the register did not absolve responsibility.
13.2.3 The Committee noted the Healthcare Governance and Risk Management Committee minutes of 5 April 2011 and the information therein.

14. Internal Audit Reports

14.1 Compliance with Policies and Procedures (March 2011) and Update Report from Director of Human Resources

14.1.1 Mr Woods introduced the internal audit report on Compliance with Policies and Procedures which had been referred to the Audit Committee by the Operational Audit Sub-Committee. He advised that the audit had been commissioned by the Chief Executive, and gave an outline of the scope. The audit concluded that staff are not always being made aware of new or amended policies and procedures, and staff’s awareness cannot be readily evidenced. Also, the volume and range of policies can contribute towards confusion. Mr Woods mentioned that managers gain assurance of compliance through building controls into processes, supervising work and reviewing performance and incident reports, but non-compliance with policies and procedures has been a recurring theme highlighted through other audit work.

14.1.2 Mr Boyter presented the previously circulated action plan to improve awareness and compliance with policies and procedures. He advised the Committee that he had nominated NHS Lothian as a pilot site for the first phase of the Human Resources system in September 2011. The Committee noted that a revised procedure on the development, approval and communication of policies would be presented to the HR Policy Group, the Clinical Policy Group, Executive Management Team and finally to the Lothian Partnership Forum for approval. Mr Egan requested that the report and action plan also be submitted to the Staff Governance Committee for consideration.

14.1.3 The Committee were advised of revisions to all managers’ personal development plans to include mandatory objectives.

14.1.4 Mr Boyter advised the Committee that work to map policies and procedures on the intranet was ongoing. In response to his suggestion the Committee agreed that the Quarterly Workforce report would be revised to include a paragraph to highlight the progress of mandatory training.

14.1.5 The Committee agreed to endorse the action being taken and agree the later implementation date of 30 September 2011 for approval of the revised procedure on the “Development of NHS Lothian Policies and Procedures”.

14.2 Internal Audit – Progress Report May 2011

14.2.1 Mr Woods gave a brief overview of the report and highlighted the completed 2010 plan, the schedule for 2011 and recent increase in fraud activity. The Committee noted that the increased activity helped evidence that systems were working to identify fraudulent acts and the application of the zero tolerance approach.
14.2.2 The Committee noted the previously circulated Internal Audit Progress Report May 2011 and the assurances therein.

14.3 Internal Audit - Annual Report for 2010/11

14.3.1 Mr Woods spoke to the annual report and confirmed that Internal Audit’s work indicated that reasonably adequate and effective internal controls had been operating throughout the year. He summarised that Internal Audit could report positively against the guidance for supporting completion of the Statement on Internal Control.

14.3.2 The Committee agreed to accept the report.

14.4 Counter Fraud Services Quarterly Report – March 2011

14.4.1 Mr Woods noted the Counter Fraud Services quarterly reports underlining Operations HARRIER and DILL from NHS Lothian. He then advised that NHS Lothian staff continued to show a healthy commitment towards reporting suspected fraud.

14.4.2 Professor Barbour queried whether additional processes of assurance could be applied to independent contractors. Mr Miller assured the Committee that processes for General Practitioners were sufficient, although further work was required with PSD regarding the payment verification process for dentistry. Further assurances in respect of optometry and the changing processes in pharmacy would also be sought. Mrs Goldsmith advised the Committee that she had met with PSD to discuss ownership noting the challenges related to the current payment systems.

14.4.3 Professor Barbour called for a map of accountability to clarify where claims paperwork went, who was accountable for ensuring that payments were made appropriately and who should be contacted in respect of implementing additional processes. Members agreed that Professor Barbour’s suggestion would be a step towards a managerial approach that would replace the current administrative approach.

14.4.5 Members were advised that discussions at the Community Health Partnerships had taken place on this subject however a detailed debate was still required to ensure that all issues were resolved.

14.4.4 Mr Miller agreed to prepare an accountability map and present it at the next Operational Audit Sub-Committee.

14.4.6 The Committee agreed to accept the CFS Quarterly Report – March 2011.

14.5 Counter Fraud Services – Patient Exemption Checking – Annual Reporting Package 2010/11

14.5.1 The previously circulated report to provide the Committee with information on the latest analysis of the levels of fraud or error within claims for exemption from patients’ charges was received.
14.5.2 The Committee noted that the estimated fraud/error had reduced in all areas for Lothian and now stands at £1.4m and that the estimated potential fraud and error had reduced in Dental and Ophthalmic but increased in Pharmacy. Mrs Goldsmith advised the Committee that this was an estimated figure and the situation with Pharmacy should improve with the abolishment of prescription charges.

14.5.3 The Committee noted that whilst the comparative level of estimated fraud/error and estimated potential fraud/error was falling, it is still not at an acceptable level. There is a residual risk to the Board, and this should be reflected in the appropriate risk register.

14.5.4 Mr Miller advised the Committee that he acted on behalf of the Community Health Partnerships, in his role he ensured that all issues were regularly communicated to the Primary Care Joint Management Group and Community Health Partnerships meetings. Overall it was the responsibility of the Community Health Partnerships to acknowledge and action the information that Mr Miller provided.

14.5.5 Building on Mr Miller’s mapping exercise, further work should be undertaken to reduce the risk of fraud or error within patient exemption charges.  

SG

14.6 Quality Outcomes Framework and Contract Review Update

14.6.1 Mr Miller gave a detailed presentation on the quality outcomes framework and contract review. He highlighted that 8 practices received the full number of points, all practices had received payment, 2 had been identified for targeted visits and some were required to provide further information. He assured the Committee that he was satisfied with the level of assurance and evidence that had been received.

14.6.2 Mr Egan expressed concerns that he had received a number of complaints regarding accessing General Practitioners within 48 hours. Members agreed that this should be included in the risk analysis section of Mr Miller’s report to the Operational Audit Sub-Committee. Work in respect of financial leverages would also be teased out and inserted into the report to the Operational Audit Sub-Committee.

DM

14.6.3 Mr Miller advised the Committee that some practices had been reviewed in relation to issues with fridge temperatures and quality of practice leaflets; recoveries would be sought if these issues were not resolved. He went on to note that contracts were reviewed every year by the PCCO and findings were reported to the Primary Care Joint Management Team and Community Health Partnerships.

14.6.4 Mr Miller reiterated that the processes in place were laid out in the Framework, the Primary Care Joint Management Group received regular updates, and any action would be anticipated and brought back in collaboration with Mr Miller.
14.6.5 The Committee noted the Quality Outcomes Framework/ Statutory & Contractual Review verbal update, as a source of assurance for the Statement on Internal Control.

14.7 Fraud Intelligence Alerts

14.7.1 The Committee noted the previously circulated Counter Fraud Services bulletins and the information therein.

14.7.2 Mr Woods provided assurances that the bulletins had been disseminated to appropriate colleagues. The Committee agreed to continue to receive Counter Fraud Services bulletins. The Chair requested that the bulletins be copied to the Foundation Director of the Edinburgh and Lothians Health Foundation.

15. External Audit Reports

15.1 NHS Lothian: 2010/11 Review of Internal Controls - the previously circulated report on NHS Lothian: 2010/11 Review of Internal Controls from Ms Woolman was received.

15.1.1 Ms Woolman spoke to the report highlighting the key messages in relation to effective management of assets and interests, preventing material misstatement, error fraud or corruption, and compliance of established policies, procedures, laws and regulations. The report did not include any “high priority” matters.

15.1.2 The Chair noted that Ms Woolman and Ms Russell were approaching their end of term as members of the external audit team, and thanked them for their support and hard work over their years of service.

15.1.3 Mr Egan expressed concerns about some themes apparent from the recommendations presented by the external auditors, in particular that recommendations are not always being actioned by service managers. Mrs Goldsmith assured the Committee that work to resolve these issues was ongoing. Members agreed that they should take this opportunity to look at the stock management process including the health and safety aspect of stock management.

15.1.4 The Committee agreed to accept the report.

16. General Corporate Governance

16.1 2010/11 Healthcare Governance Committee Annual Report to Lothian NHS Board - the previously circulated report to provide the Committee with the annual report of the Healthcare Governance & Risk Management Committee, so as to provide a source of assurance with respect to the Statement on Internal Control was received.
16.1.1 The Committee discussed the risk of significant incidents not being alerted to the members of the Healthcare Governance & Risk Management Committee. It was agreed that the Chair would have a discussion with Professor Murray to ensure that all relevant issues were being systematically fed through the Healthcare Governance and Risk Management Committee.

16.1.2 In response to Dr Winstanley comments on the format of the report, Mr Payne agreed to review the format of the committee annual report template, so as to improve the 2011/12 annual reports.

16.1.3 The Committee accepted the report provided as a source of assurance to support the Statement on Internal Control.

16.2 Lothian NHS Board Annual Report of the Chair of the Finance & Performance Review Committee Period Ending 31 March 2011 - the previously circulated report to provide the Committee with the annual report of the Finance & Performance Review Committee, so as to provide a source of assurance with respect to the Statement on Internal Control was received.

16.2.1 The Committee agreed that the frequency of meetings needed to be clarified in particular when there were special or irregular meetings. Mr Boyter’s attendance would also be clarified to state that he had attended 4 out of 4 meetings since his appointment.

16.2.2 The Committee accepted the report provided as a source of assurance to support the Statement on Internal Control.

16.3 NHS Lothian Risk Management Annual Report 2010/11 – the previously circulated report to provide the Committee with the annual report in respect of NHS Lothian Risk Management, so as to provide a source of assurance with respect to the Statement on Internal Control was received.

16.3.1 Ms Bennett gave an overview of the risk management annual report, summarising the main developments made by the risk management team in respect of policies and procedures, developing the risk register and strengthening the alert and monitoring mechanisms through the management line.

16.3.2 Ms Bennett advised the Committee that the Risk Team were proposing linking the risk register to the clinical standards of care and corporate objectives to make it more meaningful. Dr Winstanley supported the proposed changes.

16.3.3 Mr Egan expressed concerns that Health and Safety representatives did not have access to DATIX and had not been included in the walk arounds. Ms Bennett assured the Committee that the walk arounds would be reviewed in the near future.

16.3.4 The Committee accepted the report provided as a source of assurance to support the Statement on Internal Control.

Ms Bennett left the meeting
16.4 2010/11 Annual Report from the Information Governance Assurance Group - the previously circulated report to provide the Committee with the annual report in respect of the Information Governance Assurance Group, so as to provide a source of assurance with respect to the Statement on Internal Control was received.

16.4.1 The Committee questioned whether there was staff governance or partnership representation on the Information Governance Assurance Group. Members also requested clarification in respect of the links between the Information Governance Assurance Group and the Healthcare Governance and Risk Management Committee. Mr Payne would pick these issues up out with the meeting.

16.4.2 The Committee accepted the report provided as a source of assurance to support the Statement on Internal Control.

16.5 2010/11 Summary Assurance Report on Best Value – the report to brief the Committee on how NHS Lothian progresses the duty of Best Value was received. It was agreed that future versions of the report should give more detail on the elements of the Staff Governance Standard.

16.5.1 The Committee accepted the report provided as a source of assurance to support the Statement on Internal Control.

16.6 Lothian NHS Board Annual Report of the Chair of the Operational Audit Sub-Committee Period Ending 31 March 2011 - the previously circulated report to provide the Committee with the annual report of the Operational Audit Sub-Committee was received.

16.6.1 The Committee accepted the report provided as a source of assurance to support the Statement on Internal Control.

16.7 NSS Service Audit Reports 2010/11

16.7.1 Mrs Goldsmith introduced the NSS Service Report 2011 in respect of Practitioner Services Division, National IT Services and Financial Services.

16.7.2 Ms Woolman advised that Audit Scotland received a statement of assurances from the external auditor for NSS which provided the required assurances.

16.7.3 The Committee acknowledged the unqualified opinions from the service auditors for the three areas and accepted these as a source of assurance in respect of the Board’s systems of internal control.

16.9 SFR 18.0 – Summary of Losses and Payments for the Year Ended 31 March 2011 – the previously circulated report to provide the Committee with an opportunity to review the summary of losses and compensations payments incurred throughout 2011 was received.
16.9.1 Mr Woods identified errors in paragraphs 3.2 and 3.5, and noted that the appendix was incomplete. It was agreed that the revised appendix would be circulated with the minutes. SG

16.9.2 The Committee discussed processes in place for collection of payment from overseas visitors. As well as being discussed recently by the Counter Fraud Action Group, Mrs Goldsmith advised the Committee that this item was on the Executive Management Team agenda. She agreed to feedback any progress to the Committee. SG

16.9.3 The Committee noted the paper.

16.10 Formal Consideration of Resources Available to the Committee - the Committee agreed that the resources made available to the Committee (e.g. through audit days and supplementary support) had been adequate for the Committee to discharge its functions.

16.10.1 However the Committee acknowledged that the Board will have 7 or 8 new members next year, and this will have a bearing on the membership of the Audit Committee. It was agreed that there needed to be succession plans in place to ensure that the Committee continued to have the necessary skill set within its membership. SGR/ AP

17. Annual Accounts

17.1 Statement on Internal Control - a previously circulated paper, together with the draft letter Statement on Internal Control was received.

17.1.1 Mr Martin spoke to the Statement on Internal Control and the Committee noted the arrangements put in place to support the statement.

17.1.2 Following its review of the draft Statement on Internal Control, the Committee agreed to support the Statement and recommend to the Board that, subject to minor correction in relation to Mutuality and Equality Committee, the letter be signed by the Chief Executive on its behalf. BM

17.2 Representation Letter - the Committee received a previously circulated report, together with a draft Letter of Representation to the External Auditors.

17.2.1 Following discussion, it was agreed that the statement properly represented confirmation to the External Auditors on matters arising during the course of their audit of the accounts for the year ended 31 March 2011, and to recommend to the Board that the letter be adopted subject to minor amendments in respect of identified drafting errors. SG

17.2.2 Mrs Goldsmith assured the External Auditors that she supported the statements within the letter of representation.
17.3 External Audit - Lothian NHS Board - Report to those charged with Governance on the 2010/11 Audit - a previously circulated report to those charged with governance on the 2010/11 Audit was received.

17.3.1 Ms Woolman spoke to the report highlighting preparative work, matters arising, outcomes and that the audit opinion was unqualified.

17.3.2 The Committee agreed to accept the report subject to the minor amendments to paragraph 8 and 12.

17.4 Annual Accounts for the Year ended 31 March 2011 - the Committee received the annual accounts for 2010/11 and proceeded to scrutinise each page of the accounts in detail.

17.4.2 Following a detailed consideration of the annual accounts for 2010/11, a number of minor amendments to the annual accounts were agreed, areas for further clarification and minor amendments to Board members details. Subject to these amendments, the Committee agreed to recommend to Lothian NHS Board that it approve and adopt the annual accounts for year ended 31 March 2011.

Professor Barbour, Mr Peacock and Mr Egan left the meeting.

17.5 NHS Lothian, Audit Committee Annual Report from the Chair – Year Ending 31 March 2011 – the Committee approved the previously circulated NHS Lothian, Audit Committee Annual Report from the Chair – Year Ending 31 March 2011.

17.6 Lothian NHS Board Audit Committee – 2010/11 Notification to the Health & Wellbeing Audit Committee – the previously circulated letter and attached action plan was received.

107.6.1 The Committee agreed to approve the letter subject to the minor amendments suggested by Mr Woods in relation to recent fraud cases.

18. Any Other Competent Business

18.1 The Committee noted that there were no other items of competent business.

19. Date of Next Meeting

19.1 It was noted that the next scheduled meeting of the Audit Committee would be held on Monday, 11 October 2011 at 9.00am in Waverley Gate, Edinburgh.
## FINANCE & PERFORMANCE REVIEW COMMITTEE

### RUNNING ACTION NOTE

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<th>Action Required</th>
<th>Lead</th>
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<th>Action Taken</th>
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<tr>
<td><strong>Management of Drug Spend (9 June &amp; 28 October 2010, 13 April 2011)</strong></td>
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<td>• A further report on progress on LRP in pharmacy should be submitted</td>
<td>SG/PM</td>
<td>03/10/11</td>
<td>Further proposals for LRP currently being developed and another on prescribing being reviewed</td>
<td>Scheduled for October meeting</td>
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<tr>
<td><strong>Royal Hospital for Sick Children (9 June 2010, 13 April &amp; 8 June 2011)</strong></td>
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<tr>
<td>• A cost comparison should be made against the cost of providing shelving for medical records against scanning the records and holding them electronically.</td>
<td>JKS</td>
<td>03/10/11</td>
<td>Business Case being considered by EMT 05/10</td>
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<tr>
<td>• Recommend to the Board that the Chief Executive of the Scottish Futures Trust be invited to a Board meeting to give a presentation outlining the role of the Scottish Futures Trust</td>
<td>SG</td>
<td>28/09/11</td>
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<tr>
<td>• Draw up a detailed briefing for Non-Executive members outlining the key risks as part of the briefing at the 13 September Finance &amp; Performance Review Committee meeting.</td>
<td>SG</td>
<td>13/09/11</td>
<td>Presentation on key aspects including risks provided</td>
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<tr>
<td>• Feed in any particular question to the Director of Finance in order that these could be dealt with at the special meeting of the Committee on 13 September 2011</td>
<td>All</td>
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<td><strong>Gullane GP Practice Reprovision - Initial Agreement (9 February, 13 April &amp; 8 June 2011)</strong></td>
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<td>• Provide update on funding for future years</td>
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<td>Action Required</td>
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<tr>
<td><strong>Financial Position</strong> (9 February &amp; 13 April 2011)</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>Work currently underway on HRGs – due to be completed September</td>
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<tr>
<td>• Check whether a recent campaign against waste by Lanarkshire NHS Board had proved effective</td>
<td>SG</td>
<td>03/10/11</td>
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<td>To be incorporated as part of Prescribing paper</td>
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<tr>
<td><strong>Property - Asset Management and the Strategic Framework for Developments</strong> (13 April 2011)</td>
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<tr>
<td>• Provide regular updates on the strategic direction in asset management and future capital developments</td>
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<td>Work underway through ICIC</td>
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<tr>
<td><strong>Delivery of Local Reinvestment Programmes in 2011/12</strong> (8 June 2011)</td>
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<tr>
<td>• Working towards a set of primary care activity indicators</td>
<td>AMcM</td>
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<td>Work underway</td>
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<tr>
<td><strong>Performance Management</strong> (, 8 June 2011)</td>
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<tr>
<td>• Include quality indicators/headers and stretch targets if appropriate in future reports</td>
<td>AMcM</td>
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<td></td>
<td>Work underway</td>
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<tr>
<td><strong>Shared Services Possibilities for NHS Lothian</strong> (13 April 2011, 8 June 2011)</td>
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<td>Work in progress</td>
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<tr>
<td>• Take the paper back to Council colleagues to take further action to implement the recommendations</td>
<td>AB</td>
<td>01/08/11</td>
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<tr>
<td>• Bring forward detailed proposals to the Committee</td>
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<td>• Present a further report to the October meeting</td>
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<td>Capital Investment Programme 2011/12 to 2015/16</td>
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<td>• Change the format of the appendix to quote funding in a more relevant and concise way</td>
<td>SG</td>
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Minutes of the Meeting of the Finance & Performance Review Committee held at 9.00am on Wednesday, 17 August 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Mr R Y Anderson (In the Chair); Mr A Boyter; Mr R Burley; Mr E Egan; Mrs S Goldsmith; Professor A McMahon; Mr B Peacock; Professor M Prowse; Mrs J K Sansbury; Dr A Tierney and Mr I Whyte.

In Attendance: Mr I Graham; Mr P Reith; Mr D A Small and Mr S Wilson.

Apologies for absence were received from Councillor J Aitchison, Professor J J Barbour, Dr D Farquharson, Mrs M Hornett, Professor J Iredale, Mr P Johnston, Dr A McCallum, Mr S G Renwick and Mr G Walker.

Appointment of Chair

Mr Anderson advised the Committee that in the absence of Mr Walker and Mr Renwick he had been asked to take the Chair. The meeting unanimously agreed that Mr Anderson should act as Chair.

Declaration of Financial and Non-Financial Interest

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

28. Minutes of the Previous Meeting

28.1 The previously circulated Minutes of the meeting held on 8 June 2011 were approved, subject to the following amendment:-

Minute 17.17 amend to read: ‘Mr Egan commented that, as agreement on the plans for ownership of the land had not yet been resolved, and there was an anticipated further year to the completion of the project, he remained anxious that specialist children’s services could become concentrated in the west of Scotland.’
29. Matters Arising

29.1 Royal Hospital for Sick Children and Department of Clinical Neurosciences Reprovision Project (Minute 17) – a previously circulated report providing an overview of the key activities, issues, risks and decisions required to allow a procurement of the revenue financed non-profit distribution model, fundamental to the reprovision of the Royal Hospital for Sick Children and the Department of Clinical Neurosciences at Little France was received.

29.1.2 Mrs Goldsmith advised the Committee that a summary of the role of the Scottish Futures Trust had been received indicating that it was intended to provide both expert advice and provide a governance role in relation to value for money. She advised that there would be four key stage reviews undertaken and further detail as to what these would encompass was still awaited. Work was being undertaken to examine the process in terms of risk.

29.1.3 Mrs Sansbury commented that the project was being reviewed far more than any other project with which she had been involved. There was no clear understanding at this stage of how the Scottish Futures Trust proposed to run the key stage reviews.

29.1.4 The Chair emphasised the need for a clear audit trail and communications plan throughout this exercise.

29.1.5 Mr Egan noted that two days prior to their forthcoming visit to the Royal Infirmary of Edinburgh, the Scottish Futures Trust was continuing to change the ground rules and he emphasised the need for discussion at the Board to take place.

29.1.6 Dr Tierney expressed her concern that the entire project continued to be delayed and proposed that the Director of the Scottish Futures Trust be invited to attend the Board itself in order to explain the reason for these delays.

29.1.7 It was agreed to recommend to the Board that the Chief Executive of the Scottish Futures Trust be invited to a Board meeting to give a presentation outlining the role of the Scottish Futures Trust. SG

29.1.8 Mr Burley commented that he was unsure of the locus of the Scottish Futures Trust in some of the areas they were investigating.

29.1.9 Mrs Sansbury confirmed that NHS Lothian continued to be the accountable body in respect of the delivery of the project. Mr Whyte commented on the unusual number of reviews being undertaken.

29.1.10 Mrs Sansbury advised that the concept design and the reference design were being developed by the design team and work to date had been reviewed and influenced by staff, patients and carers. The design would be signed off before the next meeting of the Committee. The application for planning for
consent in principle had been submitted at the end of July and was expected to be discussed by the Planning Committee in November.

29.1.11 Mrs Sansbury advised that negotiations with Consort continued to progress Supplementary Agreement 6 to secure the land and access for the project. Outstanding issues to be resolved included agreement on the classification of the change, the link interface between two buildings, land evaluation and car park income. It was noted that all other items had been agreed in principle. Work was underway to understand Consort’s concerns and also to determine what facilities management should be contained within the budget. It was noted that Mr Renwick had now been invited as a Non-Executive member of the Project Board.

29.1.12 Mrs Goldsmith advised that procurement was a well-established and legal process and once legal agreement had been reached with Consort, it would be going out to tender in November 2011. A significant amount of information would go out to the market and as much preparatory work as possible was being undertaken.

29.1.13 Mr Egan commented on the need to keep revisiting what was expected of Mrs Sansbury and Mrs Goldsmith who were leading the project, as well as continuing with their regular work. He commented that, because of the need to go through the Scottish Futures Trust, NHS Lothian would have to agree a revenue commitment for the next 30 years in terms of the non-profit distribution model. He commented on the number of the disadvantages of the option including the duplication of facilities.

29.1.14 Mrs Sansbury advised that revenue support would be received from the Scottish Government.

29.1.15 In response to a question from Dr Tierney, Mrs Sansbury advised that the PPP was a similar model in many ways to the PFI one.

29.1.16 Following discussion on the complexity and risk profile of the project, Mrs Goldsmith advised that she would be drawing up a detailed briefing for Non-Executive members outlining the key risks as part of the briefing at the 13 September Finance & Performance Review Committee meeting.

29.1.17 Mrs Goldsmith advised that she would be picking this up at the next stage and members were asked to feed in any particular question to herself in order that these could be dealt with at the special meeting of the Committee on 13 September 2011.

29.1.18 The Committee agreed to note the programme of activities and associated decisions required to allow public procurement of the project to proceed; to approve the proposed delivery arrangements for facilities management services in the new building and to approve the delegated authority of the Project Board to approve NHS Lothian’s Official Journal of the European Union notice for the Royal Hospital for Sick Children and the Department of Clinical Neurosciences project at Little France, together with the pre-
qualification questionnaire for interested organisations and the scoring methodology for pre-qualification submissions to shortlist three bidders.

30. Shared Services Position Update

30.1 A previously circulated report from the Director of Human Resources & Organisational Development on the forward workplan for shared services options, refreshed to reflect a number of material influences presenting during the past 12 weeks was received.

30.2 Mr Boyter explained that this was one of a series of updates and advised that links were being developed with the Transport Committee chaired by Mr S G Renwick. Almost all of the partners had participated in a recent event and committed to following up on the shared services debate. Some partners might take a lead in similar areas. Mr Boyter advised that the City of Edinburgh had their own fuel depot, the use of which by NHS Lothian might be both financially and operationally beneficial. Stevenson College could service vehicles at cost and proposals would be brought back for the period 2012/13 onwards. Templates mapping out the possibilities were being prepared and would be issued shortly.

30.3 Mr Boyter undertook to bring forward detailed proposals to the Committee and confirmed that he would be taking advice from Procurement.

30.4 Mr Boyter advised that NHS Lothian sharing options would be considered at the next meeting of the Finance & Performance Review Committee.

30.5 Mr Egan welcomed the report and partnership representation on the group. He emphasised that shared services had been an objective for a number of years.

30.6 Professor Prowse suggested that there were possible efficiency savings to be achieved through sharing training, although there were potential difficulties with IT where systems were not compatible.

30.7 Mr Boyter confirmed that shared training in a number of areas was being examined as were other ways of sharing services with partners. The Committee agreed to note the shared services position update and endorse the recommendations contained therein. It was agreed that a further report should be presented to the October meeting.

31. Replacement of a CT Scanner at St John’s Hospital and a Bi-Plan Angiographic Suite at the Department of Clinical Neurosciences, Western General Hospital

31.1 A previously circulated report seeking approval for the replacement of a CT scanner at St John’s Hospital and a Bi-Plan Angiographic suite at the Department of Clinical Neurosciences at the Western General Hospital was received.
31.2 Mrs Goldsmith explained that the CT scanner was leased and changes in the accounting treatment meant that it was now brought on to the balance sheet of NHS Lothian.

31.3 Mrs Sansbury advised that the existing equipment had broken down three times in the last few weeks and the purchase of the replacement equipment would help achieve performance targets, as well as improving services to patients.

31.4 Mr Egan supported the Business Case welcoming the commitment to the future of St John’s Hospital and the Western General Hospital that this represented.

31.5 The Chair commented that the current replacement policy did not appear to accommodate the speed of advance in technology, which could mean disproportionate amounts of equipment becoming obsolete at the same time.

31.6 Mrs Sansbury commented that a draft imaging strategy was being worked on and further work was being carried out on the business cases for an MRI scanner at St John’s Hospital.

31.7 Mrs Goldsmith commented that a number of items of equipment at the Royal Infirmary of Edinburgh would be due for renewal at the same time and confirmed that she had been in discussions with the Scottish Government over this.

31.8 The Committee noted that the proposal had been approved by the Lothian Medical Equipment Review Group and the Lothian Capital Investment Group and agreed, in principle, by the University Hospitals Division Senior Management Team on 2 June 2011.

31.9 Bearing this in mind, it was agreed to approve the expenditure of £700,000 for the CT scanner for St John’s Hospital and £1.2m for the Neuro-Vascular suite, from the existing approved Lothian Medical Equipment Review Group budget to replace this essential equipment.

32. Gullane GP Practice Provision – Standard Business Case

32.1 A previously circulated report and Standard Business Case for the reprovision of Gullane GP practice was received.

32.2 The Chair welcomed Mr Small to the meeting. Mr Small outlined the need for this reprovision as Gullane GP practice was no longer fit for purpose and confirmed that this was the East Lothian CHP top priority. Mr Small advised that the Business Case had been approved by the Executive Management Team, as well as East Lothian CHP Sub-Committee, NHS Lothian Primary Care Finance & Performance Group, NHS Lothian Capital Steering Group and the NHS Lothian Capital Investment Group. In addition, the agreement was subject to approval from Audit Scotland for the capital grant proposal.
32.3 Mr Small explained that the project was being taken forward through Hubco in partnership with East Lothian Council who owned the site to be used, and were leading the management of the project. He advised that the East Lothian CHP management team had delegated authority to approve the stage 2 from Hubco for final agreement.

32.3 Mr Egan commented that he fully supported this Business Case and sought clarification on any potential knock-on effects arising from the reprovision of services.

32.4 Mr Small confirmed that the existing practice arranged its own maintenance and the NHS cleaning specifications had been taken into account in the standards and included in the detailed guidance.

32.5 Mr Burley sought clarification on whether the impact on the built environment was being taken into account and Mr Small confirmed that this would be taken on board and the impacts checked with the Public Health lead, Margaret Douglas.

32.6 Mr Whyte advised that public meetings had been held where some concerns about traffic and parking had been addressed and Mr Egan commented that this was a good news story for the people of East Lothian.

32.7 The Committee agreed the Standard Business Case.

33. Financial Position to 30 June 2011

33.1 The Committee received a previously circulated report containing an overview of the financial position of NHS Lothian for the first three months of the financial year 2011/12.

33.2 Mrs Goldsmith tabled a paper on the first quarter financial review for 2011/12, which had been considered by the Executive Management Team on the previous day.

33.3 Mrs Goldsmith advised that, as previously discussed, NHS Lothian was reporting a significant overspend for the year to date (£2.8m as at 30 June 2011). This reflected both under-delivery of the efficiency target (£2.1m) and overspends on other budgets (£0.7m).

33.4 The key areas of concern were the achievement of planned savings, GP prescribing, critical care nursing, cancer services and unplanned activity (UNPACS).

33.5 Mrs Goldsmith provided assurance to the Committee that a recovery plan was in place to offset slippage on efficiency savings. Whilst there were still some concerns, it was important to note that achievement of the targets was more advanced than had ever been the case at this stage of the year.
33.6 Mrs Goldsmith advised that much work was being carried out on prescribing, although national changes in prices had an adverse effect of £3.7m in Lothian. Lothian was moving up to the Scottish average and this was being followed up with the Scottish Government, as it reflected Lothian’s high levels of savings in previous years. CHP General Managers were meeting to consider proposals for discussion with General Practitioners to better manage prescribing.

33.7 Mrs Goldsmith reported that unplanned activity and out-of-area transfers continued to present a problem at the University Hospitals Division. The Executive Management Team had agreed to proceed with the necessary management action and financial balance would be achieved by the end of the financial year.

33.8 Mr Burley questioned why the impact of prescribing had not been reflected in the budget, and Mrs Goldsmith explained that the overspend was not predictable because so many products were reliant on looking at the average cost per item. The Scottish Government had already been informed that promised price reductions were not coming through the Health Boards.

33.9 Professor Prowse commented that such costs would be difficult to manage and suggested that Research & Development might review the potential benefit to patients of newly approved drugs.

33.10 Mrs Goldsmith replied that Dr Farquharson would be sponsoring a 5x5x5 initiative to look at ways of addressing this problem and Professor Prowse suggesting making use of knowledge transfer partnerships in order to gain a wider input of expertise.

33.11 Mr Egan expressed his disappointment that it had not been possible for these figures to be discussed at the July Board meeting and emphasised the need for work on achieving savings to start as early as possible in the financial year. He expressed concern that some General Practitioners appeared to be acceding to requests from patient for prescriptions for particular medications instead of prescribing medications they considered necessary.

33.12 Mr Egan commented that he was still concerned at the failure to implement some policies and emphasised the need to provide incentives to General Practitioners and their staff to identify ways of saving money.

33.13 Dr Tierney commented that the quarterly report was re-assuring, although she was concerned at the continuing problem of rising prescribing costs. She suggested emphasising the rising drug costs and would be interested to see the outcome of the Local Recovery Plan for the pharmacy strategy coming forward at an earlier stage.

Mr Peacock left the meeting.

33.14 Mrs Goldsmith undertook to check whether a recent campaign against waste by Lanarkshire NHS Board had proved effective.
33.15 The Committee agreed to recognise the seriousness of the financial position so far for the year and endorsed the management action required to deliver the statutory target of break-even.

34. Capital Investment Programme 2011/12 to 2015/16

34.1 Mrs Goldsmith introduced a previously circulated report giving an update on progress against the agreed capital programme for the current year, including the expenditure position to June 2011.

35.2 Mrs Goldsmith advised the Committee that following the issue of the circular CEL 32 (2010) in August 2010, the way that capital resources were distributed nationally had been radically altered. This change in approach impacted on the local management of capital programme and the operational challenges this posed would be discussed with representatives from the Scottish Government Health Directorates towards the end of August.

35.3 The Committee noted that in line with this, NHS Lothian had been given an initial capital allocation of £65.3m which would be supplemented by a contribution of £0.1m from other health systems for the regional eating disorders unit and a donation of £0.4m from Walk-the-Walk for the second best theatre. The local capital available was, therefore, £65.8m as outlined in the paper.

35.4 Mr Whyte commented that the figures in the appendix quoting funding, NHS Lothian expenditure profile and variance was not particularly helpful and Mrs Goldsmith undertook to change the format to provide information in a more relevant and concise way.

35.5 In response to a point made by Professor Prowse on the need for a strategy for eHealth, Mrs Goldsmith advised that Dr Farquharson had re-instated the Informatics Board and work on this was in hand.

35.6 The Committee agreed to note the expenditure of £12.2m on the agreed capital programme for the first three months of the financial year and the capital position overall.

36. Performance Management

36.1 A previously circulated report providing an update on the most recently available NHS Lothian performance data as reported through local and national systems was received.

36.2 Professor McMahon advised the Committee that of the 33 items monitored, on the most recent data, NHS Lothian met the overall target on 6 occasions, was on trajectory to reach but had not yet met, the final target on 8 occasions, was off trajectory on one occasion, did not meet the overall target on 9 occasions and there was no data available yet because of new or revised targets on 9 occasions.
Overall, performance had improved on a number of key areas since the previous month. Healthcare associated infection rates had moved positively to be on trajectory again although a number of other areas continued to be off trajectory as outlined in the circulated paper.

Professor McMahon advised that progress was being made in bringing down GP and inpatient day case activity numbers and these should be back on-line in September. A specific report on accident and emergency services would be brought to the October meeting of the Committee. Work was underway to reduce inappropriate attendances at accident and emergency.

Professor McMahon reported that issues with care home capacity in Edinburgh was impacting on delayed discharge figures which were not as positive as would have been preferred, but these should be back on track by October.

Professor McMahon advised that new operators had been appointed to a number of the homes previously managed by Southern Cross and issues concerning the quality of care were being looked into. He emphasised that local authorities had the responsibility for standards in these homes.

Mr Egan commented that neither local authorities nor Health Boards had the resources to fund care homes that failed and contingency plans would be needed in case there were further problems.

Professor McMahon advised that NHS Lothian was commenting on a consultation on the care for older people. The contract with General Practitioners and other healthcare staff was being used to pick up any healthcare concerns in these establishments.

Professor Prowse commented that appropriately qualified staff in educational establishments could be mobilised in partnership if this proved necessary. Professor McMahon advised that the Board had contingency plans, although formal responsibility rested with local authorities who had been asked to share their contingency plans with NHS Lothian.

The Committee agreed to receive the report and note the actions being taken on behalf of responsible Directors where performance was off trajectory.

Workforce Efficiencies within NHS Lothian

The Committee received a previously circulated report giving an update on progress with the planned workforce reductions and reviewing performance management of sickness absence.

Mr Boyter introduced the report and tabled the latest comparison of sickness absence rates showing NHS Lothian’s variable performance to June 2011. Mr Boyter indicated that as 70% of NHS Lothian expenditure was in relation to staffing costs, these costs had to be reduced by a combination of workforce design, workforce efficiency and workforce effectiveness.
37.3 Dr Tierney commented that workforce efficiencies would become more difficult to achieve as time went on and sought re-assurance about the consequences and potential risks. She suggested that such reports should comment on these risks and given re-assurance as to how they were being dealt with.

37.4 Mr Boyter undertook to include a new section on the quality of service provided and the work being undertaken to ensure continuity of care. He accepted that staff numbers could not continue to be reduced indefinitely and that the demographic implications of future service requirements were being examined, as was the use of healthcare assistants. A refreshed Human Resources Strategy would be brought to the November Board meeting.

37.5 The Committee agreed to note the reduction of 318 whole time equivalent staff in post hours since 1 April 2011 compared to June 2011 and to note the position in regard to sickness absence and the sickness rate of 3.67% for April, 3.77% for May and 3.74% for June 2011.

38. Annual Report of the Chair of the Finance & Performance Review Committee

38.1 The Committee received the previously circulated annual report of the Chair of the Finance & Performance Review Committee, which had been considered by the Audit Committee on 21 June and had formed part of the formal assurance process for the annual accounts. The final draft of this report had not been available until after the June meeting of the Committee and the Committee agreed to endorse the annual report of the Chair of the Finance & Performance Review Committee.

39. Detect Cancer Early Programme

39.1 Professor McMahon introduced a tabled paper on the detect cancer early programme, which required a response to the Scottish Government Health Directorates by 26 August 2011.

39.2 Professor McMahon advised that the Executive Management Team had endorsed the proposed response to the consultation. It had been agreed that the Chief Operating Officer should be the Executive cancer lead to be responsible for cancer target compliance and to be the NHS Lothian point of contact for all delivery group communications, along with the Acting Director of Strategic Planning.

39.3 The Committee noted the position and Professor McMahon advised that a fuller report would be brought to the Committee in October and the Committee agreed to note the position.

The meeting closed at 11.35am.
### Significant Event Analysis (October 2010)
- 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.

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<td><strong>Significant Event Analysis (October 2010)</strong></td>
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<td>Draft consultation August 2011 For approval at the Clinical Policy Group 07/09/11</td>
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### Adults with Incapacity (Scotland) Act 2001 – Part 5 (February 2011)
- The Chair also requested an update report in 2012.

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### Meticillin Resistant Stapylococcus aureus Screening
- Mr Egan asked about funding after 2013 and reported that this posed a risk for the future. Members noted that there could be an opportunity cost as more nurse time and treatment but this could be balanced by a reduction in the number of infections and reductions in antimicrobial prescribing. It was noted that this was a complicated issue that needed further consideration.

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<td><strong>Meticillin Resistant Stapylococcus aureus Screening</strong></td>
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### Patient Falls
- Mrs Hornett agreed that a reduction in the number of falls at home was an important issue and would be considered in more detail. Mr Egan suggested working with local councils to improve the pavements and also to encourage people to clear their own pavements during snowy and icy conditions. Members also suggested producing a communications strategy to make people aware of how to prevent falls at home.

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<td><strong>Patient Falls</strong></td>
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<td>October 2011</td>
<td>Awareness and public education regarding slips trips and falls in the community already in place across all partnerships in Lothian. Numerous examples of work undertaken in CHP’s to see, assess and intervene with older people to prevent them from falling. In terms of community safety, pavements and falls prevention is not a priority within Councils,</td>
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higher community safety priorities include such issues as antisocial behavior which prevents older people feeling safe to go out and exercise. All areas have discussed this with their local councils.

### NHS QIS Pre-JAG Endoscopy Assessment Visits (August 2011)

- The Committee remained concerned regarding the endoscopy units at Western General Hospital and the Royal Infirmary Edinburgh. The Committee requested an update with detailed actions with dates and timelines to the next meeting. An audit of specimen flow should also be carried out. Mrs Todd agreed to take these issues forward.

  JT/AKM  October 2011

### Business Continuity Management (June 2011)

- Mr Egan raised concern regarding a possible backlog in maintenance work that had not been addressed in the report. It was agreed that this issue should be clarified before the Committee accept the report. Dr Winstanley suggested that internal audit should also consider evidence that actions had been implemented and endorsed.
- There followed some discussion on whether extra resources should be allocated to business continuity management. It was agreed that Mr Boyter would discuss this with Professor McMahon.

  JD  October 2011

  AB/AMcM

### Nursing Home Update (August 2011)

- An update on the Southern Cross care homes would come to the next meeting.

  MH  October 2011

### Framework for the Management of Public Health Incidents (August 2011)

- The Chair requested that this report go to the Area Clinical Forum. Dr Winstanley also pointed out that NHS Health Boards were accountable to the Scottish Government Health Ministers – not the Scottish Government Health Directorates as stated in the Framework on page 5. Ms Garden also raised concern that there was no link to the Joint Health Protection Plan.

  AKM/PM  October 2011

### Information Governance (August 2011)
The Committee noted that there was less clarity around data protection and the university health systems and the use of patient data for research purposes. The Committee agreed that this needed to be more explicit and required further consideration.

**NHS Lothian Public Protection Services Update (August 2011)**

- There were also concerns raised regarding adult protection and the number of vulnerable adults at risk. The Committee felt that a risk assessment was required and Mrs Hornett agreed to take this forward.


- The Committee requested that an update report on the work carried out to reduce the number of maternal suicides come back to the Committee in 9 months.

**Prison Healthcare (August 2011)**

- Professor McMahon agreed to send the implementation plan around to the Committee in advance of the October meeting. He would also attend the next meeting to give an update.
CHAIR'S REMARKS

The Chair welcomed members to the meeting. The Chair pointed out that this was Professor Tierney’s last meeting of the Health Care Governance and Risk Management Committee. The Chair, on behalf of the Committee, thanked Professor Tierney for all her hard work and support for the Committee.

The meeting started with a patient story DVD.

23. COMMITTEE CUMULATIVE ACTION NOTE AND MINUTES OF THE PREVIOUS MEETING: 7 JUNE 2011

23.1 The minutes of the previous meeting on 7 June 2011 were approved as a correct record. Subject to the following amendments: 15.1.1 “flowed” should read “following”. The Chair referred to the cumulative action note from the previous meeting and reported that the business continuity update would come to the October meeting.

24. MATTERS ARISING

24.1 Decontamination of Re-useable Invasive Medical Devices

24.1.1 Dr McCallum presented the report on the decontamination of re-useable invasive medical devices throughout NHS Lothian. She went through the keys issues and the key risks. She highlighted that the Endoscopy Units at Western General Hospital and Royal Infirmary Edinburgh remained the biggest concern. Key risks were detailed in the attached Risk Register (Appendix I). Committee members requested that a detailed action plan with clear timescales come to the next meeting. There was also some discussion on the cleaning of the equipment and it was suggested that other staff groups could also clean the equipment, for example
the health technicians. Dr Winstanley asked about single use equipment and reusable equipment. Dr Farquharson reported that each case was assessed on an individual basis.

24.1.1.2 The Committee supported the Director of Public Health and Health Policy’s actions outlined in the paper however remained concerned regarding the endoscopy units at Western General Hospital and the Royal Infirmary Edinburgh. The Committee requested an update with detailed actions with dates and timelines to the next meeting.

AKM

24.1.2 NHS QIS Pre-JAG Endoscopy Assessment Visits

24.1.2.1 Mrs Todd presented the report to the Committee. She explained that this report updated the Committee on actions taken against the recommendations for both endoscopy units at Western General and St Johns Hospitals following their JAG visit. She went through the actions that were not yet complete and highlighted that there were concerns regarding patient surveillance. It was noted that there was a backlog of surveillance patients that needed to be screened. Clinical and administrative validation of surveillance referrals were carried out on an ongoing basis by consultants in partnership with waiting list staff and patients were being assessed in terms of risk. The Committee referred to the section on decontamination and requested a further update on decontamination with timescales. An audit of specimen flow should also be carried out. Mrs Todd agreed to take these issues forward.

JT

24.2 Nursing Home Update

24.2.1 Mrs Hornett gave a verbal update to the Committee. She referred to the closure of the Elsie Inglis care home and reported that the ward in the Astley Ainslie had now closed and all the residents had been transferred to permanent placements. The police investigation was continuing. She added that an update on the Southern Cross care homes would come to the next meeting.

MH

25. Emerging Issues

25.1 There were no emerging issues to report.

26. SAFE CARE

26.1 Framework for the Management of Public Health Incidents

26.1.1 Dr McCallum presented the Framework for the Management of Public Health Incidents. She reported that the framework emphasised the role of Health Boards in protecting health within the context of shared responsibility with local authorities. She added that there were reservations regarding the reporting arrangements as it stated in the report that NHS Boards were responsible for the overall performance of the arrangements for planning and managing public health incidents. There was
also lack of clarity around how these arrangements would interface with those in England with respect to matters reserved for Westminster – chemical, biological, radiological and nuclear issues. In addition, there were concerns regarding the scientific and technical advisory cell. She highlighted the four aspects of performance management and governance that needed to be considered: oversight of the investigatory role, the requirement to report appropriately to key committees with corporate responsibility, monitoring and oversight of the implementation of recommendations and the monitoring and oversight of the dissemination of lessons learnt. It was noted that the response time had been very short and the response had been issued on 11/07/2011. The Chair requested that this report go to the Area Clinical Forum. Dr Winstanley also pointed out that NHS Health Boards were accountable to the Scottish Government Health Ministers – not the Scottish Government Health Directorates as stated in the Framework on page 5. Ms Garden also raised concern that there was no link to the Joint Health Protection Plan.

AKM

26.2 Information Governance

26.2.1 Dr McCallum gave an update on information governance. She highlighted that the use of the fair warning automated auditing tools to identify potential inappropriate access to hospital information systems had been put in place under the review and guidance of the Fairwarning Strategy Group. This followed a letter to all staff noting commencement. She added that there had been a dramatic decrease in the number of alerts for inappropriate access.

26.2.2 Professor Tierney commented that there was often confusion amongst the public regarding data protection and asked about communication with the public. Dr McCallum reported that a booklet had been developed for patients being admitted into hospitals with information on data protection. The Committee noted that there was less clarity around data protection and the university health systems and the use of patient data for research purposes. The Committee agreed that this needed to be more explicit and required further consideration.

DF/MH/AKM

26.2.3 The Committee commented that there had been huge improvements in the management procedures of data protection and IT security incidents and it was important to maintain standards.

26.3 Healthcare Associated Infection Update

26.3.1 Dr McCallum presented the routine report to the Committee. The Committee noted that NHS Lothian was on target to achieve the Health Efficiency Access Treatment target of 0.26 cases or fewer per 1000 acute occupied bed days by March 2013. The Committee noted this success and commented on the hard work and effort from everyone involved.
26.4 NHS Lothian Incident Report January – March 2011

26.4.1 Dr Farquharson spoke to the NHS Lothian Incident Report January – March 2011. He explained that the main themes continued to be patient falls, violence and aggression and medication incidents. He reported that work was being taken forward in NHS Lothian on medication management. The Scottish Patient Safety Programme were also looking at ways to ensure safety measures were in place to address risks identified with high risk medicines.

26.4.2 The Incident Management Policy had been revised along with the Incident Management Operational Procedures and this had gone live on 1 August 2011. He referred to item 3.1.2 and reported that the target for nursing and midwifery administrative errors had been reduced from a 20% reduction to a 15% reduction by March 2012. Professor Prowse referred to the administration errors and asked about dyscalculia screening. Mrs Hornett reported that an NHS Education Scotland (NES) pilot was in progress to consider testing for dyscalculia and the results of this pilot would come back to the Committee. The Committee noted that this was not just an issue for nursing staff but also for medical staff.

26.4.3 Mrs Bennett reported that the KPIs outlined in the tables in appendix 2 were not appropriate and that the new KPIs would be on the next report to the Committee. Professor Tierney asked about violence and aggression incidents and whether there were any comparisons with data from other health boards. Mrs Bennett reported that violence and aggression incidents were in the top three incidents in most other Health Boards in Scotland. Mr Egan also pointed out that violence and aggression incidents were discussed in more detail at the NHS Lothian Staff Governance Committee and the Health and Safety Committee agendas.

27. EFFECTIVE CARE

27.1 Action Plan to Improve Awareness and Compliance with Policies and Procedures

27.1.1 Mr Boyter referred to the circulated action plan to improve awareness of and compliance with policies and procedures. He highlighted that this was a systematic approach and would be out for consultation from 30 June 2011 – 5 August 2011. The action plan had been considered by the Audit Committee and the Staff Governance Committee. The Committee welcomed the report and the action plan. Mr Payne added that the staff appraisals would also be used to improve awareness of policies and procedures.

27.2 NHS Lothian Public Protection Services Update

27.2.1 Mrs Hornett gave a verbal update to the Committee. She highlighted that an internal audit on adult protection outcomes would come to the next meeting. In relation to child protection, she highlighted that a summary report on the findings from the recent HMIE Inspections of Services to Protect Children would come to the next meeting in October, she reported that initial feedback had been positive. She informed the Committee that a training module on public protection was being developed that would incorporate training on adult protection and child protection to make the system more streamlined. Mr Egan had reservations and pointed out that there were still no resources available for child protection advisers. There were
also concerns raised regarding adult protection and the number of vulnerable adults at risk. The Committee felt that a risk assessment was required and Mrs Hornett agreed to take this forward.

27.3 Management of New Anticoagulants into Clinical Practice

27.3.1 Dr Farquharson introduced the report. He highlighted that there was a new range of anticoagulant drugs currently in the late stages of clinical development which had the potential to impact significantly on both financial and clinical safety issues within NHS Lothian. This was a standing item on the ADTC agenda. It was noted that there had been a short life working group set up to consider this in more detail and to discuss engagement with the public. The Committee noted that a paper would be going to the next EMT meeting on difficult decisions and affordability. Dr Williams pointed out that it would be necessary to work with the clinicians to take this forward and put a process in place.

27.4 Report of the Triennial UK Confidential Enquiry into Maternal Deaths

27.4.1 Dr Graham Mackenzie spoke to this report. The Committee went through the recommendations. Dr Mackenzie added that smoking cessation; more accurate diabetes screening and more capacity for treating maternal obesity would have important implications for prevention and impact. The Committee felt that this would be worthwhile but were concerned regarding the cost of these services. Concern was raised regarding the increase in sepsis related deaths and the number of maternal suicides. Dr Mackenzie reported that the perinatal mental health team at St John’s Hospital and the adolescent mental health service had considerable expertise that could potentially be used to develop training and support for midwives in identifying and managing women experiencing or at risk of mental health problems. Dr McCallum added that NHS Lothian were working towards reducing the number of maternal suicides. The Committee requested that an update report on the work carried out to reduce the number of maternal suicides come back to the Committee in 9 months.

27.5 NHS Lothian Risk Register Report

27.5.1 Dr Farquharson spoke to the report. He reported that information on the top 10 risks for the Board would come to the next meeting in October. Ms Bennett reported that the risk titles in the report would be reviewed as not all the headings were effective at capturing the true meaning.

27.6 Prison Healthcare

27.6.1 Professor McMahon tabled an updated report on prison healthcare. The report advised the Committee on the work being done locally to support the transfer of responsibility for prison healthcare HMP Edinburgh and HMP Addiewell from the prison service to NHS Lothian. The responsibility for prison healthcare will transfer to NHS Lothian on 1 November 2011. He pointed out that HMP prison Edinburgh had an average daily population of 900 prisoners which from 25 July 2011 also included 114 women offenders. HMP Addiewell had a population of 796 male
prisoners. He highlighted that one of the key objectives was to ensure prisoners receive healthcare services equivalent to that delivered in community settings with equal access to the range of enhanced primary care and secondary care services as provided to all other citizens. The Committee acknowledged that a lot of work had gone into this work and the report understated the level of achievement. Dr Winstanley asked about the arrangements for primary care services and how the policy on methadone would be applied. Professor McMahon explained that a full risk assessment would be carried out. The Committee noted that the prison service would be hosted by East Lothian CHP so Mr Whyte suggested that the information on the risk register should also go to East Lothian CHP. With regards to the policy on methadone, it was noted that the prisoners would have appropriate access to methadone and there would be a range of treatment options for prisoners with addictions – including GPs and Keep Well. Committee members referred to the 114 women prisoners and reported that this could be a significant risk and the needs of the women would need to be considered in more detail. Mr Boyter pointed out that this would be discussed at the Staff Governance Committee.

27.6.2 The Committee noted that the transfer could lead to more opportunities to reduce reoffending as prisoners would have more connections to services when they were released from prison.

27.6.3 Professor McMahon agreed to send the implementation plan around to the Committee in advance of the October meeting. He would also attend the next meeting to give an update.

AMcM

27.7 The Scottish Academic Health Sciences Collaboration (SAHSC) Bioresource and Tissue Governance Unit

27.7.1 The Committee considered the report on the Scottish Academic Health Sciences Collaboration (SAHSC) Bioresource and Tissue Governance Unit. Dr Farquharson explained that the report proposed the establishment of a central resource within NHS Lothian to coordinate all existing research tissue banks and collections within the Health Board. This resource would promote and facilitate research within the Health Board. Professor Tierney asked about the use of donated tissue. Dr Farquharson agreed to feed this back to the Chair of the SAHSC to see if this was possible.

28. PERSON CENTRED CARE

28.1 Measuring and Improving Person Centred Care in NHS Lothian

28.1 The Committee noted the report.

29. OTHER MINUTES: EXCEPTION REPORTING ONLY

29.1 The Committee noted the following sets of minutes:

- Minutes of NHS Lothian Health and Safety Committee: 24/05/2011
- Minutes of the Mutuality and Equality Governance Committee: 31/05/2011
- Minutes of the Area Drug and Therapeutic Committee: 01/04/2011
• Minutes of the Lothian Infection Control Advisory Committee: 09/05/2011
• Minutes of the Primary and Community Services Healthcare Governance and Risk Management Operational Group: 10/05/2011

30. EXCEPTION REPORTING ONLY

30.1 The Committee approved the following items:

• Pregnancy and Newborn Screening Annual Report
• Impact of Hand Hygiene on Infection Rates
• Hand Hygiene NHS in Lothian Acute Hospitals
• Update of Public Health and Health Policy Business Continuity Arrangements for Health Care Governance and Risk Management Committee

31. ANY OTHER COMPETENT BUSINESS

31.1 There was none.

32. DATE OF NEXT MEETING - Tuesday 4 October 2011 – from 9:00 in Room 7, Waverley Gate

Other Meetings for 2011

• 15 December 2011 from 1pm – 3pm – please note change of time and date

All meetings to be held in Room 7, Waverley Gate from 9am.
<table>
<thead>
<tr>
<th>Action Required</th>
<th>Lead</th>
<th>Due Date</th>
<th>Action Taken</th>
<th>Outcome</th>
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</thead>
<tbody>
<tr>
<td><strong>Workforce Model for Medicine of the Elderly</strong> (13 December 2010)</td>
<td>JKS</td>
<td>20/06/11</td>
<td>A presentation on the progress with the workforce redesign and the uniqueness tool was given by Rob Packham to the Committee in June 2011</td>
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<td>• Provide an update on the position in six months time</td>
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<td><strong>Releasing Time to Care</strong> (27 June 2011)</td>
<td>SG</td>
<td>07/10/11</td>
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<td>• Pick up the unconfirmed cost figures of the project with the</td>
<td>MH</td>
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<td>Scottish Government Health Directorate’s Director of Finance.</td>
<td>LT</td>
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<td>• Provide a further update in 2012</td>
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<td>• Offer structured guided tours for the public/patient</td>
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<td>representatives to the relevant sites of services under</td>
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<td>discussion at the Committee such as the Sutherland ward, Lanfine Unit and</td>
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<td>other facilities taking part in Releasing Time to Care.</td>
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<tr>
<td><strong>Lothian Long-Term Conditions Collaborative: Progress Report</strong> (13 December 2010)</td>
<td>AMcM</td>
<td>11/04/11</td>
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<tr>
<td>• Provide further updates on progress</td>
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<td>A final report from this project was received by the committee at April 2011 meeting (item 4.2)</td>
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<td><strong>Lanfine Unit – Review and Redesign of Service to People</strong></td>
<td>AMcM</td>
<td>12/12/11</td>
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<td>with Progressive Neurological Conditions** (27 June 2011)</td>
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<td>• Bring a plan to Committee for the way forward, together with details of what</td>
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<td>the Unit’s outcomes were and how these differed from the rehabilitation</td>
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<td>service provided in the community.</td>
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<td>Action Required</td>
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<tr>
<td>Improving Care, Investing in Change (18 April 2011)</td>
<td>ALL</td>
<td>07/10/11</td>
<td>To be discussed with Chairman prior to October Meeting</td>
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<tr>
<td>• Discuss with the Chair which of the remaining 22 projects the Committee would wish to receive fuller details on at future meetings and agree on the frequency of future reports on progress with the overall Improving Care, Investing in Change programme to the Committee</td>
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<td>Demographic Trends (27 June 2011)</td>
<td>AKM</td>
<td>07/10/11</td>
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<td>• Consider the suggestion of an audio visual change to help in reaching different areas of the population</td>
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<td>Future Direction (18 April 2011)</td>
<td>AKM</td>
<td>07/10/11</td>
<td>A report will be provided to the committee</td>
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<td>• Provide a briefing paper on kite-marking with key bullet points</td>
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<td>• Bring a report to a future meeting of the Committee proposing ideas for discussion</td>
<td>AMcM/DF</td>
<td>07/10/11</td>
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<tr>
<td>Location of GP Practices in Lothian (27 June 2011)</td>
<td>SG</td>
<td>07/10/11</td>
<td>The map will be used for the next prioritisation (2012/2013) of Capital Investment in Primary Care</td>
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<td>• Sense check the map with the Capital Investment Group to ensure that the appropriate criteria on the distribution of general practices is being followed.</td>
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<tr>
<td>Sutherland Ward - Progress of the Review and Redesign of Services (27 June 2011)</td>
<td>AMcM</td>
<td>07/10/11</td>
<td>This will be provided for the October meeting</td>
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<td>• Provide a further update report should detailing the outcomes of the review, the redesign proposals and the implementation plan to deliver service change.</td>
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Minutes of the Meeting of the Service Redesign Committee held at 2.00pm on Monday, 27 June 2011 in Meeting Room 7, Waverley Gate, 2-4 Waterloo Place, Edinburgh.

Present: Professor J Iredale (Chair); Dr B Agrawal; Ms L D’Arcy; Councillor P Eadie; Dr D Farquharson; Mr D Forbes; Mrs S Goldsmith; Mrs M Hornett; Dr A McCallum; Dr B McKinstry; Dr S Mackenzie; Ms L Tait and Dr A Tierney.

In Attendance: Mrs S Allan; Ms R Laskowski; Mr R Packham and Mr P Reith.

Apologies for absence were received from Ms J Anderson, Ms V Baker, Mr A Boyter, Ms C Craig, Dr J Hopton, Professor A McMahon, Mrs J K Sansbury and Dr C J Winstanley.

Declaration of Financial and Non-Financial Interest

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

11. Minutes of the Previous Meeting

11.1 The Minutes of the previous meeting of the Service Redesign Committee held on 18 April 2011 were approved, subject to the following amendments:-

Minute 8.3 to read “Dr McCallum flagged up the fact that Forensic services had made very good progress and it was noted that the report due in spring 2011 should be ready by summer 2011.”

Minute 9.6 to read “The Chair suggested that kite marking would be best practice and Dr McCallum undertook to provide a briefing paper on demographic change.”

12. Matters Arising from these Minutes

12.1 Demographic Trends – Dr Agrawal suggested that an audio visual change would help in reaching different areas of the population and Dr McCallum undertook to consider this suggestion.
12.2 Update on Releasing Time to Care – a previously circulated report providing an update on progress of the Releasing Time to Care project within NHS Lothian was received.

12.2.1 Mrs Hornett spoke to the paper and explained that the resolution of the issue of the cost of licensing had been delayed until a response had been received from the Scottish Government. Mrs Hornett explained that the project was led by a senior nurse with a team of ten facilitators seconded from the service. The team’s objective was to systematically facilitate all clinical teams across NHS Lothian through the three foundation modules of the project over a three month period.

12.2.2 Mrs Hornett explained that it was anticipated that, from the inception of the project in June 2009 until the anticipated end in March 2012, the team would have facilitated 526 wards/departments across NHS Lothian. The pilot site of ward 202 in the Royal Infirmary of Edinburgh had demonstrated amongst other things, an overall savings of 6% on its ward budget between July 2008 and March 2009.

12.2.3 It was noted that, whilst all clinical areas were uniquely different in terms speciality and leadership, it was anticipated (and supported by the roll-out in England) that the Releasing Time to Care project could have a positive impact on all teams and clinical areas.

12.2.4 Councillor Edie queried the cost of the project and Mrs Hornett explained that the figures remained unconfirmed. Mrs Goldsmith undertook to pick this matter up with the Scottish Government Health Directorate’s Director of Finance. SG

12.2.5 Dr Tierney suggested that the improvements achieved under Releasing Time to Care could be mainstreamed rather than being the subject of a separate stand-alone project.

12.2.6 The Committee agreed to note the progress of the Releasing Time to Care project across NHS Lothian and to receive a further update in 2012. MH

12.2.7 Dr Agrawal suggested that the public/patient representatives be offered structured guided tours to the relevant sites of services under discussion at the Committee such as the Sutherland ward, Lanfine Unit and other facilities taking part in Releasing Time to Care.

12.3 Location of GP Practices in Lothian – the Committee received a previously circulated large scale map showing the distribution of GP practices in Lothian. The Committee noted that there seemed to be a reasonable distribution of general practices throughout Lothian and Mrs Goldsmith undertook to sense check the map with the Capital Investment Group to ensure that the appropriate criteria on the distribution of general practices was being followed. SG
13. **Lanfine Unit – Progress of the Review and Redesign of Services to People with Progressive Neurological Conditions**

13.1 The Chair welcomed Ms Laskowski to the meeting. Ms Laskowski introduced a previously circulated report outlining the progress achieved to date with the review of services delivered via the Lanfine Unit to people with progressive neurological conditions.

13.2 Ms Laskowski explained that Edinburgh CHP had agreed the remit for a full review of the service provided via the Lanfine Unit at Liberton Hospital. It was noted that nine focus groups had been utilised in total and alternatives to the current method of service delivery were being examined.

13.3 The Chair indicated that the Committee was seeking an understanding of the achievements of the Unit and asked Ms Laskowski to come back with a plan for the way forward, together with details of what the Unit’s outcomes were and how these differed from the rehabilitation service provided in the community. **AMcM**

14. **Sutherland Ward – Progress of the Review and Redesign of Services**

14.1 Ms Laskowski introduced a previously circulated report on the progress achieved to date with the review of services delivered via the Sutherland ward at the Astley Ainslie Hospital which delivered post-acute rehabilitation to people who had experienced amputation.

14.2 Ms Laskowski explained that the review of the services provided from Sutherland ward of the Astley Ainslie Hospital was about developing a vision for a redesigned service within the current financial framework and the local reinvestment plan requirements of the Edinburgh CHP.

14.3 Dr McCallum commented Lothian was a source of world-wide knowledge on this subject and there was an opportunity to achieve improved performance.

14.4 Ms Laskowski commented it was not clear that costs were being recouped from other NHS Boards and Mrs Goldsmith advised that appropriate costs should be being apportioned to other NHS Board.

14.5 Ms D’Arcy commented it would have been helpful to see an explanation of why there were longer stays in the Unit.

14.6 Ms Laskowski indicated that local practice had delayed discharges and Dr Mackenzie suggested that the specific patient pathways should be the focus of concentration rather than the ward itself.

14.7 Ms Tait indicated that Ms Craig had submitted written comments suggesting that library services be involved in the visioning event, and Ms Laskowski agreed to consider this.
14.8 The Committee agreed to note the progress made to date with the review of the Sutherland ward and the timelines within which a proposals for redesign and associated implementation plans would be developed and reported.

14.9 It was agreed that a further update report should be submitted in October 2011 detailing the outcomes of the review, the redesign proposals and the implementation plan to deliver service change. AMcM

15. Clinical Strategy

15.1 It was agreed to defer consideration of the clinical strategy to the next meeting.

16. Financial Overview: 2011/12 and Beyond

16.1 Mrs Goldsmith gave a presentation outlining the financial implications of the Scottish budget on the NHS Lothian allocation for 2011/12 and explained that based on current trends there was the potential for a substantial gap between income and expenditure over the next few years. Mrs Goldsmith explained that the Executive Management Team was monitoring the implementation of the local reinvestment plan and the achievement of agreed savings targets. There was a need for new approaches to deliver improved services at reduced costs.

Dr Mackenzie and Mrs Hornett left the meeting.

16.2 The Chair commented the Service Redesign Committee should have financial representation and emphasised the cross-over with the Finance & Performance Review Committee. Mrs Goldsmith indicated that she hoped to be a regular attender at Service Redesign Committee meetings and indicated it would be helpful to have a similar session dealing with the capital programme.

16.3 The Committee noted that there was a need for discussion around disinvestment as part of the clinical strategy.

17. Update on Workforce Model for Medicine of the Elderly

17.1 The Chair welcomed Mr Packham to the meeting.

17.2 Mr Packham gave a presentation explaining that, following the study undertaken on revised healthcare models for the Royal Victoria Hospital, it was anticipated that in-patient numbers could be reduced by 30%, with a new model of care being phased in and mainstreamed. The particular model used for medicine of the elderly had a wider application through NHS Lothian as a whole with the potential to achieve results similar to Releasing Time to Care and increasing the move to community-based services. The Committee noted that the health technician concept was woven firmly into the revised system and would enable improved results to be obtained without the need for increased levels of specialist support.
17.3 The Committee agreed to invite Mr Packham to speak to the December 2011 meeting on how this was being taken forward throughout NHS Lothian.

17.4 The Chair thanked Mr Packham for his presentation.

18. **Hepatitis C Managed Care Network’s 2010/11 Annual Report**

18.1 The Committee agreed to defer consideration of this matter to the next meeting.

19. **Transport and Access Committee Minutes**

19.1 The Committee received for information the previously circulated Minutes of the Transport and Access Committee meeting held on 19 May 2011.

The meeting closed at 4.10pm.
Note of the meeting of the East Lothian Community Health Partnership Sub-Committee held on Wednesday 29th June 2011 at 2pm in the Quay Complex, Musselburgh.

Present: Iain Whyte (Chair) (IW)
David Small, General Manager (DS)
Dr Jane Hopton, Assistant General Manager (JH)
Dr Ian Johnston, Medical Director (IJ)
Dr Graham Alexander, General Practitioner Representative (GA)
Ann McCarthy, PPF Representative (AM)
Gill Colston, PPF Representative (GC)
Morag Barrow, Allied Health Professional Manager (MB)
Lynne Hollis, Associate Director of Finance (LH)
Fiona Mitchell, Acute Sector (FM)
Tony Segal, Carers of East Lothian (TS)
Ronnie Hill, East Lothian Council (RH)

In Attendance: Drew McErlean, Minutes (DMcE) - Minutes
John Boyce, Public Health Practitioner (Minute Item 18.2)
Steven Wray, Public Health Practitioner, (Minute Item 20.2)
Lorraine Cowan, Clinical Services Manager for Liz Cregan, Chief Nurse (LC)
Ian Binnie, East Lothian Council for Murray Leys (IB)

Apologies: Murray Leys, East Lothian Council (ML)
Liz Cregan, Chief Nurse (LC)

18. Welcome and Apologies

18.1 Apologies were noted as above.

18.2 Health Improvement HEAT Targets – SPHP Community Health Partnership Profiles for East Lothian.

John Boyce referred to the papers which had been circulated in advance of the meeting, noting the various sources of the statistics. A summary sheet detailing the key issues was also circulated to the meeting.

In general terms the results for East Lothian are positive. John Boyce summarised the actions being taken in relation to each HEAT target to further improve performance.

In relation to adult issues there are 3 aspects where the performance was below the national average.

These are –

- Patients hospitalised in the home after a fall – age 65+
- Household assessed as homeless
- People living in 15% most ‘access deprived’ areas.
In response to a question from the Chair, Morag Barrow noted the initiatives being progressed to reduce falls and how these should in due course result in performance being better than the national average.

On Children’s issues, Anne McCarthy noted concerns that not all children are receiving an annual dental check up. John Boyce explained that national policy had changed to sampling rather than checking all children and noted the actions being taken in the Start Programme at Whitecraigs and Wallyford where 60% of children have routine dental checks.

Decisions

The report was noted and it was agreed that updates on progress will be reported annually with interim updates on a 6 monthly basis.

DS

19. Minutes of the Previous Meeting Held 21st April 2011

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


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

The East Lothian Older People’s strategy has been formally approved by East Lothian Council and the Lothian Health Board.

David Small will provide regular updates at every second meeting of the CHP Sub Committee – beginning in October 2011.

DS

20. Matters Arising / Action Note

The items on the Action Note were reviewed and the Note will be updated accordingly.

20.1 Continuity and Quality of Service in Care Homes.

The Sub Committee received a verbal report from the General Manager and Ian Binnie.

The General Manager noted the public interest in recent high profile issues relating to Care Homes.

It was reported that Southern Cross have 2 care homes in East Lothian. These are currently running at 50% of capacity. Separately from the Company’s ongoing viability issues Improvement plans in response to Social Care and Social Work Improvement Scotland inspections one of these homes are being progressed. Social work support has been placed on site where necessary to assist with training.
It was noted that contingency plans for potential issues with care homes are being refined by the council and this work is being progressed with a number of partners, including the Lead GP Practices. Safety, Legal, employment and management issues are being considered as well as the financial implications.

Dr Graham Alexander noted that the impact on the GP Lead Practices for these homes had been very significant.

Ian Binnie noted the need for early recognition and reporting of issues to allow prompt remedial intervention. It is important that all NHS and Social Work staff entering such premises are aware of the need to report any concerns no matter how minor or isolated they may appear to be. Ronnie Hill noted this is particularly important for residents who do not have any family or visitors.

Dr Ian Johnston noted that the enhanced services contract for GPs in relation to Care Homes was originally aimed at preventing hospital admissions by improving care planning and had been successful in achieving this. It was not intended to provide an overall inspection process. However GP’s spotting any issues of concern would report these.

Dr Ian Johnston commented that East Lothian appear to admit patients to Care Homes at an earlier age than other parts of Lothian and therefore stays are longer. The model used in West Lothian is different, with admission tending to be later and stays subsequently shorter. There may be opportunities to learn from this model.

Ronnie Hill noted that it may be appropriate to consider in more detail Care at Home services as part of the Older Peoples Strategy.

Fiona Mitchell suggested that a strategic risk assessment of care home failures impact was urgently required.

Decisions

The update was noted. It was agreed the Community Health Partnership and Council should continue to work closely on contingency planning.

20.2 Equally Well Report

Steven Wray referred to the paper and various appendices which had been circulated in advance of the meeting.

The paper noted that East Lothian had been announced as a test site for the Scottish Government’s health inequality strategy Equally Well in October 2008.

The rationale for the test site was ‘Breaking the Cycle’ – referring to the need to prevent the risk of dis-advantage in health outcomes being passed from one generation to the next.

The Key findings from an evaluation by Queen Margaret University were
noted and overall the programme was regarded as having been very successful with a range of key issues positively impacted.

Steven Wray outlined how the work would be built on and circulated a paper to the meeting which detailed what was planned for the second phase. Ronnie Hill reviewed the details highlighting that engagement with local service needs is key. The resources required to deliver the programme have been costed at £225k annually.

The paper recommended that

- The Sub Committee should note the progress made on the test site.
- Service Managers and strategic leads should plan for the mainstreaming of key learning issues.
- Managers and professional leads should be closely involved with the review of early years services commissioned by the Children’s Services Chief Officers Group.

**Decisions**

The recommendations in the paper were agreed.

It was agreed that the plans for Phase 2 appeared to be targeting the required direction of travel and the General Manager and the Chair of the CHP will meet with officials from East Lothian Council to consider how the initiative can be taken forward and the funding implications.

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**20.3 East Lothian Community Health Partnership Annual Declaration of Interests**

It was noted that the process was complete for 2011 – 2012.

**20.4 Gullane GP Practice Re-provision – Standard Business Case**

The Sub Committee considered a report which had been circulated in advance of the meeting. The report was a Standard Business Case for re-provision of the Gullane Medical Practice.

The business case noted that the premises of the Gullane Medical Practice are no longer fit for purpose and has a long standing high priority rating for re-provision.

The capital cost is £2.632 million and this is included in the Capital Plan. NHS Lothian will make a capital grant to East Lothian Council – this will require Audit Scotland approval.

The revenue consequences for the Community Health Partnership are £70,513 and there is sufficient revenue available in current commitments to make this neutral. The GP Practice has accepted the increase in service charge costs to the practice.

This will be the first East Lothian project to be delivered by the Hubco.
It was confirmed by the General Manager that in response to concerns raised at a public meeting, issues of road safety and parking would be of paramount importance in the development.

Decision

It was agreed that the Standard Business Case should be progressed via the governance process as detailed in the papers.

20.5 **Edenhall Project Phase One – Standard Business Case**

The Sub Committee considered a report which had been circulated in advance of the meeting. This was a standard business case for the re-location of services from Edenhall Hospital to Herdmanflat (Phase 1).

The paper noted that a large number of services will re-locate from Edenhall to the new Musselburgh Primary Care Centre in Spring 2012.

Training / Professional Development Unit and Fire Training Unit and the Health Promotion Unit are not included in this project.

The project covers those other services for which accommodation needs to be re-provided at Herdmanflat Hospital.

Subject to approval it is planned that work at Herdmanflat is aimed at being completed with all impacted services re-located by the end of October 2011.

Decisions

It was agreed that the paper should be progressed via the governance process outlined in the business case.

It was agreed that any proposals to re-name the Herdmanflat site should be treated very sensitively and take full account of local views through an involvement process. The General Manager will ensure that the Project Manager is fully aware of potential concerns on this issue.

20.6 **Audit Scotland : Audit of Community Health Partnerships**

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

The General Manager referred to the key findings of the report and noted that East Lothian had performed better than Scotland generally on measures such as reduction in delayed discharges, reduction in rates of emergency admissions etc which were key objectives for Community Health Partnerships.

The General Manager noted that a Self Assessment Questionnaire would need to be completed by each CHP in response to the report and that the timescales for this were very tight with an initial response needed at NHS Lothian by 8th July.

Dr Graham Alexander noted that in his opinion the report accurately
described the feelings of most GPs about CHPs, especially in relation to shared services.

The Chair noted it is recognised that the way in which CHPs engage with GPs needs to be enhanced and he will be working with the General Manager and GPs to consider how this can be achieved in East Lothian.

Lynne Hollis noted that she had been part of the Project Advisory Group and that some of the activity measures were still at the developmental stage and this was recognised.

Anne McCarthy noted that in general she felt there had been insufficient delegation to CHPs to deliver outcomes and that movement of resources had not kept pace with the demands placed on CHPs. The Chair noted that CHP budgets had increased and pointed to the examples of long term conditions funding and the change fund.

Decisions

David Small will circulate the Self Assessment Questionnaire by e-mail and members were asked to send concise comments to the General Manager as early as possible.

20.7. East Lothian Single Outcomes Agreement

The Agreement has been formally approved, is in the implementation stages and will be circulated to the Scottish Government for noting.

21.0 General Manager’s Report

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

The May 2011 validated census for East Lothian showed 12 East Lothian residents delayed in total with none delayed over 6 weeks.

In relation to capital projects the following update was made.

- Musselburgh Primary Care Centre remains on track for completion in Spring 2012.
- A seminar was held on 12th May with a range of internal and external stakeholders to re-launch the planning process for East Lothian Community Hospital.

On Reshaping Care For Older People Change Fund, East Lothian Council held a workshop with stakeholders and partners including the CHP on 13th May to go through the outline plans in more detail.

The Older Peoples strategy was approved at the extraordinary CHP Sub Committee meeting on 18th May following approval by the council on 17th May. It was then approved by the NHS Lothian Board on 25th May.

In relation to Healthcare Associated Infection, the CHP has been carrying out audits of its hospital facilities to assess compliance with the
Healthcare Environment Inspectorate audit tool. The work is complete for Roodlands Hospital and it has shown the need for significant work in some areas. The costs of this work have been reported to the Estates Department for inclusion in their overall costings for compliance. Audits are being carried out at Herdmanflat, Belhaven and Edington Hospitals and it is intended to bring a fuller report to the sub committee in August 2011 with an action plan and associated costs.

**Decisions**

The report was noted.

**21.1. Staff Governance Report**

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

The staff turnover rate in the period 1st March to 31st May 2011 was 2.04% (annualised rate is 8.12%).

The sickness absence rate for May 2011 was 4.6% - which was 2.37% long term absence and 2.23% short term absence.

**Decisions**

The report was noted.

**21.2. Finance Plan for 2011 - 2012**

The Sub Committee considered the Financial Plan for 2011 – 2012 which had been circulated in advance of the meeting.

Lynne Hollis outlined the details in relation to NHS Lothian in Part A of the Report and Part B of the plan which related to East Lothian CHP. The overall budget for East Lothian CHP was £58.924 million and this has been formally signed off the CHP Management Team.

The Local Re-investment Programme has a target of savings of £1.507 million and the details of the projects to underpin this target were circulated with the Financial Plan.

A letter outlining the Prescribing efficiency targets has been sent to GP Practices.

The GMS financial plan will be brought to the next meeting of the CHP Sub Committee on 25th August 2011.

The key risks in the plan were noted as waiting times funding, Local Re-investment Programme, Prescribing costs and GMS.

Dr Graham Alexander asked about the apportionment of management costs between East Lothian CHP and Midlothian CHP. The General Manager confirmed that this is a shared budget but that local cost centres are used to ensure that costs are accurately allocated. Lynne Hollis will confirm the details to Dr Alexander.
It was noted that some Nursing staff have moved between East Lothian and Midlothian to cover some gaps and address skill mix issues. The General Manager noted that he felt further savings in Nursing could still be made as activity levels had not been accurately tracked historically and there was evidence of slack in the system.

In response to a question from Graham Alexander, it was confirmed by Lynne Hollis that a process to manage the movement of resource to track shifts to community based treatment was being put in place through the Integrated Resource Framework. However this would take some time to become fully efficient.

Fiona Mitchell noted that all areas are looking very closely at what changes need to be made to reflect the reality of a very different financial climate in which head count reductions are inevitable.

Decisions

The report was noted.

21.2.1. GMS Expenditure by Community Health Partnership – Quarter 4 2010

The Sub Committee considered a report which had been circulated in advance of the meeting. Lynne Hollis asked that the Sub Committee consider the level of detail they would like to have reported to them in the future and whether if data was shown at GP Practice level it should be anonymous.

It was noted that in relation to quality of Premises the report would suggest that East Lothian is falling behind other areas.

Anne McCarthy commented that Tranent premises were a key issue. David Small noted that a paper detailing proposals for temporary premises would be brought to a CHP Sub Committee meeting this year.

The Chair noted that he felt the report showed the need for more strategically focused discussions on how ‘outlying’ practices on key measures should be managed.

Decisions

It was agreed that a report showing the global sum equivalents would be very useful.

It was agreed that an assessment of what the Musselburgh and Gullane re-provisions would have on the premises rating would be useful.
21.2.3. **Financial Position as at 31st May 2011**

A verbal update was provided to the CHP Sub Committee.

It was noted that the CHP was overspent by £138,000 as at 31st May 2011. £53,000 of this was in relation to Prescribing. The CHP is on target to achieve the planned Local Re-investment Programme efficiencies.

It was noted that there is evidence that the introduction of free prescriptions has resulted in patients asking for items such as paracetamol and skin care remedies on prescription which would previously have been purchased over the counter.

**Decisions**

The update was noted.

22.0. **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 a pilot of Junior Doctor rota at Roodlands will begin in August 2011.

The report noted that in relation to Herdmanflat Hospital / Community Psychiatry, The new Lothian Mental Health Strategy “A Sense of Belonging” removes the current interface at age 65 so that patients of all ages must have equal access to all services. This means the Community Health Partnership will have to re-align services to comply e.g. access to Intensive Home Treatment Team, Psychological Services etc. Discussions have started on this.

The CHP is undertaking work with Primary Care Teams to deliver the new domains of the QOF. Meetings now arranged in protected learning time on 31 August 2011 and 26 October 2011 to look at referrals then emergency admissions and prescribing.

Either East Lothian Community Health Partnership or Midlothian Community Health Partnership assumes responsibility for the healthcare of prisoners’ in HMP Edinburgh and HMP Addiewell in November 2011. The Clinical Director noted concerns about the potential impact on the complaints system from the number of complaints that prisoners make in relation to healthcare issues.

The General Manager advised that Prison Healthcare will be a Hosted Service and the management arrangements have still to be clarified. The CHP will be responsible for the budget. Lynne Hollis noted that the Scottish Government is aware that there are a number of aspects of the Prison Healthcare budget to be addressed over the course of the next year. Other parts of the CHP budget will not be adversely impacted by any issues that arise in relation to Prison Healthcare budget.

**Decisions**
The report was noted.

23. **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.

**Child Protection**

There were 57 children recorded on the Child Protection Register for East Lothian as at 3rd May 2011.

**Hospital Nursing**

All three hospital sites within East Lothian are participating in the releasing time to care project. Good progress was reported.

All infection control audits continue monthly with significant improvement noted in the hand hygiene audits.

As from 1st August medical staff cover for Roodlands will be provided from the HAN team at the Royal Infirmary.

**Community Mental Health**

Training workshops on challenging behaviour proved to be very successful.

The Kaizen event roll out will take place on 29th June. The action plan is progressing.

**Healthcare Associate Infection Standards**

The series of mock HEI Inspectorate audits at Roodlands Hospital have now been completed and work to improve compliance and knowledge is on-going.

There are 194 Cleanliness Champions registered.

The following results were noted

**East Lothian CHP Managed Hospitals**

*Staphylococcus aureus bactereamias (SABs)* from 6 March 2011 - 6 June 2011 0 cases.

**Clostridium difficile** from 6 March 2011 - 6 June 2011 x 0 cases.

**East Lothian Community**

*Clostridium difficile* 6 March 2011 - 6 June 2011 x 3 cases.

**Outbreaks of Norovirus 8 December 2010 - 8 March 2011**

There have been no outbreaks in East Lothian for this reporting period.
Decisions

The report was noted.

23.1 Joint Inspection of Child Protection Services East Lothian

The Sub Committee considered the full report of Social Care and Social Work Improvement Scotland.

The report noted the particular strengths and the examples of good practice identified in the inspection which took place in January and February 2011.

It was noted that of 6 key issues 3 had been classified as 'very good' and 3 as 'good'.

Where areas of improvement were noted in the report, action plans have been developed.

Decisions

The report was noted and those involved in the services covered by the Inspection were congratulated on achieving a very positive report.

24. AHP Manager’s Report

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

The report provided an update on the podiatry strategy presentation which was made to the CHP Sub Committee on 24\textsuperscript{th} February 2011.

The report noted that the recommendations made in that presentation have not changed, in particular, that the service in East Lothian will use 5 instead of 7 sites.

The use of low volume small, single chair clinics should be reduced in the short term and ultimately stopped. Where clinics operate less than 3 days a week opportunities for amalgamation should be taken. Cognisance of local population sizes has been taken.

The report noted that in relation to nail care, simple foot care such as toenail trimming / cutting rarely required the skills of a trained Podiatrist. The paper outlined the approach being taken to train, patients/ families and Care Home staff in simple foot care.

The project team will attend meetings in the local communities impacted by the proposals, facilitated by the Public Partnership Forum (PPF) to discuss these changes. Anne McCarthy advised that the PPF does not support the application of the strategy to the number of clinics and emphasised that she wants the meetings with local communities to be constructive consultation.
Anne McCarthy noted that she felt that Day Centres may prove to be suitable premises and Morag Barrow undertook to consider this.

Decisions

The report was noted.

It was agreed that AHP management would attend meetings in the communities directly impacted by the proposed changes to listen to the views of the patients.

25. **Hosted Services**

25.1. **LUCS**

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

The report noted the development of the LUCS training role in particular in relation to Doctors training ST1s and ST3s.

The LUCS financial position and pressures was noted by Dr Jane Hopton emphasising the need for LUCS to maximise workforce efficiency or face the option of reducing activity.

Anne McCarthy asked if Dr Hopton felt that GP Practices should be covering some of the ‘out of hours’ services. Dr Hopton noted that she felt this was worthy of consideration, especially for salaried doctors employed directly by the NHS, although she recognised this was a national issue and that it could not be introduced locally.

Dr Graham Alexander commented that he felt the Consortia of Doctors available needed greater encouragement.

Dr Hopton wished to formally recognise the contribution of Karen Brown who had been seconded to LUCS as Clinical Nurse Manager since 2008 and was now moving to another role.

Decisions

The report was noted.

25.2. **Health Promotions**

There was no business covered under this item.

26. **Carers Forum**

26.1. A verbal update was provided to the meeting.

Tony Segall noted that funding for the Carers Information Strategy had
been top-sliced and locally this meant that some initiatives would have to be stopped or reduced. Tony Segall expressed the view that the decision making process had not been fully inclusive of Carer organisations and he noted his concern at the approach taken.

Decisions

The update was noted. Lynne Hollis will determine where and when within NHS Lothian the decision was made to top-slice the allocation.

27. Public Partnership Forum (PPF)

27.1 The Sub Committee considered minutes of the PPF Meeting of 5th April 2011 which were circulated in advance of the meeting.

The minutes proposed a planned change of name to East Lothian Health Network – the Public Partnership Forum in East Lothian.

It was requested that where so many large papers are being issued for meetings that summary papers should be included in place of the full paper or that web page links should be included.

The Chair noted that an unusually large number of externally produced papers had been tabled for this particular meeting.

Decisions

The minutes were noted.

The Change of name was supported by the CHP Sub Committee.

The General Manager will seek to include short summaries of papers or web-links in the future.

28. Community Health Partnership Committee Appointments

28.1. The formal documentation for the appointment of Ronnie Hill to the CHP Sub Committee is to be completed.

29. Re-design of Overnight Service at Roodlands Hospital

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

The paper set out the reasons behind the current medical rota being unsustainable and recommended a pilot of overnight support from the Hospital at Night Service at the Royal Infirmary of Edinburgh. The pilot will begin in August 2011.

This will provide a better training experience for junior doctors.

An audit of night time calls had been undertaken between January and March of 2011 and appropriate processes and controls had been
developed to deal with the underlying issues for each of the calls.

Lorraine Cowan confirmed that Nursing Management was satisfied with the training and the documented procedures that had been developed. The paper set out the practical and financial implications of the change.

The proposal has been approved by the University Hospital Division and the CHP Management Team.

Anne McCarthy noted that not having a Doctor present on a hospital site could lead to the impression of the downgrading of a service. Dr Ian Johnston noted that he felt the arrangements being proposed would make the Roodlands site more sustainable for the long term.

Decisions

The recommendations were agreed and Dr Ian Johnston will report back on the progress of the pilot at the December meeting of the Sub Committee.

30. A.O.C.B.

30.1. Minutes of the Private Session Meeting held on 21st April 2011.

It was agreed that this could be taken as an item at a public session of the Sub Committee.

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

31. Date of next meeting

It was agreed that the next meeting would take place on Thursday 25th August 2011 at 2.00pm. The Quay Complex Musselburgh
<table>
<thead>
<tr>
<th>Topic</th>
<th>Decision</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>11.3.1. Financial Report</td>
<td>A short training session by David King on Financial issues will be arranged for Wednesday 5 October at 12.15 in the Boardroom at Waverley Gate for any members of the CHP Sub Committee who wish to attend.</td>
<td>DK/DMcE</td>
</tr>
<tr>
<td>18.1. Sexual Health</td>
<td>Dr Ewen Stewart will provide a written update in 6 months and will attend a meeting of the CHP Sub Committee on an annual basis to provide an update</td>
<td>DMcE</td>
</tr>
<tr>
<td>19.3.1. Finance Report to 30th June 2011</td>
<td>A review of the position as at the end of Quarter 1 will project the year-end position and a report of this will be brought to the meeting of the CHP Sub Committee on 5 October 2011. A recovery plan has been produced.</td>
<td>DK</td>
</tr>
<tr>
<td>19.4. Consultation on the Health Inequalities Framework</td>
<td>There was strong support for the adoption of the Marmott principles. The consultation responses showed substantial agreement that delivery of mainstream services needs fundamental change. David Jack will provide a detailed update at the meeting of the CHP Sub Committee on 5 October 2011.</td>
<td>DJ</td>
</tr>
<tr>
<td>19.7. PCCO Issues</td>
<td>Duncan Miller will provide a written report at a future meeting of the Sub Committee on the outcome of the QOF Quality and Productivity work.</td>
<td>DM</td>
</tr>
<tr>
<td>19.8. Your Community / Your Health</td>
<td>It was agreed that Kate Burton would be invited back to a future meeting of the CHP Sub Committee to demonstrate the Teach Back Technique being used in the project.</td>
<td>DMcE</td>
</tr>
<tr>
<td>19.10. Pharmaceutical Care Services Plan</td>
<td>The plan will be updated and brought back to a future meeting of the CHP Sub Committee. The updating will include consultation with the North and South Edinburgh PPFs</td>
<td>AM</td>
</tr>
<tr>
<td>19.13. Re-shaping Care for Older People</td>
<td>The concerns expressed by Seb Fischer on the resources for Carers will be fed back to the Director of Health and Social Care.</td>
<td>RA</td>
</tr>
</tbody>
</table>
Note of the meeting of the Edinburgh Community Health Partnership Sub-Committee (Public Session) held on Wednesday 3rd August 2011 at 1.00 p.m. in the Boardroom, Waverley Gate, Edinburgh.

Present: Bob Anderson, (Chair)  
Robert Aitken, Acting General Manager Edinburgh CHP  
David King, Head of Finance  
Bashir Wadde, Optometrist  
Jim Kendall, South Edinburgh Public Partnership Forum  
Jim Brown, North Edinburgh Public Partnership Forum  
Dr Ramon McDermott, General Practitioner  
Lynda Cowie, Chief Nurse, Edinburgh CHP  
Maureen Reid, South West Edinburgh LHP  
Cllr Paul Edie, Council Elected Representative  
Dr Margaret Douglas, Consultant in Public Health Medicine  
Ella Simpson, EVOC  
David Jack, Head of Strategic Support, City of Edinburgh Council  
Seb Fischer, VOCAL  
Angela Lindsay, AHP Manager, Edinburgh CHP (minute items 19.10 – 24)

In Attendance: Ewen Stewart, General Practitioner, Minute Item 18  
Helen Morgan, City of Edinburgh Council, Minute Item 19.5  
Duncan Miller, General Manager PCCO Contracts Minute Items 19.6 and 19.7  
Kate Burton, Public Health Practitioner, Minute Item 19.8  
Paul Hambleton, City of Edinburgh Council, Minute Item 19.9  
Aileen Muir, Pharmacy Consultant, Minute Item 19.10  
Dick Fitzpatrick, Project Manager, Minute Item 20.1  
Iris McMillan, PPF – deputising for William Hardie  
Drew McErlean, Acting Secretary

Apologies: George Walker, Depute Chair  
Dr Ian McKay, Clinical Director, Edinburgh CHP  
Fiona McCready, Pharmacy Representative  
Frances Fraser, North West Edinburgh LHP  
Stuart McLauchlan, Staff Partnership Representative  
Peter Gabbitas, Director of Health and Social Care  
Dr Pete Shishodia, General Practitioner  
William Hardie, North Edinburgh Public Partnership Forum  
Lyn McDonald Acute Sector, Director of Operations  
John Davidson, Dental Practitioner

17. Welcome/Introduction/ Declarations of Interest/ Apologies

There were no declarations of interest made.

The apologies were noted as above.

The members of the public in attendance were welcomed.

17.1 Minutes of Previous Meeting held on 1st June 2011

The minutes were agreed as being a true and accurate record of the meeting.
17.2 **Matters Arising Not Covered on the Agenda**

11.3.1. **Financial Report**

A short training session by David King on Financial issues will be arranged for Wednesday 5th October at 12.15 in the Boardroom at Waverley Gate for any members of the CHP Sub Committee who wish to attend.

**18. Presentations**

18.1. **Sexual Health**

The Sub-Committee considered a paper which had been circulated in advance of the meeting. Ewen Stewart noted the key issues from the report.

The report detailed key drivers with the potential for a significant impact on sexual health provision and service delivery. The responses to these drivers were highlighted.

The report highlighted that after consultation with the Sexual Health Team at the Scottish Government, NHS Lothian developed an email service for assessment of severe distress in relation to Erectile Dysfunction (ED). The Changes in ED regulations will result in a rise in prescriptions and in turn there will be increased costs for the Prescribing budget, which may be substantial.

The current key issues for Primary Care and the CHPs include condom provision, development of contact tracing for STI and the provision of sexual health information.

The report noted the importance of the opening of the new Chalmers Centre for sexual health and highlighted the other key issues for 2011 – 2012. The Chair noted that the new centre is an excellent facility providing a valuable and effective service.

**Decisions**

The report was noted.

Dr Ewen Stewart will provide a written update in 6 months and will attend a meeting of the CHP Sub Committee on an annual basis to provide an update.

**19. Items for Discussion / Information**

19.1. **Chairman’s Report**

The Chair provided a verbal update on activities he had undertaken since the previous meeting in relation to his role as Chair of the CHP.

- An Armed Forces event at the City of Edinburgh Council Chambers.
- South Edinburgh PPF meeting in the week beginning 25th July which had been a very useful and informative session.

**Decisions**

The update was noted.
19.2. **Clinical Director’s Report**

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

The report provided updates in relation to

- **The GP In reach pilot**

  The number of patients attending A & E who could safely be redirected back to their GP is relatively small (i.e. less than 5%).

  The Lothian Medical Committee and GP Sub Group support the development of a redirection model.

  Dr Ramon McDermott noted it seemed as though the model is being developed differently from what was originally envisaged. The Acting General Manager noted that an independent assessment of the pilot would be conducted and would address any changes to the original scope of the work.

- **Cancer and Palliative Care**

  The Liverpool Care Pathway had secure funding for a fixed term 2 year project to implement the pathway.

  Development funding has been secured on a recurring basis for the Lymphoedema service.

- **Mental Health**

  The report highlighted the Acute Model of Care including proposals for developments over the next 3 – 6 months. The report gave details on key areas that would provide focus for the implementation of Dementia Strategy.

  It was noted that measures for the success of the Dementia Strategy are being developed at a national level.

- **QOF Peer Review arrangements for the Edinburgh CHP**

  The report outlined how the External Peer Review meeting process would be operated.

  - **The appointment of Dr Robin Balfour as Clinical Lead for North West Edinburgh LHP.**

**Decisions**

The report was noted.
19.3. **Finance Report**

19.3.1. **Finance Report to 30th June 2011**

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

The CHP is reporting a net overspend of £730k for the 3 months to 30th June 2011. Prescribing is overspent by £320k mainly as a consequence of increased volumes.

Core services are overspent by £270k and Hosted services by £120k. There are financial pressures within the Community Equipment Store and continence services.

A review of the position as at the end of Quarter 1 will project the year-end position and a report of this will be brought to the meeting of the CHP Sub Committee on 5th October 2011. A recovery plan has been produced.

The Chair noted that the financial position is subject to very close review on a monthly basis by the Performance Management Sub Group.

**Decisions**

The update was noted.

19.3.2. **Financial Plan for 2011 – 2012**

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

The plan provided details for both NHS Lothian and Edinburgh CHP. The Edinburgh CHP budget is £228.615m with a target of £4,356 of Local Reinvestment Programme savings (LRP).

The paper outlined the key issues impacting the budget and the risks in the plan. The key risks relate to Waiting Times, Achievement of the LRP target, Prescribing and the GMS funding model. Prescribing is a very significant financial pressure in the system.

**Decisions**

The report was noted.

19.4. **Health Inequalities**

A verbal update was provided by David Jack. The Health Inequalities Standing Group met in the week beginning 25th July and the key issues were.

- Consultation on the Health Inequalities Framework

There was strong support for the adoption of the Marmott principles. The consultation responses showed substantial agreement that delivery of mainstream services needs fundamental change. David Jack will provide a detailed update at the meeting of the CHP Sub Committee on 5th October 2011.
• Development of an Annual Report

A report is being developed which will detail the progress made on the initiatives and priorities that had previously been identified.

• Grant Funding Decision

A commissioning strategy for Health Inequalities funding is being developed.

The Chair noted that the report by the NHS Lothian Director of Public Health is available via the NHS Lothian website and recommended that members of the CHP Sub Committee take the opportunity to refer to the report.

David Jack suggested that Sexual Health issues may be an appropriate subject to be demonstrated on a map similar to those circulated for the June meeting of the CHP Sub Committee.

Seb Fischer noted concerns about the commissioning process used for the allocation of Fairer Scotland Funding as organisations had to wait for an unacceptable period of time to learn the funding decisions. David Jack advised that Fairer Scotland Funding would no longer exist and that many lessons had been learned which will help to improve future funding allocation processes to ensure improved availability of information to the Voluntary Sector.

Ella Simpson noted that the Health Inequalities Standing Group consultation resulted in helpful dialogue across a range of groups.

Decisions

The report was noted.

19.5. Edinburgh Learning Disability Plan

The Sub Committee considered a report which had been circulated in advance of the meeting. Helen Morgan attended the meeting to note the key issues in the service plan for 2010 – 2011.

The three key messages in the plan are

• Promoting choice and control for all people with learning disabilities in Edinburgh.
• Better local services for people with complex needs
• Making the money go further.

The report referenced the key issues including

• Employment
• Travel – the council wants to increase the number of children in school travelling independently at an earlier age. A pilot study of 2 children is underway and a further 8 children have been identified to progress this over the next 2 years.
• Housing with shared support. Cllr Paul Edie noted the very positive impact of this work.

Decisions

The report was noted. The Sub Committee recognised and commended the success achieved by the Housing with Shared Support initiative.
19.6. **GP Enhanced Local Service Support for People in Care Homes**

The Sub Committee considered a report which had been circulated in advance of the meeting. Duncan Miller attended the meeting to note the key issues.

The report provided details on the background of how the Anticipatory Care Home Contract was developed. The report noted the background to the contract arrangements highlighting the role of Lead GP Practices.

Duncan Miller noted that in response to recent issues at some Care Homes there will be a move away from voluntary reporting to statutory reporting by the Care Homes to the Questionnaires issued. This will need to be agreed with the Lothian Medical Committee,

It was noted that Care Homes are either under Private Sector or City of Edinburgh Council ownership rather than NHS Lothian ownership.

The Chair noted that he felt the report was designed to give assurance that Care Homes are subject to an appropriate level of scrutiny.

**Decisions**

The paper was noted and accepted.

19.7. **PCCO Issues**

A verbal update was provided by Duncan Miller referencing the following items

- **Quality and Outcomes Framework Quality and Productivity work**
  
  Duncan Miller explained how this process is operated.
  
  This includes work on the number of referrals that are made to Secondary Care and the volume of unscheduled admissions to Secondary Care. Practices undertake peer group reviews and there is also an external review process.
  
  This work is focused on particular Care Pathways. Duncan Miller advised that some of the Care Pathways are currently very focused on Secondary Care and need to be developed to cover all aspects of the service.
  
  Ramon McDermott noted that GPs will respond if they are identified as being an ‘outlier’ on a particular aspect patient care.

- **QOF Prepayment Verification Meeting**
  
  A review of GP activity is undertaken by the PCCO to check that Practices have done what they are contracted to do and have been paid the correct amount for these services. This is a very robust process.

- **Contractual and Statutory Review**
  
  Returns are made by Practices and have to be supported by evidence. Duncan Miller advised that a small number of practices have some issues and these are being addressed.

- **Protecting Vulnerable Groups requirements for Performers Lists**
  
  The new Disclosure requirements cover all contractors and these organisations have to demonstrate they are able to work with vulnerable groups. This also covers employees of the contractors.

The Chair noted the importance of the issues on which Duncan Miller had reported.
Decisions

The update was noted.  

Duncan Miller will provide a written report at a future meeting of the Sub Committee on the outcome of the QOF Quality and Productivity work.

19.8  

Your Community / Your Health

The Sub Committee considered a report which had been circulated in advance of the meeting. Kate Burton attended the meeting to note the key issues.

The initiative had been launched on 17th May 2011; an event which the Chair noted he had attended and felt it had been a very positive experience although some of the response times from the IT equipment in use appeared to be a little slow. Kate Burton undertook to follow up on this.

This is a health information project which aims to provide young people in the Pilton, Muirhouse and Granton areas with accessible quality assured health information. The project has been developed in partnership with a range of organizations, providing information that is mainly internet based.

A teach back will be used to ensure that information provided is understood.

Kate Burton noted that to date take up levels have not been as high as had been hoped for and so an outreach service has been developed to try to boost the number of people accessing the service.

The project will be subject to full evaluation and the report is expected to be produced by the end of March 2012.

Decisions

The report was noted.  

It was agreed that Kate Burton would be invited back to a future meeting of the CHP Sub Committee to demonstrate the Teach Back Technique being used in the project.

19.9  

A City for All Ages

The Sub- Committee considered a report which had been circulated in advance of the meeting. Paul Hambleton attended the meeting to note the key issues.

The report was a full evaluation of A City for All Ages which is Edinburgh’s long term strategy to reduce discrimination and provide better opportunities and services for older people in Edinburgh.

The evaluation found that the initiative had been a significant asset for the city and for its older population and recommended that it continues to a new phase. However it was noted that these findings must be seen against changing needs and an increasing population above retirement age.

In response to a question from the Chair, Paul Hambleton agreed that the public may not readily identify or recognise what ‘A City for All Ages’ is.
Ella Simpson commented that this initiative was introduced 10 years ago and there was now a desire to 'mainstream' the underlying processes and noted a concern that this could result in the key messages being diluted.

The Chair asked if within Edinburgh there was recognition of the contribution that older people could make. Paul Hambleton noted that he feels there is.

Iris Middleton asked if an economic impact assessment of the initiative had been carried out. Paul Hambleton noted that some of the work has had such a review done but that the economic benefits of some elements were very difficult to measure.

Decisions

The evaluation and significant achievements to date were noted.

The future actions in the report were agreed.

It was agreed that the report should be shared with Neighbourhood Partnerships and any other appropriate organisations.

19.10 Pharmaceutical Care Services Plan

The Sub Committee considered a report which had been circulated in advance of the meeting. Aileen Muir attended the meeting to highlight the key issues.

The report noted that the new Community Pharmacy contract seeks to move away from payment for the dispensing of medication to making better use of the skills and knowledge of Pharmacists. The report also referred to the commissioning process for new pharmacies.

All pharmacies will be required to provide 4 core pharmaceutical care services.

- Chronic medication service
- Acute medication service
- Minor ailment service
- Public Health service.

The report noted the details underpinning each of these services and the additional services that are agreed with NHS Lothian via locally negotiated contracts. Not all Pharmacies participate in these local services.

The Chair asked if the contract covered hours of service as well as geographic areas of service. Aileen Muir advised the contract specifies core hours of service. Edinburgh does reasonably well in terms of non core hours service and a rota system can be implemented if a gap is identified.

Cllr Paul Edie noted concerns that established Pharmacies can object to the creation of new Pharmacy services and asked if this is via legislation or locally managed Standing Orders. Aileen Muir advised this is via legislation. Cllr Edie commented that he feels some parts of the city require an improved service.

Bashir Wadde noted that Pharmacies are licensed and it is only when a Pharmacy closes that someone else can apply for that licence. This is different from Optometrists where greater commercial competition is allowed.
The Chair noted that he felt there were opportunities to increase the level of co-location of Pharmacies within or next to Health Service premises or other commercial enterprises.

Collection and delivery services are not part of the current contractual arrangements. The NHS does not currently pay Pharmacies to deliver but may have to do so if there was some element of contractual obligation on the part of Pharmacies to provide such a service. Some members of the Sub Committee felt that demand would increase as the number of elderly and frail members of the population increased in the future.

Aileen Muir advised that ultimate governance responsibility for the plan rests with the Board of NHS Lothian. If the Board want to include collection and delivery as part of the locally enhanced service contract there would be a not in-significant financial cost which in the current climate there may be very little appetite for.

David Jack commented that he sensed some concerns within the Sub Committee in relation to quality of service issues from Pharmacies. Aileen Muir advised that some work on qualitative service measures for Pharmacies was underway and these will eventually form part of the contract.

The plan will be updated and brought back to a future meeting of the CHP Sub Committee. The updating will include consultation with the North and South Edinburgh PPFs. Jim Kendall noted that it will be important to frame exactly what the limits of any discussion are so that expectations are appropriately managed on what can be expected.

Decisions

The plan was noted.

19.11 Review of CHPs

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

The report noted the very negative media responses to the recent Audit Scotland Report on CHPs.

The report detailed the activities in Edinburgh which addressed the recommendations made in the Audit Scotland Report noting that many of these had been in place for several years.

Jim Brown asked if the report was a fair reflection of Edinburgh CHP. The Chair noted that he did not feel this was the case as it generalised a number of issues and the response of the media had very much focused only on the very negative aspects of the report.

Seb Fisher noted that he feels the e-Carer agenda is not guided by any meaningful guidelines about how the relationship between the NHS and the Voluntary Sector should operate.

Ella Simpson noted that she felt there needed to be more emphasis in the response document to the willingness of organisations to work closely together and examples to demonstrate this would help to strengthen the report.
The Chair noted that he sensed some people felt the tone of the response could be interpreted as being defensive and there is no need for that to be the case as the work of the Edinburgh CHP is largely very positive.

Decisions

The report was noted and the Acting General Manager will discuss with the Director of Health and Social Services how the tone of the report can be modified to emphasise the positive work of the Edinburgh CHP.

19.12 Management Arrangements

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

The key issues were noted as

- Co-location of management teams to a single site at the Astley Ainslie Hospital.
- Rationalisation of the Core Management Team and more efficient attendance of meetings.
- Re-alignment of the Keepwell project responsibilities to a single team.
- The impact of the NHS Lothian Allied Health Professionals (AHPs) review.

Decisions

The report was agreed.

19.13 Re-shaping Care for Older People

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

The report provided an update on the Change Fund for Older Peoples Services. The Acting General Manager noted that the report had been discussed at meetings of the North and South Edinburgh PPFs in the week beginning 25th July 2011.

The report noted how the change fund will be used to progress key aims of the national and local strategies.

Four key themes are being progressed via the Change Fund.

- Care Pathways.
- Longer term services and settings.
- Training communication and culture change.
- Co-production and community capacity.

Jim Kendall noted that Appendix B of the report had set out a very large number of measures and questioned if this was manageable. The Acting General Manager advised that the national measures are the key items and that many of the local measures are sub-sets of the national measures.

Jim Kendall noted that he felt a future report would need to set out exactly what ‘success’ would be regarded as.
Ella Simpson noted that co-production and capacity building is well focused on delivering change and this needs to be very precisely scoped. Ella Simpson noted that if needed she would be happy to attend PPF meetings to outline the work being done.

Seb Fischer noted concerns that a lot of dependency appears to be based on the work of unpaid Carers and there needs to be focus on the support these people will require. Seb Fischer advised he is concerned that Carer issues are not being adequately funded. More resource will be required to reflect the increased dependency on un-paid Carers.

Angela Lindsay noted that at several meetings the concerns noted by Seb Fischer had been reflected and advised that opportunities to influence the use of Change Fund allocations still existed.

Seb Fischer noted concerns that Carer and Voluntary Organisations are not getting early access to Consultation Papers. Ella Simpson noted that this will be looked at in the Scoping Phase and emphasised that Carer issues will not be excluded. The concerns have been highlighted and are recognised.

Seb Fischer noted that the report on the Carer Information Strategy was very positive in particular in recognising the role of Older Carers.

Decisions

The report was noted.

The concerns expressed by Seb Fischer on the resources for Carers will be fed back to the Director of Health and Social Care.

20. Items for Decision Making

20.1 Royal Edinburgh Hospital Initial Agreement

The Sub Committee considered an Initial Agreement for the re-provision of services on the Royal Edinburgh Hospital campus.

The report was seeking support for the statement of strategic intent for a high level plan to develop the REH campus incrementally over a number of years. The report detailed the background of the work done to date and provided an outline timetable covering the hospitals impacted by the project.

The report also sought support for the strategic intention to re-provide existing mental health and learning disability services accommodation currently on the Royal Edinburgh Hospital site.

The development is part of commitment to reducing the number of hospital sites. Capital costs for the detailed options are estimated at between £60m and £181m from a ‘do minimum’ option to a full new build programme.

The key risks of uncertainty over funding, agreement on models of care, dependency on the sale of sites and potential increased costs for clinical and support services were highlighted.
Jim Kendall noted the report provided a very good outline of the way forward for these services and asked if the funding was in place to deliver phase 1 in the 3 – 5 year timeframe. Dick Fitzpatrick advised that the project would not have been taken forward to this stage if it was felt that the funding was not secure.

Margaret Douglas commented that the report gave a very positive analysis of the Health Inequalities issues and it had been very useful to have Public Health Involvement in the progress of the project to date.

It was confirmed in response to a question from Seb Fischer that Carer have been involved in all of the project sub-groups to date and will continue to be involved in all future phases of the project.

The Chair noted this was a very exciting project which was long overdue.

Decisions

The Initial Agreement was approved by the Sub Committee.

21. Items for Review

21.1. 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 any new actions agreed for future meetings.

21.2. Minutes from other Groups

21.2.1. Edinburgh CHP Performance Management Sub-Group – 18th May and 15th June 2011 - Copies of the minutes were circulated to members and noted.

21.2.2. Edinburgh Alcohol and Drugs Partnership 9th March 2011- A copy of the minutes was circulated to members and noted.

21.2.3. Edinburgh CHP Health and Safety Committee – 11th May 2011 – A copy of the minutes was circulated to members and noted.

The Chair noted that the Performance Management Sub Group now reviews the report which the CHP submits to the NHS Lothian Health and Safety Committee.

21.2.4. Edinburgh CHP Health Inequalities Standing Group – 21st March 2011. – A copy of the minutes was circulated to members and noted.

21.2.5. Edinburgh CHP Quality Improvement Team – 27th May 2011. A copy of the minutes was circulated to members and noted.

21.2.6. Carer Information Strategy – 10th May 2011 - A copy of the minutes was circulated to members and noted.

21.2.7. Primary Healthcare Governance and Risk Management Group 10th May 2011 -
A copy of the minutes was circulated to members and noted.

21.2.8. Edinburgh CHP Partnership Forum – 24th May 2011 - - A copy of the minutes was circulated to members and noted.

21.2.9. North Edinburgh PPF – 25th May 2011 - A copy of the minutes was circulated to members and noted.

21.2.9. South Edinburgh PPF – 26th May 2011. -A copy of the minutes was circulated to members and noted.

Jim Kendall noted that at the meeting of the South Edinburgh PPF on 27th July there had been a presentation on Discharge policy which had been very well received, resulting in a very lively discussion.

Jim Brown noted the same presentation had been made to the North Edinburgh PPF and that the PPF was very keen to be involved in any further development of the policy. The PPF also felt that perhaps the word ‘discharge’ had a rather negative implication and that a more appropriate word or phrase could be identified.

21.3. LHP Reports

There was no business raised.

22. Questions from Members of the Public in Attendance

22.1. There were no questions.

23. Any Other Competent Business

There was no other business raised.

24. Date and Time of Next Meeting

24.1 The next meeting of the Edinburgh CHP Sub-Committee is scheduled for Wednesday 5th October 2011 at NHS Lothian, Waverley Gate, Edinburgh.
16. Apologies and Welcome

Apologies were noted as above.

16.1. Royal Edinburgh Hospital Campus

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

The report was seeking the agreement of the Sub Committee for the strategic intent to develop the Royal Edinburgh Hospital (REH) Campus incrementally over a number of years.

The report also sought the agreement of the Sub Committee to

- Support the strategic intention to re-provide existing mental health and learning disability services accommodation currently on the REH site and to further explore the relocation of services from Astley Ainslie and Liberton.

- Acknowledge and support the move to an outline business case when appropriate.
The report outlined the key issues and the options for development. The capital implications ranged between £60m (do minimum) to £181m – (complete new build). Procurement is likely to be via Hubco.

The key risks relate to funding, agreement of models of care, dependency on the sale of hospital sites and the non development of community based off-site solutions for some services.

Colin Anderson referenced the dis-investment which Midlothian had made from 50% of beds at the REH due to low occupancy. The re-investment from that had been successfully made in community based mental health services. Dick Fitzpatrick noted that the work he is doing is focused purely on in-patient accommodation. Reinvestment in community services is being addressed via the Health and Wellbeing Strategy.

The Chair noted concerns about the phasing of the work over 10 years as some of the current Learning Disabilities accommodation is already sub-standard and asked that the phasing of the work be looked at. Dick Fitzpatrick confirmed this would be re-considered. Jane Hopton noted that she felt that Learning Disability services had to have a higher priority than other services covered by the proposal.

David King noted the need for absolute certainty over the capital costs as any changes there have consequential revenue impacts.

**Decisions**

The agreement was approved in principle subject to work being done to look at the phasing in relation to Learning Disability services.

16.2. **Pharmaceutical Care Services Plan**

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

The report gave the background to the development of the Pharmaceutical Care Services Plan for 2012 as required for each NHS Board.

The paper noted that a short-life working group had been formed to develop the plan.

Four core pharmaceutical care services have been defined as

- Chronic Medication Service
- Acute Medication Service
- Minor Ailment Service
- Public Health Service.

The paper provided the details underpinning these services.

Hamish Reid asked what opportunities existed for newly qualified Pharmacists to establish small independent businesses. Aileen Muir noted that theoretically a level playing field on new opportunities exists but that the financial power of the national and multi-national companies made it very difficult for new companies to gain a foothold. The larger companies
are also felt to provide greater business continuity. The Scottish Government is looking at the rules on commissioning in the context of meeting local needs.

It was confirmed by Aileen Muir that there are plans to develop quality indicators around Pharmacy services but these are at an early stage.

The Chair noted the importance of accommodation issues and making sure that premises have facilities for discreet and confidential discussions with patients. Aileen Muir noted that there is a separate piece of work being done to define the minimum accommodation for Pharmacies.

The Chair asked how Pharmacies can get reassurance about the competence of Care Home staff to follow Pharmacy instructions on the administration, storage and disposal of medicines. It was noted that Care Homes must have a documented policy on the management of medicines and this is subject to inspection by Social Care and Social Work Improvement Scotland.

Decisions

David Small noted that the contract with Care Homes is subject to re-negotiation from time to time and as Chair of the Pharmaceutical Contracts Committee within NHS Lothian he will ensure that the issues discussed at this meeting are taken to a meeting of that Committee.

The report was noted.

16.3 Neighbourhood Planning and Health

This will be covered at the meeting scheduled for 29th September 2011.

16.4 Health and Wellbeing

This will be covered at the meeting scheduled for 29th September 2011.

17. Minutes of the Previous Meeting held 25th May 2011

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

18. Matters Arising / Action Plan

18.1 Action Plan

The Action plan was reviewed and will be updated accordingly.

18.2 Continuity and Quality of Service in Care Homes

David Small and Colin Anderson provided a verbal update in relation to the care home in Midlothian which is owned by Southern Cross.

A new provider will be taking over the management of the home. There have been no operational issues identified although there are some staff vacancies that need to be filled.
Bed occupancy is at 90% The general environment at the care home appears to be good and there have been no concerns raised over the quality of care. Close monitoring is continuing via a series of meetings involving the appropriate professionals.

Decisions

The Chair noted that bed occupancy levels need to be closely monitored on an on-going basis and there is also a need to provide re-assurance to the public on the situation.

18.3 Audit Scotland Audit of Community Health Partnerships (CHPs)

The Audit Scotland Review of Community Health Partnerships and the Self Assessment which had been drafted on behalf of Midlothian CHP had been circulated in advance of the meeting.

The Chair noted his concerns that Audit Scotland had not made it clear that the report was based on a review of a small number of CHPs and he emphasised that Midlothian CHP had not provided any input to the report.

David Small referred to the Self Assessment and commented that there are opportunities for East Lothian and Midlothian to respond together to emphasise the positive actions already underway some of the issues highlighted in report.

Colin Anderson noted other reports had highlighted positive examples of Health and Social Work acting together. It was noted that there appeared to be no imminent plan to re-structure CHPs and therefore there are opportunities to act locally to bring about further improvement.

Colin Anderson noted that he felt it was wrong to have so much focus on governance issues as these were not what mattered to the general public.

The Chair noted that the Chair of East Lothian CHP has been invited to a meeting of the Midlothian CHP Sub Committee.

George Wilson noted that the PPF had been very disappointed with the general tone of the report and that it had not reviewed the work of all CHPS as that would have resulted in a more balanced viewpoint being generated.

Decisions

Members of the CHP Sub Committee were invited to send any comments on the self assessment to David Small.

18.3. Midlothian Single Outcome Agreement

The document ‘Midlothian Moving Forward’ which is the 2010 – 2013 Single Outcome Agreement had been circulated in advance of the meeting.

David Small noted that the report will be brought back to the CHP Sub Committee periodically to report on the progress that has been made.

The Chair asked what was the biggest achievement in relation to the Single Outcome Agreement in the past year.
David Small noted that he felt this was the action taken in Older Peoples’ Services and reductions in delayed discharges.

Colin Anderson commented that from a Council perspective the work done to re-shape care for older people and people with mental health issues in a community setting was noteworthy.

Hamish Reid commented that from a GP perspective he thought there was a genuine improvement in the way that Health and Social Services are working together to provide appropriate models of care for patients.

Decisions

The report was noted.

19. **General Manager’s Report**

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

**Delayed Discharges**

The June census reported 10 patients delayed but there no patients in short stay beds and no patients over 6 weeks. The position has deteriorated from the May census and is being impacted by difficulties within individual care homes in Edinburgh and Midlothian.

**Capital Projects**

Dalkeith and Penicuik Health Centre Projects remain on track.

The General Manager has asked the CHP Projects Manager to update the primary care premises strategy to take account of the latest housing development plans.

Cllr Aitchison advised that any further housing development in Gorebridge would be dependant upon the building of the Edinburgh – Borders rail link as the road infrastructure is inadequate. Cllr Aitchison advised that the Shawpark development is likely to proceed at some time in the future.

**Performance Management**

The General Manager is developing a routine report for Sub-Committee discussion which will report activity levels, performance against HEAT targets and key measures in Primary Care.

**Committee Paper Format**

A new format for committee papers is being introduced which will include assessment of risk and details of any public involvement.

Decisions

The report was noted.
19.2. **Staff Governance Report**

The Sub Committee received a report which was circulated to the meeting.

The sickness absence rate for the CHP in June 2011 was 4.52%. The year to date sickness absence rate is 4.05%.

The Chair noted concerns over the negative aspects of some media reports on the way sickness absence was being managed by NHS Lothian and stressed that staff with genuine ill health issues would be supported and that appropriate and fair action would be taken in relation to staff who did not have genuine health issues.

**Decisions**

The report was noted.

19.3.1. **Finance Report to 30th June 2011**

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

The CHP is reporting a net overspend of £214k for the period to 30th June 2011. The Chair noted that it was very helpful to have early reporting of the position at the end of the first quarter of the financial year available.

Core Services are overspent by £102k, Hosted Services by £40k. A key issue is the actioning of Local Reinvestment Program (LRP) efficiencies in accordance with the predicted phasing pattern.

Prescribing is overspent by £68k and this is volume related. This is a very significant financial pressure.

The CHP Management Team is preparing a recovery plan to bring the financial position into balance. A quarter 1 review will be conducted which will project the year end position. The recovery plan will be tabled at the meeting of the CHP Sub Committee scheduled for 29th September 2011.

The Chair noted the large number of premises that services operate from and suggested that there are significant opportunities to rationalise the number of buildings used.

**Decisions**

The report was noted.

19.3.2. **Financial Plan**

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

The plan outlined the details in relation to NHS Lothian in Part A of the Report and Midlothian CHP in Part B of the plan. The overall budget for Midlothian CHP was £64.718 million and this has been formally signed off by the CHP Management Team.
The Local Re-investment Programme has a target of savings of £1.919 million and the details of the projects to underpin this target were circulated with the Financial Plan.

Expenditure is predicted to grow more than income hence the need for a substantial efficiency savings programme.

Decisions

The report was noted.

20. Clinical Director Report

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

This included the final report of the East and Midlothian Quality Improvement Team (QIT). The report highlighted the strong level of patient involvement. The role of the QIT is to share good practice. David Small noted that the QIT report may form part of the planned KPI reporting.

Hamish Reid noted that he felt a significant overspend in Prescribing was inevitable as the budget that had been set for 2011 – 2012 was lower than the expenditure incurred in 2010 – 2011.. David Small noted that the net position across Lothian will be managed to try to achieve financial balance including bringing forward additional efficiency plans.

The Chair noted his appreciation of the work carried out by the Clinical Director and other members of the team in relation to prescribing.

The report noted that the CHP was currently investigating a patient’s death where prescribed medicines may have been a factor. A formal investigation has been established and the family of the patient are being kept fully informed.

Decisions

The report was noted.

21. Chief Nurse Report

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

Child Protection

The draft Midlothian HMie Child Protection Inspection report had been received for comment and the final version will be received in August 2011.

A working group has been set up to look at the impact of national child protection guidance on services and practice.

There were 159 children in 77 families on the child protection register for May 2011. It is felt that early intervention work is the reason for this
significant increase in numbers. It was confirmed that both Health and Social Services feel there is sufficient resource available to cope with the increased workload. There is very close monitoring of caseloads.

**Adult Protection**

Performance data for Adult Protection across East Lothian and Midlothian is being developed.

A new Offender Management Committee has been established.

**Community Nursing**

Most of the Cluster teams have now begun this new approach to working.

The report also provided updates in relation to Releasing Time to Care, New Uniforms and the Liverpool Care Pathway.

Developments at the Midlothian Community Hospital including the Health Promoting Hospital scheme were noted as was the work of the Community Mental Health Team with the Dementia Demonstrator Project.

There were no significant issues in relation to Healthcare Associated Infections to report.

The Infection Control Nurse has delivered the first three of a series of infection control education sessions at the Midlothian Community Hospital. Two mock Healthcare Environmental Inspectorate Audits have been carried out at Midlothian Community Hospital. The need to improve staff knowledge had been identified as an issue and this is being actioned.

**Decisions**

The report was noted.

**22. AHP Manager Report**

The Sub Committee received a verbal update on the Lothian Wide AHP service review.

This is focusing on skill mix issues to reduce the current level of dependency on highly qualified staff in carrying out routine procedures. There will be some efficiency savings made amongst higher banded staff.

Each of the CH(C)Ps in Lothian will be allocated a lead for a particular aspect of the AHP Service and for East and Midlothian this will be dietetics.

**Decisions**

The update was noted.
23. **Hosted Services**

23.1 **Learning Disability Services**

23.1.a. **Clinical Governance and Risk Management Issues**

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

The paper highlighted the progress made in the re-configuration of current in-patient assessment and treatment units. The changes are positive and have resulted in a significantly improved environment.

The Learning Disability service has a comprehensive risk management infrastructure in place.

There has been very good support from Estates to facilitate the key changes required but work on other environmental aspects needs to be accelerated. Jane Hopton noted that the issue of Resourcing from the Capital Planning Team is being resolved.

23.1.b. **Re-Design of Learning Disability Services**

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

The report noted the need to increase the intensity of the work that can be done across Lothian to support patients in a community setting.

The report noted the need to have the appropriate staffing and physical environment within Lothian to avoid having to place people away from Lothian.

The need to address the in-patient care for women was emphasised as that has not happened in the way it had been envisaged when Gogarburn was re-provided.

The plans are a robust blueprint to be taken forward but the challenges in providing the resources to support the models of care are significant.

David King commented that it was vital that financial pressures were highlighted at as early a stage as possible.

David Small noted the impacts from these plans on the planned development of the Royall Edinburgh Hospital. This will require close coordination.

Colin Anderson commented that Midlothian Council fully embraces the vision outlined and is committed to the modernisation of day services for Learning Disability patients.

The Chair noted the importance of maximising opportunities to work alongside the Royal Edinburgh Hospital. Jane Hopton advised there had been detailed discussions with a range of parties on the correct model of care for patients with Forensic needs – trying to identify how things could
be done differently. Service users have been consulted in the development of each care pathway too.

Decisions

The report was supported.

Health Promotion Service

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

- The achievements and challenges of the Join Health Improvement Partnership (JHIP) in 2010 – 2011.
- The plans of the JHIP for 2012 – 2013.
- Capacity Building within Midlothian Community Hospital.
- Neighbourhood Planning

Decisions

The update was noted.

24. Carers Forum

The Sub Committee received a verbal update.

Recruitment of an Unpaid Carer to join the Midlothian Carer Action Group is progressing.

There is a meeting of the Carers Strategy Planning group on 8th September to focus on the Carer Information Strategy. Both Health and Social Care will be represented at this meeting.

Funding support will continue for VOCAL and Alzheimer's.

Decisions

The update was noted.

25. Public Partnership Forum

The minutes of a meeting held on 24th March 2011 had been circulated in advance of the meeting and were considered by the Sub Committee. The key issues noted were in relation to:

- The PPF away day.
- Podiatry – further consultation is required on the re-provision of services proposals.
- Carer engagement.

Decisions

The update was noted.
26. **A.O.C.B.**

26.1. **Community Planning Working Group**

George Wilson circulated a paper to the Sub Committee noting that the Community Planning Working Group had signed off an application to the Big Lottery Fund Improving Futures Fund.

Subject to a Business Plan being submitted the bid will be funded in full to the value of £878,782.50. The activities to be undertaken with the funding were noted and these are in relation to developing a multi agency early intervention programme that will empower families in Midlothian with multiple risk factors to take control of their situation.

26.2. **Dementia**

Colin Anderson noted that Midlothian is a demonstration site for a programme supported by both NHS Lothian and Midlothian Council which will be focused on early diagnosis of dementia. This is a programme which was developed and has been very successful in New Zealand. Colin Anderson will report on progress to a future meeting of the CHP Sub Committee.

26.3. **Employment Training Opportunities for People with Learning Disabilities**

The Chair noted the very positive work being done by some key employers in the area and suggested that it may be useful to invite some of these employers to a future meeting of the CHP Sub Committee to give a presentation on what they do. Colin Anderson noted that he was aware that one particular employer would be very keen to take up such an invitation.

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

Thursday 29th September 2011 @ 14.00 in the 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 28TH JUNE 2011

Present - Theresa Douglas (Chair), Ellen Glass (Vice-Chair), Mike Boyle, Janet Campbell, John Cochrane, Bruce Ferrie (substituting for John McGinty), and Jane Houston

Apologies – Robin Burley, John McGinty and Jim Forrest (CHCP Director)

In Attendance - Jennifer Scott (Interim Head of Council Services), Marion Christie (Head of Health Services), Lynne Hollis (Associate Director of Finance, NHS Lothian), Dr James McCallum (Clinical Director), Alexis Burnett (Communications Manager, NHS Lothian), Gill Cotrell (Chief Nurse), Robert Naysmith (Clinical Director, NHS Lothian Salaried Dental Service), Paul Silk (SCISWIS), Julie Cassidy (Patient/Public Involvement Worker, NHS Lothian), Kimberly Morgan (West Lothian Young Health Forum), Chris Haywood (Risk and Insurance Officer, West Lothian Council), Kenneth Ribbons (Internal Audit Manager, West Lothian Council)

1. MINUTE OF MEETING OF THE BOARD – 24 MAY 2011 -

The Board approved the Minute of its Meeting held on 24th May 2011 as a correct record.

2. RUNNING ACTION NOTE -

The Board considered the Running Action Note (which had been circulated) and agreed and noted the following:-

a. In relation to Item 1, the up-to-date version of Westlife, which had just gone to print, included a section congratulating staff on the achievement of Investors in People.

b. In relation to Item 3, the Board noted that most actions had been completed or were in progress. The Board heard that the use of community council notice boards to promote CHCP messages and events was also being explored.

c. In relation to Item 6, in response to a question raised, the Chair confirmed that discussions regarding premium rate telephone contracts were taking place outwith Board meetings.

d. In relation to Item 7, the latest edition of Health Link had included information about the St. John’s/ERI bus service

e. In relation to Item 8, 4 information sessions were currently being arranged for all staff.

Decisions -

1. To note and agree the Running Action Note.
2. To agree that all items except for Item 2 could be marked as “complete” and removed.

3. **MINUTE – CHCP SUB-COMMITTEE**
   
The Board noted the Minute of the Meeting of the CHCP Sub-Committee held on 17th March 2011.

4. **MINUTE – LOTHIAN NHS BOARD PRIMARY CARE AND COMMUNITY PARTNERSHIP COMMITTEE**
   
The Board noted the Minute of the Meeting of the Lothian NHS Primary Care and Community Partnership Committee held on 11th May 2011.

   In relation to Item 24.1.1., the Chair advised the Board that the costs of CHCP meetings being held in public in West Lothian were not cost prohibitive.

5. **MINUTE – NHS LOTHIAN PRIMARY CARE JOINT MANAGEMENT GROUP** -
   
The Board noted the Minute of the Meeting of the NHS Lothian Primary Care Joint Management Group held on 12th May 2011.

6. **MINUTE – NHS LOTHIAN PRIMARY CARE FORWARD GROUP** -
   
The Board noted the Minute of the Meeting of NHS Lothian Primary Care Joint Management Group held on 24th May 2011.

   James McCallum agreed to report the Board’s concerns about the use of the term “challenging behaviour” back to the Group. The term was considered to stigmatise and the Board was of the view that alternative terms should be used instead.

7. **CHAIR’S REPORT** -
   
The Board considered a report (which had been circulated) by the Chair advising the Board of the activities carried out by her since the last meeting. The report advised the Board of activity in relation to the CHCP Sub-Committee, visits to the Psychiatric Day Hospital Westpark and the Memory Treatment Centre at St. John’s, as well as a visit to Whitburn to visit the Answer Project and attendance at the most recent meeting of the Stakeholders’ Group.

   **Decision** -

   To note the contents of the report.

8. **PRESENTATION - “LISTEN TO US” DVD**
   
   Julie Cassidy (CHCP Patient/Public Involvement Worker) and Kimberly Morgan (West Lothian Youth Health Forum) provided the Board with a presentation on the Youth Health Forum’s “Listen to Us” DVD. Kimberly explained that the DVD had been developed following a residential meeting in 2009 when there had been a lot of discussion on what it was like for young people requiring health care. As a result, the Youth Health Forum had decided to produce a DVD to ensure that GP practices and other health and care professionals understood how their attitudes could affect young people's experiences of using the services they provided.
The DVD contained real life scenarios and had been designed primarily to elicit discussion amongst health professionals. It was considered essential that when the DVD was presented elsewhere in the future, it should be done with representatives from the Youth Health Forum in attendance.

The Board heard that the West Lothian Young Carers had also contributed to the DVD to spread their message of the importance of involving young carers in every aspect of their parent’s care, particularly where it related to medication. They had also asked to be involved in future training with the Youth Health Forum.

Gill Cotrell undertook to ensure that the message about young carers was fed back to District Nurses and Health Visitors and also to the Youth Forum.

Decisions -

1. To note the terms of the DVD presentation.

2. To note that the DVD would be presented to the Primary Care Forum meeting in August in order that the Forum could decide where it should be presented in future, and that it was important for Youth health Forum representatives to be present at such presentations.

3. To note for the future the suggestion that the DVD should be edited and uploaded to YouTube in a bid to spread the messages further.

4. To record thanks to all involved in the production of the “Listen to Us” DVD, and to Kimberly and Julie for their interesting and informative presentation.

9. DENTAL SERVICE AND OUTREACH TRAINING ST JOHN’S HOSPITAL -

The Board considered a report (which had been circulated) by the Clinical Director, Salaried Primary Care Dental Services which provided an update on the operation of the Dental Service and Outreach Training at St. John’s Hospital since its opening in the autumn of 2009.

Orthodontic and hospital dental services had moved from OPD4 to the new unit and the regional maxillo-facial service in OPD4 had gained one additional fully equipped dental surgery and one additional consulting room. The facilities provided an improved dental service for St. John’s inpatients, an improved service for patients requiring maxillo-facial services and the outreach training of dental health professionals and dental foundation dentists in St. John’s Hospital. It was anticipated that utilisation would increase as national problems in recruitment to the dental profession were resolved.

Decisions -

1. To note the report.

2. To request that Board members be provided with figures on the number of patients who had used the new Dental Service and Outreach Centre in its first two years.

10. RISK MANAGEMENT -

The Board considered a report by the CHCP Director (which had been circulated) advising of progress made since the last report to the Board in controlling risk to
the Partnership and reviewing the CHCP Risk Register in accordance with the strategy noted by the Board. When the risks had been reviewed in April 2011, there had been no major risks since the last review. The content of new Bribery Act had been considered but did not pose any major risks as it had primarily been written to put rules in place for people selling overseas.

Senior Managers had held a joint meeting to review, identify and quantify key risks to the Partnership in April 2011. As a result of the review, changes were made to the control measures shown in the risk register. The updated risk register, which showed the key risks and proposed improvement actions after the review, together with the Risk Exposure Grid and Risk Tolerance Matrix used in the risk identification and quantification process, were shown in the appendices to the report.

In response to concerns expressed about recent events involving private home care providers, the Board was assured that weekly contingency planning meetings were taking place to ensure the partnership is in a position to respond to any problems that may arise in West Lothian. The Board noted that an additional review of risks may be necessary following the publication of Audit Scotland’s report on its review of CH(C)Ps.

Finally, the Board heard that Chris Haywood would be retiring in the autumn and that Kenneth Ribbons, Internal Audit Manager, would take over responsibility for risk assessment. On behalf of the Board, the Chair thanked Chris for her assistance to the Board and wished her a long, happy and healthy retirement.

Decision -
To note the contents of the report.

11. CHCP SUB-COMMITTEE WORKPLAN -

The Board considered a report (which had been circulated) by the CHCP Director updating the Board on progress of staff in delivering the CHCP Sub-Committee Workplan for the period from 1st October 2010 to 31st March 2011.

Following the recent Sub-Committee development event in April, it had been agreed that the format for the next workplan would be revised and updated to incorporate comments. The new version would be themed around the four outcomes that the Sub-Committee was charged with delivering, linked to Life Stages and would be updated on a six-monthly basis.

Decision -
To note the report.

12. PERFORMANCE MANAGEMENT IN THE CHCP -

The Board considered a report (which had been circulated) by the CHCP Director advising of the development of performance management within the CHCP.

The appendix to the report provided information on the broad suite of key operational performance indicators across activity within the CHCP. Due to the transition from the current CIS information system to the new TRAK system, some indicators were unable to be populated with data at present. The position would be resolved by the next report on performance to the Board.
Work was ongoing to extend the range of performance indicators to include measures related to GP practices and community nursing. It was anticipated that these would be included in the next report on performance to the Board.

The report incorporated indicators related to the national community care outcome framework which had been integrated within the Single Shared Assessment Process using the West Lothian eCare application. West Lothian was the first in Scotland to have incorporated the national community care outcomes within routine business processes and was the first area to be able to report on those regularly and consistently.

The Chair advised that Kenny Selbie (West Lothian Council) and James Glover (NHS Lothian) had intimated that they would be reviewing both the Performance and Care Homes Governance Framework Reports to determine whether they required an Equality Impact Assessment.

**Decision**

To note the report.

13. **CLINICAL GOVERNANCE**

The Board considered a report by the Clinical Director (which had been circulated) advising that Clinical & Staff Governance in General Practice: NHS Circular PCA (M) (2010) had been issued to all General Practices with the expectation that it be used as a guide and checklist to make sure practices were fulfilling their legal, contractual and professional obligations.

The report identified priorities and areas for development which supported a continuous improvement process in achievement of the Clinical & Staff Governance Standards.

The CHCP already provided an established mechanism to support clinical and staff governance in General Practice which was essential to ensuring quality services were delivered across West Lothian. The incorporation of the new guidance would enable progress to be monitored and recorded. The CHCP had already made good progress around some of the priorities and were actively engaging with General Practices. The CHCP management team would continue to work in partnership with General Practices to build on existing good practice and support the delivery of the highest quality healthcare services to the people of West Lothian.

**Decision**

To note the report and support the CHCP in actioning the guidance and achieving required governance standards.

14. **CARE HOMES – GOVERNANCE FRAMEWORK**

The Board considered a report by the Acting Head of Council Services (which had been circulated) providing an update on the Governance Framework for Care Homes in West Lothian including the inspection framework undertaken by Social Care & Social Work Improvement Scotland, the National Care Home monitoring arrangements by Social Policy Contract & Commissioning Team and their complimentary relationship in the management of the National Care Home Contract.
The National Care Home Contract aimed to raise the quality of care provided in care home across Scotland, standardise the terms and conditions within the contract and, as far as possible, the funding of placement in care homes. The contract had been designed with sufficient flexibility to allow for each local authority’s structure in respect of assessment, care management and financial arrangements and simplified the process for local authorities when arranging, paying for and monitoring the placement of a person in a care home outside their geographical boundary.

The report went on to provide the Board with (a) full information in the inspections undertaken by SCSWIS, (b) the terms of the Memorandum of Understanding and (c) the monitoring role of the Contract & Commissioning Team.

The report concluded by explaining that if significant concerns were ever raised by the regulator in relation to a care service with whom the council had a contractual arrangement, the council’s first response would be to take whatever steps were necessary to ensure that the care needs of the vulnerable adults concerned were and would continue to be met. The level of action would be determined by the urgency and seriousness of the situation at the time.

The avoidance of care home closures was not always possible or desirable and that the good practice guidance issued by COSLA in 2011 in relation to the closure of care homes would be followed if required.

Decisions

1. To note the report.

2. That the Contracts & Commissioning Team be asked to ensure that members of the Board were made aware of any issues regarding care homes in West Lothian as soon as possible, particularly where issues arose outwith meetings of the Board.

15. STAFF GOVERNANCE -

The Board considered a report (which had been circulated) by the Acting Head of Council Services and the Head of Health Services updating the board on staff issues within the CHCP.

In relation to council services, the report advised of the E learning application (Learn Pro) which would be used to continue to develop the workforce and also of a reduction in staff sickness and resultant financial savings.

In relation to the Health Services, the report provided information on Releasing Time to Care which had been fully implemented in continuing care wards and mental health wards. A review of Mandatory Training had been undertaken with gaps identified and an improvement plan put in place. The recommendations arising from the Lothian Allied Health Professions (AHP) Review were also outlined. Finally, the Board was informed of a decrease in staff absence in the Health Service as well.

Decisions -

1. To note the information provided.
2. To support the CHCP in its participation and development of the first multi-agency e-learning Adult Support and Protection module.

3. To support CHCP management in the delivery of training to GPs, the implementation of the Council’s revised policies and procedures in sickness absence, the implementation of Releasing Time to Care, and the review of mandatory training through Health & Safety.

16. 2011/12 REVENUE BUDGET – MONITORING REPORT AS AT 31ST MAY 2011

The Board considered a report (which had been circulated) by the Acting Head of Council Services and the Head of Health Services providing a joint report on financial performance in the CHCP based on figures for the period to 31st May 2011.

In terms of the council's financial position, the service forecast was to break even for the year. As yet no major pressures had emerged. The first full monitoring would be in August and would be reported to the next Board meeting with an updated forecast based on detailed discussions with budget holders. It would also outline the agreed risk areas that would be monitored monthly.

In terms of the health service financial position, the forecast was also to break even with a number of variances set out in the report.

The financial position of the West Lothian Community Health and Care Partnership would be closely monitored and reported upon on a monthly basis.

Decision

To note the report.

17. DIRECTOR’S REPORT

The Board considered a report (which had been circulated) by the CHCP Director setting out key areas of work in which the partnership had been involved since the last meeting.

The Board was advised of work carried out in relation to the CHCP Sub-Committee, Junior Health & Social Care Academy, official opening of Norvell Lodge and the publication of the Audit Scotland review of CH(C)Ps since their inception.

The Board agreed that a response to the Audit Scotland report should be prepared for agreement at the next meeting as the relatively negative view held by Audit Scotland was not shared locally given the achievements of the West Lothian CHCP to date.

It was suggested that it would be worth undertaking the CHCP self-assessment process to provide evidence to support a response to Audit Scotland. In addition, the Board agreed that it may be worth waiting to see the terms of the Christie Commission Report, which was also due to be published.

Decisions

1. To note the report.
2. That a draft response to Audit Scotland be presented to the next meeting of the Board.
CHAIRMAN’S REPORT

1. Internal

1.1 Chalmers Sexual Health Centre - On 31 August I hosted a Ministerial visit to the Chalmers Sexual Health Centre. Michael Matheson MSP formally opened the building, was shown round, and met staff. The staff told the Minister they had been busy in the preceding four weeks of operation, with evidence of previously unmet demand. Chalmers Hospital refurbishment cost £8M.

1.2 Penicuik Medical Centre - Also on 31 August I formally opened an extension to the Penicuik Medical Centre. The enlarged building has improved both waiting and reception areas, and has increased treatment, administrative and storage space.

1.3 Crisis Centre - To mark the launch of the National Mental Health Strategy, the Health Minister (Michael Matheson MSP) visited NHS Lothian’s Crisis Centre in Smith’s Place, off Leith Walk, on 5 September. The Centre provides 24 hour support for mental health outpatients. I escorted the Minister while he met staff and service users.

1.4 LEAP - I officiated at the latest LEAP graduation ceremony on 9 September, covering for the Vice Chair.

1.5 MSPs - Also on 9 September, I chaired our quarterly meeting of regional MSPs. All of the attendees were newly elected members, and we were able to brief them on current plans.

1.6 Launch of Novalis Tx Linear Accelerator

On 20 September I hosted the Cabinet Secretary when she opened the Linear Accelerator. The Western General Hospital is the first in Scotland (and one of only a handful of cancer centres in Europe) to benefit from the Novalis Tx Linear Accelerator. The treatment system offers advanced, highly precise radiotherapy treatment and gives the chance of a cure to those with previously untreatable tumours.

1.7 Midlothian Community Hospital - On 26 September I hosted another Cabinet Secretary’s opening ceremony - this time the Midlothian Community Hospital in Bonnyrigg.
1.8 **Visits** – My visits this period included the West Lothian CHCP on 27 September.

2. **External**

2.1 **NHS Event** - I attended the NHS event in Glasgow on 23 August. Delegates were briefed on Scottish Government policy developments.

2.2 **The Scottish Mental Health Arts and Film Festival National Launch** - I joined the Director of Public Health at the launch of the Scottish Mental Health Arts and Film Festival in Edinburgh on 1 September. This festival seeks to raise the profile of mental health via arts events throughout Scotland.

2.3 **Inch View** - On 13 September, I joined the Chair of the Edinburgh CHP Partnership Board (Bob Anderson) when he co-hosted with (Cllr Norman Work) the opening of the City’s third new publicly owned care home at Inch View in Gilmerton Road. Staff explained to visitors how the Centre is geared up to dementia - over half of the 60 residents had the condition.

2.4 **Annual Leave Arrangements** - During this period I took a two week holiday.

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**Charles Winstanley**  
Chairman  
15 September 2011
CHIEF EXECUTIVE’S REPORT

1. Local Initiatives

1.1 Visit to St John’s Hospital – As part of my regular programme, I visited St John’s Hospital on July 8. The visit focussed on the Head and Neck directorate at St John’s Hospital and I saw advanced and very valued work of the Laser Unit within the Plastic Surgery department and, in particular, its remarkable results for children. I also visited the Department of Plastic Surgery and Burns which provides a supra-regional service for a population of 1.4 million. Colleagues explained to me how, in recent years, improved safety levels and the reductions in road traffic accidents had led to a welcome reduction in the volume of burns cases, with an accompanying need for fewer beds. I also visited the Ear, Nose and Throat service which, again, is a regionally based service having transferred from Edinburgh in 2009.

Overall, it was another excellent visit and all the staff I met had considerable pride in their services which continue to develop as part of the growth and investment in St John’s Hospital.

1.2 2nd International Conference on Compassionate Care hosted by NHS Lothian and our partners in Edinburgh Napier University - The 2nd International Conference on Compassionate Care took place at Napier Sighthill Campus on June 23 and 24. The event attracted over 250 delegates from the United Kingdom, Europe, Africa and America. The conference featured keynote presentations, including one from Sue Davies, Associate Professor of Nursing at Winona State University in the United States, as well as over 30 workshops and round table discussions. This event is now established as an important part of our continuing efforts to make compassionate care the hallmark of all of our services.

1.3 BioQuarter Scottish Partners Executive Meeting – NHS Lothian hosted this meeting at Waverley Gate on August 25, chaired by Scottish Enterprise and attended by NHS Lothian representatives. The meeting heard progress reports on the development of the Scottish Centre for Regenerative Medicine and the very exciting bid being submitted to UK Government in support of the creation of a Technology Innovation Centre within the Edinburgh BioQuarter.
2. **National Initiatives**

2.1 **Scottish Partnership Forum** – I attended the Scottish Partnership Forum meeting on August 12. The meeting was given an update on a range of issues including the Partnership Structures Review being led nationally and progress on the Patient Rights (Scotland) Act 2011.

2.2 **NHS Scotland Event 2011 – Quality in Action** – Along with the Chairman and other colleagues from NHS Lothian, I attended this event on August 23-24 in Glasgow. The theme for the conference was Quality in Action and a number of NHS Lothian colleagues were leading sessions and presenting posters at the event.

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*James Barbour*

*Chief Executive*

*31 August 2011*
QUALITY REPORT

1 Purpose of the Report
1.1 This report presents the updated Quality Report for September 2011.

2 Recommendations
The Board is asked to:
2.1 Review the quality measures presented.
2.2 Endorse the new approach taken with the Quality Report.

3 Discussion of Key Issues
3.1 Following an informal review of the first year's Quality Improvement Reports, this report sets out a new approach, with key changes as follows:

3.1.1 For the core measures, the report presents only the data and a brief accompanying summary. The narrative is replaced by a technical appendix;

3.1.2 For the effectiveness measures, over the course of the year a priority area will be considered at each board meeting (diabetes, stroke, Coronary Heart Disease, cancer, mental health, and early years). This will be accompanied by a summary of other measures which will be considered at the Board's Healthcare Governance and Risk Management (HCGRM) Committee;

3.1.3 For this report, diabetes is considered. The summary of measures reviewed by the HCGRM committee will start in the November report.

3.2 This report exceeds the limit for a standard Board paper; it does so as it combines a number of other reports and is also in line with the good practice that boards focus a significant proportion of their time (20-25%) on quality issues.

3.3 The latest key quality results are as shown in Table 1; the constraints in relation to each of these data items have been presented to the board in previous quality reports.

3.4 The diabetes effectiveness measures are broadly in line with those in Scotland as a whole. Nonetheless, there is room for improvement and this paper outlines some examples of actions in place to address this.
### Table 1: Summary quality results, August 2011

<table>
<thead>
<tr>
<th>Measure</th>
<th>Aim/target</th>
<th>Summary Results at August 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>HSMR</td>
<td>HSMR less than one.</td>
<td>HSMR remains stable at less than one for all three acute sites.</td>
</tr>
<tr>
<td></td>
<td>SPSP <em>national</em> target to reduce HSMR by 15% by December 2012.</td>
<td>Small reductions in HSMR at RIE (3.7%), WGH (6.5%).</td>
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<tr>
<td></td>
<td></td>
<td>- <em>Figures 1a &amp; 1c</em></td>
</tr>
<tr>
<td>Adverse Events</td>
<td>SPSP target to reduce by 30% by December 2012.</td>
<td>Significant (42%) reduction in the adverse event rate from baseline period (2007).</td>
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<tr>
<td></td>
<td></td>
<td>- <em>Figure 2</em></td>
</tr>
<tr>
<td>Hospital Associated Infection (HAI)</td>
<td>HEAT targets for SABs and CDI relate to episodes/acute occupied bed days.</td>
<td><em>S. aureus</em> Bacteraemia achieving HEAT target.</td>
</tr>
<tr>
<td></td>
<td>HEAT target for hand hygiene is 90% compliance. Local stretch target of 95%.</td>
<td><em>C. difficile</em> Infection – achieving HEAT target.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hand Hygiene – achieving HEAT target and local stretch target.</td>
</tr>
<tr>
<td>Incidents with associated harm</td>
<td>Reporting of incidents with harm should not increase.</td>
<td>The reporting of incidents with associated harm remains stable - <em>Figure 4</em></td>
</tr>
<tr>
<td>Complaints</td>
<td>National target to acknowledge 100% of complaints within 3 days and to respond to 80% of complaints within 20 days</td>
<td>Increase (12%) in formal complaints in the last quarter.</td>
</tr>
<tr>
<td></td>
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<td>- <em>Figure 5a</em></td>
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<td></td>
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<td>3-day compliance – 99%. Improvement on previous quarter</td>
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<tr>
<td></td>
<td></td>
<td>20-day compliance – 83%. Improvement on previous quarter</td>
</tr>
</tbody>
</table>
Figure 1a - Quarterly Hospital Standardised Mortality Ratios in Royal Infirmary of Edinburgh, October 2006 – March 2011

Figure 2 - Rate of Adverse Events per 1000 patient days. September 2007 to October 2010

Figure 1b - Quarterly Hospital Standardised Mortality Ratios in St John’s Hospital, October 2006 – March 2011

Figure 3a – Progress against HEAT Target for S.aureus Bacteraemia (SAB)

Figure 1c - Quarterly Hospital Standardised Mortality Ratios in Western General Hospital, October 2006 – March 2011

Figure 3b – Progress against HEAT Target for C.difficile Infection (CDI)
Figure 4: Number of incidents associated with moderate or major harm or death reported per month in NHS Lothian (July 2010-June 2011)

Figure 5b – 20-Day Response Target across NHS Lothian, Quarterly

Figure 5a – Formal Complaints per quarter across NHS Lothian (Apr 2009-June 2011)
3.5 Effectiveness Measures

3.5.1 Patients with diabetes are cared for across both primary and secondary care. Much of this care is focussed on reducing the long term complications of diabetes which include kidney failure, eye problems (retinopathy) and other vascular problems. These complications can be reduced by controlling blood sugars, controlling blood pressure and not smoking. The effectiveness measures presented for diabetes therefore represent measures of good diabetes care or outcomes.

3.5.2 The measures are as follows:

- Diabetes mortality;
- Blood pressure control for people with Type 1 and Type 2 diabetes;
- Diagnosis of end stage renal failure in people with Type 1 and Type 2 diabetes;
- Control of blood sugars for people with Type 1 and Type 2 diabetes;
- Recording of smoking status for people with Type 1 and Type 2 diabetes;
- Percentage of eligible diabetic population successfully screened for retinopathy.

The data presented are from the Scottish Care Information Diabetes Collaboration (SCI DC information system); no additional relevant analyses are available from McKinsey Healthtracker at this time.

3.5.3 Diabetes mortality is similar in Lothian to in Scotland overall (Table 2). Of those for whom data is available, 44% of people with Type 1 diabetes and about a third of people with Type 2 diabetes have their systolic blood pressure controlled within SIGN limits; similar to the position across Scotland. It is important to note that tight control of blood pressure may not be appropriate in all cases; particularly those patients with additional medical problems. The proportions of those with types 1 and 2 diabetes who develop end stage renal failure are also similar to Scotland overall.

Table 2: Overall diabetes mortality, blood pressure control and end stage renal failure for patients with type 1 and type 2 diabetes for Lothian and Scotland (2010)

<table>
<thead>
<tr>
<th></th>
<th>Lothian % (n)</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes mortality</td>
<td>3.4% (n)</td>
<td>3.5%</td>
</tr>
<tr>
<td>Systolic blood pressure controlled within SIGN guideline limits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 1</td>
<td>43.9% (1588)</td>
<td>45.4% (10886)</td>
</tr>
<tr>
<td>Type 2</td>
<td>31.4% (8362)</td>
<td>31.5% (62028)</td>
</tr>
<tr>
<td>Recorded</td>
<td>88% (3618)</td>
<td>86% (23977)</td>
</tr>
<tr>
<td>Not recorded</td>
<td>12% (491)</td>
<td>14% (3933)</td>
</tr>
<tr>
<td>Diagnosis of end stage renal failure</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Type 1</td>
<td>0.9% (36)</td>
<td>1.2% (325)</td>
</tr>
<tr>
<td>Type 2</td>
<td>0.6% (174)</td>
<td>0.4% (912)</td>
</tr>
</tbody>
</table>

Diabetes mortality = People on diabetes register who died in prior year/(people with diabetes alive + those who died in prior year)
Blood pressure control = percentage of patients with Systolic BP $\leq$ 130 mmHg recorded in previous 15 months (within SIGN guideline limits)
Source: Scottish Diabetes Survey 2010, which is taken from the Scottish Care Information Diabetes Collaboration (SCI DC information system) in both primary and secondary care
3.5.4 Approximately one fifth of patients with Type 1 and two thirds of patients with Type 2 diabetes achieve the tightest blood glucose control; this is similar to the Scottish picture (Table 3). It is of concern that both in Lothian and across Scotland as a whole approximately one third of patients with type 1 diabetes have particularly poor blood glucose control (HbA1c >9). One approach currently being taken in NHS Lothian to improve this is to target hospital in-patients, as at any one time approximately 15% of inpatients are recorded as having diabetes. This ‘Think Glucose’ campaign aims to improve the care of inpatients with diabetes, while allowing them to safely use their own insulin. This focuses on regular glucose monitoring and reassessment of needs to ensure that each patient's changing insulin requirements are appropriately responded to. It is hoped that this improved care will shorten inpatient stays to an average closer to that of people without diabetes.

3.5.5 An additional approach includes the DESMOND initiative (Diabetes Education and Self Management for Ongoing and Newly Diagnosed) which is available to patients who are newly diagnosed with Type 2 diabetes. Similarly, DAFNE (Dose Adjustment for Normal Eating) aims to improve patient understanding of glucose control and is available at Lothian’s acute sites for people with Type 1 diabetes.

Table 3: Blood sugar control in previous 15 months for patients with type 1 and type 2 diabetes for Lothian and Scotland (2010)

<table>
<thead>
<tr>
<th>Control of blood sugar</th>
<th>Lothian</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type 1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c &lt; 7.5 (&lt;53 mmol/mol)</td>
<td>23.8%</td>
<td>21.8%</td>
</tr>
<tr>
<td>HbA1c 7.5 - 9.0 (53-75 mmol/mol)</td>
<td>42.5%</td>
<td>39.9%</td>
</tr>
<tr>
<td>HbA1c &gt; 9.0 (&gt;75 mmol/mol)</td>
<td>33.8%</td>
<td>38.3%</td>
</tr>
<tr>
<td>Type 2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HbA1c &lt; 7.5 (&lt;53 mmol/mol)</td>
<td>65.7%</td>
<td>64%</td>
</tr>
<tr>
<td>HbA1c 7.5 - 9.0 (53-75 mmol/mol)</td>
<td>21.8%</td>
<td>22.3%</td>
</tr>
<tr>
<td>HbA1c &gt; 9.0 (&gt;75 mmol/mol)</td>
<td>12.5%</td>
<td>13.7%</td>
</tr>
</tbody>
</table>

HbA1c measures how well diabetes is controlled; the lower the level, the better the control
Source: Scottish Diabetes Survey 2010, which is taken from the Scottish Care Information Diabetes Collaboration (SCI DC information system) in both primary and secondary care

3.5.6 Smoking status is well recorded in diabetic patients and Lothian has a higher proportion of ex-smokers than in Scotland overall (Table 4). Lothian successfully screens 87% of patients eligible for diabetic retinopathy over a 15 month period, slightly higher than in Scotland overall (Table 5).
Table 4: Recording of smoking status for patients with type 1 and type 2 diabetes for Lothian and Scotland (2010)

<table>
<thead>
<tr>
<th>Smoking status recorded</th>
<th>Lothian</th>
<th>Scotland</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker (%)</td>
<td>25.2</td>
<td>24.3</td>
</tr>
<tr>
<td>Ex-smoker (%)</td>
<td>36.6</td>
<td>21.7</td>
</tr>
<tr>
<td>Never smoked (%)</td>
<td>38.2</td>
<td>54</td>
</tr>
<tr>
<td>Recorded (n)</td>
<td>4037</td>
<td>26775</td>
</tr>
<tr>
<td>Not recorded (n)</td>
<td>72</td>
<td>1135</td>
</tr>
<tr>
<td><strong>Type 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current smoker (%)</td>
<td>21.2</td>
<td>18.7</td>
</tr>
<tr>
<td>Ex-smoker (%)</td>
<td>39.7</td>
<td>36.8</td>
</tr>
<tr>
<td>Never smoked (%)</td>
<td>39.1</td>
<td>44.6</td>
</tr>
<tr>
<td>Recorded (n)</td>
<td>28110</td>
<td>207155</td>
</tr>
<tr>
<td>Not recorded (n)</td>
<td>169</td>
<td>1124</td>
</tr>
</tbody>
</table>

Source: Scottish Diabetes Survey 2010, which is taken from the Scottish Care Information Diabetes Collaboration (SCI DC information system) in both primary and secondary care.

Table 5: Number of appropriate diabetic eye screenings within the previous 15 months (type 1 and type 2) for Lothian and Scotland (2010) (includes those screened by the Diabetic Retinopathy Screening Programme, those attending ophthalmology clinics and those clinically suspended)*

<table>
<thead>
<tr>
<th>Retinal screening</th>
<th>Lothian n (%)</th>
<th>Scotland n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type 1</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Retinal screening</td>
<td>3337 (83.7)</td>
<td>21,604 (80.2)</td>
</tr>
<tr>
<td><strong>Type 2</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total screened or suspended</td>
<td>24,688 (83.7)</td>
<td>179,340 (86.1)</td>
</tr>
<tr>
<td>Not Recorded</td>
<td>28,025 (86.9)</td>
<td>200,944 (85.4)</td>
</tr>
<tr>
<td></td>
<td>4241</td>
<td>34254</td>
</tr>
</tbody>
</table>

Source: Scottish Diabetes Survey 2010, which is taken from the Scottish Care Information Diabetes Collaboration (SCI DC information system) in both primary and secondary care.

†Note children under the age of 12 are excluded from screening.

* Patients can be suspended temporarily or on a permanent basis. Reasons for temporary suspension include people who are out of the country or unavailable for a limited period. People may be permanently suspended if they are unable to tolerate screening; permanent suspension also includes patients who have died.

4 Key Risks

4.1 Maintaining HSMR reductions at RIE and WGH. and delivering a reduction at St John’s Hospital. However, HSMRs continue to be less than 1 on all three acute sites, indicating that the number of observed deaths is fewer than the expected number.

4.2 Achieving the national 3-day and 20-day response rate target for complaints.

5 Risk Register

5.1 Maintaining HSMR reductions is captured on the Risk Register under Standard of Clinical Care (1077) and is identified as a medium risk.

5.2 Maintaining the national complaints targets is captured on the Risk Register under Litigation Exposures (1082) and is identified as a high risk.
6  Impact on Health Inequalities

6.1 The work set out by this paper, which incorporates existing data and the development and monitoring of new indicators, will have a positive impact on inequality.

7  Impact on Inequalities

7.1 This paper is a report on progress against the NHS Lothian Quality Improvement Strategy and so does not in itself require an impact assessment. The constituent elements of the Quality Improvement Strategy have been subjected to impact assessment as they have been developed, including the HEAT programmes (assessed in March & April 2010), 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.

8  Involving People

8.1 There is extensive patient and carer involvement through the Diabetes Network at a local and national level.

9  Resource Implications

9.1 There are no resource implications associated with this report.

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List of Appendices

Appendix 1: Technical Appendix
Technical Appendix

Hospital Standardised Mortality Ratio (HSMR)
HSMR is the ratio of observed deaths to expected deaths within 30 days of admission to hospital. If the HSMR for a hospital is less than 1, then fewer hospital deaths within 30 days of admission are occurring than expected. HSMRs are therefore used as system level ‘warnings’ for areas for further investigation. It must be emphasised that the quarter to quarter changes should be interpreted with caution. HSMRs cannot be compared between hospitals or boards; the comparison should only be against the expected number of deaths. There is some controversy about their use, but they remain widely used in this way.

Adverse Events
Adverse events are currently measured at the three main acute sites using retrospective case note reviews using the ‘Global Trigger Tool’. An external review by the Institute for Healthcare Improvement (IHI) in February 2010 confirmed that NHS Lothian’s case note review process was robust and set the baseline for adverse event rates at 52 adverse events per 1,000 patient days.

S.aureus Bacteraemia (SAB) rate
This represents a HEAT target. From April 2011, new targets were set based on Acute Occupied Bed Days (AOBD). For NHS Lothian the target is to achieve a rate of less than 0.26 episodes of SABs per 1,000 AOBD by year ending March 2013.

C.difficile Infection (CDI) rate
This represents a HEAT target. From April 2011, new targets were set based on Total Occupied Bed Days (OBCD). For NHS Lothian the target is to achieve a rate of less than 0.39 episodes of CDI per 1000 AOBD by March 2013.

Incidents associated with harm
Incidents are reported using the DATIX system which records incidents that affect patients or staff. The category and degree of harm associated with each incident are also recorded. An increase in reporting of incidents is considered to be indicative of an improving safety culture and this is monitored in all Senior and Clinical Management Teams. Incidents associated with harm should not increase and this is the trend monitored at NHS Board level.
REPORT FROM THE ORGAN DONATION COMMITTEE 2010/2011

1. Purpose of the Report

1.1 To report to the Board on progress with organ donation and related activity in NHS Lothian for the year 2010-2011 (i.e. 1/4/10– 30/3/11).

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

2. Recommendations

The Board is recommended to:

2.1 Note the report and the reassurance it provides that NHS Lothian is fully engaged with the task of contributing to the government’s goal of improving the UK’s organ donation rate.

3. Discussion of Key Issues

3.1 National context

3.1.1 The UK has long had one of the lowest rates of organ donation. In 2007 the UK rate was 12.9 donors per million population compared with 15.3 in Germany, 20.7 in Finland and 35.5 in Spain. In 2008 a national (UK) Organ Donation Task Force published 14 recommendations for improvement, ranging across issues of day-to-day clinical management to complex definitional, ethical and legal matters as well as professional and public education.

3.1.2 The Task Force set as the target a 50% increase in the donation rate over 5 years, but this now looks unlikely to be met. In Scotland the rate stood at 12.7pmp on 31/3/11, lower than Wales (27.7), N. Ireland (22.3) and England (15.8) even although the proportion of Scotland’s population on the Organ Donor Register is the highest (at 36.5%). The Committee is planning a brainstorming session to try to understand these differences.

3.1.3 Although NHS Lothian is a key contributor to organ donation (and transplantation) in Scotland, in most areas the number of potential donors is both small and highly variable. Therefore, individual Boards have not been set specific targets. Instead, each Board is tasked with maximising its own performance, and this goal is driving the Committee’s work.
3.2 NHS Lothian structures

3.2.1 The Board’s Organ Donation Committee first met in May 2009. In 2010-11 it held 4 meetings, as required. Membership has expanded to include expertise in tissue donation, and also an A&E consultant in view of the rising role of A&E in donor identification. Minutes of meetings go to the Healthcare Governance and Risk Management Committee and, in turn, to the Board.

3.2.2 Responsibility for promotion and coordination of organ donation at clinical level is vested in the Board’s three Clinical (medical) Leads for Organ Donation who cover RIE, WGH & St John’s and RHSC, and in three Senior Nurses for Organ Donation, two based in RIE, one in WGH. NHS Lothian also has a peripatetic Tissue Donor Co-ordinator. Organ donation activity is monitored by the Potential Donor Audit (PDA) and the data passed to NHS Blood and Transplant. In turn, NHS BT issues 6-monthly activity reports that enable Boards to compare their own performance with national statistics (see 3.4).

3.2.3 Ensuring that no opportunity for organ donation is missed anywhere across the organisation is now understood as the crux of the matter by the Committee. Any missed cases now must be reported to the Committee. Two missed cases occurred during 2010-11. In one case it was agreed that referral should have been made, that this indeed was a missed potential donor, but in the other case there would not have been any prospect of viable donation. The clinicians concerned received feedback and it is now standard practice for the weekly M&M (mortality and morbidity) meetings in the intensive care units to review each case for donation potential and discuss any non-referrals.

3.2.4 Although the Committee has focused during 2010-11 on donor identification and clinical management of donation, it also has continued to address the wider surrounding agenda (e.g. see 3.3). NHS Lothian is making a strong contribution to the wider organ donation agenda. Some Committee members (and other NHSL staff) have led or contributed to national initiatives in leadership, education, policy and legislation for organ donation and the Chair has been active in the National Chairs’ Group in Scotland that meets quarterly.

3.3 Awareness-raising

3.3.1 Awareness-raising about organ donation and encouraging sign-up to the NHS Organ Donor Register (ODR) is important because family consent to donation is much more likely when they know (or are told) that the person had registered their wish to become an organ donor.

3.3.2 The Committee worked with Communications on the ‘Sign up to save a life’ campaign that was launched on 31/10/10 and has won several awards. The toolkit included a website (an offshoot of NHS Lothian’s home page) with a direct link to the NHS Organ Donor Register, a film that profiled local donor and recipient families, other downloadable resources and a mobile phone app (the first produced by a Health Board in Scotland). Access to the toolkit has been offered to large organisations across Lothian, including banks and insurance companies, the universities and supermarket chains. There has been a high level of interest.
3.3.3 The subsequent increase in ‘sign-ups’ to the ODR cannot be attributed only to this campaign because national TV ads were running in Scotland during autumn 2010, but there was a large rise in new registrants from Lothian towards the end of the year. In the whole of 2010 there were 26,083 new Lothian registrations. At the end of 2010, 36.5% of Scotland’s population was on the OD Register, but in Lothian, it reached 44.1% (n= 349,432). This was the 2nd highest in Scotland, after NHS Highland at 47.4%. All other Boards were below 40% (incl. Greater Glasgow and Clyde at 34.1%). The Committee set a target a year ago to reach 50% in Lothian by August 2011. Data are not yet available for the latter part of this year.

3.3.4 Future campaigns will continue to focus on the groups that are least well represented on the ODR (incl. males and ethnic minority groups) and everyday publicity of organ donation will continue in ‘Connections’ and by making NHS BT-provided leaflets available in patient and visitor areas in all hospitals, this already having been done for all GP practices across NHS Lothian. New patients registering with a GP are now routinely invited (on the form) to join the Organ Donor Register. The new requirement by DVLA for driving licence applicants to agree (or not) to join the ODR is widely expected to have a significant impact.

3.3.5 The Committee also has considered how awareness-raising should be done in NHS Lothian itself, as a large employer. A survey in 2010 by West Midlands SHA (the lead strategic health authority in England for organ donation) found 71% of their staff (n=838) were prepared to be an organ donor, but only one-third had joined the Register. It is reasonable to surmise that these findings are broadly generalisable. The Committee invited the Employee Director to participate in a recent discussion and, with the benefit of his helpful ideas and advice, an action plan is now being drawn up. A designated day of high-profile publicity will start off the staff campaign.

3.4 Transplant and Donation activity

3.4.1 Although the number of donors pmp is not rising in line with the target, the average number of organs per donor is increasing. However, although 202 organs were transplanted in Scotland in 2009-10, there will still as many as 654 people on the transplant waiting list in November 2010 and at least 18 had died while waiting in the preceding 6 months. NHS Lothian is one of Scotland’s two transplant centres. From 1/4/10-31/3/11, in addition to 29 patients transplanted from 29 living donors, 83 patients received transplants. 68 of these received organs from 20 donors after brain death (DBD) and the other 15 from 9 donors after circulatory death (DCD). The numbers of organs transplanted by type were kidney (38 DBD, 14 DCD), pancreas (7), liver (20 DBC, 1 DCD), heart (4 DBD) and lung (10 DBD).

3.4.2 The twice-yearly NHS BT activity reports on donation are based on a verified version of the data provided to them from Boards using the Potential Donor Audit (PDA). Figures are returned confidentially to each Health Board, also broken down by hospital, and with UK data for comparison. The data sets are complex, and with recognised limitations, but the Committee now understands how to interpret these reports. Appendix 1 shows key statistics extracted for this report from the NHSBT report for 2010-2011, received in July.
3.4.3 NHS Lothian is performing above the UK average on all of the key parameters of donation after brain death (DBD). The conversion rate (i.e. conversion of a potential donation into an actual one) is impressive at 67% compared with the national average of 54%. While the scope for improvements is small in numerical terms, there still is scope to improve. The Committee has agreed that neurological death testing consistently should reach 100% and feedback should be given to clinicians in all cases when this is not done. The rate of referral to a SN-OD can (and should) rise. The authorisation rate (i.e. family consent), although already high at 70%, arguably can be increased and, for that reason, all staff who act as ‘requesters’ are to be offered special communication training. The Committee also has supported the plan that donor (and non-consenting) families be followed up by the SN-ODs, after a suitable interval, to find out about their experience and what might be improved.

3.4.4 Where NHS Lothian falls short of UK average figures is in donation after circulatory death (DCD). This is in spite of having expertise in DCD, and having shared that with other Boards. The problem lies in the inherent difficulty of identifying ‘imminent death’. The current criteria are recognised as problematical and are under national review. Meantime the Committee has supported the more conservative approach of the CLODs in NHS Lothian so that patients are not referred as potential DCD organ donors, and families are not approached, when it is obvious that donation and transplantation will not be viable. Although our DCD referral rate is low (15% c.f. 44% for the UK), our conversion rate is almost twice the national average (23% c.f. 12%), this suggesting that the conservative approach is well judged. Also, not reflected in the NHS BT data is the increasing activity in NHS Lothian in tissue donation after DCD. During the period 1/4/10 to 31/3/11 there were 12 multi-tissue donors (including heart valves, tendons and skin) in the A&E departments at St John’s Hospital and Edinburgh Royal Infirmary.

4. Key risks

4.1 There are no key risks attached to the recommendation in para 2.1.

5. Risk Register

5.1 Failure of NHS Lothian to fully engage in organ donation would impact on patient experience and care.

6. Impact on Health Inequalities

6.1 Advice has been given that a formal impact assessment of this report is not required.

7. Involving People

7.1 The Committee benefits by having a donor family member. It intends also to appoint a transplant recipient. NHS BT recommends that both perspectives are represented.
8. Resource Implications

8.1 There are no resource implications of the recommendation in para 2.1. In the longer term, more organ donors (and organs) carry cost implications for donating and transplant units and teams. At the same time, transplantation has recognised cost benefit as the treatment of choice for those patients from whom there is no other option.

Professor Alison Tierney
Non-Executive Board Member, Chair of the Organ Donation Committee
30 August 2011

Contact email: Emily O'Connor, Committee Administrator:
emily.o'connor@nhslothian.scot.nhs.uk
APPENDIX 1

Key statistics extracted from the activity report on organ donation provided to NHS Lothian by NHS BT in July 2011 for the year 2010-2011. The full report (12 pages) can be obtained on request.

1 April 2010 –30 March 2011

<table>
<thead>
<tr>
<th></th>
<th>DBD</th>
<th>DCD</th>
</tr>
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<tbody>
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<table>
<thead>
<tr>
<th></th>
<th>NHSL</th>
<th>UK</th>
<th>NHSL</th>
<th>UK</th>
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<tbody>
<tr>
<td>ND tested rate</td>
<td>97</td>
<td>72</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Referral rate</td>
<td>74</td>
<td>85</td>
<td>15</td>
<td>44</td>
</tr>
<tr>
<td>Approach rate</td>
<td>100</td>
<td>93</td>
<td>55</td>
<td>47</td>
</tr>
<tr>
<td>Adjusted authorisation rate</td>
<td>70</td>
<td>65</td>
<td>53</td>
<td>51</td>
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<td>Observed authorisation rate</td>
<td>67</td>
<td>-</td>
<td>50</td>
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<tr>
<td>Conversion rate</td>
<td>67</td>
<td>54</td>
<td>23</td>
<td>12</td>
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</tbody>
</table>

Abbreviations:-
DBD = Donors after Brain Death, DCD = Donors after Cardiac Death
ND = Neurological Death

Definitions:-
Referral rate = % referred to/discussed with a SN-OD (Senior Nurse for Organ Donation)
Approach rate = % of families of potential donor approached for authorisation (i.e. consent)
Authorisation rate = % families approached who consented (adjusted = for ethnicity)
Conversion rate = % of potential donors who became actual donors

Comments/explanatory notes:
1. NHS Lothian’s ND (neurological death) testing rate is well above the UK average. Last year the Committee set a 100% target for this. This is achievable.
2. Referral of potential donors to SN-ODs (Senior Nurses for Organ Donation) is regarded as good practice and, even although we have expert CLODs (Clinical Leads for Organ Donation) in NHS Lothian, the Committee has asked to see an improvement in the referral rate, particularly for DBD.
3. DCD statistics are more complex, as explained in the report, on account of the difficulty of defining ‘imminent death anticipated’. This under review. Meantime, the Committee supports the cautious stance of our CLODs in order to avoid an approach to families when there is expert clinical judgement that actual donation is very unlikely to be feasible.
NHS LOTHIAN

Board Meeting
28 September 2011

Medical Director/Acting Director of Strategic Planning

CLINICAL STRATEGY

1 Purpose of the Report

This paper provides the Board with an update on the development of a clinical strategy for NHS Lothian.

Any member wishing additional information should approach the Acting Director of Strategic Planning.

2 Recommendations

The Board is recommended to:

2.1 Receive this update and support the next steps outlined;
2.2 Agree to a change in the strategy’s title; and
2.3 Note the groups engaged to date and those scheduled for engagement.

3 Discussion of Key Issues

3.1 Work is underway to develop a high level framework for the redesign of clinical services within NHS Lothian over the next ten years.

Since June, the Medical Director, the Acting Director of Strategic Planning and the Associate Director of Strategic Planning have been involved in a series of engagement meetings with the public, staff and external agencies. The schedule of groups/fora engaged so far, together with those still to be engaged, is set out in appendix 1. It should be noted that this is not exhaustive and will be added to constantly.

In these discussions support has been forthcoming on the need for a strategy. Initial engagement has been to discuss and to seek agreement on the themes to be used to guide both delivery and development of services.

Seven key themes have been identified to underpin this approach. These are:
- Needs-based services
• Effective, seamless and safe care
• Efficient services, outcomes focused
• Innovative learning organisation
• Partnership working
• Health improving
• Addressing health inequalities

3.2 Feedback from Engagement Process to Date

On 17 August a public and patient engagement event was held, introduced by Miss Tracey Gilles, Associate Divisional Medical Director for Surgical Services. It involved 34 participants from across a range of interest groups. Since this event, staff engagement sessions have occurred with more arranged. By the end of October, meetings will then have taken place within each partnership area and across professional disciplines. Comments from all of these discussions, as well as those still due to occur, are being used to inform the progression of the strategy.

The clinical strategy featured at the meeting on 9 September between the Executive Management Team and the Lothian’s MSPs, where the approach was received positively. It was also discussed in detail at a meeting on 16 September with Harvard Business School’s Professor Richard Bohmer.

Overall, the feedback received has stressed the aspects outlined below.

Firstly, the seven key themes outlined above were supported, although it was felt that there may be some potential for drawing the themes together, perhaps within one clear statement.

Secondly, while the need to engage people early in the process was understood, there was a desire to have more tangible issues, such as those set out at 3.3 in this paper, to grapple with rather than concepts. It was suggested that discussion should move on to proactively state what the future model of care looked like and to avoid responding solely to the key drivers.

Responding to this feedback, additional emphasis is now being placed on how NHS Lothian can assure delivery of safe, effective care and what systems are to be in place to secure this future. Much of this will be underpinned by the Board’s Quality Strategy.

Thirdly, the strategy’s working title, “How we treat people” was not felt to place sufficient importance on the mutuality between the patient and the professional expected in healthcare. As such, an alternative has been proposed - “Our Health, Our Future”. The Board is asked to support this title.

Finally the need for a consistent, open and transparent approach was identified by both staff and public groups, a view also aired at the Service Redesign Committee meeting on 12 September.

To address this it is intended that relevant information to the strategy, such as the output from the event on 17 August, will be posted on the NHS Lothian website.
and communicated widely using established channels such as team brief, connections and healthlink.

3.3 Next Steps

As indicated above, discussions over the strategy and the seven themes will continue over the coming weeks; these will be reported to the Board at its next meeting on 23 November.

Between the September and the November Board meetings, further engagement will be undertaken with staff, as outlined in appendix 1, as well as patient representatives. In addition it is proposed that the Service Redesign Committee focus significantly on this matter at its next meeting on 17 October.

This will then feed into the Board development day on 26 October.

It is important to re-emphasise that this work will be an overarching strategic approach. It is not intended to replace any work already agreed by the Board and will complement other strategic work now underway. These will come to the Board in due course and will include the development of a children and young people’s strategic plan and continuing work on redesigning the care of older people.

One of the key changes facing NHS Lothian and which will require further work is that of medical training. Work being progressed nationally, regionally and at a local level will inform the dimensions of the November Board paper.

In addition to this work, there is also the need to develop key strategic plans for a number of service areas, such as cancer, affected by other key drivers such as demography.

The Board is asked to support these initial next steps.

4 Key Risks

The Scottish Government has set appropriate standards of involvement and engagement on redesign. The clinical strategy must comply with these standards. If these processes are deferred, there is the danger of challenge through lack of necessary compliance. If the timetable to achieve redesign is not observed, there may be potential that new models are not in place to be assured of person centred, safe and effective care.

5 Risk Register

There are no additional implications for the risk register from the contents on this paper.
6 Impact on Inequalities and Health Inequalities

An Equality and Diversity Impact Assessment has already been undertaken for the initial outline of the approach being taken to develop the clinical strategy. Further work will be undertaken as appropriate and as this work progresses.

7 Impact on Inequalities

Although a focus on inequalities features within the strategy document, detailed assessment of impact will, as above, be relevant from October onwards as new models of care are developed.

8 Involving People

The process described above is in line with Scottish Government guidance. The Scottish Health Council has been involved to ensure that it has been appropriately designed.

As indicated above, the principle public involvement event for the current stage of the process occurred on 17 August and a future event, specifically engaging Faith groups is planned for early November.

9 Resource Implications

The costs relating to consultation on the strategy are to be met from within the Strategic Planning budget. Work is also underway to agree the staffing required to support this process; it will be led by Strategic Planning but will require input as well as actual support from other teams across different Directorates. In addition strong governance is required and it is envisaged that the Service Redesign Committee and the Finance & Performance Review Committee will provide this function.

Andrew Jackson
Associate Director, Strategic Planning
20 September 2011
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NHS Lothian Clinical Strategy Engagement Events

Meeting Attended / In Diary

- Strategic Planning Team
- Public Health and Health Policy Directorate
- UHD SMT
- Clinical Strategy Event - public / patient
- Area Clinical Forum
- Health & Safety Committee
- East Lothian CHP Sub Committee
- Allied Health Profession meeting
- Staff Governance Committee
- Clinical Board
- Informatics Board
- Service Re-Design Committee
- Lothian Area Division of Psychiatry
- Directorate Governance Group
- Pharmacy Senior Management Team
- Midlothian CHP Sub Committee
- Faith Group
- Primary Care Forward Group
- Lothian Area Pharmaceutical
- Lothian Partnership Forum
- Lothian Area Medical Committee
- Nurse Directors Meeting
- West Lothian CH(C)P sub-committee
- Edinburgh CHP
1 Purpose of the Report

1.1 The purpose of this report is to provide the Board with an overview of the financial position of NHS Lothian for the first four months of the financial year 2011/12.

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

2 Recommendations

The Board is recommended to:

2.1 Note the overspend of £3.058m as at the end of July 2011 with the key components being a £1.821m shortfall against the NHS Lothian Local Reinvestment Plan (LRP) target (also referred to as efficiency target) and a £1.052m overspend on prescribing;

2.2 Note that all responsible Directors have confirmed to the Director of Finance the timelines for delivery of their full efficiency target (through the quarter 1 review exercise) and where there is delay in implementation, the non-recurring schemes being used to offset the shortfall.

3 Discussion of Key Issues

Overall Position

3.1 NHS Lothian is reporting an over spend of £3.058m for the first four months of financial year 2011/12. This reflects under delivery of £1.821m against the Local Reinvestment Plan (LRP) target (also referred to as efficiency target) and £1.237m of overspends on other budgets, represented in the main by prescribing pressures. Non recurring NRAC support of £1.6m has been included in the month 4 position to recognise demographic related pressures agreed in principle. In addition, £1m of additional funding to offset prescribing price increases has been reflected in the position for the period. This has been provided from flexibility with the strategic reserves, identified as part of the analysis for the Quarter 1 review.
3.2 The month 4 results are summarised in Table 1 below:

### Table 1 – Financial Position to 31 July 2011

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Outstanding Efficiency Savings</th>
<th>Net of Efficiency Savings</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>£k</td>
<td>£k</td>
<td>£k</td>
</tr>
<tr>
<td>University Hospitals Division</td>
<td>(1,918)</td>
<td>(898)</td>
<td>(1,020)</td>
</tr>
<tr>
<td>CH(C)Ps</td>
<td>(2,730)</td>
<td>(402)</td>
<td>(2,328)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>(631)</td>
<td>0</td>
<td>(631)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>(410)</td>
<td>(521)</td>
<td>111</td>
</tr>
<tr>
<td>NRAC/prescribing support</td>
<td>2,631</td>
<td>0</td>
<td>2,631</td>
</tr>
<tr>
<td>Under/(Over)spend</td>
<td>(3,058)</td>
<td>(1,821)</td>
<td>(1,237)</td>
</tr>
</tbody>
</table>

3.3 Divisional commentary is set out below and detailed figures are included in Appendix 1.

### Income and Allocations

3.4 During July, a number of further allocation adjustments were confirmed by the Scottish Government Health Directorates (SGHD; these were in line with anticipated levels.

3.5 As a result of the implementation of a new financial system, work has not yet concluded on the development of a systematic report for all other income. This will continue to develop over the coming months.

### University Hospitals Division

3.6 The University Hospitals Division is reporting an overspend of £1.918m for the period to date; this comprises an underspend of £0.016m against budgets; slippage of £0.898m against the agreed LRP target; and a shortfall of £1.036m against local Divisional savings.

3.7 There is concern within the Division over the unexpected Nursing budget overspend in a number of clinical management areas, particularly given the detailed pan Lothian Nursing Review and subsequent budget setting exercise undertaken in late 2010/11. A key area of concern is within Critical Care, as a result of high levels of patient dependency and occupancy seen during the first quarter. The Medical Division has taken action to address the nursing overspends which currently stand at £0.6m for 4 months. However the Critical Care overspends are only partially offset by additional income and the Division are examining the position to identify what management action is required.

3.8 The overspends on staffing are offset by the medical staffing underspend totalling £1.06m which is broadly equivalent to the additional funding generated by the local LRP initiative.
3.9 The division has reported an improved clinical supplies position, principally within drugs expenditure. However there are fluctuations in equipment costs which have prompted an internal review.

3.10 The Division has improved its year to date position on LRP by £0.078m in the month and further plans to reduce the year to date gap have been identified.

3.11 Accordingly, subject to the LRP and Waiting Times target risks, the Division anticipates being able to deliver breakeven against the baseline budget by the year end.

**Primary and Community**

3.12 The CHPs / CHCP / Primary Care services are reporting a net overspend of £2.730m for the period. This over spend comprises three broad issues: prescribing (£2.053m); slippage on non-prescribing LRP (£0.149m) and hospital & community (HCH) services (£0.528m). Recovery plans have been prepared by the CHPs.

3.13 The Prescribing budget is £2.053m over spent (approximately 5%), of which £0.253m relates to slippage on the savings target. This is a significantly worse position than that seen during the first quarter. More up to date data, including declared volumes for June, has been used to review the year to date position, and to project an out turn forecast for the financial year. This suggest that without further action, the overspend on the prescribing budget could reach £6.1m of an overspend by the year end.

3.14 The key drivers behind this position are:-

- A considerable change in the forecast prices. The prescribing budget was set on the basis that prices would fall in year. Although they have fallen, they have not fallen to the extent anticipated, thus generating a considerable financial pressure. This pressure is in the region of £1m for the year to date, and has been offset with funding from the strategic reserves, as highlighted through the Quarter 1 review.

- There has also been an increase in volumes above the levels anticipated in budget setting. The budget was set on the basis of an increase of c. 3.4%, whereas the information currently available shows an increase of 5.6%.

3.15 Following a detailed review by the CHCPs/CHPs on the prescribing position a number of actions have been agreed to reduce the current spend levels. In parallel discussions are taking place with GP colleagues to consider piloting an ‘enhanced’ service to manage the prescribing budget. This will be considered by the Primary Care Forward Group.

3.16 Operational overspends across the CHPs relate largely to core services including: family planning; management costs, joint equipment store, continence services, and continuing care services within the Edinburgh CHP; substance misuse within the Midlothian CHP; LUCS medical staffing within the East Lothian CHP; and mental health medical locums and nurse bank within the West Lothian CHCP. Recovery plans have been developed by the Edinburgh and East & Midlothian CHPs to bring the position back to breakeven. West Lothian CH(C)P is currently projecting a break-even position.
3.17 Slippage on the LRP target is largely attributable to the Edinburgh CHP, Midlothian CHP and Prescribing. Within all CHPs there is still an element of the LRP target.

A range of management actions has been agreed across CHPs to identify further LRP savings and address the upward trend on volumes.

**Corporate Budgets**

3.18 Corporate Budgets are £0.410m overspent after four months, linked to slippage on the delivery of LRP across the Division (£0.521m), and budget overspends in eHealth (£0.34m) and within the Estates element of Facilities Management (£0.21m).

3.19 The under spends in HR (£0.15m), Planning (£0.12m), Pharmacy (£0.23m) and Nursing (£0.9m) are offsetting the over spends on other budgets, and are driven largely through vacancies.

**Strategic Budgets**

3.20 Strategic Budgets are reporting a £0.631m overspend for the quarter, which is largely related to UNPAC costs (£0.641m). Closer scrutiny of the activity relating to high cost Psychiatric/ Learning Disability referrals is already underway and positive discussions with the Acting Director of Strategic Planning and Director of Public Health to determine management actions which may rectify the position. This will, in part, require some capital investment to ‘support’ local facilities and thus the timeline for delivery of this potential solution will be extended.

**Efficiency & Productivity**

3.21 Whilst there remains a gap in the level of savings identified to date, £48.2m of plans have been identified against the £50.1m savings target required, with work ongoing in a number of areas to determine the agreed phasing for delivery through the year. The graph below shows progress to date, with further details shown in Table 2.
3.22 As highlighted, £10.4m of savings have been achieved during the first four months of the year. It is important to note that the full year effect of the schemes generating these savings is in the region of £23m, and this is underpinned by 285 wte staff reductions.

Table 2 – Efficiency & Productivity Programme 2011/12

<table>
<thead>
<tr>
<th>Division</th>
<th>Current Year Target £000</th>
<th>Actual Plans Identified £000</th>
<th>April - July Target £000</th>
<th>April – July Actual £000</th>
<th>Slippage £000</th>
</tr>
</thead>
<tbody>
<tr>
<td>UHD</td>
<td>26,840</td>
<td>25,618</td>
<td>7,042</td>
<td>6,144</td>
<td>(898)</td>
</tr>
<tr>
<td>CH(C)Ps/PCCO</td>
<td>14,514</td>
<td>14,262</td>
<td>2,531</td>
<td>2,129</td>
<td>(402)</td>
</tr>
<tr>
<td>Corporate Budgets</td>
<td>7,005</td>
<td>6,507</td>
<td>2,045</td>
<td>1,524</td>
<td>(521)</td>
</tr>
<tr>
<td>Strategic Budgets</td>
<td>1,771</td>
<td>1,778</td>
<td>590</td>
<td>590</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>50,130</td>
<td>48,165</td>
<td>12,208</td>
<td>10,387</td>
<td>(1,821)</td>
</tr>
</tbody>
</table>

3.23 Continued management focus on delivery of the efficiency target is critical to the achievement of financial balance this year. Ongoing discussion, detailed reporting and agreement of further management actions are being led by the monthly Efficiency & Productivity Group.

Capital

3.24 Expenditure of £16.2m has been incurred to the end of July against the programme for the year, reflecting progress with the re-provision programme. Major areas of core spending include: the Royal Victoria Building; Musselburgh Primary Care Centre; Chalmers Sexual Health Centre; Dalkeith Medical Centre; the birthing suite at the Royal Infirmary of Edinburgh, and development expenditure on the new Royal Hospital for Sick Children at Little France. Further details are set out in Appendix 2.

Activity

3.25 Appendix 3 contains high level activity figures for the four months to 31 July 2011, with the same months’ activity during the two previous years shown for comparative purposes. Average activity in the 12 month period August 2010 to July 2011 is also reported. As previously reported, capacity in other providers’ facilities, e.g. Spire and Golden Jubilee, has been excluded from the figures in an effort to ensure consistency over the years.

3.26 April 2011 was characterised by a high number of public holidays with Easter falling well into the month, unlike the previous years, and with the additional public holiday for the Royal Wedding. This partially explains the main variances reported below.
3.27 In summary, the activity position for the April to July 2011, compared to the same period in 2010, is as follows:

- Decrease in elective admissions of some 967 admissions (equating to 9%)
- Increase in emergency admissions of over 1517 admissions (6.2%)
- Overall for inpatient admissions an increase of 550 (1.6%)
- Day cases down by 331 cases (1.7%)
- Decrease in new outpatients of just under 2,928 (3.8%)
- Increase in births of 3% reflected entirely through the RIE site.
- Increase in diagnostic procedures of 13% (reflecting previous months’ efforts were made to achieve the 6 week maximum wait by the end of May)

3.28 As previously reported, it is planned to supplement the high level activity figures with an analysis of casemix based on HRGs (Healthcare Resource Groups, groupings of activity which consume similar levels of resource – which are based on a combination of procedure, age and co-morbidities). Two meetings have now been held with the Health Intelligence Unit (HIU) to discuss how this should be taken forward and a methodology has now been agreed. This work will now be progressed, concentrating initially on a site-based analysis, starting with RIE site.

4 Key Risks

4.1 The outcome of the Quarter 1 Review, presented to EMT on 16 August, confirmed that we can deliver financial balance by 31 March 2012, but this requires concentrated management action. Furthermore, there remain a number of inherent uncertainties and associated risks

4.2 Notwithstanding the various actions being put in place to address the difficult financial position, and the view that financial balance remains achievable, the risks which remain largely unquantified and may further impact as we move through the year include:

- R&D funding – confirmation of allocation is awaited and any reduction in funding will have a direct impact, given the extent to which costs are already embedded within the system.
- SLA income – the ongoing, discussions with other NHS Boards may create further financial pressures. Unless this matter can be resolved in the next few weeks, there may be no other option than to seek intervention from the Scottish Government Health Directorates Director of Finance.
- Dabigatran – following approval of the use of this drug by SMC, there are major cost implications across NHS Lothian, and indeed Scotland. An assessment of how this can be managed and the potential offsets is being undertaken by the ADTC.
- Southern Cross – the ongoing impact of the closure of these nursing homes has not been quantified in financial terms, but it is recognised that there may be a need to ensure there is appropriate facilities available for all individuals affected.
5 Risk Register

5.1 Whilst there are inherent risks in the delivery of a balanced financial position, there is nothing further which needs to be added to the Board’s Risk Register at this time.

6 Impact on Health Inequalities

6.1 This document is to advise the Board of work undertaken and performance against financial targets. An equality impact assessment is not required.

7 Impact on Inequalities

7.1 Refer to 6.1 above.

8 Involving People

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

9 Resource Implications

9.1 The resource implications are described in above.

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21 September 2011
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List of Appendices

Appendix 1: NHS Lothian Financial Position by Service Area April - July 2011
Appendix 2: NHS Lothian Allocations July 2011
Appendix 3: NHS Lothian Activity Summary July 2011
### NHS Lothian Expenditure Summary July 2011

#### APPENDIX 1

<table>
<thead>
<tr>
<th><strong>UNIVERSITY HOSPITAL DIVISION</strong></th>
<th><strong>Annual Budget 2010-11</strong></th>
<th><strong>YTD Budget</strong></th>
<th><strong>YTD Actual</strong></th>
<th><strong>Variance</strong></th>
<th><strong>Prior Year Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Medical</strong></td>
<td>112,088</td>
<td>37,421</td>
<td>38,074</td>
<td>(653)</td>
<td>(894)</td>
</tr>
<tr>
<td><strong>REAS &amp; MOE</strong></td>
<td>65,300</td>
<td>21,532</td>
<td>21,762</td>
<td>(230)</td>
<td>(200)</td>
</tr>
<tr>
<td><strong>Surgical</strong></td>
<td>74,945</td>
<td>24,978</td>
<td>25,039</td>
<td>(61)</td>
<td>(577)</td>
</tr>
<tr>
<td><strong>Labs, A&amp;T, Critical Care, HDSU</strong></td>
<td>113,246</td>
<td>38,100</td>
<td>38,437</td>
<td>(336)</td>
<td>(1,298)</td>
</tr>
<tr>
<td><strong>Women &amp; Children &amp; Neuroscience</strong></td>
<td>89,404</td>
<td>29,249</td>
<td>29,305</td>
<td>(56)</td>
<td>(309)</td>
</tr>
<tr>
<td><strong>Radiology, Cancer &amp; Head &amp; Neck</strong></td>
<td>93,695</td>
<td>31,277</td>
<td>32,174</td>
<td>(897)</td>
<td>(559)</td>
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<tr>
<td><strong>Corporate</strong></td>
<td>21,878</td>
<td>1,888</td>
<td>1,574</td>
<td>(314)</td>
<td>(1,272)</td>
</tr>
</tbody>
</table>

**Total:** 570,555 184,444 186,363 (1,918) (2,565)

<table>
<thead>
<tr>
<th><strong>CHCP/CHPs/PCCO</strong></th>
<th><strong>Annual Budget 2010-11</strong></th>
<th><strong>YTD Budget</strong></th>
<th><strong>YTD Actual</strong></th>
<th><strong>Variance</strong></th>
<th><strong>Prior Year Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>East Lothian CHP</strong></td>
<td>59,514</td>
<td>20,946</td>
<td>21,356</td>
<td>(409)</td>
<td>(290)</td>
</tr>
<tr>
<td><strong>Edinburgh CHP</strong></td>
<td>232,482</td>
<td>83,140</td>
<td>84,685</td>
<td>(1,545)</td>
<td>(1,093)</td>
</tr>
<tr>
<td><strong>Midlothian CHP</strong></td>
<td>64,520</td>
<td>22,404</td>
<td>22,834</td>
<td>(430)</td>
<td>(227)</td>
</tr>
<tr>
<td><strong>West Lothian CHP</strong></td>
<td>93,102</td>
<td>31,060</td>
<td>31,393</td>
<td>(333)</td>
<td>(147)</td>
</tr>
<tr>
<td><strong>PCCO</strong></td>
<td>25,204</td>
<td>(2,877)</td>
<td>(2,864)</td>
<td>(12)</td>
<td>(27)</td>
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**Total:** 474,822 154,673 157,403 (2,730) (1,749)

<table>
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<tr>
<th><strong>STRATEGIC BUDGETS</strong></th>
<th><strong>Annual Budget 2010-11</strong></th>
<th><strong>YTD Budget</strong></th>
<th><strong>YTD Actual</strong></th>
<th><strong>Variance</strong></th>
<th><strong>Prior Year Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>SLAs/UNPACs/Non Contract Activity</strong></td>
<td>9,848</td>
<td>3,417</td>
<td>4,099</td>
<td>(683)</td>
<td>(264)</td>
</tr>
<tr>
<td><strong>Capital charges and Asset Impairments</strong></td>
<td>36,759</td>
<td>12,424</td>
<td>12,512</td>
<td>(88)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Provisions for Pension Costs and Claims</strong></td>
<td>10,368</td>
<td>1,383</td>
<td>1,290</td>
<td>94</td>
<td>185</td>
</tr>
<tr>
<td><strong>Commissioning from 3rd Sector</strong></td>
<td>12,923</td>
<td>5,567</td>
<td>5,516</td>
<td>51</td>
<td>(27)</td>
</tr>
<tr>
<td><strong>Reserves and Uncommitted Allocations</strong></td>
<td>35,487</td>
<td>(857)</td>
<td>(851)</td>
<td>(6)</td>
<td>(68)</td>
</tr>
</tbody>
</table>

**Total:** 105,385 21,934 22,565 (631) (174)

<table>
<thead>
<tr>
<th><strong>CORPORATE BUDGETS</strong></th>
<th><strong>Annual Budget 2010-11</strong></th>
<th><strong>YTD Budget</strong></th>
<th><strong>YTD Actual</strong></th>
<th><strong>Variance</strong></th>
<th><strong>Prior Year Variance</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Chief Executive’s Department</strong></td>
<td>525</td>
<td>177</td>
<td>170</td>
<td>7</td>
<td>0</td>
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<tr>
<td><strong>Medical Director</strong></td>
<td>941</td>
<td>143</td>
<td>111</td>
<td>32</td>
<td>17</td>
</tr>
<tr>
<td><strong>Consort</strong></td>
<td>42,945</td>
<td>13,888</td>
<td>13,951</td>
<td>(63)</td>
<td>39</td>
</tr>
<tr>
<td><strong>Communications</strong></td>
<td>572</td>
<td>190</td>
<td>197</td>
<td>(6)</td>
<td>4</td>
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<tr>
<td><strong>E health</strong></td>
<td>19,664</td>
<td>7,338</td>
<td>7,714</td>
<td>(375)</td>
<td>(127)</td>
</tr>
<tr>
<td><strong>Facilities Management</strong></td>
<td>75,013</td>
<td>23,940</td>
<td>24,276</td>
<td>(336)</td>
<td>(618)</td>
</tr>
<tr>
<td><strong>Finance and capital planning</strong></td>
<td>11,810</td>
<td>3,901</td>
<td>3,970</td>
<td>(69)</td>
<td>(23)</td>
</tr>
<tr>
<td><strong>Human Resources &amp; OH&amp;S</strong></td>
<td>10,576</td>
<td>3,047</td>
<td>3,055</td>
<td>(8)</td>
<td>(123)</td>
</tr>
<tr>
<td><strong>Nursing</strong></td>
<td>3,599</td>
<td>195</td>
<td>119</td>
<td>76</td>
<td>19</td>
</tr>
<tr>
<td><strong>Pharmacy</strong></td>
<td>12,025</td>
<td>3,819</td>
<td>3,644</td>
<td>175</td>
<td>101</td>
</tr>
<tr>
<td><strong>Planning</strong></td>
<td>3,358</td>
<td>1,054</td>
<td>939</td>
<td>115</td>
<td>47</td>
</tr>
<tr>
<td><strong>Public Health</strong></td>
<td>3,532</td>
<td>1,123</td>
<td>1,085</td>
<td>37</td>
<td>36</td>
</tr>
<tr>
<td><strong>Other</strong></td>
<td>459</td>
<td>(433)</td>
<td>(439)</td>
<td>6</td>
<td>(30)</td>
</tr>
</tbody>
</table>

**Total:** 185,017 58,382 58,792 (410) (657)

| **NRAC** | 7,932 | 1,631 | 0 | 1,631 | 0 |
| **Offset to Prescribing price changes** | 1,000 | 1,000 | 0 | 1,000 | 0 |

**Total:** 1,344,711 422,064 425,122 (3,058) (5,144)
## NHS Lothian Capital Expenditure Position April – July 2011

### APPENDIX 2

<table>
<thead>
<tr>
<th>PROJECT SPECIFIC FUNDING</th>
<th>Agreed Programme £m</th>
<th>Expenditure to date £m</th>
</tr>
</thead>
<tbody>
<tr>
<td>Royal Victoria Hospital</td>
<td>25.336</td>
<td>7.463</td>
</tr>
<tr>
<td>Royal Hospital for Sick Children</td>
<td>1.910</td>
<td>2.159</td>
</tr>
<tr>
<td>Musselburgh Primary Care Centre</td>
<td>12.245</td>
<td>3.519</td>
</tr>
<tr>
<td>Chalmers Hospital</td>
<td>0.498</td>
<td>0.399</td>
</tr>
<tr>
<td>Dalkeith Medical Centre</td>
<td>2.186</td>
<td>1.331</td>
</tr>
<tr>
<td>GDP dental premises</td>
<td>0.500</td>
<td>0.000</td>
</tr>
<tr>
<td>Radiotherapy - Phase 6</td>
<td>0.052</td>
<td>0.000</td>
</tr>
<tr>
<td>Radiotherapy - Phase 7</td>
<td>1.649</td>
<td>0.367</td>
</tr>
<tr>
<td>Wester Hailes (NHS Component Only)</td>
<td>2.304</td>
<td>0.000</td>
</tr>
<tr>
<td>West End Medical Practice</td>
<td>0.060</td>
<td>0.000</td>
</tr>
<tr>
<td>Gullane Medical Practice</td>
<td>0.387</td>
<td>0.000</td>
</tr>
<tr>
<td>RIE Lifecycle Costs</td>
<td>4.605</td>
<td>0.000</td>
</tr>
<tr>
<td>Other Unapproved</td>
<td>4.250</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>SCHEMES OVER DELEGATED LIMIT</strong></td>
<td><strong>55.982</strong></td>
<td><strong>15.238</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>FORMULA FUNDING</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Statutory Compliance</td>
<td>4.886</td>
<td>0.260</td>
</tr>
<tr>
<td>Medical Equipment</td>
<td>6.382</td>
<td>0.538</td>
</tr>
<tr>
<td>E-Health Strategic Priorities</td>
<td>2.000</td>
<td>0.036</td>
</tr>
<tr>
<td>National PACS Refresh 2007-17</td>
<td>0.129</td>
<td>(0.000)</td>
</tr>
<tr>
<td>Traffic management</td>
<td>0.487</td>
<td>0.093</td>
</tr>
<tr>
<td>Expansion of renal capacity RIE</td>
<td>0.851</td>
<td>0.000</td>
</tr>
<tr>
<td>Chemotherapy e-Prescribing &amp; Administration System</td>
<td>0.058</td>
<td>0.028</td>
</tr>
<tr>
<td>Observation Ward A&amp;E RIE</td>
<td>0.278</td>
<td>0.000</td>
</tr>
<tr>
<td>Management of Finance Leases</td>
<td>0.000</td>
<td>0.000</td>
</tr>
<tr>
<td>MCH Capital Grants</td>
<td>0.099</td>
<td>0.000</td>
</tr>
<tr>
<td>Birthing suite (SJH)</td>
<td>0.393</td>
<td>0.002</td>
</tr>
<tr>
<td>Birthing suite (RIE)</td>
<td>1.962</td>
<td>0.000</td>
</tr>
<tr>
<td><strong>SCHEMES FUNDED BY FORMULA</strong></td>
<td><strong>17.525</strong></td>
<td><strong>0.957</strong></td>
</tr>
</tbody>
</table>

| OTHER                                        |                      |                        |
| Asset Sales                                  | (2.585)              | 0.000                  |

| OTHER SCHEMES                                | (2.585)              | 0.000                  |

| TOTAL                                        | 70,922               | 16.195                 |
NHS Lothian
Activity Summary July 2011

## Elective Inpatient Admissions by CMT

<table>
<thead>
<tr>
<th></th>
<th>Apr - July 2009</th>
<th>Apr - July 2010</th>
<th>Apr - July 2011</th>
<th>Mthly Ave Aug 10 to July 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>214</td>
<td>223</td>
<td>186</td>
<td>58</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>2014</td>
<td>1878</td>
<td>1782</td>
<td>450</td>
</tr>
<tr>
<td>MOE/Stroke, REAS</td>
<td>136</td>
<td>153</td>
<td>93</td>
<td>29</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>2877</td>
<td>2917</td>
<td>2721</td>
<td>696</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>1551</td>
<td>1327</td>
<td>1254</td>
<td>314</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>1239</td>
<td>940</td>
<td>740</td>
<td>236</td>
</tr>
<tr>
<td>Oncology</td>
<td>1249</td>
<td>1070</td>
<td>946</td>
<td>251</td>
</tr>
<tr>
<td>Critical care</td>
<td>18</td>
<td>11</td>
<td>10</td>
<td>3</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>2524</td>
<td>2269</td>
<td>2055</td>
<td>521</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>203</td>
<td>120</td>
<td>129</td>
<td>58</td>
</tr>
<tr>
<td>West Lothian CHP</td>
<td>34</td>
<td>37</td>
<td>62</td>
<td>17</td>
</tr>
<tr>
<td><strong>All elective inpatient admissions</strong></td>
<td>12059</td>
<td>10945</td>
<td>9978</td>
<td>2633</td>
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</tbody>
</table>

## Emergency Inpatient Admissions by CMT

<table>
<thead>
<tr>
<th></th>
<th>Apr - July 2009</th>
<th>Apr - July 2010</th>
<th>Apr - July 2011</th>
<th>Mthly Ave Aug 10 to July 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>11828</td>
<td>12169</td>
<td>13141</td>
<td>3230</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>991</td>
<td>954</td>
<td>1071</td>
<td>269</td>
</tr>
<tr>
<td>MOE/Stroke, REAS</td>
<td>297</td>
<td>259</td>
<td>390</td>
<td>86</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>4292</td>
<td>4062</td>
<td>4301</td>
<td>1059</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>1180</td>
<td>1116</td>
<td>1012</td>
<td>265</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>1049</td>
<td>1096</td>
<td>1125</td>
<td>272</td>
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<tr>
<td>Oncology</td>
<td>731</td>
<td>725</td>
<td>806</td>
<td>200</td>
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<tr>
<td>Critical Care</td>
<td>344</td>
<td>323</td>
<td>419</td>
<td>106</td>
</tr>
<tr>
<td>Women &amp; Children (excl Maternity)</td>
<td>3554</td>
<td>3468</td>
<td>3460</td>
<td>888</td>
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<tr>
<td>East Lothian CHP</td>
<td>145</td>
<td>143</td>
<td>124</td>
<td>36</td>
</tr>
<tr>
<td>West Lothian CHP</td>
<td>141</td>
<td>132</td>
<td>115</td>
<td>26</td>
</tr>
<tr>
<td><strong>All emergency inpatient admissions</strong></td>
<td>24552</td>
<td>24447</td>
<td>25964</td>
<td>6437</td>
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</tbody>
</table>

## Births

<table>
<thead>
<tr>
<th></th>
<th>Apr - July 2009</th>
<th>Apr - July 2010</th>
<th>Apr - July 2011</th>
<th>Mthly Ave Aug 10 to July 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Births - RIE</td>
<td>2209</td>
<td>2219</td>
<td>2326</td>
<td>579</td>
</tr>
<tr>
<td>Births - St John's</td>
<td>1067</td>
<td>952</td>
<td>944</td>
<td>243</td>
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<tr>
<td>Home Births</td>
<td>66</td>
<td>55</td>
<td>56</td>
<td>13</td>
</tr>
<tr>
<td>Births - Total</td>
<td>3342</td>
<td>3226</td>
<td>3326</td>
<td>835</td>
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</tbody>
</table>

## Neonatal Unit Occupied Bed Days

<table>
<thead>
<tr>
<th></th>
<th>Apr - July 2009</th>
<th>Apr - July 2010</th>
<th>Apr - July 2011</th>
<th>Mthly Ave Aug 10 to July 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive care</td>
<td>778</td>
<td>663</td>
<td>1069</td>
<td>209</td>
</tr>
<tr>
<td>High dependency</td>
<td>703</td>
<td>731</td>
<td>751</td>
<td>218</td>
</tr>
<tr>
<td>Special Care</td>
<td>2283</td>
<td>2325</td>
<td>2339</td>
<td>610</td>
</tr>
<tr>
<td>All NNU Bed Days</td>
<td>3764</td>
<td>3719</td>
<td>4159</td>
<td>1037</td>
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</table>
### Day cases by CMT

<table>
<thead>
<tr>
<th></th>
<th>Apr - July 2009</th>
<th>Apr - July 2010</th>
<th>Apr - July 2011</th>
<th>Mthly Ave Aug 10 to July 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>282</td>
<td>268</td>
<td>282</td>
<td>68</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory</td>
<td>1254</td>
<td>968</td>
<td>948</td>
<td>225</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>2155</td>
<td>2285</td>
<td>2159</td>
<td>553</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>866</td>
<td>875</td>
<td>849</td>
<td>230</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>3671</td>
<td>3852</td>
<td>3500</td>
<td>935</td>
</tr>
<tr>
<td>Oncology</td>
<td>6476</td>
<td>6883</td>
<td>7168</td>
<td>1705</td>
</tr>
<tr>
<td>Anaesthesics &amp; Theatres</td>
<td>1</td>
<td>3</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Women &amp; Children (excl maternity)</td>
<td>4913</td>
<td>4520</td>
<td>4443</td>
<td>1123</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>43</td>
<td>113</td>
<td>82</td>
<td>21</td>
</tr>
<tr>
<td><strong>All day cases</strong></td>
<td>19661</td>
<td>19767</td>
<td>19436</td>
<td>4861</td>
</tr>
</tbody>
</table>

### Diagnostic procedures (scopes)

<table>
<thead>
<tr>
<th></th>
<th>Apr - July 2009</th>
<th>Apr - July 2010</th>
<th>Apr - July 2011</th>
<th>Mthly Ave Aug 10 to July 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>GI</td>
<td>6107</td>
<td>6738</td>
<td>7600</td>
<td>1693</td>
</tr>
<tr>
<td>Urology</td>
<td>1376</td>
<td>1525</td>
<td>1730</td>
<td>437</td>
</tr>
<tr>
<td><strong>All scopes</strong></td>
<td>7483</td>
<td>8263</td>
<td>9330</td>
<td>2130</td>
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</tbody>
</table>

### New outpatients by CMT

<table>
<thead>
<tr>
<th></th>
<th>Apr - July 2009</th>
<th>Apr - July 2010</th>
<th>Apr - July 2011</th>
<th>Mthly Ave Aug 10 to July 2011</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>9426</td>
<td>9129</td>
<td>9754</td>
<td>2452</td>
</tr>
<tr>
<td>Cardiology, Thoracic &amp; Respiratory,</td>
<td>5004</td>
<td>4641</td>
<td>4288</td>
<td>1080</td>
</tr>
<tr>
<td>MOE/Stroke, REAS</td>
<td>886</td>
<td>942</td>
<td>1344</td>
<td>330</td>
</tr>
<tr>
<td>General Surgery &amp; Urology</td>
<td>10035</td>
<td>10201</td>
<td>9569</td>
<td>2098</td>
</tr>
<tr>
<td>Musculo-Skeletal</td>
<td>10161</td>
<td>9914</td>
<td>9337</td>
<td>2455</td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>18239</td>
<td>17817</td>
<td>17170</td>
<td>4368</td>
</tr>
<tr>
<td>Oncology</td>
<td>4294</td>
<td>4603</td>
<td>5090</td>
<td>1213</td>
</tr>
<tr>
<td>Anaesthesics &amp; Theatres</td>
<td>310</td>
<td>389</td>
<td>396</td>
<td>98</td>
</tr>
<tr>
<td>Women &amp; Children</td>
<td>17987</td>
<td>17981</td>
<td>16397</td>
<td>4220</td>
</tr>
<tr>
<td>East Lothian CHP</td>
<td>1607</td>
<td>1379</td>
<td>743</td>
<td>183</td>
</tr>
<tr>
<td>West Lothian CHP</td>
<td>821</td>
<td>855</td>
<td>835</td>
<td>209</td>
</tr>
<tr>
<td><strong>All new outpatients</strong></td>
<td>78770</td>
<td>77851</td>
<td>74923</td>
<td>18706</td>
</tr>
</tbody>
</table>
1 Purpose of the Report

The purpose of this report is to provide an update to the Board members on the most recently available NHS Lothian performance data on Waiting Times as reported through local and national systems.

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

2 Recommendations

The Board is recommended to:

2.1 receive this update report covering recent waiting times performance; and

2.2 note the actions being taken to ensure Access Targets are brought back on trajectory.

3 Discussion of Key Issues

The following table outlines the overall performance against each target, using the most recent available data:
<table>
<thead>
<tr>
<th>Measure</th>
<th>Current Target / Milestone</th>
<th>Lothian Performance Current Period</th>
<th>Assessment</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Suspicion of Cancer referrals (62 days)</strong></td>
<td>95%</td>
<td>98.4%</td>
<td>√</td>
</tr>
<tr>
<td>Breast</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cervical</td>
<td>66.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Colorectal</td>
<td>98.8%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Head &amp; Neck</td>
<td>85.7%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lung</td>
<td>96.3%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lymphoma</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Melanoma</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ovarian</td>
<td>90%</td>
<td></td>
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<tr>
<td>Upper GI</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urological</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>31 day DTTTT - all cancers</strong></td>
<td>95%</td>
<td>99%</td>
<td>√</td>
</tr>
<tr>
<td><strong>18 weeks RTT: Composite Performance</strong></td>
<td>83.3%</td>
<td>90.3%</td>
<td>√</td>
</tr>
<tr>
<td><strong>New outpatients - max 12 weeks from referral</strong></td>
<td>0</td>
<td>117</td>
<td>X</td>
</tr>
<tr>
<td><strong>Inpatient Case - max 9 weeks</strong></td>
<td>0</td>
<td>287</td>
<td>X</td>
</tr>
<tr>
<td><strong>Drug and Alcohol Treatment - max 5 weeks from referral</strong></td>
<td>65%</td>
<td>74%</td>
<td>√</td>
</tr>
<tr>
<td>Wait for key <strong>diagnostic tests &gt; 4 weeks</strong></td>
<td>0</td>
<td>478</td>
<td>X</td>
</tr>
<tr>
<td>MRI</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>CT</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Barium</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ultrasound</td>
<td>0</td>
<td></td>
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</tr>
<tr>
<td>Upper endoscopy</td>
<td>196</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lower endoscopy</td>
<td>39</td>
<td></td>
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</tr>
<tr>
<td>Colonoscopy</td>
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<td></td>
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</tr>
<tr>
<td>Cystoscopy</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>A&amp;E Waits - % of patients waiting 4 hours or less</strong></td>
<td>98%</td>
<td><strong>97.20%</strong></td>
<td>X</td>
</tr>
<tr>
<td><strong>Cataract Waiting Times - max wait 18 wks outpatient and inpatient combined</strong></td>
<td>0</td>
<td>0</td>
<td>√</td>
</tr>
<tr>
<td><strong>Hip Surgery Waiting Times - % of Hip Fracture operations within 24 safe operating hours</strong></td>
<td>98%</td>
<td>99%</td>
<td>√</td>
</tr>
<tr>
<td><strong>Wait for cardiac intervention to be &lt; 15wks (angiography, angioplasty and CABG)</strong></td>
<td>0</td>
<td>0</td>
<td>√</td>
</tr>
<tr>
<td><strong>Audiology</strong> - numbers waiting over 18 weeks from referral to assessment or from assessment to hearing aid fitting.**</td>
<td>0</td>
<td>12</td>
<td>X</td>
</tr>
</tbody>
</table>

3.2 In the latest period, the following seven 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 the 18 weeks referral to treatment target
• Drug and Alcohol maximum of 5 weeks referral to treatment waiting times
• Cataract waiting times standard – a maximum of 18 weeks
• Hip fracture operations within 24 safe operating hours
• Cardiac interventions – less than 15 weeks waiting times standard

4 Key Risks

The following performance measures are those where NHS Lothian are currently off trajectory and therefore are considered risks to the organisation. Actions being taken are noted.

4.1 New Outpatient and Inpatient Standards

Several acute areas continued to have waiting time difficulties during July and these are persisting during August. Actions are underway to ensure that the waiting time performance returns to normality as soon as possible.

The provisional position reported at the end of July is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Outpatients</th>
<th>Inpatients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ophthalmology</td>
<td>63</td>
<td>0</td>
</tr>
<tr>
<td>ENT</td>
<td>0</td>
<td>208</td>
</tr>
<tr>
<td>Pain control</td>
<td>28</td>
<td>0</td>
</tr>
<tr>
<td>Scoliosis</td>
<td>26</td>
<td>79</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>117</strong></td>
<td><strong>287</strong></td>
</tr>
</tbody>
</table>

4.2 Wait for Diagnostic Tests

In line with the agreement with the Scottish Government Health department waits for these tests (upper and lower endoscopy and colonoscopy) will fluctuate between four and six weeks. The six week standard is currently being met, although it is anticipated that there will be breaches of the six weeks at end August - due to increasing referrals from colorectal outpatients - with the six week standard being achieved again at the end of September. Waits for the remaining five of the eight key tests are at a maximum of four weeks.

4.3 A&E Waits

At the end of July, we fell just short of meeting the 98% target, sitting at 97.2%. However, recent data available for August confirms that we hit an average of 98% across A&E. We will continue to focus our efforts here to maintain performance through:
• ensuring 100% performance for Flow 1 (minors)
• reducing time to first assessment within Emergency Departments
• testing the revised medical handover model at the RIE site between specialties to improve patient flow from CAA to specialties
• continuing to push for 11am discharges
• reducing Length of Stay
• ensuring reliable and responsive "pull" from downstream sites and maintaining a focus on delayed discharge numbers remains important.

4.4 Audiology

Waiting times for audiology have improved significantly and we are now only marginally away from meeting our target of no waits longer than 12 weeks for a stage of the audiology pathway. By the end of 2011, waits are to be reduced to a total pathway time of 18 weeks (nine weeks for each stage).

5 Risk Register

5.1 There are no issues highlighted within this report that require to be escalated to the corporate risk register at this stage.

6 Impact on Health Inequalities

6.1 As a report on progress, this paper does not require impact assessment in its own right. The HEAT performance framework has been subjected to impact assessment, with programmes assessed individually for impact on health inequalities in the wider population since April 2010 rather than overall. These assessments focus on underlying content of targets, e.g. both smoking cessation and cardiovascular health checks are examples of specific targets related to health inequalities.

7 Impact on Inequalities

7.1 As above, an assessment is not required on this paper. Impact assessments have been carried out on the underlying content of targets.

8 Involving People

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

9 Resource Implications

9.1 There are no additional resource implications relating directly to the provision of this report, other than those already associated with the delivery of these waiting times standards.

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1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board note the performance of NHS Lothian and Local Authority partners in tackling delayed discharge.

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

2 Recommendations

The Board is recommended to:

2.1 Note the results of July and September 2011 census in relation to the local targets and the national 6 week standard.

3 Discussion of Key Issues

3.1 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.

3.2 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)</th>
<th>Complex Codes</th>
<th>6 Weeks+ (National standard - 0)</th>
<th>Short Stay (Target - 0)</th>
<th>Average length of stay</th>
</tr>
</thead>
<tbody>
<tr>
<td>July</td>
<td>125</td>
<td>95</td>
<td>29</td>
<td>26</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>August</td>
<td>131</td>
<td>96</td>
<td>36</td>
<td>26</td>
<td>3</td>
<td>35</td>
</tr>
</tbody>
</table>

3.3 At census point in July and August, NHS Lothian continues to report high numbers of patients delayed and with 26 patients delayed over the 6 week national standard this is significantly higher than previous months. The main reason continues to be the continued effects of the closure of Elsie Inglis care home in Edinburgh, which has removed 65 beds (1.5% of Lothian total).
3.4 The table below sets out the performance across the Partnership areas for August and July. Numbers less than 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></td>
<td>August</td>
<td>July</td>
<td>August</td>
<td>July</td>
</tr>
<tr>
<td>Overall</td>
<td>81</td>
<td>75</td>
<td>&lt;5</td>
<td>11</td>
</tr>
<tr>
<td>Over 6 weeks</td>
<td>25</td>
<td>25</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Short Stay</td>
<td>&lt;5</td>
<td>(&lt;5)</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

3.5 In Edinburgh the local target of 48 was not achieved with the partnership reporting 75 and 81 delays in July and August respectively, with 25 delayed over six weeks in both months. As noted above, care home choice remains the largest challenge, both in terms of overall capacity and people exercising their right of choice.

The Edinburgh partnership are committed to meeting the local target by end of October and have put in place a range of options to ensure the best possible outcome for hospital delayed discharge patients which includes:

- Reassessment of those needing nursing homes to determine whether a package of care at home might be appropriate to meet their needs
- Work to increase capacity of the overnight service for those receiving home care - this will allow those with more complex needs to be supported
- Conclusion and report on audit analysing reasons why people go into care homes and to consider what, if any, alternative or additional services would be required in order to support them at home
- Processes are being put into place to work with local care homes to ensure vacancies are noted at the earliest possible opportunity and to negotiate wherever possible for placements funded at local authority rates

3.6 East Lothian continues to report an overall improvement with no patients delayed over 6 weeks. East Lothian have now had no delays over 6 weeks for the last 6 months, and with less than 5 delays in August, represents continued improvement.

3.7 Midlothian has figures below 10 in both July and August and have had no delays over 6 weeks since December 2010.

3.8 West Lothian have patients delayed both overall and over 6 weeks but the number is below the reportable level of 5.

3.9 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 August and July.

<table>
<thead>
<tr>
<th></th>
<th>Edinburgh</th>
<th>East Lothian</th>
<th>Midlothian</th>
<th>West Lothian</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>August</td>
<td>July</td>
<td>August</td>
<td>July</td>
</tr>
<tr>
<td>Complex Codes</td>
<td>18</td>
<td>11</td>
<td>&lt;5</td>
<td>&lt;5</td>
</tr>
</tbody>
</table>

3.10 There has been a slight increase in the number of patients who are coded as complex rising to 36 in August. The increase is attributable to just under 10 patients who are going through the welfare guardianship process.
Despite the increase in overall numbers, the average length of stay continues to reduce, currently at 117 days compared to 269 days 12 months ago. Lothian has the fewest number of complex coded delay patients.

NHS Lothian still compares favourably against other areas of Scotland for overall numbers of delays. The latest National published data is for July 2011 and we continue to be above the Scottish average on overall delays (table 1). Table 2 shows Lothian in comparison to other Boards in relation to complex coded delays, where again we are one of the better performing Boards, reflecting our continued attention on these patients

**Table 1**

<table>
<thead>
<tr>
<th>NHS Board area of treatment</th>
<th>Number of delays per 100,000 population</th>
<th>Number of &gt;2 week delays per 100,000 population</th>
<th>Population</th>
<th>Total</th>
<th>Number out with the six week discharge planning period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dumfries &amp; Galloway</td>
<td>3.4</td>
<td>0.0</td>
<td>147,883</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>Western Isles</td>
<td>3.8</td>
<td>0.0</td>
<td>26,234</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Grampian</td>
<td>4.4</td>
<td>0.0</td>
<td>543,634</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Shetland</td>
<td>4.6</td>
<td>0.0</td>
<td>21,595</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td>Orkney</td>
<td>9.7</td>
<td>0.0</td>
<td>26,536</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>11.3</td>
<td>0.4</td>
<td>587,399</td>
<td>64</td>
<td>2</td>
</tr>
<tr>
<td>Lothian</td>
<td>11.5</td>
<td>3.1</td>
<td>835,968</td>
<td>95</td>
<td>26</td>
</tr>
<tr>
<td>Highland</td>
<td>11.8</td>
<td>3.2</td>
<td>313,435</td>
<td>37</td>
<td>10</td>
</tr>
<tr>
<td>Tayside</td>
<td>13.5</td>
<td>6.3</td>
<td>390,298</td>
<td>64</td>
<td>1</td>
</tr>
<tr>
<td>Scotland</td>
<td>13.9</td>
<td>1.8</td>
<td>6,265,013</td>
<td>722</td>
<td>95</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>14.5</td>
<td>3.7</td>
<td>293,697</td>
<td>42</td>
<td>11</td>
</tr>
<tr>
<td>Ayrshire &amp; Arran</td>
<td>15.9</td>
<td>6.0</td>
<td>365,381</td>
<td>55</td>
<td>0</td>
</tr>
<tr>
<td>Fife</td>
<td>16.7</td>
<td>1.4</td>
<td>366,360</td>
<td>63</td>
<td>5</td>
</tr>
<tr>
<td>Greater Glasgow &amp; Clyde</td>
<td>19.9</td>
<td>2.0</td>
<td>1,165,526</td>
<td>237</td>
<td>33</td>
</tr>
<tr>
<td>Borders</td>
<td>28.2</td>
<td>6.2</td>
<td>113,450</td>
<td>32</td>
<td>7</td>
</tr>
</tbody>
</table>

**Table 2**

<table>
<thead>
<tr>
<th>NHS Board area of treatment</th>
<th>All patients delayed with complex needs per 100,000 population</th>
<th>Population</th>
<th>All patients delayed with complex needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>D&amp;O</td>
<td>0.0</td>
<td>147,883</td>
<td>0</td>
</tr>
<tr>
<td>A&amp;A</td>
<td>3.0</td>
<td>365,472</td>
<td>11</td>
</tr>
<tr>
<td>Lothian</td>
<td>3.5</td>
<td>835,968</td>
<td>29</td>
</tr>
<tr>
<td>Borders</td>
<td>4.4</td>
<td>1,134,450</td>
<td>5</td>
</tr>
<tr>
<td>Grampian</td>
<td>4.4</td>
<td>543,634</td>
<td>24</td>
</tr>
<tr>
<td>Fife</td>
<td>4.9</td>
<td>360,300</td>
<td>10</td>
</tr>
<tr>
<td>Highland</td>
<td>5.7</td>
<td>313,435</td>
<td>18</td>
</tr>
<tr>
<td>Scotland</td>
<td>6.9</td>
<td>6,265,013</td>
<td>312</td>
</tr>
<tr>
<td>Tayside</td>
<td>7.3</td>
<td>390,298</td>
<td>39</td>
</tr>
<tr>
<td>O&amp;G&amp;C</td>
<td>8.6</td>
<td>1,165,526</td>
<td>102</td>
</tr>
<tr>
<td>Forth Valley</td>
<td>8.9</td>
<td>293,697</td>
<td>28</td>
</tr>
<tr>
<td>Orkney</td>
<td>9.7</td>
<td>26,536</td>
<td>2</td>
</tr>
<tr>
<td>Lanarkshire</td>
<td>11.5</td>
<td>587,399</td>
<td>65</td>
</tr>
<tr>
<td>Shetland</td>
<td>13.9</td>
<td>21,699</td>
<td>3</td>
</tr>
<tr>
<td>Western Isles</td>
<td>38.1</td>
<td>26,234</td>
<td>10</td>
</tr>
</tbody>
</table>
Finally, as a percentage of overall beds in a Board area occupied by Delayed Discharges (quarterly released national data), Lothian sits at 2.8% against an overall Scottish average of 3.5%.

4 Key Risks

4.1 The key risks are the increasing number of delays and the resulting pressure this creates on patient flow across health and social care. The implementation of the Local Transformation Plans through the Change Fund in supporting the shift in the balance of care from institutional to community based settings will begin to impact positively on the number of delays.

4.2 A further risk is the current situation with Southern Cross Care Homes with NHS Lothian and Councils continuing to monitor the situation to ensure there is no adverse effect. Currently seven out of eight Southern Cross care homes in Lothian have operators identified and processes are underway for de-registration and registration and the other, which is in West Lothian, continues to be monitored and supported by the council.

5 Risk Register

5.1 The risks associated with delayed discharge continue to be managed in partnership with local authorities.

6 Impact on Health Inequalities

6.1 This section is not relevant to this performance report.

7 Impact on Inequalities

7.1 This section is not relevant to this performance report.

8 Involving People

8.1 This section is not relevant to this performance report.

9 Resource Implications

9.1 There are no direct resource implications associated with this report.

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HEALTHCARE ASSOCIATED INFECTION UPDATE

1 Purpose of the Report

1.1 The purpose of this report is to update the Board on progress and actions to manage and reduce Healthcare Associated Infection across NHS Lothian. Any member wishing additional information should contact the Executive Lead in advance of the meeting.

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* (MRSA) and Meticillin Sensitive *Staphylococcus aureus* (MSSA) Bacteraemia to target resources for a sustained reduction and continue the roll-out of the MRSA 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 maintain standards in anticipation of announced and unannounced Healthcare Environment Inspectorate visits.
- Continued the provision of detailed reports to the public, as required by the Scottish Government.

3 Discussion of Key Issues

3.1 *Staphylococcus aureus* Bacteraemia: there were 26 episodes of *Staphylococcus aureus* Bacteraemia recorded in August 2011 (4 Meticillin Resistant *Staphylococcus aureus*, 22 Meticillin Sensitive *Staphylococcus aureus*), compared to 16 in July 2011 (1 Meticillin Resistant *Staphylococcus aureus*, 15 Meticillin Sensitive *Staphylococcus aureus*). Currently, NHS Lothian is on trajectory to achieve the Health Efficiency Access Treatment Target of 0.26 cases or fewer per 1000 acute occupied bed days by March 2013. This translates to no more than 265 cases of *Staphylococcus aureus* Bacteraemia in 2011-12 and no more than 213 in 2012-13.
3.2 *Clostridium difficile* Infection: there were 25 episodes of *Clostridium difficile* Infection in patients aged 65 or over in August 2011, compared to 23 in July 2011. Currently, NHS Lothian is on trajectory to achieve the Health Efficiency Access Treatment Target of 0.39 cases or fewer by 1000 acute bed days by March 2013. This translates to no more than 342 cases of *Clostridium difficile* Infection in patients aged 65 or over in 2011-12 and no more than 326 in 2012-13.

3.3 Hand hygiene: the 14th bi-monthly national hand hygiene audit report was published on 27/7/2011. This indicated that NHS Lothian is achieving a hand hygiene compliance of 96%, exceeding the overall national average compliance of 95%. Most staff groups continue to improve, achieving 97-100% compliance throughout this audit period. Ongoing work continues to focus on improving hand hygiene compliance amongst medical staff groups and areas of non-compliance. The 15th bi-monthly national hand hygiene audits have recently been undertaken. This report, which will be published on 28/9/2011, indicates an improvement in medical staff group compliance for NHS Lothian.

3.4 Meticillin Resistant *Staphylococcus aureus* National Screening Programme: all NHS Boards will be asked to ensure local delivery against the operating protocol by the end of March 2012. Transitional funding has been provided for 2011-12. NHS Lothian is continuing to transition to the new policy currently, with a focus on the following workstreams:

3.4.1 Screening activity: to date the Screening Programme has screened more than 400 patients and the results have been encouraging. We are achieving over 85% compliance with the use of the clinical risk assessment, 100% compliance with the screening of identified high risk patients and 45% compliance with the use of the perineal screen. The compliance with perineal screening has been lower due to the number of patients refusing this screen, primarily medicine for the elderly patients; however, all of this group has been appropriately screened using the alternative nose and throat swabs. A second wave of rollout has commenced (all of medicine for the elderly, Western General Hospital day surgery and Intensive Therapy Unit.) This will enable the system to be stress-tested for volume of samples and high numbers of elective patients and to further investigate the impact of the policy prior to the heavy demands of the winter season.

3.4.2 Process development: a TRAK version of the clinical risk assessment has been developed and deployed successfully to wards. This has greatly reduced the administration work for ward level nursing staff and enabled automated data collection and auditing that greatly reduces the surveillance workload. The surveillance database has also been updated to reflect the demands of the new policy and this will enable the automated generation of reports.

3.4.3 Communications: a presentation is to be delivered to several key user groups and a schedule for public partnership meetings has been established. A new wave of hospital based road shows for patients and staff will commence in September.

3.5 Mandatory Surveillance: from 1/7/2011, the mandatory surgical site surveillance has moved to the Health Protection Scotland Light Methodology to accommodate the Point Prevalence Surveillance which is being carried out during September and October 2011. The Point Prevalence Survey covers all acute areas within NHS Lothian and 25% of non-acute areas.
3.6 Healthcare Environment Inspectorate: the Healthcare Environment Inspectorate carried out an unannounced inspection at the Royal Infirmary of Edinburgh on 18/8/2011. During the inspection there were nine clinical areas inspected: Accident and Emergency; Ward 205; Ward 107; Ward 203; Combined Assessment Area; Ward 208; Ward 202; Ward 109; Ward 110. The draft report was received on 7/9/2011, with the Action Plan to be returned to the Healthcare Environment Inspectorate by 15/9/2011. The final report is expected to be published on 28/9/2011.

3.7 Antimicrobial Management Team update:
3.7.1 The Chief Medical Officer (2011)05 letter advised of revisions to the national antibiotic prescribing indicators that support the Health Efficiency Access Treatment Target for _Clostridium difficile_ Infection.

3.7.2 The Scottish Antimicrobial Prescribing Group has made slight changes to the data to be collected. Since April 2011, the empirical prescribing indicator has focused on improving compliance with policy and documenting cases of non-compliance, allowing trends to be identified and addressed. In clinical areas where the Prescribing Indicator is measured, compliance with guidelines is at target level for the RIE and WGH but documentation of indication for antibiotic treatment is below target. For surgical prophylaxis, the data collection focused on colorectal surgery. Compliance with the Surgical Prophylaxis Policy is improving although not yet at target level. Administration of single dose antibiotic prophylaxis is currently at the target level.

3.7.3 Antimicrobial Stewardship: the principles of antimicrobial stewardship apply to antibiotic use in all areas. Currently, the national Prescribing Indicators stipulate minimum areas for measurement. NHS Lothian captures the required data: empiric prescribing indicators are captured in a ‘front door’ area on each acute site; surgical antibiotic prophylaxis is monitored in colorectal surgery; the primary care seasonal variation in quinolone use (National Prescribing Indicator) is monitored for each General Practice directly from PRISMS data. Prescribing Indicator compliance reports are fed back to the relevant Clinical Teams for discussion and action.

3.7.4 Additionally, NHS Lothian has three antibiotic related local prescribing indicators for prescribing in General Practice, with one having been updated. They measure total antibiotic use, co-amoxiclav use and combined quinolone and cephalosporin prescribing (new 2011/12).

3.7.5 Prescribing patterns and _Clostridium difficile_ Infection: NHS Lothian currently monitors 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 the rate of _Clostridium difficile_ Infection.

3.7.6 Antibiotic expenditure: the total expenditure for 2011/12 remains down 20% from the same period in 2010/11. There appears to be an increase in expenditure on oral agents and a decrease in parenteral agents. Reduced cannulation supports efforts to reduce _Staphylococcus aureus_ Bacteraemias.

3.8 Domestic Services: Infection Control Toolbox talks have commenced for Domestic and Laundry Services across Lothian. Infection Prevention and Control Nurses have been involved in the composition and delivery of the Toolboxes. The Sign off sheet for domestic tasks that was introduced following the Healthcare Environment Inspectorate Inspection at the Western General Hospital has been updated to now include a daily
signature from the nurse in charge of the ward. This will be rolled out to all domestic services in NHS Lothian including PFI partner at the RIE.

4 Key Risks

4.1 The key risks associated with failure to address the recommendations are:
- *Staphylococcus aureus* Bacteraemia has the potential to lead to a need for additional treatment and an extended stay in hospital.
- Consideration of bed allocation and patient movement has to be given to those patients identified as colonised with MRSA as part of the MRSA Screening programme.
- Failure to comply with hand hygiene increases the risk of transmission of infection.
- Use of high risk antimicrobials has the potential to increase the risk of *Clostridium difficile* Infection.
- There is the potential for Healthcare Environment Inspectorate inspectors to find adverse areas of cleanliness or standards of practice, which could lead to adverse publicity for NHS Lothian.

5 Risk Register

5.1 The Healthcare Associated Infection Corporate Risk Register is currently graded high. The risk register includes a series of general and specific controls. These include norovirus outbreaks and escalation, hand hygiene, Health Efficiency Access Treatment targets, Health Protection Scotland targets, decontamination issues and impact on reputation.

6 Impact on Health Inequalities

6.1 There are no new issues with the Equality Diversity Impact Assessment as this is a routine update. However, 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.

7 Impact on Inequalities

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

8 Involving People

9 Resource Implications

9.1 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.

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13 September 2011
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List of Appendices

Appendix 1: Scottish Government Health Department Record Cards for NHS Lothian
SAB May to July 2011 recorded the lowest numbers for 2011 but in August 2011 there were 26 cases recorded, highest number recorded in the last eight months.

CDI Since April 2011 CDI figures have remained stable with an average of 37 cases per month.

SAB HEAT Target Whilst NHS Lothian are not currently achieving the HEAT Target for SAB, there has been a considerable reduction during quarter 2 of 2011. With the continuation of this NHS Lothian should achieve the target by March 2013.

CDI HEAT Target for Patients aged 65 and over For the period October 10 to August 11 NHS Lothian have achieved the target set at a rate of 0.39 or less per 1000 OBDS. The challenge going forward is to maintain this or reduce even further.

Hand Hygiene Monitoring Compliance

<table>
<thead>
<tr>
<th>Date</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>S-10</td>
<td>96%</td>
</tr>
<tr>
<td>O-10</td>
<td>91%</td>
</tr>
<tr>
<td>N-10</td>
<td>93%</td>
</tr>
<tr>
<td>D-10</td>
<td>95%</td>
</tr>
<tr>
<td>J-11</td>
<td>95%</td>
</tr>
<tr>
<td>F-11</td>
<td>97%</td>
</tr>
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<td>98%</td>
</tr>
<tr>
<td>A-11</td>
<td>98%</td>
</tr>
<tr>
<td>M-11</td>
<td>97%</td>
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Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over

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Quarterly Rolling Year *Clostridium difficile* Infection Cases per 1000 Total Occupied Bed Days for HEAT Target Measurement

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Quarterly Rolling Year *Staphylococcus aureus* Bacteraemia Cases for HEAT Target Measurement

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**Royal Infirmary of Edinburgh**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 4 SAB during July 2011 and 6 SAB during August 2011.

**Clostridium difficile Infection (CDI)**
There were 11 CDI during July 2011 and 9 CDI during August 2011.

This is the new Report Card Format introduced by Scottish Government July 2011

**Hand Hygiene Monitoring Compliance**

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MRSA Bacteraemia Cases**

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**MSSA Bacteraemia Cases**

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**Western General Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There was 1 SAB recorded during July 2011 and 1 during August 2011.

**Clostridium difficile Infection (CDI)**
There were 16 CDI during July 2011 and 8 CDI during August 2011.

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This is the new Report Card Format introduced by Scottish Government July 2011

**Hand Hygiene Monitoring Compliance**

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**
**St John's Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**
There were 2 SAB recorded during July and 2 during August 2011.

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during July and 5 during August 2011.

---

**Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MSSA Bacteraemia Cases**

This is the new Report Card Format introduced by Scottish Government July 2011.
Liberton Hospital

**Staphylococcus aureus Bacteraemia (SAB)**
There were NO SAB recorded during July and 1 SAB during August 2011.

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during July and 1 CDI during August 2011.

This is the new Report Card Format introduced by Scottish Government July 2011

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

**MRSA Bacteraemia Cases**

**MSSA Bacteraemia Cases**

12
**Staphylococcus aureus Bacteraemia (SAB)**
There were NO SAB recorded in July and 1 in August 2011.

**Clostridium difficile Infection (CDI)**
There were NO CDI recorded in the last 12 month period.

This is the new Report Card Format introduced by Scottish Government July 2011

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**Royal Victoria Hospital**

**Staphylococcus aureus Bacteraemia (SAB)**

There was 1 SAB recorded during July and NO SAB during August 2011.

**Clostridium difficile Infection (CDI)**

There was 1 CDI recorded during July and NO CDI during August 2011.

This is the new Report Card Format introduced by Scottish Government July 2011

**Hand Hygiene Monitoring Compliance**

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**Clostridium difficile Infection (CDI) Cases in Patients ages 15 and over**

**MRSA Bacteraemia Cases**

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**MSSA Bacteraemia Cases**

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**Community Hospitals**

**Staphylococcus aureus Bacteraemia (SAB)**
There were only 2 SAB recorded in the last 12 month period.

**Clostridium difficile Infection (CDI)**
There was 1 CDI recorded during July 2011 and 1 CDI during August 2011.

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**Total Staphylococcus aureus Bacteraemia (SAB) Cases**

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**MRSA Bacteraemia Cases**

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**MSSA Bacteraemia Cases**

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This is the new Report Card Format introduced by Scottish Government July 2011.
Out of Hospital Infections

**Staphylococcus aureus Bacteraemia (SAB)**
There were 8 SAB recorded during July and 14 SAB during August 2011 that were identified as Out of Hospital Infections.

**Clostridium difficile Infection (CDI)**
There were 7 CDI recorded during July and 11 CDI during August 2011 that were identified as Out of Hospital Infections.

This is the new Report Card Format introduced by Scottish Government July 2011.
WEBCASTING AND COMMUNICATIONS WITH KEY PARTNERS AND THE COMMUNITY

1 Purpose of the Report

1.1 The purpose of this report is to recommend that the Board consider the possibility of webcasting Board Meetings and note methods currently being considered to create stronger communications with key partners and the community.

1.2 This paper is produced in response to the issues of webcasting and communications being raised as linked matters at the last meeting of the Board.

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

2 Recommendations

The Board is recommended to:

2.1 Take a decision on the prospect of webcasting future meetings of the Board based on one of the options outlined.

2.2 Note the work that is underway in relation to communication with key partners and the community and decide what sort of further engagement is required.

3 Discussion of Key Issues

Context

3.1 Discussion has taken place at previous Board Meetings about engaging with key partners and the community in relation to Board business. Feedback from other NHS Boards has been used to inform ways to encourage broader representation and interest.

3.2 One suggestion has been to webcast meetings of the Board to allow greater public access and increase transparency to meetings. The other has been to find a
mechanism to engage with key partners and the community to allow them to alert
the Board of NHS Lothian to issues that they would like to see discussed.

**Webcasting**

3.3 Webcasting of meetings is used by a number of public sector bodies across the
UK. In Scotland no NHS Board currently webcasts its meetings, however it is a
system used by the Highland Council.

3.4 The Highland Council system is run by a third party private company which uses
existing videoconferencing equipment fitted to the Council Chamber in Inverness. Each webcast is hosted live and archived for 12 months on the company’s website
but with branding for Highland Council associated with the relevant page. Visitors
who want to see the webcast connect through a link on Highland Council’s own
website.

3.5 This system costs Highland Council around £130 per hour and allows them to
monitor the statistics on a monthly basis, both for the live viewing and for archive
viewing. An initial pilot project was deemed a success and a contract is now in
place until April 2013 following a tendering process.

3.6 Currently, the NHS Lothian data network is not capable of streaming large volumes
required for live transmission of webcasts without substantial investment in
infrastructure. That leaves us with a number of options based around the recording
of meetings which could then be viewed at a later time.

**Option 1**

3.7 The simplest and cheapest option which also involves the least amount of staff
time can be undertaken by the Videoconference Team within Telecoms with some
minimal input from the Communications Team. It is to use Waverley Gate Meeting
Room 7’s or 8’s videoconference unit(s) to record the meeting (and presentations)
from across the room or from in front. Recordings are made on a VC recorder.

3.8 On the internet, the recording can be downloaded from the VC recorder, potentially
edited into “bitesize chunks” and uploaded onto NHS Lothian’s existing YouTube
site (http://www.youtube.com/user/NHSLothian) . There is no cost for uploading
files to YouTube – all online storage and streaming problems are taken care of.
NHS Lothian would still have full control over user access, if deemed necessary;
whether comments can be made on the material; and maintain the ability to
instantly delete the material, if required.

3.9 For internal purposes on the Intranet, this recording can be downloaded from the
VC recorder and converted to a standard video format, placed on one or more
NHS Lothian servers and made available on the NHS Lothian intranet via a link. If
required, the footage could be edited before being made available.

3.10 Alternatively we could host the edited video on YouTube (as above) and simply
allow the url of each new NHS Lothian video to be allowed to be viewed through
the network eg: http://youtube.com/watch?v=DG-0ck-5mBw NOT the whole of
YouTube.
Option 2

3.11 As above but have one or two, preferably tri-pod mounted, camcorders in the room to record the meetings rather than the VC unit(s). If the meetings are going to be the advertised six hours in duration then they would have to be mains operated. The cameras would have to be set up before each meeting and the recordings will have to be started and stopped manually.

3.12 The main advantage of this option is that it would provide a better quality, consistent picture and the meeting would still be documented if network goes down. If two cameras are used then there are two microphones – may produce better audio in certain situations.

3.13 The disadvantage is the physical presence of two cameras on tripods which may be distracting to Board members and the staff time involved in setting up and taking down the cameras.

Option 3

3.14 Alternatively we could provide full video coverage of the meetings which could be resourced either in-house or outsourced. This would require at least one camera-person, preferably with two cameras to provide greater coverage and editing opportunities. More advanced microphones would be used and it would be recommended to provide a lighting kit too.

3.15 The advantages of this option would be that we would achieve the best recording which could have multiple uses. We have the skills in-house or could get a contractor to do this.

3.16 The disadvantages are that it would be expensive for an external contractor and there could be a delay whilst waiting for final version. If we opted to do this option in-house then new equipment would need to be purchased. Having a camera person/people continually in room, moving kit around, may be off-putting for presenters and audience in the Board room.

Evaluation

3.17 On selection of any one of these options statistical analysis is easy to carry out to show the number of people viewing the Board meetings. That analysis could be reported back to the Board after a trial period to determine whether the webcasting of meetings is a success or not.

3.18 This could be supported by articles in Health Link and on the NHS Lothian website, Facebook and Twitter pages asking for feedback from the public and key stakeholders as to the benefits of having webcasts.

3.19 As part of the NHS Lothian induction process attention could be drawn to the fact that the Board has webcasts of its meetings. Staff would be encouraged to watch Board meetings to engage with issues that will be of interest to them.
Communications with Key Partners and the Community

3.20 Previous Board meetings have discussed mechanisms for creating stronger communications with key partners and the community. The Board already makes itself more accessible by visiting, in rotation, each of the local authority areas once a year.

3.21 The Communications Team is working closely with the Public Involvement Team to explore ways to encourage greater participation and awareness in the work of the Board. It is recognised from research carried out by the Public Involvement team that Board attendance by members of the public and community groups is very low across Scotland. All Boards advertise their meetings in the public and many also advertise through key partner groups such as Patient Partnership Fora (PPFs) to encourage interest. They have noted that attendance has only increased when an item is contentious.

3.22 The initial feedback from members of the PPFs in Lothian has shown some key issues to be aware of in terms of engagement with key partners and the community. These include:

- Lack of awareness that Board meetings are open to the public
- Timing of Board meetings
- Length of Board meetings
- Knowing what is on the agenda and the availability of papers in advance of meetings
- Use of NHS jargon and staff clearly explaining the context
- Difference between a public meeting and a meeting open to the public

3.23 Feedback from early research shows that if the Board wants to engage further with key partners and the community then it would have to adapt its meetings. This could be by holding a public question and answer session at which members of the public would be able to ask questions of Board members and receive answers or the promise to find answers.

3.24 This approach could have many advantages in terms of public engagement with the Board but could also tie up time with specific and detailed questions having to be answered on top of an agenda that already takes around five hours to discuss.

3.25 Communications and Public Involvement are willing to bring a further paper to the Board exploring this area in greater detail, if Board members wish to progress. In accordance with the requirements of public involvement detailed discussion with community groups on possible proposals for engaging at Board meetings would be part of the development of that paper.

4 Key Risks

4.1 NHS Lothian could be deemed to be lacking in openness and transparency if it does not embrace new ways of making the decision-making processes of its most strategic body (the Board) accessible to as wide an audience as possible.
4.2 The potential cost associated with webcasting could be seen as a negative at a time when efficiencies are being made in other areas.

4.3 Webcasting could actually decrease attendance at the Board as people would only need computer access to see the meeting and not have to turn up in person.

4.4 Making Board meetings public meetings as opposed to open to the public would mean extra resource being put in to deal with potentially detailed and specific queries.

5 Risk Register

5.1 There are no risks listed in the Register associated with public engagement in the decision making processes of the Board, but that there may be some reputational risks that develop once the work programme that this paper sits within is taken further forward and that these will be added to the Register as appropriate.

6 Impact on Inequalities

6.1 A Rapid Impact Assessment was carried out in May 2011 on a wide range of proposals to develop public engagement with the decision making processes of the Board, including making Board meetings more accessible, improving the availability of papers, wider promotion of meetings and the timing and content of meetings. Broadly the impact on inequality was agreed to be positive. In addition, a further more focused Rapid Impact Assessment was carried out in August 2011 to consider the impact of lay representation on the Board and its committees. This programme of work was also found to be likely to have a positive impact on inequality.

7 Involving People

7.1 Involving people in the development of strategies, policies and service redesign is part of the ongoing work of NHS Lothian. Public Partnership Forums, established under statutory guidance to Community Health (and Care) Partnerships, provide a mechanism for promoting the routine involvement of local people in the design and delivery of the health services they use. Any further development of this agenda will involve engagement with PPFs and community groups.

8 Resource Implications

8.1 The use of in-house teams will not require any extra financial input. Cost would only be associated with the purchase of new equipment or the contracting of a third party to carry out the work. No budget has been identified for this work, as yet, but discussion would take place depending on what option the Board agrees to take forward.
8.2 It is expected that fully costed options in relation to public engagement will be brought forward at a later stage between Communications and Public Involvement.

Stuart R Wilson
Director of Communications
15 September 2011
stuart.wilson3@nhs.net
COMMITTEE MEMBERSHIPS AND TERMS OF REFERENCE

1 Purpose of the Report

1.1 The purpose of this report is to invite the Board to agree the appointment of Paul Edie as a member of the Finance & Performance Review Committee in place of Alison Tierney; the appointment of Stephen Renwick as Vice Chair of the Finance & Performance Review Committee; the appointment of Shulah Allan to the Mutuality & Equality Governance Committee in place of Theresa Douglas and to the West Lothian Community Health & Partnership Board in place of Robin Burley; the appointment of replacement members to the West Lothian Community Health & Partnership Sub-Committee and changes to the terms of reference of the Finance & Performance Review Committee and the Staff Governance Committee.

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

2 Recommendations

The Board is recommended to agree:

2.1 the appointment of Paul Edie as a member of the Finance & Performance Review Committee in place of Alison Tierney

2.2 the appointment of Stephen Renwick as Vice Chair of the Finance & Performance Review Committee

2.3 the appointment of Shulah Allan to the Mutuality & Equality Governance Committee in place of Theresa Douglas and to the West Lothian Community Health & Partnership Board in place of Robin Burley.

2.4 the appointment of Claire Kenwood Associate Clinical Director to replace James Hendry, Stewart Murdoch to replace John Alexander as representative from the Scottish Ambulance Service and Moira Niven to replace Gordon Ford, Senior Officer from Education Services on West Lothian Community Health & Care Partnership Sub-Committee.

2.5 amended terms of reference for the Finance & Performance Review Committee (Appendix 1) with the amendments double underlined.
2.6 amended terms of reference for the Staff Governance Committee (Appendix 2) with the amendments double underlined.

3 Discussion of Key Issues

3.1 Alison Tierney’s term of office on the Board ends on 30 September 2011 and it is proposed that Paul Edie be appointed to replace her as a member of the Finance & Performance Review Committee.

3.2 The Terms of Reference of the Finance & Performance Review Committee have been amended to allow for the appointment by the Board of a Vice Chair. It is proposed that Stephen Renwick be appointed as Vice Chair of the Committee.

3.3 Theresa Douglas is coming off the Mutuality & Equality Governance Committee and it is proposed that Shulah Allan be appointed to replace her.

3.4 Robin Burley is coming off the West Lothian Community Health & Partnership Board and it is proposed that Shulah Allan be appointed to replace him.

3.5 Following the disbanding of the Primary & Community Partnership Committee it now falls to the Board directly to approve changes to the membership of the Community Health Partnership and Community Health & Care Partnership Sub-Committees. It is proposed that Claire Kenwood, Associate Clinical Director, be appointed to replace James Hendry, that Stewart Murdoch be appointed to replace John Alexander as representative from the Scottish Ambulance Service and Moira Niven be appointed to replace Gordon Ford, Senior Officer from Education Services.

4 Key Risks

4.1 Failure to appoint replacement members to Board Committees could lead to problems achieving a quorum for meetings.

5 Risk Register

5.1 There are no implications for NHS Lothian’s Risk Register.

6 Impact on Health Inequalities

6.1 This is an administrative matter and has no impact on Health Inequalities.

7 Impact on Inequalities

7.1 This is an administrative matter and has no impact on Inequalities.
8 Involving People

8.1 These proposals maintain the ration of non-Executive Board members on Committees.

9 Resource Implications

9.1 There are no resource implications arising from these recommendations.

Peter Reith
Secretariat Manager
21 September 2011
peter.reith@nhslothian.scot.nhs.uk

List of Appendices

Appendix 1: Amended Terms of Reference for the Finance & Performance Review Committee

Appendix 2: Amended Terms of Reference for the Staff Governance Committee
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.
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. **One of the Non-Executive Board Members shall be appointed Vice Chair of the Committee by the Board.**
- 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
- **Robin Burley**

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.

10 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.

11 Reporting Arrangements:

The Committee will report to the Board by means of submission of minutes to the next available Board meeting.
STAFF GOVERNANCE COMMITTEE

Remit:

- Generally to support the creation of a culture within the health system, where the delivery of the highest standard possible of staff management is understood to be the responsibility of everyone working within the system and is built upon partnership and collaboration.

The Committee will introduce structures and processes which assure that this is happening by-

- Monitoring, evaluating and approving strategies and implementation plans
- Support any policy amendment, funding/resource submission to achieve the staff governance standard
- Be responsible for the timely submission of all the data required as part of the performance and accountability framework.

Membership:

- NHS Board Chair
- 1 x CHP Chair or Vice Chair (previously all CHP Chairs/Vice Chairs)
- NHS Lothian Employee Board Member
- 1 x Local Authority Member
- NHS Lothian Director of Human Resources
- 2 x Representatives from the Area Partnership Forum

Others to attend as necessary

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 four times a year.

12 Quorum:

No business shall be transacted at a meeting of the Committee, unless at least four (previously six) members are present of which two (previously 3) are members of Lothian NHS Board. Any Member may be represented by a Deputy at any meetings.

13 Reporting Arrangements:

The Committee will report to the Board by means of submission of minutes to the next available Board meeting.

The Chair of the Committee will present an annual report to the Board.
1 Purpose of the Report

1.1 The purpose of this report is to present an overview of the findings of the national adult inpatient survey on patient experience.

2 Recommendations

The Board is recommended to:

2.1 Note the findings and the Healthcare Experience Indicator 2010 – 2011 for all Boards in Scotland.

3 Discussion of Key Issues

3.1 This is the second national survey in the Better Together Patient experience programme. 4252 people who stayed overnight in one of 8 NHS Lothian hospitals were sent a survey. The response rate was 49% (range 46 – 76% for all boards with the NHS Waiting Times Centre reporting 76% nearly 20% more than the next highest response rate at 56%) NHS Lothian response rate was 40.3% in 2009 – 2010. The episode of care could be up to 18 months ago.

3.2 The findings show NHS Lothian to be the most improved of any mainland board. Half the boards in Scotland showed improvements in the experiences of inpatients at others the results were similar to last year and in 2 boards they were worse.
These are presented in table 1.

### Table 1

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>2011</th>
<th>2010</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>79.3</td>
<td>79.2</td>
<td>0.1</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>79.8</td>
<td>81.1</td>
<td>-1.3</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>79.3</td>
<td>79.0</td>
<td>0.3</td>
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<tr>
<td>NHS Fife</td>
<td>77.4</td>
<td>76.9</td>
<td>0.5</td>
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<tr>
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<td>74.5</td>
<td>74.2</td>
<td>0.3</td>
</tr>
<tr>
<td>NHS Grampian</td>
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<td>77.3</td>
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<td>77.0</td>
<td>-0.4</td>
</tr>
<tr>
<td>NHS Highland</td>
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<td>*-1.2</td>
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<tr>
<td>NHS Lanarkshire</td>
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<td>74.7</td>
<td>-1.2</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>79.1</td>
<td>78.3</td>
<td>0.8</td>
</tr>
<tr>
<td>NHS Orkney</td>
<td>82.4</td>
<td>85.5</td>
<td>*-3.1</td>
</tr>
<tr>
<td>NHS Shetland</td>
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<td>0.9</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>79.7</td>
<td>80.6</td>
<td>*-0.9</td>
</tr>
<tr>
<td>NHS Western Isles</td>
<td>86.0</td>
<td>84.9</td>
<td>1.1</td>
</tr>
<tr>
<td>NHS National Waiting Times Centre</td>
<td>91.9</td>
<td>91.1</td>
<td>0.8</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td><strong>78.1</strong></td>
<td><strong>78.3</strong></td>
<td><strong>-0.2</strong></td>
</tr>
</tbody>
</table>

3.2.1 The Quality Outcome Indicator is one of 12 national indicators. They are intended to show national progress towards achievement of the Quality Ambitions. This indicator brings together the 2010 / 2011 adult inpatient survey and the 2009 / 2010 GP patient experience survey.

Table 2 presents the national indicators.

### Table 2

<table>
<thead>
<tr>
<th>NHS Board</th>
<th>Inpatient Component</th>
<th>GP Component</th>
<th>Overall</th>
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<tbody>
<tr>
<td>NHS Ayrshire &amp; Arran</td>
<td>79.3</td>
<td>81.7</td>
<td>80.5</td>
</tr>
<tr>
<td>NHS Borders</td>
<td>79.8</td>
<td>84.9</td>
<td>82.4</td>
</tr>
<tr>
<td>NHS Dumfries &amp; Galloway</td>
<td>79.3</td>
<td>84.6</td>
<td>81.9</td>
</tr>
<tr>
<td>NHS Fife</td>
<td>77.4</td>
<td>80.9</td>
<td>79.2</td>
</tr>
<tr>
<td>NHS Forth Valley</td>
<td>74.5</td>
<td>81.8</td>
<td>78.1</td>
</tr>
<tr>
<td>NHS Grampian</td>
<td>78.3</td>
<td>80.6</td>
<td>79.5</td>
</tr>
<tr>
<td>NHS Grater Glasgow and Clyde</td>
<td>76.5</td>
<td>83.4</td>
<td>80.0</td>
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<tr>
<td>NHS Highland</td>
<td>82.8</td>
<td>85.3</td>
<td>84.0</td>
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<tr>
<td>NHS Lanarkshire</td>
<td>73.5</td>
<td>80.1</td>
<td>76.8</td>
</tr>
<tr>
<td>NHS Lothian</td>
<td>79.1</td>
<td>81.4</td>
<td>80.2</td>
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<tr>
<td>NHS Orkney</td>
<td>82.4</td>
<td>91.0</td>
<td>87.7</td>
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<tr>
<td>NHS Shetland</td>
<td>83.5</td>
<td>81.0</td>
<td>82.3</td>
</tr>
<tr>
<td>NHS Tayside</td>
<td>79.7</td>
<td>82.7</td>
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<tr>
<td>NHS Western Isles</td>
<td>86.0</td>
<td>86.3</td>
<td>86.2</td>
</tr>
<tr>
<td>NHS National Waiting Times Centre</td>
<td>91.9</td>
<td>-</td>
<td>91.9</td>
</tr>
<tr>
<td><strong>Scotland</strong></td>
<td><strong>78.1</strong></td>
<td><strong>82.2</strong></td>
<td><strong>80.2</strong></td>
</tr>
</tbody>
</table>
3.3 NHS Lothian Findings

3.3.1 Reports are available for NHS Lothian and each of the 8 sites. Appendix 2 sets out the positive responses to the 5 questions summarising ‘overall’ care experience of each by site as compared to similar hospitals. Generally there is most improvement potential at Royal Victoria Hospital, Astley Ainslie and Liberton Hospitals.

3.3.2 Appendix 3 describes specific care components. Patients report high levels of confidence and trust but as across Scotland, preparing to discharge is an area for improvement.

3.3.3 Appendix 4 sets out NHS Lothian’s response as compared to NHS Greater Glasgow and Clyde, Lanarkshire and Tayside and Grampian. Lothian comes out top for the majority of summary indicators (10 out of 14), which is a huge improvement on last year’s performance (first for 3:14). Improvements have been seen across questions relating to overall care and treatment, hospital environment, patients being treated with respect and care, trusting staff, patients understanding what was happening to them and being physically comfortable. Lothian scored most positively on the summary indicator regarding patients being treated with care (94%). Lothian also scored in the 90% range for summary statements regarding being treated with respect, trusting the people looking after them, understanding what was happening and being physically comfortable as could be expected.

3.3.4 Appendix 5 presents the data for Lothian by top 5 and bottom 5. These changed for last year. Nationally the question with the 2nd most negative change from 2010 results is “I was happy with the food and drink that I received”. NHS Lothian difference from last year is -3% with the RIE -6% from last years and the lowest positive score of all NHS Lothian sites. However, small improvements in most sites were reported about people getting help with eating and drinking when they need it. The question where patients experience was worse than last year was the percentage of patients who were told how long that they could have to wait in A&E. This fell by -5% to 49%. NHS Lothian difference from last year was -4% at 46% There is only 1 change from last years figures and that is, “Doctors now introduce themselves” stipulated within 5 of the top 5 for what medications are for.

The question “where patients experience was worse than last year was the percentage of patients who were told how long that they could have to wait in A&E”

<table>
<thead>
<tr>
<th></th>
<th>2010</th>
<th>2011</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>46%</td>
<td>49%</td>
</tr>
</tbody>
</table>

3.3.5 Areas where NHS Lothian showed improvements from last year include:-

- “I got help with washing and dressing when I needed it” +5%
- “There was enough time to talk to doctors” +5%
- “Doctors washed / cleaned their hands” +6%
- “Nurses washed / cleaned their hands” +5%
Compared to last year, there were no questions for which NHS Lothian patients were significantly less likely to report a positive response.

3.4 Action plans were developed by the services based on the 2009 / 2010 findings. To comply with the Participation Standard patients and the public must be involved in this work which is achieved by various Quality Improvement teams, Senior Management groups, Patient Networks and Improving the Patient Experience group, including the Nutrition subgroup. The reports have been widely circulated to site and function leads (e.g. catering) and CHP general managers to review their local results and address relevant issues.

3.4.1 As examples of improvements 2 issues have been given considerable focus over the last 12 – 18 months. Pan Lothian improvements in discharge planning have been put in place, but are not yet featuring in this survey. ‘Knowing who is in charge of the ward is also an area of Pan Lothian action though the national uniform policy and the Leading Better Care Senior Charge Nurse Role Modernisation programme. Improvement in these indicators would be expected in the next survey.

3.4.2 Dignity and respect are positively reported in this survey:-

- “I was treated with respect” 93% positive +2% from last year
- “I was treated with care” 94% positive +2% from last year
- “I was able to get adequate pain relief when I needed it” 92% positive +2% from last year
- “The main ward or room I stayed in was clean” 93% positive +2% from last year
- “I had privacy when being examined and treated” 94% positive

4 Key Risks

4.1 The risks from this paper are to the reputation of NHS Lothian and its services. Generally NHS Lothian is showing improvements but some specific issues and site specific results need localised action. Media coverage has been balanced recognising the range of ways patient experience and feedback is collected and used to improve services nationally NHS Lothian’s performance is at the level of Scotland’s best when compared with similar health systems.

5 Risk Register

5.1 Risks associated with poor care, complaints, litigation and reputation of NHS Lothian are documented on the corporate risk register. The use of this and other patient experience measures directs improvement plans to address patient concerns, helping to manage risks.
6 Impact on Health Inequalities

6.1 The better Together Programme and this survey have had full equality impact assessments similar to the national analysis in Lothian.

55% were 65 and over  
25% were 50-64 years  
12% were 35-49 years  
8% were 16-34 years  
45% were male  
55% were female  
33% did not have any limiting illness or disability.

Nationally 98% indicated that they were heterosexual / straight while 2% indicated that they were gay / lesbian, bisexual or other. Further analysis of the results related to inequalities is ongoing.

7 Involving People

7.1 As set out in paragraph 3.4, the Participation Standard required and measures NHS Lothian’s improvement of patients and the public in the action planning and ongoing monitoring. Media statements have been developed and used by local papers.

8 Resource Implications

8.1 NHS Lothian uses patient perspectives as its survey contractor as part of the national framework agreement. The cost to NHS Lothian was £12,000. This will be a regular survey with one new national survey being introduced this year for Maternity Services. The national GP survey is funded by the Scottish Government Health Department.

Pat Dawson  
Associate Nurse Director  
15 September 2011  
Pat.Dawson@nhislothan.scot.nhs.uk

List of Appendices

Appendix 1: Better Together National Ranking  
Appendix 2: Better Together NHS Lothian By Site ‘Overall’ Statement  
Appendix 3: Better Together NHS Lothian Summary – Ranking / Care  
Appendix 4: Better Together NHS Lothian Summary – Comparator Boards  
Appendix 5: Better Together NHS Lothian Summary – Top 5 Bottom 5
**NHS Lothian Key:-**

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>RIE</td>
<td>Royal Infirmary Edinburgh</td>
</tr>
<tr>
<td>WGH</td>
<td>Western General Hospital</td>
</tr>
<tr>
<td>SJH</td>
<td>St Johns Hospital</td>
</tr>
<tr>
<td>Roodlands</td>
<td>Roodlands Hospital</td>
</tr>
<tr>
<td>RVH</td>
<td>Royal Victoria Hospital</td>
</tr>
<tr>
<td>AAH</td>
<td>Astley Ainslie Hospital</td>
</tr>
<tr>
<td>Liberton</td>
<td>Liberton Hospital</td>
</tr>
<tr>
<td>PAEP</td>
<td>Princess Alexandria Eye Pavilion</td>
</tr>
</tbody>
</table>
BETTER TOGETHER NHS LOTHIAN 2011
PERFORMANCE AGAINST MAINLAND HEALTH BOARDS FOR THE HEALTH CARE EXPERIENCE AND QUALITY OUTCOME INDICATORS.

HEALTH CARE EXPERIENCE INDICATOR

QUALITY OUTCOME INDICATOR
**BETTER TOGETHER NHS LOTHIAN SUMMARY**

The graphs show the percentage of positive scores by hospital and statement. The pink dots indicate the average for the relevant hospital type (e.g., Teaching Hospital (RIE & WGH), Large Hospital (S.J.H), Long Stay Hospital (ROODLANDS, RVH, A AH & LIBERTON), Other Hospitals (PAEP)).

**TREATMENT** I got the best treatment for my condition

**TRUST** I trusted the people looking after me

**KNOWLEDGE** I understood what was happening to me

**COMFORT** I was physically comfortable as I could expect to be

**DISCHARGE** I was confident I could look after myself when I left hospital
Lothian comes out top for the majority of summary indicators (10 out of 14), which is a huge improvement on last year’s performance.

Improvements have been seen across questions relating to overall care and treatment, hospital environment, patients being treated with respect and care, trusting staff, patients understanding what was happening to them and being physically comfortable.

The only summary indicators that Lothian has performed less positively relate to their admission to hospital and arrangements made for leaving hospital.

However, for these two indicators, Lothian still came second amongst all the teaching boards scoring 83% and 75% respectively.

Lothian scored most positively on the summary indicator regarding patients being treated with care (94%).

Lothian also scored in the 90% range for summary statements regarding being treated with respect, trusting the people looking after them, understanding what was happening and being physically comfortable as could be expected.
**TOP 5 RESULTS**

1. I UNDERSTOOD HOW AND WHEN TO TAKE MY MEDICINES: 97%
2. THE INFORMATION I WAS GIVEN BEFORE ATTENDING HOSPITAL HELPED ME UNDERSTAND WHAT WOULD HAPPEN: 97%
3. DOCTORS INTRODUCED THEMSELVES TO ME: 97%
4. I HAD PRIVACY WHEN BEING EXAMINED AND TREATED: 94%
5. I WAS TREATED WITH CARE: 94%

**BOTTOM 5 RESULTS**

1. I WAS HAPPY WITH THE FOOD AND DRINK THAT I RECEIVED: 67%
2. I WAS GIVEN HELP WITH ARRANGING TRANSPORT: 61%
3. I KNEW WHO WAS IN CHARGE OF THE WARD: 61%
4. I WAS NOT BOTHERED BY NOISE AT NIGHT: 50%
5. I WAS TOLD HOW LONG I WOULD HAVE TO WAIT IN A&E: 46%
1 Purpose of the Report

The purpose of this report is to update the Board on the contribution that is made to the work of SEAT through the NHS Lothian Chief Executive, Employee Director and Executive Management Team colleagues in driving this work forward on a regional basis; and to note and discuss specific issues in relation to NHS Lothian as appropriate.

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

2 Recommendations

The Board is recommended to:

2.1 Note that the July meeting of SEAT did not take place due to a significant number of SEAT members being on annual leave. Therefore this report is limited in terms of progress to report in advance of the next meeting which is due to take place on 23 September.

2.2 Acknowledge some of the agreed SEAT work streams that NHS Lothian Executive Directors and the Employee Director are involved with and any implications where appropriate for the workings of NHS Lothian.

3 Discussion of Key Issues

3.1 Board members will have noted previously that there are five work streams which are underway and which look at driving forward opportunities across SEAT in relation to quality and efficiency.

Each work stream has a lead officer and in all cases NHS Lothian is well represented and indeed takes a lead role in a number of these. These areas of work will be standing items for this report and we will report on other work steams by exception and relevance to the Board. As stated above, at the time of writing
this Board paper, the next meeting of SEAT is 23 September. Therefore a fuller report will be provided at the next Board meeting.

3.2 In the work stream on rebalancing care, the Chief Operating Officer has a joint lead with NHS Borders. Work is progressing to look at the management of orthopaedic services between NHS Lothian and NHS Borders. Analysis is currently underway in relation to activity levels and this will also be costed.

3.2 The Director of Public Health and Health Policy is leading the work on performance standards and minimising variation. The Director has engaged staff across SEAT but equally she has engaged a number of clinical colleagues across Lothian in relation to this work. Particular focus is on collaborative working that will enhance the efficiency of the public health function with the additional benefits of greater resilience and better use of existing capacity. This work is about examining areas of limited or no clinical value and benchmarking procedures across SEAT Boards with the aim of minimising variation and maximising productivity.

3.4 Another work stream is focusing on complex care and in particular the needs of people with learning disabilities who are out of area. The Acting Director of Strategic Planning is engaged in this work stream.

3.5 The work stream on Technology is being lead by Dr Stella Clark from NHS Fife and John Sturgeon from the NHS Lothian eHealth team is a member of this group. The key components of the technology work are to undertake a stock take of technology available and emerging across the region and assessment of its current use to identify potential for highest financial savings. Radiology is being considered as an area that with the use of technology could be profiled differently in terms of out of hours reporting and skill mix across the region. This is being scoped.

3.6 Corporate Shared Services is the fifth work stream and the Director of Human Resources and Organisational Development, along with the Employee Director, are members of this work stream. Directors of Public Health in the region via the NHS Lothian Director of Public Health have been asked to look at any efficiencies and more productive ways of working within public health across the region.

Additional work streams to note:

3.7 The 12 bedded regional Eating Disorder Unit which will be based at St John’s is still due to open. Building work will be completed by 5 December. The recruitment of staff is underway but there has been some difficulty in appointing to key posts of Consultant and charge nurse from within SEAT Boards. This means that we are now recruiting nationally. Timescales for the Unit being open and taking patients is now January 2012.

3.8 The non surgical oncology review commissioned by SCAN will be producing its initial findings in due course and will be reported back to the Board through this report and the regular update direct from the Interim Director of SEAT. The timing of this work will sit well with the agreement provided though ICIC that NHS Lothian should commission a scoping of an Initial Agreement to review the future model for
the Edinburgh Cancer Centre; this will sit within the overarching Cancer Strategy being commissioned and the wider clinical strategy work now underway.

4 **Key Risks**

4.1 Partnership working is a key element of ensuring the successful delivery of the projects/works strands highlighted above. The work of the Interim Director with others is to ensure that we have an agreed work plan and that we minimise any risk to progress not being made and in turn maximise the opportunities offered through regional working.

5 **Risk Register**

5.1 Boards will be expected to record any issues as appropriate within their own risk register.

6 **Impact on Health Inequalities**

6.1 The thrust of all of the work streams identified above will be to either reduce inequalities or drive improvements in the delivery and access of care and treatment. No individual equality impact assessment has been undertaken in respect of writing this paper as this is simply highlighting and commenting on existing work streams.

7 **Impact on Inequalities**

7.1 As above.

8 **Involving People**

8.1 Within individual work streams people will be involved in the shaping of any proposals but also in any consultation that may be required in respect of any proposed changes to service delivery.

9 **Resource Implications**

9.1 The resource implications are none in respect of the writing of this paper which has simply acted to provide further information in respect of work already underway and fully supported.

Alex McMahon
** Acting Director, Strategic Planning**
15 September 2011
Alex.mcmahon@nhslothian.scot.nhs.uk
## 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 Government:

<table>
<thead>
<tr>
<th>No.</th>
<th>Code/Version</th>
<th>Description</th>
<th>Date</th>
<th>Responsible</th>
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<tbody>
<tr>
<td>1</td>
<td>CEL(2011)022</td>
<td>Human Resource aspects of foundation and specialty training programmes: Changeover dates from 2011-12</td>
<td>14/7/2011</td>
<td>DHR &amp; OD</td>
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<tr>
<td>2</td>
<td>PCA(D)(2011)004</td>
<td>General Dental Services</td>
<td>14/7/2011</td>
<td>DOF, COO, GMPCC</td>
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<td>4</td>
<td>SGHD(CMO)(2011)008</td>
<td>Seasonal Influenza vaccination programme 2011-12</td>
<td>5/7/2011</td>
<td>DOF, DPHHP, GMPCC</td>
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<tr>
<td>5</td>
<td>PCA(O)(2011)002REVIEW</td>
<td>General Ophthalmic services eyecare integration</td>
<td>19/07/11</td>
<td>COO, GMPCC, DOF</td>
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<tr>
<td>6</td>
<td>EFA(2011)001</td>
<td>Domestic type Beko/Lec fridge freezers (various colours)</td>
<td>18/07/11</td>
<td>DOF, DOF GMPCC</td>
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<tr>
<td>7</td>
<td>PCS(DD)(2010)006APPENDIXB</td>
<td>Pay and conditions of service for dental public health, community dental staff and salaried general dental practitioners</td>
<td>28/7/11</td>
<td>DOF, DHR &amp; OD, COO, GMPCC</td>
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<td>8</td>
<td>SGHD(CMO)(2011)010</td>
<td>JCVI advice on the pneumococcal vaccination Programme for people aged 65 years and older.</td>
<td>15/08/11</td>
<td>DPHHP,</td>
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<tr>
<td>9</td>
<td>PCA(M)(2011)012</td>
<td>The general medical services 2011/12 settlement: QOF Quality and Productivity indicators</td>
<td>15/08/11</td>
<td>DOF</td>
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<td></td>
<td>PCA(P)(2011)009</td>
<td>Additional pharmaceutical services: Public health service poster campaigns.</td>
<td>22/08/11</td>
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<tr>
<td>11</td>
<td>PCA(P)(2011)010</td>
<td>Pharmaceutical services: Community Pharmacy Practitioner Champions</td>
<td>25/08/11</td>
<td>DOF, GMPCC</td>
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<tr>
<td>12</td>
<td>PCA(D)(2011)005</td>
<td>General Dental Services. Amendment No 120 to the statement of dental remuneration – incorporation of childsmile practice into the statement of dental remuneration.</td>
<td>05/09/11</td>
<td>DOF, GMPCC</td>
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Douglas Weir  
Corporate Services Manager  
20 September 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